Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday, 9th November 2023, commencing at 9:00am

Lecture Theatre 2, Institute in the Park

AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (9:00am-9:15am)							
1.	**23/24/165**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/166**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/167**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **5th October 2023.**	**D**	Read enclosure
4.	**23/24/168**	**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.	**23/24/169**	**9:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**23/24/170**	**9.30 (5 mins)**	**NHS England Sexual Safety in Healthcare Organisational Charter.**	N. Askew	For discussion and approval.	**D**	Read report
7.	**23/24/171**	**9.35 (10 mins)**	**Strategy Brochure.**	D. Jones/ C. Beaver	For discussion and approval.	**D**	Read brochure
8.	**23/24/172**	**9.45 (15 mins)**	**System Update; including:** • **Children's Health Alliance update.** • **National update.**	L. Shepherd/ D. Jones	To receive an update on the current position.	**N**	Presentation

			• **Provider Collaboratives update** • **Children and Young People Committee.** • **Beyond.**				
Operational Issues							
9.	**23/24/173**	**10.00 (50 mins)**	• **M7 Flash Report/ Operational Overview.** • **Integrated Performance Report for M6, 2023/24.** • **Finance Update for M6, 2023/24.** • **Digital, Data and Information Technology Update.**	Executives/ Divisions R. Lea K. Warriner	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M5 position. To provide an update on the current position.	**A** **A** **A**	Read enclosure/ report Presentation Read report
10.	**23/24/174**	**10.50 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	J. Halloran	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
11.	**23/24/175**	**11.00 (10 mins)**	**Learning Following the Letby Case.**	A. Bass/ N. Askew/ E. Saunders	For information and discussion.	**A**	Read report
12.	**23/24/176**	**11.10 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report

13.	**23/24/177**	**11.15 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 18.10.23.** - **Approved minutes from the meeting held on the 20.9.23.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 19.7.23.	**A**	Read enclosures
Game Changing Research and Innovation							
14.	**23/24/178**	**11.20 (5 mins)**	**Research Update; including:** • **Top research metrics.** • **Update on large bids.**	J. Chester	To receive an update on the current position	**A**	Presentation
The Best People Doing Their Best Work							
15.	**23/24/179**	**11.25 (10 mins)**	**People Plan Highlight Report; including:** • **EDI Update.**	M. Swindell	To receive an update on the current position. To provide an update on key areas and updates from the system on the workforce.	**A** **A**	Read report Read report
Strong Foundations (Board Assurance)							
16.	**23/24/180**	**11.35 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 23.10.23.** - **Approved minute from the meeting held on the 25.9.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 30.8.23.	**A**	Read enclosures
17.	**23/24/181**	**11.40 (10 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
18.	**23/24/182**	**11.50 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight**	K. Byrne/	To escalate any key risks, receive updates and note the approved minutes from the 22.6.23.	**A**	Read enclosures

			Report from the meeting held on the 12.10.23. - **Approved minutes from the meeting held on the 13.7.23.**	J. Revill			
19.	**23/24/183**	**11.55 (5 mins)**	**Proposed Constitutional Change.**	Chair/ E. Saunders	To receive and approve the proposal to amend the Trust's Constitution.	**D**	Read enclosure
Items for Information							
20.	**23/24/184**	**12.00 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
21.	**23/24/185**	**12.04 (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
Lunch (12:05pm-12:30pm)							
Date and Time of Next Meeting: Thursday, 7th December 2023, 9:00am, Lecture Theatre 2, Institute in the Park							

REGISTER OF TRUST SEAL
The Trust seal was not used in October

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M6, 2023/24	R. Lea

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 5th October 2023 at 11:00am**
LT4, Institute

	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Vice Chair/Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Dr. F. Marston	Non-Executive Director	(FM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance:	Mr C. Beaver	Deputy Director of Communications	(CB)
	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. I. Gilbertson	Deputy Chief Digital and Information Officer	(IG)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Director of Finance	(RL)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Mrs. E Rees	Executive Assistant (minutes)	(ER)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
Staff Story:	Ms. A.M. Davies	Innovation & Inequalities Programme Manager	(AD)
Apologies:	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. J. Grinnell	Managing Director/Chief Finance Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)

Staff Story

The Chair welcomed Anne-Marie Davies to the meeting. Ms Davies shared with the Board that it was Black History Month and updated on the events taking place within the Trust. She then talked about her experience and the experiences of other members of staff from Black, Asian and Minority Ethnic Groups and she challenged the Board think about how they could improve the experience of those members of staff within Alder Hey.

The Chair thanked Ms Davies for sharing her experiences and congratulated her on the Associate Non-Executive role at Liverpool Heart and Chest Hospital.

23/24/135 Welcome and Apologies

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

23/24/136 Declarations of Interest

There were none to declare.

23/24/137 Minutes of the Previous Meeting

The minutes from the meetings held on the 7 September 2023 were agreed as an accurate record of the meeting.

23/24/138 Matters Arising and Action Log

There were no matters arising and it was confirmed that all actions were on track.

23/24/139 Chair/CEOs Update

Trust Strategy Board
The Chair gave an update on the Strategy Board which had met before the Board and felt uplifted by the progress and direction of travel.

Louise Shepherd advised that the Strategy Board supported:

- The focus on the two priorities 'Get me Well' and 'Personalise my Care'
- The 6 promises for children and young people.

The Chair advised that Ana Samuel had been appointed as the new Lead Governor replacing Marilyn Mornington.

The Chair thanked those involved in the recent major incident and noted particular thanks to the communications team.

Louise Shepherd stated that a C&M ICB Children's Committee had now been formed and wanted to record thanks to the Chair of the ICB for supporting this as well as the Beyond Programme. She noted that she and the Chair had recently met with Liam Robinson, Leader of Liverpool City Council which was really positive.

It was noted that in terms of architecture across the City, the Liverpool Joint Committee was going well with the recommendations of the Carnell Farrar review being implemented across the system and LUFT was no longer in soft 4.

Louise Shepherd advised that there was still a large gap in relation to finances and the Trusts would come together to look at corporate services and a formal review of the financial model would be taking place led by Pete Shanahan. She added that James Sumner would be moving into the Liverpool Women's Hospital as Chief Executive from 1 December and would be looking to improve the situation with a plan for recovery and would give an opportunity to work with the trust and cement a strong partnership.

The Chair reflected on some of the issues of the LL trial and that the Board today was really focussed on quality and safety.

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

23/24/140 Operational Issues

M6 Flash Report/Overview

The Board received an update on the 7 key priority areas and the following highlights:
Delivering the Patient Safety - Good compliance with sepsis management and recruitment into investigations to complete the incident reviews.
Increase people availability and wellbeing – good progress with staff turnover and sickness and metrics will be brought back in the next 6 months.
Advance our clinical research portfolio and innovation pipeline – little hearts at home being scaled up, process to identify future research projects and progress on the research strategy.
Handover Springfield Park to our community **-** the park programme will be reviewed to mitigate delays.
Improve access to care and reduce waiting times – a number of challenges and ED performance had dropped. If performance improved to over 80% then some capital monies would be received as a reward.
Financial Sustainability – update on the agenda
Safely deploy Alder C@re – update on the agenda

Jo Revill asked about the recommendations from the recent review in research and innovation and how they would feed into the Strategy. John Chester advised that a response was given to each of the sections which would be discussed at the next R&I committee. Adam Bateman advised that one of the key recommendations was for enhancing the commercial approach and the futures update at the Strategy Board would be taking on the lessons from that report.

Resolved:
The Board received and noted the Flash Report for Month 6.

Integrated Performance Report, M5 2023/24

The Board received the M5 Integrated Performance Report for August and the Executive leads' fed back on their respective areas:

Community and Mental Health Division

- Reduction on waiting times.
- Staff turnover continues to reduce.
- Continued focus on completion of clinic letters within 30 days.
- Increase in time to access Initial Health Assessment and recruiting external medical support.
- ADHD and ASD waiting times were still challenging.
- 5 breaches in the eating disorder waiting time due to patient choice.
- National Patient Safety Alert received for the shortage of ADHD medication. Risk assessments were taking place for the children and young people affected and there might be an impact on waiting times. Actions needed to be completed by the end of October.

Medicine

- Sustained compliance with all standards for cancer care.
- PAU pilot commenced 8th August primarily focused on improving this indicator by offering direct assessment for GP and other health professionals to a Paediatric assessment.

- ED performance continues an improving trend, achieving 92% in 4 hours in month.
- PALs and complaints response times had improved.
- Concerns regarding Sepsis and a deep dive would be reported via SQAC.
- 93% for Friends and Family Test in ED.
- PDR compliance aiming for 90% by end of October.

Surgery
The Board was advised of the current situation in the theatre department, which had been a result of Industrial Action, recruitment and sickness. A more stable system was required and this was presented to the Executive Team where they supported the reduction of 15 scheduled sessions per week between October to January.

Resolved:
The Board noted the Integrated Performance Report.

Forward Look for Winter 2023/24

The Board received an update on the Forward Look for Winter, which was presented by Adam Bateman.

It was noted that the plan was split into 3 parts focussing on attendance avoidance, admissions avoidance and hospital occupancy and flow and build on previous years.

The Chair stated that it felt holistic in the way it had been put together, learning from previous years and on the front foot compared to other years.

Resolved:
The Board noted the Forward Look for Winter 2022/23.

Implementation of Alder Care

The Board received the update on the implementation of Alder Care, which was presented by Ian Gilbertson.

It was noted that the paper summarised the successful deployment of Alder Care, with rigorous processes in place. There were some small delays which pushed back the launch by 24 hours. During the first 3 weeks command and control was in operation and strategic command remained in place. The team were currently working through the remining priorities and working to get the reporting back online and were already planning for optimisation.

The Chair thanked the team for all their hard work and support during the go live.

Resolved:
The Board received and noted the report.

Staff Vaccination Status

The Board received a proposal on the approach for the vaccinations for the autumn booster, which was presented by Nathan Askew. He highlighted that 90% of staff had received the measles vaccination and noted that a small number of staff would be contacted personally to be asked to take up the vaccine.

Resolved:
The Board received and noted the report.

Finance Update for M5 2023/2024

Rachel Lea advised that there was an in-month surplus of £14k in Sept and £1.49m deficit year to date, which was in line with the plan. Industrial Action continued to impact on delivery of activity and incurring additional costs which presented an ongoing risk to the plan. Financial assessment continued on strategic initiatives to quantify savings and the CIP had improved with 88% identified in year. Scenario analysis was being looked at and would be brought back to the November meeting.

The Chair asked whether the Trust should be identifying any additional risks in the system. Rachel Lea advised that this information would be taken to RABD and would bring further information to the November Board.

Resolved:
The Board received and noted the Finance report.

23/24/141 Alder Hey in the Park Campus Development Update

The Board received an update on the Campus Development, which was presented by David Powell. He advised that preparation work would commence on the Neonatal build and this would take 6 months and the contracts were being finailsed for sign off.

It was noted that there were some drainage issues in relation to the park and would aim to get this resolved in the timescale agreed for handover at the end of November.

Resolved
The Board received and noted the Campus Development Update.

23/24/142 Liverpool Neonatal Governance

The Board was provided with an update in relation to the governance arrangements of the Liverpool Neonatal Partnership (LNP) and detailed the next steps which will be incorporated into a more formal review.

Resolved
The Board:

- Noted the contents of this report.
- Approved the course of action.
- Agreed that an update would be provided in 3 months with a full report in 6 months.

23/24/143 Patient Safety Incident Response Framework

The Board received the Patient Safety Incident Response Framework which was presented by Nathan Askew. He advised that 3 members of staff had worked tirelessly on this piece of work and noted it had been approved via SQAC.

Patient Safety Incident Response Policy and Plan

It was noted that the response plan was very prescriptive and would need to be submitted to the ICB following Board approval.

Resolved
The Board received and approved the Patient Safety Incident Response Policy and Plan and the governance processes associated with it.

23/24/144 Serious Incident (SI) Report

The Board was provided with oversight of the incidents that were 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 – 31st August 2023. The following points were noted:

- Zero Never Events were declared during the reported period.
- Zero StEIS incidents were declared during the reported period.
- **2** SIs were open during the reporting period.
- The Trust was compliant with Duty of Candour.

It was noted that there had been a never event during September and this would be reflected in next month's report.

Resolved:
The Board received and noted the contents of the Serious Incident report from 1 – 31st August 2023.

23/24/145 PALs and Complaints and Report Q4

The Board received the PALs and Complaints report, which was presented by Nathan Askew. This report provided an overview of formal complaints and informal PALS concerns received and completed between April to June 2023 (Q1). Due to some ongoing data quality issues the reports provide a focus on performance and uses analysis where possible, it has not been possible to present the usual depth of learning from concerns and complaints which will be included in the Q2 report.

He noted that the number of formal complaints had reduced and the Trust were managing a number of complex cases. There had been no referrals to the Parliamentary and Health Service Ombudsman. PALS continued to reduce and acknowledged the work that the Divisions had done to improve in this area.

Resolved:
The Board noted the position statement for Complaints and PALS for Q1.

23/24/146 Mortality Report Q1

The Board received the Mortality report, which was presented by Alfie Bass. He highlighted the training for the Medical Examiners was still ongoing and the report would include neonates for the next quarter.

R**esolved:**
The Board noted the contents of the Mortality update for Q1.

23/24/147 DIPC Report Q1

The Board received an update on Infection, Prevention and Control within the Trust, which was presented by Alfie Bass. He advised that the report was a work in progress and going forward would have a much bigger focus on the IPC function. The IPC committee has now restarted and a number of workstreams would feed into this.

Resolved:
The Board noted the DIPC update for Q1.

23/24/148 Safety and Quality Assurance Committee

The approved minutes from the meeting held on 19.7.23 were submitted to the Board for information and assurance purposes. The committee received papers for information in August as there was no meeting. There was nothing to highlight from September's meeting.

Resolved:
The Board noted the highlight report and the approved minutes from the meeting held on 19.7.23.

23/24/149 Fit and Proper Person's Policy

The Board received the Fit and Proper Person's Policy.

Resolved:
The Board received and approved the Fit and Proper Person's Policy

23/24/150 Wellbeing Guarding Dashboard

The Board received an update on Wellbeing Guardian nine principles with the action plan, which was presented by Jo Revill. She advised that the actions were in progress with one action in red and noted there were some actions to pick up relating to principle 8 from today's meeting.

Resolved:
The Board received and noted the actions and approved the current action plan.

23/24/151 People Plan Highlight Report

The Board received an update on the People report, which was presented by Melissa Swindell. She highlighted that the staff survey had been launched 2 weeks ago and the response rate was currently at 29%.

EDI Update
The Board received an update on they key strategic and operational issues impacting the organisation for Equality, Diversity and Inclusion (EDI). The following points were highlighted:

- The Award Ceremony was being held for the Navajo Charter Mark, the Trust was the first Children's Hospital to receive the award.
- The Trust was working toward the Bronze Status for the NW BAME Assembly Framework.
- The Finance Team were given recognition for all the work within their department on Inclusion and EDI

- The SALs team had won an International Award and Jo Potier would be going to Portugal to receive the award.

The Board congratulated the Finance and SALs team for all their hard work.

Resolved:
The Board noted:

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

23/24/152 People and Wellbeing Committee

The approved minutes from the meeting held on 11.7.23 were submitted to the Board for information and assurance purposes. At the September meeting there was an update on the annual workplan, the people strategy and communications on the promotion of Vision 2030. It was noted that turnover was still high within the Divisions but lots of work was ongoing to understand the data and improve the data capture. Sickness absence was also reducing.

Resolved:
The Board noted the update and approved the minutes from the meeting held on 11.7.23.

23/24/153 Vision 2030 – Collaborating in Communities

The Board received an update on Vision 2030, collaborating in communities, which was presented by Dani Jones. She highlighted the C&M multi agency work to address the commissioning gap for children and young people with complex needs and work was progressing with the W&C transformation programme.

Resolved:
The Board noted the update.

23/24/154 Resources and Business Development Committee

The approved minutes from the meeting held on 30.8.23 were submitted to the Board for information and assurance purposes. Rachel Lea noted that a presentation was received on the costing system which was well received and would be rolling this out across the Divisions. They received an update on Alder Care, ODN Network and the Campus. The Divisions would be presenting their Q2 positions to the meeting in October.

Resolved:
The Board noted the update and approved the minutes from the meeting held on 30.8.23.

23/24/155 Board Assurance Framework Report

The Board was provided with assurance on strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite, which was presented by Erica Saunders. She noted that there had been a good discussion at the Strategy Board with new risks added for Vision 2030 which would be updated following this meeting.

Resolved:
The Board received and noted the contents of the Board Assurance Framework.

23/24/156 Any Other Business

There was none to discuss.

23/24/157 Review of the Meeting

The Chair thanked everyone for their contribution during the meeting. There was lots of discussion about safety and quality and the operational agenda. She acknowledged some of the challenges around the Vision 2030 but there had been great progress. She noted the issues in Theatres and actions arising from the staff story.

Date and Time of Next Meeting: Thursday 9 November 2023 at 9.00am at L2, 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
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for December 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	Dec-23	**19.1.23** - This item has been deferred to February's Trust Board. 29.3.23 - This item has been deferred to May's Board. **27.4.23 -** This item has been deferred to June's Board. **3.6.23 -** The ToR will be submitted to the Board in September once they have been reviewed by RABD. **1.9.23** - The ToR will be submitted to the Board in October once they have been reviewed by RABD. **4.10.23** - The ToR will be submitted to the Board in November once they have been reviewed by RABD. **23.10.23** - The ToR will be submitted to the Board in December once they have been reviewed by RABAD. **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	Dec-23	**15.12.22** - A piece of benchmarking work is taking place to ascertain a response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **29.3.23** - This action is linked to new risk system and is unchanged pending the go live of InPhase in April. **27.4.23** - The new risk system is due to go live on the 10.5.23 therefore an update will be provided in June. **1.7.23** - This action has been deferred until September. **1.9.23** - This action has been deferred to October. **4.10.23** - This action has been deferred to November. **23.10.23** - This action has been deferred to December. **ACTION TO REMAIN OPEN**
6.7.23		Staff Story	Meeting to take place with Will Simmons and Christine Hill to discuss the support/resources that the Pathology Service requires to progress the Super Hub model.	L. Shepherd/ J. Grinnell	7.9.23	Dec-23	**7.11.23** - A meeting is in the process of being scheduled. An update will be provided in December. **ACTION TO REMAIN OPEN**
Actions for March 2024							
7.9.23	23/24/106.2	Operational Issues	*Finance* - Submit a half yearly report on the cash share model that is emerging and provide detail in terms of how it is being managed from a risk perspective in the system.	R. Lea	7.3.23	On track March-24	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
7.9.23	23/24/105.2	Vision 2030 Strategy Update	*Strategy Document* - Arrange for a subset of the Board to meet in order to review the image that is to be included in the strategy document, the 'Plan on a Page' and the final draft of the brochure.	D. Jones	5.10.23	Closed	**23.10.23** - This action has been addressed. **ACTION CLOSED**
7.9.23	23/24/105.1	Chair's and CEO's Update	*Aftermath of the Letby Case* - Submit a report to the Trust Board to provide assurance that Alder Hey is an organisation that recognises the critical importance of listening to staff and addressing concerns that are raised.	A. Bass/ N. Askew/ E. Saunders	9.11.23	Closed	**23.10.23** - A report is to be submitted to the Board in November 2023. **ACTION CLOSED**
7.9.23	23/24/106.1	Operational Issues	*IPR (Division of Surgery)* - Conduct a piece of work on theatres to address the challenges that are being experienced in Surgery.	J. Grinnell/ B. Pettorini	9.11.23	Closed	**27.10.23** - This action has been addressesed. A report was submitted to the Exec Team on the 28.9.23 and the Operational Board on the 26.10.23. **ACTION CLOSED**
7.9.23	23/24/110.1	Brilliant Basics Update	Invite the Chair of Lancashire and South Cumbria NHS FT; David Fillingham to see the BB work that is taking place across the Trust, the process and the impact.	L. Shepherd	9.11.23	Closed	23.10.23 - David Fillingham will be visiting the Trust in November. **ACTION CLOSED**
7.9.23	23/24/110.2	Brilliant Basics Update	Look at the possibility of having a complete wrap around the change programmes and having a single benefits programme.	N. Palin	9.11.23	Closed	**7.11.23** - Work is continuing to progress the 2023/24 Brilliant Basics (BB) Delivery Plan. As the Trust progresses with the development of the 2024/25 Integrated Strategic Plan, it will align the BB delivery actions as across cutting to enable the Vision 2030 Strategy. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	NHS England Sexual Safety in Healthcare Organisational Charter
Report of:	Nathan Askew Chief Nursing, AHP and Experience Officer
Paper Prepared by:	Nichola Osborne Associate Director Safeguarding & Statutory Services

Purpose of Paper:	Decision ■ Assurance ☐ Information ■ Regulation ☐
Action/Decision Required:	To note ☐ To approve ■
Summary / supporting information	The briefing paper outlines the plan to improve awareness, reporting and responses to sexual assault, harassment, abuse, and violence across the NHS. This includes an overview of data and statistics, the newly launched NHS England plan to improve Sexual Safety in the NHS and summarises the actions needed to be undertaken to implement the Sexual Safety in Healthcare – Organisational Charter.
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:	Resource requirements will be assessed through the working group and if required will be addressed through the Trust processes.

