Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 4th May 2023, commencing at 9:00am

Lecture Theatre 4, Institute in the Park, Alder Hey

AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00AM-9:15AM)							
1.	**23/24/01**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/02**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/03**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **30th March 2023.**	**D**	Read enclosure
4.	**23/24/04**	**9:19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**23/24/05**	**9:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**23/24/06**	**9:30 (15 mins)**	**Patient Safety Strategy; including:** • **Plan for 2023/24.**	Patient Safety Strategy Programme team	For information and assurance purposes.	**A**	Presentation
Strategic Update and External Partnerships							
7.	**23/24/07**	**9:45 (20 mins)**	**Vision 2030 Strategy Update:** • **Implementation of the Vision 2030 Strategy.** • **Plan for Year 1.** • **Monitoring of the Plan**	L. Shepherd/ J. Grinnell/ D. Jones	To receive an update on the work that is taking place on the Vision 2030 Strategy.	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			for Year 1.				
8.	**23/24/08**	**10:05 (10 mins)**	**Growing Great Partnerships; including:** • **ICS Update.**	D. Jones	To receive an update.	**N**	Read report
Operational Issues							
9.	**23/24/09**	**10:15 (60 mins)**	• **Integrated Performance Report for M12.** • **Proposal for changes to the IPR, 2023/24.** • **Initial 'flash' report.** • **Finance Report for M12, 2022/23** • **Financial Plan for 2023/24.** • **Digital, Data and Information Technology Update.**	Exec Leads/ Divisional Leads K. Warriner K. Warriner R. Lea R. Lea K. Warriner	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. For approval. For information and discussion. To receive an update on the current M12 position. To receive an update. To receive an update on the current position.	**A** **D** **N** **A** **A** **A**	Read report Read report Read enclosure Presentation Presentation Read report
10.	**23/24/10**	**11:15 (5 mins)**	**Industrial Action Update.**	N. Askew	To receive an update on the current position.	**A**	Verbal
Lunch (12:15pm-12:35pm)							
11.	**23/24/11**	**11:20 (10 mins)**	**Alder Hey in the Park Campus Development Update; including:** • **Land buy back update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation. To receive an update on the current position.	**A** **A**	Read report Verbal
12.	**23/24/12**	**11:30 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 24.4.23.** - **Approved minutes from the meeting held on the 27.3.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 27.3.23 .	**A**	Read enclosure
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
13.	**23/24/13**	**11:35 (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
14.	**23/24/14**	**11:40 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 19.4.23.** - **Approved minutes from the meeting held on the 22.3.23.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 22.3.23.	**A**	Read enclosure
Game Changing Research and Innovation							
15.	**23/24/15**	**11:45 (5 mins)**	**Research and Innovation Committee:** - **Chair's verbal update from the meeting held on the 18.4.23.** - **Approved minutes from the Innovation Committee meeting held on the 6.2.23.**	S. Arora	To escalate any key risks, receive updates and note the approved minutes from the 6.2.23.	A	Read enclosure
The Best People Doing Their Best Work							
16.	**23/24/16**	**11:50 (10 mins)**	**People Plan Highlight Report.**	M. Swindell	To receive an update.	**A**	Read report
17.	**23/24/17**	**12:00 (10 mins)**	**EDI Update.**	M. Swindell/ G. Dallas	To receive an update on the current position.	**A**	Read report
18.	**23/24/18**	**12:10 (15 mins)**	**Equality Act:** • **WRES Report.** • **WDES Report.** • **Gender Pay Gap**	M. Swindell	For noting.	**N**	Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			Report.				
19.	**23/24/19**	**12:25 (15 mins)**	**FTSU Update; including:** • **Freedom to Speak Up – Review Tool for Boards.**	K. Turner E. Saunders	To receive a quarterly FTSU update. For information.	**A** **N**	Read report Read report
Lunch (12:40 – 13:00)							
Strong Foundations (Board Assurance)							
20.	**23/24/20**	**13:00 (10 mins)**	**Recognition of the Trust as a Going Concern.**	R. Lea	For assurance and approval.	**D**	Read report
21.	**23/24/21**	**13:10 (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
22.	**23/24/22**	**13:15 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 20.4.23.** - **Approved minutes from the meeting held on the 12.1.23.**	K. Byrne	To escalate any key risks, receive updates and note approved the minutes from the 12.1.23.	**A**	Read enclosure
23.	**23/24/23**	**13:20 (5 mins)**	**Directors' Register of Interests**	E. Saunders	For assurance purposes.	**A**	Read report
Items for information							
24.	**23/24/24**	**13:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
25.	**23/24/25**	**13:29 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 8th June 2023, 9:00am, Meeting Room TBC							

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

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M12, 2022/23	R. Lea

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 30th March 2023 at 9:00am**
in Meeting Room 2 and 3, Liverpool Innovation Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
`	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Board/Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 22/23/311	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Item 22/23/316	Ms. V. Charnock	Arts Co-ordinator	(VC)
Apologies	Mrs. S. Arora	Non-Executive Director	(SA)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Dr. U. Das	Director of Medicine	(UD)

22/23/305 Welcome and Apologies

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

22/23/306 Declarations of Interest

There were none to declare.

22/23/307 Minutes of the previous meetings held on Thursday 23rd February 2023
Resolved:
The minutes from the meeting held on the 23rd of February were agreed as an accurate record of the meeting. .

22/23/308 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

22/23/309 Chair's and CEO's Update

Louise Shepherd opened the meeting by drawing attention to the great position the Trust is in at the end of the year despite the challenges that the NHS has experienced during 2022/23. On behalf of the Board, Louise Shepherd thanked all those involved for the hard work that has taken place to help the Trust achieve this position. The Board was advised that two hours has been set aside during the meeting to talk about the future of Alder Hey and the work that has taken place to progress the Vision 2030 Strategy.

Liverpool Health Partners (LHP) - The Board was advised that LHP is in a much better place than it was nine months ago as a result of a refresh and coalescing around the research opportunity that Liverpool presents. Work is being undertaken with higher education institutes to look at how LHP can move forward with its partners. There is a renewed energy following the appointment of the new Vice Chancellor of the University of Liverpool, Tim Jones who is very interested in the LHP concept and becoming an integral partner. Tim Jones has agreed to Chair the LHP Board on an interim basis and Seamus O'Neil has been appointed as the interim Managing Director for LHP. This will bring the wider eco system into the partnership and help cement the city's assets.

NHS Providers Chairs and CEOs Session – The Chair provided an overview of the session that was arranged by NHS Providers for Chairs and CEOs on the 23.3.23. The Chief Finance Officer for NHSE/I, Julian Kelly presented to the group and drew attention to the importance of reducing agency spend and increasing productivity. A discussion took place on finance and the lack of public confidence in the NHS.

Children and young people (CYP) were referred to as was mental health and it was acknowledged that a strategy is required for CYP, and the issues relating to mental health need to be addressed. Concerns were raised by the various Chairs and CEOs in relation to staff retention, workforce burnout, industrial action, deteriorating buildings, the lack of social care in the adult sector and Covid not being over. During the workshop, the Chair shared information on the proactive work that is taking place at Alder Hey and the progress that is being made with the Trust's Vision 2030 strategy.

Vision 2030 Strategy – The chair set the scene for receiving the Vision 2030 Strategy presentation and drew attention to the experience and talent that the Trust has that will drive the strategy forward to help children and young people (CYP) have a healthy future that Alder Hey is aspiring to in its vision. Louise Shepherd highlighted the line of sight between the three pitches and the Trust's vision; local, regional, and national and emphasised the importance of having a narrative that will provide the public with assurance that the NHS is moving forward.

The Chair concluded this item by congratulating Louise Shepherd on her appointment as the new Chair of the National CYP Transformation Board.

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

22/23/310 Vision 2030 Strategy Update; including:

The Board received the Vision 2030 strategy report and a video that has been produced to support the socialising of the strategy internally and externally. The

report provided detail on the following areas;

- The Trust's vision.
- How the strategy has been developed.
- Areas of need from a CYP perspective.
- The engagement that has taken place with CYP, families and staff.
- Supporting staff via the Trust's People Plan.
- Delivering the 2030 Strategy.
- Leading the change
- Next steps.

It was pointed out that Alder Hey has built up strong partnerships and a strong voice for CYP during a period of time when complex changes are taking place and it is this that will support the delivery of the Vision 2030 Strategy. It is necessary to weave in the organisation's ambitions whilst understanding local, regional and national requirements in order to meet the changing needs of CYP and families. The strategy provides a clear line in terms of how the Trust connects with its partners. The Trust's focus remains on improving health outcomes for CYP and families, and in turn, delivering healthier futures. The strategy also recognises the importance of CYP's happiness and wellbeing, as a core part of their healthiness. It was pointed out that there is a lot to be done to enable CYP to have a holistic experience, for example, children don't think that mental health and physical health should be treated separately and yet they attend different services.

Attention was drawn to the detailed population segment analysis of service users' needs on page 8 of the report and it was pointed out that each cohort of CYP has different needs and yet often their care is organised and delivered in the same way. In order to make a difference it is necessary to recognise the different needs for each cohort therefore the Trust conducted genuine, robust engagement sessions with CYP and families which allowed the organisation to test its ideas about creating a world where children and young people can live their best lives. The Trust's approach was co-designed with CYP and families to enable all voices to be heard, across all cohorts. It was reported that CYP and families share Alder Hey's ambition for the future, but they also had some frustrations and ideas for areas that the organisation can learn from to make the future better. The Trust received feedback as a result of the engagement sessions which highlighted that 74% of respondents want a healthier, happier, and/or fairer future.

The 'Plan on a Page' was referred to (*page 15 of the report*) and the Board was advised of the work that has taken place on outcomes and the work that is to be undertaken to build capability/capacity to create some of the new outcome measures.

An overview was provided of the changes that need to be made to design and implement a governance model that provides the organisation's ambition with space and capability to thrive. There was a focus on the proposal and Terms of Reference (ToR) for the new Strategy Board that is to be created which will meet on a quarterly basis before the main Trust Board.

It was reported that the Strategy Board ToR will be underpinned by a specific work plan and strategic dashboard reflective of the organisation's agreed outcomes; the work plan will include provision for the Strategy Board to meet in public when in formal decision-making mode. It is proposed that the Strategy Board will have its own Board Assurance Framework (BAF) which will be driven by the work of the four proposed delivery clusters which focus on key areas of need: Get me well,

personalise my care, improve my life chances and bring me the future today, each of which will contain programmes of work with associated outcomes.

Attention was drawn to the way in which the organisation will approach risk in terms of delivering the 2030 Strategy. There is to be a BAF approach and it was reported that a great deal of work has already taken place around risk appetite. The Board is yet to discuss and agree its risk appetite in relation to the new aspects of the 2030 Strategy that relate primarily to areas of need, but it is recognised that to deliver the Trust's ambition it might be necessary to cease or radically change some historical activities. The risk inherent in this will be carefully assessed and quantified.

Responses were provided to a number of questions that were raised relating to the new governance model in terms of what it will mean for the Trust Board and what the new structure that sits under the Trust Board will look like. A query was also raised about the process for measuring and monitoring the impact and outcomes of the four delivery clusters which focus on key areas of need.

The Chair pointed out that the new governance model outlines a different way of working and recognised that it is work in progress. The Board took time to discuss the remit of the Trust Board and the new Strategic Board.

The Chair asked Board members if they were in agreement to ratify the 2030 Strategy and approve the proposed approach to evolving the organisation's governance arrangements to oversee the strategy. The Board confirmed its agreement of these recommendations.

Louise Shepherd thanked the Associate Director of Transformation, Natalie Palin for the amount of work that has been conducted on the Vision 2030 Strategy.

Resolved:
The Board ratified the Vision 2030 Strategy and approved the proposed approach to evolving the organisation's governance arrangements to oversee the strategy.

2023/24 Integrated Annual Plan

The Board received the 2023/24 Integrated Operational Plan that sets out Alder Hey's objectives for the year ahead and the underpinning workforce, financial and activity plans. It was pointed out that 2023-24 is a pivotal year as the Trust embarks on the implementation of its 2030 strategy.

An overview of the paper was provided and attention was drawn to the eight key priorities of the plan and the approach for delivering them. It was pointed out that during the forthcoming year there will be a real focus on patient safety, increasing the size of the workforce, advancing Alder Hey's clinical research portfolio, handing Springfield Park back to Liverpool City Council, improving access to care/addressing the challenges of waiting lists and remaining financially sustainable.

Attention was drawn to the reflections element of the report and some of the Trust's key achievements in 2022/23; awarded the Freedom of Sefton Borough, won the national HSJ Award for Elective Recovery as part of the Children's Hospital Alliance Paediatric Recovery Partnership, achieved financial controls, launched innovative apps.

A slide was shared with the Board to advise of the approach that is to be used to

deliver the 2023/23 Annual Plan. The following points were highlighted:

- Senior Responsible Officers will be assigned for each strategic initiative.
- The Transformation team will focus on driving the ten strategic goals.
- New strategy deployment score card will be produced to track performance, progress and impact. Oversight and assurance will be provided by the Strategy Board.
- In year priorities will need to be addressed.
- Divisions are key to the success of the plan and will need to be supported.
- The Integrated Performance Report will continue to be produced.

Financial Planning – The Trust has set its target for 2023/24 at breakeven and is planning to remain within its allocation and hit the breakeven target. There is a minimum efficiency recurrent target of 5% and a requirement for signed commissioner contracts for all activity provided. Work has been taking place with the Divisions and the plan was submitted to the national team on the 30.3.23.

John Grinnell explained that the plan is in draft form as there may be some national changes laid out in April that will require further work to be conducted. It was pointed out that the pay award has brought a new dynamic to the financial plan and there is a need to understand what it means for trusts at local level.

The Chair felt that the 2023/24 Integrated Annual Plan sets out the issues for the Trust and thanked all those involved in compiling the report as it is a splendid piece of work.

Resolved:
The Board approved the 2023/24 Integrated Annual Plan.

People Plan

The Board was presented with the Vision 2030 People Plan for Alder Hey. A number of slides were shared which provided the following information:

- *We are a people organisation* - There are four objectives that link to the People Plan; look after each other, create a sense of belonging, embrace new ways of working, learn and grow for the future.
- The reality of the operating environment and market highlights the need for the Trust to think differently; challenging labour market, growing NHS workforce challenges, cost of living crisis, staff wellbeing and burnout. Compounding this is the Trust's current workforce dynamics therefore there is a need for a shift in mindset to drive the Vision 2030 forward.
- The design principles for the Vision 2030 People Plan.
- Developing the Trust's People Plan.
- The estimated impact of the Trust's people interventions.

Points were raised about the possibility of being able to craft training programmes with universities and colleges to ensure students have specific skills that the Trust is looking for in future employees, developing a paediatric workforce for the future, and having a brand that will depict Alder Hey as a family friendly organisation that leads in this area.

The Chair asked as to how this area of work will be taken forward and queried the next steps. The Board was advised that resources are required to progress the Vision 2030 People Plan therefore a business case is to be compiled and submitted

to the Executives for approval. It was confirmed that the Board will receive progress updates and assurance on particular activities via the People and Wellbeing Committee (PAWC).

Resolved:
The Board noted the 2030 Vison People Plan presentation.

Futures in Vision 2030

The Board received a presentation on Futures in the Vision 2030 Strategy. A number of slides were shared that provided information on the following areas:

- *The Trust's vision*: A healthier, happier and fairer future where every child and young person can achieve their full potential.
- *CYP Areas of Need:* Get me well, make my care more personal, improve my life chances, bring me the future today.
- *Strategic Goals:* Unrivalled experience, supporting colleagues, pioneering breakthroughs, collaborating for CYP, smartest ways or working.
- *Strategic Initiatives:* Futures.
- Creating better solutions to real problems.
- Priorities for patient impact.
- Physical and virtual delivery structure.
- Integrated infrastructure and futures facility.
- Collaborating to meet the needs to CYP and removing internal barriers to focus on priorities and facilitate delivery.
- Designing and deploying the strategy;
    - Q1: A portfolio review will be undertaken and in depth conversations will take place with staff to test the strategy.
    - Q2: (Implementation Plan): Work will take place to shape leadership and governance around the five areas of opportunity.
    - Q3/4: The Trust will lock in delivery partners, secure external investment, and agree as to which solutions are to be launched/progressed.

The Board felt that real progress has been made on this area of work and discussed the cultural change that will be required to drive this programme forward, and the work that will need to take place if the Trust decides to progress its international strategy. The Chair confirmed the Board's support for the development of an international strategy.

The Chair thanked John Chester and Adam Bateman for their presentation and advised that updates on progress will be received via the Research and Innovation Committee and the Resources and Business Development Committee (RABD).

Resolved:
The Board noted the presentation on Futures and confirmed its support for the development of an international strategy.

ICS Update

The Board received a progress update on the ICS. A number of slides were shared Which provided the following information:

- System – What's new?
  Cheshire and Merseyside ICS;
  - Place delegations remain unclear.
  - New governance proposals are to be submitted to the ICB in March;
    - CYP Board (Sub-committee).
    - North West Specialised Services Committee (Joint Working Agreement).
    - Oversight of Liverpool Women's Hospital (LWH)/new Care Model (Sub-committee).
  - Hewitt Review is being finalised (*Publication end of March 2023*).

  Health Care Partnership;
  - Joint 5 year forward plan – CYP prioritised.
  - Links with HCP Chair are developing.

  Beyond;
  - Beyond Conference was attended by 120 partners from NHS, Social Care, VCSE sectors and was facilitated by Young People

  CMAST Provider Collaborative;
  - Selected for national Provider Collaborative Innovator Scheme (one of 9).

  LDMHC Provide Collaborative;
  - Proposals for future governance are still being worked up.
  - Building in emphasis on CYP community services.

  Liverpool Place;
  - Looking at priorities for urgent care and maternity following the outcome of the Liverpool Clinical Review.
  - Strategic Board with LWH is in development.
  - One Liverpool Population Health Summit – Work is taking place collectively to look at the architecture in Liverpool.

It was reported that the CMAST Provider Collaborative has agreed to come together to coalesce around community services and it was pointed out that Alder Hey's contribution to this will be invaluable. It was felt that the work done collectively will be vital to the next step of the collaborative's development, as will the Children's Board.

For clarity purposes, the Chair felt that it would be beneficial to receive a paper that provides an overview of the various bodies detailed in the update to see how they interlink, the impact that they have on CYP, and determine the Trust's influence.

22/23/310.1 Action: DJ

Resolved:
The Board noted the ICS update.

Liverpool Clinical Services Review - Update

NHS England (NHSE) have been informed of the outcome of the Liverpool Clinical Services Review and are waiting to hear about the direction that will be taken to move forward with the recommendations, and the framework that is to be developed for doing this in collaboration. A further meeting will take place in September with NHSE to provide an update on progress.

It was reported that a number of trusts will work in collaboration on solving the clinical sustainability challenges that LWH are facing which are affecting women's health in Liverpool, and the development of a wider acute services strategy.

The Board was advised that a Clinical Services Review meeting took place on the 29.3.23 to look at a structure for bringing acute services together as a collaborative.

Attention was drawn to the importance of working collectively to support LWH in the next phase.

Resolved:
The Board noted the Liverpool Clinical Services Review update.

22/23/311 DIPC Report Q3

The Board received an update on infection, prevention, and control (IPC) for the quarter 3 reporting period. A number of slides were shared that provided information on the following areas:

- IPC exception report for February 2023.
- Data on Klebsiella cases, E. coli cases and Pseudomonas cases.
- The impact of Covid-19 on multidrug-resistant organisms causing healthcare-associated infections.
- Risks.

The Board was advised of the relaunch of the IPC Policy as masks are no longer in use in inpatient areas. It was pointed out that there will be some adjustments to the policy for certain areas but overall it is a symbolic move for Alder Hey. John Grinnell thanked the Director of IPC, Bea Larru for leading this area of work in a scientific and safe way.

Resolved:
The Board noted the IPC report for Q3

22/23/312 Operational Issues

Integrated Performance Report, M11

The Board received the Integrated Performance Report (IPR) for Month11. An update was provided on the following areas of the IPR:

- Outstanding Safety - *Safe;*
  - There were no Serious Incidents or Never Events reported in February.
  - It was confirmed that there has been a continued improvement in inpatient sepsis screening.
  - There has been a reduction in the number of patients deteriorating from an inpatient bed admitted to Critical Care.
  - The Emergency Department (ED) achieved 83% compliance against a 90% target for the administration of antibiotics within 1 hour for sepsis.
  - There was an increase in reporting of the use of physical restrictive intervention. This relates to one person on the acute site.
  - *Nursing Workforce:* There were no red shifts in February. It was reported that the Trust will be reviewing the guidance for safe staffing ahead of the winter.

- *Outstanding Safety - Caring;*
  - There has been an improvement in the Friends and Family Test (FFT) scores and a reduction in complaints.
  - The Trust has seen a continued improved performance in relation to responding to PALS concerns within 5 days and complaints within 25 days.

- Recovery and Access – *Effective*
  - The Board was advised of the high level of recovery in outpatients.
  - Waiting time for Diagnostics is now at 75% within 6 weeks and showing special cause variation due to successful improvement actions.
  - The Trust has achieved 100% compliance with cancer access standards.

- Recovery and Access – *Responsiveness*
  - The number of patients waiting for treatment has significantly increased over the last twelve months. The main factors relate to the impact of industrial action, provision of mutual aid, and a significant increase in ENT as a result of urgent referrals taking priority. For the year ahead a target of >66 weeks has been agreed for RTT patients post-industrial action rather than 52weeks.

    It was reported that all patients waiting for treatment >78 weeks have been offered an appointment, this includes provision of mutual aid to the Royal Manchester Children's Hospital (RMCH). Unfortunately a small number of patients were either ill and unable to attend or refused the allotted time provided.

- Well Led – *Great Place to Work (People)*
  - Sickness absence is above target at 5.8% but showing small improvements.
  - Mandatory training remains above target.
  - PDRs have shown an improvement in month with over 72% now completed. It was confirmed that the target will be met by the end of March 2023.
  - Turnover remains high at 15%. Work is taking place to address this issue and is a main focus for the Trust.

- Well Led – *Financial Sustainability* (*Finance)*
  - M11 - The Trust is reporting a surplus of £2.2m which is £1.1m ahead of the planned position.
  - It was reported that the Trust is expected to achieve a forecasted outturn position of £6.1m as approved in M10 and is seeking to increase a further £1m to £7.1m to help support Cheshire and Merseyside.
  - The Cost Improvement Plan target of £17.3m has been achieved.
  - There is a short fall of 43% in recurrent CIP which will be carried over into 2023/24.

- Well Led – *Risk Management*
  - A focus is required to ensure risks are reviewed on the respective date.

- Well Led – Safe Digital System – *Digital*
  - The Trust's new intranet is live.
  - Progress has been made on the new Risk and Incident Management system ahead of the planned 'Go Live' date in April 2023.
  - Aldercare 'Go Live' planning is in progress with an approved go live window of early September 2023. Progress continues on the build, but it was pointed out that there are delays to automated pharmacy solutions. Work is taking place with the pharmacy team and the Division of Medicine to support progress. It was reported that the programme has gone through the second gateway and the organisation is preparing for implementation readiness. The Trust has appointed a manager to work on the go live package for colleagues.

Community and Mental Health Division

- The Division was successful in a joint bid for peer support workers in ASD.

- It was reported that a provisional date of the 11.4.23 has been provided in terms of moving into Sunflower House.
- PDR compliance for the Division is at 93%.

The Chair advised Non-Executive Directors to liaise with Lisa Cooper if they would like to have a tour of Sunflower House.

Division of Medicine

- Work is taking place to understand the concerns that have been raised about the Sepsis Policy not being followed in ED.
- The Division is working together to look at the way it allocates surgical lists in order to improve efficiency.

Division of Surgery

- On the day cancellations have increased due to sickness/emergencies. It was reported that staff sickness rates are the highest they have ever been.
- *Dentistry*: The Dentistry outsourcing service has commenced and numbers are starting to improve.
- *ENT*: The Division has looked at options to reduce the volume of patients waiting for treatment and the team has agreed to conduct additional activity during the week. Despite this there is still a large volume of patients that need to be seen therefore a decision has been made to outsource the ENT service. Three Paediatric Consultants have been selected who could offer their services.

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

Industrial Action

The Board was advised of the forthcoming five-day industrial action that is being taken by junior doctors from the 4th of April to the 8th of April. It was confirmed that plans are in place as per previous industrial action and the Trust is confident that it will have enough cover during this period of time. Discussions are taking place ahead of the 4th to look at maximising day surgery and adjusting some of the arrangements that can be addressed after the strike action. The BMA has issued another rate card from the 1.4.23 with a small increase based on inflation. The message from the Medical Director of the region is that trusts should move to this new rate card. It was reported that the Trust is awaiting correspondence today from the Integrated Care Board (ICB) confirming this arrangement. On behalf of the Board, Louise Shepherd thanked all those involved in keeping the hospital operational and safe during industrial action.

Resolved:
The Board received and noted the content of the IPR for Month 11.

22/23/313 Alder Hey in the Park Campus Development Update

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

- *Neonatal and Urgent Care Development* – The blue light road (BLR) work is due to be completed on the 3.4.23. It was reported that this is five weeks later than anticipated due to an LV cable diversion required to the Institute in the Park. This work was being managed by the Trust under a separate project that

was instructed but has since been added to Morgan Sindall's scope of works due to dependencies with the BLR diversions.

- *Sunflower House Construction* –It was confirmed that the second phase of the move is imminent.
- *Fire Compliance/Sprinklers (Sunflower House Car Park)* - Due to a risk relating to fire compliance a decision has been made to close the car park under Sunflower House for a six-month period until a sprinkler system has been installed.
- *Police Station* – There has been a delay in getting the design released for the modernisation of the Police Station. It was confirmed that work is taking place to address this matter.
- *Park Reinstatement* Park – Work is progressing and discussions are on-going regarding a strategy for lighting connection.

Resolved
The Board received and noted the Campus Development update provided on the 30.3.23.

22/23/314 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 21.2.23 were submitted to the Board for information and assurance purposes. During March's meeting the Committee focussed on the year end, the cash in the bank and international development.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 21.2.23.

22/23/315 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 1.2.22 to the 28.2.23. The following points were highlighted:

- The Trust declared zero Never Events and zero SIs during the reporting period.
- There were zero SIs opened during the reporting period, and one SI investigation was closed.
- It was confirmed that the Trust is fully compliant with Duty of Candour.
- The action plan relating to StEIS reference 2022/20661 was closed during the reporting period. Nathan Askew thanked the consultants involved who drove the actions forward.

Louise Shepherd felt that the SI report has improved remarkably of late and thanked all those involved in achieving this. It was reported that the Associate Director of Nursing and Governance, Jackie Rooney has been fundamental in managing this area of work.

Resolved:
The Board received the Serious Incident report for the period from the 1.2.23 to the 28.2.23.

22/23/316 Arts for Health Programme

The Board received an update on the Arts for Health programme. A number of slides were shared that provided information on the following areas:

- Overview of the programme.
- Benefits of the programme; increases self-esteem/confidence, reduces anxiety and isolation, reduces the need for medication and shortens the length of stay in hospital.
- 'Music Matters' evaluation.
- Priorities for the Arts Strategy.
- Key projects for 'Minds Matter'
- Plans for a three year photography, animation and film making programme to support mental wellbeing and recovery which is being funded by Children in Need.
- Arts interventions for patients referred to the Trust's Eating Disorder Youth Service (EDYS).
- *Theatrical Minds*: On-going programme running on the Mental Health In-patient Unit with the Everyman and Playhouse Theatres to boost confidence and self-esteem, promoting recovery and re-engagement with education.
- *Creative Pathways*: Two year programme with partners, Tate Liverpool, National Museums Liverpool and DaDaFest, funded by the Arts Council.
- *The Dreams Programme*: Social prescribing programme with offers CAMHS patients aged 8-18 years up to ten hours of contact time with an artist of their choice. Sessions are individual and tailored to patients' needs.
- *The Lullaby Project:* Four month programme delivering twice weekly sessions on the Neonatal Unit supporting parents and carers.
- *Music ED:* Music is used within critical procedures to help distract the child. Procedures are delivered more effectively and calmly, with greater patient compliance.
- The impact of the programme and the priorities for 2023/24.

A discussion took place after the presentation concluded and a number of suggestions were made by Board members in relation to;

- Adapting the music element of the programme to support staff health and wellbeing.
- Linking elements of the 'Arts for Health' programme with the Trust's 2030 Vision Strategy.
- Looking at using the park space for families and patients.
- Progressing the research and social prescribing angle.
- Linking in with Liverpool Lighthouse Charity who use engagement with the arts in the community to improve people's wellbeing.

Nathan Askew informed the Board that work is taking place to develop a more strategic approach for this area of work which will link in with patient experience, etc. The Charity is also supportive of this work which will help the Trust move forward with its vision.

The Chair thanked Vicky Charnock for the incredible single-handed work that has taken place throughout the year and drew attention to the importance of ensuring that this programme is an integral part of the Trust's Vision 2030 Strategy. The Chair invited Vicky to attend a forthcoming informal meeting with the governors to showcase the work of the 'Arts for Health' programme.

22/23/316.1 Action: KMC

Resolved:
The Board noted the update on the 'Arts for Health' programme.

22/23/317 Safety and Quality Assurance Committee (SQAC)

The approved minutes from the meeting held on the 22.2.23 were submitted to the Board for information and assurance purposes. During March's meeting the Committee received a report that highlighted the shortage of medicine in the Pharmacy department and the mitigations in place to address this national issue. The Committee also focussed on the work that is taking place on transition. This relates to the number of patients aged 14+ who will be discharged back to their GP or will need support when transitioning onto adult services

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 22.2.23.

22/23/318 Government Offer in Principle for the NHS Agenda for Change Workforce

The Board received the report detailing the Government's offer in principle for the NHS Agenda for Change Workforce. It was reported that a simplified version of the report will be shared with the organisation and discussions are taking place with RCN colleagues about arranging a session on this matter for their members.

Resolved:
The Board received and noted the Government's offer in principle for the NHS Agenda for Change Workforce.

22/23/319 People and Wellbeing Committee (PAWC)

The approved minutes from the meeting held on the 18.1.23 were submitted to the Board for information and assurance purposes. During March's meeting the Committee received the People Plan, the 2022 Staff Survey results and approved the following reports; Workforce Race Equality Standard (WRES) report, the Workforce Disability Standard report (WDES), the Consultants and SAS Job Planning Policy and the Reasonable Adjustment Policy. The Committee also agreed the Trade Union Partnership and discussed risk profiling/tolerances.

Resolved:
The Board noted the update and approved minutes from the meeting held on the 18.1.23.

22/23/320 Equality, Diversity, and Inclusion (EDI) Steering Group

The approved minutes from the meeting held on the 16.1.23 were submitted to the Board for information and assurance purposes. During March's meeting the Committee focussed on the EDI strategic plan and governance structure, staff network guidelines, gender pay gap figures and how the Trust compares to other organisations. A deep dive took place around the Clinical Excellence award, and it was felt that further work needs to be done on inclusivity. Going forward the group will review a particular case that lessons can be learnt from and is looking to embed zero tolerance across the Trust via the Chairs of the Staff Networks.

Resolved
The Board noted the update and approved minutes from the meeting held on the 16.1.23.

22/23/321 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 a full suite of deep dives have taken place during the course of the year which the Assurance Committees found really helpful.
- Attention was drawn to the issue relating to the shortage of medicine. It was confirmed that a discussion is going to take place with the Chief Medical Officer and the interim Chief Pharmacist about whether this matter should be classed as a standalone risk or a gap in control/assurance.

Resolved:
The Board received and noted the contents of the Board Assurance Framework report as at the end of February 2023.

Corporate Risk Register
Resolved:
The Board received and noted the Corporate Risk Register for the reporting period 1.12.22 to the 31.1.23.

22/23/322 Any Other Business

There was none to discuss.

22/23/323 Review of the Meeting

It was felt that a number of important decisions have been made as a result of the time set aside to discuss the Trust's Vision 2030 Strategy. The Chair pointed out that as the Trust moves forward in its new format consideration will need to be given at all times in terms of the decisions made by Alder Hey and how they impact the system. The Chair endorsed the comments made about the remarkable year end position the Trust is in and paid credit to all those involved who helped Alder Hey achieve this position.

On behalf of the Board, the Chair bid Ian Quinlan farewell and wished him all the very best for the future. The Board reflected upon Ian's time as a Non-Executive Director with the Trust and drew attention to the work and projects that he has been instrumental in progressing over the years. The Chair and Chief Executive thanked Ian for being a wonderful colleague and helping the Trust to manage its finances via his role as Chair of RABD.

Date and Time of Next Meeting: Thursday the 4th May at 9:00am, LT2, 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 May 2023							
27.10.22	22/23/179.1	Freedom to Speak Up (FTSU) Update	*Deputy FTSUG Position* - Review the current time provided to the FTSUG and consider as to whether this time could be increased. Compile a plan for moving forward.	K. Turner/ E. Saunders/ K. Byrne	15.12.22	May-23	**29.3.23** - An update will be provided in May when the FTSU report is submitted to the Board. **ACTION TO REMAIN OPEN**
23.2.23	22/23/287	Mortality Report, Q3	Liaise with Julie Grice to discuss the possibility of adjusting data from prior years to show a more like for like comparison in table and graphs in the report.	A. Bass	30.3.23	May-23	
Actions for June 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	Jun-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. **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. **ACTION TO REMAIN OPEN**
24.11.22	22/23/208.1	Board Assurance Committees	Arrange for a patient story to be shared with the Board in May based on the Sensory Project that was discussed at SQAC.	K. McKeown	25.5.23	Jun-23	29.3.23 - It has been arranged for this story to be shared in June. **ACTION TO REMAIN OPEN**
Actions for July 2023							
24.11.22	22/23/198.1	Integrated Performance Report - Divisional Performance Update	*Division of Medicine* - Invite the Histopathology Team to April's meeting to provide an update on the work that is being undertaken by the team (post mortems and placenta work for North Wales/support for Birmingham Children's hospital, etc.)	M. Carmichael/ K. McKeown	27.4.23	July-23	29.3.23 - The Histopathology Team are to be invited to July's meeting. **ACTION TO REMAIN OPEN**
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	On track July-23	
Actions for October 2023							
27.10.22	22/23/185.1	Review of Meeting	Invite a black member of staff to present to the Board during 'Black History Month'.	K. McKeown	26.10.23	On track Oct-23	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
26.1.23	22/23/243.1	Chair/CEO's Update	*GIDS* - Provide an update on the gateways for the Gender identify Development Service.	L. Cooper	30.3.23	Closed	**27.4.23** The revised gateways have been submitted to NHS England for consideration and agreement. **ACTION CLOSED**
30.3.23	22/23/316.1	Arts for Health Programme	Invite Vicky Charnock to the informal governors meeting with the Chair to showcase the work of the 'Arts for Health' Programme.	K.McKeown	30.3.23	Closed	**27.4.23** - Vicky Charnock is attending the informal governors meeting with the Chair on the 17.5.23. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Strategy 2030**
Report of:	Dani Jones, Director of Strategy and Partnerships John Grinnell, Deputy CEO/ DOF
Paper Prepared by:	Dani Jones, Director of Strategy and Partnerships John Grinnell, Deputy CEO/ CFO Natalie Palin, Associate Director of Transformation Erica Saunders, Director of Corporate Affairs Melissa Swindell, Chief People Officer Mark Flannagan, Director of Marketing and Communications

Purpose of Paper:	Decision ■ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	March 2023, Strategy Board Paper Board Strategy workshops across 22/23
Action/Decision Required:	To note ☐ To approve ■
Link to: **Trust's Strategic Direction & Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Impact:	

1. Introduction

This paper provides an overview of the continued development of our 2030 Strategy and reviews progress against the mobilisation milestones (*as detailed in the Board paper: Strategy 2030 – March 23).* The management and oversight of our mobilisation plan is reported into Strategic Execs on a weekly basis. This allows for transparency and shared accountability in supporting the first phase of our strategy mobilisation.

Over the last month progress has been sustained against the mobilisation plan. The impact of the on-going industrial action has required an extension of deadlines, for staff engagement and mobilisation of Strategic Initiatives workshops. The extension of timescales against the original milestone plan, is not predicted to impact on the material completion of the milestones but provides a more realistic position around individuals capacity to be fully engaged.

The Executive Team are dedicating a proportion of their development session (May), to further advancing the tactics and approach around Governance, CYPF areas of need, and management of the 2030 Strategy Programme.

2. Background and current state

The Trust Board has approved the Strategy 2030 (March 23), with next steps of continuing to evolve our governance arrangements, pivot our change programme and review our leadership approach. This paper provides an update on the progress against the mobilisation plan, as detailed in table 1 : -

Table 1: Mobilisation Plan 2030 Strategy

Mobilisation	By when	RAG Status*
1. Strategic Initiatives - Initiation	Qtr. 1-2	In progress – however capacity risks in 'Our People' strategic initiatives need to be resolved
2. Confirmation of Executive Leadership portfolios and required capacity and capability	Qtr. 1	In progress – completion May 23
3. Implementation of our Strategy 2030 Governance Structures	Qtr. 1	In progress first Strategy Board scheduled (July 23) with supporting governance 'engine room' being finalized
4. Establishment of 'CYPF Areas of Need'	Qtr. 1-2	Draft plan, wider stakeholder engagement across quarter 1, to share plan at first Strategy Board
5. Delivery of our Financial Strategy	Qtr. 2	In progress
6. Our 2030 – Narrative and Communication Plan	Qtr. 1	In progress – Engagement Deadline extension (End May 23), overall completion date not comprised.
7. Development of our Strategic Outcomes – Strategy Exec dashboard	Qtr. 2	Proposal in development
8. Development of Strategic Initiatives – Programme Governance	Qtr. 1	In progress – amended governance approach, in development for final endorsement June 23

**Rag status: Blue to start, Orange in progress, Green completed, Red off Track*

3. Mobilisation of our strategic Initiatives and Executive Portfolios

The mobilisation of our strategic initiatives is dependent on alignment of Executive Leads to all our strategic goals and areas of needs, to ensure that the Strategy plan meets its objectives and delivers the projected benefits. The Strategy 2030 Board paper (March 23) outlined a specific step of updating Trust Board in respect to changes to Executive Leadership portfolios to support achievement of the 2030 strategic direction. The finalisation of this process is due in May 2023 and a full update will be provided thereafter.

Whilst the Executive Director Portfolios are finalised the development of the specific strategic initiatives is being held with key Execs, and wider stakeholders, across professional groups. A standard methodology supported by facilitated workshops led by our Delivery Management Office, is designed to take our conceptual visions into deliverable programmes. This ideation, initiation and implementation is being managed through the Trust's programme management framework.

Table 2: Status update development of our Strategic Initiatives

Strategic Initiatives	Initiation Status	Workshops*	Due Date – Initiation
1.1. CYP&F Engagement & Experience	30%	3 complete	23 June
2.1 Thriving at Alder Hey	0%	TBC	23 June
2.2 Professional Development Hub	0%	TBC	21 Sept
2.3 Future Workforce	0%	TBC	21 Sept
3.1 Futures	0%	30/06/23	21 Sept
4.1 Building Communities	0%	16/05/23	23 June
4.2 Children and Young People's system	0%	16/05/23	21 Sept
5.1 New Care Models	0%	Mid-June date TBC	21Sept
5.2 Digital and Data	0%	05/05/23	23 June
5.3 Insight-led Decisions	0%	05/05/23	21 Sept

**NB. The phasing dates is to provide appropriate amount of time to support robust development. Plus, recognition of areas in need as an important step change that will underpin the wider strategy.*

Status update Strategic Initiatives

- Leadership conversations and facilitated workshops have been arranged with 7/10 Strategic Initiatives.

- There is a risk in the mobilisation of the Strategic Initiatives that sit broadly under **Supporting Our People**, due to the lack of leadership capacity and headspace to develop into full programmes of work *(Thriving at Alder Hey, Professional Development Hub, and Future Workforce*). The mitigation of this

risk is aligned to the outline financial principles which support the mobilisation (Section 6)

Next steps: To continue the development of strategic initiatives in line with the detailed plan.

4. Implementation of our Strategy 2030 Governance Structures

The Trust Board (March 23) approved the development of the Strategy Board, the first meeting has been scheduled for July 23. The inaugural Strategy Board will provide members with an opportunity to review the TOR and the draft work plan, in addition to oversight of the overall strategy development and delivery.

Given the level of industrial action it is inevitable that this has impacted on available Executive capacity, to review the draft proposal for the governance and reporting responsibilities aligned to the Strategy Board and into Strategic Execs. To provide an adequate opportunity to review and develop this, it has been added on the Executive agenda for the development session scheduled in May 23.

Next steps: The detailed schematics, tactics and TOR will be included in the Strategy Board July 23.

5. Establishment of 'CYPF Areas of Need'

The development of our 2030 strategy using a population health-based approach; is undoubtedly the biggest shift in our strategy from traditional NHS models. The effective mobilisation of the 'CYPF Areas of need' will be essential for ensuring that we truly 'organise ourselves' around CYPF requirements and deliver the level of change that children and families have told us they want to see by 2030.

Over the next two quarters we will be testing our thinking around the mobilisation of the 'Clinical Advocates for CYPF areas of need'. This is to ensure that we have a robust framework. The draft proposal for how we mobilise the CYPF areas of need, will be discussed as part of the agenda for the Executive Director Development Day. Wider clinical engagement with key stakeholders both internal and external, will also help us to evolve our thinking, gain buy in and create a shared understanding around what we are seeking to achieve.

Next steps: The CYPF Areas of Need establishment plan, will be shared as part of the agenda for the Strategy Board (July 23).

6. Delivery of our Financial Strategy

The delivery of our financial strategy is scheduled for completion in Qtr. 2 and this is progressing at pace but we do have a risk to delivery against this timeframe to highlight to the Board. Progress on the economic case has been challenging given the ongoing pressures with the national planning round and it would be appropriate

to reassess the timeframe and work required with RABD and report back to the board as part of the next update.

We have continued with finalising an updated version of the long-term financial model `base` case which will take us to 2030. This will be updated to reflect the strategic impact of the strategic initiatives as they develop or as the environmental context changes.

We have however begun the development of some key principles for the mobilisation of our strategic initiatives. The need to agree a set of principles is to ensure that all programmes (regardless of when mobilised) are supported through appropriate investment through a `Seed' investment if required. We will conduct an early phase review through the Executive team, of the investment required and the return on investment to appropriately prioritise the areas that will require investment and also any areas that may need to be progressed at slower pace due to financial constraints and where repurposing may be needed.

Alongside the development of the strategic initiatives, Year 1 of the strategy must also deliver on the transformation change required to achieve the 23/24 Cost Improvement Target of 5% (£17.7m). We cannot have a separate transformation programme to deliver this and therefore work is underway to align opportunities for `quick` Year 1 benefits that will support the significant financial saving that is required this year.

7. 2030 Narrative and communication Plan

The aim of the engagement phase is to allow colleagues to create awareness of Vision 2030, supporting them to have their own conversation in teams and provide input to final strategy for Trust Board sign off, and to begin to build a shared belief – a shared "mission" - in the 2030 vision (Qtr. 1 23/24). As detailed in our 2030 Strategy Board report, we have undertaken a high level of engagement with CYPF and targeted engagement with our people and partners.

Our focus in Qtr. 1 has been about engaging with more layers of Alder Hey, recognising that the initial stages has been engaged heavily with our senior leaders. This current stage of engagement is designed to be undertaken at the team and individual's level. A range of support materials have been produced and made available to assist leaders and individuals with conversations.

It was previously our intention that the detailed staff engagement would be completed by the end of April 2023. In listening to our people and being sensitive to the broader context of working in the NHS and levels of industrial action, we have extended our deadline until the end of May 23. This will not impact on the completion of a final strategy document, which will be shared at the July strategy board.

The feedback that we have received to date, has indicated that teams and individuals have welcomed an opportunity to have a discussion around and agree with the vision. Following the completion of the engagement at the end of May 2023

a detailed report, will be produced with thematic recommendations for inclusion in our Strategy 2030.

The Director of Communications is the SRO for the completion of the engagement plan (with weekly reporting into Strategic Execs). The respective Executive Directors are accountable for ensuring that as many of their teams have an opportunity to have their voices heard. Monitoring of progress forms part of the weekly status update to Execs.

8. Development of our Strategic Outcomes

Our ability to understand if we are achieving the overarching outcomes is reliant on the development of a suite of Performance Measures (linked to plan on a page, Appendix 1). The development of a suite of strategic measures will provide transparency and an ongoing mechanism to monitor progress and achievement.

The 2030 Strategy outcomes will require new methodologies, which will be delivered under the scope of our Strategic Initiative, '**Insight Led Decisions'**. The Programme Initiation framework will support an understanding of current state, future state, and a detailed mobilisation plan.

Whilst the outcome suite is developed proxy indicators aligned to the IPR (as refreshed for 2023), will be used. The Deputy CEO/CFO and Chief Digital and Data Officer are joint SROs for the 'Insight Led Decisions' strategic initiatives.

9. Development of Strategic Initiatives – Programme Governance

Our **2030 Strategy Programme** will be managed in accordance with our programme management standards and supported by our change and programme professional across the trusts. The Delivery Management Office resources and focus is already pivoted to support the mobilisation of our strategic initiatives. The current programme documentation has been updated to reflect the CYPF needs based approach. Modifications to our governance standards is currently underway. The adaptation is required to reflect 'areas of need' and the collaborative leadership and delivery approach.

As we progress through the development of our strategic initiatives over the next two quarters, the development of our dependency / interdependency map, resource and governance framework will provide transparency around assurance, risk management, decision making and collective prioritisation.

10. Conclusion

This paper provides an overview of progress against the high-level mobilisation milestones. Progress has continued to be maintained since last reporting, despite the inevitable disruption that the on-going industrial action has caused. Dates have been extended for our people engagement, but the overall completion date is not current compromised.

Changes to Executive Leadership portfolios to support achievement of the 2030 strategic direction, will be finalised in May 2023 and a full update will be provided thereafter.

The report highlighted a level of risk in the mobilisation of the 'Our People' strategic initiatives, due to leadership capacity. The financial principles outlined in section 6, provide details of the proposed mitigation to avoid a delay in mobilisation.

The Executive team have scheduled specific time in May to finalise the governance tactics and approach; and to refine the mobilisation of 'CYPF areas of need' plan, to allow further engagement before a formal presentation at Strategy Board.

11. Recommendations & proposed next steps

The recommendations following this paper are to note the progress that has been made to date in the mobilisation of our 2030 Strategy recognising the importance of establishing effective ways of working, transparency, and accountability to support our long-term ambitions.

Next steps

1. To continue the development of strategic initiatives in line with the detailed plan.
2. To continue the development of our governance approach including, schematics, tactics, and TOR.
3. To continue to develop our approach in supporting the mobilisation of 'CYPF areas of Need'.
4. To continue with our people engagement as detailed and provide results and recommendations following completion.
5. To continue to develop our programme management approach to ensure effective alignment with our areas of need and overall strategic direction.

Appendix 1: 2030 Plan on a Page

Plan on a Page

Vision	Objectives	Delivered Through (Exec Lead)		Outcomes	Measures
Healthier, happier, fairer futures where every child & young person achieves their full potential	Delivering the best possible outcomes and experience for CYP&F	**1.Outstanding care and experience**	1.2 CYP & Families Engagement and Experience	• Happier children, young people and families • Rated as Outstanding • Designing our care around the needs of CYPF	• Family QALY [H] • CYPF Experience • System Service Experience Management Quotient (SEMQ [H] • Staff Thriving Index [H] • Social Value [H • (Happy) Community Index [M] • Variation in Health and Care Outcomes [L] • Clinical Service Capacity [H] • Resource Optimisation [L] • Ecosystem Contribution [H] • Innovation Adoption Rate [M] • Productivity / Economic Gain [H]
	Supporting our colleagues to have fulfilling careers in a community that thrives	**2. Supporting Our People**	2.1 Thriving @ Alder Hey 2.2 Professional development hub 2.3 Future Workforce	• **Our People are thriving:-** a. have a sense of belonging and are actively engaged b. have the time, space and opportunity to improve the quality of care and meet the needs of CYPF • We invest in our people and their teams to ensure they can have amazing careers • New skills and capabilities across a dynamic and flexible workforce • Right sized workforce renowned for new ways of working • A borderless CYP workforce across communities	
	Pioneering to find novel solutions and treatments	**3. Pioneers Breakthroughs**	3.1 Futures	• State-of-the-art "Hospital Without Walls" • Northern Institute for Child Health & Well-Being • International Post-Graduate School • National Forum on Health Inequalities • Integrated paediatric data network	
	Working with partners to improve life chances of CYP	**4. Collaborating for Children and Young people**	4.1 Building communities 4.2 CYP system	• The heart of a CYP health and care system renowned, regionally and nationally • A convener of the system with frictionless, sustainable and shared CYP resources • We will be a valued anchor institution that attracts inward investment and creates opportunities across our communities	
	Ensure delivery of the very best health and care outcomes for CYPF locally, regionally, nationally and internationally	**5. Smartest Ways of Working**	5.1 New Care Models 5.2 Digital and Data 5.3 Insight led decisions	• Accessible models of care implemented around the needs of CYPF • World class resilient specialist services • Digital Centre of Excellence driving productivity, speed, scale and quality • Collaborating across communities to ensure CYPF only need to tell their story once • Insight Unit recognised as a global centre of excellence for CYPF intelligence	
CYPF Needs (Get me well, Make my care more personal, Improve my life chances, Bring me the Future Today)					

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

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

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

Growing Great Partnerships

This paper marks a year of reporting to the Board of Directors with quarterly updates and assurance of progress and risk management within the Trust's established health and care partnerships. The Trust continues to make progress in its partnership ambitions and work tirelessly to ensure CYP are captured in system priorities at all levels.