Does this relate to a risk? Yes ☐ No ■					
Risk Number	Risk Description				Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Executive Summary

1. The briefing paper outlines the plan to improve awareness, reporting and responses to sexual assault, harassment, abuse, and violence across the NHS. This includes an overview of data and statistics, the newly launched NHS England (NHSE) plan to improve sexual safety in the NHS and summarises the actions needed to be undertaken to implement the Sexual Safety in Healthcare – Organisational Charter.
2. In June 2023, NHSE wrote to all Integrated Care Boards (ICBs) and NHS Provider Trusts to acknowledge the media spotlight on the prevalence of sexual assault, harassment, and abuse in the NHS. The letter emphasised the importance of redoubling and strengthening efforts to ensure that every part of the NHS takes a systematic zero- tolerance approach to sexual misconduct and violence, keeping patients and staff safe.
3. On the 04 September 2023, NHSE launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. The charter has been developed by NHSE, lived experience organisations, professional bodies, employers, and partners across healthcare.
4. Next steps for Alder Hey are outlined along with a proposed action plan to improve sexual safety within the Trust. This includes signing up to the NHS Sexual Safety Charter and a commitment to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles by July 2024.
5. The prevalence of sexual assault, harassment, violence, and abuse within the NHS is not fully understood. The Trust has a statutory responsibility to keep the children, young people, and their families safe from abuse within our care and staff safe from unwanted, inappropriate and/or harmful sexual behaviours within the workplace. Those who work, train, and learn within the healthcare system have the right to be safe and feel supported at work.
6. It is vital that the Trust has a clear commitment and strong stance in relation to sexual safety within the NHS to increase reporting of sexual assault, harassment, abuse, and violence; and instil confidence that this will be addressed.

Introduction and Background

7. This purpose of this briefing paper is to outline the plan to improve awareness, reporting and responses to sexual assault, harassment, abuse, and violence across the NHS. This includes an overview of data and statistics, the newly launched NHSE plan to improve Sexual safety in the NHS and summarises the actions needed to be undertaken to implement the Sexual Safety in Healthcare – Organisational Charter.
8. In June 2023 NHSE wrote to all Integrated Care Boards (ICBs) and NHS Provider Trusts to acknowledge the media spotlight on the prevalence of sexual assault, harassment, and abuse in the NHS.
9. This was in response to several reports and findings in relation to the prevalence of sexual harassment and assault in the NHS such as ‘Breaking The Silence - Addressing Sexual

Misconduct in Healthcare' an Independent Report on Sexual Misconduct conducted by the Working Party on Sexual Misconduct in Surgery by Colleagues in the Surgical Workforce

10. The letter emphasised the importance of redoubling and strengthening efforts to ensure that every part of the NHS takes a systematic zero- tolerance approach to sexual misconduct and violence, keeping our patients and staff safe.

11. In the letter from NHSE Trusts were asked to do the following:

    - Nominate a Domestic Abuse and Sexual Violence (DASV) Executive and Operational Lead
    - Review Trust policies, support, and training for staff
    - Sign up to the DASV on the NHS Futures Platform

12. The agreed DASV Executive Lead is Nathan Askew, Chief Nursing, AHP and Experience Officer and the Operational Lead is Nichola Osborne, Associate Director Safeguarding & Statutory Services and this has been provided to NHSE and Designated Professionals for Safeguarding at Cheshire and Merseyside ICB (C&M ICB) as requested.

13. The NHSE letter has been shared with relevant leads in Human Resources (HR) and Risk and Governance.

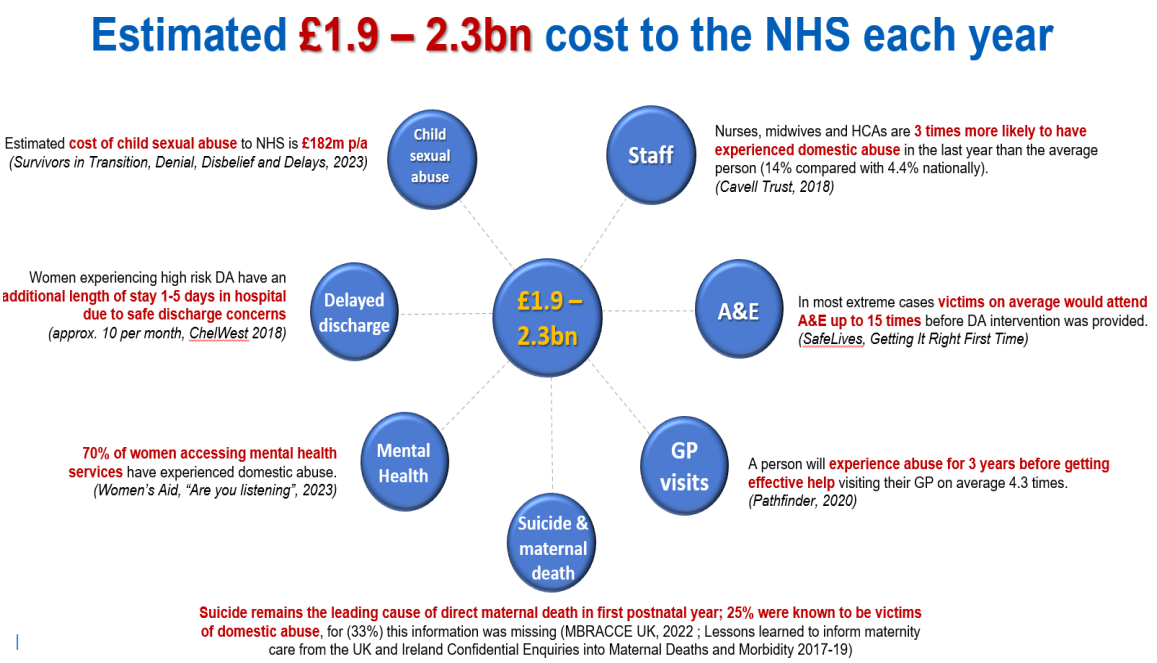
14. An action plan has been outlined below which includes a review of Trust policies, support, and training for staff.

15. In addition, the Trust has signed up to the DASV workspace on the NHS Futures Platform and have been receiving information cascaded to the DASV Leads.

16. Key Statistics:

- 1 in 4 women and 1 in 6-7 men will experience domestic abuse in their lifetime. ONS data, 2022
- 1 in 4 women and 1 in 18 men have been raped or sexually assaulted as an adult. Rape Crisis England & Wales
- 58% of women (3 in 5) have experienced sexual harassment, bullying or verbal abuse at work. TUC Poll, 2023
- 43% of women (2 in 5) have experienced at least three incidents of sexual harassment. TUC Poll, 2023
- Health and social care staff are more likely to experience these crimes.
- Black and minority, disabled, and LGBTQ+ communities experience abuse at a disproportionate rate.
- Perpetrators are most likely to discuss behavioural concerns with a GP.

17. Estimated Cost and Impact of Domestic Abuse and Sexual Violence to the NHS is shown in the diagram below:



Sexual Safety in Healthcare – Organisational Charter

18. On the 04 September 2023, NHSE launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. The charter has been developed by NHSE, lived experience organisations, professional bodies, employers, and partners across healthcare.

19. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. Signatories to the charter commit to implementing all ten commitments by July 2024.

20. NHSE have signed the Charter and have urged all Trusts and ICBs to join as signatories. It is believed that signing up to this charter will send a clear and powerful message to NHS staff that we take their experiences seriously.

21. As a Trust it is essential that the correct action to identify, safeguard and care for individuals who have been or are being sexually assaulted or abused is taken.

Sexual Safety in Healthcare – Organisational Charter

As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.

2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

These commitments will apply to everyone in our organisation equally.

Where any of the above is not currently in place, we commit to work towards ensuring it is in place by July 2024.

Domestic Abuse and Sexual Violence (DASV) Leads

22. NHSE will use the new network of NHS DASV Leads across the system to help share and promote good practice, identify issues, and develop practical solutions in relation to implementation of the charter as quickly and effectively as possible.

23. Identified DASV Leads across the system will be supported by NHSE via quarterly webinars. Both DASV Leads for Alder Hey attended the first webinar on 17 October 2023 which included an introduction to the DASV programme and the network, as well as sexual safety and charter implementation.

24. A Sexual Safety Toolkit has been cascaded to DASV Leads to support conversations in relation to sexual safety in the workplace. This toolkit will be used to support the Trust action plan.

NHS Staff Survey

25. To help Trusts to have a clearer view of the situation in their organisation, NHSE has included a new question in the NHS Staff Survey which was published in October 2023.

26. The question is: '*In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault*.'

27. The anonymous data gathered from this question will help NHSE and individual Trusts to understand the potential prevalence of sexual misconduct in and inform further action planning to protect and support staff.

Next Steps

28. NHSE has set up an expert advisory group who have been tasked with reviewing NHSE policies, training, and support, and they will share model guidance, e-learning and other products with Trusts, as they are developed.

29. The following action are proposed as appropriate next steps for Alder Hey:

Update Job Descriptions

30. Job descriptions need to be updated to include responsibilities in respect of the Domestic Abuse & Violence Executive Lead and Operational Lead.

Trust Commitment to the Sexual Safety Charter

31. Alder Hey Trust to sign the Sexual Safety Charter and commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles by July 2024.

32. As a Trust it is essential that the right action to identify, safeguard and care for individuals who have been or are being sexually assaulted or abused is taken. It is believed that signing up to this charter will send a clear and powerful message to NHS staff that we take their experiences seriously.

Review and Update of Policies and Staff Support Offer

33. Trust policies need to be updated to reflect our responsibilities in respect of sexual safety. These would include HR and safeguarding policies in relation to appropriate staff conduct, managing allegations against staff and disciplinary processes.

34. Safeguarding, HR, Risk and Governance and the Chaperone Policy need to clearly articulate how to manage, record, and respond to allegations from children, young people and their families regarding sexual assault, harassment, and abuse.

35. Other relevant policies would include the Zero Tolerance Policy which needs to reflect a truly zero tolerance approach to sexual assault, harassment, violence, and abuse.

36. Staff support policies need to be reviewed to strengthen references to sexual safety within the NHS and outlining avenues of reporting and support within the Trust which would include the DASV Leads, Safeguarding, Freedom to Speak Up, Staff Advice & Liaison Service (SALS).

37. NHSE have suggested Trusts consider developing a standalone dedicated Sexual Safety Policy, however it appears this work will be led by NHSE and/or the ICB.

Agree Central Recording and Reporting of Data

38. Data capture is a key commitment in the charter, and we will need to consider how we collect data regarding staff and patients who experience these crimes within the Trust.

39. Our existing incident reporting system InPhase has the relevant incident reporting categories to capture abuse of both children and young people as well as staff. To ensure this data is captured appropriately there may need to be more clarity around what categories should be used and where to find them.

40. As outlined above in paragraph 24, NHSE has included a new question in the NHS Staff Survey which will published in October 2023. The Trust will need specifically review staff responses to this question when we receive the results of the NHS Staff Survey.

Workforce Development and Training

41. The Trust will need to ensure that staff understand their responsibility to act if they witness these behaviours and that they have the confidence that their concerns will be taken seriously. There should be opportunities to refer to sexual safety within the NHS in established training such as Trust induction and in safeguarding training.

Conclusion

42. The prevalence of sexual assault, harassment, violence and abuse within the NHS is not fully understood. The Trust has a statutory responsibility to keep the children, young people, and their families safe from abuse within our care and staff safe from unwanted, inappropriate and/or harmful sexual behaviours within the workplace. Those who work, train, and learn within the healthcare system have the right to be safe and feel supported at work.

43. It is vital that the Trust has a clear commitment and strong stance in relation to sexual safety within the NHS to increase reporting of sexual assault, harassment, abuse, and violence; and instil confidence that this will be addressed.

Recommendations

44. The Trust Board is asked to endorse Alder Hey signing up to the Sexual Safety Charter and approve the steps outlined above in developing a robust action plan to fulfil the Trust's statutory safeguarding responsibilities.

Appendix 1 - DASV Legislative and Strategic Framework

Legislation/ Strategy	Duties
Domestic Abuse Act 2021	✓ Positive duty to tackle domestic abuse; applies to both our patients and our staff. ✓ Children are recognised as victims in their own right, including when they have not suffered any physical injuries. ✓ Domestic abuse has a much wider definition including economic, honour and faith-based abuse, and FGM. ✓ New offence of non-fatal strangulation.
Health and Care Act 2022	✓ Duty on ICBs to set out steps to address the particular needs of victims of abuse (including domestic and sexual abuse) in their Joint Forward Plans.
Police, Crime, Sentencing and Courts Act 2022	✓ Duty on ICBs to contribute to a partnership assessment of 'serious violence' in local areas. 'Serious violence' now includes domestic abuse and sexual offences ✓ Strategies and interventions in place to prevent serious violence.
Victims Bill 2022	✓ Duty on ICBs to collaborate in commissioning services to support victims of domestic abuse, sexual violence and serious violence.
Women's Health Strategy 2022	✓ Violence Against Women and Girls is seen as a public health issue ✓ Greater awareness of healthcare services that can provide specialist treatment and support for victims of sexual violence and FGM, such as sexual assault referral centres and FGM clinics. ✓ Prioritisation of prevention and reduction of violence against women and girls. ✓ Services and staff are able to equipped to support victims of violence and abuse, and respond to both victims and perpetrators. ✓ NHS and social care staff who are victims of violence against women and girls are better supported in the workplace and are aware of how to access any support they may need. ✓ Learnings and recommendations from the Domestic Homicide Review that relate to health organisations are taken forward, and embedded into the healthcare system at a national and local level.
Violence Against Women and Girls Strategy 2021	✓ Develop guidance that promotes evidence-based approaches to violence against women and girls through the new ICSs. ✓ NHS England to review and build on their workforce policies to ensure safe, effective processes are in place to support staff affected by VAWG.
Domestic Abuse Plan 2022	✓ Funding through the Home Office to support the gathering of evidence for and commissioning of domestic abuse focussed health care interventions.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	**Vision 2030 - brochure**
Report of:	**N/A**
Paper Prepared by:	Dani Jones and Colin Beaver

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The aim of the brochure is to explain Vision 2030 in broad terms, providing enough detail to win internal and external support for and involvement with our refreshed strategy.
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:	

Does this relate to a risk? Yes ☐ No ☑					
Risk Number	Risk Description				Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

NHS
Alder Hey Children's
NHS Foundation Trust

A HEALTHIER, HAPPIER AND FAIRER FUTURE FOR CHILDREN AND YOUNG PEOPLE

VISION 2030

VISION 2030

p026

A Healthier, Happier and Fairer Future for Children and Young People

OUR ASPIRATION
To be world-leading

NHS
Alder Hey Children's
NHS Foundation Trust

The Needs of Children, Young People and Families

- Get me well
- Personalise my care
- Improve my life chances
- Bring me the future

Outstanding care and experience

Collaborate for children & young people

Revolutionise care

Support our people

Pioneering breakthroughs

respect | excellence | innovation | together | openness

FOREWORD

What do we mean by ‘a fairer future’?

To us, **‘a fairer future’** means a world where educational opportunity, health and wellbeing isn’t limited by a child’s social, economic or ethnic background.

It’s an Alder Hey where all of our people enjoy equality in recruitment, training, pay and progression, reward and recognition; where they feel ‘seen’, and where they feel they belong.

With Vision 2030, we will equip ourselves with more knowledge; learning and growing together with our partners so that we can remove internal and external processes and barriers that might sustain inequity.

Welcome to Alder Hey, one of Europe’s biggest and busiest children’s healthcare providers, and considered amongst the best in the world. We look after 330,000 children and young people each year, treating everything from common illnesses to highly complex and specialist conditions.

It’s these children and young people, and their families, that inspire us; that motivate our aspiration to not only give them the best clinical care, but also support them to feel happy, safe and confident as they play, learn and grow, in a world where they are not limited by their social, economic or ethnic background.

In short, we want to help them, and children and young people everywhere, to achieve their full potential.

Over the last 10 years, we have come a long way, guided by a clear vision of where we wanted to be, and driven by the belief, passion and world-class expertise of our people who make the very best care possible.

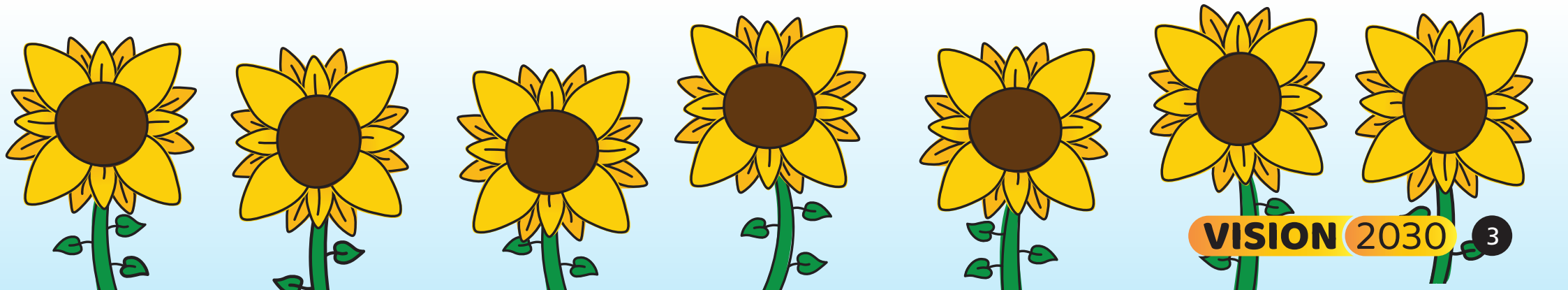
But as society changes so too do health and care needs. There are new pressures facing children, young people and families, and new pressures facing Alder Hey and the care system that we are a part of. To meet the challenge that those pressures bring, we need to develop our knowledge, expertise, and assets, and leverage them – working alongside our system partners – to bring improvements for children, young people and families everywhere. We must work to ensure that our people too are healthy and happy, and are able to reach their own potential.

By focusing our efforts locally and regionally, we hope to make an impact nationally and globally.

We have created this strategy to make our Vision 2030 a reality and to galvanise us to tackle the challenges we each of us face, together, to create a happier, healthier, and fairer future for children and young people.

Dame Jo Williams
Chair

Louise Shepherd, CBE
Chief Executive



INTRODUCTION

What's your vision for 2030? What kind of future do you want for our children and the generations to come? How do you think you might help enable that future if you start to act now?

These are some of the questions that have preoccupied us in the development of our Vision 2030 strategy. It's a strategy for Alder Hey to help us continue to do what we already do well, only better; but it's also about understanding our place in the world, what we want from the future and how we might use the platform we've worked hard to achieve to facilitate that future.

Fuelling it all is a steadfast ambition to work alongside like-minded partner organisations to create a world where children, young people and their families can live their best lives.

But our ambition is challenged by a fast-changing environment.

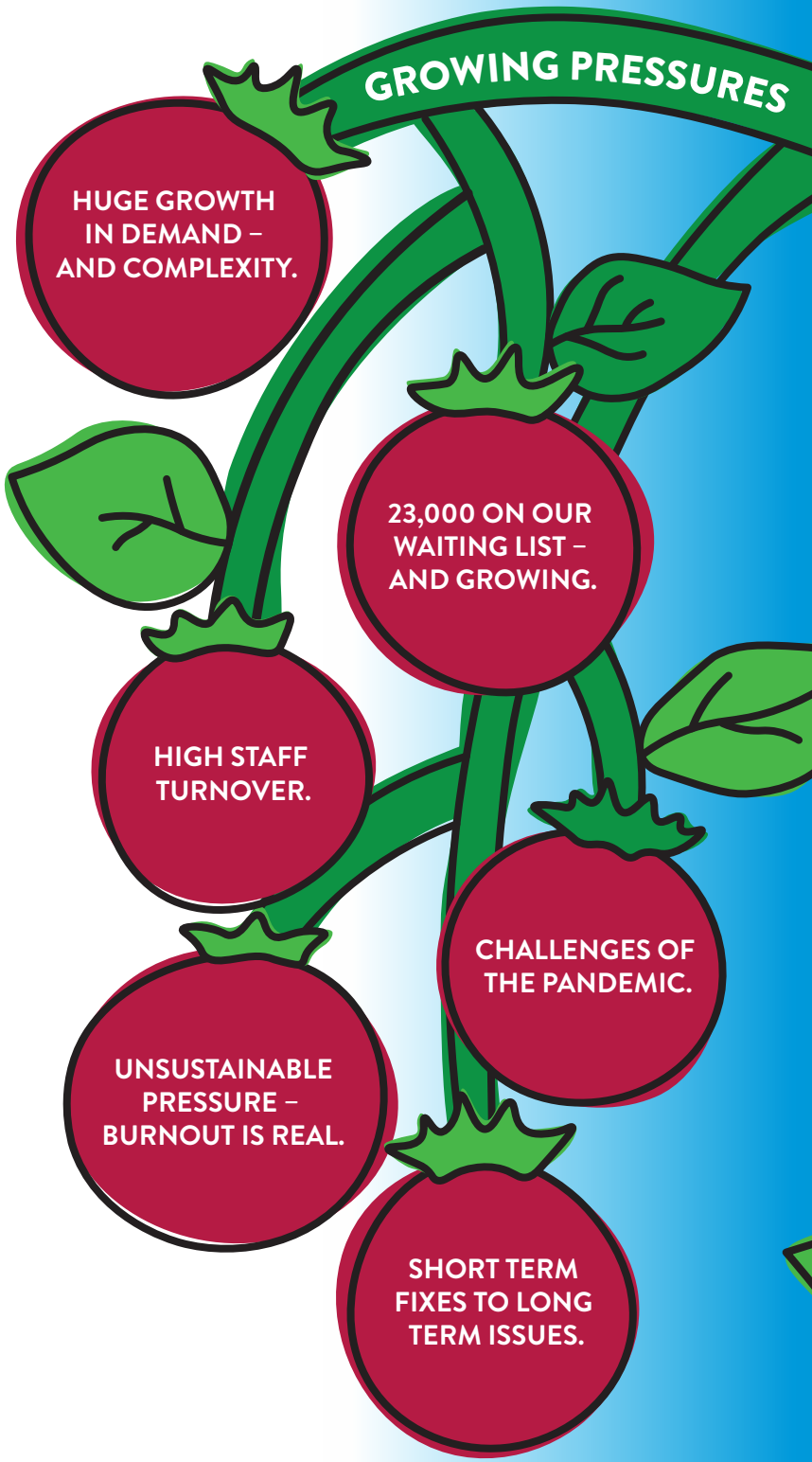
The needs of children and young people are evolving, with many more living with long-term and complex health conditions. Austerity has led to closure of children's centres and a lack of investment in prevention services, whilst the Covid 19 pandemic has had a fundamental impact upon children and young people. It has left in its wake an enormous recovery challenge, having exacerbated health inequalities, with poorer health, wellbeing, and educational outcomes, and a mental health crisis for the youngest in our society.

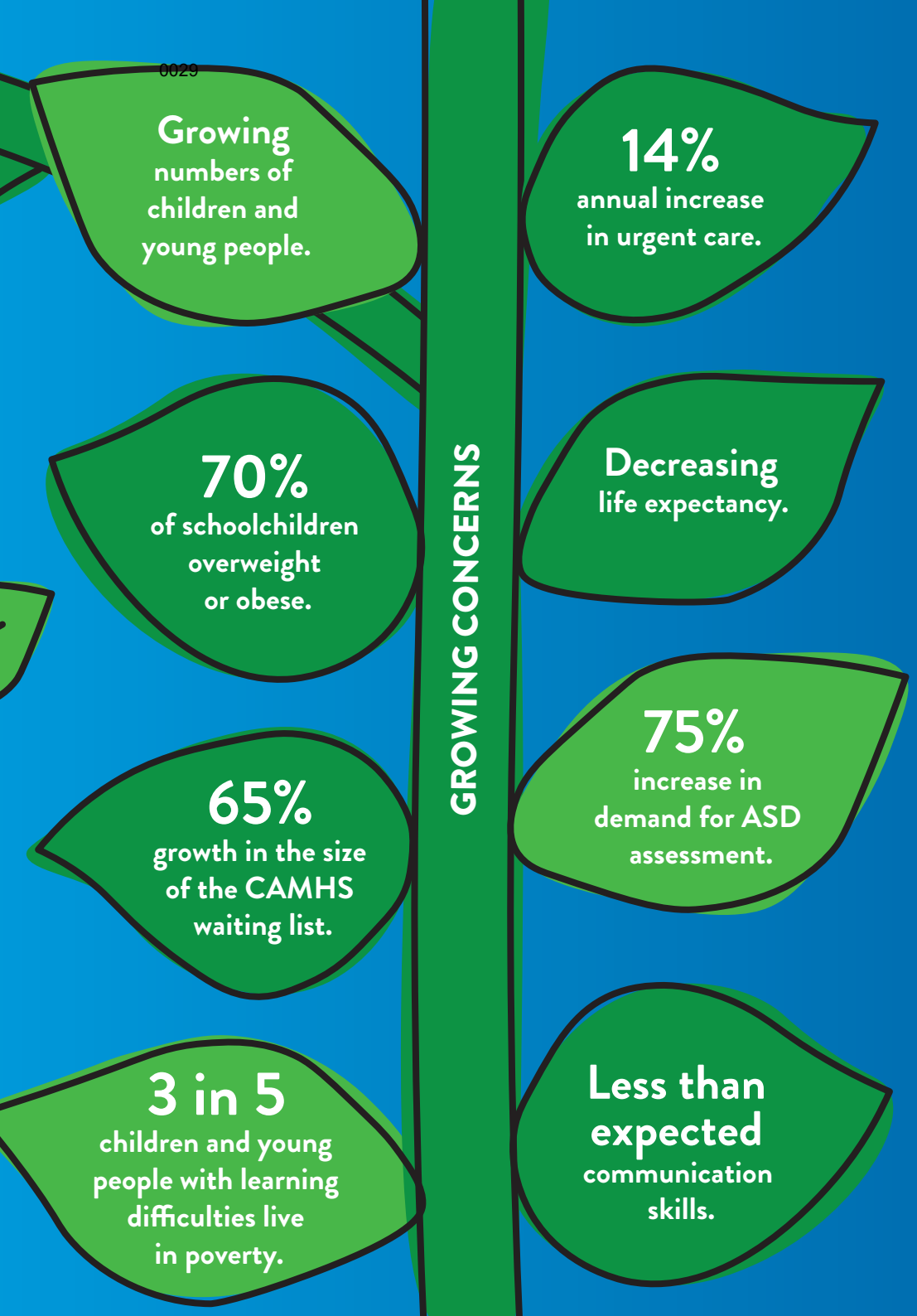
And children and young people's needs are not homogenous; one size does not fit all.

To help galvanise us to meet the challenges we face, we have articulated a Vision that builds upon the strong foundations we have laid down and will inspire us into the future, helping us to be resilient irrespective of the obstacles we might face. That Vision is:

A healthier, happier and fairer future for children and young people.

Alder Hey is full of inspired, creative, and passionate people with the skills and knowledge to make a real difference. It is our people, alongside our experience, and knowing that we have partners who share our commitment, that gives us the confidence that we can deliver our Vision.





What does this tell us?

We're seeing a huge growth in demand, with two out of three of the children and young people we treat coming from deprived areas. This growth in demand is putting great pressure on us and partners who provide care and support for children and young people.

It is also impacting our people. Workforce challenges within the NHS, alongside those in the national labour market are, on their own, significant. They are however exacerbated by external factors in the economy – such as the growing cost of living – and the legacy of the pandemic. Our people are feeling the pressure; their wellbeing is suffering; burnout is real.

This tells us that we will have to do something different.

We must work with our partners, as a system, to truly join up services in ways that make sense to children, young people and their families. We need to provide more personalised care closer to home and school, putting prevention and wellbeing at the heart of how we do things, and playing a more meaningful role in tackling inequity at its roots.

We want to create a world where children, young people and their families can live their best lives, and our people can do their best work.

SEEING CLEARLY: STRATEGY DEVELOPMENT

In developing Vision 2030, we focused our attention fully on the needs of our children, young people and families, and on the needs of our people.

We undertook an extensive analysis of the children and young people who use our services. We considered: which services they use, how often they use them and for how long, and what combinations of clinical services they need. We also scrutinised demographic data, including age, gender, ethnic background and where they live and travel from, alongside important socio-economic factors such as income, education, and employment, all of which play a major role in someone's health and wellbeing.

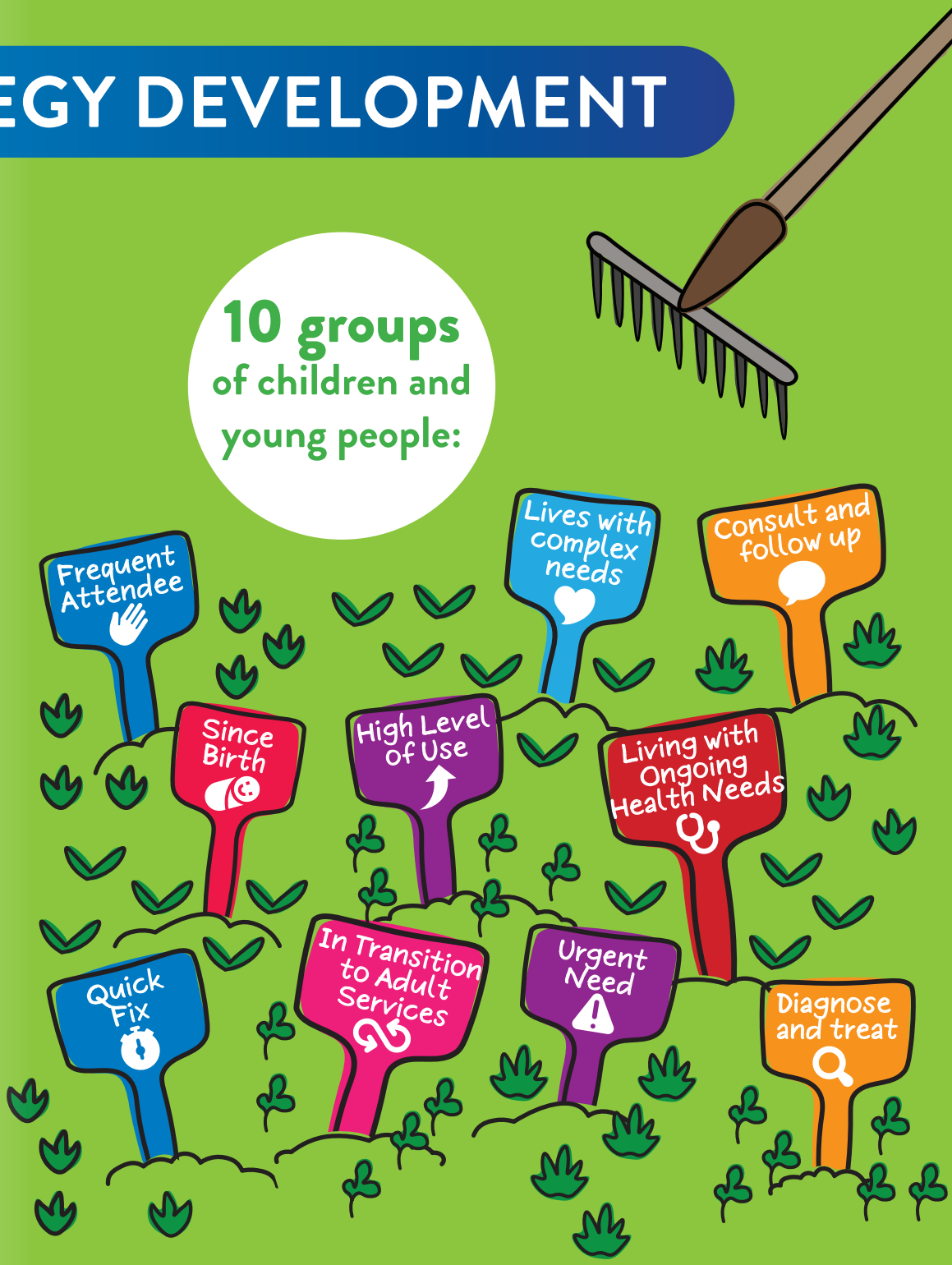
This analysis opened our eyes to some important learning. It showed us that, broadly speaking, children and young people have varying needs that can be described across 10 groups. Each group might require different things from us, yet we traditionally deliver our services to all groups in the same ways.

Stepping back and looking at these groups collectively we were able to identify needs that were common across more than one group. This enabled us to describe the 4 major 'areas of need'.

What if we organise ourselves around these 4 areas of need, instead of the more traditional service-led model? Could we deliver a more personalised experience and better meet the needs of children and young people?

We believe so.

To that end, we will take a population-health based approach to meeting these four areas of need, whilst recognising that individual children, young people, and families' needs do not remain static.



WE HEAR YOU

The feedback that children, young people and families have shared with us on their lived experiences and what they actually need is at the heart of Vision 2030.

They have spoken to us loud and clear, and given us a strong understanding of how we can make a difference to them, both within Alder Hey, and through collaborating with our partners in the health and care system.

Children have told us:

"We need you to..."

Get me well

Children in this group told us they need a relatively quick fix.

"I don't want to go to hospital unless I have to. I want to be looked after by people nearby who know me, and I want to be seen quickly when it's best for me. Treat me as me."

Bring me the future

Children and young people are ambitious for their own futures, for their families and their communities.

"I want to know you're always trying to find new and better ways to look after me, and I want the best people to want to work at Alder Hey so I can be treated by them."

Improve my life chances

Children in our community need support from many different services, not just Alder Hey.

"I need you to keep me healthy so I can go to school and learn and get a job I like one day. Don't let me get lost in this big, complicated system. It can be so confusing. I need your help to join up the support I need."

Personalise my care

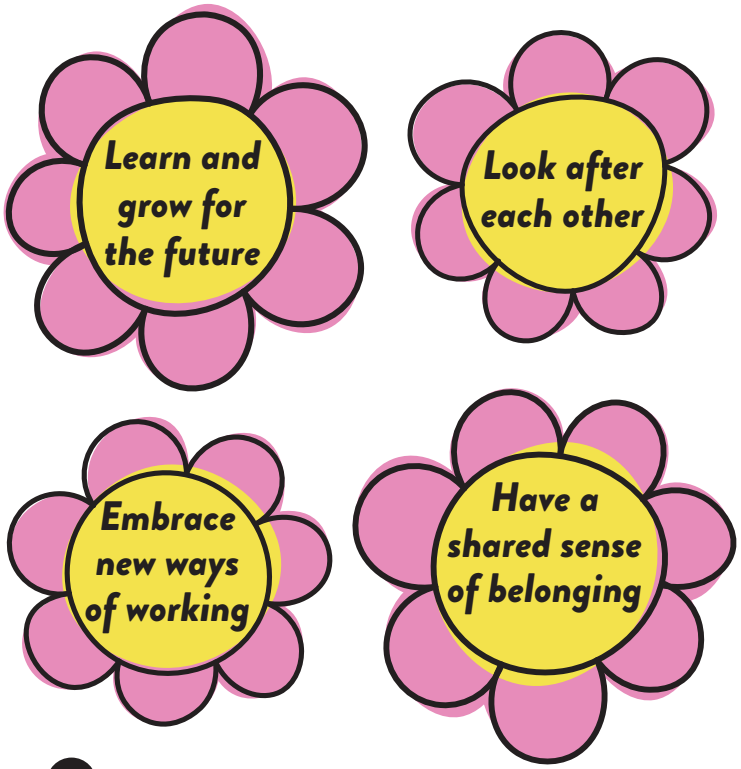
Children in this group are living with a long-term condition or complex health need and are often looked after by lots of different specialties.

"I want care that is connected up. I don't want to feel like I'm being treated by different people. I don't want to spend a lot of time in hospital. I want your help to be independent and live my life."

OUR PEOPLE

Our people are our greatest strength, renowned for their outstanding care. But we need to create a healthier, happier, fairer environment for them to thrive in so that they can together deliver Vision 2030.

We need to support them to have fulfilling careers and make Alder Hey a place where they want to be; a place where we:



As with our children and young people, there is no 'one size fits all' approach to achieving this. We need to reframe our approach and offer targeted solutions according to differing needs. And this is what we have done.

Built on a deep analysis of our workforce, we have developed the most sophisticated understanding of our people that we have ever had – our people viewed through the frame of their needs rather than professional groups, service structures or bandings.

This has helped us to identify three key areas where we can make transformational changes:

Thriving @ Alder Hey

finding and keeping the best people, giving them a reason to stay.

The Professional Hub

the best people don't want to stand still; let's nurture that.

Future Workforce

designing and developing a future-proofed workforce that shifts and shapes around an evolving landscape.

Within each of these strands we have developed needs based promises of benefit and reward for our people, supporting them to thrive and do their best work.

In delivering these needs-based benefits and interventions, we will create an environment where our people:

- ✔ **feel connected, safe, healthy, happy, supported and are performing at their best.**
- ✔ **have the time, space and opportunity to improve.**
- ✔ **are diverse, valued for their differences and feel included.**
- ✔ **experience consistent and effective talent management across the trust.**
- ✔ **feel confident and able to embrace change.**
- ✔ **believe we have a fair and just culture.**

OUR GOALS

To successfully meet the 4 areas of children and young people's needs, we will focus on achieving 5 major cross-cutting goals.

Push ourselves to always provide the best possible experience for children, young people and families, continually testing this with them and building on their feedback.

Use our combined knowledge and resources to develop and deliver a system that children, young people and families can find their way round and get the best out of.

Harness the latest technologies to ensure delivery of the very best health and care outcomes for children, young people and families. Do things differently. Do things better.

Understand our people better. What drives them? Develop shared motivations and ambitions by treating them as individuals and ensuring that they can have fulfilling careers.

Break through barriers to breach new ground in paediatric treatment and healthcare. Feed the spark of inspiration by creating an environment that supports exploration and innovation.

0034

WHAT WE WILL DO

Get me well

Fast, unfussy care delivered locally by a truly joined-up team of adjacent services, collectively focused on one thing: getting children and young people back to health with the minimum of disruption to family and homelife.

- **Develop paediatric capacity** and capability in communities through new care models to deliver care closer to home.
- **Develop community sector led models** for community resilience, providing expert-trained and peer-led local support for conditions such as bronchiolitis, healthy weight, physical activity and oral health.
- **Maximise use of technology** to deliver virtual medicine and digitally enabled models of care.
- **Build prevention** into more hospital and clinical pathways.
- **Support children, young people and families** to manage their own physical and mental health and wellbeing through technologies for self-care.
- **Support families to identify those parts of the health and care system** that best meet their needs and play our part in making this easy to navigate and joined up.

Personalise my care

For children and young people with complex or long-term needs, their care is as much a part of their lives as going to school, so it should complement homelife, not detract from it, supporting safety, independence, and control. We will cultivate a centre of excellence that recognises – and delivers – this.

- **Every child and young person** with complex and long-term needs will have a named care-coordinator to integrate their care and reduce unplanned service use.
- **Personalised, joined up approaches** for empowering families and young people with complex care needs.
- **Personalised medicine** tailored to an individuals' needs.
- **Design virtual and digitally** enabled care models that keep more children and young people at home or in school.
- **Deliver resilient joined-up specialist services** ensuring children and young people in some of the most deprived parts of the country can access world-leading services.

0035

Improve my life chances

Work as a system with partners to redraw the map of health and social care, ensuring that all children, young people and families, particularly those unfairly impacted by health inequalities, can always find the right care they need and plot a journey back to health.

- **Create employment and education opportunities** for children, young people, and our local community as an anchor institution.
- **Amplify children, young people and families' issues,** such as respiratory/clean air and obesity, through advocacy and influencing policy.
- **Co-create the collaborative health and care system** that is jointly accountable for children and young people.
- **Protect the planet** for future generations by reducing our environmental impact towards net zero.
- **Deliver measurable social valu**e to our communities.
- **More joined up, borderless care** with a much greater focus on prevention and wellbeing, delivered through strong relationships and collaborations.

Bring me the future

Nurture our instinct to break through barriers in the pursuit of 'better' for children, young people and families: better care, better medicines, better treatments… Harness the potential offered by cutting-edge health tech to deliver for children, young people and families.