This quarter the report will focus on:

National	• Children's Hospital Alliance
North West (Regional)	• CYP Specialist Services and delegation to Integrated Care Systems (ICSs) • NW Paediatric Operational Delivery Networks (ODNs) – CHD ODN

Cheshire & Merseyside	• The Hewitt Review – and implications for Children and Young People
	• C&M Integrated Care System (C&M ICS) update
	  ○ Shaping the system for Children and Young People
	  ○ "Beyond" - ICS CYP Programme update
	  ○ Provider Collaborative Updates – Acute & Specialist (CMAST) and LD/Mental Health and Community (LDMHC)

Place Partnerships	• Liverpool Place • Sefton Place
Partnership Governance	• Partnership Quality Assurance Round (PQAR) programme

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

The CHA undertook a reflective piece at the close of 22/23, demonstrating strong collaborative progress in a range of programme areas.

CHA Priority Themes

Highlights included a complete evaluation of the innovation-led 'was not brought' project, pioneered by Alder Hey. The artificial intelligence (AI) solution identifies children and young people at risk of not being brought to an appointment and offers an opportunity for an intervention to ensure the child is able to attend. The AI tool was found to have identified patients to at least an 80% accuracy level, and amongst the most high-risk patients (c. 70-80% likelihood of not attending) there was an average 52% reduction in WNB levels, through a range of different interventions nationally. Learning is being shared both across CHA partners and nationally.

The CHA has also led work around elective recovery, developing a Childrens Hospital Alliance Risk Tool (CHART) which has a systematic and targeted approach to waiting list prioritisation for children and young people. This recognises that children need a more nuanced prioritisation tool than adults, given the impact of delayed surgeries and interventions on a child or young persons' development. The CHART pilot is currently under evaluation, and if found to be validated and successful will be recommended for spread nationally for CYP.

Progress has been made in addressing the impact of poverty through implementation of 'Sophie's Legacy' funding for pilots to feed families of children in hospital. This is currently under implementation in Alder Hey and receiving very positive feedback from families.

The CHA has successfully influenced national policy, for example influencing the Urgent and Emergency Care Strategy and elective tool kit to reflect children and young people specifically, and has supported paediatric system pressures, the planning round and strike impacts.

Louise Shepherd (Alder Hey CEO) has now taken up her new national CYP Transformation Board Chair role, and as such has stepped down as co-chair of the CHA. Ruth Brown CEO of Sheffield Children's Hospital has been elected to replace her as co-chair of the CHA alongside Mat Shaw CEO of Great Ormond Street Hospital. Alder Hey remain committed partners in the CHA with strong representation at multiple levels.

2. North West (NW - Regional)

a. CYP Specialist Services – Delegation to ICSs

Integrated Care Boards (ICBs) in the North West have reviewed the list of 'in scope' services and agreed (at the North West Commissioning Integration Working Group on 29 September 2022) on those that are suitable for single ICB planning (and decision making) and those that will require collaboration and governance arrangements across all three North West ICBs. The vast majority of children's specialised services fall into the 'multi-ICB' category, and therefore the NW-wide level governance is of paramount interest to Alder Hey.

An initial list of 59 specialised services was identified for delegation in April 2023. The 3 NW ICBs will take on delegated responsibilities in shadow form from April 2023, in partnership with NHSE Specialist Commissioners, developing clearer governance arrangements and financial allocations over the course of 2023/24, with a view to full delegation from April 2024.

From April 2023, a joint working model with NHSE will be legally underpinned by a Joint Working Agreement and statutory Joint Committee between NHSE and the three ICBs in the North West for these 59 specialised services. A paper was shared with C&M ICB in March 2023 recommending the ICB enter into a Joint Working Agreement and progress the work to establish statutory joint committee arrangements with NHS England and NHS Greater Manchester and NHS Lancashire and South Cumbria ICBs for the 2023/24 period. The minutes and decision have not yet been published but Trust Board will be kept appraised in future reports.

Of note, NHSE have clarified that there are no plans to delegate ODNs to ICSs; they will continue to be commissioned by NHSE in collaboration with the ICS to maximise benefits. Therefore, NHS England remains accountable for ODNs, and the 2 NW tertiary providers remain accountable as hosts. The North West Paediatric Partnership Board (NWPPB – jointly chaired by Alder Hey and Royal Manchester Children's Hospital) will continue working with Specialist Commissioners and the NW ICSs to consider and mitigate the impact and optimise the benefits associated with the planned of delegation of specialist services to ICS's, during this shadow year.

A paper will be presented to Trust Board in Q2 23/24 outlining the delegation arrangements to date, impact and risks, and actions/mitigations we are taking as a Trust.

b. NW Women & Children's Transformation Programme

2023/24 will see the full development of the NW Specialist Commissioning Women and Children's 'case for change', which is driving 3 transformation programmes to ensure equitable access and standards of care across the NW:

• the *Neonatal Transformation (Critical Care) Review*
• the *Paediatric Critical Care (L1 &2) and Surgery Review*
• the *Children's Cancer service specification* (Primary Treatment Centres and Paediatric Oncology Shared Care Units)

Alder Hey are playing a full role and are engaged in multiple ways. The NWPPB (Alder Hey and RMCH) will continue to work in partnership with NW Specialist Commissioning and partners across the system to support both the content of the case for change where appropriate and to implement the recommendations. All relevant jointly hosted ODNs (Alder Hey and RMCH) are engaged in the transformation programme. Alder Hey hosted the NW 'GIRFT' Surgery in Children 'deep dive' visit from the national CYP Clinical Director and team in March 23. In addition, Dr Adrian Hughes has taken on a part-time role as clinical lead with the NW Specialist Commissioning team for the W&C programme.

Timescales to note are:
- Gateway One – 28th April 2023
- Gateway Two – October 2023

c. NW Paediatric Operational Delivery Networks – Update

In the last paper to the Board (January 2023) an overview of the 5 NW paediatric Operational Delivery Networks (ODNs) was shared. This paper will provide an update on the Congenital Heart Disease (CHD) All Age ODN.

Congenital Heart Disease (CHD) All Age ODN

To facilitate visibility and equity of access to CHD services across the North West, the ODN has secured match funding from NHSE to develop and implement an all-age CHD database. The database will have the ability to track and account for all patients and help mitigate the risk of extended waiting times or patients being lost to follow up. This will in turn provide assurance against national standards. The database will go live in Q2 23/24 in Level 1 and 2 centres and be phased in Level 3 centres the following year.

Alder Hey, RMCH and the CHD ODN continue to work together to address longstanding challenges in delivering equitable access to paediatric cardiology services across the North West. All parties are collating robust data and evidence to support the case for change for a single service. This includes a full self-assessment against the national CHD standards and an evaluation of the current risk associated with finding a solution to providing a single service model for paediatric cardiology.

The CHD ODN are working to disaggregate the risk around paediatric provision to reflect individual Trust situations, to enable more effective mitigation of risks and clarity of ownership and responsibility for mitigating actions.

Phase one of a joint business case will be submitted to NHSE in Q1 23/24 for additional investment in resource at RMCH; phase two for a single service will subsequently follow (date tbc).

3. Cheshire & Merseyside

a. The Hewitt Review[1] – and implications for Children and Young People

The Rt Hon Patricia Hewitt's independent review into how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed was published in April 23. The report makes 36 recommendations to maximise the opportunities ICSs bring to population health and wellbeing. It is an in-depth review and provides a helpful overview of the issues hindering progress and placing burden on system players.

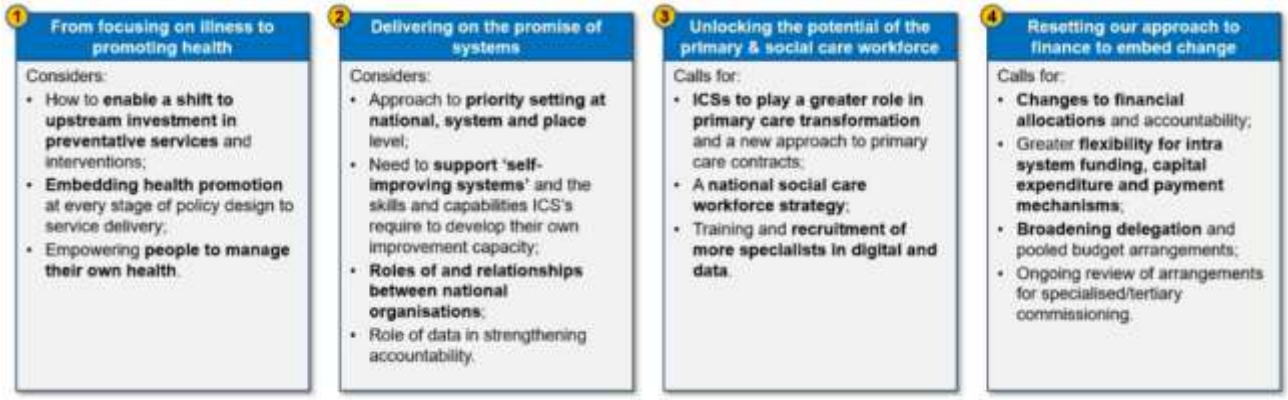
The report describes the opportunity presented by the introduction of ICSs and reinforces the need to embed collaboration and partnership working to address the challenges facing the health and care system. A central premise of the review is to shift away from centrally driven, performance

[1] The Hewitt Review: an independent review of integrated care systems (publishing.service.gov.uk)

management culture, to one of learning and improvement, where national and regional bodies support local ICSs on more partnership centred footing, enabling local variation. It calls for a reduction in the number of centrally driven targets (no more than 10) and streamlined reporting requirements.

The review makes a welcomed commitment to prevention, and a strong case for a shift in the level of resource invested – specifically recommending the share of ICS budgets spent on prevention increase by at least 1% over the next 5 years, as well as increasing the public health grant allocation. The review makes no recommendations as to the roles of Providers and ICBs.

Whilst the implications of the proposals are not yet certain (the government has committed to review the recommendations in due course) there is much alignment with Alder Hey's Strategy 2030, given the strong focus on improvement of CYP life chances. The 4 chapters of the review are summarised here;



Implications for paediatrics and / or Alder Hey, should the recommendations be accepted, include:

- **Prevention** – there is a focus on preventative elements of care for children which implies out of hospital care will be prioritised;
- **Funding** – 1% of budgets will be diverted from acute care within 5 years, and national funding pots are likely to be eliminated;
- **Data** – accessible data must include recently established paediatric dashboard;
- **Prioritisation of children** – there is a risk of children being deprioritised nationally, given the proposed limitation to no more than 10 central priorities.

The national **Child Health Equity Collaborative** (in which the 'Beyond' programme hosted at Alder Hey is a leading partner) is called out as an example of good practice in the review. This is detailed further in the Beyond update below.

The C&M ICB received an update on the Hewitt Review in April 2023 and are awaiting the response from Government to the findings and recommendations; after which the ICB will consider how the recommendations could be adopted locally, where appropriate and beneficial.

b. C&M Integrated Care System (C&M ICS) update

i. Shaping the system for Children and Young People

The C&M ICS have recognised the need to continue both building, and simplifying, the system for children and young people. Alder Hey continues to lead and partner to shape the system around children and young people. This includes the proposal for an ICS CYP Board, which would offer a single line of sight of all elements of the CYP system collectively and help take forward learning and

best practice across the patch. The ambition is to create a coherent CYP system, which would likely have the following interconnected components;

- A single line of sight at ICB level, for the totality of CYP (a CYP Board)
- A whole-system (health and care) integrated transformation/delivery programme (Beyond – established)
- A robust health delivery network with clear roots in both the C&M Acute and Specialist Trust (CMAST) provider collaborative, and the Learning Disability, Mental Health, and Community (LDMHC) provider collaborative, each overseeing appropriate elements of CYP delivery;
- A network of Directors of Children's Services across the 9 Local Authorities leading on both DCS shared priorities, and system-wide partnership priorities with Beyond (established).

Trust Board will be kept appraised of these proposals as they develop.

ii. Beyond – C&M CYP Transformation Programme update

Health Inequalities

Beyond supported a successful system-wide bid for the CYP Health Equity Collaborative (as aforementioned)> This is a collaboration between Barnardo's, the Institute for Health Equity and 3 ICSs (C&M, South Yorkshire, and Birmingham & Solihull) to co-design a CYP Health Equity Framework and a dynamic measurement tool, in partnership with CYP, and VCSE partners. This is a major opportunity to influence and advocate for children and young people; the Collaborative Board is chaired by Sir Michael Marmot and includes representation from several national CYP leads. Inductions are ongoing and a work programme is under development for delivery 2023-2025.

Beyond is also linked with the "All Together Fairer" (Marmot) programme, mapping oversight of children's recommendations. Work is continuing into 2023/24 to understand the collective effort to deliver CYP Marmot recommendations, and to ensure effective oversight / governance. Core20PLUS5 for CYP also aligns closely with Beyond objectives and key deliverables will be included in workstream objectives.

Strategic Influence

Strong system engagement is in place with Place, Provider and Clinical involvement reflected in both the Beyond Board and workstream leadership. This reflects partnership working that recognises the complexity and multiple stakeholders involved within the CYP arena.

Beyond has contributed to the HCP strategy and Joint Forward Plan to ensure that the needs of CYP are reflected within system prioritisation. An ICB CYP Board has been proposed, and Beyond is supporting development and review of the range of metrics that will enable a single line of sight across the range of children and young people's delivery.

Beyond Conference

The "Beyond: *Navigating the Future Conference"* took place 7th March 23. This highlighted the breadth of work within the context of shaping the future for CYP in C&M. It was preceded by five CYP and family engagement events across C&M to help design the event and co-create questions for a panel of system leaders to answer. Key messages were heard from local CYP voices and regional and national CYP leads, including the Chair of C&M ICB and the Children's Commissioner for England. The conference was attended by 127 delegates. The conference focused on *Children at Home*, *Children in the Community* and *Children in Education*.

Workstream Delivery

The programme continues with key programmes of work in line with ICS / NHSE priorities, adding Oral Health for 23/24 in line with Core 20+5 CYP.

Existing programmes of work will already reach over 40,000 beneficiaries by the end of 2023/24. This will be further expanded as recently commissioned programmes of work are mobilised.

During March/April 23 additional expressions of interest/bids have been submitted for a range of NHSE projects including:

- Epilepsy Specialist Nurse – Regional
- Epilepsy Specialist Nurse – Levelling Up
- Epilepsy: Integrated Mental Health
- Epilepsy: Youth Workers
- Early Years Intervention (Oral Health)
- MH Champions in Acute Wards
- Expansion of CEW service

iii. Provider Collaborative updates

Alder Hey continue to play an active role in both the CMAST (C&M Acute and Specialist Trusts) and the LDMHC (Learning Disability, Mental Health & Community) Provider Collaboratives.

Within CMAST, Alder Hey lead the Paediatric Elective Recovery Group, bringing together regional paediatric teams to collaborate on advancing paediatric elective recovery. The team are now implementing the successful bid for funding to establish an elective recovery hub for C&M with an initial focus on improving access to paediatric dental services. In addition, C&M's Virtual Ward programme has allocated funding to build upon the proof-of-concept virtual ward established at Alder Hey.

The LDMHC provider collaborative has ongoing work on the proposal for future governance and commissioning arrangements for the ICB. The collaborative is developing its role relating to children and young people and considering initial proposals that a focus on paediatric speech and language therapy, autistic spectrum disorder and attention deficit hyperactivity disorder waiting times through the collaborative could support positive improvements system-wide. The collaborative's value proposition is being finalised and will be brought to Trust Board for consideration in the coming months.

4. Place Partnerships

a. Liverpool Place - One Liverpool Programme: Healthy Children & Families

This work programme is jointly led by Alder Hey's Director of Strategy and Liverpool City Council's Consultant in Public Health CYP lead (joint SROs). The segment ambition is to drive a better future for CYP and Families in Liverpool, working together to deliver the Liverpool City Plan / One Liverpool ambition of a 'healthier, happier, fairer Liverpool for all'. As shared in the last paper, the five emergent areas of focus and delivery identified collaboratively as key areas to address health inequalities across the city – *Better Start, Growing Well, Good Respiratory Health, Healthy Neighbourhoods and Mental Health & Emotional Wellbeing.*

A Population Health Summit took place in February 2023 with representation from senior leaders from across the local health and care system. The aims of this event were to –

- Socialise the high-level plan for all 5 segment areas (healthy children and families, disabilities, complex lives, long term conditions, frailty and dementia, disabilities) and the neighbourhood ICCT (integrated community care team) programme;
- Share the expected vision for the segment and how we will work differently this winter;
- Discuss the ambition and longer-term vision for the segment and the neighbourhood programme will operate in 5 years' time (considering the new model of care, pooling of resources and workforce model).

Partner discussions on the day endorsed the content of the Healthy Children and Families Segment plan and recognised the links with e.g., the complex lives and disability segments. System leaders acknowledged the gaps in some key leadership roles in Liverpool and the impact that has on overarching governance (and therefore delivery) of the programme, complicated by Place leadership changes and the current Executive recruitment phase at LCC. Alder Hey's CEO is working with Liverpool Provider Alliance partners on provider governance and senior sponsorship for this programme of work.

Work now continues in the city to review component parts of the One Liverpool plan, their risks, and gaps, and ensure that the different elements align effectively and create sufficient/ complementary impact for Winter.

b. Tacking poor outcomes in Liverpool - Contain Outbreak Management Fund (COMF)

The partnership between the Trust and Public Health Liverpool has led to the Trust has receiving COMF funding (a national allocation) to tackle poor and declining child health outcomes in Liverpool, as a direct impact of the coronavirus pandemic.

In collaboration with Public Health colleagues, four schemes have been identified and mobilised. Each initiative will be fully evaluated, reporting through the Trust's Health Inequalities & Prevention (HIP) Steering Group and up to Safety and Quality Committee (SQAC). Projects that can demonstrate impact will be recommended to commissioners for consideration in future service development.

Healthy Weight Programme Mini Grant Scheme	Prevention in Pathways Targeted intervention	Restrictive Food Intake Pilot	Mini Mouth Care Matters
• Alder Hey hosts a city-wide partnership grant scheme to support healthy weight and improving mental wellbeing in children and young people. • This scheme has associated clinical leadership. • Seven organisations have received funding to deliver projects in areas of higher deprivation across Liverpool • All projects are in the mobilisation phase.	• Alder Hey has created a survey and toolkit the objective of which is to signpost families to existing services with a focus on key health issues and the wider determinants of health: debt, fuel poverty, food poverty/insecurity, emotional wellbeing (child and mother), obesity, oral hygiene, household smoking, immunisations. • This work is being delivered in partnership with Liverpool Citizens Advice.	• Many children are currently open to services at Alder Hey and identified as having problems with eating linked to anxiety and/or sensory processing difficulties. Health consequences can include tooth decay, obesity, nutritional deficiency and/or weight loss. • This group intervention pilot in partnership with Children's Centres, targets children and young people who do not currently meet the threshold for specialist CAMHS or dietetics.	• Oral health is intricately linked to the general health and wellbeing of the body. • The proposal aims empower medical & allied healthcare professionals to take ownership of the oral health care of any AH in-patient with a hospital stay of more than 24 hours. • A project clinical lead has been appointed will create training packages to be delivered to ward staff to support them to deliver oral health care advice.

c. Sefton Partnership

The 'Live Well Sefton' plan continues to develop with the final strategy scheduled to be available 10 May 2023. "Start Well" is one of the three ambitions. This will involve children and young people up to age 18, but also those up to age 25 years with additional needs. This ambition will focus on the 4 action areas –

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

The Trust is engaged across the breadth of governance of the Sefton programme and is a key partner within the strategic and operational element of delivery.

Links are also developing with Knowsley Place through both Alder Hey's leadership teams and Beyond at a C&M level.

5. Alder Hey Partnership Governance

Following the MIAA report of our newly developed Partnership Governance Framework, where the resulting opinion was one of **"substantial assurance"**, we continue to build our approach to partnership quality assurance rounds (PQAR).

The next partnership to undergo the PQAR will be with RMCH for the NorCESS service and is expected to take place in Q2 23/24.

A forward schedule for PQARs will be developed during Q1 23/24.

6. Risks and Issues to Highlight

- The Board is asked to recognise the potential longer-term implications of the Hewitt Review, should the recommendations be accepted;

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

7. Recommendations

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Integrated Performance Report (March 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:	

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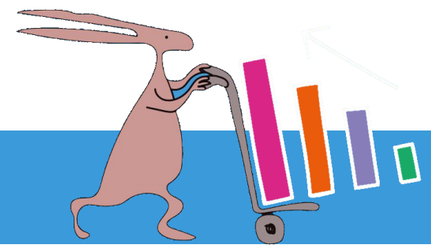
NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: April 2023



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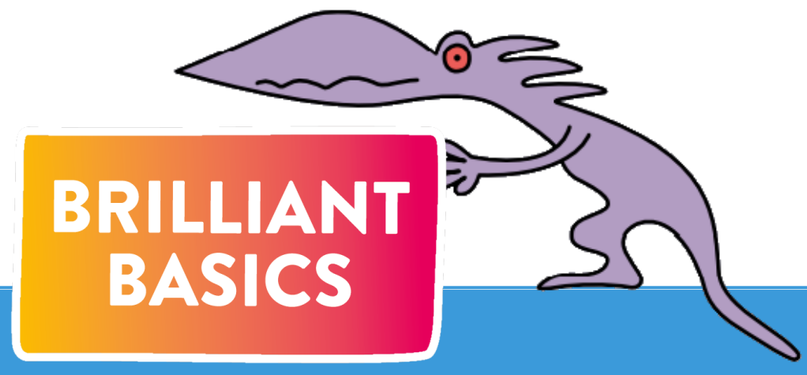


Icon Definitions

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

Integrated Performance Report | April 2023

Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe

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

Highlights:

Continued positive reporting culture and sustained improvement in sepsis compliance in the inpatient areas. Unplanned admission to critical care continuing to reduce and good compliance with IPC metrics. Downward trend in pressure ulcers.

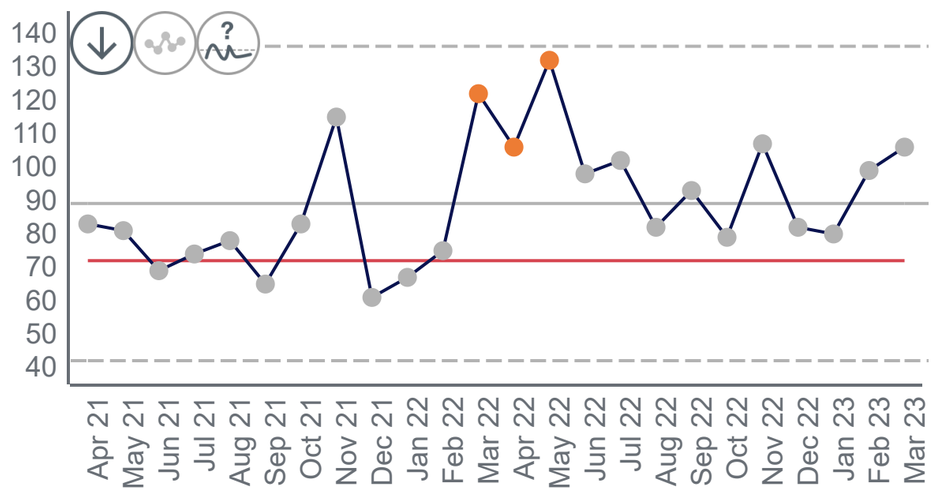
Areas of Concern:

Restrictive interventions increase due to a complex young person on the acute site. Ed sepsis compliance needs continued support to achieve target.

Forward Look (with actions)

Further understanding of the improvement work in ED planned and to understand how to maximise patient experience and sepsis compliance

Number of Incidents rated Minor Harm and above



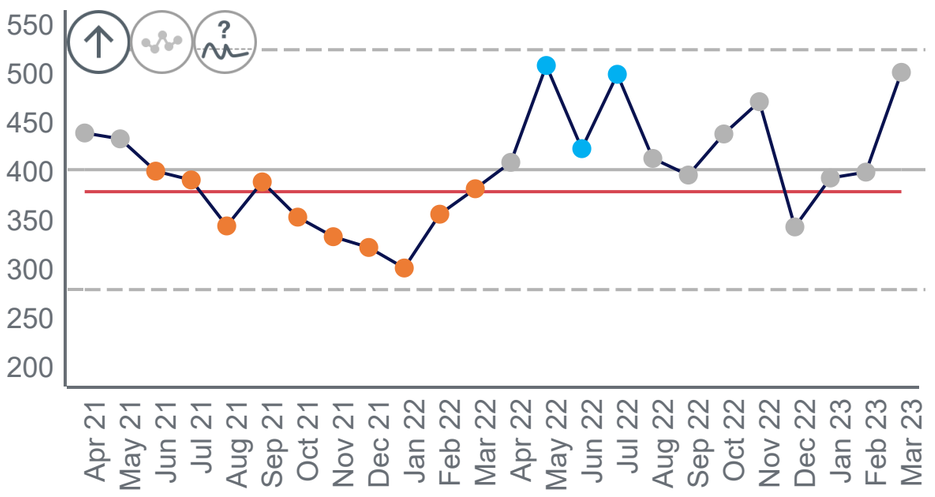
Technical Analysis:

Of the 106 incidents in Mar, 102 were minor harm and 4 moderate/major harm. Overall the Number of Harms per month continues to remain stable and demonstrates common cause variation. The mean figure of 89 incidents per month is higher (falling short) than the target (72pcm) and there has been no evidence of a reduction in harm over the last year.

Actions:

Continue to work through the patient safety board to look at overall reduction in incidents with harm

Number of Incidents rated No Harm and Near Miss



Technical Analysis:

A high number of Near Miss and No Harm incidents reflects an open reporting culture. Over the last year, 11 out of 12 months have been above (passing) the target which is positive – although technically this still demonstrates common cause variation.

Actions:

Continue to monitor the improvement in this metric

Outstanding Safety - Safe - Metric Summary

Metric	Date	Value	Mean	Target	Variation	Assurance
Number of Incidents rated Minor Harm and above	March 2023	106	89	72		
Number of Incidents rated No Harm and Near Miss	March 2023	502	403	380		
Number of Serious Incidents (Steis reported)	March 2023	1	1	0		
Number of Never Events	March 2023	0	0	0		
Sepsis % Patients receiving antibiotic within 60 mins for ED	March 2023	84	85	90		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	March 2023	100	91	90		
Number of Medication Errors resulting in harm (minor harm and above)	March 2023	5	4	4		
Pressure Ulcers G2-4	March 2023	3	4	5		
Use of physical restrictive intervention	March 2023	27	15			
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)	March 2023	11	22	30	L	
Hospital Acquired Organisms - MRSA (BSI)	March 2023	0	0	0		P
Hospital Acquired Organisms - (C.Difficile)	March 2023	0	0	0	L	
Hospital Acquired Organisms - MSSA	March 2023	1	1	0		

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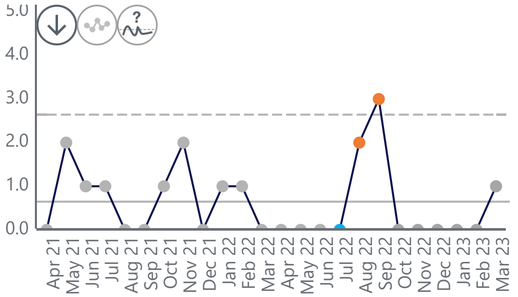
Integrated Performance Report | April 2023

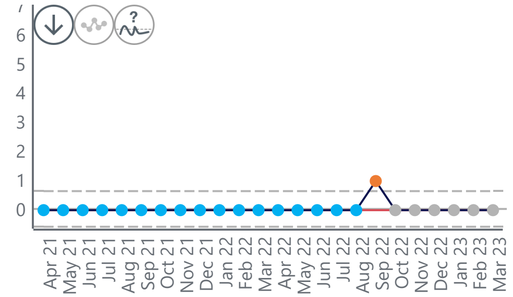
Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe - Watch Metrics

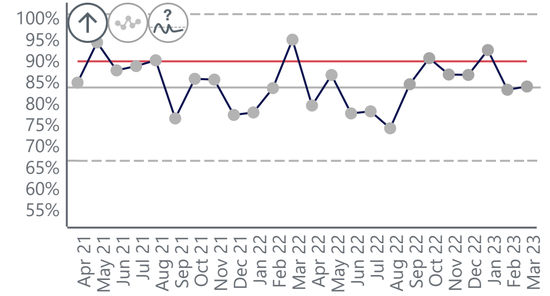
Number of Serious Incidents (Steis reported)



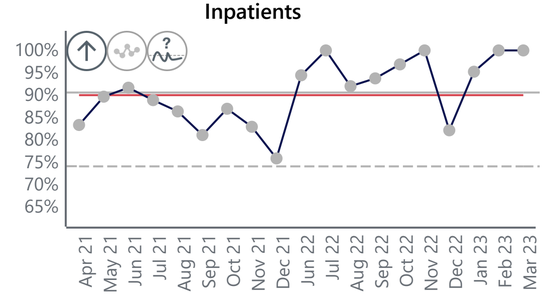
Number of Never Events



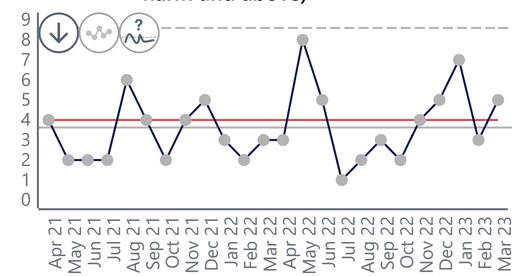
Sepsis % Patients receiving antibiotic within 60 mins for ED



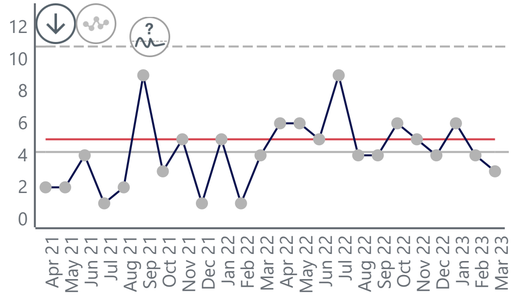
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



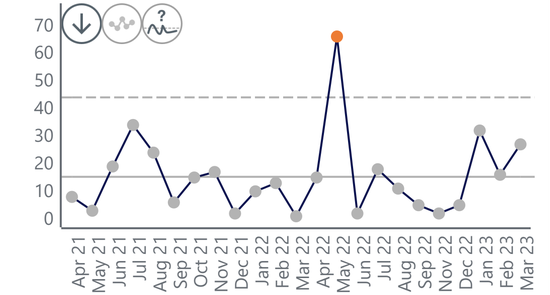
Number of Medication Errors resulting in harm (minor harm and above)



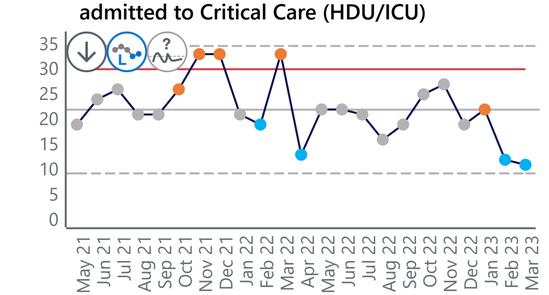
Pressure Ulcers G2-4



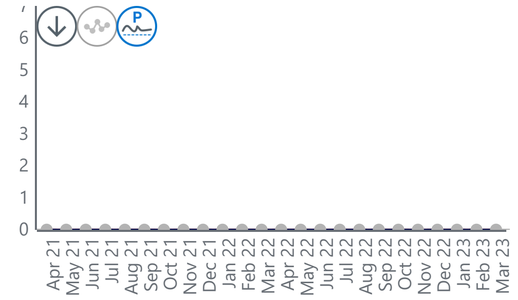
Use of physical restrictive intervention



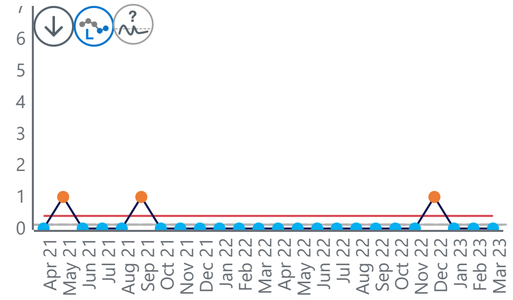
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



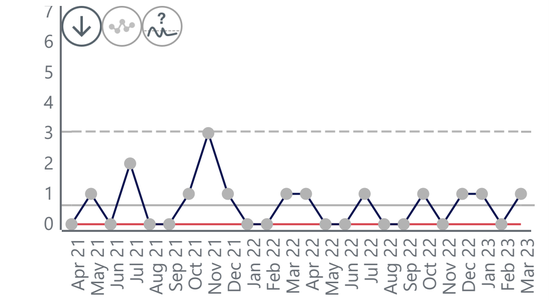
Hospital Acquired Organisms - MRSA (BSI)



Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Outstanding Safety - Caring

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

Highlights:

Continued good performance with PALS responsiveness despite and increase in contacts. Inpatient FFT scores above target.

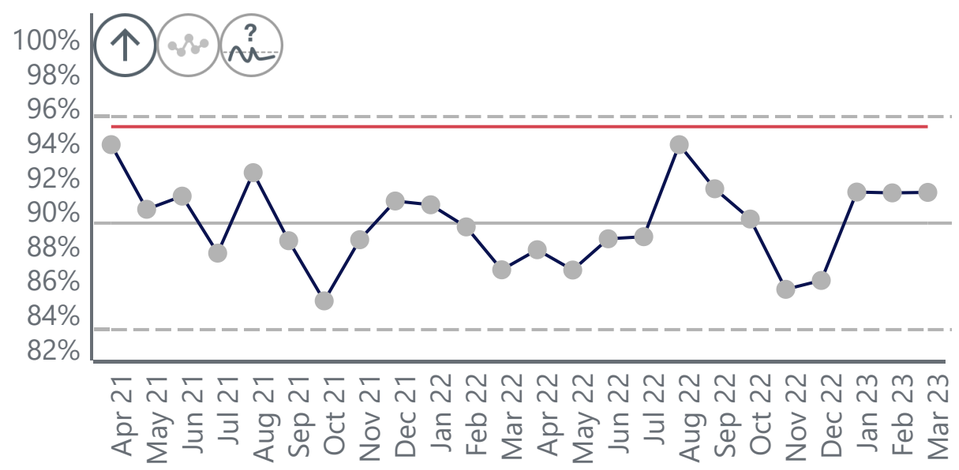
Areas of Concern:

Decline in ED FFT and the contribution to the overall trust position.

Forward Look (with actions)

A focus on improving the experience in ED and on the timely resolution of complaints

F&F Test - % Recommend the Trust



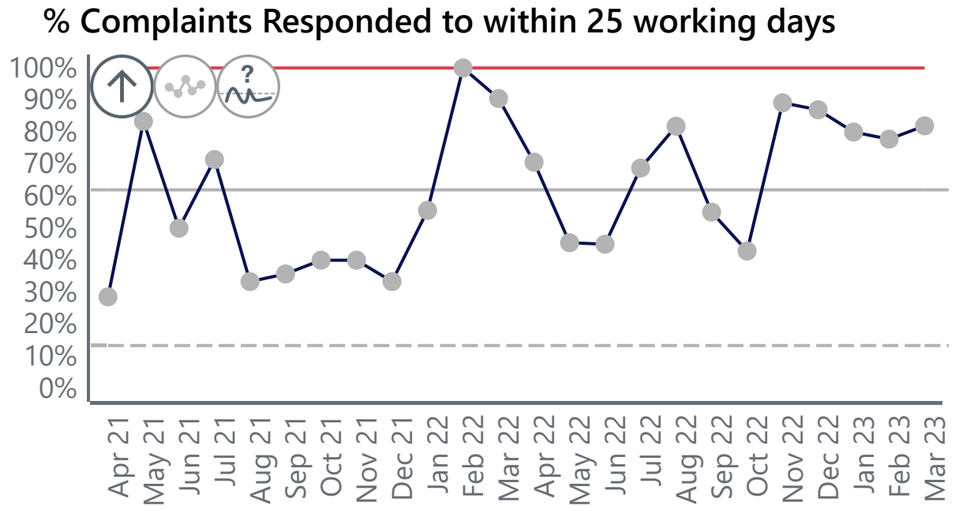
Technical Analysis:

FFT scores in March remain flat at 91% – ED is at 77.5% and with only Inpatients exceeding the 95% target. We have not met the target of 95% in any month over the last two years. The data continues to demonstrate normal cause variation with no underlying improvement.

Actions:

Focus on improvement of experience in ED which is at 77.5% to increase overall trust position.

% Complaints Responded to within 25 working days



Technical Analysis:

March response rate of 82% is consistent with recent months. There have now been 5 consecutive months above the mean, which is a positive indication and if sustained till May will show an underlying improvement. With a 100% target, further actions are required to improve performance.

Actions:

There has been significant improvement in this metric against target, continue to monitor and review target level.

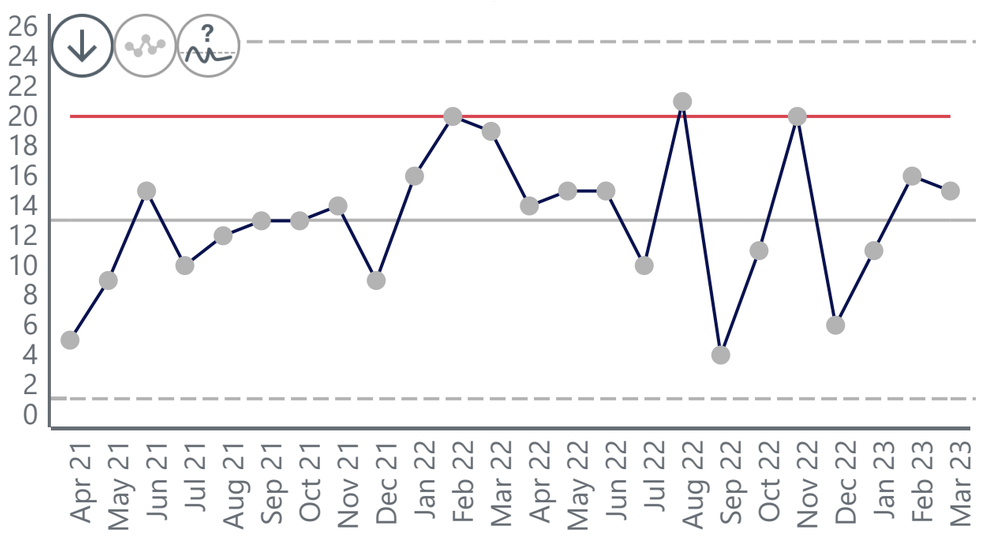
Integrated Performance Report | April 2023

Alder Hey Children's NHS Foundation Trust

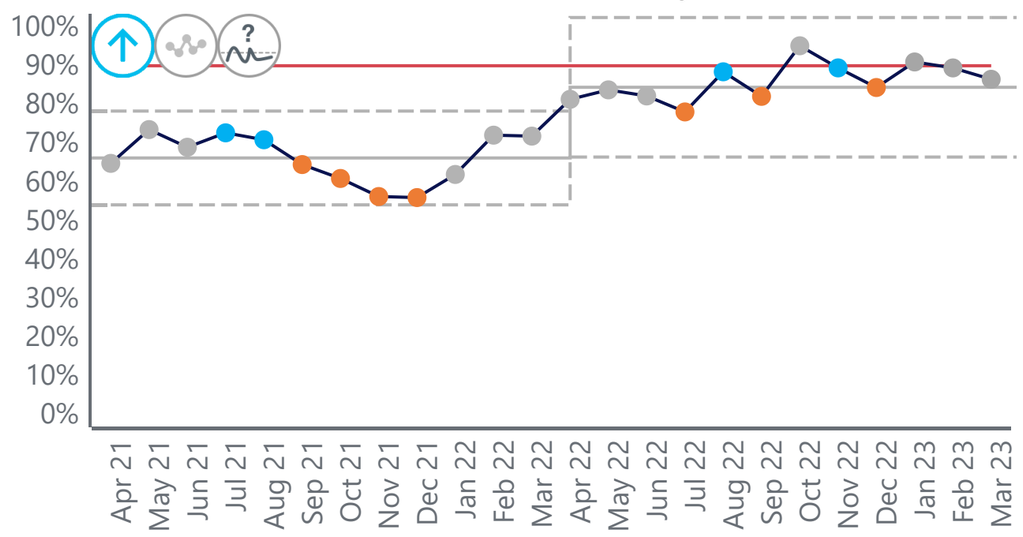
Outstanding Safety - Caring - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	March 2023	91	95	89		
% Complaints Responded to within 25 working days	March 2023	82	100	62		
Number of formal complaints received	March 2023	15	20	13		
% PALS Resolved within 5 Days	March 2023	87	90	76		
Number of PALS contacts	March 2023	183	150	137		
F&F ED - % Recommend the Trust	March 2023	78	95	70		

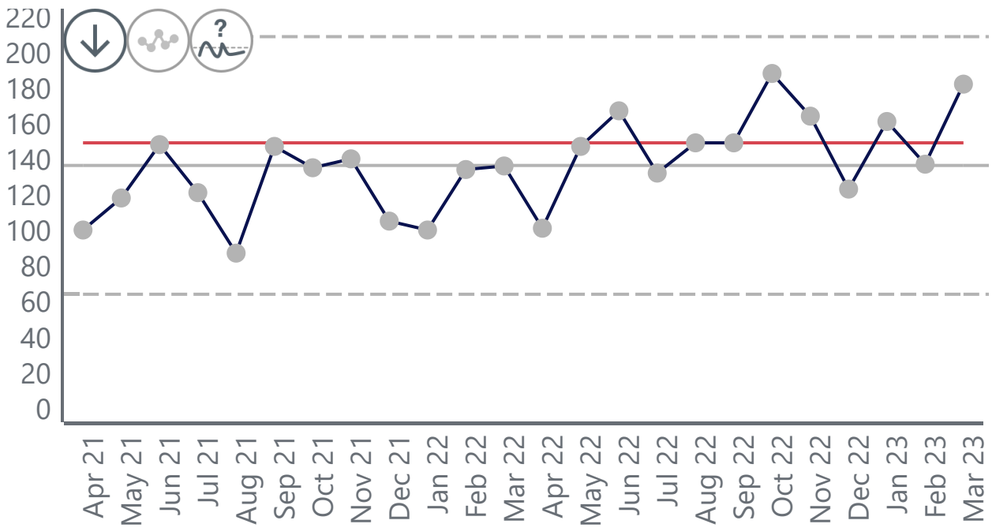
Number of formal complaints received



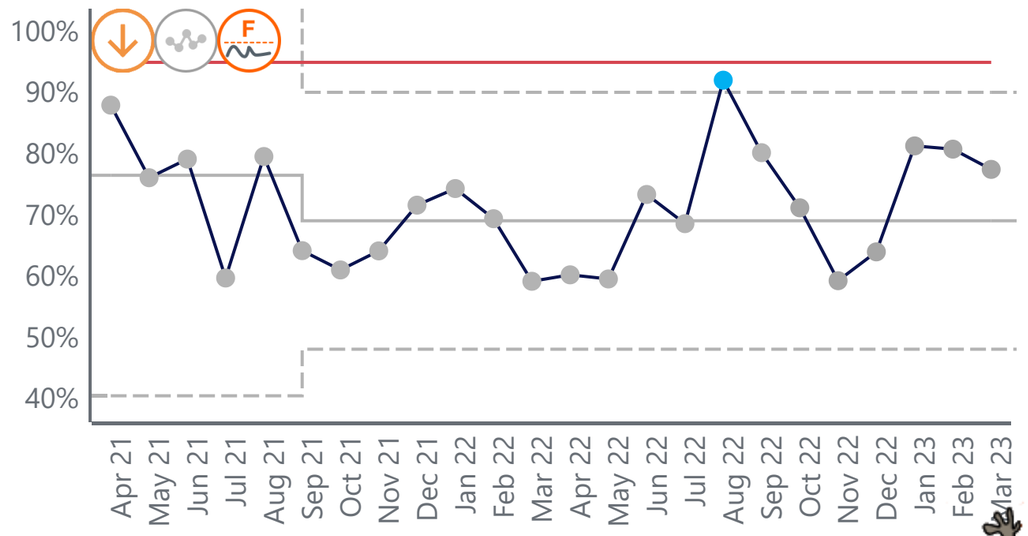
% PALS Resolved within 5 Days

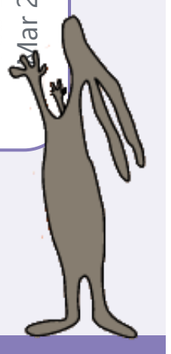


Number of PALS contacts



F&F ED - % Recommend the Trust





Recovery & Access - Effective

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• Achieving the WNB target, with a rate of 9% (third consecutive month where performance is significantly below mean) • Improving trend in the number of clinical letters being completed within 10 days

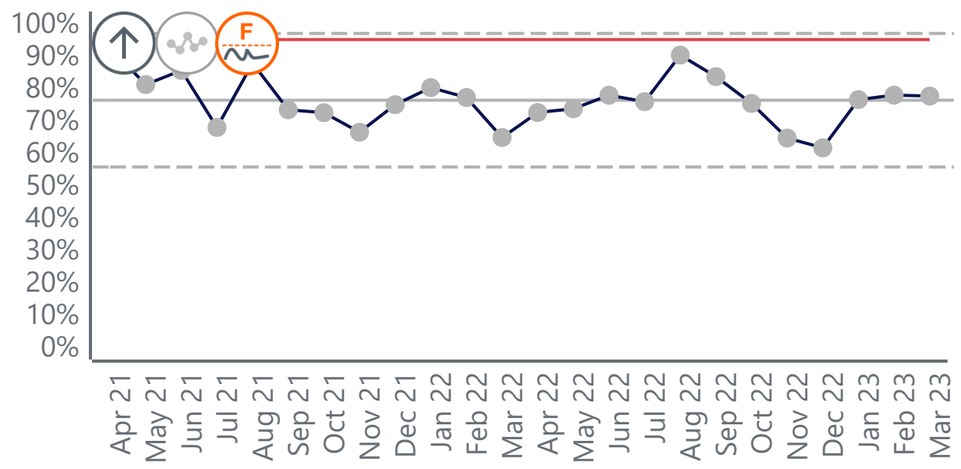
Areas of Concern:

• Whilst timeliness of care in the Emergency Department is meeting the new national target of 76%, performance is static at 78%.

Forward Look (with actions)

• Emergency Department: 1) move to consistent delivery of senior decision-making model (Rapid Assessment & Treat (RAT)), from 24 April) 2) increase utilisation of the new Urgent Treatment Centre 3) increase evening and out-of-hours cover (June 2023) • Investigation into root cause of decline in virtual consultations (April 2023) • Surgery and Medicine to take enhanced actions and provide support to areas where clinic letters are still outstanding after 30 days (1 May 2023)

ED: % treated within 4 Hours



Technical Analysis:

March performance of 78% is consistent with January and February. Impact of UTC and other actions has not yet led to demonstrable improvement in performance. The mean performance Is 76%, which is in line with the new national standard (effective from April 2023).