- **Establish a Northern Institute of Child Health & Wellbeing,** a centre of excellence in research and innovation, which along with the Alder Hey Academy is a recognised leader in improving children and young people's health and life chances.
- **Deliver a state of the art 'healthcare anywhere' capability,** a digitally enabled, technologically enhanced hybrid of on-site and virtual clinical services, as close as possible to the everyday environment for children, young people and families.
- **Go beyond physical health,** incorporating mental health and emotional wellbeing for more holistic approaches to care in the optimum setting.
- **Personalised medicine,** integrating multi-source data and technologies to build a complete picture of each patient and individualise prevention, treatment, and care.
- **Evaluate and deploy better drugs, tests** and devices in hospital and community settings.

SUSTAINABILITY

Finance

We operate in a challenging financial environment which is likely to become only more so. We must recognise this as a fact of life and own it.

We need to embrace efficiency and choose where and on what we spend our money, wisely. We must be creative in our resourcefulness and identify new and diverse income streams that endure.

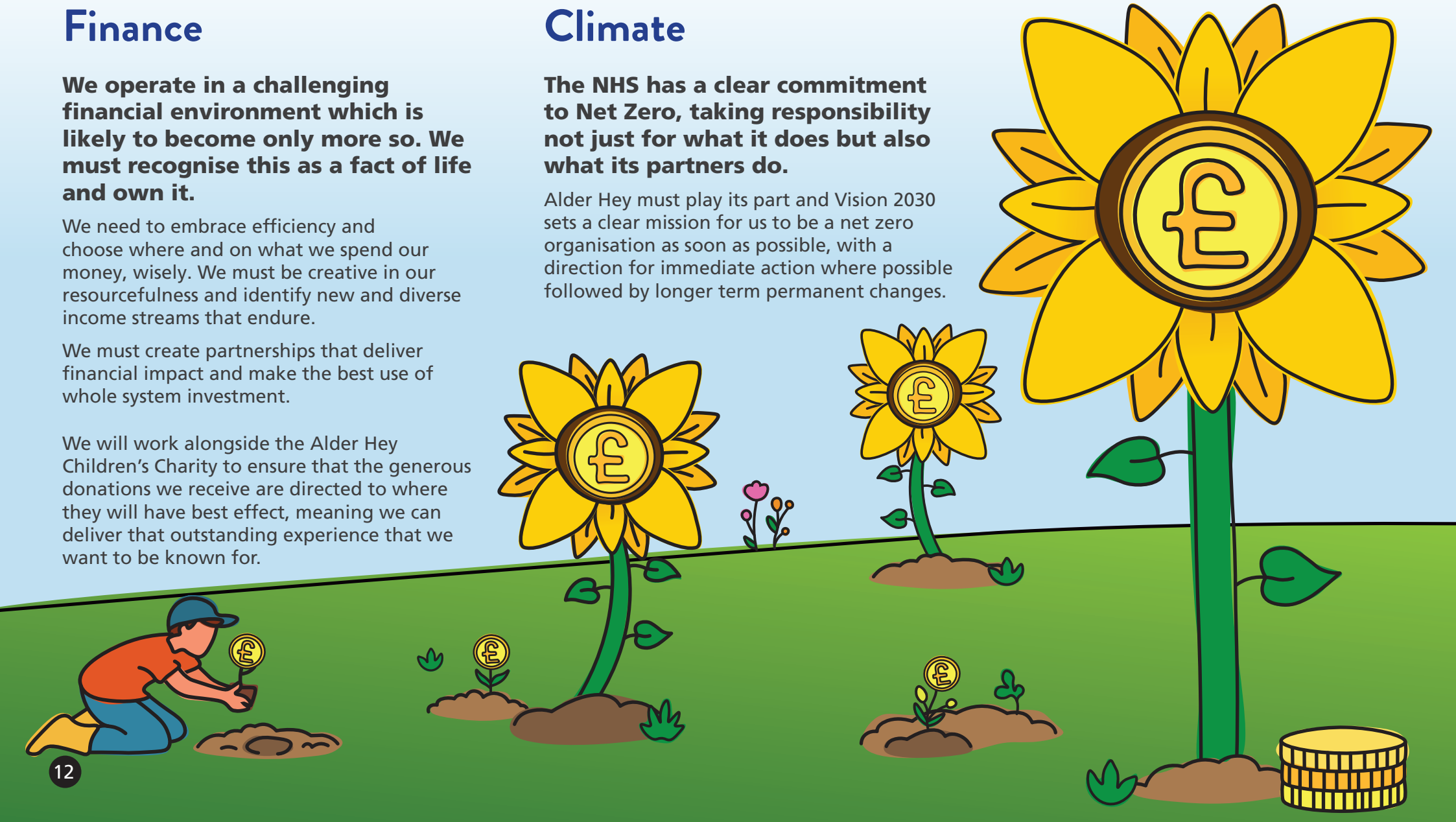
We must create partnerships that deliver financial impact and make the best use of whole system investment.

We will work alongside the Alder Hey Children's Charity to ensure that the generous donations we receive are directed to where they will have best effect, meaning we can deliver that outstanding experience that we want to be known for.

Climate

The NHS has a clear commitment to Net Zero, taking responsibility not just for what it does but also what its partners do.

Alder Hey must play its part and Vision 2030 sets a clear mission for us to be a net zero organisation as soon as possible, with a direction for immediate action where possible followed by longer term permanent changes.



WORKING IN PARTNERSHIP

Alder Hey can only truly deliver healthier, happier and fairer futures if we work alongside our partners in the communities we serve, through a collaborative health and social care system that has a shared focus on the needs of children and young people.

We have established great collaborations in communities:

- **Locally we have strong relationship**s with academic, local authority, public health, city region and voluntary sector partners.
- **In Cheshire and Merseyside,** we have established the "Beyond" Children & Young People's programme and the system architecture for children and young people.
- **In the North West** we collaborate on a paediatric partnership with Royal Manchester Children's Hospital.
- **Nationally, we play a strong role** in the Children's Hospital Alliance.
- **Globally, we deliver** mutually beneficial international health partnerships.

Our Vision 2030 reflects the strategic aims of our partners, at local, system and regional levels; it directly aligns with the Cheshire & Merseyside Health and Care Partnership strategy and Integrated Care Board's Five-Year Plan, as well as others.

Together, Alder Hey, Liverpool, Cheshire and Merseyside and the wider Northwest of England, has a great platform to tackle challenges head on.

For all of us, giving every child the best start in life is a priority.

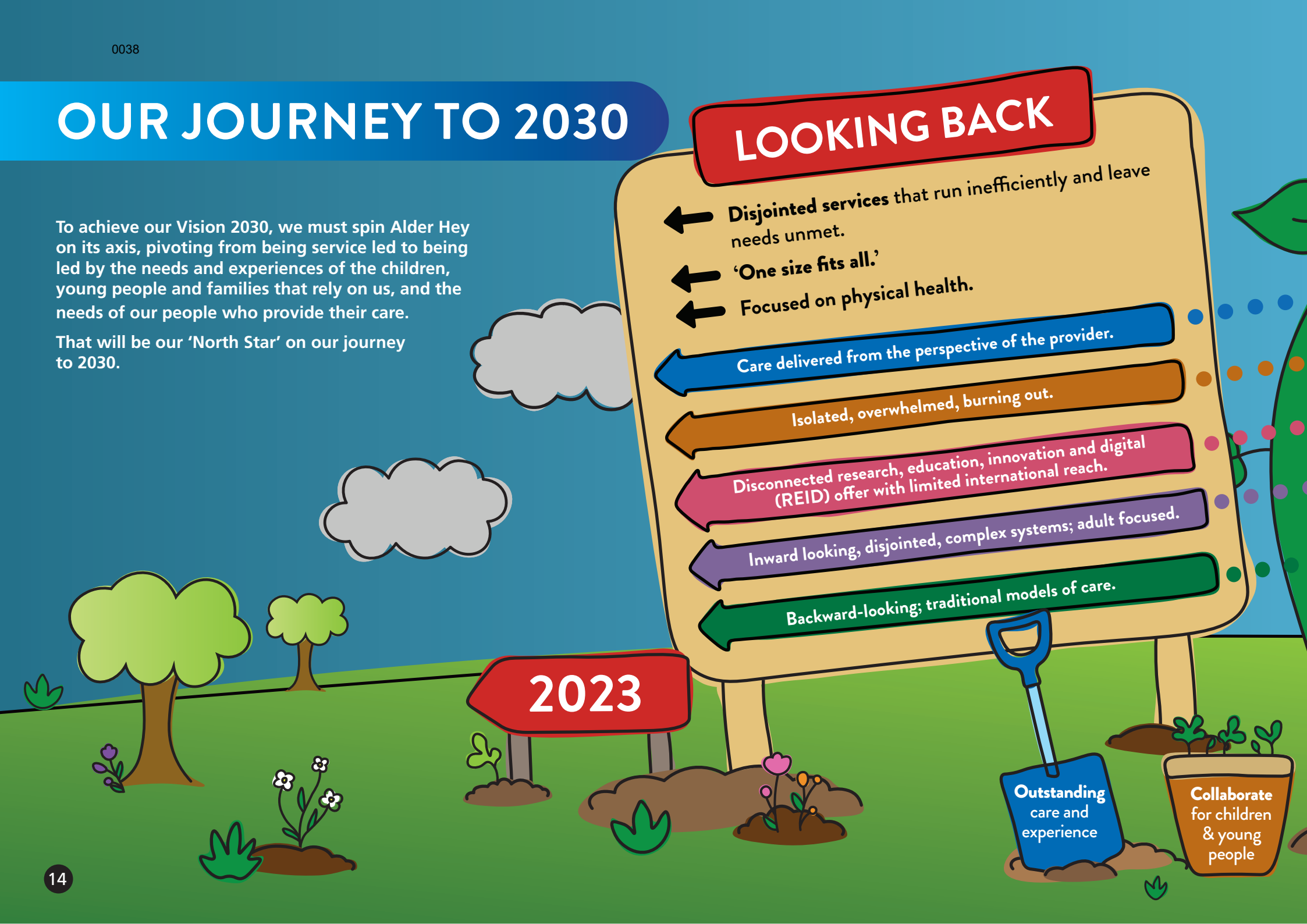
Together, in partnership, we must lead the way.

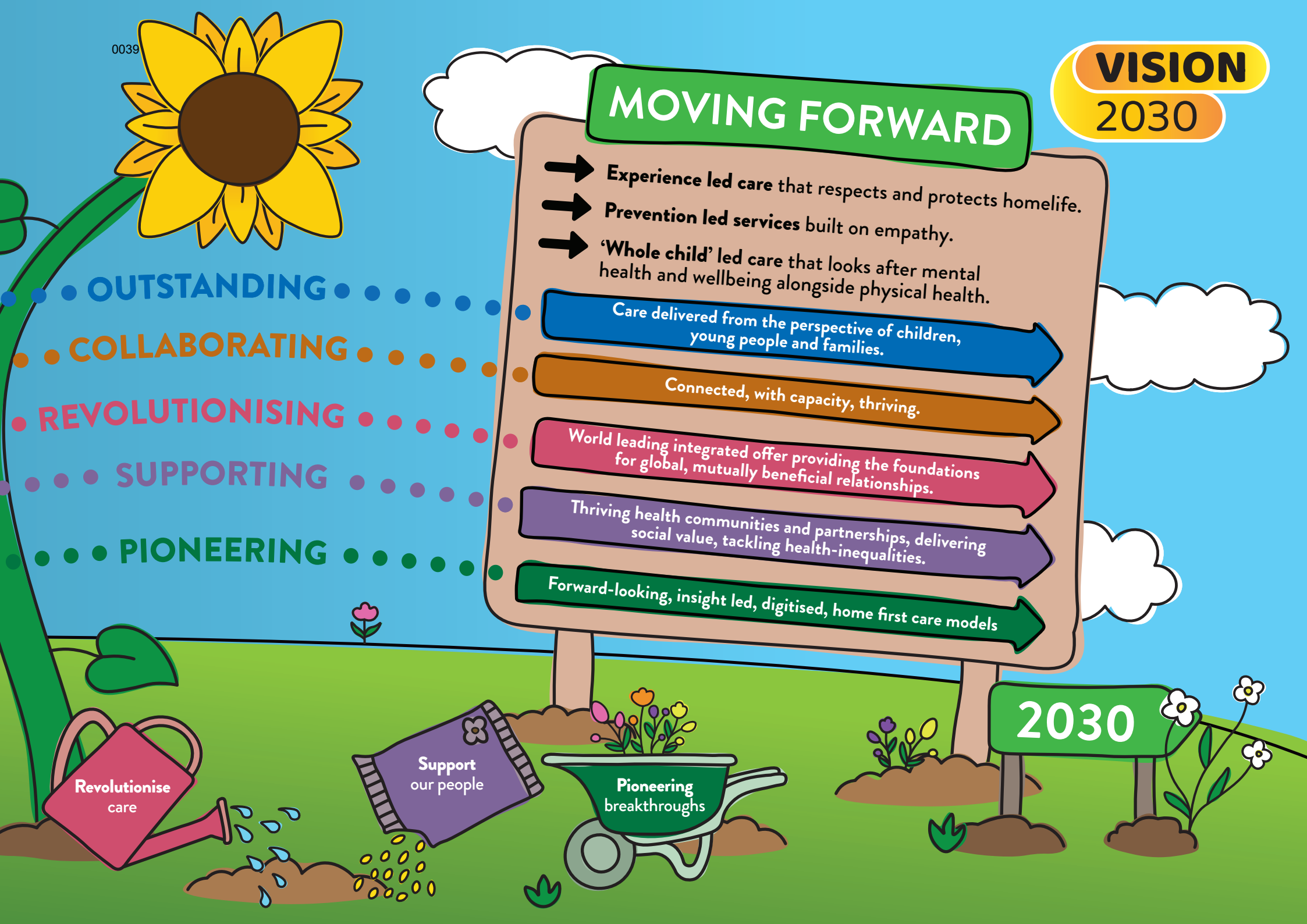
Only together, can we succeed, and deliver a future where all children and young people are able to get the best quality care regardless of who they are, where they live or their background.

OUR JOURNEY TO 2030

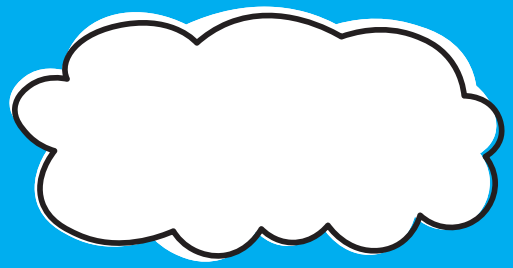
To achieve our Vision 2030, we must spin Alder Hey on its axis, pivoting from being service led to being led by the needs and experiences of the children, young people and families that rely on us, and the needs of our people who provide their care.

That will be our 'North Star' on our journey to 2030.




0039
VISION
2030
MOVING FORWARD
Experience led care that respects and protects homelife.
Prevention led services built on empathy.
'Whole child' led care that looks after mental health and wellbeing alongside physical health.
OUTSTANDING
COLLABORATING
REVOLUTIONISING
SUPPORTING
PIONEERING
Care delivered from the perspective of children, young people and families.
Connected, with capacity, thriving.
World leading integrated offer providing the foundations for global, mutually beneficial relationships.
Thriving health communities and partnerships, delivering social value, tackling health-inequalities.
Forward-looking, insight led, digitised, home first care models
Revolutionise care
Support our people
Pioneering breakthroughs
2030

0040



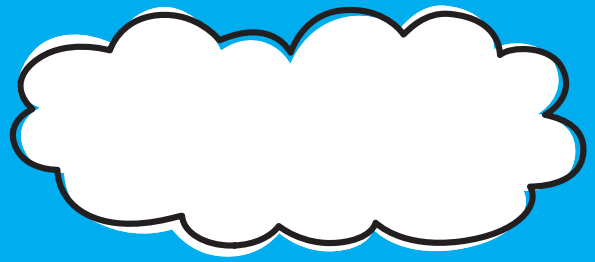
VISION 2030

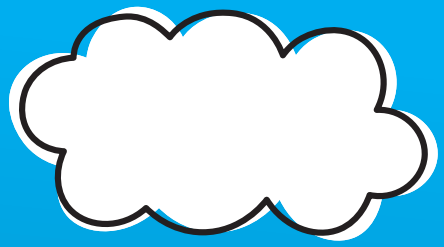
If you want to explore how we might support each other to create a healthier, happier and fairer future for children and young people, contact us at:

Vision2030@alderhey.nhs.uk

Alder Hey Children's NHS Foundation Trust,
Eaton Road, Liverpool, L12 2AP

www.alderhey.nhs.uk





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NHS Foundation Trust

Integrated Performance Report | October 2023

Alder Hey Children's NHS Foundation Trust

Flash Report -October 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for October
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0	**4**
		Number of Serious Incidents (Steis reported)	0	**0**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**1**
		FFT - % Recommending Trust	> 95%	**89.5%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Staff Turnover	*<13%*	***12.0%***
Collaborating for CYP	Handover Springfield Park to the community	Return Springfield Park to Liverpool City Council	By Nov 2023	**Completion of the majority of works Dec '23 with final installations and completion scheduled for end Mar '24**
Smartest ways of Working	Improve Access to Care and Reduce Waiting Times	ED: % treated within 4 Hours	> 76%	**69.5%**
		Number of RTT Patients waiting >65weeks	0	**236**
		Number of ASD & ADHD Patients waiting >65weeks	0	**Not Available : AlderCare**
		Elective Recovery (Vol)	> 106%	**102%**
		Diagnostic Performance	> 90%	**Not Available : AlderCare**
	Financial sustainability	Revenue position – Year End forecast	12.3m Surplus	**£12.3m surplus**
	Aldercare optimisation	Optimisation of Aldercare	TBC	**Optimisation programme has been scoped and is being initiated**

Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary

Published 7 November 2023

Strategic Goals	2023-24 Operational Priorities	Progress in October 2023	Areas of challenge
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• Launch of our CYP promises • Working group commenced to implement Martha's Rule • Agreed approach to maintain our food offer to families as part of Sophie Legacy	• Change in categorisation of pressure ulcers may lead to an increase in grade 3. 4 • Increase in incidents with minor harm
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Thriving Leaders management essentials programme, development of first draft • Needs based Health and Wellbeing approach is now Business as usual • Senior operational group meeting identified interdependencies and priority areas of focus	• Capacity and resource remains a challenge due to business case still not agreed.
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• Research strategy on track to be finalised at Jan R&I Committee • MRI business case submitted • Contract signed for £1.8m NIHR award for Dan Perry (Operative or Non-Surgical Treatment of Perthes' Disease)	• Reduced commercial income due fewer trials commencing in Q1 and 2 influenced by national landscape • Reduced clinical support service capacity for clinical trials • Increased financial challenge in CRD due to increased LHP subscription
Collaborating for CYP	**4. Handover Springfield Park to our community**	• Preparations for lighting completed in existing Park • Installation of Infant & Junior Playgrounds progressing well • Plans progressing for tree pits, natural play areas and sowing of grass for sports pitches.	• Areas of residual trust infrastructure works that are blocking full possession for the park Contractor. • Anti-social behaviour including trespass and graffiti on new play equipment. • Liverpool City Council taking over areas that are now out of the 2-year maintenance period.
Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Diagnostic and cancer access remains good • Activity levels have recovered in October with elective activity at 102% of 19-20 levels (up from 85% in September)	• High level of demand in ED and service gaps leading to 70% of C&YP being seen within 4 hours. Action: source additional urgent care capacity and review surgery emergency pathways.