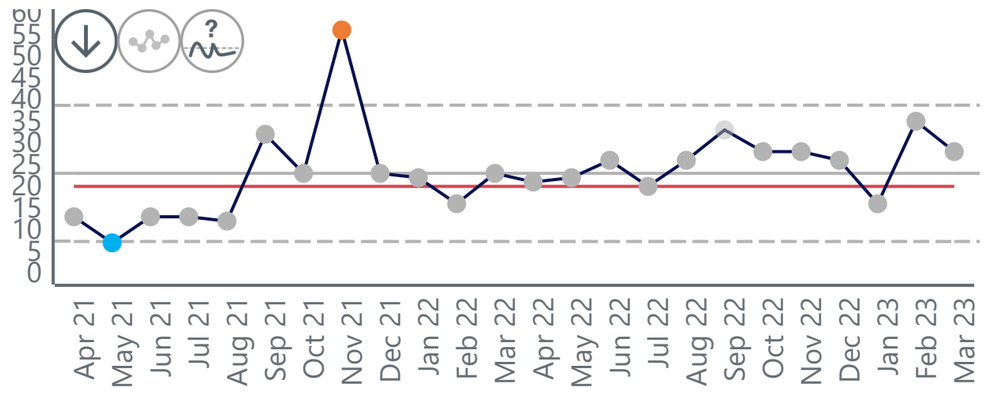
Actions:

Emergency Department: 1) move to consistent delivery of senior decision-making model (Rapid Assessment & Treat (RAT)), from 24 April) 2) increase utilisation of the new Urgent Treatment Centre 3) increase evening and out-of-hours cover (June 2023)

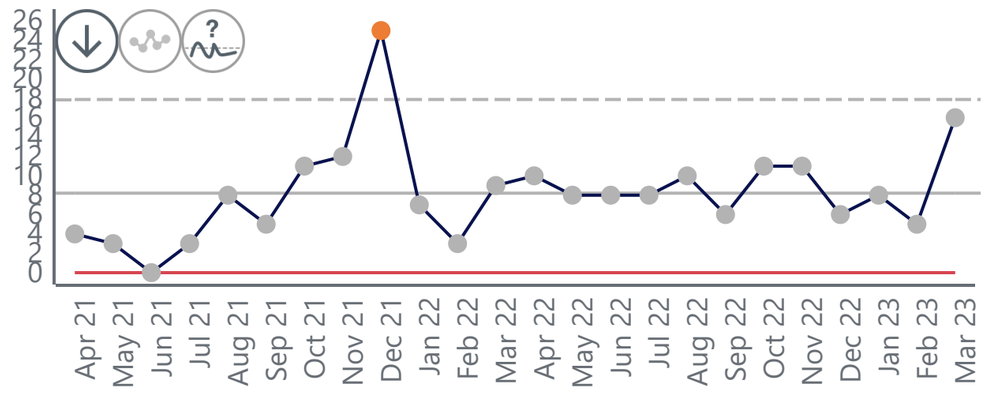
Recovery & Access - Effective - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	March 2023	78	95	76.30		F
Number of Cancelled Operations (on day of admission for a non-clinical reason)	March 2023	28	20	23.42		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	March 2023	16	0	8.21		?
Number of Super Stranded Patients (21 days)	March 2023	41	30	37.83		?
% Virtual Outpatients (national standard 25%)	March 2023	24	25	28.92		?
% Was Not Brought Rate (All OP: New and FU)	March 2023	9	10	9.69		?
% of Clinical Letters completed within 10 Days	March 2023	69	95	59.86		F

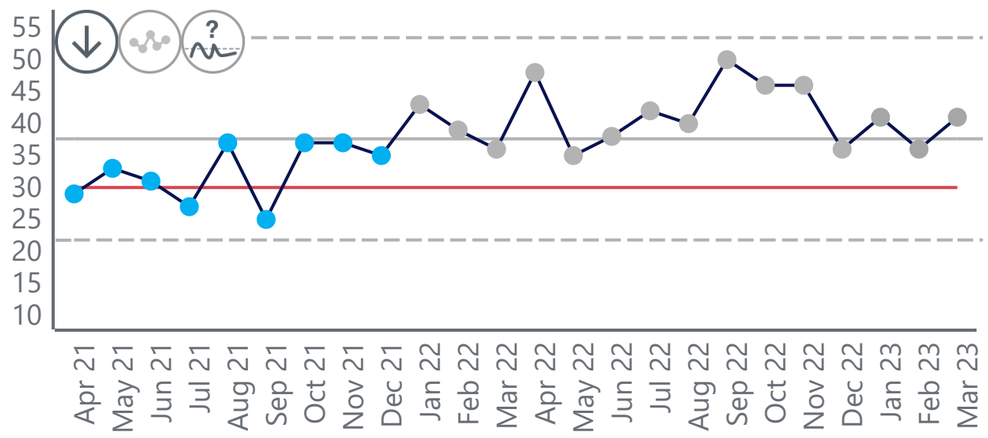
Number of Cancelled Operations (on day of admission for a non-clinical reason)



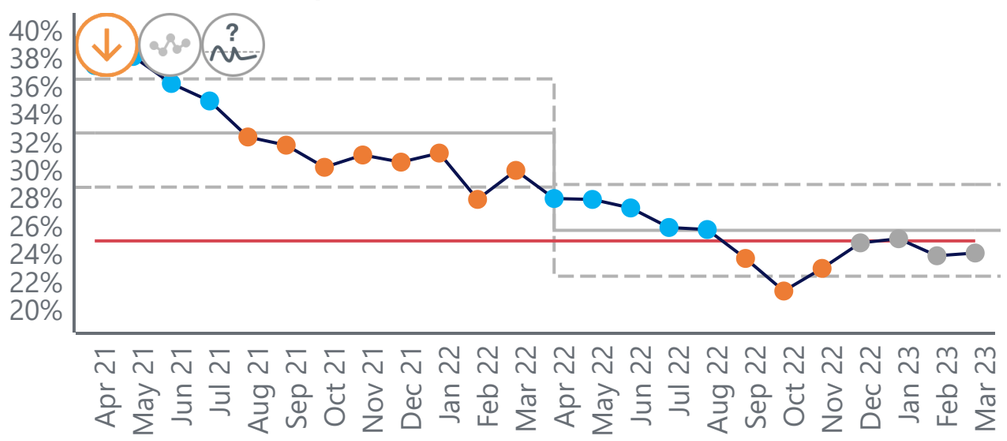
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days



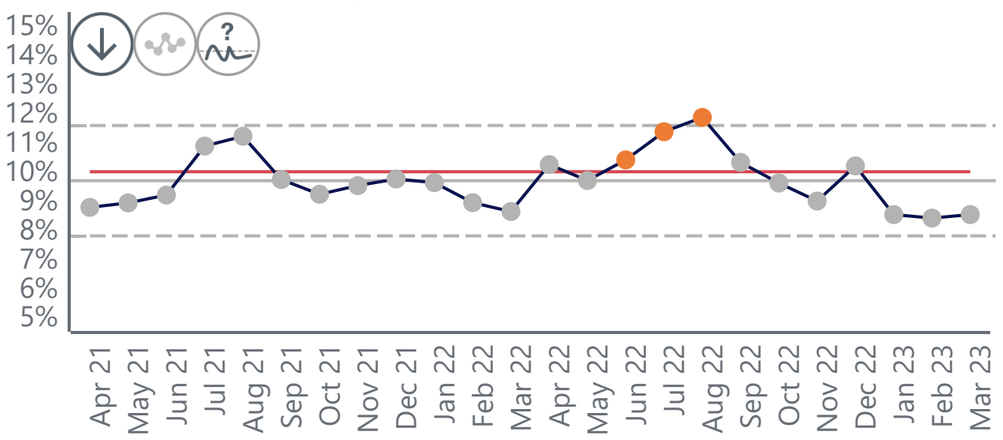
Number of Super Stranded Patients (21 days)



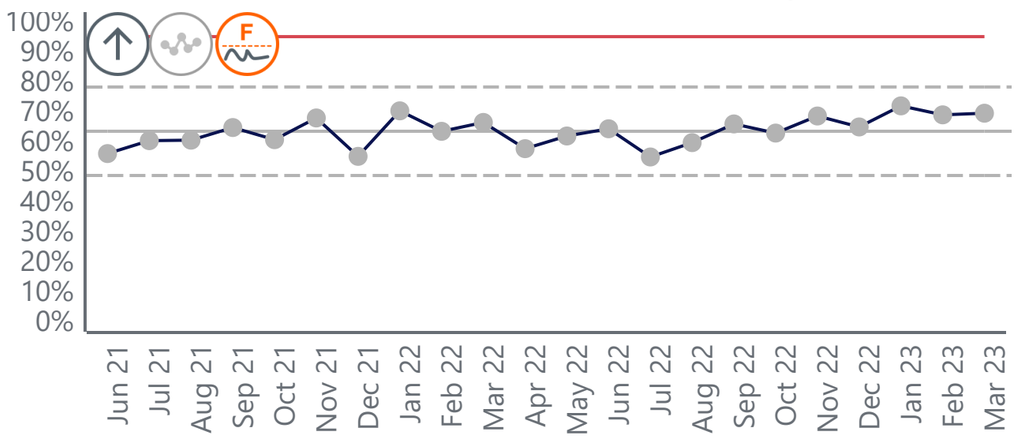
% Virtual Outpatients (national standard 25%)



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



% of Clinical Letters completed within 10 Days



Recovery & Access -Responsive

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• Improving access to diagnostic tests, within 84% now completed within 6 weeks • Only 8 patients waiting over 78 weeks for treatment, amongst the best in the region, and all patients with this waiting time have chosen not to access treatment sooner • Access to cancer care

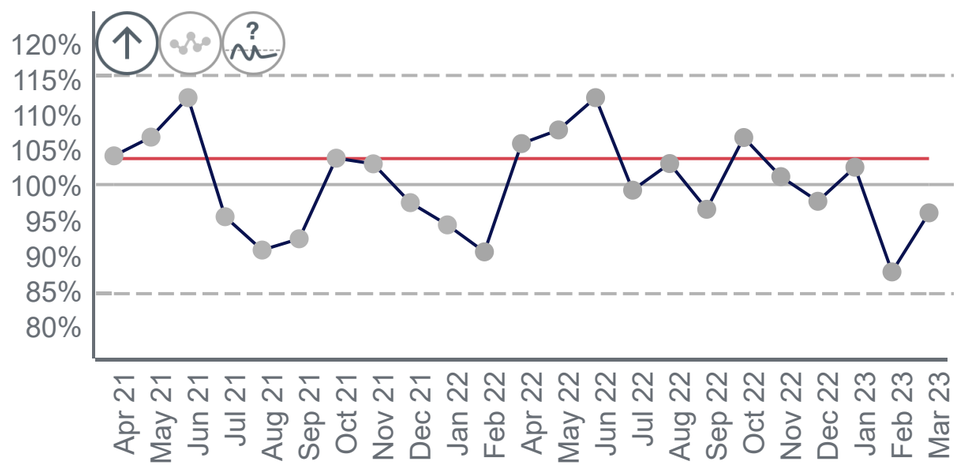
Areas of Concern:

• Rising number of patients waiting over 52 weeks, caused by the cumulative effect of industrial action and a capacity deficit in ENT • Significant growth in waiting list size • Only 1 patient did not receive access to cancer care in line with waiting time standard but this was due to the patient not being brought for their appointment

Forward Look (with actions)

• Actions to improve waiting times in ENT (see actions in the driver metric section) • Capacity and demand analysis (paper to Executives 20 April 2023) identifying specialties where we have a significant underlying capacity issue • Investment plans and productivity plans for 5 specialties with significant capacity gap (May 2023)

% Recovery for DC & Elec Activity Volume



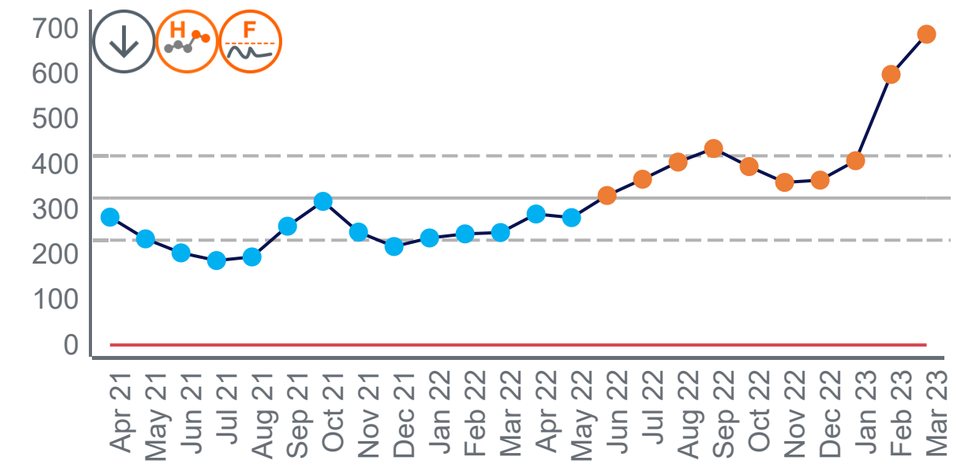
Technical Analysis:

Mar 23 performance of 96% by volume is below the target although improved performance from Feb 23 (88%). Mar 23 was impacted by strike action but elective casemix supported financially. Monthly variation continues to demonstrate common cause variation.

Actions:

Recovery has been adversely affected by the impact of industrial action on the 13 and 15 March with the cancellation of c. 65 operations

Number of RTT Patients waiting >52weeks



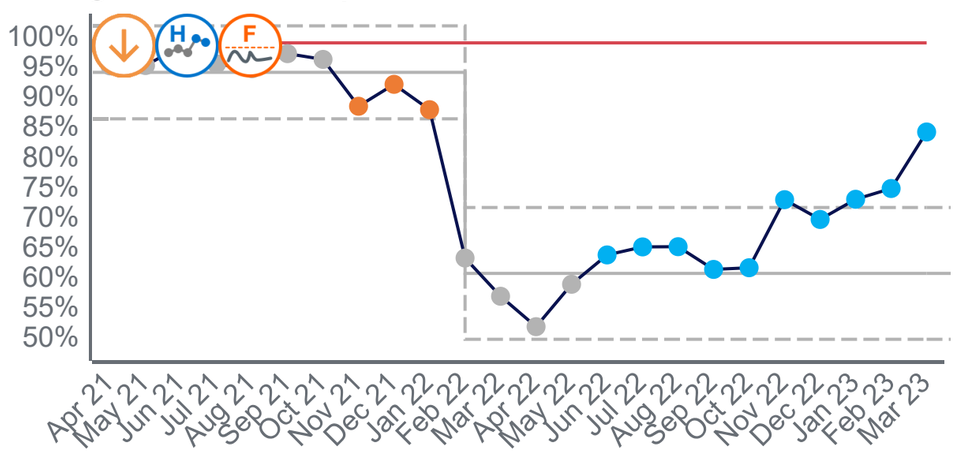
Technical Analysis:

The number of RTT patients >52wks has significantly increased again, and is now at 688. The main factors relate to impact of Industrial Action, provision of Mutual Aid (focus on zero >78wks) and a significant increase in ENT as a result of urgent referrals taking priority. ENT now has 343 patients >52weeks, represents 49.9% of the Trust total.

Actions:

Actions to reduce waiting times in ENT a) in-sourcing model (from June 2023) to increase capacity b) formally requesting mutual aid from other providers in C&M for some lower complexity work (April 2023) c) use of opt-in service for long wait patients, proven to reduce the size of the waiting list (May 2023)

Diagnostics: % Completed Within 6 Weeks of referral



Technical Analysis:

Diagnostic waiting times continue to improve, with March reaching 84%. Special Cause variation has been observed which demonstrates the sustained success of the improvement actions in place. Actions continue to be implemented in Sleep and Scopes to drive further improvement

Actions:

Increasing the number of patients accessing sleep studies, including the new home sleep service, with a trajectory to clear the backlog by July 2023

Recovery & Access -Responsive - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	March 2023	96	104	100.61		?
Number of RTT Patients waiting >52weeks	March 2023	688	0	325.42	H	F
Diagnostics: % Completed Within 6 Weeks of referral	March 2023	84	99	65.90	H	F
RTT Open Pathway: % Waiting within 18 Weeks	March 2023	54	92	61.63	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	March 2023	95	100	99.28	L	P
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	March 2023	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	March 2023	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	March 2023	100	100	93.48	H	?
Cancer: Faster Diagnosis within 28 days	March 2023	100	75	94.29	H	P
% Recovery for OP New & OPPROC Activity Volume	March 2023	114	104	103.26	H	?
% OPFU Activity Volume	March 2023	95	85	105.49	L	F
Waiting List Size	March 2023	25,208		19,788.17	H	?

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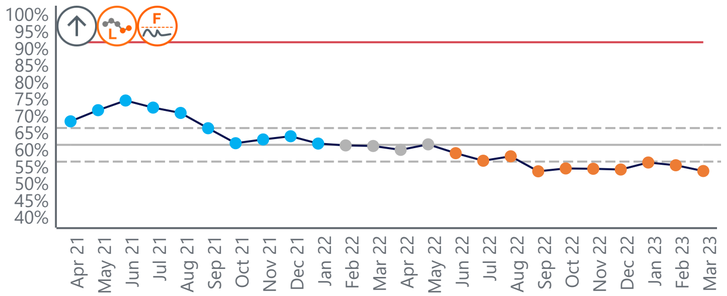
Integrated Performance Report | April 2023

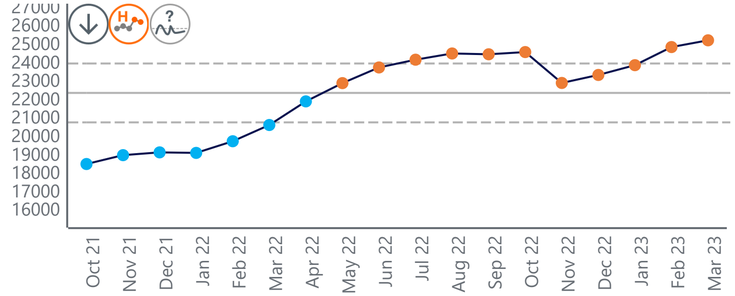
Alder Hey Children's NHS Foundation Trust

Recovery & Access -Responsive - Watch Metrics

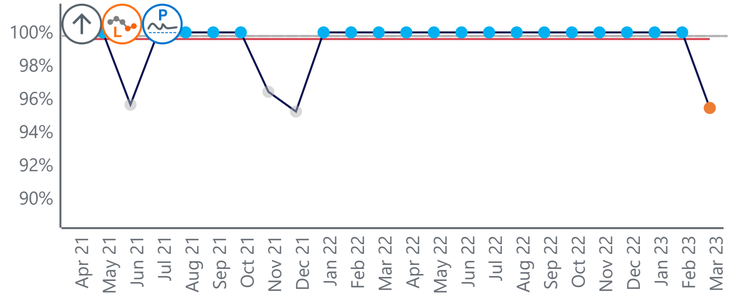
RTT Open Pathway: % Waiting within 18 Weeks



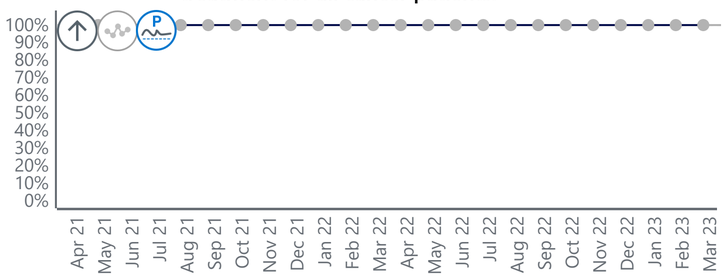
Waiting List Size



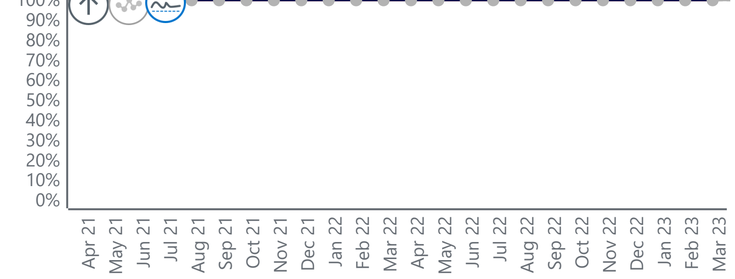
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



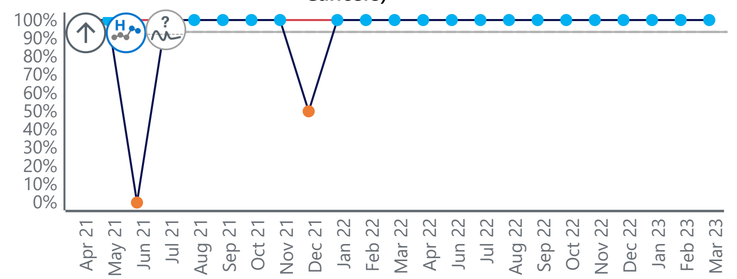
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



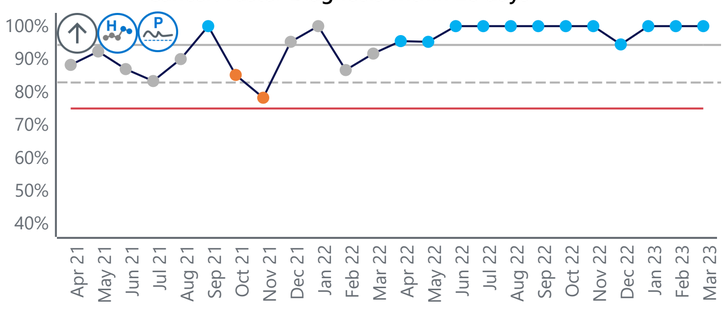
All Cancers: 31 day wait until subsequent treatments



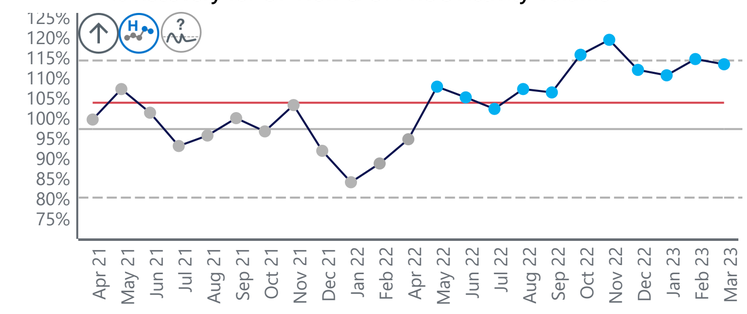
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



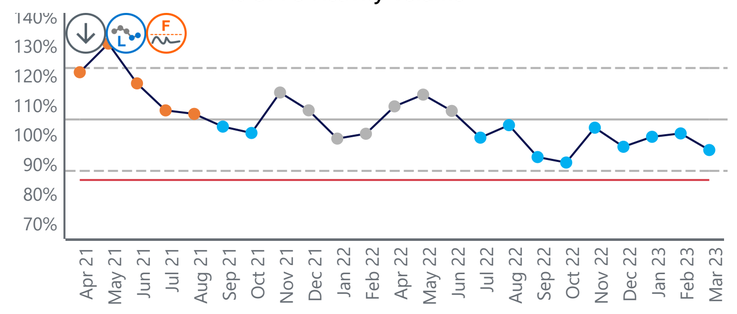
Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



% OPFU Activity Volume



Well Led - Great Place to Work - People

SRO : Melissa Swindell, Chief People Officer

Highlights:

All clinical divisions met or exceeded the PDR target of 90%; the new PDR window commenced on 1st April 2023. Mandatory training remains above the Trust target at 94%.

Areas of Concern:

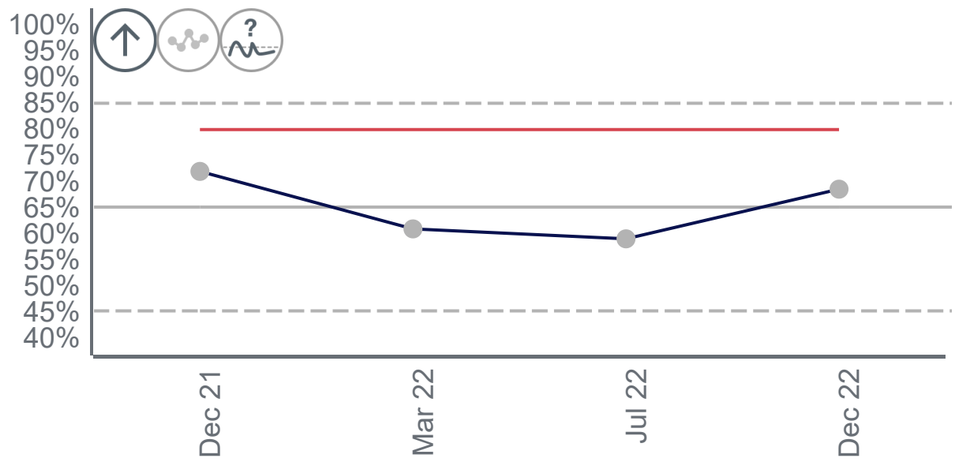
Turnover remains high at 15% and a key priority.

Forward Look (with actions)

Prioritising supporting sickness absence, retention initiatives and wellbeing within core 'business as usual'. 2023/24 key deliverable have been defined within the people plan, focusing on:

1. Thriving Leaders, 2. Recruitment and retention (find and keep), 3. Future Workforce 4. Professional Development Hub.

% Staff who recommended Alder Hey as a place to work



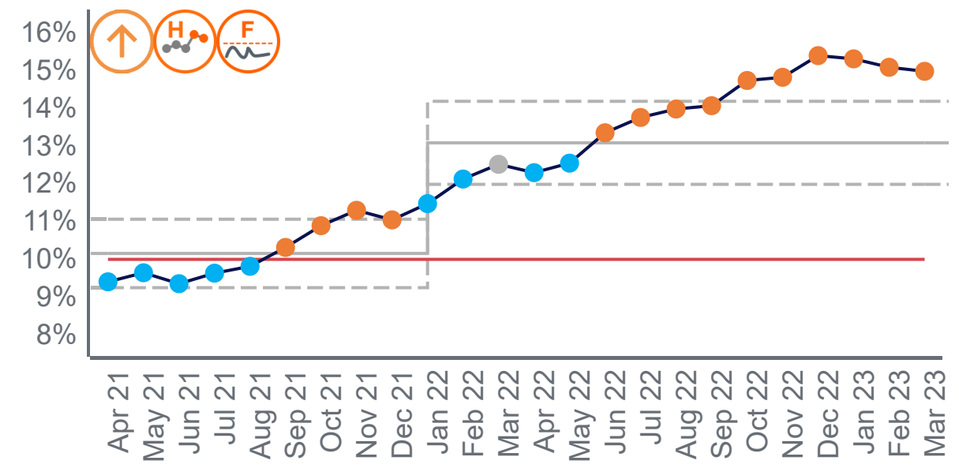
Technical Analysis:

Dec 22 performance of 69% is from national staff survey and therefore is considered a more reliable indicator than previous data points. Given current frequency of the data it is not possible to observe statistical trends, however is it noted that Dec 22 (69%) is lower than Dec 21 (72%) and lower than 80% target.

Actions:

Methodology to capture more data throughout the year in development.

Staff Turnover



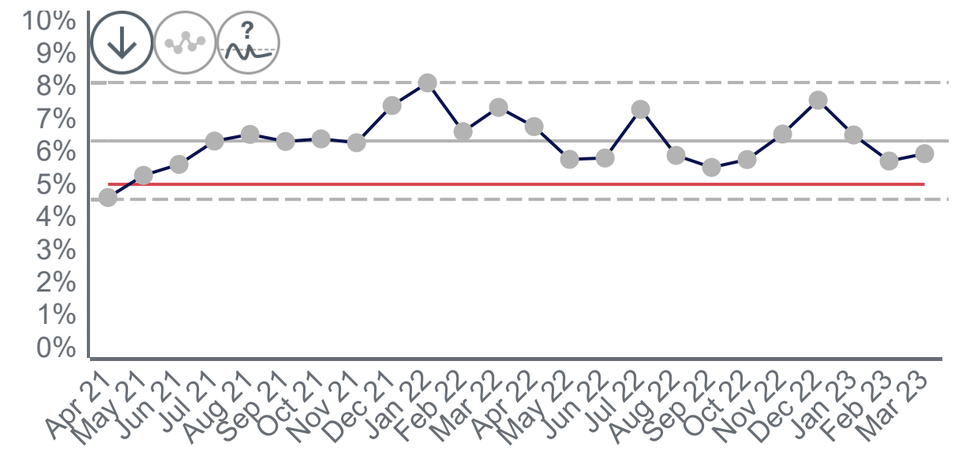
Technical Analysis:

Staff Turnover remains 15% in March, 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:

Retention programme is a key priority for 2023, building on work undertaken in the previous year. Detailed qualitive and quantitative data is provided to the divisional teams quarterly to support detailed analysis and actions.

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in March is 6.0%, Feb is 5.8%; the mean is 6.3% and remains above the 5% target. This comprises STS at 2.0% and LTS at 3.9%. Still demonstrating common cause variation, and has been above (falling short) of the target for the last 2 years (since May 2021). Further actions are required to drive improvement to achieve the target.

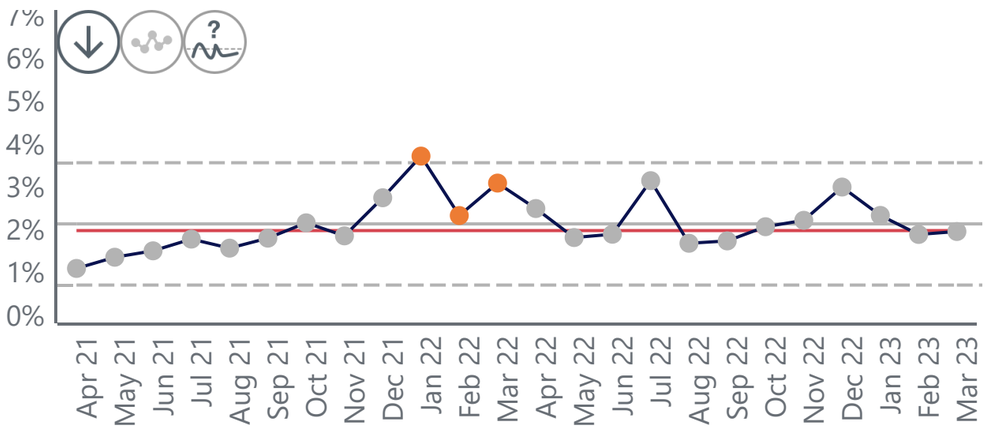
Actions:

Continue to monitor actions to reduce absence including return to work completion and OH referrals in particular, with additional manager training specifically focused on getting the most from an occupational health referral to be rolled out shortly.

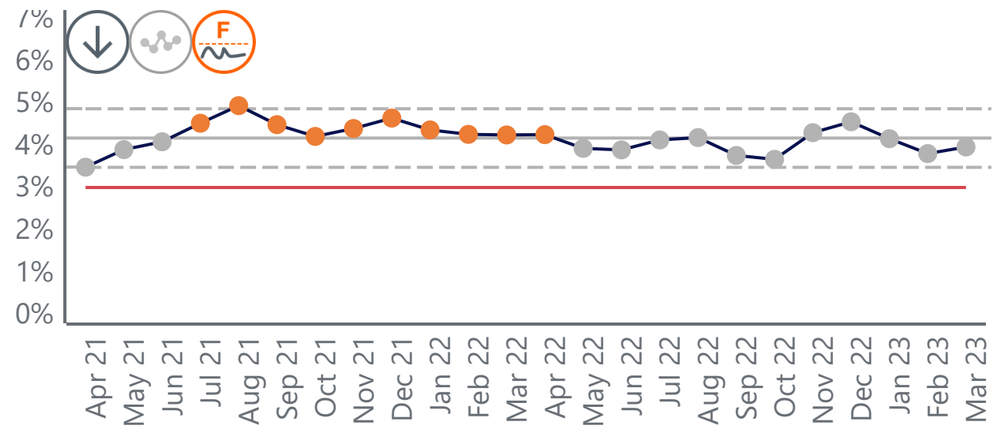
Well Led - Great Place to Work - People - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Staff who recommended Alder Hey as a place to work	December 2022	69	80	65.18		?
Staff Turnover	March 2023	15	10	13.46	H	F
Sickness Absence (Total)	March 2023	6	5	6.33		?
Short Term Sickness	March 2023	2	2	2.16		?
Long Term Sickness	March 2023	4	3	4.17		F
Mandatory Training	March 2023	94	90	92.33		P
% PDRs completed since April	March 2023	93	90	46.42	H	F
Medical Appraisal	March 2023	60	100	57.91	H	F

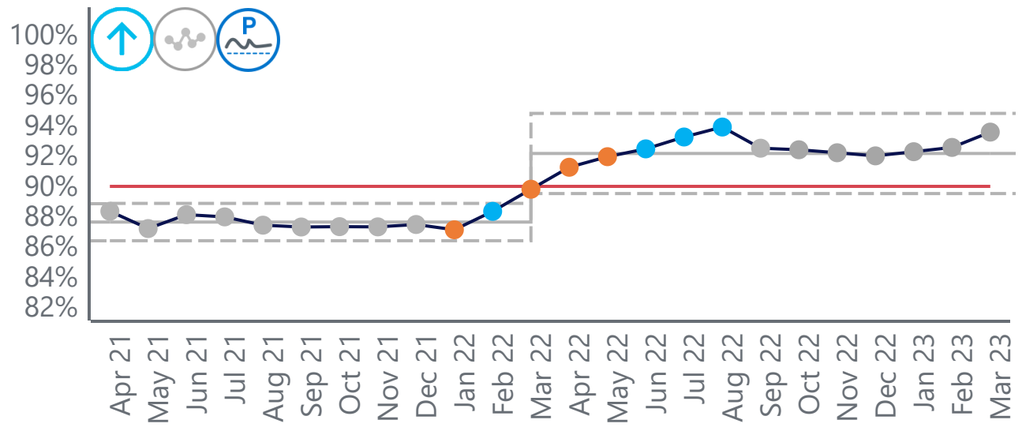
Short Term Sickness



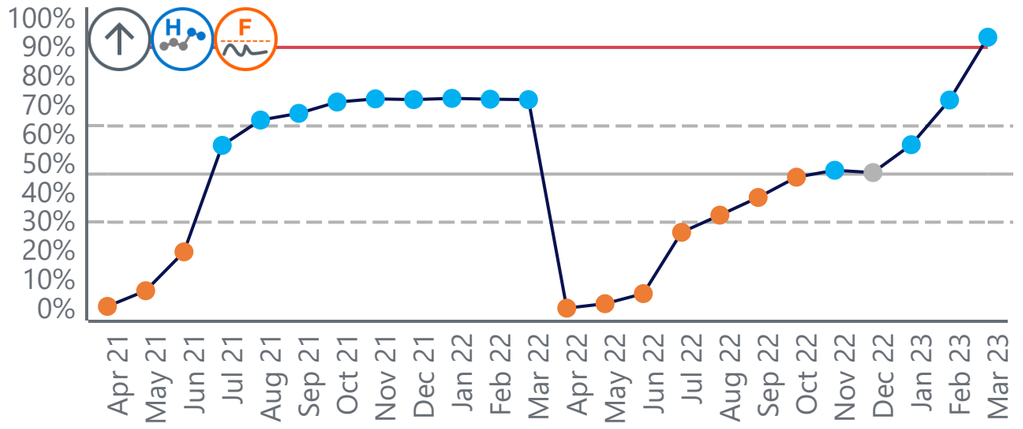
Long Term Sickness



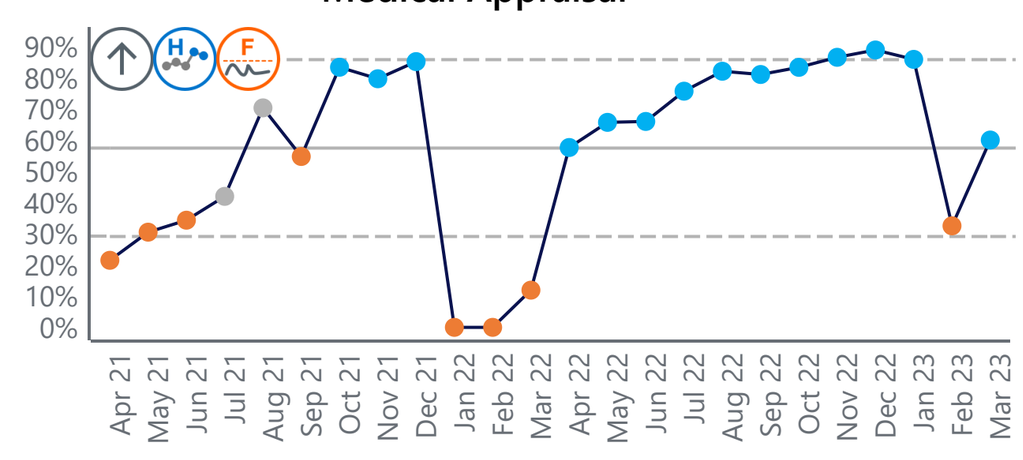
Mandatory Training



% PDRs completed since April



Medical Appraisal



Integrated Performance Report | May 2023

Alder Hey Children's NHS Foundation Trust

Well Led - Financial Sustainability - Finance

SRO : Rachel Lea, Deputy Director of Finance

Highlights:

For March (M12), the Trust is reporting a surplus position of £0.1m which is £1.0m behind the planned position. For the year end position (M1-12) the Trust is reporting a surplus of £5.5m which is £0.8m ahead of plan. £17.3m Cost Improvement Plan target now achieved. Recurrent CIP achievement reached £7.1m with the £5.4m gap now factored into 23/24. Cash has remained high in line with the plan, capital position also as expected.

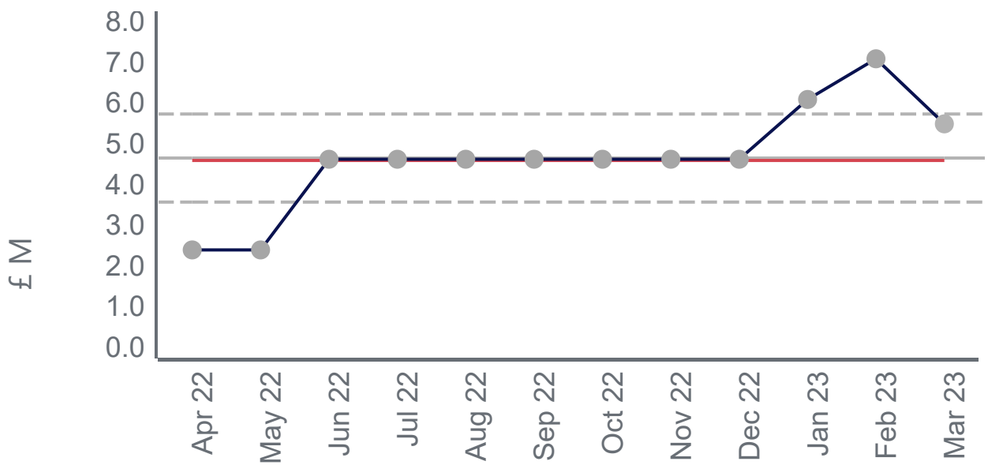
Areas of Concern:

A 43% gap remains in recurrent CIP identified with no transformational schemes in the plan. Challenges remain as we head into 23/24 financial year including inflationary pressures within energy, drugs, non pay and an increase in temporary/premium pay despite activity below 19/20 levels. Did not achieve the 104% ERF threshold.

Forward Look (with actions)

Continued cost control to ensure financial grip & control as we head into 23/24. Urgent focus required on recurrent efficiency. Divisional finance panel meetings will continue in the new year. Triangulation of costs/activity/workforce through the hospital optimisation project and will inform the monitoring of 23/24 budgets.

Revenue Position (Year End Forecast)



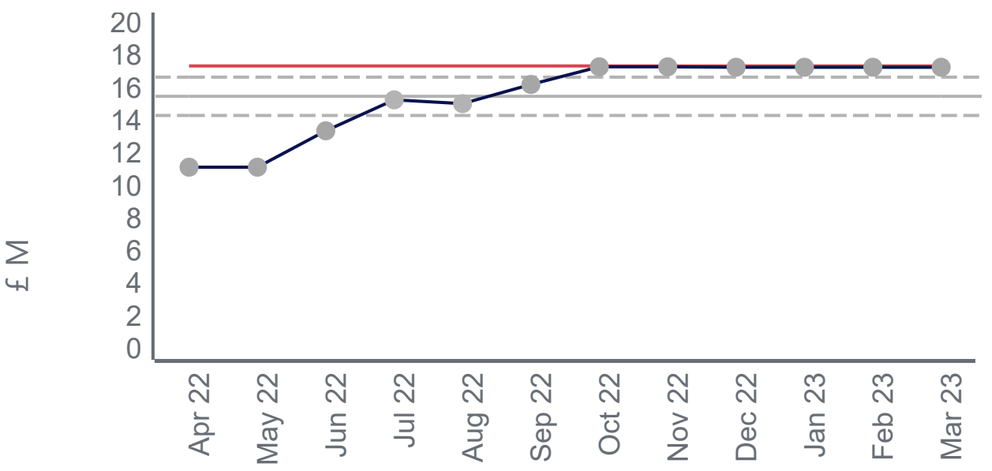
Technical Analysis:

Achieved £5.5m surplus against a plan of £4.6m

Actions:

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

CIP Position In Year (Year End Forecast)



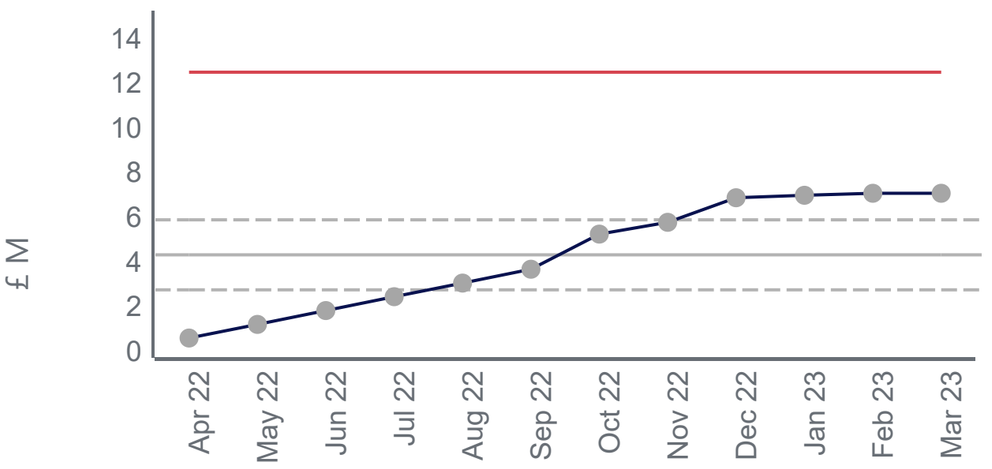
Technical Analysis:

CIP Target now achieved in year.

Actions:

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

CIP Position Recurrent/Full Year Effect



Technical Analysis:

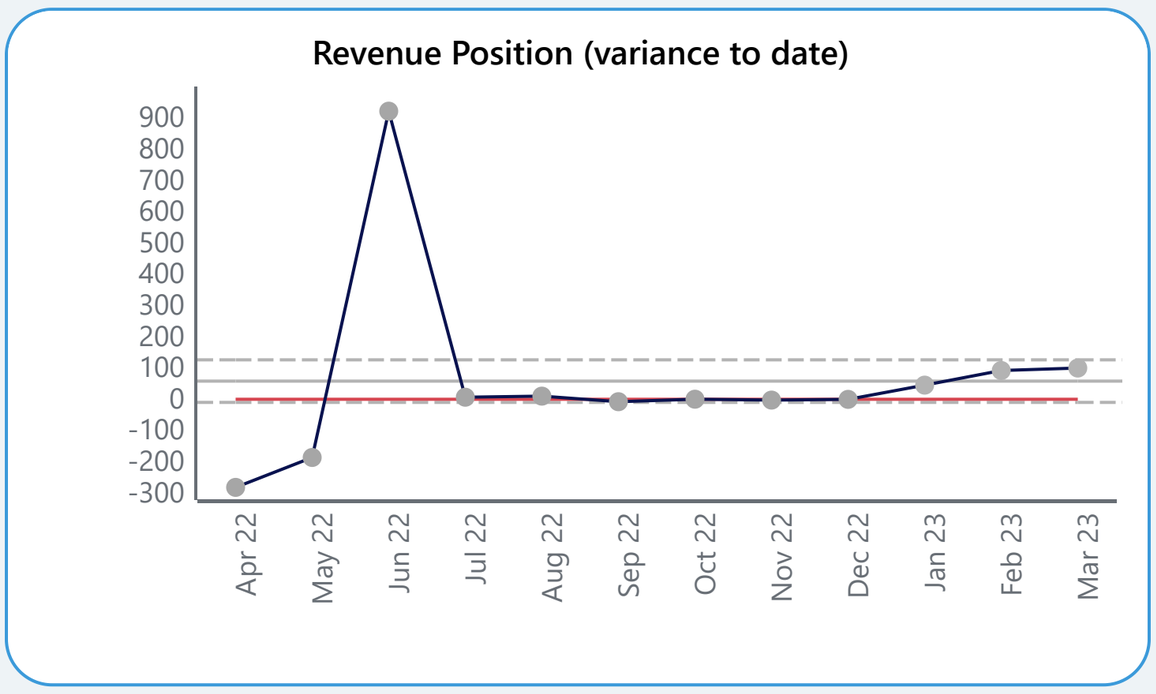
£7.1m recurrent CIP identified resulting in a gap of £5.4m which has now been included in 23/24 plans

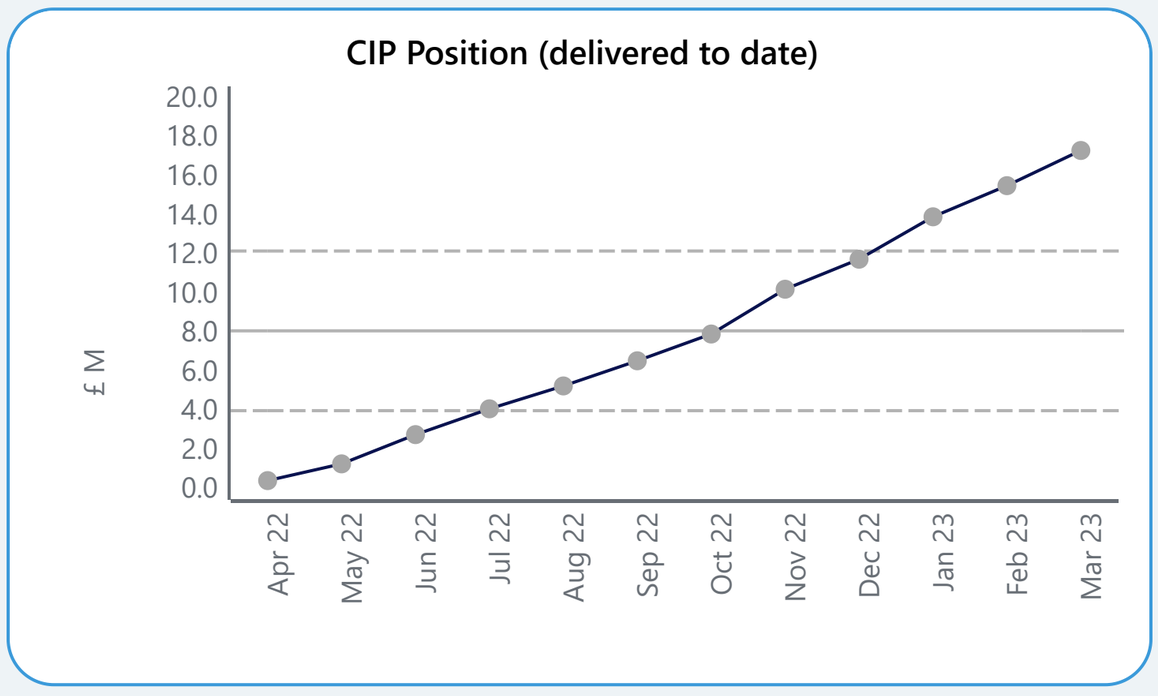
Actions:

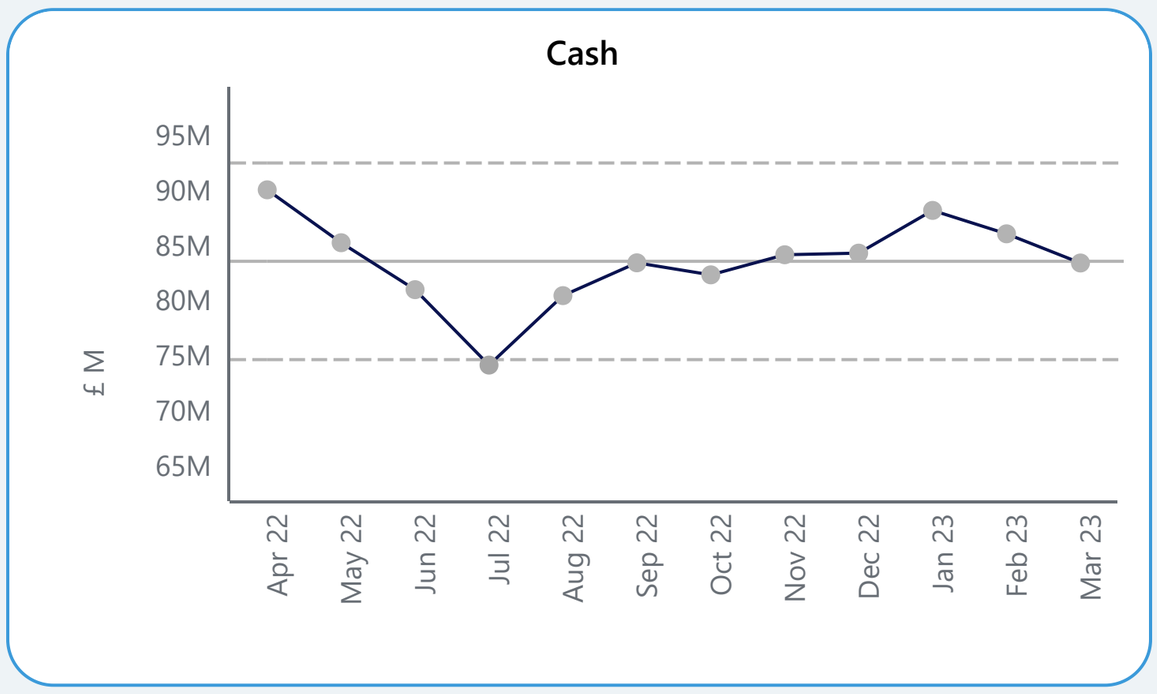
Support required with exec leads and transformation to identify the large scale opportunities either through existing programmes/projects or if not likely to deliver and for new schemes to be agreed & supported.

Well Led - Financial Sustainability - Finance - Metric Summary

Metric	Date	Value	Target	Variation	Assurance
Revenue Position (Year End Forecast)	March 2023	6	5		
CIP Position In Year (Year End Forecast)	March 2023	17	17		
CIP Position Recurrent/Full Year Effect	March 2023	7	13		
Revenue Position (variance to date)	March 2023	100	0		
CIP Position (delivered to date)	March 2023	17			
Cash	March 2023	83,478,000			







Well Led - Risk Management

SRO : Erica Saunders, Director of Corporate Affairs

Highlights:

All Divisional and Corporate Functions' high moderate longstanding risks (risks with a score of 12 on the risk register >12 months) reviewed with monthly oversight of progress from corporate governance team. Monthly risk register validation meetings continue with corporate oversight. Work on development of new form with QA of transfer data for InPhase continues.

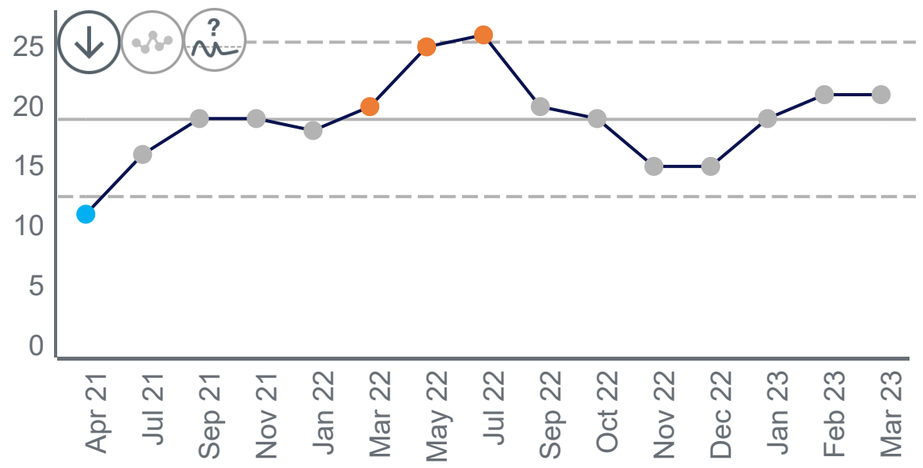
Areas of Concern:

Increasing number of risks overdue risk review has increased compared to previous month. Number of risks with no agreed action plans. Escalated to corporate services lead/Executive or Divisional governance team and directors for immediate review and progress update. Details escalated to Exec of Corporate services to risk leads

Forward Look (with actions)

Ongoing review of open risk, risks with no risk score and overdue actions with relevant teams. Risks with no action plan or overdue review escalated to Divisional, corporate and Exec leads. Plan for implementation of new risk management system (InPhase) on target for GO LIVE 2nd May 23

Number of High Risks (scored 15 and above)



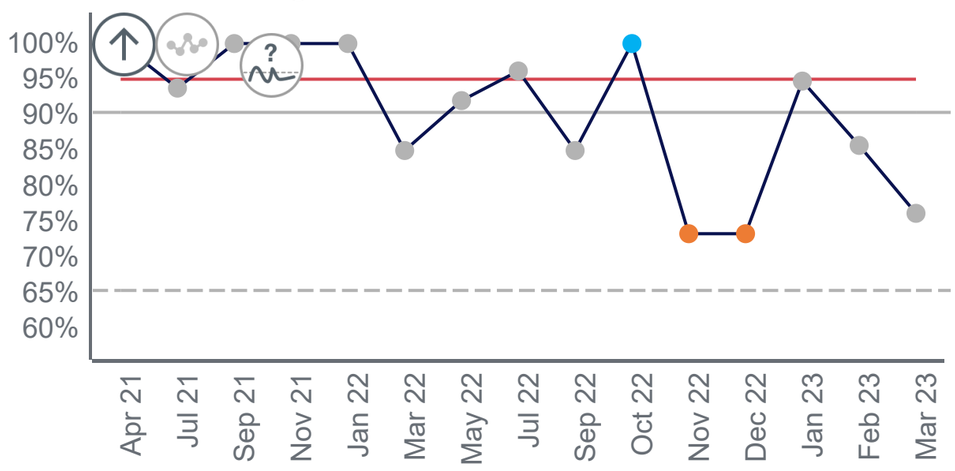
Technical Analysis:

There are 21 High Risks on the risk register at the end of March, which is comparable to Jan & Feb. Overall, this remains stable and is within the normal range.

Actions:

Continue to meet with Divisional and Corporate Services leads as part of the monthly risk review process to review progress of mitigation against existing risks. Divisions/ Services to continue with cleanse and update of risk registers: focused work with service leads/divisions with oversight from corporate governance team. Continued focus on high risks at Risk Management forum individually or

% of High Risks within review date



Technical Analysis:

Compliance of reviewing High risks within date is variable, with 5/21 risks overdue at the end of March. Action is required to ensure consistent compliance with the 95% target.

Actions:

5 outstanding risk reviews have been escalated to relevant risk owner, corporate services lead/Executive or Divisional governance team and directors for immediate review and progress update. Details escalated to Exec of Corporate services

Well Led - Safe Digital Systems - Digital

SRO : Kate Warriner, Chief Digital and Information Officer

Highlights:

• Aldercare • Cycle 4 of AlderCare patient journeys underway • NHS England commencing assurance review of Aldercare programme • Clinical safety briefing completed for key clinical leaders • Go live timing proposed for early Sep 2023 • National Faster Data Flows solution configured • Training commenced on new Risk and Incident Management System • Final design selected for new Trust website • Medical consent forms clinically approved

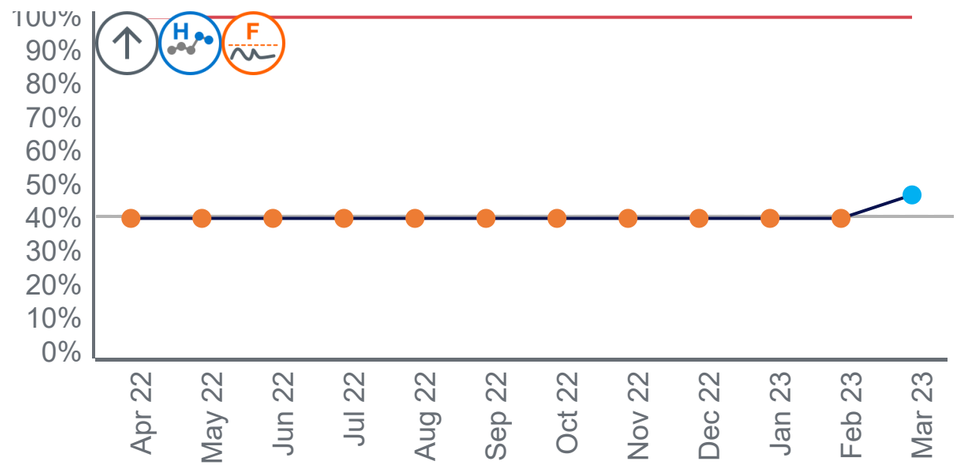
Areas of Concern:

• Aldercare • Completion of AlderCare build to time and quality still contains risks especially for EPMA • Gateway 2 formal review completed, work off items in place for a number of criteria • Aldercare reporting workstream in exception, recovery plan and daily monitoring in place • National changes to incident forms has caused a small delay to Risk and Incident system go live - mitigation plan in progress

Forward Look (with actions)

• Aldercare • Gateway 2 work off plan for outstanding items • Gateway 3 scheduled for May 2023 • Finalise training material • Work with Meditech to finalise go live date • New external website launch – date TBC • New risk and incident management system Trust wide go live • Medical Consent Go Live

Alder Care - Divisional Critical Criteria



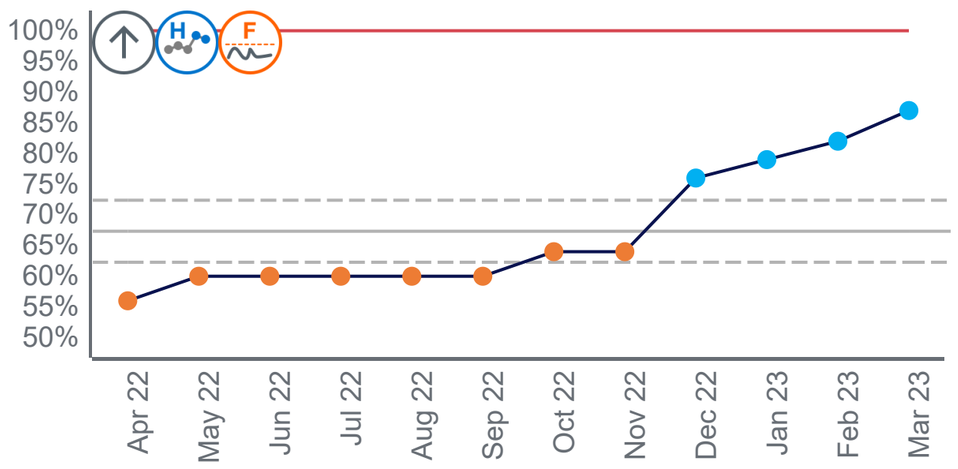
Technical Analysis:

7/15 critical criteria complete. Remainder awaiting system build, resolution of P1 issues or key decisions (e.g. WHO checklist). Performance metric is for "sign off" so percentage only increases once each item is fully signed off by CXIO team.

Actions:

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

Alder Care - % System Build Completion



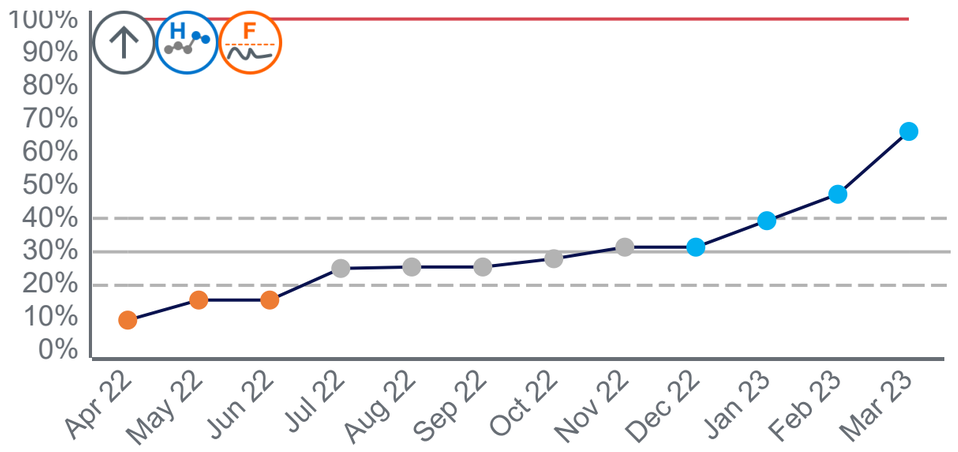
Technical Analysis:

This metric monitors build across all workstreams. Build completion continues to increase in line with individual trajectories but with delays noted for Specialty Packages. EPMA remains ahead of the re-baselined forecast.

Actions:

1. Continue build
2. Monitor progress on EPMA build (47%)

Alder Care - % Speciality documentation build

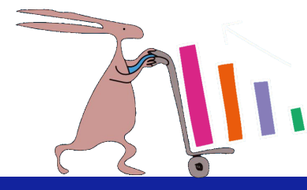


Technical Analysis:

35 of 59 specialty documents have now been completed, with others partially built. Formal sign off processes continue with Divisions to speed up sign off progress.

Actions:

1. Continue build (66%) and sign off process (15%)
2. Work with divisions to sign off Specialty Packages build



Divisional Performance Summary - Community & Mental Health

SRO : Lisa Cooper, Community & Mental Health Division

Highlights

• Recruited to new Consultant psychiatry post in Eating Disorders • Attended a careers day in Edge Hill • Maintain high level of virtual outpatient attendances • High level of contacts with Crisis Care Team (908 contacts) highest month in 22/23 • Reduction in long waiting patients in CAMHS in line with improvement plan • Achieved PDR compliance across Division by end march (94%) • Partial occupation of Sunflower House, allowing children to access facilities on a day attender basis

Areas of Concern

• Increase in PALS contacts with the Division, themes are access times and communication and medication enquiries • Continued high level of demand for ASD and ADHD pathways, impacting on waiting times • Compliance with Initial Health Assessment for children new into care • Continued water safety issues in Catkin and Sunflower House, leading to delay in occupation of Sunflower House

Forward Look (with actions)

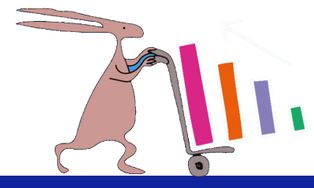
• Continued focus on Was Not Brought rates to support increased attendance and reduce waiting times, including use of WBN predictor tool • Focus on IHA compliance and improvements in compliance with assessment timescales • Move of Clinical Health Psychology to the Division, review underway with service to understand demands and actions to support team going forward.

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	March 2023	22	15	18.83		
Number of Incidents rated No Harm and Near Miss	March 2023	114	80	75.13		
Use of physical restrictive intervention (MH Tier 4)	March 2023	2		9.56		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	March 2023	4	6	3.13		
Number of PALS contacts	March 2023	71	45	44.54		



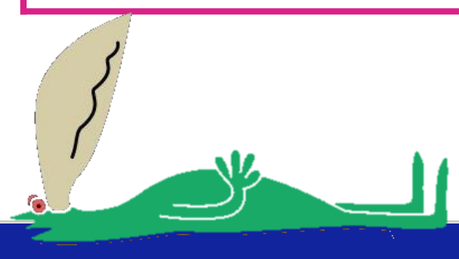
Divisional Performance Summary - Community & Mental Health

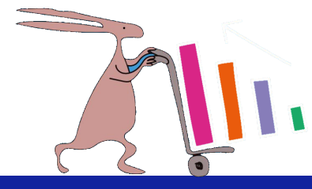
Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Virtual Outpatients (national standard 25%)	March 2023	55	25	53.36		P
% Was Not Brought Rate (All OP: New and FU)	March 2023	13	10	14.21		F
% of Clinical Letters completed within 10 Days	March 2023	67	95	59.49		F
CYP1 - Number of visitors to the site	February 2023	2053		1,443.35		?
CYP1 - Number of Referrals	March 2023	117		97.70	H	?
CYP1 - Number of Referrals Accepted	March 2023	57		40.39	H	?

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of RTT Patients waiting >52weeks	March 2023	2	0	1.96		?
RTT Open Pathway: % Waiting within 18 Weeks	March 2023	45	92	54.31	L	F
% Recovery for OP New & OPPROC Activity Volume	March 2023	98	104	130.73		?
% OPFU Activity Volume	March 2023	149	85	131.79		?
CAMHS: Number of Patients waiting >52weeks	March 2023	25	0	8.21	H	?
CAMHS: First Partnership - % Waiting within 18 weeks	March 2023	63	92	63.31	L	F
CAMHS: Paired Outcome Scores	November 2022	19	40	29.25		?
CAMHS: Crisis / Duty Call Activity	March 2023	908		679.46		?
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	March 2023	89	95	82.86		?
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	March 2023	67	95	66.67		?
ASD: % Incomplete Pathways within 52wks	March 2023	65	90	71.39	L	F
ASD: % Referral to triage within 12 weeks	March 2023	100	100	100.00		P
ADHD: % Incomplete Pathways within 52wks	March 2023	62	90	78.14	L	F
ADHD: % Referral to triage within 12 weeks	March 2023	100	100	100.00		P
IHA: % Complete within 20 days of starting in care	March 2023	4	100	9.54		F
IHA: % complete within 20 days of referral to Alder Hey	March 2023	5	100	27.22		F





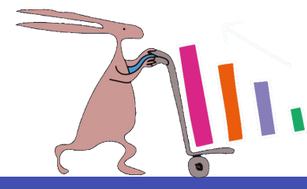
Divisional Performance Summary - Community & Mental Health

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	March 2023	16	10	13.60	H	F
Short Term Sickness	March 2023	2	2	1.78		?
Long Term Sickness	March 2023	4	3	4.01		?
Mandatory Training	March 2023	96	90	94.84		P
% PDRs completed since April	March 2023	94	90	51.89	H	F
Medical Appraisal	March 2023	44	100	50.42		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	March 2023	20	0	6.36		?



Divisional Performance Summary - Medicine

SRO : Urmi Das, Division of Medicine

Highlights

• Continued compliance with Sepsis antibiotics standard across the wards • DC/EL/OP recovery rates despite Industrial action • Diagnostics performance now at 86% within 6 weeks • PDR compliance 93% by year end • Mandatory Training at 94% • Continued compliance with cancer standard; TWW breach in month was patient/parent DNA; child stepped off cancer pathway following subsequent review

Areas of Concern

• ED performance stagnating, not showing improvement in last 3 months • 300 letters over ten days not signed • F&F and Sepsis in ED – renewed focus by new Head of Nursing • Sickness absence – reducing but still a cause for concern re hotspots

Forward Look (with actions)

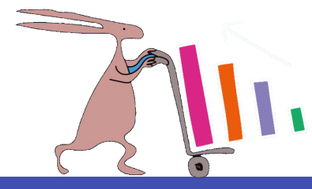
• Revised ED Improvement Focus – review of staffing • Ensuring PDR compliance maintained • CD review of non-compliance with clinical standards supported by HR • Focus on recovery and RTT – ambition to achieve 18 weeks by March 24 • Ensure planned diagnostics

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	March 2023	32	15	21.29		
Number of Incidents rated No Harm and Near Miss	March 2023	182	140	151.54		
Sepsis % Patients receiving antibiotic within 60 mins for ED	March 2023	84	90	84.78		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	March 2023	100	90	92.44		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	March 2023	3	6	4.54		
Number of PALS contacts	March 2023	43	45	42.88		
F&F ED - % Recommend the Trust	March 2023	78	95	70.17		F



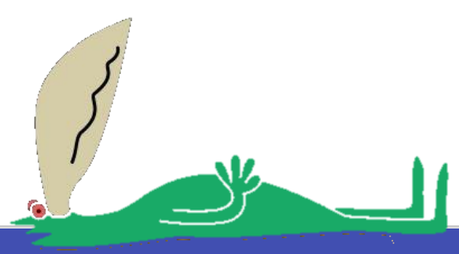
Divisional Performance Summary - Medicine

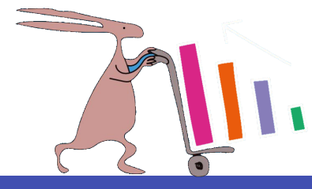
Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	March 2023	78	95	76.30		?
Number of Super Stranded Patients (21 days)	March 2023	20	20	26.50		?
% Virtual Outpatients (national standard 25%)	March 2023	26	25	35.58	L	P
% Was Not Brought Rate (All OP: New and FU)	March 2023	7	10	8.83		?
% of Clinical Letters completed within 10 Days	March 2023	67	95	58.22		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	March 2023	106	104	111.08		?
Number of RTT Patients waiting >52weeks	March 2023	12	0	14.71		?
Diagnostics: % Completed Within 6 Weeks of referral	March 2023	86	99	68.23	H	F
RTT Open Pathway: % Waiting within 18 Weeks	March 2023	60	92	67.41	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	March 2023	95	100	99.28	L	?
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	March 2023	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	March 2023	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	March 2023	100	100	93.48	H	?
Cancer: Faster Diagnosis within 28 days	March 2023	100	75	94.29	H	P
% Recovery for OP New & OPPROC Activity Volume	March 2023	160	104	109.56	H	?
% OPFU Activity Volume	March 2023	98	85	110.23		F





Divisional Performance Summary - Medicine

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	March 2023	14	10	12.87	H	F
Short Term Sickness	March 2023	2	2	2.50		?
Long Term Sickness	March 2023	4	3	4.69	L	F
Mandatory Training	March 2023	94	90	91.62		?
% PDRs completed since April	March 2023	94	90	44.51	H	F
Medical Appraisal	March 2023	48	100	54.98		F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	March 2023	-5	0	-1.71		?

Divisional Performance Summary - Surgery

SRO : Benedetta Pettorini, Division of Surgical Care

Highlights

• Incident reporting for no harm/near miss increased showing an improved reporting culture • Retained 100% antibiotics within 60 mins for Sepsis • Retained 100% PALS and formal complaints response against target despite increase in contacts • WNB at trust target of 8% • Virtual OP decreased in month

Areas of Concern

• Patients not re-booked within 28 days increased due to impact of IA capacity reduction & focus on treating all patients to achieve 0 > 78 weeks • Clinic letters unsigned within 30 days declined within month • Super stranded patients increased in month • No. of patients > 52 weeks as per trajectory. Main challenges are PDEN & ENT. Impact of capacity challenges, increase in demand & impact of IA & increased urgent patients • Clinical letters unsigned within 30 days has declined in month

Forward Look (with actions)

• Although decreased, cancelled operations on the day (non-clinical) remains a key focus with new processes in place • ACOO/DD to write to all individuals with letters unsigned over 30 days & continued monitoring via governance leads. Review with BI/transcription a report to pull any clinic attends with no letter dictated • Division work to a reduced virtual target due to cohort of patients however action to review March performance as decreased in month • Key action plans via A3 for PDEN & ENT recovery which include insourcing, add. Sessions & mutual aid

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	March 2023	49	40	47.88		
Number of Incidents rated No Harm and Near Miss	March 2023	180	150	158.96		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	March 2023	100	90	87.14		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	March 2023	8	6	4.79		
Number of PALS contacts	March 2023	61	45	42.25		

Divisional Performance Summary - Surgery

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Cancelled Operations (on day of admission for a non-clinical reason)	March 2023	28	20	21.54		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	March 2023	15	0	7.29		?
Number of Super Stranded Patients (21 days)	March 2023	21	30	11.29	H	F
% Virtual Outpatients (national standard 25%)	March 2023	17	25	17.37		F
% Was Not Brought Rate (All OP: New and FU)	March 2023	8	10	8.58		?
% of Clinical Letters completed within 10 Days	March 2023	72	95	61.12	H	F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	March 2023	92	104	90.32		?
Number of RTT Patients waiting >52weeks	March 2023	674	0	308.75	H	F
Diagnostics: % Completed Within 6 Weeks of referral	March 2023	60	99	46.45		F
RTT Open Pathway: % Waiting within 18 Weeks	March 2023	53	92	60.27	L	F
% Recovery for OP New & OPPROC Activity Volume	March 2023	89	104	97.92		?
% OPFU Activity Volume	March 2023	84	85	98.80	L	?

Divisional Performance Summary - Surgery

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	March 2023	14	10	12.69	H	F
Short Term Sickness	March 2023	3	2	2.48		?
Long Term Sickness	March 2023	3	3	3.67		?
Mandatory Training	March 2023	92	90	91.42		?
% PDRs completed since April	March 2023	93	90	41.51	H	F
Medical Appraisal	March 2023	74	100	62.15		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	March 2023	-7	0	-3.96		?

Divisional Performance Summary - Corporate

SRO : Erica Saunders, Director of Corporate Affairs

Highlights

• Positive engagement in all service areas in monthly review of risks and actions required regarding any overdue risks. 62% of corporate risks in date on 15th March 2023 • Mandatory training for Corporate Services remains above the 90% target for the months Dec 2022-Feb 2023 • Sickness absence saw a slight decrease in February to 5.85% from the previous month (against a target of 5%) • The PDR rate for band 7+ currently stands at 92.75% (against a target of 90% by end of July 2023).

Areas of Concern

• Staff turnover rates remain an area of focus, currently sitting at 17.45% (as at 22nd March) • Return to work completion is currently sitting at 86.67% against a target of 100% (as at 22nd March) • PDRs for all AFC staff below 90% target at 85.57% (as at 22nd March) • In the

Forward Look (with actions)

Not yet agreed with CSC group, however Chair to suggest focus on:
• Ensuring all risks are reviewed within timescale • Deep dive into vacancies across corporate areas to determine if any opportunities for progression/changes to skill mix • EPRR Manager to be invited to join group to ensure compliance in corporate areas

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	March 2023	16	10	14.76	H	F
Sickness Absence (Total)	March 2023	8	5	6.77		?
Short Term Sickness	March 2023	1	2	1.71		?
Long Term Sickness	March 2023	7	3	5.07	H	F
Mandatory Training	March 2023	94	90	92.72	H	P
% PDRs completed since April	March 2023	93	90	50.98	H	F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	March 2023	11	0	-9.14		?

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Safe Staffing & Patient Quality Indicator Report
December 2022

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Availablity		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 - FTE	HCA - FTE	RN - %	HCA - %	RN - %	HCA - %	RN - %	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good	Pals	Complaints
Burns Unit	91%	82%	100%	-	3641	**95**	38.33	21.26	15.64	0.80	4.57%	20.00%	0.00%	0.00%	2.62%	6.45%	2	25	0	4	3	100%	0	0
HDU	58%	37%	58%	34%	6380	**272**	23.45	28.49	64.59	2.61	14.59%	-24.41%	1.54%	0.00%	12.95%	2.27%	13	104	11	15	2	50%	0	1
ICU	67%	86%	67%	13%	13706	**450**	30.46	28.49	148.95	4.00	6.74%	75.00%	0.67%	0.00%	7.20%	41.94%	13	159	0	2	0	0%	0	0
Ward 1cC	91%	90%	84%	71%	4744	**577**	8.22	11.02	59.69	6.45	3.43%	-39.77%	0.00%	0.00%	9.67%	9.92%	2	36	0	3	4	75%	1	0
Ward 1cN	60%	0%	67%	-	2629	**211**	12.46	12.46	30.90	1.00	7.13%	17.70%	2.99%	0.00%	14.77%	0.00%	2	23	3	12	1	100%	0	0
Ward 3A	81%	77%	87%	88%	7068	**708**	9.98	10.49	50.41	10.90	-8.81%	20.09%	0.00%	0.00%	11.81%	15.73%	4	29	0	9	20	100%	0	0
Ward 3B	77%	94%	81%	-	4329	**345**	12.55	12.55	39.81	3.92	-7.19%	-14.48%	0.00%	0.00%	7.30%	30.05%	0	19	0	28	4	75%	0	0
Ward 3C	102%	107%	94%	108%	7859	**810**	9.70	9.33	57.11	4.23	-1.52%	38.04%	0.00%	0.00%	10.88%	1.53%	2	62	1	6	9	88.89%	1	0
Ward 4A	73%	53%	76%	107%	7317	**666**	10.99	10.49	65.03	5.99	2.49%	8.11%	0.00%	0.00%	14.67%	10.91%	1	50	2	5	19	89.47%	0	0
Ward 4B	62%	82%	56%	87%	7429	**515**	14.43	11.70	39.85	31.29	7.14%	0.61%	2.50%	0.00%	16.44%	16.68%	16	95	1	16	12	91.67%	0	0
Ward 4C	80%	96%	74%	103%	6443	**807**	7.98	11.20	50.65	10.57	-7.06%	10.59%	1.96%	9.54%	15.73%	18.32%	8	94	2	23	23	91.30%	2	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

There continues to be high levels of sickness on the medical wards, 3B, 3C, 4B & 4C. Ward 4C had an outbreak of flu during December, resulting in increased numbers of staff off sick. A robust focus with ward managers and matrons which has significantly reduced sickness levels in January. Ward 4B has started HR drop-in sessions w/c 13th February and ward 3B started a workstream in September to focus and support staff wellbeing and retention.

Ward 4B medication incidents have decreased since November but still the highest reported ward. 9 of the 16 were reported as near miss, 6 no harm and 1 minor harm. Themes recorded were CD audit and storage. Actions taken have included a CD Pharmacist working with the ward. All lessons learnt from incidents and near misses are shared with staff.

Surgery

Ward 1cC had a low fill rate for HCAs on the night shifts, however HCA is not always required and is reviewed weekly throughout the month.

Ward 4A had 5WTE off on long term sick for a prolonged period. Ward 3A & 4A still have a high requirement for 1:1s which has required NHSP cover.

Critical Care

Following a successful recruitment day, several new nurses commenced in critical care in October but will be supernumerary for 4 months (till January 2023) and not included in numbers. Staffing in critical care for the month of December was challenged as a number of experienced staff had left to join the response team. High levels of sickness particularly on HDU contributed to reduced staffing levels.

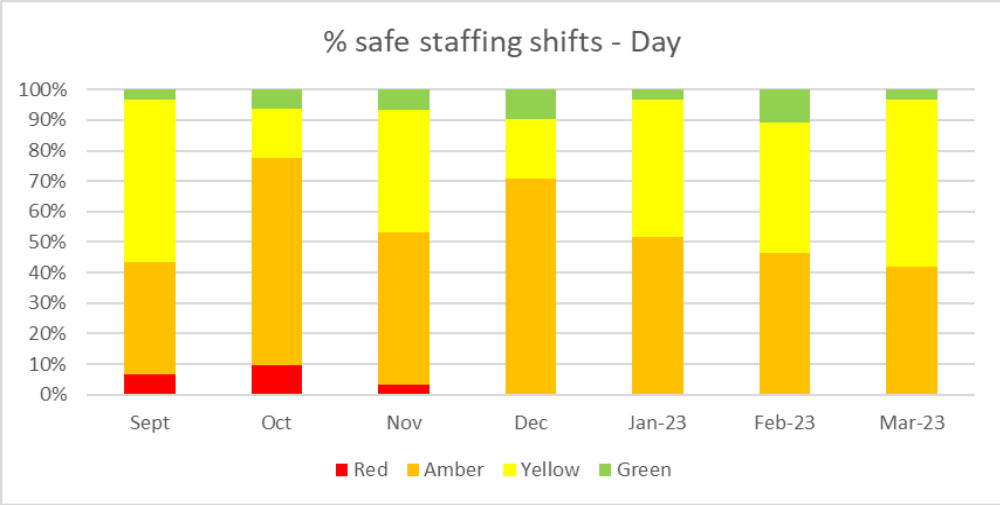
Summary

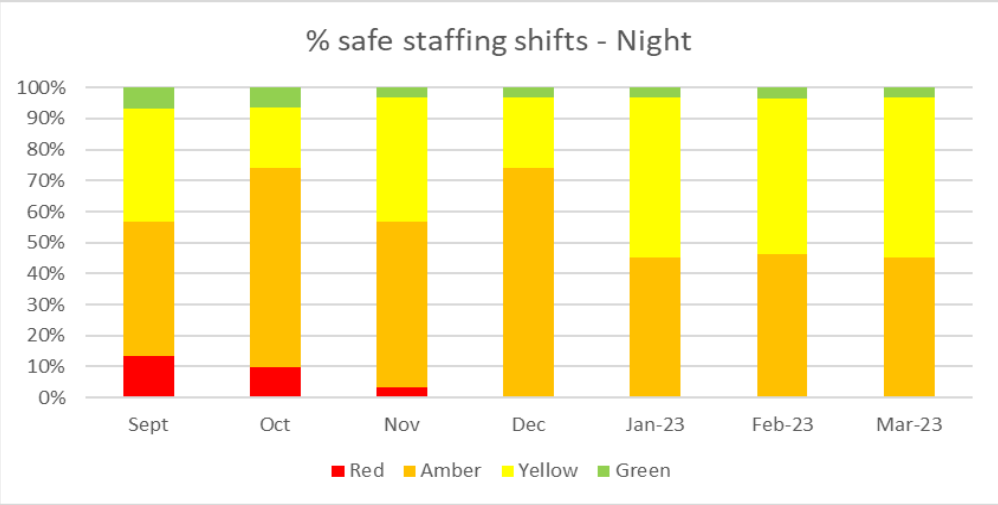
CHPPD benchmarks equally on most wards with the exception of Ward 4C due to high levels of sickness in the month. Burns CHPPD remains higher than the national benchmark. This is explained by Alder Hey incorporating a day case clinic nurse within the unit and staffing numbers. Critical care CHPPD despite reduced staffing levels compares favourably with national benchmark.

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

Summary of March staffing

Staffing rag has been similar to previous months. 0 red days have been recordered since November indicating an improvement in staffing levels.





Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Integrated Performance Report – 2023/24 Proposal**
Report Of:	Kate Warriner, Chief Digital and Information Officer Adam Bateman, Chief Operating Officer
Paper Prepared by:	Alex Garbett, Associate Director of Data & Analytics Andrew McColl, Associate COO

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

Integrated Performance Report – 2023/24 Proposal

1. Executive Summary

As part of Annual Planning and the development of the new 2030 Vision and strategy the IPR requires a refresh to reflect the objectives and priorities for the 2023/24 financial year. This report details the following changes:

- Introduction of a Flash Report
- Updates to section titles, including 3 new areas
- Updates to current suite of metrics, including additional clarity on source of targets, internal and external requirements
- Removal of Metric Summary Tables
- Updates to Divisional summary sections, with additional detail in Performance Review Meetings

The Trust Board is asked to approve these proposed changes, with implementation in May and new report available for Trust Board on 8 June.

2. Background

The 2023/24 Integrated Operational Plan, approved by Trust Board in March, sets out our objectives and priorities for coming year. This plan for the next 12 months sits alongside and aligns with the long-term strategy, 2030 Vision, as we seek to deliver a healthier, happier and fairer future for children and young people.

In 2022/23 the Trust adopted a new Integrated Performance Report (IPR) which replaced the Executive Scorecard and Corporate Report. This report was aligned to CQC domains and strategic objectives and priorities. The report provided a new approach which linked to Brilliant Basics and Making Data Count principles and facilitated the following improvements:

- Reduction in length of report and volume of metrics
- Use of Watch and Drive metrics, to focus on agreed priorities
- Use of SPC Charts, which are statistically and visually more effective
- Consistent and structured commentary, with emphasis on actions.

3. Proposed Changes for 23/24

3.1 Flash Report

With the realignment of meeting dates for Trust Board into the next month (ie March IPR would be presented in May Board) we will introduce a new ‘flash report’ to the IPR. The aim of the flash report is to highlight a small number of metrics which the Board needs to know promptly without waiting for the next IPR, one month in arrears, which may require immediate action. This approach provides the Board with high level oversight of selected operational objectives, with full details in the subsequent IPR.

The flash report will contain the following metrics:

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0 (zero)	x
		Number of Serious Incidents (Steis reported)	0 (zero)	x
		Number of Never Events	0 (zero)	x
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0 (zero)	x
		FFT - % Recommending Trust	> 95%	x
Supporting our Colleagues	Increase people Availability and Wellbeing	Sickness Absence Total	< 5%	x%
		Staff Turnover	*<13%*	*x%*
Collaborating for CYP	Handover Springfield Park to the community	Return Springfield Park to Liverpool City Council	By Nov 2023	On / Off track
Smartest ways of Working	Improve Access to Care and Reduce Waiting Times	ED: % treated within 4 Hours	> 76%	x %
		Number of RTT Patients waiting >65weeks	0 (zero)	x
		Number of ASD & ADHD Patients waiting >65weeks	0 (zero)	x
		Elective Recovery	> 106%	x%
		Diagnostic Performance	> 90%	x%
	Financial sustainability	Revenue position – Year End forecast	Break even	£m
	Safely Deploy Alder C@re	Alder C@re deployed	By Sept 2023	On / Off track

The flash report will be completed at pace and would be circulated to board members 48 hours prior to board, showcasing data from the immediate month prior. A table of delivery is outlined below, with detail of the flash report highlight where less than 48 hours delivery is required (May 2023) or where the Flash Report cannot deliver a full months data (Jan 2024).

Board Date	Papers due out	IPR	Flash report released
4th May	27th April	March data	3rd May
8th June	1st June	April data	6th June
6th July	29th June	May data	4th July
7th Sept	31st Aug	June data	5th Sept
5th Oct	28th Sept	August data	3rd Oct
9th Nov	2nd Nov	Sept data	7th Nov
7th Dec	30th Nov	Oct data	5th Dec
11th Jan	4th Jan	Nov data	9th Jan
1st Feb	25th Jan	Dec data	30th Jan
7th Mar	29th Feb	Jan data	5th March

3.2 Section Titles

Section titles will be updated to align to strategic goals and operational objectives, in line with the annual plan:

2022/23 IPR	2023/24 IPR	
Outstanding Safety - Safe	**Unrivalled Experience:** Safety	
Outstanding Safety - Caring	**Unrivalled Experience:** Caring	
Recovery & Access – Effective	**Smartest Ways of Working –** Accessible Services: Effective	
Recovery & Access - Responsive	**Smartest Ways of Working –** Accessible Services: Responsive	
	Collaborating for CYP – Reducing Health Inequalities: Responsive	New Section
	Collaborating for CYP – Green Plan: Well Led	New Section
Great Place to Work (People) – Well Led	**Supporting our People:** Well Led	
Financial Sustainability – Well Led	**Smartest Ways of Working –** Financial Sustainability: Well Led	
Risk Management – Well Led	**Risk Management:** Well Led	
Safe Digital Systems – Well Led	**Smartest Ways of Working –** AlderC@re: Well led	
	Pioneering Breakthroughs – Research and Innovation: Well Led	New Section

3.3 Update to Suite of Metrics

The comprehensive proposal to updated metrics can be found in Appendix A. A summary of significant changes is detailed below:

- Number of Incidents will be per 1,000 bed days which will enable the organisation to benchmark more effectively
- % PALS Resolved within 5 days now a drive metric
- % Was Not Brought Rate now a drive metric
- Number of Community Patients waiting >65weeks a new drive metric
- Health inequalities, new section with 3 new drive metrics
- Green Plan, new section with 3 new drive metrics
- % Staff who recommended Alder Hey as a place to work removed, to be replaced by a “Thriving Index” which is in development
- Alderc@re metrics to be updated in the lead up to go live
- Pioneering Breakthroughs – Research and Innovation, new section with 3 new drive metrics

Any metrics which are removed from the IPR will still be available in appropriate governance structures, eg in Divisional Performance Review packs.

Based on feedback received, we will also provide additional clarity in the IPR regarding the target for each metric, including whether the target is set internally or externally and whether there is any regulatory or statutory component to each metric.

3.4 Removal of Metric Summary Tables

As part of the implementation of the new IPR in September 2022 both a table of metrics and SPC charts were provided to help the board transition to utilising SPC Charts. This additional

table of metrics was a duplication of information already made available in the IPR via the SPC Charts.

For 2023/24 we propose to remove the metric summary tables, to make the report more concise and remove duplication. All agreed metrics will included in the IPR in SPC / graphical format, so the removal of these summary tables will not reduce the information available to the Board.

An Example of the table to be removed is shown below:

Outstanding Safety - Safe - Metric Summary

Metric	Date	Value	Mean	Target	Variation	Assurance
Number of Incidents rated Minor Harm and above	February 2023	100	89	72		
Number of Incidents rated No Harm and Near Miss	February 2023	400	398	380		
Number of Serious Incidents (Sis) reported)	February 2023	0	1	0		
Number of Never Events	February 2023	0	0	0		
Sepsis % Patients receiving antibiotic within 60 mins for ED	February 2023	83	85	90		
Sepsis % Patients receiving antibiotic within 60 mins for inpatients	February 2023	100	90	90		
Number of Medication Errors resulting in harm (minor harm and above)	February 2023	4	4	4		
Pressure Ulcers G2-4	February 2023	5	4	3		
Use of physical restrictive intervention (MH Tier 4)	February 2023	16	15			
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)	February 2023	12	22	30		
Hospital Acquired Organisms - MRSA (BSI)	February 2023	0	0	0		
Hospital Acquired Organisms - (C.Difficile)	February 2023	0	0	0		
Hospital Acquired Organisms - MSSA	February 2023	0	1	0		

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3.5 Updates to Divisional Summary Sections

In 2023/24 we will improve the Divisional Summary sections, with the following changes:

- Remove metric tables and replace with SPC charts, which are visually easier to understand and observe trend in performance
- Increased space for commentary, to ensure Divisional reports at Board are comprehensive
- Reduce the number of metrics for each division included in the IPR, with primary focus on drive metrics (see Appendix A). This will be supplemented with a comprehensive Divisional Performance Review pack for each Division (see Appendix B), which will be used at Performance Review meetings with the executive team

This approach will allow the Board to focus on the key areas in each division whilst benefiting from the increased clarity of using SPC charts rather than the metric table approach. This will allow the IPR to remain a concise document, with more insight and additional space for divisional commentary whilst solidifying governance structures with additional detail reported in Divisional Performance Review meetings with executive colleagues.

4. Summary and Conclusion

Following the Annual Planning and the development of the new 2030 Vision, the IPR has been reviewed and updated to reflect the challenges and goals for the 2023/24 financial year. The changes include:

- Introduction of a Flash Report
- Updates to section titles, including 3 new areas
- Updates to current suite of metrics, including additional clarity on source of targets, internal and external requirements
- Removal of Metric Summary Tables
- Updates to Divisional summary sections, with additional detail in Performance Review Meetings

The Trust Board is asked to approve these proposed changes, with implementation in May and new report available for Trust Board on 8 June.

Appendix – Full Review of the Suite of Metrics for IPR 2023/24

Unrivalled Experience: Safety

Drive / Watch	2022/23 Metric	Action	Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	Number of Incidents rated Minor Harm and Above	Change Currency	Drive	Incidents of harm per 1,000 bed days (rated Minor harm and above)	tbc	Y	Y	Y	Y
Drive	Number of Incidents rated No Harm and Near Miss	Change Currency	Drive	Number of Incidents rated No Harm and Near Miss per 1,000 bed days	Tbc	Y	Y	Y	Y
Watch	Number of Serious Incidents (Steis reported)	Unchanged	Watch	Number of Serious Incidents (Steis reported)	0 (Zero)				
Watch	Number of Never Events	Unchanged	Watch	Number of Never Events	0 (Zero)				
Watch	Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients	Unchanged	Watch	Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients	> 90%				
Watch	Sepsis: % Patients receiving antibiotic within 60 mins for ED	Unchanged	Watch	Sepsis: % Patients receiving antibiotic within 60 mins for ED	> 90%				
Watch	Number of Medication Errors rated Minor harm and above	Change Currency	Watch	Medication Errors rated Minor harm and above per 1,000 bed days	TBC				
Watch	Pressure Ulcers G2-4	Unchanged	Watch	Pressure Ulcers G2-4	< 5				
Watch	Use of physical restrictive intervention	Unchanged	Watch	Use of physical restrictive intervention	< 20				
Watch	Number of Unplanned Admissions to Critical Care (HDU/PICU)	Unchanged	Watch	Number of Unplanned Admissions to Critical Care (HDU/PICU)	< 30				
Watch	Hospital Acquired Organisms - MRSA (BSI)	Unchanged	Watch	Hospital Acquired Organisms - MRSA (BSI)	0 (Zero)				
Watch	Hospital Acquired Organisms - C.difficile	Unchanged	Watch	Hospital Acquired Organisms - C.difficile	0 (Zero)				
Watch	Hospital Acquired Organisms – MSSA	Unchanged	Watch	Hospital Acquired Organisms – MSSA	0 (Zero)				
		New metric from annual plan	Watch	Number of employees trained in new Level 1 of Patient Safety	> 90%				

Note – Safe Staffing report will continue to be included as an addendum to the IPR

Unrivalled Experience: Caring

Drive / Watch	2022/23 Metric	Action	Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	F&F Test - % Recommend the Trust	Unchanged	Drive	F&F Test - % Recommend the Trust	> 95%				
Drive	% Complaints Responded to within 25 working days	Change target from 100% to 90%	Drive	% Complaints Responded to within 25 working days	> 90%	Y	Y	Y	Y
Watch	Number of formal complaints received	Unchanged	Watch	Number of formal complaints received	< 20				
Watch	% PALS Resolved within 5 Days	Change from Watch to Drive	Drive	% PALS Resolved within 5 Days	> 90%	Y	Y	Y	Y
Watch	Number of PALS contacts	Unchanged	Watch	Number of PALS contacts	< 150				
Watch	F&F ED - % Recommend the Trust	Unchanged	Watch	F&F ED - % Recommend the Trust	> 95%				

Smartest Ways of Working – Accessible Services: Effective

Drive / Watch	2022/23 Metric	Action	Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	ED: % treated within 4 Hours	Change target from 95% to 76% (national guidance)	Drive	ED: % treated within 4 Hours	> 76%		Y		
Watch	Number of Cancelled Operations (on day of admission for a non-clinical reason)	Unchanged	Watch	Number of Cancelled Operations (on day of admission, non-clinical reason)	< 20				
Watch	Number of Patients cancelled on the day of surgery, not re-booked within 28 Days	Remove (no financial penalty in 23/24 contract)							
Watch	Number of Super Stranded Patients (21 days)	Unchanged	Watch	Number of Super Stranded Patients (21 days)	< 30				
Watch	% Virtual Outpatients (national standard 25%)	Remove (not a current priority for improvement)							
Watch	% Was Not Brought Rate (All OP: New and FU)	Change from Watch to Drive and change target to 8%	Drive	% Was Not Brought Rate (All OP: New and FU)	< 8%	Y	Y	Y	
Watch	% Clinical Letters completed <10 Days	Unchanged	Watch	% Clinical Letters completed <10 Days	> 95%	Y	Y	Y	
		New metric from annual plan and national guidance	Watch	Theatre Utilisation (Capped Touch Time)	> 85%				
		New metric from annual plan and national guidance	Watch	Virtual Ward Bed Days (based on 80% occupancy of 20 beds)	> 480 bed days pcm				

Smartest Ways of Working – Accessible Services: Responsive

Drive / Watch	2022/23 Metric	Action
Drive	% Recovery for DC & Elec Activity Volume (national standard of 104%)	**Change of Target**
Drive	Number of RTT Patients waiting >52weeks (Incomplete pathways, OP&IP)	**Change threshold from 52ww to 65ww, as per national standards**
Drive	Diagnostics: % Completed Within 6 Weeks of referral	**Change from Drive to Watch** **Change target from 99% to 90%**
Watch	RTT Open Pathway: % Waiting within 18 Weeks (OP & IP Combined)	**Remove – focus on longest waits (>65ww)**
Watch	Cancer: 2 week wait from referral	**Unchanged**
Watch	31 day wait from decision to treatment	**Unchanged**
Watch	31 day wait until subsequent treatments	**Unchanged**
Watch	31 days from urgent referral for suspected cancer to first treatment	**Unchanged**
Watch	Cancer: Faster Diagnosis within 28 days	**Unchanged**
Watch	% Recovery for OP New & OPPROC Activity Volume (national standard of 104%)	**Change of Target**
Watch	% OPFU Activity Volume (national standard reduce volume to 85%)	**Remove – no impact on ERF payment in 23/24**
Watch	Waiting List Size	**Unchanged – Remove target**
		New metric from annual plan
		New metric from annual plan

Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	% Recovery for DC & Elec Activity Volume (Internal Target of 106%)	106%		Y	Y	
Drive	Number of RTT Patients waiting >65weeks (Incomplete pathways, OP&IP)	0 (zero)		Y	Y	
Watch	Diagnostics: % Completed Within 6 Weeks of referral	> 90%		Y	Y	
Watch	Cancer: 2 week wait from referral	93%				
Watch	31 day wait from decision to treatment	93%				
Watch	31 day wait until subsequent treatments	93%				
Watch	31 days from urgent referral for suspected cancer to first treatment	90%				
Watch	Cancer: Faster Diagnosis within 28 days	75%				
Watch	% Recovery for OP New & OPPROC Activity Volume (internal target of 126%)	126%	Y	Y	Y	
Watch	Waiting List Size	24,000				
Drive	Number of ASD & ADHD Patients waiting >65weeks	0 (zero)	Y			
Watch	% Individual Health Assessments completed within 20 days of referral	100%	Y			
Watch	CAMHS: Number of CYP waiting to start treatment >52weeks	0	Y			

Collaborating for CYP – Reducing Health Inequalities: Responsive

Drive / Watch	2022/23 Metric	Action	Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
		New metric from annual plan	Drive	Difference in Median Waiting time for patients with LD on the waiting list.	0 (zero)	Y	Y	Y	
	No metrics in 22/23 IPR	New metric from annual plan / CORE20Plus5	Drive	Oral Health: Number of children <10 years old waiting >52wks for tooth extraction	0 (zero)			Y	
		New metric from annual plan / CORE20Plus5	Drive	CAMHS: Number of CYP of BAME background referred	TBC				

Collaborating for CYP – Green: Well Led

Drive / Watch	2022/23 Metric	Action	Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
		New metric from annual plan	Drive	Green Plan: Reduce Carbon Footprint – 10% reduction on 2021/22 baseline of 9,357 tonnes of CO2	702 pcm				
	No metrics in 22/23 IPR	New metric from annual plan	Drive	Green Plan: Reduce Energy Usage – set target at 10% reduction on previous year	kWh pcm				
		New metric from annual plan	Drive	Green Plan: Reduce Waste – target £50k cost saving	£4.2wk pcm				