			• Increase in RTT patients waiting over 65 weeks for treatment: 236 patients. Action: continue with in-sourcing to deliver zero patients waiting over 65 weeks by March 2024. • Theatre sessions reduced to support staff wellbeing. • Improvement plan is being progressed in response to high demand force for ASD / ADHD pathways
Smartest ways of Working	**6. Financial sustainability**	• Reporting an in-month surplus of £1.5m in October (M7) and a £25k surplus YTD. This is in line with plan. • Industrial action • Benefits being assessed on strategic initiatives and wider change programmes. • CIP static in year with gap remaining at £2.2m in year and significant £10.4m recurrent gap.	• Only 42% of CIP has been identified as recurrent which means £10.4m will be carried into 24-25 which is unsustainable. • Ongoing action including cost control within divisions and manage pressure where possible with non-recurrent mitigations, risk to delivery in remaining months of the year. • Challenges with activity reporting impacted by implementation of Alder care as well as industrial action impact.
Smartest ways of Working	**7. Safely deploy Alder C@re**	• Aldercare deployed in September • Strategic command remains in place as part of post go live stabilisation, to be stood down in November, tracking resolution of issues in relation to Booking and Scheduling, Reporting and Theatres • Optimisation programme scoped and due to commence in November	• Resolving outstanding post go live issues

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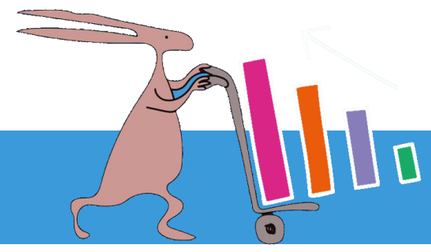
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: October 2023



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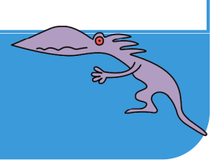


Icon Definitions

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

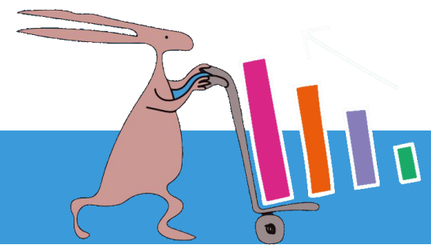
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

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



IPR Summary

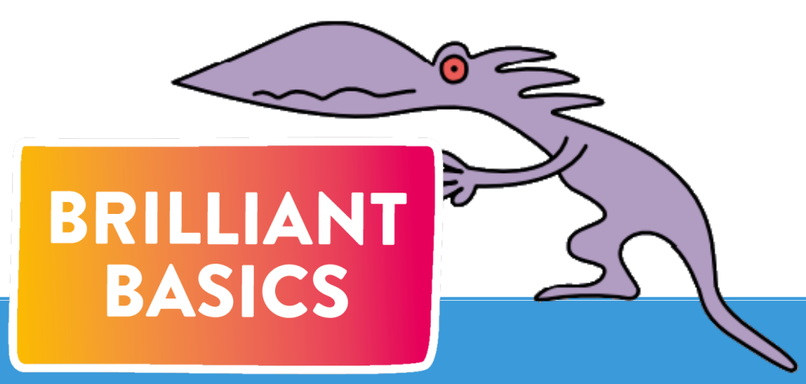
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Cancer 2-week referrals & C.Difficile demonstrates performance is consistently achieving target with an improving trend	A&E performance, F&F Recommend the Trust, Mandatory training, ED Sepsis, Deteriorating inpatients, Level 1 patient safety training are inconsistently achieving target with an improving trend	Staff Turnover, Diagnostics, CAMHS >52 wks, Long Term Sickness and ED F&F are not achieving targets but demonstrating improvement
	Common Cause	Cancer and MRSA metrics are achieving targets	Never Events, Complaints & PALs, IP Sepsis, EL/DC/OP Recovery, Cancelled Operations, WNB, Sickness, stranded patients, PDRs & ERF are inconsistently achieving target and are yet to evidence statistical improvement	RTT >65 Weeks, Theatre Utilisation, Clinic Letters completed, Medical Appraisal, are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern			>65 Wk waits ASD/ADHD are not achieving targets with a declining trend

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

- 15.9% of our metrics are consistently achieving target
- 63.6% of our metrics are inconsistently achieving target
- We are not achieving the target for 20.5% of our metrics but experiencing improvement in 4 of these metrics.

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



Unrivalled Experience - Safety

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

Highlights:

ED compliance with administration of antibiotics achieved 93% in month following targeted improvement work. No MRSA, MSSA or C diff HAIs; no MRSA HAI reported for 17 months

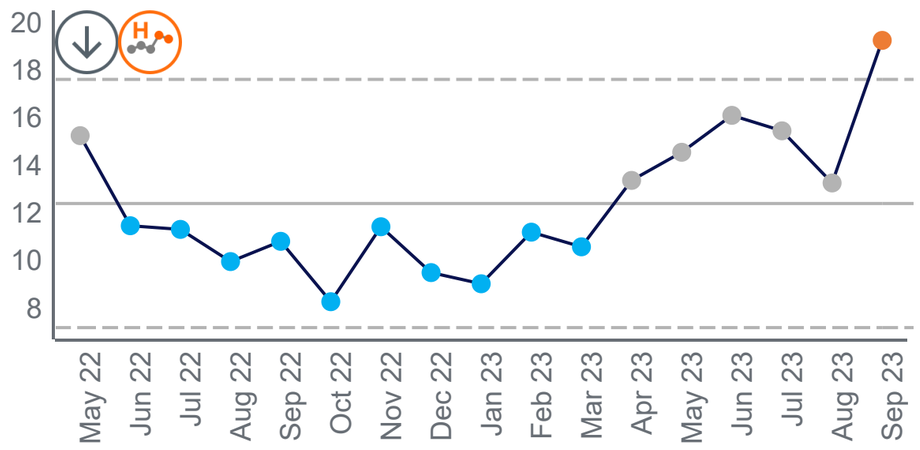
Areas of Concern:

One serious incident Never Event reported to Steis; regulatory requirements relating to Duty of Candour and 72 hour review met. High number of restrictive interventions continues however clear therapeutic plans in place

Forward Look (with actions)

Continued focus on consistently administering antibiotics within 60 minutes on ED and wards for sepsis

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



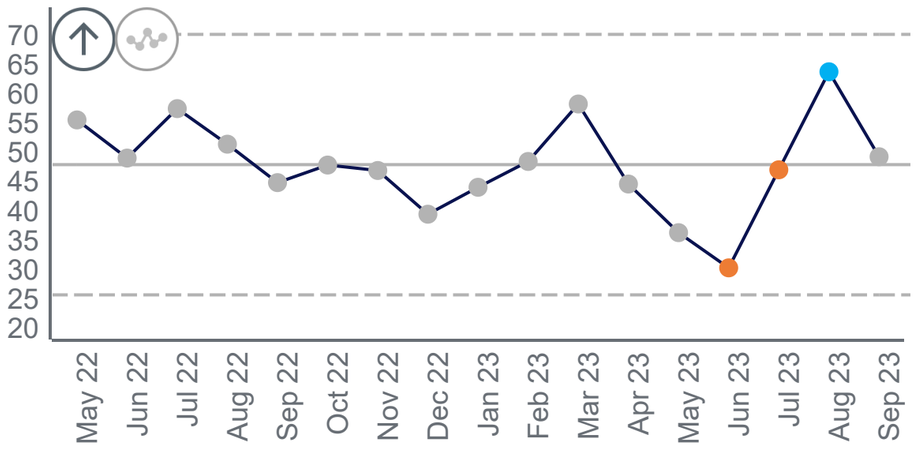
Technical Analysis:

Special cause variation has been observed in rate of harm per 1,000 bed days which also mirrors increase in Incidents of Harm increasing in month with 152 occurring in September 2023 compared to 100 in August 2023. Rates currently assessed on Physical Harm only.

Actions:

Whilst the number of incidents resulting in harm has increased this is in line with the higher number of incidents reported overall in month; continue to engender a culture of reporting. It also represents better recording of incidents, for example where a repeat blood test is required this is now captured as minor harm due to repeated procedure. The updated LFPSE tool includes some incidents as harm which may previously not have been included.

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



Technical Analysis:

Reduction in rate of no harm incidents per 1,000 bed day which correlates with volume of no harm incidents decreasing with September 2023 having 423 no harm incidents compared to 500 in August 2023. Rates currently assessed on Physical Harm only.

Actions:

Continue to encourage reporting of all incidents including no harm and near miss in order to learn from these incidents, and identify action to be taken to minimise the risk of a higher level of harm from a similar incident in the future

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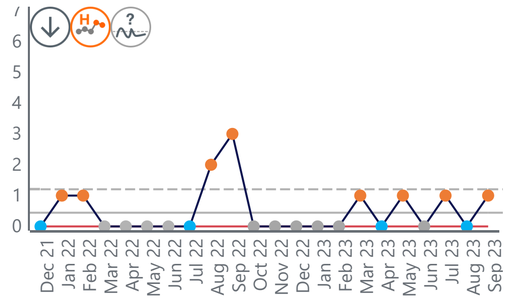
Integrated Performance Report | October 2023

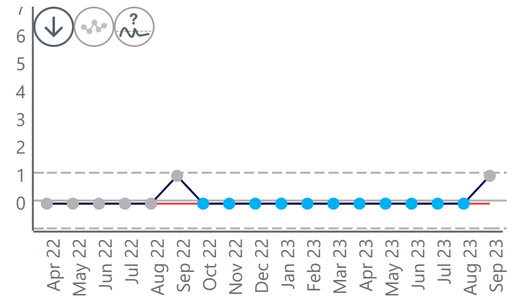
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

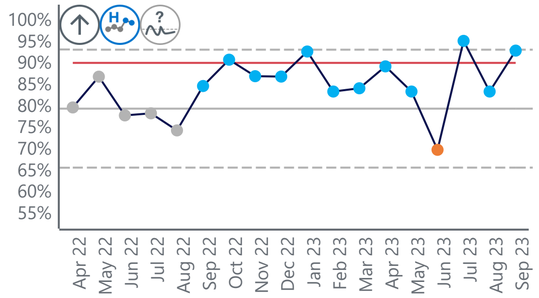
Number of Serious Incidents (Steis reported)



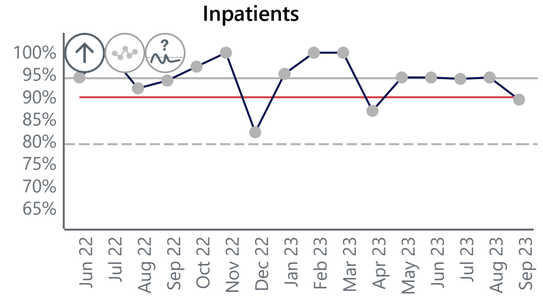
Number of Never Events



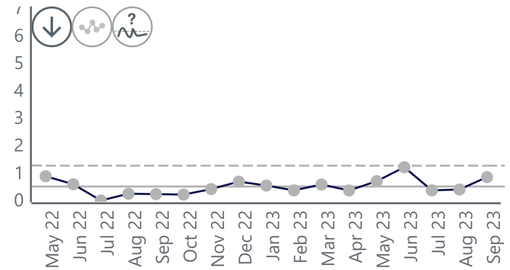
Sepsis % Patients receiving antibiotic within 60 mins for ED



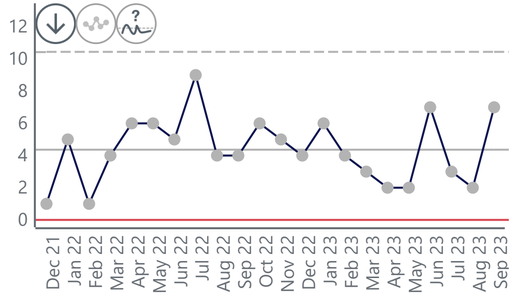
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



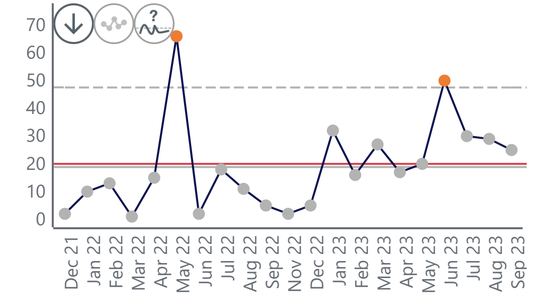
Medication Errors rated Minor harm and above per 1,000 bed days



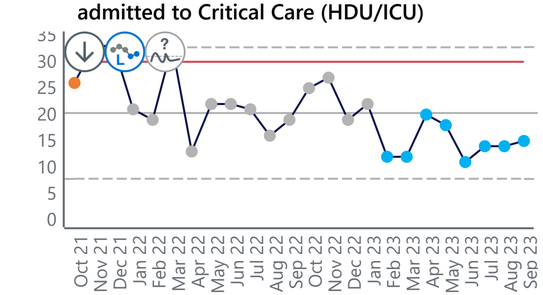
Pressure Ulcers G2-4



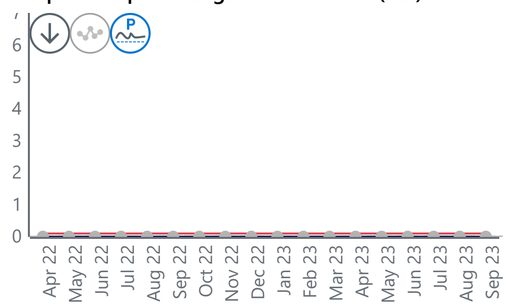
Use of physical restrictive intervention



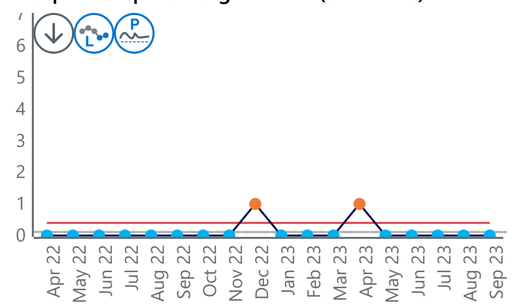
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



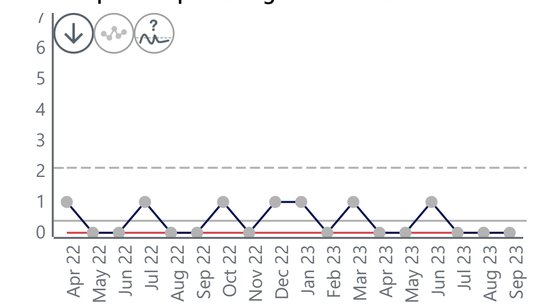
Hospital Acquired Organisms - MRSA (BSI)



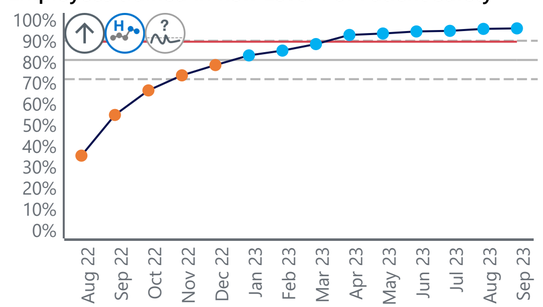
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Unrivalled Experience - Caring

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

Highlights:

Continued upward trajectory with 96% of families who responded telling us they would recommend the Trust and 93% of families in ED; ED has seen a steady and sustained improvement in the last 5 months following targeted work

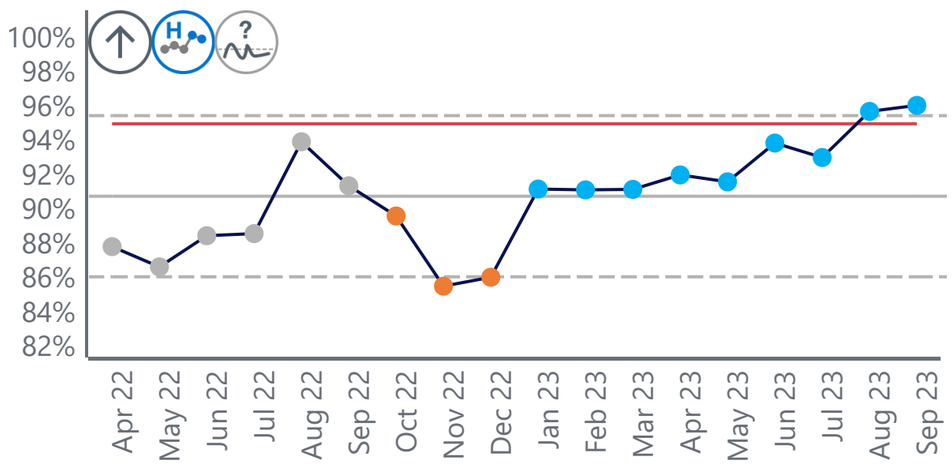
Areas of Concern:

High number of PALS in month but low number of formal complaints which is positive

Forward Look (with actions)

Improve compliance with PALS and complaints responses – strive for 100% compliance

F&F Test - % Recommend the Trust



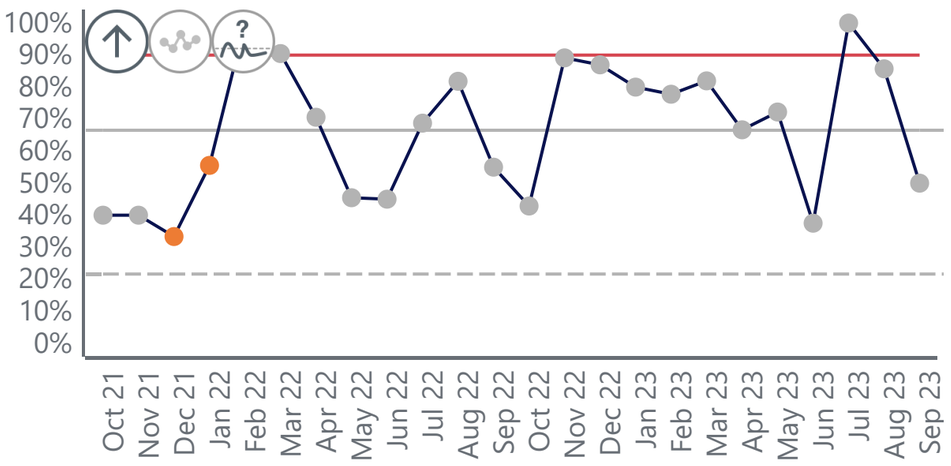
Technical Analysis:

Consistently not achieving the 95% target although Special cause variation has been observed. Performance of 96% represents a 9th consecutive month above the 12 month average of 91%. August and September 2023 being first months above target in 18 months.

Actions:

Continued upward trajectory with 96% of families who responded telling us they would recommend the Trust

% Complaints Responded to within 25 working days



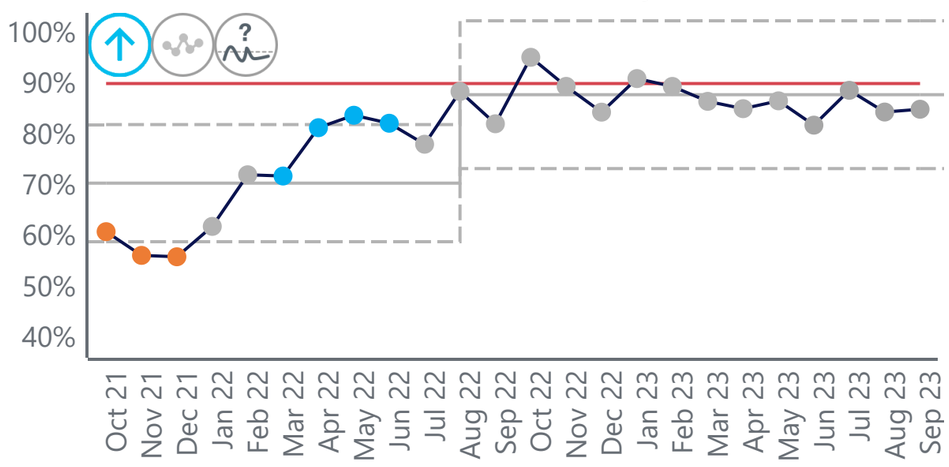
Technical Analysis:

Inconsistently achieving the 90% target with an average of 67% which shows significant fluctuation from month to month. Performance in September 2023 was 50%

Actions:

Deep dive into current complaint compliance with Divisions to be undertaken

% PALS Resolved within 5 Days



Technical Analysis:

Common cause variation has been observed with a 12 month average of 88%. Inconsistently achieving the 90% target. September 2023 performance was 85%.