Supporting Our People: Well Led

Drive / Watch	2022/23 Metric	Action	Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	% Staff who recommended Alder Hey as a place to work	Remove (monthly data not available)							
Drive	Staff Turnover	Change target from 10% to 13%	Drive	Staff Turnover	13%	Y	Y	Y	Y
Drive	Sickness Absence (Total)	Unchanged	Drive	Sickness Absence (Total)	< 5.5%	Y	Y	Y	Y
Watch	Short Term Sickness	Unchanged	Watch	Short Term Sickness	< 2%				
Watch	Long Term Sickness	Unchanged	Watch	Long Term Sickness	< 3%				
Watch	Mandatory Training	Unchanged	Watch	Mandatory Training	> 90%	Y	Y	Y	Y
Watch	% PDRs completed since April	Unchanged	Watch	% PDRs completed since April	> 90%				
Watch	Medical Appraisal	Unchanged	Watch	Medical Appraisal	100%				
		New metric from annual plan	Drive	Colleague Satisfaction – Thriving Index In Development	Tbc	Y	Y	Y	Y
		New metric from annual plan	Watch	Staff movement / Churn rate In Development	Tbc	Y	Y	Y	Y

Smartest Ways of Working – Financial Sustainability: Well Led

Drive / Watch	2022/23 Metric	Action	Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	Revenue Position (Year End Forecast)	Unchanged	Drive	Revenue Position (Year End Forecast)	£2.0m	Y	Y	Y	Y
Drive	CIP Position (Year End Forecast)	Remove (focus on recurrent CIP)							
Drive	CIP Position (Recurrent Full Year Effect)	Unchanged	Drive	CIP Position (Recurrent Full Year Effect)	£17.7m	Y	Y	Y	Y
Watch	Revenue Position (variance to date)	Unchanged	Watch	Revenue Position (Variance to date)	0 (zero)	Y	Y	Y	Y
Watch	CIP Position (delivered to date)	Unchanged	Watch	CIP Position (Delivered to date)	n/a	Y	Y	Y	Y
Watch	Cash Balance	Change currency to Liquidity rather than cash balance	Watch	Liquidity (Cash in hand, Days)	> 30 days				
		New metric from annual plan	Drive	% ERF Value (Income)	> 104%				

Risk Management: Well Led

Drive / Watch	2022/23 Metric	Action
Drive	Number of High Risks (scored 15 and above)	Unchanged
Drive	% of High Risk within review date	Unchanged

Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	Number of High Risks (scored 15 and above)	n/a				
Drive	% of High Risk within review date	> 95%				

Smartest Ways of Working – Alder C@re: Well Led

Drive / Watch	2022/23 Metric	Action
Drive	Alder Care – Divisional Critical Criteria	Unchanged
Drive	Alder Care - % System Build Completion	Unchanged
Drive	Alder Care - % Specialty Documentation Build	Unchanged

Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	Alder Care – Divisional Critical Criteria	100%				
Drive	Alder Care - % System Build Completion	100%				
Drive	Alder Care - % Specialty Documentation Build	100%				

*Metric will be updated in June to reflect the progress of AlderCare

Pioneering Breakthroughs – Research and Innovation: Well Led

Drive / Watch	2022/23 Metric	Action
	No metrics in 22/23 IPR	New metric from annual plan
		New metric from annual plan
		New metric from annual plan

Drive / Watch	2023/24 Metric	Target	C&MH	Med	Surg	CRD
Drive	Number of Chief Investigator led studies	Tbc				Y
Drive	Number of innovation solutions deployed with real-world impact	Tbc				
Drive	Number of Patients Recruited into Research Studies	> 500				Y

Appendix B – Full list of metrics proposed for Divisional Performance Packs

Unrivalled Experience: Safety

	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR	Incidents of harm per 1,000 bed days (rated Minor harm and above)	tbc	Y	Y	Y	Y
IPR	Number of Incidents rated No Harm and Near Miss per 1,000 bed days	tbc	Y	Y	Y	Y
IPR	Number of Serious Incidents (Steis reported)	0 (Zero)	Y	Y	Y	Y
IPR	Number of Never Events	0 (Zero)		Y	Y	Y
IPR	Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients	> 90%		Y	Y	Y
IPR	Sepsis: % Patients receiving antibiotic within 60 mins for ED	> 90%		Y		
IPR	Medication Errors rated Minor harm and above per 1,000 bed days	tbc	Y	Y	Y	Y
IPR	Pressure Ulcers G2-4	< 5		Y	Y	Y
IPR	Use of physical restrictive intervention	< 20	Yes – T4 MH	Y	Y	
IPR	Number of Unplanned Admissions to Critical Care (HDU/PICU)	< 30		Y – Target: 20	Y – Target: 10	
	Readmissions to PICU within 48hrs	0 (Zero)			Y	
	Step Downs out of CC out of hours	0 (Zero)			Y	
IPR	Hospital Acquired Organisms - MRSA (BSI)	0 (Zero)		Y	Y	
IPR	Hospital Acquired Organisms - C.difficile	0 (Zero)		Y	Y	
IPR	Hospital Acquired Organisms – MSSA	0 (Zero)		Y	Y	
	Hospital Acquired Organisms – RSV	0 (Zero)		Y	Y	
	Hospital Acquired Organisms - CLABSI	0 (Zero)		Y	Y	
IPR	Number of employees trained in new Level 1 of Patient Safety	> 90%	Y	Y	Y	Y
	%Consent before day of surgery	> 75%		Y	Y	
	% Pre-Op Screening	100%		Y	Y	

Note – include Safe Staffing report if this is broken down to Divisional level

Unrivalled Experience: Caring

	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR	F&F Test - % Recommend the Trust	> 95%				
IPR	% Complaints Responded to within 25 working days	> 90%	Y	Y	Y	Y
IPR	Number of formal complaints received	< 20	Yes – Target: 6	Yes – Target: 6	Yes – Target: 6	Yes – Target: 2
IPR	% PALS Resolved within 5 Days	> 90%	Y	Y	Y	Y
IPR	Number of PALS contacts	< 150	Yes – Target: 45	Yes – Target: 45	Yes – Target: 45	Yes – Target: 15
IPR	F&F ED - % Recommend the Trust	> 95%		Y		
	F&F Community - % Recommend	> 95%	Y			
	F&F Mental Health – % Recommend	> 95%	Y			
	F&F Outpatients – % Recommend	> 95%	Y			

Note – IP Survey metrics are currently excluded from this proposal

Smartest Ways of Working – Accessible Services: Effective

	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR	ED: % treated within 4 Hours	> 76%		Y		
	ED: Median Time to Triage	< 15mins		Y		
	ED: Median Time to Clinical Assessment	< 60mins		Y		
	ED: Total Time in Department >12 Hrs	0 (zero)		Y		
	ED: % Patients Left without being seen	tbc		Y		
IPR	Number of Cancelled Operations (on day of admission for a non-clinical reason)	< 20			Y	
IPR	Theatre Utilisation (Capped Touch Time)	> 85%		Y	Y	
	Theatre Sessions per Week	141			Y	
	Number of CCAD Cases per month	> 34			Y	
IPR	Number of Super Stranded Patients (21 days)	< 30		Yes – Target: 20	Yes – Target: 10	
IPR	% Was Not Brought Rate (All OP: New and FU)	< 8%	Yes – Target: 12%	Yes – Target: 6%	Yes – Target: 6%	
	% Virtual Outpatients (national standard 25%)	> 25%	Y	Y	Y	
	Hospital Initiated Clinic Cancellations <6 weeks notice	0 (zero)	Y	Y	Y	
IPR	% Clinical Letters completed <10 Days	> 95%	Y	Y	Y	
IPR	Virtual Ward Bed Days (based on 80% occupancy of 20 beds)	> 480 bed days pcm	Y			

Smartest Ways of Working – Accessible Services: Responsive

	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR	% Recovery for DC & Elec Activity Volume (Internal Target of 106%)	106%		Y – Target: tbc	Y – Target: tbc	
IPR	Number of RTT Patients waiting >65weeks (Incomplete pathways, OP&IP)	0 (zero)	Y	Y	Y	
	Community Therapy Waiting Times > 52 weeks	0 (zero)	Y			
	RTT Open Pathway: % Waiting within 18 Weeks (OP & IP Combined)	> 92%	Y	Y	Y	
IPR	Diagnostics: % Completed Within 6 Weeks of referral	> 90%		Y	Y	
IPR	Cancer: 2 week wait from referral	93%		Y		
IPR	31 day wait from decision to treatment	93%		Y		
IPR	31 day wait until subsequent treatments	93%		Y		
IPR	31 days from urgent referral for suspected cancer to first treatment	90%		Y		
IPR	Cancer: Faster Diagnosis within 28 days	75%		Y		
IPR	% Recovery for OP New & OPPROC Activity Volume (internal target)	126%	Y – Target: tbc	Y – Target: tbc	Y – Target: tbc	
IPR	Waiting List Size	24,000				
IPR	Number of ASD & ADHD Patients waiting >65weeks	0 (zero)	Y			
	ASD: % Referral to triage within 12 weeks	100%	Y			
	ADHD: % Referral to triage within 12 weeks	100%	Y			
IPR	% Individual Health Assessments completed within 20 days of referral	100%	Y			
IPR	Proportion of CYP with LD waiting >52weeks (target based on % of all CYP with LD)	tbc	Y	Y	Y	
IPR	Oral Health: Number of children <10 years old waiting >52wks for tooth extraction	0 (zero)			Y	
IPR	CAMHS: Number of CYP waiting to start treatment >52weeks	0 (zero)	Y			
	CAMHS: Referral to Help - % waiting within 6 weeks	> 92%	Y			
	CAMHS: Referral to treatment - % Waiting within 18 weeks	> 92%	Y			
	CAMHS: Crisis / Duty Call Activity	n/a	Y			
	CAMHS: Occupied bed days, day case attendance and patients on Sunflower at Home pathway	Tbc	Y			
	EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	> 90%	Y			
	EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	> 90%	Y			

Note – Imaging, Pathology and Pharmacy metrics are currently excluded from this proposal

Supporting Our People: Well Led

	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR	Staff Turnover	13%	Y	Y	Y	Y
IPR	Sickness Absence (Total)	< 5%	Y	Y	Y	Y
IPR	Short Term Sickness	< 2%	Y	Y	Y	Y
IPR	Long Term Sickness	< 3%	Y	Y	Y	Y
IPR	Mandatory Training	> 90%	Y	Y	Y	Y
IPR	% PDRs completed since April	> 90%	Y	Y	Y	Y
IPR	Medical Appraisal	100%	Y	Y	Y	Y
IPR	Colleague Satisfaction – Thriving Index **In Development**	Tbc	Y	Y	Y	Y
IPR	Staff movement / Churn rate **In Development**	Tbc	Y	Y	Y	Y

Smartest Ways of Working – Financial Sustainability: Well Led

	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR	Revenue Position (Year End Forecast)	£2.0m	Y	Y	Y	Y
IPR	CIP Position (Recurrent Full Year Effect)	£17.7m	Y	Y	Y	Y
IPR	Revenue Position (Variance to date)	0 (zero)	Y	Y	Y	Y
IPR	CIP Position (Delivered to date)	n/a	Y	Y	Y	Y
IPR	Liquidity (Cash in hand, Days)	> 30 days				
IPR	% ERF Value (Income)	> 104%	tbc	tbc	tbc	

Risk Management: Well Led

IPR	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR *	Number of Risks (All)	n/a	Y	Y	Y	Y
IPR *	% of All Risks within review date	> 95%	Y	Y	Y	Y

**IPR is only High Risks scored 15+, but proposal for Divisional Packs is to include all risks*

Need to confirm data source is available

Pioneering Breakthroughs – Research and Innovation: Well Led

IPR	2023/24 Metric	Target	C&MH	Med	Surg	CRD
IPR	Number of Chief Investigator led studies	Tbc				Y
IPR	Number of innovation solutions deployed with real-world impact	Tbc				
IPR	Number of Patients Recruited into Research Studies	> 500				Y
	Number of Active (Open) Studies - Academic	> 130				Y
	Number of Active (Open) Studies - Commercial	> 30				Y

Integrated Performance Report | April 2023

Alder Hey Children's NHS Foundation Trust

Flash Report - April 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for April
Unrivalled Experience	**Deliver our Patient Safety Strategy**	Number of Incidents rated Moderate Harm and above	0	**1**
		Number of Serious Incidents (Steis reported)	0	**1**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**2 (x1 C.Diff & x1 MRSA)**
		FFT - % Recommending Trust	> 95%	**90.86%**
Supporting our Colleagues	**Increase people Availability and Wellbeing**	Staff Turnover	*<13%*	***14%***
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%	**84%**
		Number of RTT Patients waiting >65weeks	0	**72**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,135**
		Elective Recovery	> 100%	**92%**
		Diagnostic Performance	> 90%	**87.8%**
	Financial sustainability	Revenue position – Year End forecast	Break even	**£12.3m**
	Safely Deploy Alder C@re	Alder C@re deployed	By Sept 2023	**On Track**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

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

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

Alder Hey Digital, Data and Information Technology Update

1. Executive Summary

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

Key headlines include:

- Update on National Digital Maturity Assessment
- HSJ Shortlisting
- AlderC@re Update
- Good progress with Digital and Data Futures
- Good Operational performance

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

2. National and Regional Updates

2.1 Update on National Digital Maturity Assessment

Alder Hey have successfully completed the National Digital Maturity Assessment. In line with the agreed plan, the initial results of the assessment have been peer reviewed by Liverpool Women's Hospital. In April, a wider peer review has been facilitated by the Cheshire and Merseyside ICB, following the discussion minor changes will be progressed ahead of the national deadline in May.

Following the above, the final results will be made available in May to Chief Information Officers and to the wider NHS in June. These will be aggregated at a local, regional and national level. This will give Trusts the opportunity to complete more accurate benchmarking, identify areas for improvement and leverage national investment opportunities.

2.2 External Recognition

There are two digital initiatives delivered at Alder Hey that have been shortlisted for national HSJ Awards across two categories:

- Digital Safety Category – Electronic Anaesthetic Record
- Urgent Care – Online Symptom Checker

Both solutions have made massive improvements in the Trust, relating to improved patient care, reduction in errors and a reduction in patients attending ED

3. Digital and Data Futures Progress

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

The development of AlderHeyAnywhere is still on track to be delivered back to the Trust by 21st April. The solution will then enter the testing phase and if successful, move to

deployment in May. A Business case is also in development to scope and cost out Phase 2 of the Programme.

ISLA Care is operational in 21 specialities across the trust and the current contract for the system is due to end in June 2023. A Business Case is being developed in conjunction with the engaged specialties to extend the contract further. The case will be based on evidencing the benefits the solution enables to justify any future investment.

The Trust has now launched its new and improved 'Staff Intranet' which has received positive feedback. The site is much more intuitive and provides staff with easier, quicker access to relevant information. This will be followed by the deployment of a new 'External Trust Website' which is scheduled to be deployed in the coming months.

3.2 Outstanding Records and Safe Systems

Work is well underway to design and implement a new Risk and Incident Management System across the Trust. Final design changes are being agreed with each individual team and high-level training on the system has been provided to super users. The system is aiming to be deployed in May and will provide an improved experience for users and greater reporting capabilities.

Prior to the successful launch of paperless consent across Surgery, work has been completed on developing the medical consent forms. These have now been clinically approved and are ready to be launched in May 23.

3.2.1 AlderC@re

The programme continues to progress well and is on track for early September, this was based on the timing of the technical activities, the availability of key staff, and the specific impact on elective activity due to system downtime.

The programme is currently managing a small number of risks most notably around EPMA and Reporting with mitigation plans in place and progressing well. These are being monitored through daily calls, weekly exception reports and as standing items at Programme Board.

The 'simulation hub' on the Mezzanine was launched on the 21st of March and provides a location for users to engage with the programme and the AlderCare system. Wider release of a system for users to access to familiarise themselves with the new EPR was launched from the 11th of April.

Detailed planning is now underway to set out the activities leading up to go live e.g. training, and the cutover process e.g. command centre and floorwalker support. Lessons learned are being considered from the previous Meditech V6 go live including greater training flexibility and clinical engagement.

The next steps for the programme are:

- Continue build of the system and preparation for formal testing
- Begin the detailed cutover planning in conjunction with service managers and MEDITECH including training plans

- Action the work off plan for Gateway 2 scheduled for the end of March 2023 and prepare for Gateway 3 at the end of May.

3.3 Healthier Populations through Digital, Data and Analytics

The Data Engineering team have successfully delivered the nationally mandated 'Faster Data Flows' by the agreed deadline of end of March. The aim of the programme is to implement an automated granular daily data collection, to support recovery and with this provide the NHS with a modern data architecture that enables timely, high-quality data to be used to support decision making.

Looking forward, there are two further Business Dashboards to be delivered in April for the eating disorder and Mental Health Teams, alongside this a new 'Nursing Analytics' group has been established to help prioritise and deliver enhanced analytics to the nursing workforce.

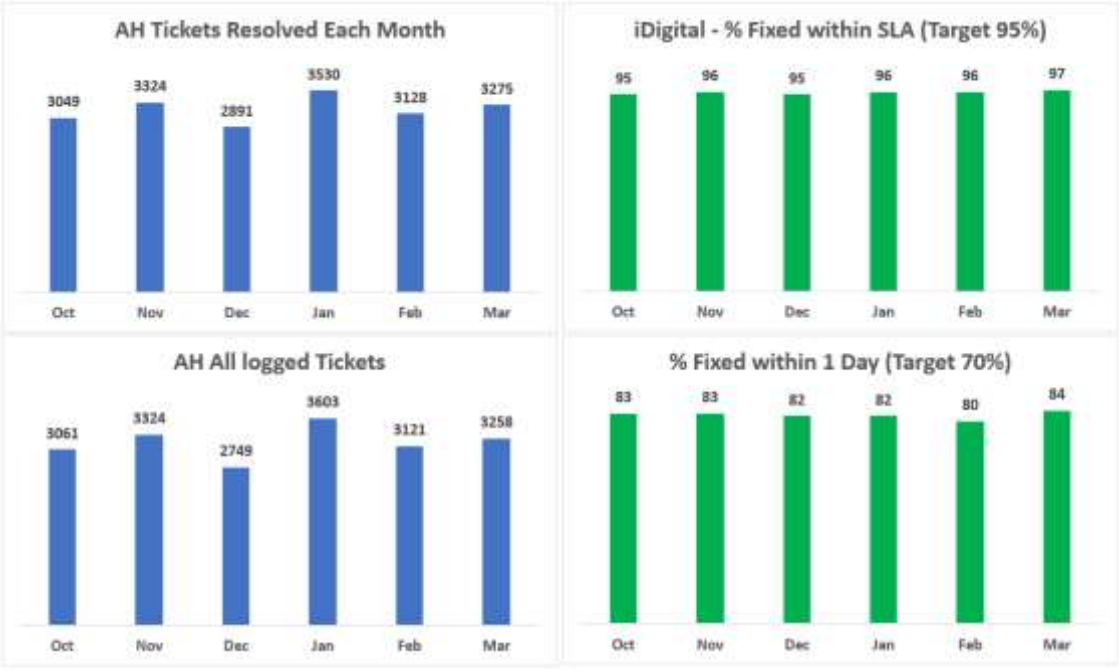
3.4 Technical roadmap and Operational Service Excellence

In response to feedback from teams around the Trust, a Technical Service Improvement Programme has been developed with some key areas identified for development. These include enhancements to the proactive ward rounds to ensure IT devices and equipment is being checked daily across the hospital, reducing the need for clinical and operational teams to log support requests and focussed improvements on key clinical areas such as PICU.

3.4.1 Operational Performance

This report provides performance from March 2023. Key highlights include:

- 97% of tickets resolved within SLA
- Fixed within 1 day consistently above target for the last 6 months and above 80%.



4. Summary and Recommendations

In summary, progress with digital and data developments and delivery at Alder Hey remain positive and the mobilisation and delivery of the new strategy continues well. The AlderCare Programme is on track to deliver in early September and continues to be closely monitored.

Operational performance remains good however, this is being bolstered by a Service Improvement Plan to help enhance user experience even further.

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

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

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development report on the Programme for Delivery

April 2023

1. Introduction

The purpose of this report is to keep RABD informed of progress, risks and actions on the key capital projects as they arise. As of Month 4 in Quarter 4 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Delay and Cost Implications to Service Diversion Works Delay to start on site date	Options to reduce programme and cost implications are being reviewed by MSC, Hive and the Development Team. Technical programme workshop scheduled for 02.05.23. to assess the feasibility of overlapping service diversions and main construction.
Sunflower House	Fire Compliance; Sprinklers Water Compliance issues upon occupation	Installation of sprinkler suppression system to car park following review. Derogation to be signed off by Executive Directors. Test results awaited. Move plan and command centre protocols developed.
Elective Surgical Day Case	Confirmation of available space to accommodate Schedule of Accommodation (SOA). Full scope of works exceeds available budget.	Budget and scope review, led by Divisional senior leadership team supported by Development Team and Day PM.
Eating Disorder Day Case Unit	Current SoA cannot be accommodated within footprint of the building.	Agreement of phasing, final designs and budget. Option appraisal for provision of additional space.
Main Park Reinstatement	Work Package Risks Affecting Phase 3 Reinstate Park.	Trust action plan in place to accelerate aspects to mitigate any programme risk.

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) & Service Diversions								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation (Dec 2024)								
Sunflower House / Catkin Construction								
Sunflower House Occupation								
Temporary Modular Office (Alder Centre)								
Temporary Modular Office (Police Station)								
Police Station Design								
Police Station Construction								
Demolition Phase 4 (Final)								
Main Park Reinstatement (Phase 2/3)								
Mini Master plan (Eaton Rd Frontage) 2 phases to plan								
Fracture / 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
BLR works completed, white lining to be undertaken just prior to the opening of the new road.	Additional prelim costs incurred for delay.	£57K cost to be allocated from contingency.
Morgan Sindall Construction (MSC) has advised on programme and issued an updated cost following the findings from the service investigations to complete service diversion routes.	Potential impact on programme delay and increase costs above budget identified.	Options to reduce programme and cost implications are being reviewed by MSC, Hive and the Development Team.
Main build start on site date will not commence May 2023 due to the issues with service diversion works.	This is likely to impact the service 'go live' date.	Technical programme workshop scheduled for 02.05.23. to assess the feasibility of overlapping service diversions and main construction.

Sunflower House Construction & Occupation

Current Status	Risks/Issues	Actions/Next Steps
Move 2 completed 24.03.23.	GT Snagging & Defects.	Review with GT aftercare team.
Finalising contract position.	GT contract claim.	GT to propose their full and final account and programme.
Staff training and familiarisation orientation has been undertaken.	Operational readiness.	Final/refresh sessions will be carried out, as required, as part of the move.
Temporary car park in operation following closure of the under croft.	Fire compliance; sprinklers.	Installation of sprinkler suppression system to car park following review. Derogation to be signed off by Executive Directors.

Current Status	Risks/Issues	Actions/Next Steps
Move 3 'Go Live' proposed for 24.04.23.	Water Compliance.	Test results awaited. Move plan and command centre protocols developed.

Modular Office Buildings

Current Status	Risks/Issues	Actions/Next Steps
Staff moved into 3SM	Water compliance 3SM.	Point of use filters in place until resolved.
2SM modular in delay due to police lease not being completed. Development Team proposal submitted for the management of office accommodation to minimise any time delay or increase costs. Will comprise of 3 main phases and is under review and will be presented to colleagues and executive team for discussion and agreement.	Potential resistance from clinical teams to new ways of working, sharing space with other teams.	Proposal to be discussed with teams and executive team to agree actions and next steps.
	Budget costs to be understood, and realigned as required.	Assessment of recurring revenue costs.

Park Reinstatement

Current Status	Risks/Issues	Actions/Next Steps
Sub 5 area: works to former access road at the end of the Blue Light Route (BLR) complete.		
A Community Liaison role has been appointed and also additional resource to support engagement and to help build relationships with the community.		Meetings planned from this month.
MUGA construction works complete.	LV power connection to Alder Road awaited to allow completion of light installation.	LCC to complete LV installation. This has been escalated

Clearance of three trees and limited vegetation to form access from new and old park undertaken.	Plans not accepted by Liverpool Planning Authority (LPA).	Park design review and meeting with LPA.

Mini Master Plan for Eaton Road Frontage

Current Status	Risks/Issues	Actions/Next Steps
Revised proposals to be presented at the 27.04.23 Executive Design Review.	None	None

Fracture and Dermatology Outpatients

Current Status	Risks/Issues	Actions/Next Steps
RIBA stage 2 information completed.	Trust governance/sign off.	Presentation to 27.04.23 Executive Design Review for approval to move to the next stage.
Initial phasing proposal developed. Staff consultation underway.	Trust's ability to manage activity, and to provide safe access/egress routes for staff, patients & emergency procedures during works. Any costs to be identified.	Initial assessment to be undertaken by the Division.
Information issued to Trust PFI team to raise Trust Variation Enquiry (TVE) with the Special Purpose Vehicle (SPV).	Provision of contractor compound & staff welfare facilities.	Trust Estates and Health & Safety leads to develop options. To coordinate with other projects being undertaken across the programme.

Elective Surgical Day Case

Current Status	Risks/Issues	Actions/Next Steps
RIBA Stage 1 report developed: • Feasibility study to assess potential layout options and phasing. • Expansion space required to enable SOA to be identified. • Early assessment of affordability and budget pressures.	Layouts not yet agreed. Consideration of operational requirements eg site & welfare compound, capacity to manage the service during works, etc. Confirmation of available (expansion) space to accommodate SoA. Full scope of works exceeds available budget,	Budget and scope review, led by Divisional senior leadership team. Agree governance structure and escalation route.

Eating Disorder Day Case Unit (EDYS)

Current Status	Risks/Issues	Actions/Next Steps
RIBA Stage 1 update: • High-level cost plan produced and reviewed with the senior leadership team. • Master site plan options identified for mitigation. • Leases and land ownership discussions progressing.	Current SoA cannot be accommodated within footprint of the building. Building condition unknown.	Agreement of phasing, final designs and budget. Commence condition surveys April 2023, following Dewi Jones Unit move to Sunflower House.

Communications

Current Status	Risks /Issues	Actions/Next Steps
Regular dialogue between development team and Communications department are now in place to cover the park development. Community Liaison Officer appointed.	Loss of reputation, locally and regionally. Lack of engagement internally and externally.	Maintain links with community and support their development work. Community sessions taken place with further provision and active engagement programme.

5. Conclusion

RABD are requested to receive and acknowledge the update provided as of 24 April 2023.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 27th March 2023 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	
	John Kelly	Non-Executive Director	
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:			
	Audrey Chindiya	Business Accountant, Medicine	
	Graeme Dixon	PFI Manager	
	Emma Hughes	Acting Manging Director for Innovation	
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Cath Kilcoyne	Deputy Director of Business Development	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Graeme Montgomery	Business Accountant, Surgery	
	Andy McColl	Associate Chief Operational Officer, Performance	
	Jill Preece	Governance Manager	
	David Powell	Development Director	
	Clare Shelley	Associate Director Operational Finance	
	Mark Flannagan	Director of Communications	(MF)
	Gary Wadeson	Business Accountant	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)

22/23/223 **Apologies:**

Shalni Arora	Non-Executive	(SA)
Erica Saunders	Director of Corporate Affairs	(ES)
Melissa Swindell	Director of HR & OD	(MS)
Jim O'Brien	Associate Development Director	

22/23/224 **Minutes from the meeting held on 21st February 2023**
The above minutes were approved as a true and accurate record.

22/23/225 **Matters Arising and Action log**
All actions had been included on the agenda.

22/23/226 **Declarations of Interest**
There were no declarations of interest.

22/23/227 **Finance Report**
Month 11 Financial Position
M11: The Trust has achieved an in-month trading surplus of £2.2m in February which is £1.2m ahead of the planned financial position. Year to date (M1-11) the Trust is reporting a surplus of £5.4m which is £1.8m ahead of plan and in line wit the revised year end forecast.

Appendix 1 and 2 gave a breakdown on spend of clinical supplies and drug expenditure:
Appendix 1 Clinical Supplies
The majority of the main drivers are linked to activity and inflation over time since 19/20. For example, spinal activity is performing well above 19/20 activity levels, and is being reflected in the spend.

As part of the 23/24 annual planning exercise, there has been a huge focus on pressures relating to non pay associated with increasing activity. As such additional

funding has been agreed to support the pressures for 23/24 and a review in Q1 will take place to measure performance against the anticipated plan position.

Appendix 2 Drug Expenditure
The main drivers of the overspend are linked to a change in funding arrangement, activity, and inflation over several years. The regional pharmacy procurement team have advised risks of further inflationary pressures that could be expected in 23/24 in the region of £1.1m.

JK asked for details on plans to reduce waste on drug usage. AC noted the work the pharmacy team are carrying out with each of the divisions to target and reduce areas of drug wastage.

Resolved:
RABD received and noted the M11 Finance report.

22/23/228 23/24 Operational Plan

RL noted a previously circulated paper with the changes from submitting a draft position of £7.8m deficit to NHSIE in February to a breakeven final position to be submitted on 30th March 2023.

JK asked for details on contingency plans, RL noted discussions to be held with Executive Directors to build this in.

JK asked for details on payment by results and what services would be increased to receive a higher income. RL gave background on work that has and continues to take place around reviewing services and income generated. AB gave further details on analysis noting the high value specialities are: cardiac, neurosurgery and spinal. As well as knowing the high value services it was noted that case mix volume also needed to be monitored.

AB went through the 8 priorities from the 23/24 Integrated plan along with details of tracking performance against them including updated through the monthly Integrated Performance Report.

A discussion was held on the financial impact the Junior Doctor Industrial Action has had on Alder Hey along with future implications on the assumptions made in the plan.

In terms of waiting times there are currently 131 patients waiting over 65 weeks for consultant led treatment. AH is projecting to achieve 0 by March 2024.

MS went through the 5% workforce increase and funding sources and noted this was before any CIP changes or vacancy rates.

Resolved:

RABD received and noted details shared on the Annual Plan for 2023-24.

22/23/229 To agree Top Risks for 23/24

Resolved:
This item was deferred until 24th April 2023.

22/23/230 CIP

Resolved:
This item was covered within the Finance report.

22/23/231 **Cash**

Cash equivalent balance remains in the Trust at M11 (£86.1m) down £2.1m on month 10 due to planned spend, and improvement in BPPC position. £10m was invested with the National Loans Fund for 3 months in Feb, expected interest £104k (4.11%).

Agreement to report back to the April committee a 5 year cash flow forecast.
Action: EK

Resolved:
RABD received M11 Cash update

22/23/232 **Campus update**

DP highlighted key risks within the campus update paper

Neonatal Project: An update on the 2 outstanding risks were received.
Sunflower House: Intending to complete move 11th April. A number of water safety issues are being looked into ahead of this move.

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

22/23/233 **Aldercare**

KW presented the report to the committee and highlighted:

- Go live date to be confirmed this week.
- Second gateway is due to start 28th March.
- Organisational ready status of the programme has commenced.

JK asked if there were concerns on the red flags around reporting. KW responded noted that issues are being worked through and there are no major concerns.

Resolved:
RABD received the monthly update on Aldercare.

22/23/234 **BAF Deep Dive: 3.6 Risk of partnership failures due to robustness of partnership**

DJ presented a number of slides highlighting key actions, gaps in control and MIAA partnership governance. It was noted this BAF risk is currently on target.

Resolved:
RABD received an update for the risks associated with partnership failures due to robustness of partnership governance

22/23/235 **Business Developments**

CK highlighted presented the above report highlighting activity from November 2022 – to February 2023:

CK attended the Arab Health Conference in Dubai. Alder Hey had the opportunity to present on the (DIT) stand. The focus was set around the 2nd Opinion Service and Education in line with the current BD strategy. Alder Hey Innovation was also represented at the conference by Catherine Kilcoyne who presented on CYP one in partnership with Mindwave and Brilliancsee Masks with (Bluetree Medical).

Meeting was held with Jenny Scott of Healthcare UK, and Jo Burn of DIT to establish the format for the development of a 'North West Consortium' a collective decision was made for Alder Hey and Liverpool Heart and Chest Hospital to be the initial Trusts to develop an initial strategic framework. Once established other Trust's will be invited to join to build commercial strength..

Project with Health on Cloud – mix of Education & Innovation – BD are supporting on this project from a commercial perspective to assess income/investment opportunity. This is a virtual platform that will provide high quality surgical, medical and nurse training internationally. It will also be available to support ICH projects. No investment required for use of platform. Alder Hey responsible for developing and providing educational content for the platform.

Resolved:
RABD received and noted the Business Development update.

22/23/236 **Month 11 Integrated Performance Report**
AB presented the IPR and highlighted:

- Access to care remains a challenge and has risen over the last few months, this is mainly ENT patients. Currently looking at external options and locums.
- Improvement has been seen in Diagnostic care and Was Not Brought rate over the period.

Resolved:
M11 IPR report was received.

22/23/237 **Communications Paper**
MF presented the communications paper and highlighted the key area that the Trust Intranet has now been launched and is live.

Resolved:
RABD received and noted the Communications paper.

22/23/238 **PFI – Building report**
Resolved:
RABD received the monthly update on PFI.

22/23/239 **Board Assurance Framework**
Resolved:
RABD received and noted the risks being monitored through the BAF.

22/23/240 **Terms of Reference**
Resolved:
Deferred to April 2023.

22/23/241 **Business Cycle**
Resolved:
Deferred to April 2023.

22/23/242 **Any Other Business**
Industrial Action

60 operations and around 400 outpatient appointments were cancelled during the IA. People needing urgent care over the three days were all seen. Further Junior Doctor Industrial action is due to take place over Easter dates are to be confirmed.

Campus Land and Nursery
JG confirmed further Extraordinary RABD meeting to be held on Wednesday 29th March 2023.

Ian Quinlan's Last RABD
On behalf of RABD JG thanked Ian Quinlan for his invaluable support and contributions to Alder Hey over the last 11 years as a Non-Executive Director/Chair as he steps down from the role.

22/23/243 Review of Meeting
The Chair noted good discussions taken place throughout the meeting.

Date and Time of Next Meeting: Monday 24th April 2023, 1300, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	Serious Incident, Learning and Improvement report 1st – 31st March 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 March 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, Clinical Quality Steering Group (CQSG), Safety and Quality Assurance Committee (SQAC) so that learning can be shared, and improvements enacted. The Trust Board receives a monthly summary report.

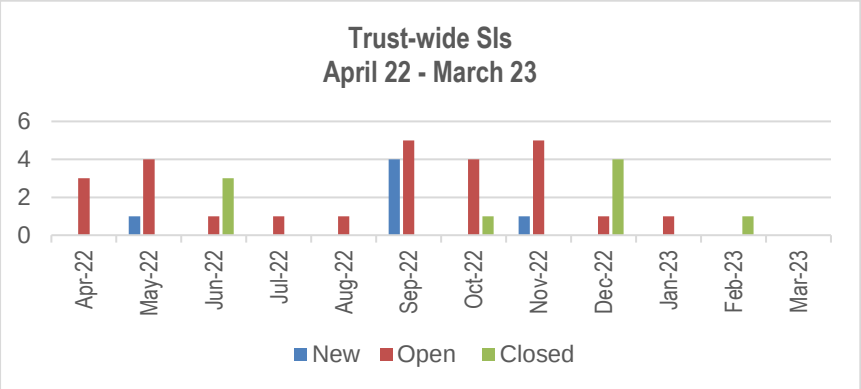
3. Local context

3.1 Never Events

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

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status March 2023



3.2.1 Declared Serious Incidents

The Trust declared **0** StEIS reportable incidents during the reporting period (1st – 31st March 2023).

3.2.2 Open Serious Incidents

0 SIs were open during the reporting period.
0 SI investigations were completed in this reporting period (1st – 31st March 2023).

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 31st March 2023), **2** SI action plans remained open and are within their expected date of completion.

Full details of the SI action plan position can be found at appendix 1.

3.3 Internal level 2 RCA Investigations

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

0 Duty of Candour responses were required during the reporting period (1st – 31st March 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.

Immediate lessons learnt from all SIs are outlined where applicable in this report.

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

Recommendations

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

Appendix 1

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Extension date agreed by commissioners	Number of extensions
2022/19971	14/09/2022	16/09/2022	Surgery	Never Event – retained foreign object post procedure.	6 1 action outstanding.	31/01/2023	30/04/2023		3
2022/23391	10/08/2022	02/11/2022	Research	Never Event – wrong side biopsy.	30 2 actions outstanding.	30/09/2023			0

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	19th April 2023 – Summary 22nd March 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 19th April 2023, along with the approved minutes from the 22nd March 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 including a specific update on the Deteriorating Patient Safety Workstream, together with an update on the Workstreams of particular focus in the reporting period: Safety Metrics; CYP as Patient Safety Partners; Learning Difficulties; AMR; Hospital Optimisation.
- SQAC received the DIPC Exception report.
- SQAC received the Assurance Emergency Department Activity Monthly update, noting the ongoing pressures within the Emergency Department.
- SQAC received Sepsis update, with good evidence regarding ongoing work and with some new issues raised regarding exemptions of training, with plans in place to review this further.
- SQAC received an amended report on the Trust wide Clinical Audit Annual Programme, following discussion held at 22nd March 2023 SQAC meeting. The Report was approved and commended for its clarity and the level of assurance it offers.
- SQAC received Trust wide Safeguarding & Statutory Services Assurance Group update
- SQAC received the Health Inequalities Steering Group update, which detailed exciting developments, with interesting questions and discussion regarding monitoring and tracking of progress in the future.
- SQAC received the Clinical Ethics Annual Report, and acknowledged the transition point in clinical ethics across the Trust. Discussion will take place between JR & Divisional Directors regarding future scope and multi-disciplinary engagement in ethics processes.
- SQAC received the Research Annual Report, which was commended for the format and clarity of the report. SQAC welcomed the continuing development of leadership within the Research Division and noted the decrease in staff turnover. SQAC also acknowledged the need to focus on quality of research interventions alongside levels of participation.
- SQAC received and approved the SQAC Annual Report, noting how busy SQAC had been in a positive way, as the Committee had become more data led and with an increased evidence base, and had focused on the transition towards the new Patient Safety Strategy.
  SQAC noted that it had been a dynamic year in terms of issues explored, and that the quality of reports had improved, giving strong assurance to SQAC members on a range of issues. All members were thanked for their contributions.
- SQAC received the External Visit & Accreditation report, with assurance provided from all the Divisions that the policy is being adhered to, to ensure good oversight of external visits and follow-up of action plans. Appropriate information/material would be captured within the Trust Annual Report and Accounts
- SQAC received the Drugs Accountable Officer/Accountability Report, which was Approved by SQAC, offline approval was confirmed from KB & JR. Thanks were expressed to Interim Chief Pharmacist.
- SQAC received the Board Assurance Framework, noting that we are entering a transition period towards alignment with the new strategy. SQAC recognised the importance of capturing the impact of and potential risks from industrial action.

- SQAC received verbal Divisional report updates, with a new written report being trialed at May 2023 SQAC meeting.

3. Key risks / matters of concern to escalate to the Board (include mitigations)
None

4. Positive highlights of note
The Trust-wide Clinical Audit Annual Programme is the output of considerable effort to bring together an overview of clinical audit activity and to align this to Trust priorities, providing much clearer oversight and assurance than existed previously in relation to Clinical Audit.

5. Issues for other committees
None.

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 22nd March 2023
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non Executive Director	(FB)
	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	John Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Christine Hill	Head of Operations – Laboratory Services, Safety Lead	(CH)
	Jo Revill	Non-Executive Director	(JRe)
	Jackie Rooney	Associate Director of Nursing Governance	(JR)
	Paul Sanderson	Acting Chief Pharmacist	(PS)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)
	Sarah Wood	Consultant Paediatric Surgeon, Safety Lead, Surgery Division	(SW)
In Attendance:	Kelly Black	Surgical Matron, Surgery Division	(KB)
	Sian Calderwood	General Manager for Urgent Care, Medicine Division	(SC)
	Bea Larru	Director of Infection Prevention Control	(BL)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	
	David Reilly	Associate Director of Digital Systems	(DR)
22/23/226	Jessica Robinson	Children & Young People Engagement Lead	(JR)
22/23/232	Matty Upton	General Manager, Division of Surgery	(MU)
	Linda Wain	Corporate Governance and Risk Manager	(LW)
	Julie Creevy (notes)	EA to Chief Medical Officer & Chief Nursing Officer	(JC)
Apologies:	Nathan Askew	Chief Nursing Officer	(NA)
	Lisa Cooper	Director of Community & MH Division	(LC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Natalie Palin	Associate Director of Transformation	(NP)

22/23/216 Welcome and Apologies

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

22/23/217 Declarations of Interest

SQAC noted that there were no items to declare.

22/23/218 Minutes of the Previous Meeting held on 22nd February 2023 – Resolved:

Committee members were content to **APPROVE** the notes of the meeting held on 22nd February 2023.

22/23/219 Matters Arising and Action Log

The Action log was received and updated.

- Nutritional complaints and treatment and procedure update was received. PB advised that a deep dive had been undertaken for a 12 month period. PB provided assurance regarding nutrition, with 1 complaint relating to nutrition.
- Generally, half of the complaints raised related to treatment and procedure, with the highest subcategory relating to the alleged failure in medical and nursing care.
- Outcome reporting, the majority (over half) had been either fully or partially upheld. Main themes regarding alleged treatment failure, within the main themes these complaints related to communication and a lack of explanation to families, with staff attitude also being identified.

- Some families had felt that there had been a lack of negotiated care, or where an existing care plan is in place, that the family felt that this was not adhered to, or updated regarding delays in referrals, waiting times and cancellations.
- PB advised that there were a couple of clinical incidents that had occurred and referred to how feedback is provided to families and training needs, with ongoing work being undertaken, the Divisions undertake specific individual actions relating to an individual complaint, with ongoing work progressing across the Divisions, e.g., Community division are working to enhance expectations, values and behaviours. Work is ongoing to improve links between ADHD, CAMHS and other divisions in identifying any particular items with regards to themes. The Deep dive would aid divisions in identifying areas of focus.
- No specific concerns had been raised.

FB alluded to the general themes regarding people and interaction which is clearly evident within the report. JR advised that the report would help triangulate work to help inform the patient safety plan, to ensure further granularity.

ABa queried whether the new Inphase system would help classify complaints, JR stated that the team are developing the new form to extract that data, teams are currently in the testing phase during week commencing 27.3.23.

FB alluded to the importance of shared language and the ability to tag incidents with key phrases to extract appropriate data. JR advised that she is happy to present a further update to SQAC in the future. JR stated that colleagues had been working with the Innovation team with regards to artificial intelligence, with innovative work progressing, which is resulting in improved insight, and would inform the lack of data analysis currently.

- ED@its best update was received – SC presented the ED@its best report which detailed a summary of staff sickness and the qualitative metrics including PALS & Complaints and Friends and Family performance metrics, in addition to detail regarding ED total attendances, discharges and triage information.
- Multiple listening events had been held, which identified 39 key problem statements, themes regarding behaviours, attitude, beliefs, leadership and management, structure & processes, and psychological safety. 31 of the key problem statements had been completed, 7 are in progress, and 1 is outstanding and requires further work and development. Overall, there had been a significant number of items completed, and had been well embedded as business as usual.
- ED@its best programme is transitioning into supporting with the system wide urgent and emergency care agenda, whilst the ED business as usual agenda, reporting and accountability and structure would continue through the Divisional management team, rather than ED@its best.

ABa stated that it would be helpful to review the performance figures for ED@its best, and the data regarding what proportion of patients are not being seen through the traditional ED route, as colleagues would be interested to review this data, to review the impact of the innovative ongoing work which had taken place. SC advised that the Executive Team would be presented with weekly reports through the UTC, to enable weekly ongoing assurance. SC confirmed that she would undertake a retrospective review in addition to the week on week performance update to be provided to colleagues.

FB stated that she would be interested to review the trend data within the ED updates and would welcome the last three months of data, accumulating. FB advised on the importance of colleagues being mindful of the seasonal position. CW advised that the trend data information would be included for April ED SQAC report, with colleagues in the Division noting requirements relating to seasonal impact.

Resolved: SC to undertake discussion offline with NA if required to determine data to be included

22/23/220 Quality Assurance Rounds Themes and risks

JR presented the Quality Assurance Rounds Themes and risks for the period 1st September 2022 – 28th February 2023, key issues as follows:-

- 17 Quality Assurance rounds had been completed, 7 Quality Assurance rounds had been postponed, the postponed Quality Assurance Rounds had all been rebooked.
- Main top 5 challenges within the Quality Assurance Rounds related to workforce, recruitment issues, staff turnover, retirement, shortage of clinic room space and waiting list backlogs.
- Main 5 successes related to services showing best practice, positive feedback from Friends & Family Test, good governance structures, good MDT teamwork, resilience and staff going above and beyond.
- Following a review of the 12 months data there had been a number of recurring themes and successes identified, the top successes were noted as excellent staff, health and wellbeing support, with good acknowledgement that there is good team support, from management team, with lots of positive FFT feedback and services demonstrating achievement to support patients and staff, safety, clinical effectiveness and responsiveness.
- The top collective challenges relate to workforce, mainly recruitment issues, retention and staff challenges workforce, recruitment issues, retention, sickness, shortage of clinic space, and backlog activities. JR referred to a number of themes relating to access to services and workforce. A number of themes are on the risk register and colleagues had linked with the Brilliant Basics team to address those areas of challenge, to enable greater focus as a Trust to those issues with the greatest potential for improvement. Whilst workforce remains a challenge there are several initiatives in place to address and improve activity. Ongoing work is progressing regarding timely triage of referrals.
- J Rooney's deputy had been appointed and will be working with the Brilliant Basics team to align programme of work. JR is not aware of any specific Quality Assurance programmes that address clinic space or workspace. With colleagues aiming to explore improved ways of data sharing. JR stated that there is opportunity to revert to Quality Assurance Rounds taking place face to face on site, with 1 hour walkabout. JR welcomed any feedback or comments.

FB thanked JR for update, and referred to staff being open and honest, and how colleagues ensure that their feedback has been heard, and that challenges raised by staff are being addressed.

AB alluded to the theme regarding access to clinics which is an ongoing challenge, AB advised that there is a need to look at which clinics can take place beyond the hospital setting and referred to the annual plan, with regards to a review of outpatient's physical capacity, and that this work would result in actions to be addressed regarding accessing clinics.

JRe welcomed the Quality Assurance rounds reverting to face to face if possible in the future.

JG alluded to slightly losing the opportunity of single connectiveness, and could be broadened out, many themes' resources, demand for services, as the process is evolved, and queried if colleagues could think differently from a slightly linear view given the complexities. JR stated that she was conscious that this is very silo at present, and that this is work in progress. FB stated that this is a reflective process.

PB referred to the theme regarding abuse of staff, and a reminder of zero tolerance approach, as staff do not always invoke the zero tolerance process as early as required.

SQAC were supportive of face to face Quality Assurance Rounds being reintroduced whenever possible and ensuring that this is an aspiration for any future Quality Assurance rounds that are scheduled to be held face to face wherever possible.

Resolved: SQAC received and **NOTED** the Quality Assurance Rounds Themes & Risk report.

22/23/221 DIPC Exception Report

BL presented the DIPC Exception Report, key issues as follows:-

- Common themes relating to an increase in Gram-Negative bacteria, 3 cases during February 2023, not all are CLABSIs. IPC colleagues meet monthly with PICU colleagues to review cases. All should have a target of 0, majority colleagues have seen an increasing number of increased pathogens.
- New risk -2747 regarding difficulty in maintaining separation of patients, with regards to insufficient curtains within the organisation to facilitate changing after discharge of each infected patient, as the Trust has exceeded the lifetime of curtains, a meeting is scheduled on 22.3.23 to review further as there is a need to have separation in open bays, to ensure appropriate cleaning. A Business case for Investment Review group is being prepared to replace window curtains with wipeable blinds and privacy curtains with screens.
- IPC colleagues are working with BI colleagues to aid receipt of more insightful data, BL welcomed any feedback from SQAC.

KB sought clarity regarding what is driving the significant increase on Gram-Negative bacteraemia's, given the nationwide increase. BL advised that adults are very different, with regards to the lack of hydration for older people, which is not applicable to Alder Hey patients. BL advised that the majority of patients at Alde Hey are complex patients, with multiple difficulties in the short gut, many of the cases are one single patient with multiple episodes, with complex patients who do not follow instructions regarding how to take care of lines, or cases are very young babies who are touching the catheter with significant challenges regarding how to maintain catheters for such patients who have multiple episodes. KB sought clarity whether this is a worsening position, or whether this related to those complex patients that are being continually reinfected, given the infection rate is higher. BL stated that this is a deteriorating position and advised that the Trust could have 1 patient who has 3 monthly episodes which has an impact on the report presented. BL advised that there are increased numbers at present.

FB requested whether there is a timeline for an update from the BI team. BL stated that she is hopeful of an improved data position in 1 months' time, and for the report to be further strengthened in 2 months to enable an improved position regarding the data presented.

JR stated that colleagues are reviewing governance, and are working with the Brilliant Basics team, as part of the antimicrobial workstream. JR referred to the actual number on table 1 and 2 of the report and queried whether this a cumulative effect – BL confirmed this is correct.

FB welcomed an overview/deep dive on DIPC cases/targets at April 2023 SQAC meeting.

Resolved: FB welcomed overview/deep dive at April 2023 SQAC meeting.
FB thanked BL for update.

22/23/222 Assurance Emergency Department Activity Monthly update

SQAC received and **NOTED** the Assurance Emergency Department Activity monthly update.

22/23/223 Quarter 3 Mortality Update

ABa presented the Quarter 3 Mortality update; key issues as follows:-

- Report provided good assurance regarding review and leadership process.
- Year on year there are increasing deaths in the hospital, this is due to a change in reporting as the Trust is now required to include all ED deaths, i.e., SUDI's.
- Medical Examiner requirements - 2 Medical Examiners had been appointed 6 weeks ago, they will be sharing the post, postholders would be based in LUFT Medical Examiner Department. Medical Examiners are to commence in post at the beginning of April 2023. Alder Hey are contributing towards the Medical Examiner post, which would allow Alder Hey 24/7 service provision due to the size of the department. ABa advised that colleagues are devising a portal to enable access the coroner, and a portal is being devised to enable access to the Medical Examiner. There is some administrative refining to be undertaken, however a Medical Examiner will be in post at the beginning of April 2023 with an appropriate process in place.

FB welcomed the good progress made with regards to the Medical Examiner appointment.

Resolved: SQAC received and **NOTED** the Mortality Update.

22/23/224 Never Event Muscle Biopsy RCA

PB presented the Never Event Muscle Biopsy RCA, the report detailed the level 2 RCA investigation report, action plan and presentation, key issues a follows:-

PB provided a comprehensive overview relating to an RCA which related to a 10 year old boy, who had been involved in a Sarepta Essence Research trial. Muscle biopsy had been taken from Right Biceps muscle rather than Left Biceps. There had been no harm to the patient and the tissue from the muscle biopsy was suitable for testing, the patient did not require any further testing, and there was no impact on the patient's continued participation in the trial.

RCA Report included care and service delivery problems, contributory factors, lessons learned and notable practice.

The investigation findings had resulted in 30 recommendations for practice which are addressed in the associated action plan.

The root cause of the incident was found to be a deviation from the study protocol and process and lack of adherence to Trust policy and process

The incident occurred on 6th January 2022 and was reported to the external trial sponsor on 7th January 2022, family had been verbally informed on 13th January 2022. There had been a delay in reporting internally, and had been reported onto Ulysses on 10th August 2022, delay due to the PI having a period of leave, and the PI understood that team members were reporting, however the team member was leaving the Trust and did not report. This was confirmed as a Never Event on 2nd November 2022.

PB advised that colleagues are on trajectory with regards to any outstanding actions on the action plan, and divisions are working hard to ensure actions are implemented for the pathway of this patient. Action plan has been shared widely across the Trust, with key messages cascaded through the Patient Safety meetings.

FB stated there are a number of specific actions for teams and alluded to staff turnover in the research team, and the appointment of new clinical trials manager, and whether SQAC required further assurance regarding the research trials operation, with regards to culture of training, readiness and awareness of the research teams, FB alluded to whether there could be any other potential concerns or any other potential failings.

KB referred to themes i.e., staff not checking the consent form, and referred to the STAT programme, and given this was delayed, and queried whether this is more complex, as this patient did not enter through the normal admissions route etc. PB referred to the delay in reporting, and advised the patient crossed a number of divisions. PB described that there was clear information regarding the PI role, and the PI is the lead for this patient. Findings identified that the work between the PI and the pathway was not clear, and that the plans did not translate. There is specific training to be undertaken with the theatre team regarding good practice to be undertaken.

JG alluded to the nuances of this individual case, and queried whether a check in is required regarding cultural issues and accountability for staff following policy and procedure, and ensuring appropriate governance and oversight, to ascertain whether colleagues feel fully assured with regards to the STAT programme and the Trust approach. PB stated that staff largely could not recall this case, and that the Trust has a very clear policy for consent form and process.

AB referred to considering all areas where any invasive procedures are undertaken and alluded to the 2015 patient safety alert, with all areas required to have those LOCSIPPs, and whether there

is a need to review all areas, to ensure procedures are clear and well embedded across the Trust, with many areas where invasive procedures are undertaken.

Resolved: JC to review SQAC Workplan with regards to LOCSIPPs to include on workplan going forward.

SQAC were supportive of the need to review the flow of cases through checkpoints to enable CRF assurance regarding trial activity and that it is not adding additional risks.
SW advised that there are themes/issues regarding listing, as meditech listing is rarely correct. SW is liaising with JR in this regard.

ABa advised that this has been an ongoing issue, whole workstream within EXPANSE, the meditech system had never been designed to take a patient to theatre. Roland Partridge is working with team to improve, as there are some restrictions in meditech and in EXPANSE that limit this. ABa advised that the Trust should have an improved listing system going forward that it not so cumbersome for users, with ongoing work taking place to address.

FB welcomed report and action plan and requested 3 & 6 monthly updates to SQAC. FB requested an appropriate group to consider whether there is any wider work required, or whether any existing work within the workstreams would address issues raised, with SQAC receiving update at April or May 2023 meeting with regards to progress to enable a further update/assurance on issues raised.

Resolved: PB, ABa, NA, JG & AB to discuss offline, to enable further update to be provided to SQAC at April/May 2023 meeting.

22/23/225 Medicine Shortage in Pharmacy

PS presented the Medicine Shortage in Pharmacy report, key issues as follows:-
Quality Assurance round held in December 2022 raised an issue regarding Medicine shortages, with regards to a quality perspective, and how this is managed, with the drugs supplied or with similar drugs. PB advised that this is a national issue which had been exacerbated by Brexit and covid, with political issues with regards to the government applying a levy nationally which had resulted in suppliers withdrawing products from the market, whilst also resulting in a 50% increase in medicine shortages.

PS advised that there is SOP in place within the Pharmacy Department. PS alluded to cost implications regarding supply and demand of medicines with a 14% cost pressure regarding generic medicine equating to approximately £1M per year, which is multi factorial. Drugs report is due to be presented to RABD on 27.3.2023. The Trust has a Task and finish group who identifies any trends within Divisions. PS attends various ICB and Regional meetings regarding drug management and purchasing. PS provided assurance to SQAC that there are appropriate processes in place, with no cancellation of treatments to date.

FB queried how effectively these concerns could be escalated with regards to the Trust patient groups across the broader system, regarding the C&YP impact, and whether this is being raised nationally. PS advised that there is a paediatric Chief Pharmacist network in place and discussions are taking place regarding commissioning of medicines, and that this issue had also been raised through the neonatal and paediatric partnership meetings. PS stated that if there were any issues regarding the supply of medications, PS would have utmost confidence to raise to Executive team colleagues in the first instance to escalate any support required.
FB thanked PS for informative update.

Resolved: SQAC received and **NOTED** the Medicine Shortage in Pharmacy report.

22/23/226 Children & Young People Engagement Forum report

JR presented the C&YP Engagement Forum report, key issues as follows:-

- Current forum consists of children and young people aged between 8-15, the C&YP Engagement Forum have 27 members, a recruitment drive is planned over the summer period.
- C&YP have been involved in Promotional videos, working with Brilliant Basics team on Brilliant basic modules, and working with colleagues regarding the Trust strategy.
- Key areas of focus for C&YP is the Young Engagement Strategy during November and December 2022 regarding consultation process. A broad range of feedback had been received with 424 responses, majority of which were positive. Suggested improvements regarding renal friendly vending machines which children and families were keen for. Responses also included suggestions for more toys and activities in waiting areas. With overall responses extremely positive.
- C&YP Engagement Forum worked in collaboration with Alder Hey Charity and had been successful in obtaining a funding bid, for £20,000 to enable a youth led programme of qualifications and accreditations and life skills workshop to be created and delivered. Work is due to commence in Quarter 4.
- Young People from the Alder Hey Forum are working with other participating groups -Transform and the Camhelions to meet with a training provider to identify a range of qualifications, training opportunities and workshops, in which young people will gain valuable skills and qualifications, that would increase confidence to transition into adulthood.
- Children & Young People Engagement Leads have been working in partnership with Youth bank & NSPCC regarding a unique opportunity on the development of a new programme launched in April/May 2023. Unique opportunity for a panel of young people to manage a £5,000 budget and distribute to other local young and community groups across the city region, theme around safety, to help empower young people, currently in the recruitment process for panel, a training programme would be undertaken once panel is in situ.
- Colleagues are working with Brilliant basics team and are incorporating information regarding engagement process at induction.

FB referred to the importance of listening to C&YP voices to help shape ongoing improvements.

FB thanked JR/AJ and children and young people and welcomed the innovation and welcomed further updates.

JG referred to methodology, and the really sophisticated approach undertaken by the Children & Young People Forum, JG stated that the 2030 vision is underpinned by a plethora of children's feedback.

FB thanked JR for Children & Young People Engagement Forum report.

Resolved: SQAC received and **NOTED** the Children & Young People Engagement Forum report

22/23/227 Trust wide Clinical Audit Annual Work Programme – 2023/24

JR presented the Trust wide Clinical Audit Annual Work Programme -2023/24, key issues as follows:

- There are a total of 20 national, and 10 local Trust priority audits, this could be amended to 11, to include LOCSIPPs.
- The Trust Annual audit plan will develop as part of an iterative process, the quality contract is still to be agreed with commissioners therefore this may slightly change.
- JR requested SQAC to agree the Trust wide clinical audit plan for nationally mandated and Trust wide priority audits.

FB queried whether further audits could be requested and approved after the programme is agreed. JR advised that she assumes that if something emerged as a priority it would need to be shared at SQAC and ARC.

KB advised that she reviews Trust priority audits, and that SQAC should understand why every audit is included on the Trust wide Clinical audit Annual Work Programme. KB stated that when reviewing the 10 audits, that there are a couple of audits that although are not nationally mandated, appear to

be externally driven in terms of the surgical site infections and the mandatory surveillance of health care acquired infections, with a couple of regular audits, i.e., tendable and ward accreditation, with 6 audits remaining. KB referred to 3 of the audits which she is not clear why these audits are included. KB referred to sepsis, transition, safeguarding & NICE guidance and sought clarity whether these items should feature as part of clinical plan or internal audit plan. KB welcomed involvement next year from SQAC members and NEDS for support in the future Clinical Audit Annual Work Programme/Plan.

KB sought assurance from SQAC whether the 10 audits were the correct audits, or whether there are any themes which are not included which should be.

JR referred to Sepsis & transition and stated that previously these had been aligned within the Divisional audit plans. JR made a plea to colleagues for the Divisional audit plans to be updated by the deadline of this month. JR would provide an update report to SQAC at April 2023 meeting, with appropriate audits removed from Divisional audits and incorporated into Trust wide priority audits. FB stated that there are issues that there would be limited value in repeating some audits on a yearly basis and advised on the importance of correct reporting cycles.

Resolved: SQAC to receive updated report at April 2023 meeting
Resolved : SQAC received, **NOTED** and supported the Draft Trust Wide Clinical Audit Annual Work Programme 2023/24, subject to final clarification regarding Trust wide priorities.

22/23/228 CQSG Key issues report

PB presented the CQSG Key issues report, key issues as follows:-

- CQSG had met on 14.3.2023, there had been a number of deferred agenda items due to timeliness of the CQSG meeting which coincided with the Junior Doctor Industrial Action.
- Divisions had escalated issues within Divisional reports for the attention by CQSG, with plans in place from Divisions to address issues, with no further assistance required by CQSG.
- CQSG noted the opening of Sunflower House on 24th March 2023.

FB thanked PB for CQSG key issues updated and welcomed the new written report.

Resolved: SQAC received and **NOTED** CQSG Key issues report.

22/23/229 Transition Report

JP presented the Transition Report update, and provided SQAC with a detailed overview of how many of the young people that are open to the Trust aged 14+, how many of those young people will be discharged back to their GP, and how many of those young people would need support onto adult services, key issues as follows:-

- Across 56 specialisms, there are 49.1K young people aged 14 or above who are either waiting or have been booked for activity for both inpatient and outpatient teams across the Trust.
- Of those 49.1K many are duplicated because they sit under more than 1 specialism. The number of unique young people aged 14 or above known to the above specialisms is 29.6K.
- Young people with lifelong conditions would require support to move onto adult services. There would be some young people at 16 who would need support to move onto complete their treatment/monitoring.
- JP is working through the data to understand what % and number the above represents of the whole caseload of 29.6K.
- Barriers to obtaining the data, regarding challenges completing the additional forms which would allow the running of reports, there is variation in practice and collation of data. With some data held in databases rather than on Meditech, some of which is for good reason with regards to specific conditions and ways of managing moving on into adulthood.
- JP referred to the culture regarding the challenges of completion of additional forms as there is anticipation by staff regarding how complex and time consuming the process is, in addition there is a variation in the age of patients moving on, with no patients moving on at age14, with the objective of planning commencing at aged 14, with some patients moving on at aged 16,18, and 19 which is partly related to how services are commissioned and the unique needs of young people.

- Proposed solution is a simple stripped back process to allow basic data collection, with a bullet point to promote the recording from age 14 onwards, to ensure that it is indicated within the clinical record that the patient is noted at aged 14 and that the discussion has commenced, to ensure colleagues are ready to plan moving once appropriate for that young person.
- JR advised SQAC of one suggested solution to make one of the fields mandatory on the EPPF which would guarantee completion, this is not mandatory at present and is not being completed. Support would be required from the BI development team, however there is currently a freeze on development and any requests would not change until early September 2023. JP queried whether colleagues would be content to wait until then, following Alder Care migration.
- JP referred to the ongoing work planned with Associate Chief Nurses, Heads of Nursing, Matrons, CMO and clinical leads regarding promoting the cultural process and promoting the importance of moving on discussions and prompting the simplified first step of moving on.
- NICE guidance compliance – progress had been made regarding standards with 100% returns
- Mean divisional compliance against standards – 93.8% (excluding CTD as support service – 95.5%)
- Areas of good practice, related to condition specific systems and process, with good practice noted across diabetes, epilepsy & asthma services.
- Ongoing work by Regional & AH Transition leads with adults' partners to identify gaps and improve pathways
- Young people with complex Neuro disability supported by Transition lead and when appropriate Complex discharge team
- Cross divisional steering group had been refreshed and relaunched working to simplify process
- Reporting to SQAC would improve as data is further analysed
- Socialising the new name of 'moving on' rather than Transition

FB thanked JP for comprehensive update and referred to JP's question with regards to whether SQAC could wait until September for support from BI. FB stated that this had to be clinically driven, and that it is not appropriate for SQAC to place demands regarding the order of which systems are aligned to particular priorities and that this had to be clinically driven, and that discussion should take place in a different forum. FB stated that she was assured that discussions are taking place, and that different specialties are thinking about moving on, and between transition leads, this would enable any identification of problem areas, and would aid any wider discussions within the system. FB stated that this is a significant improvement to raise awareness of the current issue and welcomed that divisions are identifying any problem areas.

FB welcomed SQAC receiving quarterly updates and highlighted that negotiations regarding systems should be held elsewhere.

ES referred to the confidence levels in the adult sector to be able to manage with the increased numbers of conditions as a result and during the pandemic that Alder Hey have seen i.e., eating disorders, and the worry for many parents regarding trajectory for their child, and whether this is being addressed by adult mental health services, and whether the systems is cognisant enough. JP stated that one of the actions agreed at the Steering Group was to potentially hold an information sharing event to help focus colleagues on challenges etc. JP is due raise this NA.

KB stated that it is useful to receive figures and to receive context and highlighted the importance of this work to maintain the flow of patients throughout the organisation. KB sought clarity whether this needed to be a formal project and be aligned in BB methodology and ensuring appropriate resources. JP referred to the 10 steps approach which has been embedded, and the model had been redesigned working with BB team. Feedback to date related to a mis match regarding process and usability, this is being refined at present. JP welcomed ongoing support from Brilliant Basics Team. JP to continue to think about this and reflect on this further within the next Moving on report.

JG referred to the correct analytical support required, regarding the predictive capacity and flow, and ensuring a line of sight for cohort of patients awaiting transition into adulthood and where AH commitment finishes etc. JP stated that a 'flagging' system is required, JP advised that she would consider this further.

CW advised that if colleagues spoke to individual clinicians within the Division of Medicine, that colleagues would know those patients who are due to move on, and would risk assess as appropriate.

FB thanked JP for comprehensive update and welcomed update at June 2023 meeting.
Resolved: SQAC received and **NOTED** the Transition Report.

22/23/230 Implementation of Inphase

SQAC received implementation of Inphase update within the meeting pack, key issues as follows:-

- Significant work had been undertaken, with regards to the joint procurement process with Liverpool Heart and Chest for the Implementation of Inphase. Alder Hey Children's NHS Foundation Trust current contract for Ulysses is due to expire at the end of May 2023.
- JR provided assurance that all of the modules that required a legacy form had been completed and are currently with InPhase for the testing phase of the extraction of the current data into the new system, new forms have been developed for incidents, risks and complaints, and are with Inphase for testing. In phase are due to be on site on 23rd March 2023.

Resolved SQAC received and **NOTED** the Implementation of Inphase update.

22/23/231 Board Assurance Framework

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

- ES sought feedback regarding what deep dives are required going forward.
- ES referred to any new or revised gaps in assurance that are emerging.
- A deep dive on BAF risk 1.4. Mental Health had been undertaken
- ES referred to the Medicine supply chain shortages, given that this is not just a financial issue, and referred to the gap in assurance. KB queried whether this this a risk in its own right, or gap in control.

JG advised that further thought is required regarding mitigations and where this risk should be aligned.

FB queried confidence levels when people are struggling to identify available drug and available substitutes if sub optimal and whether this is being appropriately flagged as appropriate. JG envisaged that Medicine Management Board would have oversight.

JRe referred to abuse of staff on the wards, and stated that this issue had been addressed in Quality Assurance rounds, and referred to potential different approaches undertaken by colleagues, and whether this would merit a deep dive and welcomed an update.

JRe referred to respiratory illness, and an issue regarding vaping, JRe advised that she is interested to receive an update on how the Trust is addressing respiratory illnesses and the rising of illness and the emerging issues due to environmental factors. JRe welcomed an update on how this is being addressed. FB advised that the appropriate team should be put in contact with JRe to liaise with team to enable JRe to receive an update.

FB echoed comments regarding violence for staff, if there is a difference in practice across the Trust.
PB advised that she is currently reviewing the Zero tolerance policy and advised that staff are extremely tolerant and empathetic and that there can be a delay in evoking a process, as staff are trying hard to manage the process, training is important together with clear messaging that the Trust would undertake appropriate action as and when appropriate. PB is addressing this to ensure clear campaign on zero tolerance, SQAC to receive update in due course.

FB referred to 1.4 Mental Health and referred to trends, given that C&YP are living with covid, and given that networks are stronger, and sought clarity whether there is sufficient insight and data for further scoping regarding any potential trends, and what the service would potentially look like in 3 years' time, FB welcomed scoping/predictive forward trajectory/overview.

JP advised on the continuing upward trajectory trends across all of the neuro development and mental health services. With involvement with PLACE and various MH networks reviewing whether services need to be change in the future, given the longer term and a need for a review of how services are delivered.
FB thanked ES for BAF update.

22/23/232 Divisional reports

Community & MH Division

JP presented Community & MH Division update:
Challenges:

- Water Safety in 3 storey modular Catkin and Sunflower
- Was not brought rate is currently 12%
- Increase in 52 week waits in CAMHS
- Continued increase in referrals for ASD & ADHD

Highlights:

- Move is planned to Sunflower House on 24th March 2023, daily huddles are in place to address any challenges, with detailed plan for the move in place.
- Improvement in the letters to families regarding ASD offering signposting of information ensuring improved transparency for families
- PDR 88% - with planned activity envisaged 94% by the end of March 2023
- Incident reporting continues to increase, trend shows an increase across minor harm and near misses
- 4 formal complaints, no breaches
- 123 compliments received
- 4 new risks, 0 closed, 0 overdue for review, and 3 outstanding action plans

Medicine Division

CW presented Medicine Division update:
Highlights:

- Division had seen a consistent continued improvement of sepsis compliance - 100%, with robust processes embedded, daily oversight and escalation to senior nursing is extremely positive.
- Consistent high performance report with PALS resolved within 5 days, with a reduction of PALS during February 2023. Division are encouraging ward managers to liaise with parents to resolve any issues or concerns at ward level prior to escalating to PALS, which is proving positive
- Focus on mandatory training - trajectory PDR compliance of 94% by the end March 2023
- Mandatory training currently under 93%, aiming for a consistent target of 95% over the coming months, Division are confident that this would be achieved. There is a different plan in place for mandatory training, with focus on staff attendance during the summer months to aid mandatory training compliance, with robust plan in place.

Challenges:

- Clinical letters being completed within 10 days, Division have 247 letters that are more than 30 days, plan in place to help mitigate this is with Clinical Directors ensuring real oversight, the Division are anticipating a reduction over the coming months.
- Cancer services – the Division had seen concerns raised and low morale across oncology and haematology, the Division have seen a loss of experienced staff, nurses, doctors, physios and pharmacists which is impacting the unit, this is a national issue which has been challenging, there is a robust training programme across the division in place.
- Consultant availability in Haematology services - discussions are ongoing at Executive Team level and with RMCH regarding joint working and mutual aid. Colleagues are also reviewing how specialist nurses could support haematologists during this challenging period.
- Listening event held in January 2023, positive event with feedback, and honest discussions held.

JRe sought clarity regarding the issues regarding low morale and whether this related to workforce issues and the general pressures following covid, CW stated that this is a national issue, patients

with higher acuity and higher dependency, which is a national picture, and a real lack of experienced staff, and that it had become clear that during covid that staff were not moving roles, and that staff do not want to change roles, resulting in a lack of seniority and leadership.

Surgery Division

SW presented Surgery division update:

- Division are maintaining responses to 60 minute targets, and are continuing to respond to complaint response times.
- Governance team structure had helped the reduction in clinical letters to be signed off, no letters pre 2023, with the oldest letters mid-February, with improvements made across the division.
- Despite staffing challenges and Industrial activity, activity volume is 80%, due to cases that continued - cardiac, spinal and neurosurgery with recovery levels at 108%.
- Significant improvement in DMO euro dynamics last report 80%, colleagues had worked in conjunction with Radiology to increase capacity, resulting in 100% delivery for 6 weeks.
- PDR compliance – 91%
- Was Not Brought rate is below Trust target

Challenges

- Number of the on the day cancellations had increased, mainly due to high volume lists, however due to good communication from the Divisional management team, the rebooking of patients with 28 days had increased.
- There had been an increase in the 52 week waits – there are some sub specialities with a number of gaps, Business Case is being developed to address those gaps; there are mutual aid patients who have been given dates prior to the end of March 2023. There is concern if this continues that there would be some children who attend the Trust at the 78 week target, with ongoing discussions taking place.
- Delayed discharge of a patient – engagement had taken place from Executive team and the Local Authority, unfortunately there is a substantial delayed discharge, number of significant incidents including physical harm to staff, despite good and adequate support from Prometheus, this is a significant issue for staff on 3A, there are also bed closures due to the significance of this patient.
- There are a number of Business Cases developed to address those areas of concerns. Further capacity planned in outpatients and theatre schedule.
- Division had completed activity plans for the year ahead, and BI teams have produced a tool to enable the Division to map whether they are planning to undertake the right amount of activity, tool has identified key challenge specialties for further focus, discussions are ongoing to achieve target to ensure no patients are waiting over 52 weeks for treatment.
- MU referred to the on the day cancellations, and the high volume cancelled patients on the day and the plastics list, and advised that the cancellation was unavoidable due to emergencies during the night, resulting in surgeons having to operate during the night, therefore the surgeons could not continue working the following day.

FB referred to the delayed discharge patient and hoped that any further disruption is minimised.

22/23/233 Any Other Business

None

22/23/234 Review the key assurances and highlights to report to the Board

- Good reports provided to SQAC, with positive improvements in the quality of the reports provided, with good levels of oversight and assurance provided.
- Quality and Assurance Rounds Themes & Risks report received
- DIPC Exception Report received with good discussion held, data issues are being reviewed, with the aim to strengthen future reports presented to SQAC
- ED@its best update received, SQAC welcomed a strengthened ED monthly update at April SQAC meeting
- Mortality report received
- Comprehensive Never Event Muscle Biopsy RCA received, SQAC noted the significant learning, and the general actions undertaken, with further reflections required regarding whether there are any further actions, or more generic actions that need to be undertaken regarding cultural issues.

- Management and Impact of Medicine Shortages Report received, with good discussion held.
- Children & Young People Engagement Forum report received.
- Draft Trust wide Clinical Audit Annual Work Programme 2023/24 received
- New written CQSG Key issues reported received and welcomed by SQAC
- Implementation of Inphase report received
- Transition Report received
- Divisions raised a number of issues, which are also highlighted within the CQSG key issues report.

Key Risks/matters of concern to escalate to Board – Management and Impact of Medicine Shortages Report

Date and Time of Next Meeting: - Next meeting to be held on 19th April 2023 at 9.30 am

Alder Hey Children's NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday the 6th February 2023**
Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Mrs. L. Shepherd	Chief Executive	(LS)
In Attendance	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Kirkpatrick	Assoc. Director of Commercial, Control and Assurance	(EK)
	Dr. F Marston	Innovation Consultant	(FM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
Observing:	Ms. F. Ashcroft	CEO of the Charity	(FA)
Apologies:	Mr. A. Bass	Chief Medical Officer	(AB)
	Prof. I. Buchan	Assoc. Pro Vice Chancellor for Innovation and Chair of Public Health and Clinical Informatics	(IB)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Ms. R. Lea	Deputy Director of Finance	(RL)
	Mr. D. Powell	Director of Development	(DP)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)

22/23/67 Apologies

The Chair noted the apologies that were received.

22/23/68 Declarations of Interest

There were none to declare.

22/23/69 Minutes of the previous Meeting

The minutes from the meeting held on the 12.12.22 were agreed as an accurate record of the meeting.

22/23/70 Matter Arising and Action Log

Matters Arising

There were none to discuss.

Action 22/23/39.1: *Bluetree Group Licence Update* – A meeting is scheduled to take place on the 27.02.23 to agree the next steps and to progress a Business Development Options Plan which will be submitted to the Research and Innovation (R&I) Committee in due course. **ACTION TO REMAIN OPEN**

22/23/71 Innovation Performance Report Q3

The Committee received an update on performance for Q3 2022/23. A number of slides were shared which proved information on the following areas:

- Impact report.
- Operational scorecard.
- Divisional performance: People Plan and HR metrics, risks and finance.
- Strategy deployment detail: Culture, impact growth and business development.
- Culture: Pipeline and project examples.
- Impact: Programme delivery.
- Growth: Grants funding, industry investment and benefits.
- Business development: Branding, reputation and partnerships.

A question was raised about the process for agreeing partnership arrangements. The Committee was advised that presently if an agreement does not fit into the contentious or novel category it won't be submitted to the Committee for approval. Going forward it has been agreed that when a pipeline project becomes active information will be submitted at Committee level.

Claire Liddy clarified that part of the validation process for a project for innovation is acquiring a market comparison therefore the Trust is in receipt of a detailed market comparison report which includes all of the current and emerging providers/ competitors that can be shared with the Committee for background information if required.

A discussion took place on the adverse movement between M9 and the year end and it was queried as to whether this has been formally approved. It was reported that this is a phasing point due to the profile of the spend and this information was well socialised in Q3.

Fiona Marston suggested that the following amendments be made to the performance report; include current data to enable the Committee to focus on the here and now and include dates against grants in terms of when they were awarded and when they will cease. It was also felt that it would be beneficial to review the income forecast in the strategy as there is a lot of work taking place which is not translating into income. Following discussion, it was agreed to refresh the pipeline and commercial opportunities in order to provide a forward look and set a clear context. It was pointed out that the refresh will need to be at a forensic level around the organisation's commercial assessment at the top end of the pipeline. A request was also made for further visibility to be included in the report on grant opportunities.

22/23/71.1 Action: EH

The Chair concluded this agenda item and requested that a meeting take place to discuss annual planning ahead of April's R&I meeting, and to address the points made by Committee members.

22/23/71.2 Action: EH

22/23/72 Commercial Partnerships Monitoring Report.

The Committee was provided with an overview of the Commercial Partnerships Monitoring report for Q3. During the reporting period one agreement has been completed and four are scheduled for completion in Q4, 2022/23.

It was confirmed that work is being undertaken to enhance the Commercial Partnerships Monitoring report and review the level of detail submitted to the Committee on the commercial pipeline. As part of the next R&I Committee review, discussions will take place in the next two weeks with Non-Executive Directors about the information that they would like to see in reports.

Fiona Marston felt that reports need to have less information and more of a focus on strategic alignment and impact.

Resolved:
The Innovation Committee noted the Commercial Partnership Monitoring Report for Q3, 2022/23.

22/23/73 Innovation Committee Close Down Report and Letter to Members

It was reported that the Innovation Committee will hold its final meeting under its current Terms of Reference on the 6.2.23 before being formally closed down. The Innovation Committee will be replaced by the newly formed R&I Committee, with the first formal meeting to take place in April 2023.

The 2021/22 Innovation Committee Annual Report has been updated to outline the procedure for closing down the Committee, and a letter from the Chair and the Director of R&I has been circulated to members to advise of the changes.

Resolved:
Committee members noted that the Innovation Committee was formally closed down on the 6.2.23.

22/23/74 Research and Innovation Committee Governance Structure.

The Committee received a diagram of the new R&I governance structure that will be implemented following the close down of the Innovation Committee. A detailed overview of the reporting process was provided in terms of the new reporting bodies and the activities they will undertake, as highlighted in the e-mail from the Chair of the Innovation Committee and the Director of Research and Innovation.

Feedback was received on the governance structure regarding the importance of agreeing the membership for the advisory panels and ensuring that the R&I Committee doesn't lose the opportunity to discuss items prior to being approved.

It was queried as to whether a decision has been made about the R&I Committee reporting into the new group Board. The Committee was advised that the current proposal is for the R&I Committee to report directly to the Trust Board until the 'Futures' programme of work and governance process is finalised over the next three months. It was pointed out that the Terms of Reference were approved by the Trust Board in October 2022 but may need to be amended with reference to the group Board, Committee discussion, etc.

Fiona Marston queried the information that the R&I Committee will receive going forward and asked for clarification as to whether it will be aligned with the Trust's

000129 future strategy in terms of commercial income, impact and strategic objectives. It was confirmed that this is the intention. Each item will be supported by a mini business plan which will provide detail on how it fits into the Trust's Vision 2030 Strategy/R&I Strategy along with the resources required and benefits that will be gained. All information will be received by the R&I Committee for approval and will then be submitted to the Resources and Business Development (RABD) Committee.

John Kelly raised the issue of the duplication of agenda items/membership at RABD and the Innovation Committee. It was confirmed that going forward RABD will only receive a summary of the respective reports that are submitted to the R&I Committee.

Resolved:
The Innovation Committee noted the new R&I Committee governance structure.

22/23/75 Board Assurance Framework (BAF) Report

The Innovation Committee received the BAF report for December 2022. It was reported that BAF risk 4.1 *(Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People)* will be adapted ahead of the inaugural R&I Committee meeting. It was confirmed that there is nothing to update on in terms of the risk as it is currently articulated.

Resolved:
The Innovation Committee noted the contents of the BAF report for December 2022.

22/23/76 Any Other Business

On behalf of the Innovation Committee, the Chair wished the Managing Director of Innovation, Clarie Liddy, all the very best on the impending birth of her baby daughter.

22/23/77 Review of the meeting

It was felt that the Committee had a good discussion about how it would like the new R&I Committee to operate and the information that it would like to see during meetings. The Chair pointed out that there is a lot to think about in terms of progressing the new R&I Committee.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 4th May 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 March/April 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 March is 6.0% and remains above the 5% target. This comprises STS at 2.0% and LTS at 3.9%.
- Turnover remains high at 15%, with a focused review of turnover and retention initiatives underway which will be captured in the Trust long term plans on attraction and retention
- A focused effort from the whole Trust on PDR's has seen an increase in compliance to 93% by end of March 2023

3. Industrial Action and Agenda for Change pay 'offer in principle'

On 16th March 2023 the government made a pay 'offer in principle' to the trade unions representing staff on NHS Agenda for Change (AfC) Terms and Conditions, made up in two parts as follows:

- 2022/23: a non-consolidated payment, made up of two parts - a 2 per cent non-consolidated award for all staff plus an additional backlog bonus, equivalent to an extra 4 per cent of the AfC pay bill.
- 2023/24: a consolidated pay uplift, made up of a 5 per cent headline pay uplift, combined with the introduction of a band 2 spot salary – for staff entering NHS employment at this level - which is worth a further 0.2 per cent investment onto the AfC pay bill. This is a total investment of 5.2 per cent for consolidated pay changes in 2023/24.
- A series of non-pay measures to support the NHS workforce

Unions have been consulting with their members and to date the outcome of those consultations are that the Royal College of Nursing and Society of Radiographers have rejected the offer, but Unison have accepted the offer. The outcome of the other consultations is imminent. There will be a national meeting of the NHS Staff Council on 2nd May 2023 and further update to employers will follow thereafter.

Further to the RCN rejecting the offer they announced further strike action from 8pm on Sunday 30th April (or the start of the night shift) to 8pm (or start of the night shift) on Tuesday 2nd May 2023.

Following a case brought to the high court by the government that the strike action of Tuesday 2nd May 2023 is unlawful, the judge hearing the case confirmed on 27th April 2023 that the RCN's mandate for strike action expires before Tuesday 2nd May 2023, therefore strike action on Tuesday 2nd May 2023 would be illegal. The strike will therefore cease at 1159 on Monday 1st March 2023.

Junior doctor members of Hospital Consultants and Specialists Association (HCSA) and BMA (British Medical Association) have voted to take strike action. At this time no further strike dates have been announced and negotiations on pay have not commenced.

The BMA have informed employers that a formal ballot on industrial action for consultants will open on 15th May 2023.

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

Sharon Owen
Deputy Chief People Officer
April 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Equality, Diversity and Inclusion Update**
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:	This paper will provide an update of the Trust's Equality, Diversity and Inclusion activity
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

1. Introduction

The purpose of this report is to provide the board with an update on the Trust's equality, diversity and inclusion activity.

2. Background and current state

Alder Hey Children's NHS Foundation trust aims to create a welcoming experience for all our children and young people and their families and we are committed to creating a culture that is supportive, welcoming and inclusive. We continue to build on the strong foundations set out in the Trust's People Plan, placing the needs of children, young people and their families at the heart of everything that we do, and this is reflected in our trust values. We are committed to equity of opportunity and to a proactive approach to equality which supports and encourages all staff, promoting an inclusive culture that values diversity.

In January 2023 we appointed a head of Equality, Diversity and Inclusion, Angela Ditchfield, who is working across Alder Hey and Clatterbridge Cancer Centre. They are working to embed equality, diversity, and inclusion into our day-to-day business. As an organisation we want to ensure that equality is integrated throughout and informs our decision making, continuing to build a culture of inclusivity.

2.1 Equality Monitoring

The Equality Act (2010) came into force on 1st October 2010. It replaced previous anti-discrimination laws with a single Act. The Equality Act (2010) legally protects people from discrimination, harassment or victimisation in the workplace and in wider society. The Act provides a legal framework to protect the rights of individuals and advance equality of opportunity for all. The principles of Equality, Diversity and Inclusion are integral to all that we do at Alder Hey and we want to ensure that we are all working to a consistent standard, and that equality is considered when implementing new and amended services, and workforce practices. We will work hard to demonstrate our responsibilities outlined in the Public Sector Equality Duty (PSED):

- Eradicate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Encourage and nurture good relations between different groups, learning from each other
- Strive to improve existing practices, embed new initiatives, driving forward our equality and diversity activity

To evidence our commitment to the PSED we have recently published our equality reports which includes our plans for improvement and highlights our success, these include:

- Gender Pay Gap Report
- Annual Workforce Equality, Diversity, and Inclusion Report
- Equality Delivery System 2
- Workforce Race Equality Standard Action Plan

- Workforce Disabilities Standard Action Plan

We will continue to monitor our equality data which will help to inform our approach going forward.

2.3 Equality, Diversity and Inclusion Steering Group

The Trust's Equality, Diversity and Inclusion (EDI) Steering Group provides oversight to the Trusts strategic ambitions and specific EDI goals, and to ensure that EDI is at the heart of the Trust's policies and practices as an employer, health care provider and procurer of services. Chaired by Non-Executive Director Garth Dallas, the Steering Group is working hard to provide strategic coherence and oversight across all matters related to EDI.

All North West NHS Chairs and Chief Executives recently received a letter from the North West BAME Assembly concerning the highly profiled Michelle Cox race discrimination case. A recent judgement published by an employment tribunal found that Ms Cox, a senior black nurse employed by NHS England, had been treated unfavourably because of her race and because she was willing to speak up. The BAME Assembly highlighted that this case is yet another reminder of exactly where the healthcare system is on tackling racism and race inequality. Alder Hey's EDI Steering group will respond to this response by working to support the call to action. The letter can be found in appendix 1.

The steering group provides the staff networks with a platform to report their activity, whilst providing governance and structure to the group. We will be working to develop a Equality, Diversity, and Inclusion sub group which will bring together representation from all trust divisions, ensuring that we all moving in the same direction, and working to align our objectives to the wider equality, diversity, and inclusion agenda.

2.4 Staff Networks

Alder Hey is committed to building a caring, compassionate and diverse culture where all colleagues feel supported. We want to understand how it feels like to work at Alder Hey so that we can work together to ensure our staff feel cared for, listened to and valued. The development of our equality staff networks will offer staff groups to come together in a safe space to create connections, having a shared purpose, interests and sense of belonging for our members. They will give staff the opportunity to share problems, ideas, knowledge and solutions.

We will encourage our Staff Networks to become a powerful voice and a source of positive change, enabling members to play their full part individually and collectively in the organisation, supporting the leadership team and the decision making across the organisation. Our current staff networks include:

- LGBTQIA+ network
- Race, Ethnicity, and Cultural Heritage (REACH) network
- Disabilities and Long-Term Conditions network
- Staff Menopause Group
- Veterans Staff network which is being launched 27.04.2023

We want to support our network chairs to ensure that they are equipped with the right skills and knowledge to engage and support our wider workforce and with this in mind we have acquired bespoke training which will be delivered to the new network chairs, enabling them to gain a good understanding of the roles, responsibilities and influence the network can have.

Staff Networks have a deep reach into the workforce of our organisation and most effective where lived experience and inclusion expertise can influence board-level decision making. The staff networks will work to develop plans to support the organisational objectives, reporting and providing regular updates to the EDI Steering Group. We have developed a staff network charter and supporting guidance to ensure that everyone is aware of the benefits that staff networks can bring to an organisation, it will also ensure that we have a formal structure to support the networks, providing them with a reporting channel, ensuring that their voices are heard.

2.4 Training and Education

Our Head of EDI is shared between Alder Hey and the Clatterbridge Cancer Centre which provides us with an opportunity to build strong partnerships, working collaboratively to identify any opportunities to work together. We are currently looking to develop a compassion and cultural awareness training programme which can be delivered across both organisations. We are also working together to provide our workforce with bitesize awareness sessions which will provide them with an understanding of neurodiversity. The Head of EDI will work with both organisations to ensure that any training opportunities, where possible, can be developed and delivered together, providing both organisations with opportunities to learn from each other, share experience and resources.

2.5 Communications and Events

In March 2023 the Spiritual Care Team, supported by the Head of EDI, spent time meeting children, young people, and their families. They gave out hundreds of Easter books to the children and young people. It was an encouraging event which provided time for the team to meet many of the children and their families.

In February 2023 our staff network chair held a fantastic film night to mark LGBTQIA+ history week. Our Chair talked to staff about the network and the ambitions to grow and positively impact on the experiences of our LGBTQIA+ staff at Alder Hey.

International Women's Day saw many of our staff take part in a great communication campaign. We saw staff from several different departments supporting International Women's Day

To celebrate Ramadan, we invited staff to take part in a day of fasting and to join us at an Iftar event to break the fast. It was supported by the spiritual care team and our local Abdullah Mosque. It was a fantastic event and many of our Muslim doctors who helped to ensure the event was a huge success provided food for all. Our staff, children, young people and their families also attended this joyous event. We are hoping that this will be the start of our inclusive engagement, helping to bring us together to celebrate diversity and provide us all with a better understanding of each other.

The communications team are a continuous support, and we will work together to ensure that we are raising awareness of key events throughout the year. The staff networks will be supported by the communications team and will be working together on key events.

3. Conclusion

Alder Hey starts 2023 with strong leadership commitment to equality, diversity, and inclusion. We have made some steady progress which is reflected in our staff survey results and although we have still got work to do, in the next 12 months we will focus on improving and enhancing the experiences of our staff. We want to ensure that we are understanding the deeper detail, which is provided in the data, so that we can focus our attention on areas which need the greatest support. It is an exciting time for us and we are ready to make some valuable changes which will impact on our colleagues and the children and young people we care for.

4. Recommendations & proposed next steps

We will continue to work to achieve the objectives set out in our EDI workforce plan. We will work closely with our staff networks to understand the impact of the improvement initiatives, supporting their development and empowering them to make positive changes which will enhance the experience of our workforce. We will work to ensure that we are continuously assessing risks related to equality, diversity, and inclusion and reporting these risks back to Trust Board. The Steering Group will actively support the call to action, challenging discrimination, promoting our trust policies and working with Freedom to Speak Out Guardian to ensure staff feel safe and able to speak out. We will support the Learning and Development team to develop career progression initiatives and opportunities for staff from underrepresented groups to support their leadership progression, talent succession.

Angela Ditchfield
Head of Equality, Diversity and Inclusion
April 2023

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Chairs and Chief Executives
NHS Trusts and Integrated Care Boards
North West region

By email

28 March 2023

Dear all

North West Black, Asian and Minority Ethnic Assembly Statement

A recent judgement published by an employment tribunal found that a senior black nurse employed by NHS England had been treated unfavourably because of her race and because she was willing to speak up. This case is yet another reminder of exactly where the healthcare system is on tackling racism and race inequality. NHS England Chief Executive Amanda Pritchard has stated her commitment to using the outcome of the tribunal to deliver actions so that others do not face the same or similar experience. Sadly, we know that this case is not an isolated one.

The recently published Workforce, Race Equality Standard (WRES) data for 2022 for the North West (NW) shows an increase in ethnic minority staff experiencing harassment, bullying or abuse from patients, relatives and the public in last 12 months; this is 26.4% for Black, Asian and Minority Ethnic colleagues compared to 24.2% for white staff. The representation of ethnic minority staff at board level for the NW data is 10.8%, whilst there has been a fall at exec board level to 6.8% from 7.6%; representation in the overall workforce is 14.8%.

We are writing to you as co-Chairs of the North West Black, Asian and Minority Ethnic Assembly (the Assembly) to call on you all as people in positions of power and privilege to step up in order to make sure that the NHS in our region deals with the structural and institutional barriers that result in ethnic inequalities in access, experiences, and outcomes.

Racism and discrimination have a harmful impact on individuals and communities. In the NHS this materialises as lack of appropriate treatment for health problems; poor quality and discriminatory treatment by healthcare staff; lack of high-quality ethnicity data monitoring; inadequate interpreting services for those who cannot speak English confidently; and avoidance of seeking help for health problems due to fear of racist treatment.

To root out racism, we need to critically appraise our organisational culture from top to bottom.

The North West Black Asian and Minority Ethnic Assembly was initially formed by over 70 senior NHS leaders in response to the disproportionate impact of the Covid-19 pandemic on racially minoritised colleagues and communities, to act as a critical friend and through our

network of senior leaders to push our clear stated ambition is for the NHS in the North West to be Anti-Racist and at the forefront of challenging and tackling racism.

We in the Assembly are in no doubt that tackling racism needs to be a fundamental leadership responsibility for everyone. We as assembly members urgently call on all NHS leaders across the North West;

- To commit to taking sustained action and demonstrating visible leadership on addressing racism in all its forms – interpersonal, structural, and institutional
- To prioritise addressing race inequalities in health and care both as a system and within their own organisations
- For integrated Care Boards to demonstrate a strong competence in the understanding of causes of racism and the impact this has on people's lives
- Connect with their staff by talking openly, creating an environment of compassion, respect, and safety, and to share experiences and learning from each other

As an Assembly we are keen to work with NHS England and leaders from across the North West to provide support, share insights, lived experiences of racism and inequality along with good practice and call on you to look at how you can engage with the Assembly and use the expertise of our members on this important issue.

Yours faithfully

Evelyn Asante-Mensah OBE

Chair, Pennine Care Foundation Trust And North West, Black Asian and Minority Ethnic Assembly

Richard Barker CBE

Regional Director (North West)

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 4th May 2023

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

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP QUARTERLY PROGRESS REPORT FOR THE PERIOD SEPTEMBER 2022 TO MARCH 2023

1. Purpose

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

2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed and to consider whether the Speaking Up e-learning modules should become part of mandatory training for all staff.

3. Quarter 3 and 4 data

Themes highlighted in bold are reported as part of the quarterly data collection and returned to National Guardian's Office.

Themes *	Open	Closed	Total cases	Number of total contacts
Patent Safety and Quality	0	0	0	0
Worker Safety and Wellbeing	0	1	1	4
Inappropriate Attitudes and Behaviours	8	3	11	44
Policies, Processes, Procedures, Systems	16	7	23	92
Infrastructure/Environment	0	0	0	0
Cultural	0	0	0	0
Leadership	0	0	0	0
Senior Management Issue	0	0	0	0
Middle Management Issue	0	0	0	0

***Speak Up cases often contain multiple themes; therefore, data sets do not always equate together. Reports are recorded under the worker's description.**

The nature of the role of the FTSU Guardian tends to lead to individual members of staff speaking up in relation to specific individual cases and therefore it is often difficult to see generalised themes within teams, departments, divisions or indeed across the Trust.

It should be noted that whilst the primary concern raised may not have been in relation to staff safety, when the concern is linked to inappropriate attitudes and behaviours, there is an element of staff safety and therefore where there is a breakdown of relationships, staff are encouraged to seek support from our SALs service. It must also be noted that a significant number of staff attend the SALS team with themes similar to those indicated in the table, therefore the numbers seen may not be a true reflection of the number of concerns raised. There is work underway to align these numbers regularly in order to determine total numbers across FTSU/SALS.

Generally, colleagues request that their issue be dealt with confidentially and they voice their concerns relating to future re-percussions and fear of negative behaviors/consequences as a result of speaking up. However, with support and reassurance a few staff members, have felt confident to be identified and furthermore to discuss issues openly with their senior leaders or managers. These meetings create opportunities for staff to be listened to and to understand any future actions in response and/or achieve resolution. Feedback on this process has been positive and builds on the development of an open and transparent culture, however, fear of real or perceived negative consequences continues to create a barrier to speaking up openly. The FTSU Guardian is working with representatives from HR to develop guidance on how to escalate cases and which routes of escalation can be considered.

In terms of detriment, there is currently no system/process in place to follow cases up post closure, other than the FTSUG reviewing the database each month, however going forward it is hoped that the new InPhase system will allow a programme to be created that would aid 3,6,9 and12 month review to ensure staff had not suffered a detriment post closure.

Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again and scored the process highly in terms of satisfaction.

4. Raising the profile of FTSU

Face to face attendance at corporate induction sessions has been maintained to ensure that all new starters, returners, bank staff and student nurses are aware of the role and have opportunity to meet the Guardian in person, embedding key speaking up messages.

There have been a significant number of confidential support sessions, organised by Dr Jo Potier, Associate Director of Organisational Development/SALS Lead and the FTSUG, for all staff affected by the RCN strike and the Doctors in training strikes. These have been well attended with some common themes and learning identified and shared.

The FTSUG continues to attend PAWC, JCNC, EDI Steering group and works collaboratively with HR colleagues and OD lead. The FTSUG is now a member of the Patient Safety Board, supporting the work of PSIRF; speaking up information fits into the wider patient safety or worker experience and can provide a broad picture of the culture within the Trust.

5. FTSUG Training and Development

To ensure that the FTSUG is attaining the competency level required by the National Guardian's office, the Guardian Education and Training Guide is being used in conjunction with the Trust PDR documentation. This guide builds on the foundation training provided to FTSUG's and the annual training, also required by the NGO, which supports the FTSUG to remain on the Guardian Register. The guide allows the FTSUG the ability to identify any learning needs and guidance on how to address these. There are 4 levels for each of the domains, the current FTSUG has reached level 4 on the majority of these domains with the remainder at 3 with some identified learning to attain level 4.