Actions:

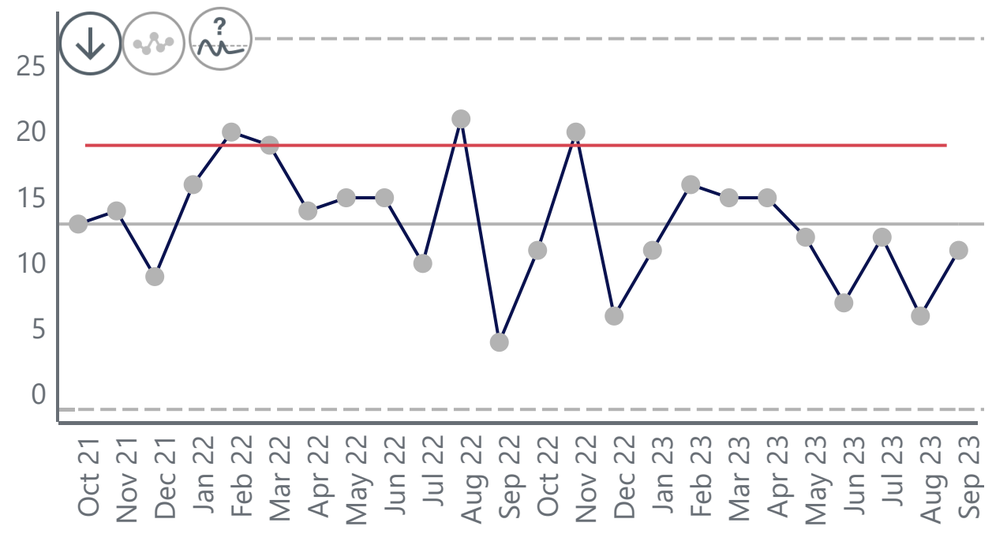
Continue the high performance achieved during the last year and endeavour to resolve all PALS concerns within 5 days

Integrated Performance Report | October 2023

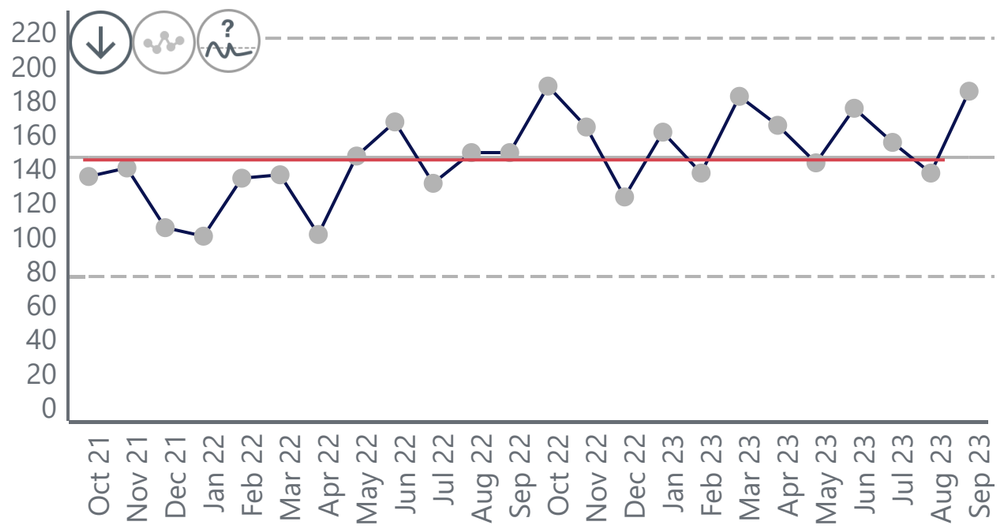
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

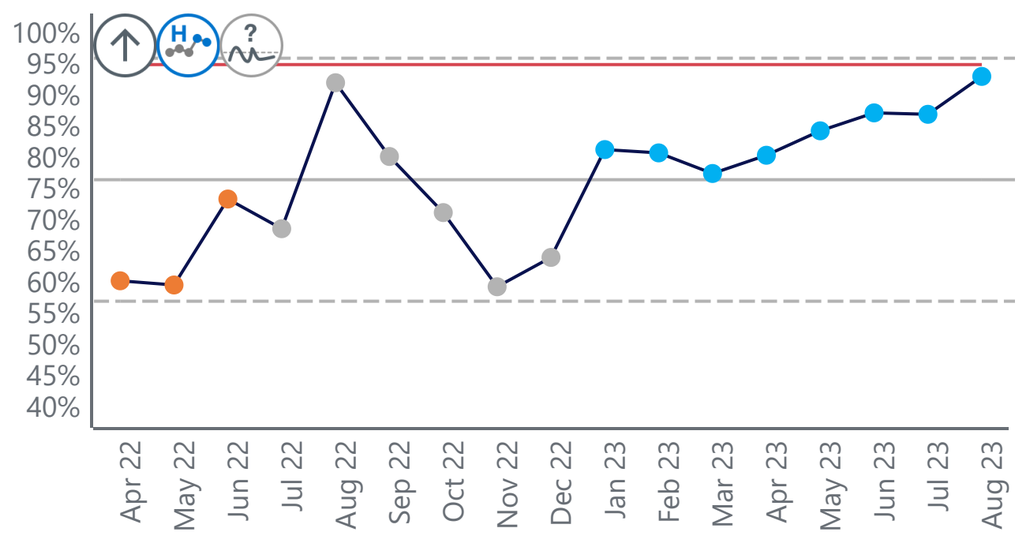
Number of formal complaints received



Number of PALS contacts



F&F ED - % Recommend the Trust



Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

4 Hour Performance in ED remains above national standard despite a challenging month in Sept with Alder Care deployment, Industrial Action and surge in attendances

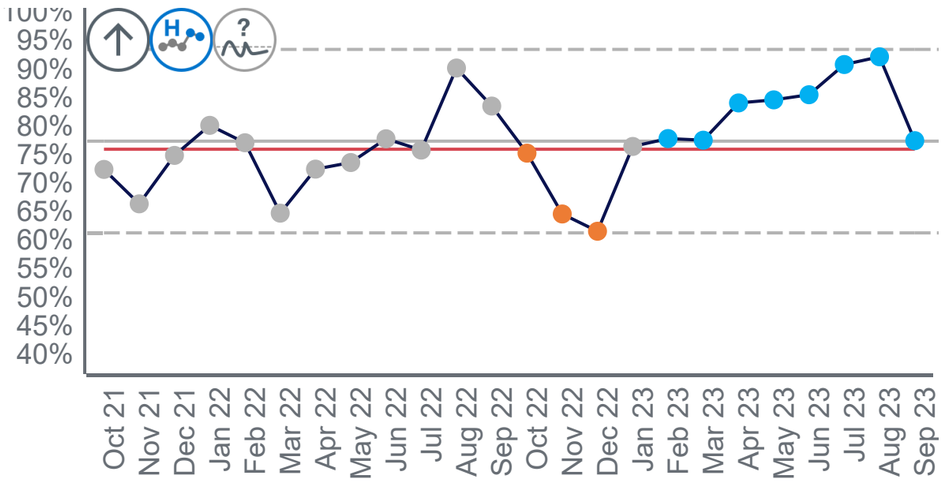
Areas of Concern:

Dip in ED performance down to 76% - although this is still above target the step down from summer months to Sep is a concern. WNB rate not demonstrating sustained improvement to date.

Forward Look (with actions)

Support for ED performance through winter remains a top priority, with key improvement actions in place (see below). New WNB improvement plan produced using Brilliant Basics methodlogy. Timeline for reports back on line (Alder Care deployment) will ensure up to date data for full suite of metrics by end of October.

ED: % Treated within 4 Hours



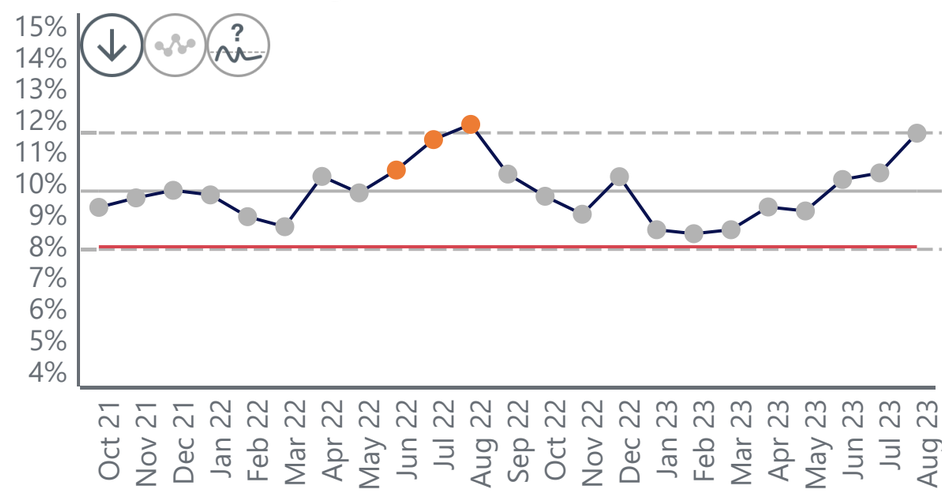
Technical Analysis:

Special cause variation has been observed showing sustained improvement, with 8 points above the mean. The Trust has achieved the national target (>76%) for the past 9 months, with September at 78% impacted by Alder and Industrial Action.

Actions:

• Increase urgent care centre capacity through GP partnerships and new Advanced Care Practitioner shifts • Start Acute Respiratory Infection Hub clinics • ED Consultant winter rota with additional evening and weekend cover • Analysis of PAU pilot • Increased clinical cover in ED overnight • Revised ED escalation agreed and published – Oct23

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



Technical Analysis:

WNB rates demonstrates common cause variation. Performance in August 2023 of 11.6% is the highest rate since August 2022 (11.9%) which identifies seasonality impact of summer school holidays.

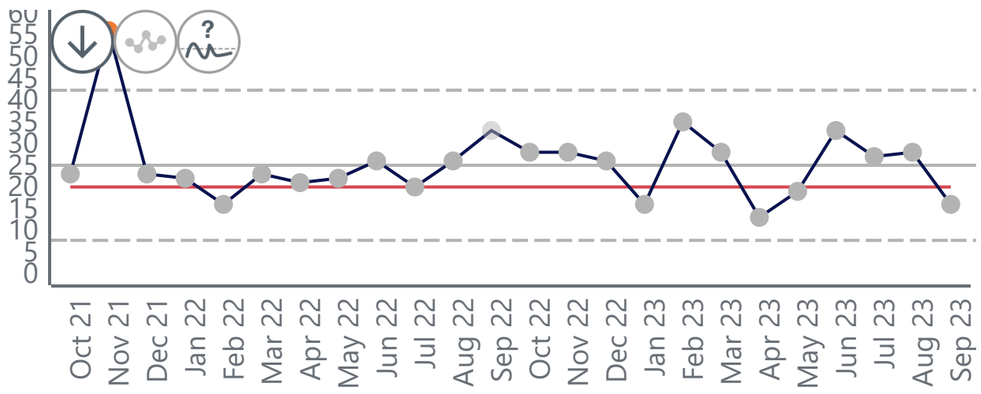
Actions:

• Specialty-level review of outpatient model and booking process where WNB is greater than 10% • WNB reminder calls expanded to include ADHD and mental health services • Alder Care Optimisation opportunities include relaunch of PDS demographic software, review of automated letter systems and improvements to the bi-directional text process

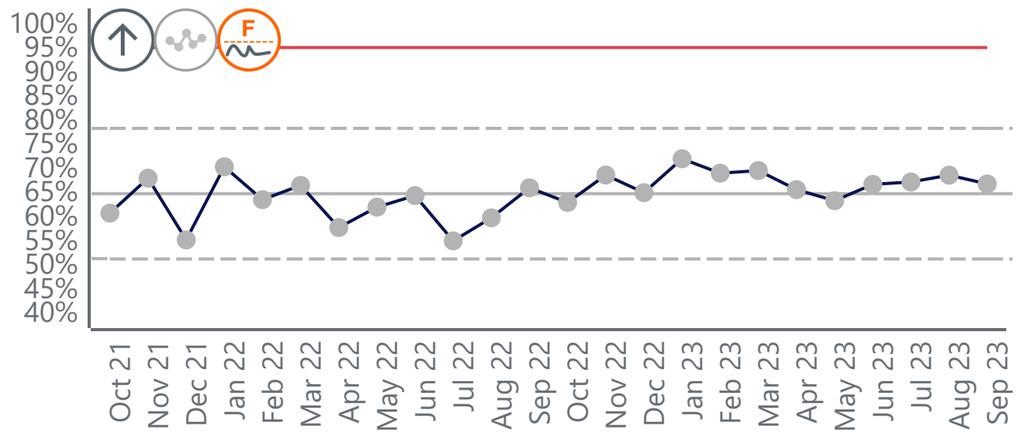
Integrated Performance Report | October 2023

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

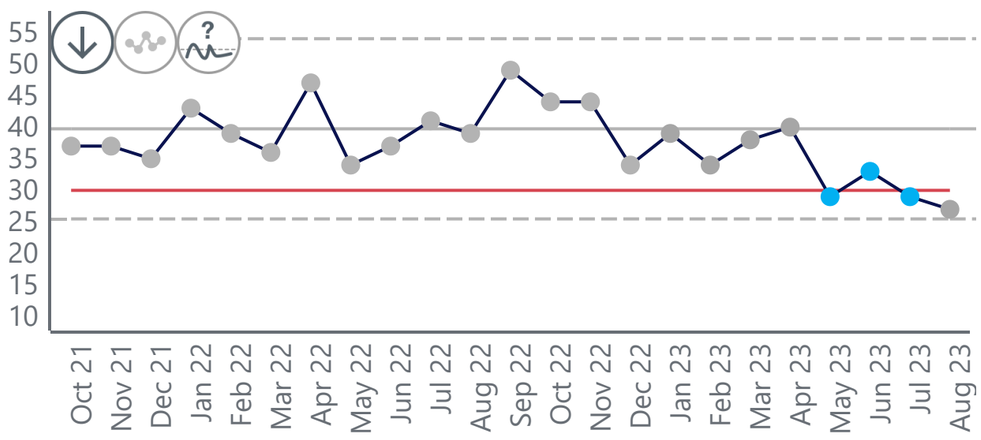
Number of Cancelled Operations (on day of admission for a non-clinical reason)



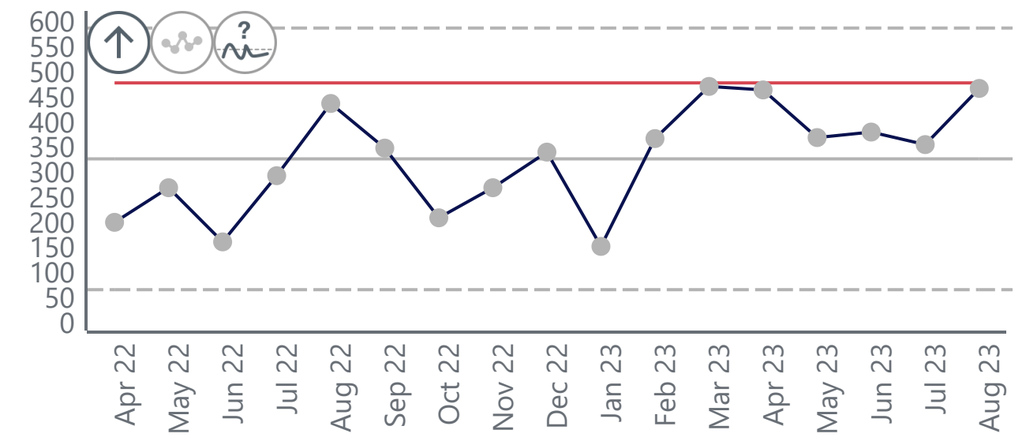
% of Clinical Letters completed within 10 Days



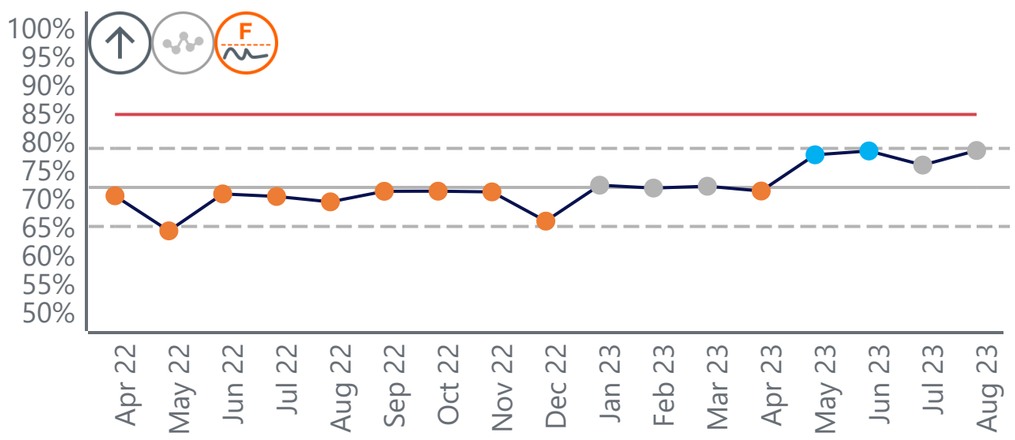
Number of Super Stranded Patients (21 days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• Good activity levels (DC&IP 85%) in the context of Alder Care deployment and Industrial Action • Successfully eliminated waits of >52weeks in CAMHS • 100% compliance for access to cancer services, exceeding national standards • Sustained improvement access to in Diagnostic pathways (DM01)

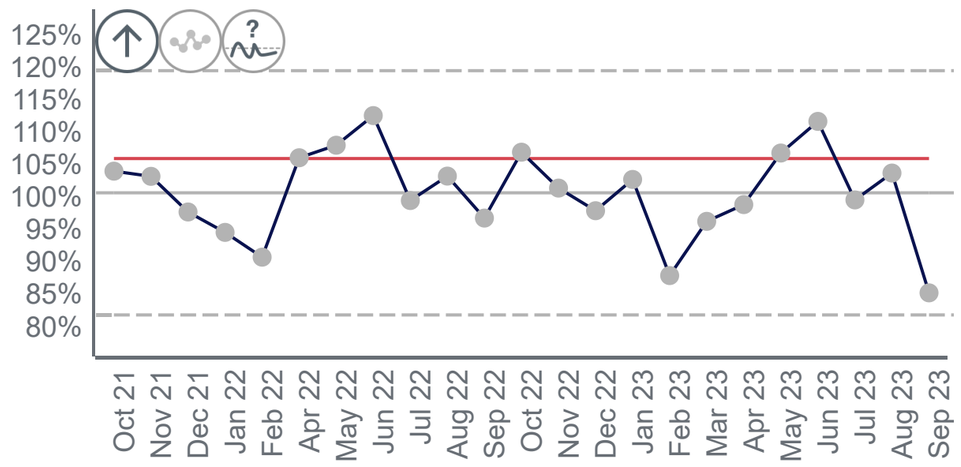
Areas of Concern:

• Ongoing Industrial Action reducing capacity for elective care • Increased number of children and young people waiting greater than 65 weeks in ENT and Dental (RTT) • Growing pressure on waiting times >65 weeks in ASD / ADHD pathways • Global shortage of ADHD medication • Demand and waiting times for Initial Health Assessments (IHAs) in Community Paediatrics

Forward Look (with actions)

Theatre activity down to 130 sessions per week to ensure sustainability and staff wellbeing through Oct-Feb – but ENT, Dental, Spinal capacity is protected. Focus on productivity and increased patients per list in Day Case to drive Recovery. ASD and ADHD improvement plans with investment in clinical, admin and project management roles.

% Recovery for DC & Elec Activity Volume



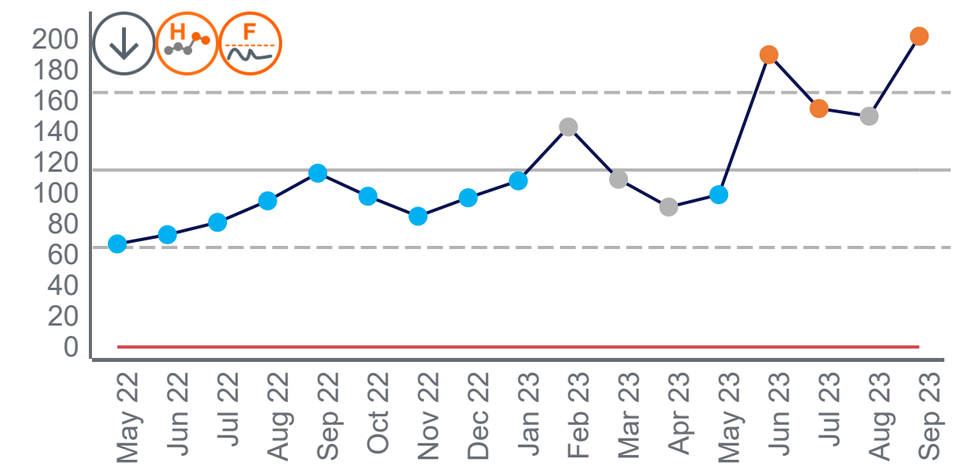
Technical Analysis:

September performance of 85% is a provisional figure due to AlderCare impact on reporting. In September we had planned for up to 24% reduction in activity due to AlderCare deployment, and also experienced 5 days of Industrial Action, so in this context 85% Recovery was good performance in month. The data series continues to demonstrate common cause variation.