6. Promoting awareness of FTSU via staff training

Below is the take up rate for Speak Up, Listen Up, Follow Up E-Learning for the period 2022/23. The training helps all staff understand the vital role they can play in a healthy speaking up culture which protects patient safety and enhances worker experience. The E-Learning modules are promoted through a variety of different channels, including new staff/student inductions and via the FTSU Champions and the FTSU page on the intranet. Due consideration should be given to whether these E-Learning modules are mandated for all staff, so that assurance can be obtained regarding staffs understanding of the speak up process and managers ability to support staff through this process. For the training to have any impact it needs to reach a large audience. For example, if managers are required to complete the "Listen Up" module there is more likelihood that raising concerns non-confidentially will be received in the right way, and by staff doing "Speak Up" they will be more confident in raising concerns in this way. At present very few staff are choosing to undertake the training that is offered.

Training figures for last PDR/Financial Year 2022/23

Course	Completed	Confirmed	Course Cancelled	Did Not Attend	Requested	Withdrawn
000 Follow Up - For Senior Managers	1					
000 Listen Up - Training for all Managers	2	4				
000 Speak Up - core training for all workers	8	14				1

7. Actions to reduce barriers to Speaking Up

The Equality, Diversity and Inclusion Steering group, supports the growth of the recently reinvigorated staff networks. As a member of this group and through the networks, the FTSUG is able to develop a greater understanding of the barriers, staff may be facing in order for them to speak up and raise concerns. It is fundamental that the FTSU service should continue to be interwoven into the networks, and the rich data collated by the networks, be used to shift culture.

The FTSUG recently attended a NGO training event '*Supporting an Inclusive Speak Up Culture for Black and Minority Ethnic People',* this was beneficial and will further support the work of the EDI Steering group and that of the FTSUG in understanding the barriers that our BAME staff face.

The purpose of the workshop was to provide NHS Freedom to Speak Up Guardians with the relevant insights, knowledge, skills, tools, and techniques to improve the NHS Speaking Up culture for black and minority ethnic staff with the learning outcomes for Guardians to be:

- Have a deep understanding of race, racism, and racial discrimination as it applies to the NHS and wider healthcare workforce.
- Speak confidently about equality, diversity, inclusion and different forms of workplace discrimination, intersectionality, microaggressions and white privilege.
- Engage with Workforce Race Equality Standard (WRES) Experts, BME Staff Networks, representatives of black and minority ethnic people.
- Work effectively with leaders and others to help create a speaking up culture that works for everyone.
- Take clear action plans back into your settings to improve your personal and professional effectiveness.

8. Freedom to Speak Up Champions

Recruitment of FTSU Champions continues, with the vision remaining one where the organisation has a diverse group of champions and for each ward/department to be supported by a champion. This selection of champions will ensure that staff have a colleague that understands the area that they work in and the barriers they may face in accessing FTSU. The role of the champion is one that promotes the principles of FTSU, signposts staff to the service and highlights the importance of staff completing the Speak Up, Listen Up training.

9. FTSU National and Regional involvement

Attendance at the NW Regional FTSUG meetings continue and is a space where shared learning can take place amongst the regions FTSUG's. Recent attendance at the NGO Conference in London was both informative and provided an opportunity for networking, following on from this conference the FTSUG has forged strengthened relationships with the FTSUG's at Mersey Care, this is to understand how they built a restorative just culture and how they have been able to sustain this work. Along with this relationship, links with the FTSUG at Liverpool University Hospitals NHS FT, have also been created, as with a workforce in excess of 13,000, it can only be expected that they will have lessons learnt that can be shared.

10. FTSU Communication Plan

A new FTSU communication plan has been developed to ensure that all staff are aware of the FTSU service and how it can support them to raise concerns safely. The plan is attached at Appendix 1.

Kerry Turner
Freedom to Speak Up Guardian
April 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts – half year update**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Director of Corporate Affairs

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	National Guardian's Office Strategic Framework 2021
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	

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

September 2021

NHS England and NHS Improvement

How to use this tool

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

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

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

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

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

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

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

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				Executives and Non-Executives support the use of the Behavioural Framework, to underpin the Trust's values and the use of them in staff PDR's. The Trust Chair periodically challenges all Board members to reflect on a particular Value at the end of a board meeting. 6. People Plan: the Trust's People Plan includes an objective that 'We will develop a working environment that encourages all staff to 'speak up' and 'listen up' and continue to support the work of our Freedom to Speak Up Guardian and Champions 7. NHS Staff Survey: The annual NHS Staff Survey results of questions related to FTSU are picked up in the Board report and factored into FTSUG's team plans.	Board development to be revisited and reviewed following launch of Vision 2030 strategy and recruitment of new NEDs
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating:	p6 Section 1 Section 2 Section 3	Full	Full	1. Executive and Non-Executive Leads: appointments have been made to both positions.	

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

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				6.Bullying and Harassment**:** The NHS Staff Survey results are used to monitor and measure progress. 7. FTSU is widely promoted across the Trust via various methods, with regular sessions on the Trust's Induction programmes. The Trust has an annual Speak Up Safely week each October.	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	Partial	Partial	The Trust's People Strategy currently incorporates the speaking up strand. Following the implementation of the national Speaking Up policy and framework, the FTSUG, Exec lead and NED lead have reviewed the position with regard to a discrete strategy.	FTSU strategy statement in draft form awaiting Board discussion and approval (April 2023).

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

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

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

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	Partial	Partial	Initial appointments predated guidance/JDs from National Guardians Office, however followed the Trust's fair recruitment process. Future appointments will follow the established process using the published FTSU guidance and example job description.	Recruitment will be reviewed if any change to the guardian arrangements were to occur.
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	Full	Full	Review of data reports and themes are completed quarterly.	Case Reviews, published by NGO, to be included in 1:1s with Executive lead and NED. Gap analysis document to be used from April 2023 onwards.
Be open and transparent					
The Trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9	Full	Full	1. Regular reports are submitted to Board, and information shared with CQC and the ICB where appropriate 2. Discussions take place with relevant oversight organisation - the National Guardian's Office and CQC upon their visits, with attendance at national meetings by Guardian. 3. Discussion within relevant peer networks take place as described above. 4. FTSU content is present within the Trust's annual report. 5. FTSU discussion takes place at the Public Board. 6. The FTSU Guardian is a member of the EDI taskforce which was established by the Board in 2020.	

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

Freedom to Speak Up Communications Plan 2023/24 – Appendix 1

April 2023

Key audiences

- Alder Hey staff – all colleagues, in every location, role and seniority
- Leaders and managers
- Executives and senior leaders
- External stakeholders – national leadership, NHSE, CQC

Key messages

- You have the Freedom to Speak Up at Alder Hey
- FTSU is a safe and secure way to raise your voice when you need to
- We want all our colleagues to feel confident to speak up when things go wrong
- Speaking up is part of caring, making sure we get things right for you, our children and young people, and their families
- Our FTSU Guardian is Kerry Turner, who leads the programme and provides advice and support to all colleagues
- We have a number of FTSU Champions who can help signpost you to the support you need

Key aims

- Re-engage the organisation with the FTSU programme, its aims, processes and outcomes
- Communicate the key processes to all staff
- Support managers to learn, and model, key FTSU principles
- Assure the organisation on FTSU activity, feedback and results

- Provide timely reports and other feedback to the regional and national community

Communications Schedule

We will refresh and relaunch our existing FTSU resources, including new posters, pull up banners, digital screens, screensavers and intranet information.

We will develop and launch a quarterly reporting schedule, embedding a regular presence and promotion of FTSU content to our audiences through a range of internal channels including emails, screensavers, digital screens, posters, broadcasts and the intranet.

We will run regular evaluation and monitoring of this communications activity, assessing impact and improving performance, through qualitative and quantitative surveying.

Activity	Audience	Channel	Details
Refresh existing FTSU hard copy resources	All Staff	Posters, pull up banners, leaflets	Updated programme details (removing previous champion info), refreshed visual, used as internal FTSU 'brand'
Refresh existing FTSU digital resources	All Staff	Screens/savers, intranet	As above
Quarterly report schedule	All staff	Email, screensaver, broadcast	Commitment to providing 'activity report' (anonymised case studies included) each quarter. Dedicated agenda item in relevant staff broadcast as suitable. Clearly identifiable FTSU communication email, intranet news story to link 'brand' with positive impact/feedback. First 'quarter' TBC.
Ad hoc communication	All Staff	Email	Use of anonymised case studies in all staff email/intranet/other broadcast media as deemed useful, avoid 'bottle neck' content waiting for quarterly schedule. Alder Hey Life and other internal channels to be considered.
FTSU Drop Ins	Managers & Leaders/All Staff	In person	Face to face drop in sessions, in all locations over course of year, to provide personal contact for managers and leaders, secondarily all staff, to ask questions, get informed, gain support. Not specifically to raise issues/report concerns. Clearly promoted to organisation to provide reassurance.

Alder Hey Children's NHS Foundation Trust

Freedom to Speak up Strategy Statement 2023

April 2023

Kerry Turner

Freedom To Speak Up Guardian

Freedom to Speak Up Guardian
www.nationalguardian.org.uk

Your voice matters

Freedom to Speak Up (FTSU) mission and values

In support of Alder Hey's 2030 Vision and Strategy a new People Plan has been developed which aims to support our staff and teams to:

- Look after each other
- Create a sense of belonging
- Embrace new ways of working
- Learn and grow for the future

FTSU is a key underpinning activity to enable staff to thrive within Alder Hey and feel listened to. Our mission is to develop an open culture and make Freedom to Speak Up (FTSU) business as usual. This supports the spirit of Our People Plan: the best place to work, with happy staff delivering the care they aspire to. Our vision is that everyone in the Trust feels safe to raise a concern with anyone and know that they will be listened to, taken seriously and the issue is acted upon appropriately.

The role of the Freedom to Speak Up Guardians:

- Provide regular and diverse communication to ensure that everyone is aware of how they can speak up.
- Raise the profile of FTSU.
- Provide advice and support in exploring concerns raised.
- Support the organisation to learn and improve from patient and staff safety concerns.
- Engage with the National Guardian's office and the regional network to share best practice.
- Ensure timely concise feedback is delivered to those who raise concerns.
- Promote and develop the Speaking Up Policy and Procedure
- Ensure that key learning related to concerns are articulated to all in an open and transparent manner, while respecting confidentiality.
- Regularly review the national case reviews to ensure that any recommendations and learning are implemented, where appropriate.

The role of Trust Board Members:

- Ensure all methods of speaking up are promoted
- Champion and help raise the profile of FTSU
- Provide advice and support in exploring concerns raised
- Support learning and improvements from patient and staff safety concerns
- Ensure timely concise feedback is delivered to those who raise concerns
- The Senior Non-Executive Director has an enhanced role within FTSU

Our strategy to deliver our mission is to:

- Ensure staff are aware of the FTSU role and their responsibility to speak up.
- Provide communication on FTSU in a variety of ways.
- Promote FTSU e-learning for all staff.
- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively.
- Share lessons learnt across the Trust to enhance the development of an open culture whilst respecting confidentiality.
- Ensure assurance processes are in place that oversee that the concerns raised are consistently and thoroughly investigated through the appropriate Trust processes.

- Receive and act on feedback from staff on FTSU to support improvement and learning.
- Regularly monitor and review FTSU policies.
- Will support our staff networks; the BAME (Black, Asian and Minority Ethnic) Network, the Disability Network and the LGBTQI+ Network.

How will we monitor and measure our progress?

We will use the following information to monitor our achievement against the strategy:

- Annual Staff Survey Results with particular emphasis to the key areas of question focused on staff reporting concerns and feeling that they are treated fairly.
- Grievances
- Exit interviews
- Retention figures
- Feedback on issues raised through the FTSU Guardian.
- Bullying and harassment reports.
- Serious incidents
- Suspensions
- Issues raised to the Care Quality Commission
- Incident reporting
- National benchmarking data from the National Guardian's Office.

How will progress be reported?

A Freedom to Speak Up quarterly report will be presented to the Trust Board by the Freedom to Speak up Guardian and the Executive Lead for raising concerns. It will include qualitative and quantitative information and other information that enable the Trust Board to fully engage with speak up to understand the issues that have been identified and received assurance about the actions being taken.

The information will include the number and type of cases being dealt with through the Guardian, an analysis of the trends, including whether the number has increased or decreased. It will also include information of any instances where people who have spoken out may have suffered detriment and recommendations for improvements.

How will we know we have made a difference?

The indicators that will demonstrate we have made a difference in achieving our vision is as follows:

- Improvement in staff survey responses in targeted speak up questions.
- Speak up concerns have satisfactory outcomes.
- Positive feedback is received from staff who speak up.
- Patient complaints and concerns reduce due to proactive intervention prompted by staff speaking up early.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	Discussion Paper to support the assessment of Going Concern for 2022/23 Annual accounts
Report of:	Deputy Director of Finance
Paper Prepared by:	Emily Kirkpatrick

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

1. Purpose

This paper is to recommend to the Trust Board that the 2022/23 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2022/23 financial statements on this basis.

2. Background

The Trust is compliant with the Department of Health and Social Care (DHSC) guidelines preparing the 2022/23 financial accounts on a going concern basis. Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption, a Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. A key consideration of going concern is that the Trust has the cash resources to meet its obligations as they fall due for the foreseeable future. For these purposes, 'foreseeable future' is considered to be twelve months from the date of signing of the annual accounts.

International Accounting Standard 1 – presentation of financial statements (IAS 1) requires the Trust directors to assess and satisfy themselves that it is appropriate to prepare financial statements on a going concern basis. The 2022/23 DHSC Group Accounting Manual (GAM) sets out the interpretation of going concern in the public sector context.

<u>Directors' assessment of going concern</u>

The specific factors that the Directors should consider in respect of their assessment of going concern are:

- Financial conditions
- Operating conditions
- Other conditions such as serious non-compliance with regulatory or statutory requirements

Having considered the above the Trust directors have a reasonable expectation that the Trust will remain in operation for the foreseeable future. The Trust has a proven track record of consistently meeting the performance and control totals set by the regulator and over the last 5 years has delivered within these targets often making significant surpluses to support the sustainability of the Trust.

As a specialist provider of children's services, the Trust is commissioned to provide services across the North West Region and nationally for highly specialised services and it is expected that NHS funding will flow from commissioners, at similar levels to that previously provided for all of these specialist services. There remains a firm requirement to still provide the services.

The Trust currently has a significant level of its own cash resource available demonstrating strong liquidity (£78.9m as at 13th April 2023).

In 23/24 there will be a 'blended' approach to funding in England. Some elements will be 'variable': elective points of delivery will be funded based on actual activity undertaken, drugs & devices will be pass-through, and there will be some adjustments for quality performance. All other areas will remain block funded. Outside of England our contracts will likely be full PBR, though that is yet to be fully agreed. Based on the updated funding arrangements, and planned activity for 2023/24, initial draft plans have been submitted to the

ICS and NHSE with a planned control total surplus of £2m. Whilst these are still yet to be approved, it is expected this will be achieved prior to the anticipated sign-off of the 2022/23 financial statements in June.

As such the Trust board can take assurance that it is reasonable to expect that the 2023/24 funding levels will be maintained based upon these plans as the actual income streams are not expected to be materially different. Arrangements beyond 2023/24 are yet to be confirmed and the Trust assumes similar arrangements to those in place for 2023/24 will be adopted.

The Trust has calculated a number of liquidity ratios based upon its provisional closing Statement of Financial Position as at 31st March 2023 as follows;

Quick Ratio	Cash & Receivables Current Liabilities	111,763		(94,595)	1.18
Current Ratio	Current Assets Current Liabilities	116,211		(94,595)	1.23

Generally the higher the ratios are the greater the margin of safety
An ideal ratio is considered to be between 1 & 1.5

The Trust has also completed a scenario analysis to assess operational liquidity for the next 18 months to September 2024 and consider what level of cash the Trust could close H2 24/25 with, expressed as a percentage of current levels and this is shown in Appendix A.

The outcome of this analysis demonstrates that in all scenarios, the level of cash available at the end of next financial year is likely to remain significant therefore all examples fully support the Directors assessment that a Going Concern basis should be adopted.

3. Conclusion

The Trust Directors have a reasonable expectation that Alder Hey Children's NHS Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements. **On this basis the Trust Board is asked to support the recommendation that the 2022/23 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2022/23 financial statements on this basis.**

Appendix A – Liquidity Scenario Analysis

Going Concern Liquidity Scenario Testing for 23/24 & H1 24/25 - 30th September 2024						
	Base Case		Upside Case - Capital Restraint		Downside Case - CIP not delivered	
	£'000	£'000	£'000	£'000	£'000	£'000
Bank & cash balance per 31st March (Draft Close)		83,478		83,478		83,478
Trust Operations 23/24 :						
Draft Planned Income (exc non cash)	371,899		371,899		371,899	
Draft Planned Expenditure (exc non cash)	(382,173)		(382,173)		(382,173)	
Draft CIP Target	17,691		17,691		17,691	
Draft Plan Capital Expenditure April - March 23	(21,101)		(21,101)		(21,101)	
		(13,684)		(13,684)		(13,684)
Downsides:						
CIP Not delivered @ 50%						(8,846)
Mitigations:						
Capital restraint 23/24 - uncommitted capital spend				2,500		
Projected Cash Balance 31/3/24		**69,794**		**72,294**		**60,949**
Trust Operations H1 24/25:						
Projected Planned Income (3% Growth)	191,528		191,528		191,528	
Projected Planned Expenditure (Incl Inflation)	(196,819)		(196,819)		(196,819)	
CIP Target - H1	9,111		9,111		9,111	
Indicative Capital Expenditure April - September 24	(4,894)		(4,894)		(4,894)	
		(1,074)		(1,074)		(1,074)
Downsides:						
CIP Not delivered						(4,555)
Mitigations:						
Capital restraint 24/25 - 1/3rd of indicative capital spend				1,615		
Projected Cash Balance 30/9/24		**68,720**		**72,835**		**55,319**
% of current cash balance		**82%**		**87%**		**66%**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Board Assurance Framework Year-end Report 2022/23 (March)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	☐ Decision ■ Assurance ☐ Information ☐ Regulation
Background Papers and/or supporting information:	Monthly BAF Reports
Action/Decision Required:	■ To note ☐ To approve
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	■ Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations**
Resource Impact:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2022/23

1. Purpose

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

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

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

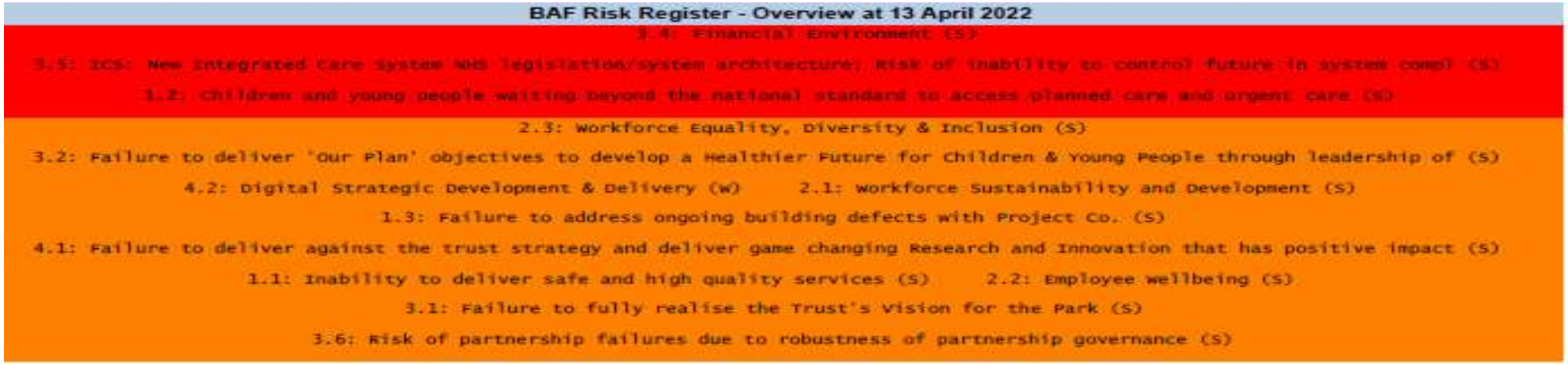
2. Review of the BAF

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

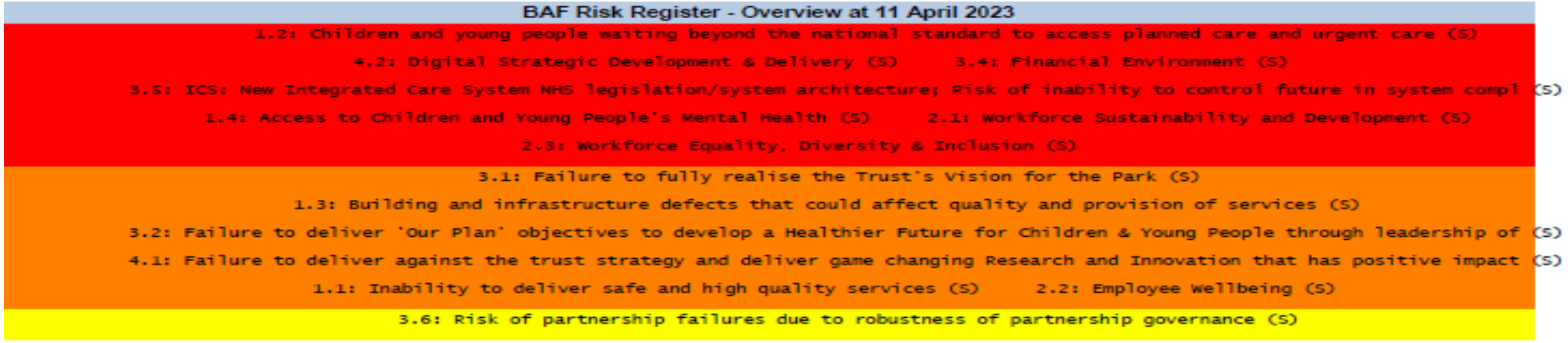
	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Resources and Business Development Committee
		Safety & Quality Assurance Committee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

3. Comparison of the BAF at the start and the end of 2022/23

BAF March 2022 overview



BAF March 2023 overview



Trend of risk rating indicated by: B - Better, S - Static, W – Worse (*Reports generated by Ulysses)*

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

4. Month-on-month overview of risk scores during 2022/23 (April 2022 to March 2023)

BAF Risk		2022									2023		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
STRATEGIC PILLAR: Delivery of Outstanding Care													
1.1	Inability to deliver safe and high-quality services	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	4x5 INCREASED	4x5	4x5	4x5
1.3	Building and infrastructure defects that could affect quality and provision of services. (Failure to address building deficits with Project Co.)	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x5 INCREASED	4x5	4x3 DECREASED	4x3
1.4	Access to Children and Young People's Mental Health	-	3x5 NEW	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5
STRATEGIC PILLAR: The Best People doing their Best Work													
2.1	Workforce Sustainability and Development	3x4	3x4	3x4	3x4	3x4	3x4	3x5 INCREASED	3x5	3x5	3x5	3x5	3x5
2.2	Employee Wellbeing	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
2.3	Workforce Equality, Diversity & Inclusion	4x3	4x3	4x3	4x3	4x3	4x3	4x3	3x5 INCREASED	3x5	3x5	3x5	3x5
STRATEGIC PILLAR: Sustainability through External Partnerships													
3.1	Failure to fully realise the Trust's Vision for the Park	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x4 INCREASED	3x4	3x4	3x4	3x4
3.2	Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3
3.4	Financial Environment	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4

BAF Risk 000170		2022									2023		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
3.6	Risk of partnership failures due to robustness of partnership governance.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x2 DECREASED	3x2
STRATEGIC PILLAR: Game-Changing Research and Innovation													
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.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
4.2	Digital Strategic Development and Delivery	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x4 INCREASED	4x4	4x4	4x4	4x4

5. Analysis of the risk ratings

It can be difficult to effectively score and update the ratings of BAF risks, because of their very nature they are often a composite of a number of lower-level risks: the risk rating score is therefore largely indicative at any point in time and any consideration of progress at the end of a year represents a direction of travel rather than an absolute score. However, the following observations can be made:

- Of the 14 risks on the BAF during the course of the year seven didn't change their risk rating
- Children and young people waiting beyond the national standard to access planned care and urgent care presents the biggest risk to the Trust currently scoring 20 (*major x almost certain)*.
- Six risks increased in score during the year:
    1. Children and young people waiting beyond the national standard to access planned care and urgent care presents
    2. Building and infrastructure defects that could affect quality and provision of services *(later decreased)*
    3. Workforce Sustainability and Development
    4. Workforce Equality, Diversity & Inclusion
    5. Failure to fully realise the Trust's Vision for the Park
    6. Digital Strategic Development and Delivery
- Risk of partnership failures due to robustness of partnership governance was reduced to its target score of 6 *(moderate x unlikely)* in February 2023.
- New risks in year:
    - ADDED May 2022: (1.4) Access to Children and Young People's Mental Health
- Risks closed in year:
    - None.

6. BAF Deep Dives during 2022/23

During the year the assurance committees received deep dive presentations allowing the opportunity to gain further understanding of the risks and the controls in place to mitigate them, along with the current gaps in controls and ongoing actions:

Safety and Quality Assurance Committee

- *Risk 1.1 Inability to deliver safe and high-quality services*:
  - a deep dive presentation was received at the October 2022 meeting noting the significant work undertaken to review gaps in controls and identify further mitigations to reduce the risk.
  - gaps in controls were addressed initially through reports relating to the 'quality priorities', and latterly through updates on projects being overseen by the PSB. These reports are usually first on the agenda for discussion/assurance. Regular reports on mental health attendances at the Trust's Emergency Department, on the ED performance against national waiting times, on actions taken by the Sepsis Steering Group and performance against the sepsis KP, and levels of medication safety incidents, were also received.
- *Risk 1.2 Children and young people waiting beyond the national standard to access planned care and urgent care:*
  - a deep dive presentation was received at the December 2022 meeting resulting in an increase in the risk score reflecting the current demand, various industrial actions and ongoing challenges within the BMA rate card. The risk was subsequently updated to reflect additional mitigations identified to improve access to care.
  - gaps in controls addressed are through the following regular reports: Safe Waiting List management programme, winter plan and monthly updates to address pressures within the Emergency Department
- *Risk 1.4 Access to Children & Young People's Mental Health:*
  - a deep dive presentation was received at the November 2022 meeting with detailed discussion on both short and long-term mitigations and the importance of capturing the strength of partnership working as part of the mitigation for this risk.
  - gaps in controls addressed through application for additional funding to support increased demand, focussing on staff wellbeing to maximise retention, quarterly reports on mental health attendances at the Trust's Emergency Department with actions for reviewing the current pathway to ensure the safety of the children and young people accessing our services as well as monitoring of performance against referral and treatment KPIs in the Integrated Performance Report.

Resources and Business Development Committee

- *Risk 1.4 Access to Children and Young People's Mental Health*
  - A deep dive presentation was received at the November 2022 meeting detailing the risks to delivery and key actions being taken forward to mitigate the increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks.
- *Risk 3.1 Failure to fully realise the Trust's Vision for the Park.*
  - A deep dive presentation was received at the December 2022 meeting noting the current position along with short and long-term mitigations. Monthly assurance reports from the Building Services Team and Campus & Park updates focusing on the current areas of capital risk.

- *Risk 3.4 Financial Environment.*
  - A deep dive presentation was received at the January 2023 meeting highlighting the impact of the changing NHS financial regime and uncertainty regarding income allocations beyond 2023/23 and beyond. A number of key actions and additional mitigations were set out to be monitored closely by RABD including inflation increases, obtaining value for money on all procurement processes and a refresh of the Long Term Financial Plan to inform future decisions.
- *Risk 3.6 Risk of partnership failures due to robustness of partnership governance*
  - A deep dive presentation was received at the March 2023 meeting resulting in a decrease in the risk score reflecting the substantial assurance received from the MIAA Partnership Governance Audit. The findings of the report noted "*a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently*".

People and Wellbeing Committee

- *Risk 2.1 Workforce Sustainability and Development*
  - A deep dive presentation was received at the October 2022 meeting with particular attention to the gaps in controls. Additional mitigations were highlighted to the committee including a new sickness absence training programme plan; the establishment of the recruitment, attraction and retention project and the establishment of a Task & Finish Group to review turnover rates and analyse the data.
  - The deep dive of this risk prompted a review of the level of risk of the future workforce and better alignment to the national plan.
- *Risk 2.2 Employee Wellbeing*
  - A deep dive presentation was received at the September 2022 meeting detailing several further actions that had been identified to further mitigate this risk including roll out of mental health awareness training for managers; ensure current staff support provision is adequate and sustainable and widen the network of support via SALS and PALS.
- *Risk 2.3 Workforce Equality, Diversity & Inclusion*
  - A deep dive presentation was received at the December 2022 meeting noting the development of an Annual EDI Plan and EDI Lead to commence in post January 2023 as part of the further mitigations to this risk.

7. Summary of BAF - at 13th April 2022

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

Ref, Owner	Risk Title	Board Cttee	Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 NA	**Inability to deliver safe and high-quality services**	SQAC	3x3	2x2	STATIC	STATIC
1.2 AB	**Children and young people waiting beyond the national standard to access planned care and urgent care**	RABD / SQAC	**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	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	IMPROVED	STATIC
STRATEGIC PILLAR: Game-Changing Research and Innovation						
4.1 CL	**Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People**	Innovation	3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development & Delivery**	RABD	4x4	4x1	STATIC	STATIC

8. Summary of March 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. Actions reviewed and evidence updated.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed; no change to score in month. Actions and controls reviewed, evidence updated.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. Actions and evidence 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 (DP)***
  SPV & Trust Board members met in March to discuss and agree a way forward. Regular meetings are to be arranged 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 the temporary ones will be removed late April. 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. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  Full review of risk and updated description and actions, in line with the annual plan presented to Trust Board on 30 March 2023. Access to elective care is now our biggest operational challenge. We have virtually delivered the standard of having no patients wait over 78 weeks by March 2023. However, the waiting list size and number of patients waiting over 52 weeks is growing, compounded by industrial action. In response, we have approved investments in high demand specialties to increase capacity. Moreover, we will review opportunities for improving productivity by addressing under-utilised theatre lists and reducing the level of was-not-brought to clinics.

- ***Inability to deliver safe and high-quality services (NA).***
  Work continues to mitigate the gaps in controls and is monitored through SQAC and Patient Safety Board.

- ***Access to Children and Young People's Mental Health***
  Risk reviewed and action closed relating to App as go live confirmed 11 April 2023.

- ***Financial Environment (JG).***
  In Year CIP and Control Total met. Key risk is now the financial environment for 23/24 which will be monitored accordingly as with 22/23.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  End of Financial Year review.

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed, score remains static due to the level of imminent change and interdependencies in 23/24. Mitigations in place in terms of resources and organisational change freeze prior to Aldercare go live.

- ***Workforce Sustainability and Development (MS).***
  Deep dive into risk undertaken at PAWC in 2023. risk remains high at 15. actions reviewed.

- ***Employee Wellbeing (MS).***
  Risk reviewed and actions updated. No change to risk rating.

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  No change to risk score, active development of strategic outline case ongoing for infrastructure funding and to increase investment.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000176

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

Strategic Aim — Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake retrieval	
2463	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.2 & 1.4
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	4.2
2332	Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West	1.2
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.2 , 2.1 & 1.4
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.2 & 2.1
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	2.1
2657	No consistent method for recording and communicating resuscitation decisions across the trust	
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	
2100	Risk of inability to provide safe staffing levels	2.1
2740	No dedicated Dietician within Cardiology therefore currently not complying with CHD standards	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.2
2755	There would be a risk to the delivery of high quality services for Children and Young People. Due to Lack of sustainable workforce plans and associated investment (Surgery)	2.1
2684	the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	2.1
2767	There is a risk that the Safeguarding Team will be unable to provide a service for children/young people and/or staff in the hospital	2.1
1524	Delayed initiation and review of ADHD medication (due to lack of capacity within the service)	2.1
2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust.	2.1
2360	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18 week referral to treatment target for routine).	
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	
2774	If both Interventional radiologists are unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma	2.1

000177

BAF Risk

1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation.	1.1 & 2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal.	1.1 & 2.1
2463	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.1
2332	Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West	1.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.1

000178

BAF Risk

1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

1.4 Access to Children and Young People's Mental Health (3x5=15)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 2.1

000179

BAF Risk

2.1 Workforce Sustainability & Development

(3x5=15)

Strategic Aim

The best people doing their best work

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1 & 2.2
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 1.2
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.1 & 1.2
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	1.2
2741	The ability to maintain OFSTED ratio's as a result of staff availability/turnover Health and Safety concerns operating the nursery in its current position in the centre of a building development	
2740	No dedicated Dietician within Cardiology therefore currently not complying with CHD standards	1.1
2755	There would be risk of delivery of high quality services for Children and Young People. Due to lack of sustainable workforce plans and associated investment (Surgery)	1.1
2684	the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	1.1
2767	There is a risk that the Safeguarding Team will be unable to provide a service for children/young people and/or staff in the hospital	1.1
1524	Delayed initiation and review of ADHD medication (due to lack of capacity within the service)	1.1
2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust.	1.1
2774	If both Interventional radiologists are unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma	1.1

000180

BAF Risk

2.2 Employee Wellbeing

(3x3=9)

Strategic Aim

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1 & 2.1

BAF Risk

2.3 Workforce Equality, Diversity & Inclusion

(3x5=15)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000181

BAF Risk

3.1 Failure to fully realise the Trust's vision for the Park (3x4=12)

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

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

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.4 Financial Environment (4x4=16)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2754	The Surgical division currently does not have a sustainable financial plan and is currently forecasting a year end deficit position.	

000182

BAF Risk

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

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.6 Risk of partnership failures due to robustness of partnership governance (3x2=6)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000183

BAF Risk

4.1 Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP
(3x3=9)

Strategic Aim

Related Corporate Risk(s)

Risk	Risk Title	Linked
2694	Delayed growth plan (strategy KPISs)	

BAF Risk

4.2 Digital Strategic Development and Delivery
(4x4=16)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	1.1

000184

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2229, 2441, 2383, 2597, 2100, 2654, 2332, 2450, 2463, 2627, 2516, 2517, 2196, 2631, 2327, 2632		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

Existing Control Measures	Assurance Evidence (attach on system)
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Corporate Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through CQSG, learning bulletin produced and learning from RCA's shared at the meeting
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
Oversight of progress with RCA actions and implementation plans is monitored through CQSG	Monitoring reports will be available from each review meeting
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2023	The sepsis leads have presented an updated position and action plan to SQAC giving increased levels of assurance. This will continue to be monitored through the reporting on the IPR and quarterly reports to SQAC

Executive Leads Assessment

February 2023 - Pauline Brown
Work continues to mitigate the gaps in controls and is monitored through SQAC and Patient Safety Board.

December 2022 - Nathan Askew
This risk has been updated based on feedback from SQAC and now should be aligned. Controls remain in place and progress has continued in relation to gaps in control, notably in increasing compliance with ABx administration

November 2022 - Nathan Askew
The risk has been reviewed and updated based on the deep dive presented to SQAC last month. Gaps in control have been updated to reflect the current position.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Children and young people waiting beyond the national standard to access planned care and urgent care		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2233, 2383, 2597, 1902, 2501, 2501, 2463, 2517		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 4x5	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Capacity and Demand modelling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care, and risk to achieve the national standard of eliminating waits >65 weeks by March 2024. Our challenged specialties include ENT, Dental, Spinal Surgery, ASD/ADHD and CAMHS. In addition, unprecedented demand for urgent care has increased the wait for clinical assessment and reduced the percentage of patients treated within 4 hours. These factors combine to create a risk that waiting times for elective and urgent care will exceed national standards, with potential detriment to experience and outcomes for Children, Young People and their families.

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

Gaps in Controls / Assurance

1. Reduce to zero the number of C&YP waiting over 65 weeks for treatment to reduce the long-wait backlog for planned care
2. In urgent and emergency care, consistently exceed national standard of 76% of patients treated within 4 hours (aspire to 85%) and a time to clinical assessment of 60 minutes

Board Assurance Framework 2023-24

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	30/06/2023	Actions refreshed in line with 2023/24 Annual plan presented at Trust board on 30 March 2023
Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	30/06/2023	Actions refreshed in line with Annual Plan presented to Trust Board on 30 March 2023

Executive Leads Assessment

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

April 2023 - Andrew Mccoll
Full review of risk and updated description and actions, in line with the annual plan presented to Trust Board on 30 March 2023.

Access to elective care is now our biggest operational challenge. We have virtually delivered the standard of having no patients wait over 78 weeks by March 2023. However, the waiting list size and number of patients waiting over 52 weeks is growing, compounded by industrial action. In response, we have approved investments in high demand specialties to increase capacity. Moreover, we will review opportunities for improving productivity by addressing under-utilised theatre lists and reducing the level of was-not-brought to clinics.

March 2023 - Andrew Mccoll
The provision of Mutual Aid to RMCH and the loss of capacity as a result of safely managing the impact of Industrial Action means that in March our primary focus is to ensure no patient is waiting >78 weeks by the end of March, in line with national standards.

There are weekly submissions to ensure every patient potentially >78wks has a date booked for treatment.

As a result of these pressures, there has been an increase in the number of patients >52wks. This is particularly driven by ENT, where actions are in place to deliver an increase in capacity for OP clinics during March and minimise the number of CYP waiting more than a year.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Building and infrastructure defects that could affect quality and provision of services		
Related CQC Themes: Safe		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Adam Bateman	Type: External, Resource And Business Development Committee	Current IxL: 4x3	Target IxL: 2x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Building defects that remain unresolved by Project Co could impact on patient services, reputation and financial sustainability

Existing Control Measures	Assurance Evidence (attach on system)
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations. Review of the action plan takes place monthly to ensure all remains on track.	
Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.	
Regular oversight of issues by Trust committee (RABD)	Monthly report to RABD on progress of remedial works
Trust Board aware of the ongoing status and issues.	Monthly report to Board on mitigation and remedial works

Gaps in Controls / Assurance

Remedial Works not yet completed; lack of confidence in timescales being met.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Undertake regular inspections on known issues/defects	31/12/2023	Regular inspections continue on a weekly basis

Executive Leads Assessment

April 2023 - Graeme Dixon
SPV & Trust board members met on the 16th March to discuss and agree a way forward. Regular meetings are to be arranged 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 the temporary ones will be removed late April. 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. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review.

March 2023 - Graeme Dixon
The SPV board members have agreed to provide a report on the corroded pipework and the associated cold water temperatures. Weekly meetings continue 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 mitigations 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 await 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. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review. The next liaison committee is set for the 16th March.

February 2023 - Graeme Dixon
The SPV board members have agreed to provide a report on the corroded pipework and the associated cold water temperatures. GD has chased (1/2/23) with the SPV general manager and was informed they are being reviewed. GD continues to meet weekly 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. The chiller works continue and we await 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. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review. The next liaison committee is set for the 16th March.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Actions from mental health workforce plan to be delivered which includes: -Improving workforce availability rate to >90% -Task & Finish group with aim to increase headcount of external staff through marketing of services and the organisation and enhancing job roles and adverts -Delivery of staff wellbeing schemes -Staff retention to be improved through review of job plans and education/training opportunities	28/04/2023	Job description task and finish group arranged regarding job roles/descriptions. Continue to meet with Cheshire & Merseyside group (workforce survey)

Executive Leads Assessment

March 2023 - Lisa Cooper
Risk reviewed and remains the same. Phase 1 for PROMS is now live but awaiting date for Phase 2 completion. Action date therefore amended to 31 March 2023

February 2023 - Lisa Cooper
Risk reviewed and update below:

Job description review this is progressing well and on course for target date

ROMs app progressing well but some delays so date extended to end February 2023.

All controls remain the same and in place for this month.

January 2023 - Lisa Cooper
Risk reviewed and action relating to waiting lists and validation completed

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2383, 2100, 2597, 2528, 2535, 2450, 2516, 2517, 2196, 2312, 2741, 2624, 2719		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to deliver consistent, high quality services for children and young people due to:
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time.
2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation.

Existing Control Measures	Assurance Evidence (attach on system)
Workforce KPIs tracked through the corporate report and divisional dashboards	Corporate Report and KPI Report to PAWC
Bi-monthly Divisional Performance Meetings.	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR	-Monthly reporting to the Board via the Corporate Report -Reporting at ward level which supports Ward to Board
Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.	ESR self-service rolled out
HR Workforce Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group established	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	New Learning and & development Prospectus Launched - June 2019
Apprenticeship Strategy implemented	Bi-monthly reports to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation	People Strategy report monthly to Board
International Nurse Recruitment	78 international nurses recruited since 2019
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to PAWC OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to PAWC
Recruitment and Apprenticeship strategy currently in development	progress to be reported to BAME task force and People and Wellbeing Committee
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance

1. Not meeting compliance target in relation to some mandatory training topics
2. Sickness Absence levels higher than target.
3. Lack of workforce planning across the organisation
4. Talent and succession planning
5. Lack of a robust Trust wide Recruitment Strategy
6. Lack of inclusive practices to increase diversity across the organisation
7. COVID related sickness impacting upon service delivery
8. Increasing turnover rates
9. Industrial action planned

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
5. Recruitment Strategy currently being developed in line with the actions set out in the NHS people plan	30/06/2023	amanded timeframes due to operational pressures
Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	30/04/2023	as above
3. Development of a methodology to roll-out across the organisation.	30/04/2023	Project plan on track

Board Assurance Framework 2023-24

Executive Leads Assessment
April 2023 - Melissa Swindell deep dive into risk undertaken at PAWC in 2023. risk remains high at 15. actions reviewed.
March 2023 - Melissa Swindell risk reviewed and actions updated
February 2023 - Melissa Swindell risk reviewed, actions on track. remains high at 15

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

Board Assurance Framework 2023-24

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of the pandemic and its impacts (PTSD, anxiety and depression rates nationally show significant rise amongst health care staff and suicide rates also rising among healthcare staff; cost of living crisis further increasing pressure for staff and poverty a known determinant of mental ill health).
2. Increase in significant mental health difficulties in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and difficulties in accessing secondary mental health provision in the community in a timely way
3. Rising demand for SALS support and permanent resource not yet in place to ensure sustainability of provision for staff
4. Increase in self-reported rates of burnout and work-related stress as assessed via 2022 Staff Survey and consistent with national picture for NHS staff
5. Lack of private space to support staff and wellbeing activities
6. Likely psychological impacts on staff due to impacts of industrial action

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Increased space to be developed for staff support and staff wellbeing. This includes SALS specific space and also space to be more widely available to staff. Consider also specific HWB budget which departments can use to enhance current wellbeing spaces	30/06/2023	Date amended as action not closed
Business case in development and now awaiting opportunity to present at appropriate forum whilst SALS also seeking external funding sources and opportunities for income generation to assist with current cost pressures.	30/04/2023	Requested feedback from Chief People Officer re outcome of business case. Awaiting feedback.
A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	01/05/2023	Meeting with EPR lead held. Agreed actions to develop Debriefing policy and guide. He will lead of draft policy and toolkit using materials developed in SALS and we will meet again to progress
Task & finish group established, led by SALS Manager and with mixed role attendance across the Trust to develop an action plan. Outputs to report to HWB Steering Group	30/06/2023	Task & finish group established and an initial action plan drafted to be reported to the HWB Steering Group in April for initial feedback

Executive Leads Assessment

March 2023 - Joanne Potier De La
Risk reviewed and actions updated. No change to risk rating

February 2023 - Joanne Potier De La
Risk reviewed and actions updated. No change to risk rating

January 2023 - Jo Potier
Risk reviewed and actions updated to reflect December activity. No change to risk rating.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: External, Known	Current IxL: 3x5	Target IxL: 4x1	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

Staff Networks still in development stage, requires further support, resource and input.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
	01/07/2023	work required to further develop the networks - led by Head of EDI Angela Ditchfield

Executive Leads Assessment

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

April 2023 - Melissa Swindell
risk reviewed, actions updated. no change to risk rating

March 2023 - Melissa Swindell
risk reviewed; no change to risk rating

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 3.1	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: David Powell	Type: Internal, Known	Current IxL: 3x4	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision.
Weekly Programme Check.	The Project Team run a weekly programme check.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group
Programme and plan (agreed with LCC and LPA) to return the park back by November 2023.	Updates on progress through Campus report .

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Set up Joint Planning meeting with community	30/09/2023	Agreed to postpone action until more substantive completion of park
Re-establish Exec Design Group	30/04/2023	Creation of agenda for 1st round meeting April 23
Establish timeline and plan for the Police station upgrade and conversion	30/06/2023	Initial plan created, now in delay. Re-work required,
Appoint community engagement team and green volunteer squad	31/05/2023	Agreement of in-principle paper

Executive Leads Assessment

April 2023 - David Powell
End of Financial Year review

March 2023 - David Powell
Prior to March Board

February 2023 - Richie Harkness
Decommission of (old) Catkin is now complete and the site is being handed over to Beech (demolition contractor) this week. A programme has been issued from the contractor, detailing a timeline for demolition of Catkin and Sub 5, and construction of swales, which will enable the ongoing remediation of land (known as phase 3 of the park) as per the agreement with LCC.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board.
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly). Partnership update & refresh of North West Paediatric Partnership Board schedule and arrangements undertaken Feb 22 Sept 22 - NWPPB Chairs Report to Trust Board attached
'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019 2030 Vision development underway with Trust Board - will succeed Our Plan once approved in early 23/24
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Implementation of the 'Healthy Children and Families' partnership group for One Liverpool.SRO Dani Jones jointly with Melisa Campbell LCC PH confirmed.	Inaugural HC&F meeting held 24.1.23 - pack attached
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities. Healthy Children & Families - Segment agreed at Provider Alliance Summit March 23
C&M "Beyond" Children's Transformation Programme - AH host and lead for C&M	Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS) 4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway. 9.11.21 - Presentation to ICS (HCP) Board - successful. Confirmation of funding for Y2 of programme received. 25.11.21 - Presentation of programme to Alder Hey Board. Fully endorsed. 27.1.22 - Presentation of Beyond programme to HCP Programme Board. ICS CEO in attendance. Programme progress accepted. 8.6.22 - C&M CYP Programme Board minutes (May) and documentation for June meeting attached for assurance of effective progress Sept 22 - Beyond Assurance Group established and reporting to Beyond Board - minutes and agendas attached Nov 22 - Presentation to ICB Chair (Children's Champion) at St Helens Town Hall; supported to cement further the CYP governance at ICB level - proposal under development

	Dec 22 - Beyond presented to Alder Hey Trust Board
2030 Vision: Alder Hey strategy refresh - Q4 21/22 - alignment with system objectives and trust ambitions	-Trust Board Strategy / 2030 Vision session scheduled Jan 22 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention - Pop Health plan developed in conjunction with Strasys to inform 2030 vision - working group established. Initial Exec session 21st April, Trust Board session 28th April - Completed Sessions underscehduling with NEDs, Governors and Working Group during May - May 22 Informal Governors Vision 2030 / Strasys session completed (attached) - May 22 Trust Board Strategy Session Vision 2030 / Strasys & futures strategies completed - June 22 Trust Board strategy session / Vision 2030 strasys session completed. - Sept 22 - Trust Board approved strategy overview / baseline paper - agreed next steps to begin wider engagement (see attached evidence) - Jan 23 - 2030 Vision update paper to Trust Board, and Trust Board Strategy session (update & Futures) - Jan 23 - Council of Governors strategy session (full overview) - Jan & Feb 23 - Divisional Strategy 'tester' sessions - Surgery, MH & Community, Medicine - all completed to date. Excellent feedback, iterating. Strategy 2030 - Approved at Trust Board March 23
Growing Great Partnerships - Quarterly Trust Board assurance report	- June 22 - Sept 22 - Jan 23

Gaps in Controls / Assurance

1. Inability to recruit to highly specialist roles due to skill shortages nationally.
2. Full completion of 2030 Vision and delivery plan

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Partner and stakeholder engagement on Vision 2030 as it is developed, and appropriate circulation/engagement following Board sign off.	30/11/2023	Action updated as above 4/11/22
6.Develop Operational and Business Model to support International and Private Patients	30/06/2023	Incorporated into Futures 2030 development plans
1. Developing a stronger understanding of paediatric workforce requirements through the Trust's 2030 Vision refresh work with Strasys - to enable trust and system workforce planning led through HRD	30/06/2023	Incorporated into 2030 People Plan developments

Executive Leads Assessment

April 2023 - Dani Jones
Risk reviewed; no change to score in month. Actions reviewed and evidence updated.

March 2023 - Dani Jones
Risk reviewed; no change to score in month. Vision 2030 progressing - scheduled update to March Trust Board.

February 2023 - Dani Jones
Risk reviewed, no change to score in month. Evidence, actions and controls reviewed and updated.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/03/2023	This work is now included as part of the optimisation work underway and originally expected Dec but due to issues outside of our control, now expected February. Annual planning and budget setting is due to be complete end of January and this will include a full bridge and detail of WTE/Activity and £ to inform the overall trust plan.
2. Five Year capital plan	31/03/2023	Capital plan submitted as part of 23/24 draft plan with some indicative allocations on areas whilst awaiting final plans. Re-profiling of spend in 23/24 has reduced the gap in year but further work required on 24/25 plans.
1. Monitor closely impact of inflation increases 2. Ensure procurement processes followed to obtain value for money 3. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2023	Inflationary pressures appear to be reducing based on latest costs for areas such as energy, however a gap still remains from the funding allocated and therefore work is continuing to understood any further mitigation on areas such as drugs, clinical supplies etc.