Actions:

Theatre activity to be managed down to 130 sessions per week (previously 145) to ensure sustainability and staff wellbeing through Oct-Feb, but with greater focus on productivity and increased patients per list in Day Case Theatre, to drive Recovery volume

Number of RTT Patients waiting >65 weeks



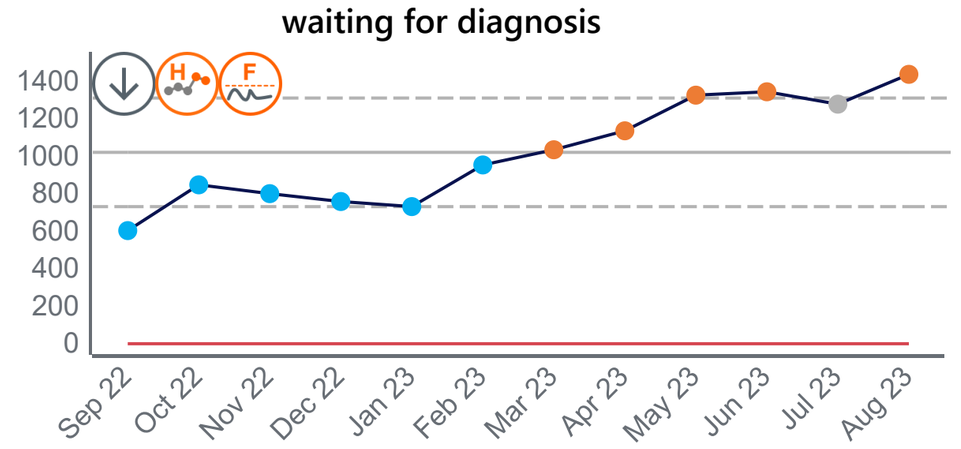
Technical Analysis:

Number of patients waiting > 65 weeks has increased in to 202 in September (150 in August). The current trend is showing special cause variation with an increase in breaches over the last 4 months. Dentistry (n=70) and ENT (n=125) make up 96% of the Trust total.

Actions:

ENT, Dental and Spinal theatre capacity will be protected in revised theatre schedule. Local action plans continue optimisation through Insourcing model

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



Technical Analysis:

On average 1020 patients are waiting for an ASD or ADHD diagnosis per month. August shows 1436 patients which is above the outer control limits, now showing special cause varation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

Actions:

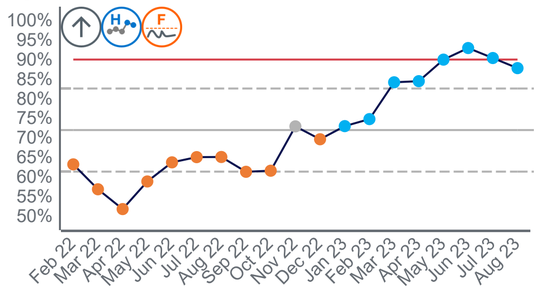
Improvement programme in place for both ASD and ADHD with: dedicated project manager support, temporary funding for clinical and admin posts, introduction of Clinical Associate in Psychology role into ASD, to mitigate gap of qualified clinical psychologists. Daily huddles in place to mitigate impact of global shortage of ADHD medication.

Integrated Performance Report | October 2023

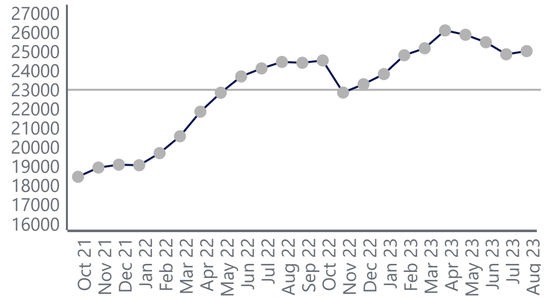
NHS
Alder Hey Children's
NHS Foundation Trust

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

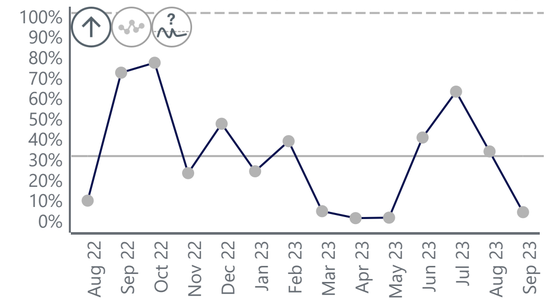
Diagnostics: % Completed Within 6 Weeks of referral



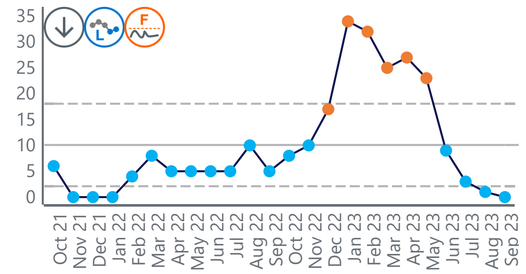
Waiting List Size



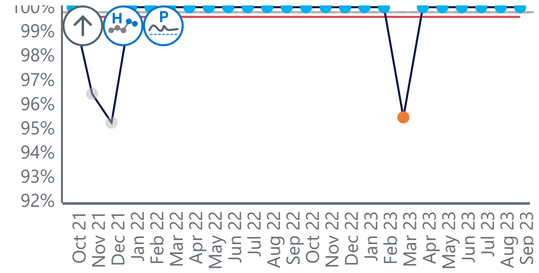
IHA: % complete within 20 days of referral to Alder Hey



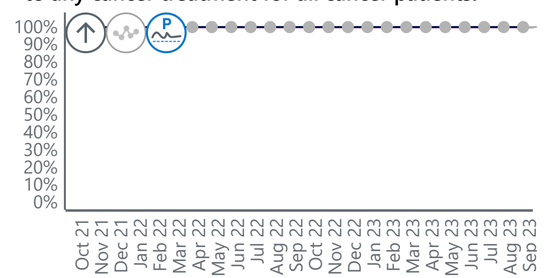
CAMHS: Number of children & young people waiting >52weeks



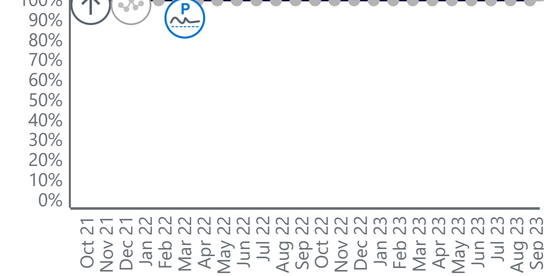
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



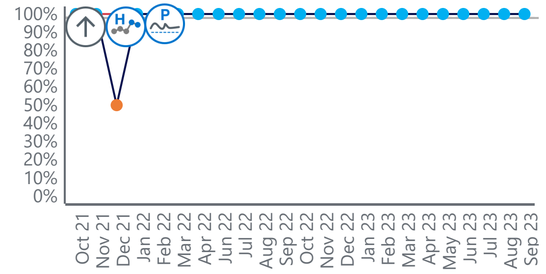
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



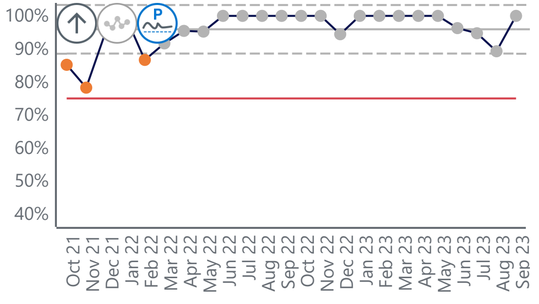
All Cancers: 31 day wait until subsequent treatments



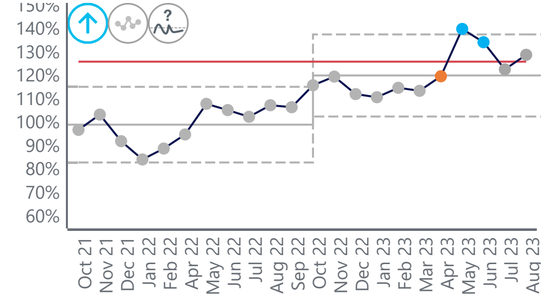
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Integrated Performance Report | October 2023

Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

Sustained reduction in staff turnover. Opportunities to scrutinise detail within each division to improve further. Improved activities within Divisions to tackle Long Term Sickness (LTS)

Areas of Concern:

Overall sickness absence 5.33%. Reduction is sustained but requires consistent, ongoing attention if staff availability position is to be improved. 90% PDR compliance reduced to 70% over summer. Potential to drop again over the winter. Attention needed to encourage quality conversations, including staying, health & wellbeing now included in process.

Forward Look (with actions)

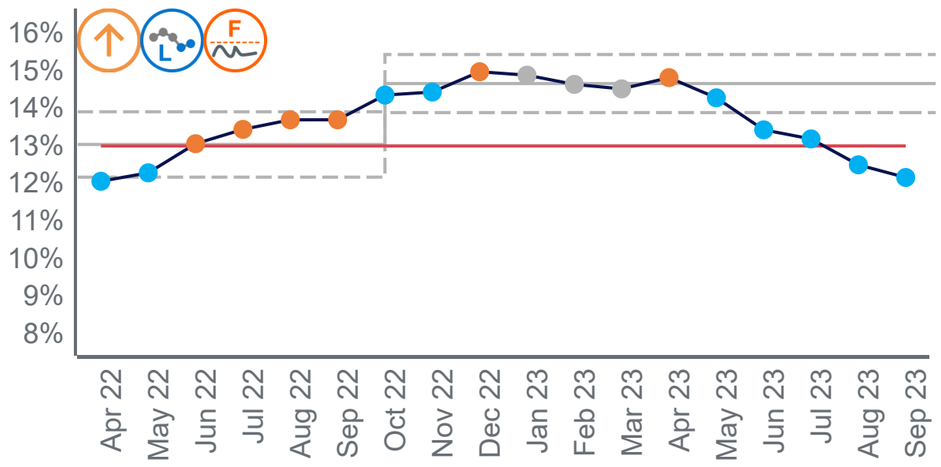
Anticipating increase in sickness absence, over the winter period as per trend of previous years. Ongoing presence around absence support/advice for Division managers. Sickness policy review, implementation & training are being developed. New resignation & exit interview online process to be trialled to capture qualitative data. Review data on PDR completions per division for ongoing action.

Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

Staff Turnover



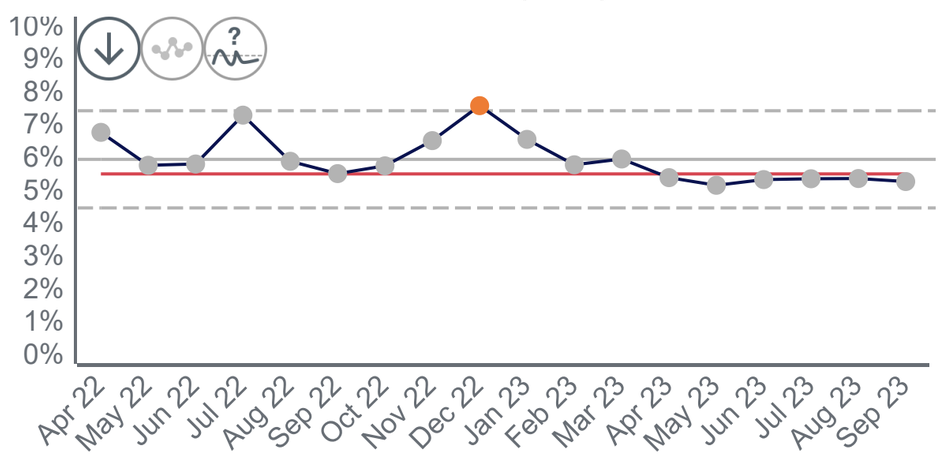
Technical Analysis:

Staff Turnover has demonstrated special cause varation, 12.2% is the 6th consecutive month with a reduction and 2nd consecutive month within target since May-22. This should continue to be monitored as high levels of staff turnover can create substantial risk for the Trust but this signals improvement.

Actions:

Relative threshold for measuring overall turnover adjusted to 13%. Turnover reduced at 12.2%, comparing favourably to 28.9% across the UK Healthcare sector (CIPD 2021). Improved Leaver details online monitoring within divisions to identify exit patterns & workforce impact.

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in September is 5.33% which is in line with the 5.5% target. A slight decrease from August at 5.36%. September performance comprises STS at 2.06% and LTS at 3.27%. Still demonstrating common cause variation however 6th consecutive month below the target.

Actions:

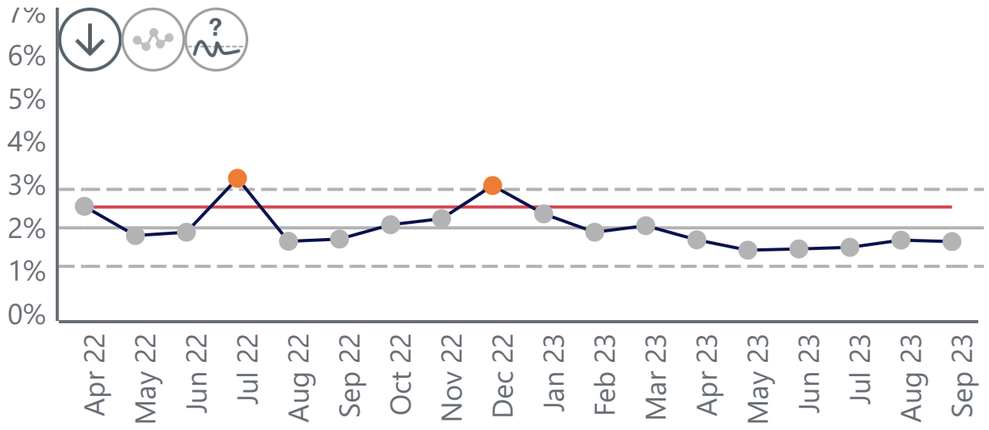
Onsite discussions and "listening" activities in Divisions; focus on Stage 3 LTS, resulting in returns or resignations. Return to Work discussions to be reinvigorated. Proactive winter vaccine programme (flu/covid) onsite now. Policy review anticipated early 2024.

Integrated Performance Report | October 2023

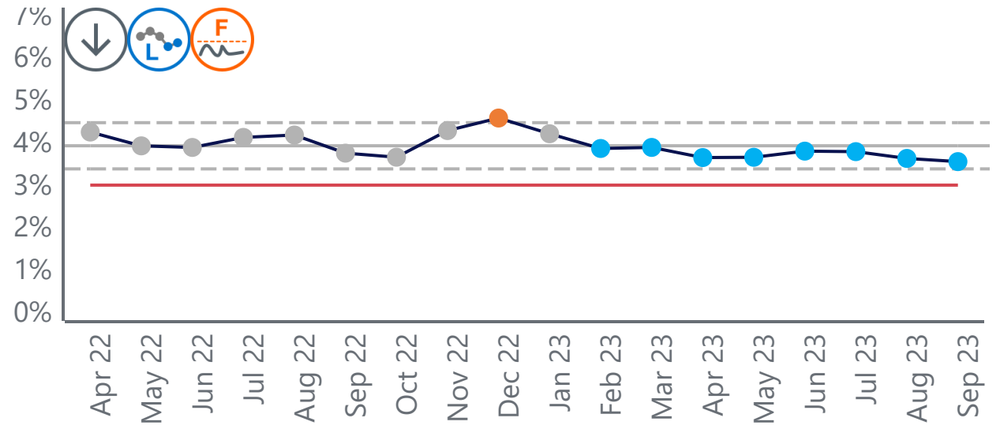
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

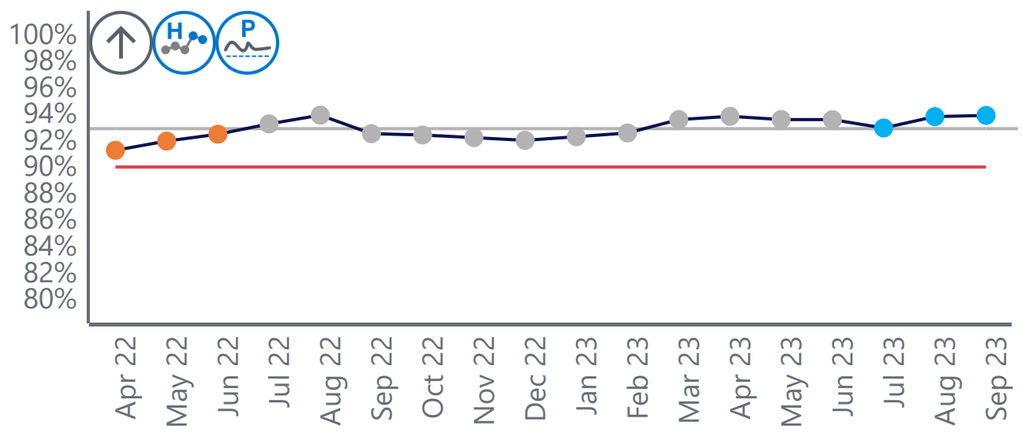
Short Term Sickness



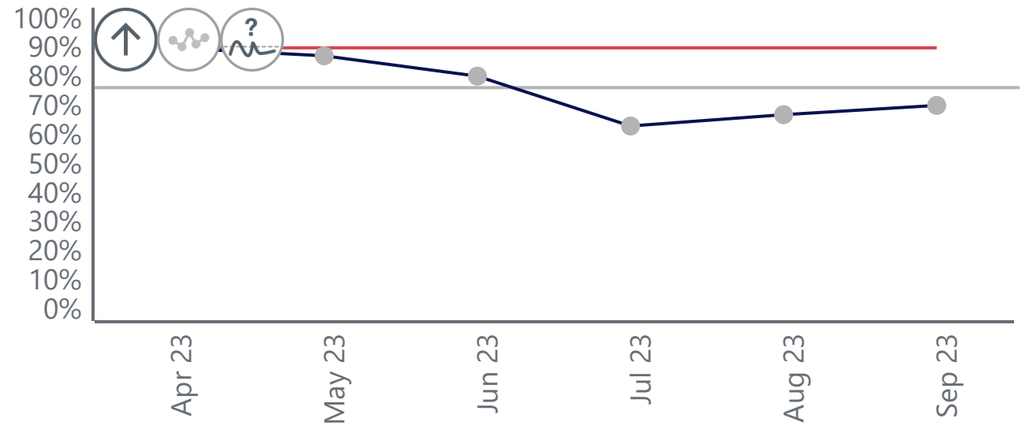
Long Term Sickness



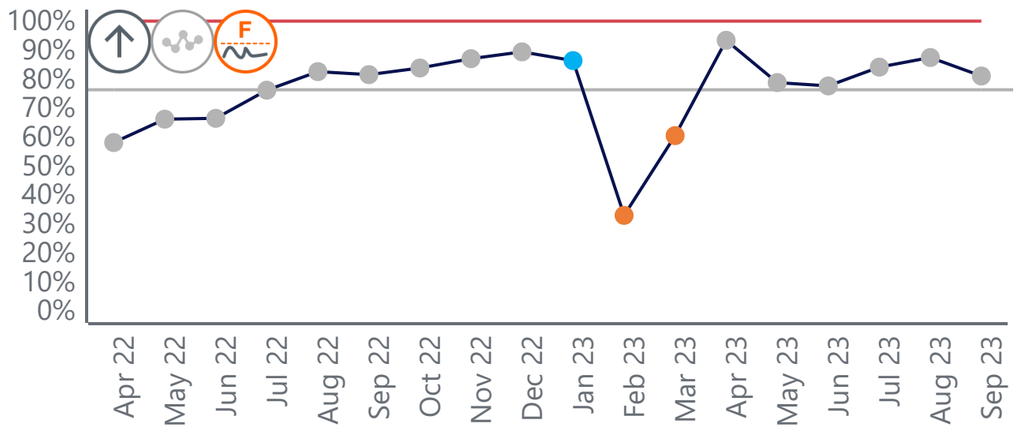
Mandatory Training



% PDRs Completed (Rolling 12 Months)



Medical Appraisal



Staff movement / Churn rate - In Development

Integrated Performance Report | October 2023

Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

In M6 the Trust is reporting a £14k surplus (£1.5m deficit ytd) which is in line plan. Forecasting to achieve £12.3m surplus subject to CIP risk & activity levels. CIP £1.0m behind plan ytd. Overall £10.7m CIP has been transacted with £4.9m in progress. Gap of £2.1m relating to trust wide transformation & transactional schemes. Cash has remained high in line with plan & capital in line with expectations.

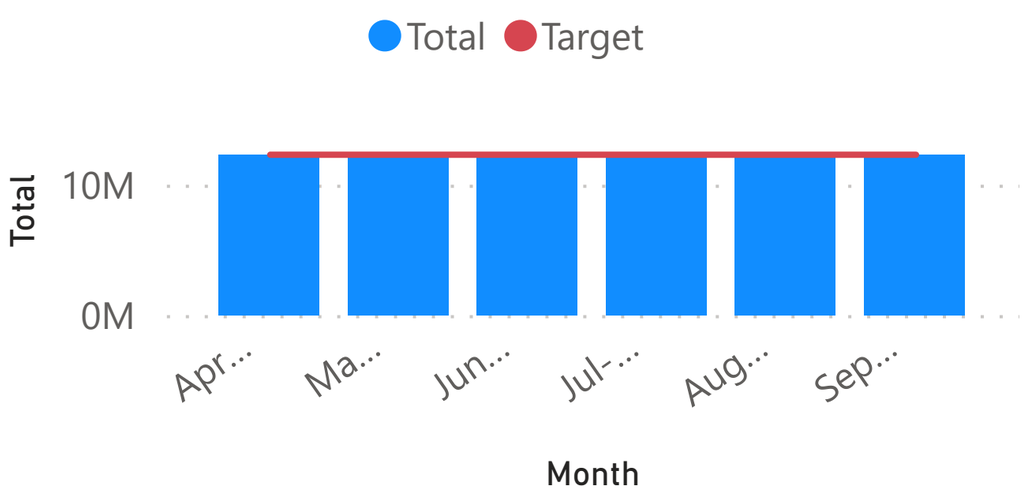
Areas of Concern:

CIP gap closing in year but trust level schemes still progressing and represents a high proportion of the unidentified value. Challenging £12.3m control total surplus plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets. Recurrent CIP also area of concern given the gap recurrently is £10.5m which will be carried into 24-25 if not identified.