Executive Leads Assessment

April 2023 - No Reviewer Entered
In Year CIP and Control Total met. Key risk is now the financial environment for 23/24 which will be monitored accordingly as with 22/23.

March 2023 - Rachel Lea
Risk reviewed and updated with progress on actions underway. No change in risk score due to current position of draft plans and ongoing uncertainty with the financial allocations.

February 2023 - Rachel Lea

Risk reviewed, actions and controls updated. No change in risk score due to current uncertainty on the 23/24 financial plan and longer term position.
January 2023 - Rachel Lea Risk reviewed. Updated action plans and control measures to reflect current position following release of the national planning guidance and expected completion dates.
December 2022 - Rachel Lea Added a gap in control regarding increasing inflation pressures and detailed action plan on controls being taken. No change to risk score in month
November 2022 - Rachel Lea BAF risk reviewed, and score remains at 16 due to the uncertainty of the financial landscape going into 23/24 and beyond. Planning is underway both internally and across C&M for 23/24 and will feed into the ongoing financial risk.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Membership of CMAST & LDMHC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST - Governance paper and TOR for Committee in Common approach presented to Trust Board in September 22 and approved. Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21) CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21) Due to Omicron wave, CMAST collaborative has focused on Hospital Cell / recovery and mutual aid approach during Dec/Jan
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	ICS Programme Highlight Report Further evidence attached to BAF 3.2 Confirmation of funding for Y2 of programme received April 22 Beyond Impact Assessment submitted to ICS Feb 23
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete Update to Trust Board April 22 Update to Council of Governors June 22 Update to Trust Board June 22 Update to Trust Board July 22 Update to Council of Governors Sept 22 Update to Trust Board Sept 22 Update to Trust Board Nov 22 Jan 23 Growing Great Partnerships Trust Board report incorporated HCP and ICS update Update to Trust Board March 23
C&M CEO Provider Collaborative - Membership - sustain collaborative working arrangements with C&M-wide colleagues to shape system and ensure influence	
C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services	TOR & System Finance Principles in development (to be attached once finalised)
Maintain effective existing relationships with key system leaders and regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Lead Provider and partnership arrangements; development of new models of care	ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development) C&M CMAST Provider Collaborative proposals (under development) Joint letter of response to Specialist Commissioners from Alder Hey and Manchester Children's in August 22 Deputy CEO represents Alder Hey at the C&M Specialist Delegation group Likely delegation will not take place until April 24 - though work will continue through DoF, DoS and partners inc. CHA and NWPPB to shape the direction for CYP specialist services
Monitoring and influencing the direction of SpecCom delegation into ICSs	Joint letter to SpecCom from NW - AH & RMCH outlining the need to work at a NW footprint Nov 22 - Development of joint NW SpecCom delegation plan with Alder Hey and RMCH - outline shared position discussed at

	NWPPB Nov 22 - to be jointly developed further during Dec/Jan
ICS CYP Board - under development, to enable single oversight of CYP at ICS level and coalescing CYP priorities, resource and delivery	

Gaps in Controls / Assurance

Uncertainty over future commissioning intentions (see BAF 3.4 re finance)
Future delegation of Specialist Commissioned services into ICSs - shadow arrangements under definition

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/08/2023	As previous
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/08/2023	Delegation of SpecCom services to ICS's delayed nationally. 23/24 shadow running year - arrangements in NW as yet unclear. AH represented at NW SpecCom development group through DCEO. Continued work with RMCH to shape NWPPB supporting role and through CHA to assess impact of delegation on range of specialist services.

Executive Leads Assessment

April 2023 - Dani Jones
Risk reviewed; no change to score in month. Actions and controls reviewed, evidence updated.

March 2023 - Dani Jones
RIsk reviewed; level of system complexity currently sustaining higher risk rating, but architecture under construction (e.g. CYP board) to help reduce risk level. Actions and evidence reviewed.

February 2023 - Dani Jones
Risk reviewed; no change to score in month. ICS arrangements still developing and delegations unclear. AH involved at all levels. Actions, evidence and controls reviewed and updated.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 3.6	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Risk of partnership failures due to robustness of partnership governance		
Related CQC Themes: No Themes Identified		Link to Corporate risk/s: 2733		
Exec Lead: Dani Jones	Type: External,	Current IxL: 3x2	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group	Control embedded.
Escalation process for risks and issues pertaining to ODNs and Joint Services	North West Paediatric Partnership Board is the escalation route for all - example papers attached. Control embedded.
Partnership Quality Assurance Framework	P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement). PQAR Framework now tested with LNP to positive effect. Development of the process and framework underway, supported by Jacqui Rooney, in line with evolving CQC quality statements approach. NorCESS joint management team have agreed to pilot PQAR for the North West - to be scheduled in Q4.
Identification of 'pilot' partner for Partnership Quality Assurance Round - Liverpool Neonatal Partnership	PQAR Pilot scheduled with LNP for October 22 with Non-Exec representatives from both partner Trusts. Pilot of Partnership Quality Assurance Round approach agreed with LWH MD. Liverpool Neonatal Partnership and presented PQAR to LNP Board in June 22 - agreed next action to identify NED rep from both Trusts to do a full PQAR with LNP (under identification/scheduling) PQAR completed with NEDs from both Alder Hey and LWH 14th October. Positive process, plus some learning to shape PQAR pack for future sessions. Draft minutes attached (one amendment pending - ABR was not in attendance) will update once final minutes agreed. Action plan and next steps within.
Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership	RMF agendas and minutes Presented to RMF inc. Divisional representatives June 22
Quarterly Board Paper reviewing progress and any key risks/issues for escalation from formalized partnerships	Quarterly Board paper - Sept 22 Quarterly Board paper - June 22 Quarterly Board paper - Jan 23
Twice-annual ODN oversight report to RABD	May 22 Report attached Nov 22 report attached.
MIAA Audit - Partnership Governance	Audit complete - MIAA returned verdict of significant assurance. To be presented to January Audit Committee. Final report attached

Gaps in Controls / Assurance

Sign up from further partners to engage in PQAR - in development (dependent on both parties subscribing)

Executive Leads Assessment

April 2023 - Dani Jones
Risk reviewed; no change to score in month. Actions and evidence reviewed.

March 2023 - Dani Jones
Risk reviewed; score reduced to target rating, based on MIAA audit and significant assurance against partnership governance. Ongoing programme of PQAR to be undertaken as business as usual within each strategic partnership.

February 2023 - Dani Jones
Risk reviewed. No change to score in month. Evidence updated, controls and actions reviewed.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation	Risk Title: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.		
Related CQC Themes: Well Led		Link to Corporate risk/s: 2694		
Exec Lead: Claire Liddy	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

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

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

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

Existing Control Measures	Assurance Evidence (attach on system)
R&I: RABD review of commercial issues per Corporate governance manuals, oversight of Innovation Ltd Corporate governance manual and oversight of deal diligence (commercial and reputational) . Trust Board oversight of shareholding and equity investments and intellectual property.	Reports to RABD / Trust Board and associated minutes
R: Establishment of Research Management Board	Research Management Board papers.
I: Innovation Committee and RABD Committee	Committee oversight of Innovation strategy with NED expertise
I: Clear Management Structure and accountability within Innovation Division	ESR Divisional Hierarchies
R&I: Plans for joint research & innovation clinical leadership	Job Description and Hierarchy
R: Clinical trials Covid recovery plan operational.	Trust Board papers
R: Research Division monthly focus on research at the Research Management Board to support strategy delivery.	Research Management Board papers
I: Legal Partner now in contract to advise on partnership structure and intellectual property	Letter of engagement
R&I: Trust Policies and online declaration portal (gifts & hospitality, sponsorship etc.)	Trust Policies and digital audit trail to audit committee
R&I: Formal Press Releases and external communications facilitated through communications department	Communications Strategy and Brand Guide
R&I: Industry Partner and AI Data governance. To adopt Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOPs
New Commercial partnerships SOP approved at IC and RABD OCT/NOV 22	
Innovation risk register expanded and included in Risk Management Group (RMG)	

Gaps in Controls / Assurance

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

Executive Leads Assessment

March 2023 - Emma Hughes
no change to risk score, active development of strategic outline case ongoing for infrastructure funding and to increase investment.

February 2023 - Claire Liddy
Reviewed FEB 23. Strategic investment action updated including timetable to March 23. Risk score no change.

January 2023 - Claire Liddy
review Jan 23. no change to risk score but note the new corporate risk of financial sustainability

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2327		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x4	Target IxL: 4x1	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Mobilisation of Y1 of Digital and Data Futures Strategy	01/06/2023	Programmes in progress, some key deployments progressed
1. Proposed change freeze of all digital programmes from April particularly in the context of preparation for Aldercare go live 2. Review of all other programmes with implementation to be achieved before April	01/05/2023	Change Freeze from May discussed with Programme Board and Execs, other programmes under review
Implementation of Alder Care Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023

Executive Leads Assessment

March 2023 - Kate Warriner
Risk reviewed, score remains static. Discussions ongoing regarding change freeze from May, progress with agreement of go live window for Aldercare in Aug/Sept 2023.

Good progress with recruitment to key roles.

February 2023 - Kate Warriner
Risk reviewed, score remains static. Work continues regarding timing of key programmes deployments in 2023.

January 2023 - Kate Warriner
BAF reviewed. Score remains appropriate. Progress with recruitment of permanent positions within iDigital Senior Management Team. Recruitment and retention focus in place. Work ongoing regarding timing of key programmes in 2023.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Audit and Risk Committee Report to Board following April's Meeting**
Report of:	**Chair of the Audit and Risk Committee**
Paper Prepared by:	Kerry Byrne, Chair of the Audit and Risk Committee

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	Audit and Risk Committee minutes and papers from the meeting that took place on the 20.4.23.
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

1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

2. Agenda items received, discussed / approved at the meeting

- Board Assurance Framework
- Update from the Risk Management Forum (RMF) including the Corporate Risk Register and Trust Risk Register Report
- Annual Report on Risk Management 2022/23
- Draft Head of Internal Audit Opinion 2022/23
- Internal Audit Progress and Follow Up Reports
- Internal Audit Charter
- Anti-Fraud Services Annual Report
- Anti-Fraud Services Work Plan 2023/24
- Outcome of the internal HR review/action plan for the fraud case submitted to the CPS
- Statement on Going Concern
- External Audit Planning Report
- Accounting Issues for 2022/23 Accounts
- Annual DMO Assurance Report for 2022/23 and Forward Plan for 2023/24 – Project Assurance
- Annual Management Assurance Report for 2022/23 and Forward Plan for 2023/24 – EPRR
- Annual Governance Statement
- ACORN Partnership Update
- ARC Workplan and Terms of Reference
- Treasury Management Policy (ratified)
- Waiver Activity Report

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

None

4. Positive highlights of note

- ARC was pleased to note that Internal Audit's annual opinion on the Trust's internal control system *was "**Substantial Assurance,** can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently"*
- ARC received the first of a number of assurance reports on key risk areas for the Trust, with further reports to be received at the June meeting. These comprise a mix of management assurance (EPRR) and semi-independent

assurance (project assurance) and also provided areas of focus for the coming year.

5. Issues for other committees

Research & Innovation Committee – ARC received a presentation highlighting the four issues outstanding in closing down the Trust's relationship with the ACORN partnership. ARC has requested that completion of these be monitored by R&I Committee with a report back to ARC to confirm completion.

SQAC – The internal audit report on "Junior Doctors – Non-Consultant Spend" highlighted a high risk weakness and complexities in budgeting for substantive and locum junior doctor posts. MIAA will follow up the specific recommendations raised and report back to ARC as per usual practice but ARC felt that the challenges within this area merited a more detailed review by SQAC and suggested that management prepare a paper in this regard.

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 12th January 2022**
Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr G Baines	Regional Assurance Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Ms. E. Kirkpatrick	Assoc. Director of Commercial, Control and Assurance	(EK)
	Mrs R Lea	Deputy Director of Finance	(RL)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
Item 22/23/91	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
Item 22/23/94	Carolyn Cowperthwaite	Assoc. Chief Nurse for Surgery	(CC)
Apologies:	Miss. J. Preece	Governance Manager	(JP)
	Mr. D. Spiller	E&Y Accounts Manager	(DS)
	Mr. J. Wilcox	Divisional Accountant	(JW)

22/23/87 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. The Committee was advised that Emily Kirkpatrick will be attending future meetings in her capacity as Finance Manager. It was also noted that Adam Bateman will be in attendance for the risk element of the agenda only.

22/23/88 Declarations of Interest

There were none to declare.

22/23/89 Minutes from the Meeting held on the 10th November 2022
Resolved:
The minutes from the meeting that took place on the 10th of November were agreed as an accurate record of the meeting.

22/23/90 Matters Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

Action 20/21/36.1: *Internal Audit Progress Report (Conduct a repeat of the Project Management Audit with a focus on non-construction projects, in 2021/22)* – The Project Management Review has been included in the Internal Audit Plan for 2022/23. **ACTION CLOSED**

Action 21/22/15.2: *Final Internal Audit Plan for 2021/22 (Conduct a piece of work over the next twelve months, in association with MIAA, to look at what the Internal Audit plan would look like if a different approach was taken by the Trust on key financial controls)* – A meeting has been scheduled to take place on the 16.1.23 to discuss the Trust's approach to the key financial controls. **ACTION TO REMAIN OPEN**

Action 21/22/36.1: *Committee Annual Reports for 2020/21 (Include a statement in the Annual Report for each committee highlighting whether relevant BAF risks are being well managed, to enable the Audit and Risk Committee to provide assurance to the Board on the overall effectiveness of the Trust's risk management process*) – Suggestions have been made in terms of presenting the narrative in the statement. It was agreed to keep this action open as the draft Committee Annual Reports aren't due to be submitted to the Audit and Risk Committee until the 20.4.23. **ACTION TO REMAIN OPEN**

Action 21/22/89.1: *Update on Risk Management Process within the Division of Surgery (During the next Risk Management Forum discuss the possibility of implementing a set of best practice standards Trust wide in order to have a standard approach for risk management)* – A peer review is to be conducted with the Divisions to agree the components that are considered essential features of good governance. The evaluation of the review will be submitted to the Risk Management Forum (RMF) to formally record as to how the Divisions will uphold the essential standards going forward. **ACTION CLOSED**

Action 22/23/11.1: *Internal Audit Plan (Submit the final version of the Internal Audit Plan for 2023/24, in January 2023)* – This item has been included on January's agenda. **ACTION CLOSED**

Action 22/23/15.1: Counter Fraud Annual Report 2021/22 (Fraud Champion Role - Provide an update on the work that has taken place to progress the Fraud Champion's role) – Emily Kirkpatrick has agreed to take on the Fraud Champion's role with the support of James Wilcox. **ACTION CLOSED**

Action 22/23/24.2: *Audit and Risk Committee Self-Assessment Exercise (Ongoing Actions (number 2) - Discuss as to whether the annual committee reports should set out the assurance they have received and their impact on the organisation's assurance framework and advise of any matters to be brought to the attention of the Audit and Risk Committee)* - Suggestions have been made in relation to this action but it was agreed that further discussion will take place during April's meeting when the annual reports are submitted to the Audit and Risk Committee. **ACTION TO REMAIN OPEN**

Action 22/23/35.2: *Internal Audit Follow Up Report (Provide an update on future plans for addressing Consultant Job Planning actions)* – Discussions have taken place regarding the Consultant Job Planning Policy and what it dictates, whilst acknowledging the changes that have taken place since the original recommendations were made. As a result of this it has been agreed to 1. Review the policy such that the requirement for alignment in terms of objectives, pay, etc is removed in favour of something more flexible

that still requires a job plan to be completed and included on the system. 2. Take practical steps to address the blockages in the current process that are affecting the number of job plans being recorded on the system. The Medical Director, Alfie Bass approved these actions therefore it will be necessary to submit them to the appropriate bodies for endorsement. It was agreed to close this action as an update on Consultant Job Planning actions will be provided in April via MIAA's Follow-up Report. **ACTION CLOSED**

Action 22/23/49.1: *Trust Risk Management Report (Trend be included in future Trust Risk Management reports to show the progress that is being made with the 25 long standing high moderate risks)* – The trend will be included in April's Trust Risk Management Report. **ACTION TO REMAIN OPEN**

Action: 22/23/60.2: *Update on the Risk Management Process within the Division of Medicine (Discuss using the Brilliant Basics methodology to trial the use of huddle boards in potential areas in the Division of Medicine based on three top risks and a weekly check in)* – The use of Huddle Boards has been implemented in the Division of Medicine but an evaluation is yet to be done. It was agreed to request a short evaluation of the pilot in order to provide an update during April's Committee meeting. This action will be included on April's agenda. **ACTION TO REMAIN OPEN**

Action 22/23/61.2: *Internal Audit Progress Report (IT Hardware Asset Management Review Report - Invite the Chief Digital and Information Officer, Kate Warriner, or a member of the IT team to January's Committee meeting to discuss the actions that have been implemented to address the gaps in control identified in the review)* – This item has been included on January's agenda. **ACTION CLOSED**

Action 22/23/65.2: *Anti-Fraud Progress Report (Case submitted to the Crown Prosecution Service for consideration - Submit the outcome of the internal HR review/action plan relating to this case, during January's meeting)* – This item has been deferred to April as the plan is in draft. **ACTION TO REMAIN OPEN**

Action 22/23/71.1: *Any Other Business (External Audit Review - Confirm as to whether a date has been agreed in terms of commencing a review of External Audit)* – It was agreed to prepare the survey in order to conduct a review of External Audit following the 2022/23 audit. The findings will be presented to the Committee during October's meeting. **ACTION TO REMAIN OPEN**

Action 22/23/78.2: *Risk Management Forum (RMF) Update; including Corporate Risk Register, Trust Risk Management Report and approved minutes from the last meeting of the RMF (Look at incorporating relevant network risks in January's Trust Risk Management Report)* – The Trust hosts the network risks but isn't responsible for them therefore it was felt that reporting these risks via RABD was an appropriate place in which to monitor them. **ACTION CLOSED**

Action 22/23/80.1: *Internal Audit Progress Report (Workforce Planning Audit - Establish a small working group to discuss the scope for the Workforce Planning Audit. The group is to include Kerry Byrne, John Grinnell, Erica Saunders, Kath Stott and Melissa Swindell)* – A workforce planning meeting has taken place to discuss and agree the Terms of reference. **ACTION CLOSED**

Action 22/23/80.2: *Internal Audit Progress Report (Mortality and Morbidity Audit - Relay thanks to the team for the work that has taken place to achieve a high assurance opinion following a review of mortality and morbidity)* – This request has been actioned. **ACTION CLOSED**

Action 22/23/16.1: *Counter Fraud Work Plan (Submit the final version of the Counter Fraud Work Plan for 2023/24, in January 2023)* – It was agreed that this item will be submitted to the Committee in April 2023 as the Anti-Fraud Service do not draft workplans early as January in the year. **ACTION CLOSED**

22/23/91 IT Hardware Asset Management Review Report.

The Committee was provided with an update on the actions that have been completed following an independent review by MIAA of IT stock management practices which concluded in February 2022. This review took place as a result of the theft of a hundred iPads in November 2021 and provided the Trust with a total of 30 recommendations to improve current practice that needed actioning. It was confirmed that work has taken place to address the recommendations identified by MIAA which focussed on security, stock checks, asset tracking processes, centralised delivery points, etc. The Committee was informed that there are two actions outstanding which relate to the screening of the new location where stock is held, and the implementation of an automated stock management system.

A follow-up assurance visit took place on the 20.12.22 and it was reported that the MIAA assessor didn't raise any concerns regarding the submitted evidence and acknowledged that improvements have been made to the stock management process. Kath Stott advised that the update on the recommendations/actions will be incorporated in April's MIAA Follow-up Report and reiterated the assessor's comments. Kath Stott advised the Committee that the assessor would like another asset management review to take place in year so that MIAA can confirm that that system is being used consistently. It was also pointed out that is imperative for the screening to be erected to protect the location where stock is held. It was confirmed that the screening will be in situ within a two week period but the implementation of the automated stock management system will be a longer term action.

Jo Revill queried the implications to the Trust's insurance cover following the theft. The Committee was advised that the insurance company haven't asked for the organisation to do anything differently following the incident but the Trust will ensure that mitigations are taken into account and any recommendations are met when renewing the 2023/24 insurance policy.

The Chair acknowledged the work that has taken place to address the recommendations and felt that it would be beneficial from an assurance perspective to have the outcome of the independent view confirmed by MIAA via their normal reporting processes.

Resolved:
The Committee noted the contents of the IT Hardware Asset Management Review Report.

22/23/92 Board Assurance Framework (BAF) Report

The Audit and Risk Committee received an overview of the BAF as at the 30.11.22. The following points were highlighted:

- The Committee was informed that the risks on the BAF have been scrutinised by the respective Assurance Committees.
- It was reported that the Assurance Committees are finding the deployment of deep dives useful, of which, two took place in November;
  - BAF risk 2.3 *(Workforce Equality, Diversity & Inclusion)* during the People and Wellbeing Committee (PAWC).
  - BAF risk 1.2 *(Children and young people waiting beyond the national standard to access planned care and urgent care)* during the Safety and Quality Assurance Committee (SQAC).

  In terms of risk 2.3 the Committee was advised that a positive discussion took place around EDI, resources and the work that is required to reinvigorate pace. Following challenge from members of PAWC the risk score was increased.

- It was pointed out that the score for BAF Risk 4.2 (*Digital Strategic Development and Delivery)* has increased in-month on the basis of the Aldercare Programme.

The Chair referred to BAF risk 2.3 and highlighted that there are only two mitigating actions in place that relate to recruitment to address this high scored risk. Following discussion, the Chair acknowledged that once people have been appointed a detailed action plan will be produced to mitigate this risk further.

The Chair drew attention to BAF risk 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) and the gaps in control that relate to derogations in a number of service areas where they don't meet specific standards. The Chair queried the reporting process for derogations and the monitoring of related action plans. The Committee was advised that the derogation in the Annual Provider Assessment relates to compliance with major trauma standards. This issue has since been resolved and the risk score reduced. In terms of the wider point/gaps in control in the BAF, this appertains to a specialist commissioner issue involving contract performance which is reported via the Resource and Business Development (RABD) Committee. In terms of providing additional assurance and oversight for NEDs it was felt that it would be beneficial to have an overarching line of sight to RABD of this area of work. Rachel Lea agreed to compile a list of derogations for information purposes and ensure it is refreshed once contracts have been agreed in the new services that the Trust needs to derogate from as part of the new commissioning.

22/23/92.1 Action: RL

The Chair queried as to whether a meeting has been re-scheduled with Project Co to discuss the various building issues. The Committee was advised that the Trust is liaising with the PFI to agree another date.

Resolved:
The Audit and Risk Committee received and noted the BAF update and recognised the work that has been done by the Committees on the deep dives.

22/23/93 Risk Management Forum (RMF) Update; including Corporate Risk Register, Trust Risk Management Report and approved minutes from the last meeting of the RMF

The Committee received an overview of the key points and areas of concern that were discussed during the RMF on the 9th of January 2023. The Chair of the RMF advised that the meeting was well attended and the level of engagement was good, but not every Division was represented therefore this matter was raised during the Divisional Performance Reviews that took place the following day.

Attention was drawn to the deep dive that was conducted by the Division of Medicine which provided oversight of the work that has taken place and offered assurance that current risks are being actively managed and reviewed. The Chair of the RMF felt confident that the Division is au fait with their new governance process which translated into the performance review material that was submitted the following day.

It was reported that the Division of Community and Mental Health will conduct a deep dive during March's RMF which will focus on mental health risks linked to BAF risk 1.4 (Access to CYP's mental health). The Committee was also advised that a Corporate Services Risk Register has been introduced to provide a similar level of transparency and accountability to that which is required of the Divisions.

The Committee was informed that December's RMF was deferred to January 2023 due to industrial action therefore the improvements made to risk scores in December may not be reflected in the current papers. The Committee was also asked to note that the deep dive highlighted in section three of the report focussed on EDI risks and not ED risks.

For the benefit of the new Non-Executive Directors the Chair provided detail on the three types of risks that are included on the Corporate Risk Register and queried as to whether going forward there should be a focus on the risks that have external dependencies with some deep dives taking place. Following discussion, it was felt that further thought should be given to this matter.

Jo Revill thanked the Chair for explaining the three areas of risk in the Corporate Risk Register but pointed out that it is difficult to understand the nature of some of the risks, particularly the ones appertaining to ADHD/ASD and major trauma. The Chair suggested making contact with Jackie Rooney to discuss areas of uncertainty and advised that risks relating to ADHD/ASD and major trauma will become more familiar as they are discussed by the Safety and Quality Assurance Committee (SQAC) on a regular basis.

Corporate Risk Register

The Committee received and noted the Corporate Risk Register for the reporting period from the 1.10.22 to the 30.11.22.

Trust Risk Management Report

The Committee received the Trust Risk Management Report for the reporting period from the 1.10.22 to the 30.11.22. The following points were raised:

- There are a total of 291 risks on the Trust Risk Register during the reporting period in comparison to 301 previously reported. 68% of risks remain in moderate category.
- There were 32 new risks identified in the reporting period, 36 closed, 16 with an increased score and 25 with a decreased score.

- High-moderate long standing risks have reduced to 30 from 37. This data will be incorporated in the next Trust Risk Management Report.
- There were two risks without an owner but this has since reduced to one.
- The top 5 risk categories remain the same; clinical, staffing levels, HR, IM&T, finance and information governance.

The Committee was advised that positive engagement is taking place on a monthly basis with service lines and Divisions. During meetings challenge is put forward around mitigation, risk scores and the length of time risks have been on the register. It was reported that a number of risks have been inherited by new members of staff and it has taken time for them to become acquainted with the process. Business cases for additional staff have also been approved but risk scores won't reduce until those staff are in post. The Committee was informed that there is a piece of work in progress around the wording and consequences of risks.

The Chair pointed out that there are 10%+ of risks that are overdue and asked that this be monitored.

Resolved:
The Audit and Risk Committee received and noted the RMF update, CRR, Trust Risk Management Report and the approved RMF minutes from the meeting held on the 25.10.22.

22/23/94 Update on the Risk Management Process within the Division of Surgery

The Committee received an overview of the risk management process within the Division of Surgery. A number of slides were shared that provided information on the following areas:

- Risk management process;
  - Rapid review weekly meetings.
  - Monthly risk review reports sent to departments.
  - Departments present a scoping paper at the Divisional governance meetings.
  - Governance team support weekly drop in sessions for departments.
- Process for approving a risk once identified.
- The purpose of departmental monthly reports.
- The support that is provided to the Division;
  - Risk and Governance administrator sends reminders to risk managers and owners to update risk in advance of due date.
  - Weekly Divisional Governance drop in sessions to support staff with Ulysses risk reviews and updates.
  - Divisional Teams' page with Risk and Governance information for staff to access.
  - Risk discussions at Rapid Review/Divisional governance meetings to challenge and troubleshoot.
- Next steps;
  - Senior team in Division will meet monthly to review all risks with departments.
  - Departments are invited to a monthly meeting on a rota basis to provide updates and assurance on the management of their risk register.
  - Challenge where risk reviews have not been performed.

The Committee felt that the presentation was very good and provided detail/assurance as a result of the work that is taking place in the Division to manage risk. The Chair referred to a number of processes that the Division has implemented which is felt were excellent ideas; drop in sessions, moving away from a chase and follow up culture, multi-disciplinary challenge of risks and having departments present on a rota basis at monthly meetings.

Carolyn Cowperthwaite informed the Committee that the Division has worked really hard to manage its risks and are at a point where staff are working with documents in a really meaningful and timely manner. It has been a journey of change in terms of making risk everyone's business but the Division now has good engagement with staff members and positive engagement from clinicians who use the drop in session facility. Attention was drawn to the great leadership that has been provided by the Governance Team and the brilliant ideas that have been submitted by staff which have helped support change/ improvements within the Division.

The Chair asked that feedback be provided to the Division following today's presentation.

Resolved:
The Audit and Risk Committee received the Update on the Risk Management Process within the Division of Surgery.

22/23/95 Internal Audit Plan, 2023/24.

The Committee received the draft Internal Audit Plan for 2023/24. The following points were raised:

- It was reported that MIAA has met with leads from the Trust and members of the Committee to discuss the 2023/24 plan.
- Within the plan there are reviews that are; core mandated, undertaken cyclically, important to the organisation's operations and areas of consideration.
- The Committee was advised that MIAA are going to provide details in the plan of the allotted days for each audit and the month they will be undertaken. Information relating to the month an audit is to be undertaken will also be included in the Internal Audit Progress Report to enable the completion of audits to be tracked more closely.

The Chair advised that the Trust is likely to move forward with an external review for risk management therefore there will be a gap in the plan. It was felt that it would be beneficial to conduct an audit on access to health records even though actions have taken place to mitigate the issues around resources and the timeliness in responding to health record requests. Following discussion, it was agreed to replace the risk management audit with a review of access to health records.

22/23/95.1 Action: KS

The Chair drew attention to three audits appertaining to areas of consideration in the plan; innovation, health inequalities and agency staff.

It was felt that a decision needs to be made about the commissioning of an external review on innovation due to the significant changes that have been made by the Trust on this area of work and it being a highly specialised area. John Grinnell advised that a Board 'Futures' strategy session is due to take place on the 16.1.23 which will incorporate

Research and Innovation (R&I,). The Trust is also awaiting the outcome of an R&I review that is being conducted by Fiona Marston. It was suggested regrouping on this matter following the next stage of discussions of the 'Futures' agenda which has innovation at the heart of it. The Chair advised that the external review of innovation is not imminent and may not be required once the R&I review has been completed, but it was highlighted that the Audit and Risk Committee is at a point in time where it requires assurance. Following discussion it was agreed to keep innovation on the plan under areas of consideration, whilst noting that that the review will be carried out via an external organisation specialised in this area.

The Chair reassured the Committee that health inequalities is an important area that requires auditing but pointed out that the Trust is not able to review this in isolation due to being part of a system. The Chair advised that she will raise this matter at the next meeting of Cheshire and Merseyside Audit and Risk Committee Chairs (arranged by MIAA) to see if a health inequality review can be carried out via a system wide approach rather than it being specific to Alder Hey.

It was reported that discussions have taken place about a review of agency staff from a cost/patient safety perspective. It was confirmed that agency costs are very low with the majority relating to non-clinical staff. This provided assurance to the Committee that the Trust is managing spend effectively. From an SQAC viewpoint there is very little use of clinical agency staff which reduces the risk to patient safety in terms of agency staff being unfamiliar with the organisation's systems and processes.

The Chair brought the discussion to a close and Committee members confirmed their approval of the Internal Audit Plan for 2023/24.

Resolved:
The Audit and Risk Committee approved the Internal Audit Plan for 2023/24.

22/23/96 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the Internal Audit Plan during the period from November 2022 to December 2022. The following points were highlighted:

- There have been three reports finalised in this reporting period;
  - *Improving NHS Financial Sustainability review* - The review confirmed that the self-assessment was fully completed and there was evidence available to support the self-assessment. MIAA made two recommendations which have been completed.
  - *Data Quality* - This review received a high level assurance opinion.
  - *Partnership Governance* – This review receive a substantial level assurance opinion.
- There are five reviews in the field work stage; Cyber, Medical Devices, Junior Doctors Non-Consultant Spend, Workforce Planning, Assurance Framework and Health Procurement Liverpool. It was confirmed that all reviews will be completed by the end of March. The Committee acknowledged the reasons for there being five reviews at the fieldwork stage at this period of time in the year.

Erica Saunders commended all those involved in achieving a high level assurance opinion following a data quality audit. Kath Stott pointed out that this opinion is a

recognition of the Trust's efforts to address the historical issues and resource factors.

The Chair referred to the NHS Financial Sustainability Review and queried the process for overseeing the action plans that have been developed as a result of the Trust scoring between 1 and 3 when answering the 72 questions on the checklist. It was reported that the Trust scored all 72 of the questions and has implemented an action plan for anything less than a score of 4. Initially there was a focus on the 12 questions that were mandated by NHSE/I but there is a full action plan in place. It was confirmed that on average the Trust scored above 3 (closer to 4) on the majority of the 72 questions therefore work is taking place to look at how the Trust can achieve a score of 5. The Trust is liaising with its peer providers and has shared its scores/improvement plans to support best practice across the patch. A suggestion was made about the possibility of the action plan being monitored by RABD therefore it was agreed to discuss this matter with the Chair of RABD, Ian Quinlan.

22/23/97.1 Action: RL

The Chair highlighted the importance of the Committee receiving assurance on the completion of the action plan, if delegated to RABD.

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit Progress Report.

22/23/97 Internal Audit Follow-up Report

The Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been made. The following points were highlighted:

- Of the 8 recommendations that have fallen due in the reporting period, 7 have been completed. There is one that is partially implemented following the consent review with approval requested from the Committee for an extension to the end of April 2023. The Committee confirmed its agreement of the extended deadline.

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit follow-up Report.

22/23/98 Anti-Fraud Progress Report; including:

The Committee received the MIAA Anti-Fraud Progress Report that sets out the work undertaken during the period from 8.9.22 to the 5.1.23. The following points were highlighted:

- *Initial Fraud Risk Assessment* - A meeting took place with the Associate Director of Nursing and Governance to discuss the initial fraud risk assessment. The risk assessment has also been shared with relevant management for review. Further meetings are to take place with finance and designated leads to address any queries relating to the risk assessment.
- *Post Event Assurance (PEA) Exercise* - The Trust was identified as one of a 109 organisations who issued extreme urgency contracts and maintained adequate records of decisions and actions taken as required by PPN01/20. The NHSCFA

noted that this result demonstrates that a significant focus on financial governance was maintained in the Trust during a challenging period for the sector

- *Purchase Order (PO) versus Non-Purchase Order Report* – In the ranking of organisations on non-PO spend as a percentage of total spend (with 1 being the lowest percentage and 210 being the highest percentage), the Trust was ranked 165. Alder Hey was one of a 147 organisations to have a non-PO percentage that was over the average of 30.30%. The NHSCFA noted that where non-PO spend occurs, an organisation is exposed to a far greater risk of fraud in the procurement process.

  It was reported that MIAA has been liaising with Health Procurement Liverpool (HPL) to review the reports of all participating bodies in the HPL Alliance. An action plan is in place to support the implementation of recommendations, and HPL have confirmed that they will be taking a single approach to ensure that all organisations are working to best practice in accordance with the outcome of the report.
- *National ESR Fraud Awareness e-Learning Module* – Current compliance for staff completion of the module is 96.78%.
- 19 local MIAA Fraud Prevention Checks (FPCs) have been issued to the Trust in the reporting period for consideration. The majority of these FPCs relate to mandate fraud alerts and require the Trust's Finance team to take appropriate action.
- *Local Proactive Exercise Overtime Review* – This exercise has been completed and it was confirmed that there was no fraud identified. A number of recommendations were made mainly around developing a set of procedure notes, updating timesheets to include an appropriate anti-fraud declaration and introducing timesheets
- *Hold to Account* - There is one joint case with LUHFT that remains open. Following submission to the Crown Prosecution Service (CPS) for consideration, on review the CPS advised that it was not in the public interest to pursue this case. The Trust's Chief Finance Officer (CFO) and LUHFT's CFO agreed with the CPS decision. The Committee was advised that both trusts are taking civil action to recover the overpayment of £8,700.27.
- It was reported that a meeting is due to take place with the Deputy Chief People Officer to discuss the outcome of the internal HR recruitment review/action plan for the case submitted to the CPS for consideration. It was confirmed that the outcome of the review will be submitted to the Committee during April's meeting.

The Chair referred to the overtime review that took place and asked that the recommendations be included in the next Anti-Fraud Progress Report for information, and an update be provided on the implementation of actions.

22/23/98.1 Action: VM

The Chair drew attention to the Purchase Order versus Non-Purchase Order Report and asked as to whether the monitoring of the action plan will be managed by HPL or whether it will it be the remit of the Trust. It was confirmed that the Trust is going to conduct a deep dive/analysis into this area of work and liaise with HPL to understand the root cause of this problem. The Trust is also open to best practice in terms of improvements taking place across other trusts. The Chair asked that an update be provided to the Committee in June on the outcome of the deep dive/analysis.

22/23/98.2 Action: RL/EK

The Chair pointed out that there is a lot of assurance provided in the Anti-Fraud Progress Report but felt that it needs to be drawn out so that it's more obvious to the Committee. The Chair agreed to liaise with Virginia Martin re ideas for drawing out the elements of assurance in the report.

22/23/98.3 Action: KB

Resolved:
The Audit and Risk Committee received and noted the Anti-Fraud Progress Report.

22/23/99 External Audit General Update

It was reported that Dan Spiller and his team have met with Emily Kirkpatrick and James Wilcox to discuss a plan for agreeing working papers and a date for visiting the Trust which has since been arranged for the first week in March. Following this, E&Y will prepare its audit plan and commence to audit the Trust's year end accounts.

Resolved:
The Audit and Risk Committee noted the update.

22/23/100 Audit and Risk Committee Work Plan for 2023/24.

The Committee received the Audit and Risk Committee workplan for 2023/24 for approval. Going forward the workplan will be presented alongside the Committee's Terms of Reference for ease. Jackie Rooney queried as to whether the Clinical Audit Annual Report for 2022/23 could be presented to the Committee in June in light of the work that is taking place around clinical audit. The Chair confirmed her agreement of this.

Resolved:
The Audit and Risk Committee approved the Committee workplan for 2023/24.

22/23/101 Risk Assessment Policy.

The Committee received the Risk Assessment Policy for approval purposes. The Chair felt that the policy should to be reviewed/updated and consideration given to reviewing the current suite of risk management policies as a whole due to the large number of them and the current separate submission of each policy.

It was reiterated that Alder Hey is intending to commission an external review of risk management in 23/24 and, as part of that, will request guidance and a view on the organisation's current suite of risk management policies. Following discussion, it was agreed to approve the Risk Assessment Policy whilst noting that a review of the suite of policies will be taking place. It was agreed to provide an update in September on this area of work.

22/23/101.1 Action: JRO

Resolved:
The Audit and Risk Committee approved the Risk Assessment policy.

22/23/102 Any Other Business

The Committee was advised that a meeting is taking place on the 13.1.23 between the Trust and the engineers/designers to discuss the installation of a sprinkler system in the car park situated under Sunflower House. It was agreed to share the outcome of the meeting with the Chair, Jo Revill and Garth Dallas ahead of January's Trust Board.

22/23/102.1 Action: RL

It was reported that the Centre has issued the national annual reporting time table for the financial statements therefore there may be some movement in terms of amending dates to meet deadlines.

22/23/103 Meeting Review

The Chair confirmed that an update will be provided to the Board on the following items:

- HFMA Financial Sustainability Review.
- The positive work and engagement that is taking place across the Trust on risk management.
- Request for RABD to take a holistic look/view of derogations.

The Chair requested that April's meeting take place on a face to face basis if possible.

Date and Time of the Next Meeting: Thursday 20th April 2022, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 4th May 2023

Paper Title:	**Directors' Register of Interests 2022/23**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	The Declarations of Interests Register enables all staff to be as open as possible and declare any actual or potential conflict of interest.
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** ■

Alder Hey Children's NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS
2022/23

	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
Dame Jo Williams (Trust Chair)		✓
Nathan Askew (Chief Nurse)		✓
Shalni Arora (Non-Executive Director)		✓
Alfie Bass (Chief Medical Officer)		✓
Adam Bateman (Chief Operating Officer)		✓
Fiona Beveridge (Non-Executive Director)	**Declaration Type:** Loyalty Interest **Body/Organisation/Individual name**: University of Liverpool **When did loyalty interest begin:** 01/04/2022 **How is this relevant to the Trust:** Employed at University of Liverpool in senior role which could, on occasion, give rise to Loyalty conflict of interest. Managed by transparent dealing and declaration where relevant and by agreement with Chair of Alder Hey NHS Trust and Vice Chancellor, University of Liverpool.	

000222	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
Kerry Byrne (Non-Executive Director)	**Declaration Type:** Outside Employment **Outside Employer**: South Lakes Housing. **Outside Employer Description:** Non Executive Director for South Lakes Housing. Sit on Board and Audit & Risk Committee **When did business interest begin:** 01/09/2018 **How is this relevant to the Trust:** No conflicts of interest. **Declaration Type:** Outside Employment **Outside Employer**: Ernst & Young LLP **Outside Employer Description:** Internal auditor in the financial services team of Ernst & Young based in their London office. I do not believe there are any conflicts with this role as it ended in 2014, some years before I joined Alder Hey as a Non-Executive Director. Despite this, I am declaring it now (July 2022) due to the current external audit tender process for which Ernst & Young have submitted a tender (the only tender). I am a panel member for selecting the external auditor. I do not know any of the Ernst & Young external audit team, other than through my professional dealings with them as an Alder Hey NED. **When did business interest begin:** 2012-2014 ***ACTUAL EMPLOYMENT DATES 03/01/2012 to November 2014*** **End Date:** November 2014 **How is this relevant to the Trust:** No conflicts of interest. **Declaration Type:** Outside Employment **Outside Employer**: Liverpool John Moore's University **Outside Employer Description:** I sit on the LJMU Board and am the Chairman of the	

000223	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	Finance Committee **When did business interest begin:** 13/11/2019 **End Date:** 24/04/2023 **How is this relevant to the Trust:** No conflicts of interest	
John Chester (Director of Research & Innovation)	**Declaration Type:** Outside Employment **Outside Employer:** Institute for Cancer Research, London **Outside Employer Description:** Honorarium for acting as external examiner for PhD viva, £150 **When did business interest begin:** 22/04/2022 **How is this relevant to the Trust:** no conflict	
Lisa Cooper (Director of Community and Mental Health Services)	**Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** Empower the Invisible Project **Description of Loyalty Interest:** This project is supporting adults with lived experience of abuse. I have been asked to be an ambassador for the project and support them with promotion of their work. **When did business interest begin:** 06/04/2021 **Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** The Princes Trust **Description of Loyalty Interest:** I am a mentor for the Princes Trust. This is not a paid position and I undertake this outside of work. I provide mentorship and support to young people seeking employment within health and social care settings. **When did business interest begin:** 01/04/2022	

000224	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	Declaration Type: Loyalty Interests **Body/Organisation/Individual name:** Survivors Trust UK **Description of Loyalty Interest:** I am a trustee of the charitable organisations Survivors Trust UK. I held this position previously and stood down in 2020 due to personal reasons. I have been reappointed to this position in April 2022. **When did business interest begin:** 01/04/2022	
Benedetta Pettorini (Director of Surgery)		✓

Garth Dallas (Non-Executive Director)		✓
Urmi Das (Director of Medicine)		✓
Mark Flannagan (Director of Marketing and Communications)		✓
John Grinnell (Deputy Chief Executive/Director of Finance)	**Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** Playworld Ltd./Grinnell Holdings Ltd **Relationship:** Company Secretary (no dealings with hospital) **Description of loyalty interest:** Spouse companies **When did business interest begin:** 19/11/2019	
Adrian Hughes (Deputy Medical Director)		✓
Dani Jones (Director of Strategy and Partnerships)		✓
John Kelly (Non-Executive Director)		✓
Rachel Lea (Deputy Director of Operational Finance)		✓

Anita Marsland (Non-Executive Director) *(left the Trust June 2022)*	**Declaration Type:** Outside Employment **Outside Employer:** Calderstones Mansion Community Interest Company **Outside Employer Description:** Non-Executive Director **When did business interest begin:** 09/09/2019 **How is this relevant to the Trust:** No conflicts. **Declaration Type:** Outside Employment **Outside Employer:** Unique Health Solutions **Outside Employer Description:** Health and Care Management Consultancy - Director **When did business interest begin:** September 2012 **How is this relevant to the Trust:** No conflicts. **Declaration Type:** Outside Employment **Outside Employer:** Public Health England. **Outside Employer Description:** Local Government Advisor. **When did business interest begin:** September 2012. **How is this relevant to the Trust:** No conflicts. **Declaration Type:** Outside Employment **Outside Employer:** The Reader **Outside Employer Description:** Chair of Board of Trustees at The Reader (None remunerated) **When did business interest begin:** September 2012. **How is this relevant to the Trust:** No conflicts.	

000227	**Declaration Type:** Outside Employment **Outside Employer:** Sefton ICP. **Outside Employer Description:** Independent Chair of the Programme Delivery Group. **When did business interest begin:** 01/03/2021 **How is this relevant to the Trust:** No conflicts. **Declaration Type:** Outside Employment **Outside Employer:** South Sefton CCG. **Outside Employer Description:** Independent Chair of Sefton Transformation Board. **When did business interest begin:** September 2018. **How is this relevant to the Trust:** NHS organisation.	
Fiona Marston (Non-Executive Director)	**Declaration Type:** Outside Employment **Outside Employer:** University of Reading **Outside Employer Description:** Royal Society Entrepreneur in Residence - personal grant from The Royal Society to support the University in specified commercial translation activities **When did business interest begin:** 26/03/2023 **How is this relevant to the Trust:** no conflict **Declaration Type:** Outside Employment **Outside Employer:** Erebagen Limited **Outside Employer Description:** Chair, CEO (Interim) and Non-executive Director of a synthetic biology company undertaking drug discovery and development **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** no conflict	

000228	**Declaration Type:** Outside Employment **Outside Employer:** NC3Rs **Outside Employer Description:** Member of Advisory Panel reviewing and assessing applications for grant funding by NC3R. NC3Rs is a UK-based scientific organisation that works nationally and internationally with the research community to replace, refine and reduce the use of animals in research and testing. **When did business interest begin:** 01/02/2021 **How is this relevant to the Trust:** no conflict **Declaration Type:** Outside Employment **Outside Employer:** Liverpool School of Tropical Medicine **Outside Employer Description:** Royal Society Entrepreneur in Residence at Liverpool School of Tropical Medicine: This appointment is governed by a consultancy agreement between myself and LSTM. Funding is provided by The Royal Society and is a personal grant awarded to me to work with LSTM to support training in commercial translation of innovative research, developing projects that build the entrepreneurial skills of staff and students, as well as their understanding of the scientific challenges being tackled in the innovation sector. The initial award was for one year from 01/02/2021 and has now been extended for a second 12 month period commencing 01/02/2022 **When did business interest begin:** 01/02/2021 **End date**: 31/01/2023 **How is this relevant to the Trust:** no conflict **Declaration Type:** Outside Employment **Outside Employer:** UK Innovation and Science Seed Fund **Outside Employer Description:** Advisor to UKI2S Seed Fund **When did business interest begin:** 20/08/2019 **How is this relevant to the Trust:** no conflict	

000229	**Declaration Type:** Outside Employment **Outside Employer:** Allergan Biologics **Outside Employer Description:** Advisor on biologics innovation. Mentor to management **When did business interest begin:** 01/04/2018 **End date**: 30/04/2022 **How is this relevant to the Trust:** no conflict	
David Powell (Development Director)		✓
Ian Quinlan (Vice Chair/Non-Executive Director)		✓
Jo Revill (Non-Executive Director)	**Declaration Type:** Outside Employment **Outside Employer:** Royal College of Paediatrics and Child Health **Outside Employer Description:** I am currently CEO of the College which is a membership body for paediatrics and child health. I resigned from this post in August 2022 and will shortly be leaving this employment. **When did business interest begin:** 01/04/2018 **End date**: 01/11/2022 **How is this relevant to the Trust:** There would be potential conflict if a business or commercial contract at the College impacted on any arrangement or contract within Alder Hey, or if there was a conflict of policies. I am not aware of any business, examinations or policy conflict. **Declaration Type:** Outside Employment **Outside Employer:** Authors' Licensing and Collecting Society **Outside Employer Description:** I am chair of ALCS, a not-for-profit body which supports	

000230	authors and illustrators and distributes money due to them through royalties. **When did business interest begin:** 01/01/2023 **How is this relevant to the Trust:** No conflict. **Declaration Type:** Outside Employment **Outside Employer:** Copyright Licensing Agency **Outside Employer Description:** I am co-chair of the CLA, a not-for-profit body which provides licensing solutions to the public sector, companies and others to enable copyright to be upheld and to support publishers, writers and artists. **When did business interest begin:** 01/01/2023 **How is this relevant to the Trust:** No conflict.	
Erica Saunders (Director of Corporate Affairs)		✓
Louise Shepherd (Chief Executive)	**Declaration Type:** Outside Employment **Outside Employer:** NHS England **Outside Employer Description:** Chair National Children's Transformation Board. **When did business interest begin:** 01/03/2023 **How is this relevant to the Trust:** No conflict. **Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** Royal Liverpool Philharmonic Society **Description of loyalty interest:** Appointed Chair of the RLPS Charity for a term of 3 Years **When did business interest begin:** 14/11/2022	
Melissa Swindell (Chief People Officer)		✓

000231 Kate Warriner (Chief Digital and Information Officer)		✓