Forward Look (with actions)

Continue cost control to reach the £12.3m surplus requirement by end of the financial year. Urgent focus required on recurrent efficiency. Further divisional finance panel meetings scheduled in September along with SDG to focus on Divisional CIP including enabler areas. Work also continues with divisions on identifying recurrent changes and benefits.

Revenue Position (Year End Forecast)



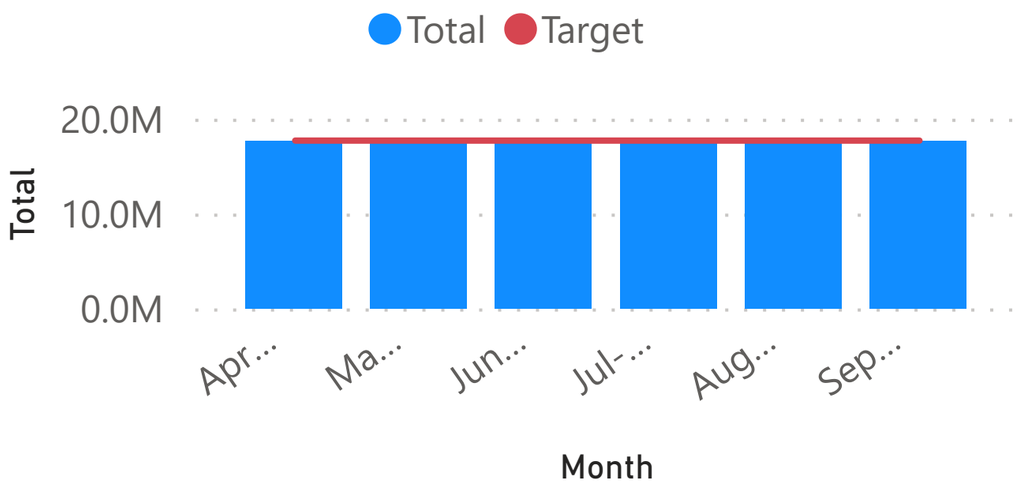
Technical Analysis:

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

Actions:

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

CIP Position (Recurrent Full Year Effect)



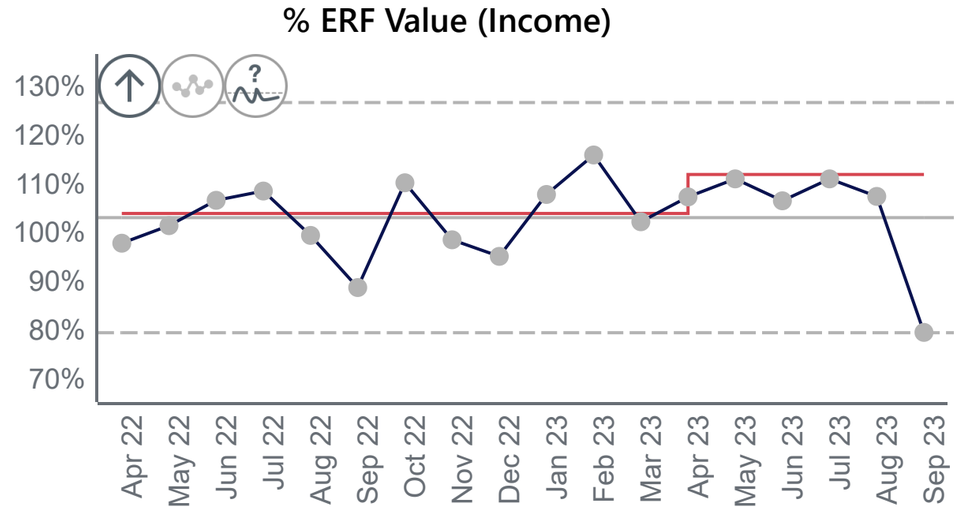
Technical Analysis:

In year CIP identified and in progress is £15.6m. Of this, £7.0m is recurrent.

Actions:

Support required with exec leads and transformation to identify the large scale opportunities. Paper submitted to execs and focus now on wider change programmes. Divisions have identified plans to meet their gap in full in year only. Still large gap recurrently of £10.5m .

% ERF Value (Income)



Technical Analysis:

September performance estimated at 79.6%. YTD performance estimated at 103.3%.

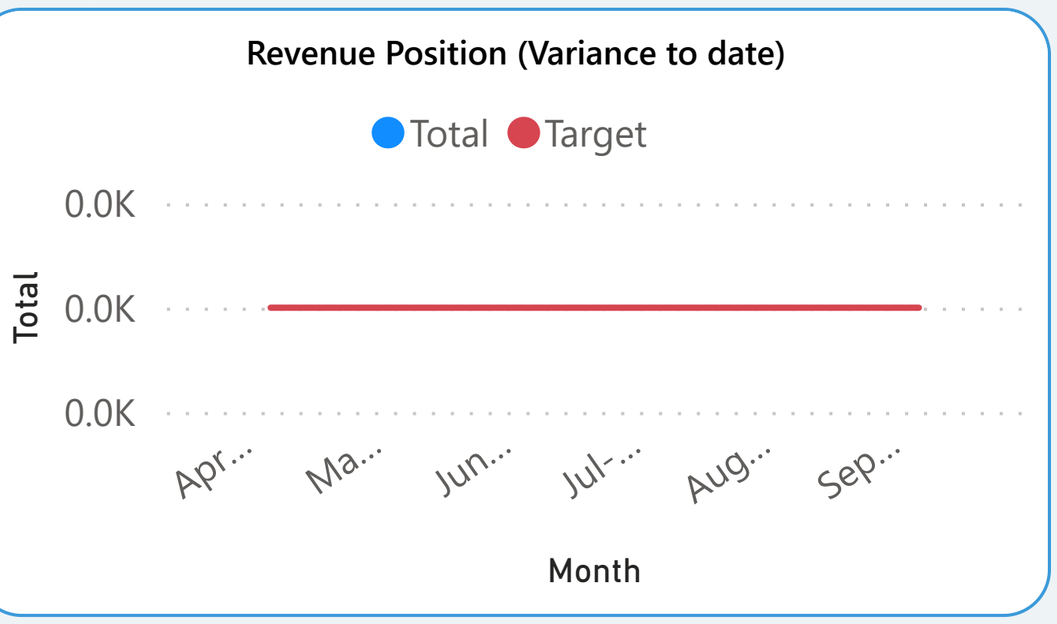
Actions:

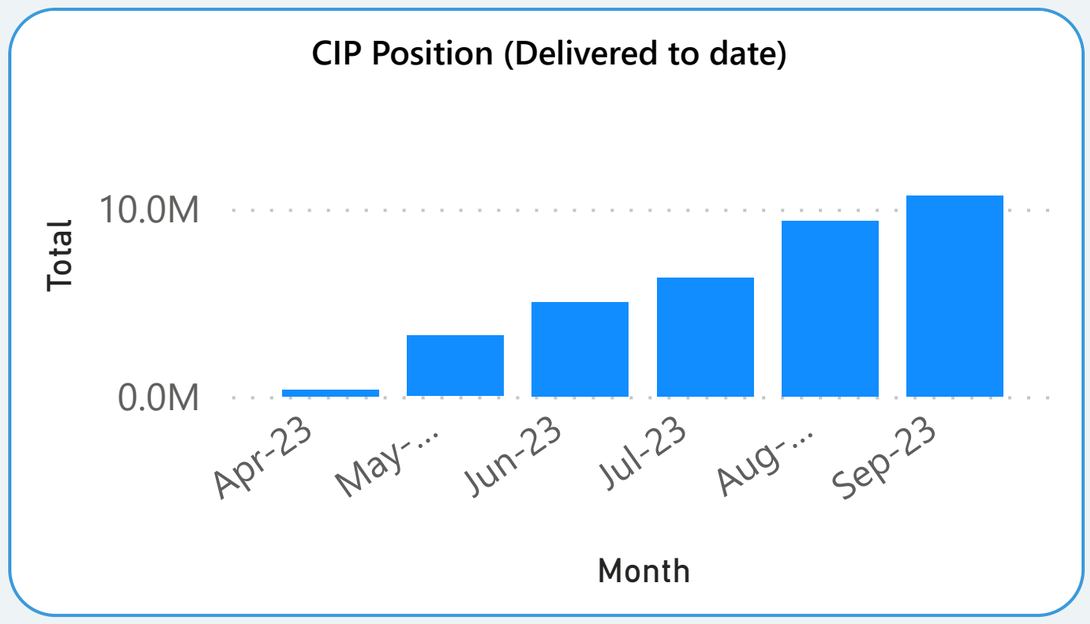
Continue to monitor those areas (at POD and speciality level) that are under performing versus plan.

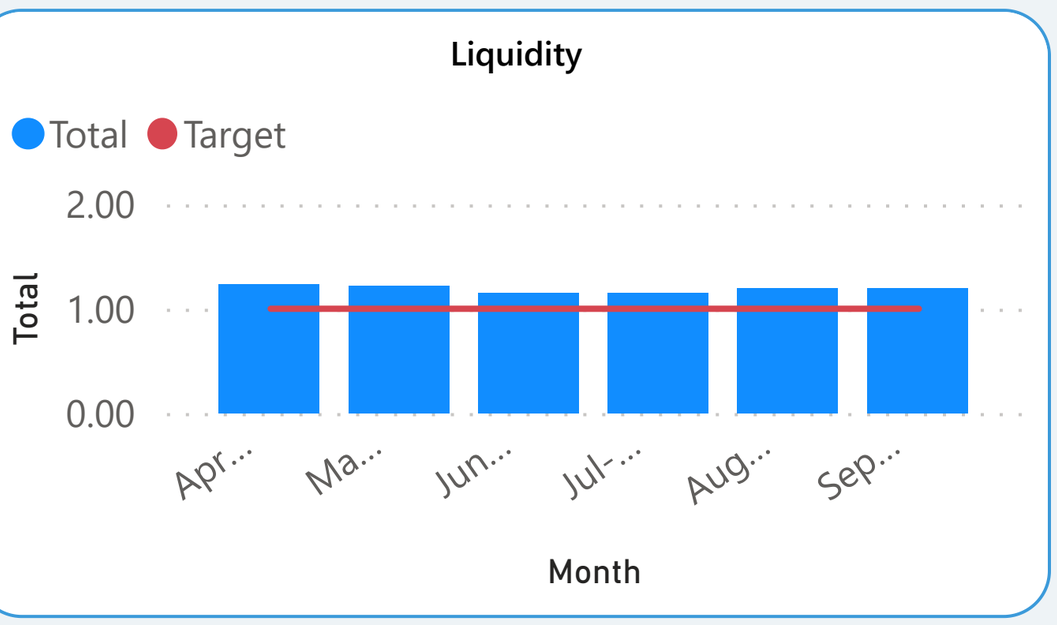
Integrated Performance Report | October 2023

Alder Hey Children's NHS Foundation Trust

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







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Risk reporting continues to be embedded with In Phase. Ongoing support provision in place via divisional governance and corporate governance teams. Weekly shared learning group established with LCHC regarding ongoing developmeent of risk reports

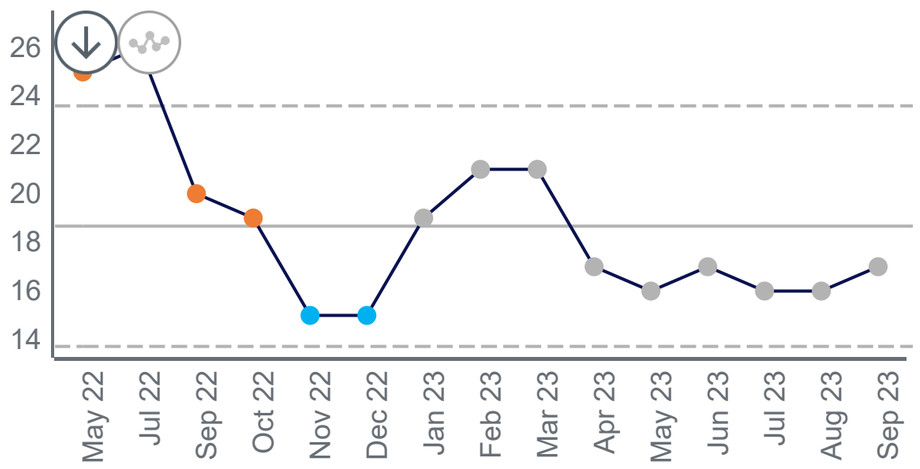
Areas of Concern:

There remains no automatic notification for upcoming/overdue risk reviews via InPhase system. Work ongoing with development of trust risk report functionality. Number of long standing high moderate risks (>12 months) on register remains static depite several mitgations in place .Escalated to Risk management forum for review. All above added to risk register No 22 score 3x4 =12.Escalated to Trust execs.

Forward Look (with actions)

Continue with support provision via risk oversight meetings/1;1 as required. Risk 22 remains open with appropriate mitigations in place. Continue to work closely with BI/Analytics on report functionality. Weekly meeting in place. Review of InPhase service specification/contract pending with Digital leads.

Number of High Risks (scored 15 and above)



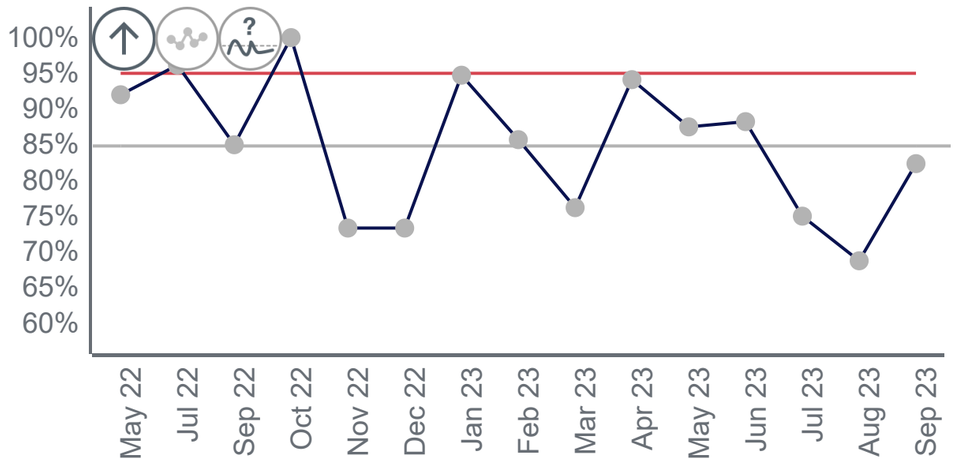
Technical Analysis:

There are 17 High Risks on the risk register at the end of September. Overall, this remains stable and is within the normal range.

Actions:

17 high risks on risk register Sept 23.

% of High Risks within review date



Technical Analysis:

Compliance of reviewing High risks within date is variable, with 3/17 risks overdue at the end of September. Action is required to ensure consistent compliance with the 95% target.

Actions:

82% (14/17) within review date

3 overdue risks have been escalated to risk owners .

Smartest Ways of Working - Safe Digital Systems- Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

The AlderC@re system went live 8th to 12th September 2023. The deployment has largely been successful with mostly positive feedback. Since Go-Live, there has been 2598 tickets raised through the Service Desk and 2520 tickets resolved. Closure rates demonstrate good progress. Ticket numbers are almost back to normal. The programme has moved out of the Go Live period into post go live stabilisation phase.

Areas of Concern:

Stabilisation Phase and ensuring all issues are resolved.

Forward Look (with actions)

We are developing plans for AlderC@re Phase 2 including an Optimisation Programme followed by assessment, design and plans for deployment of future versions. A focus will also be on the deployment of AlderHeyAnywhere following a successful pilot. The team work to deliver projects outlined in the digital component of the Trusts 2030 Strategy and will be coproducing the Insight Led Care Programme Document.

New Metric Under Development	Technical Analysis:	Actions:
	Under Review	Under Review

New Metric Under Development	Technical Analysis:	Actions:
	Under Review	Under Review

New Metric Under Development	Technical Analysis:	Actions:
	Under Review	Under Review

Collaborating for CYP - Green Plan: Well Led

SRO: Mark Flanagan, Director of Marketing and Communications

Highlights:

First joint meeting shareholder sustainability team, working on a joint carbon reduction plan.

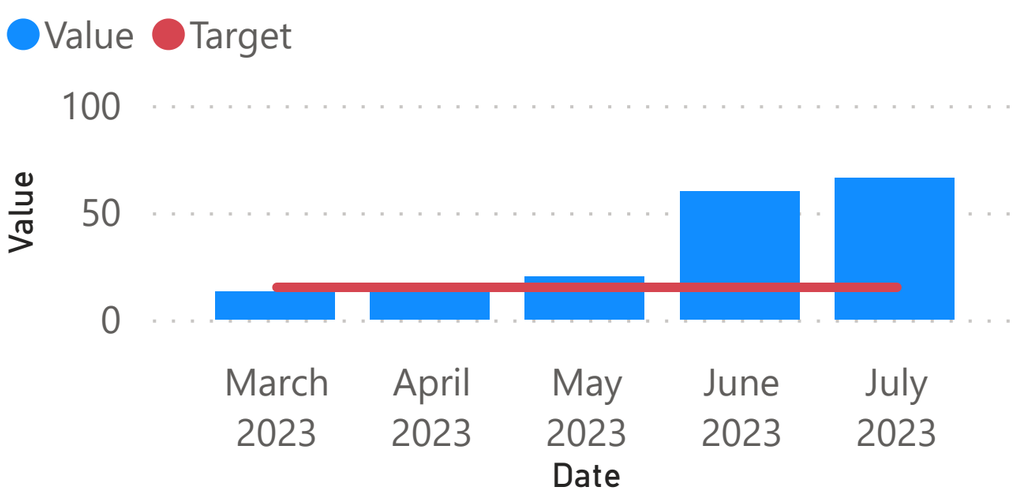
Areas of Concern:

Energy use still high while ROCK works finish. Solar panel project now looking unlikley due to local grid problems.

Forward Look (with actions)

Gloves project kicking off with IPC team, starting on 16th. Work started with City Council on "VIP lane" for housing

Green Plan: Reduce Carbon Footprint



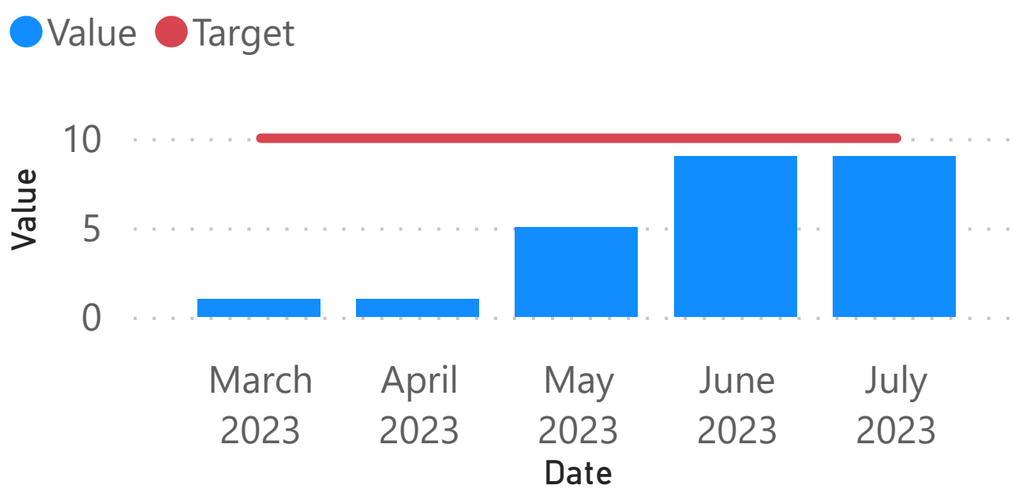
Technical Analysis:

Energy use still high

Actions:

Developing updated joint plan with SPV shareholders

Green Plan: Reduce Energy Usage

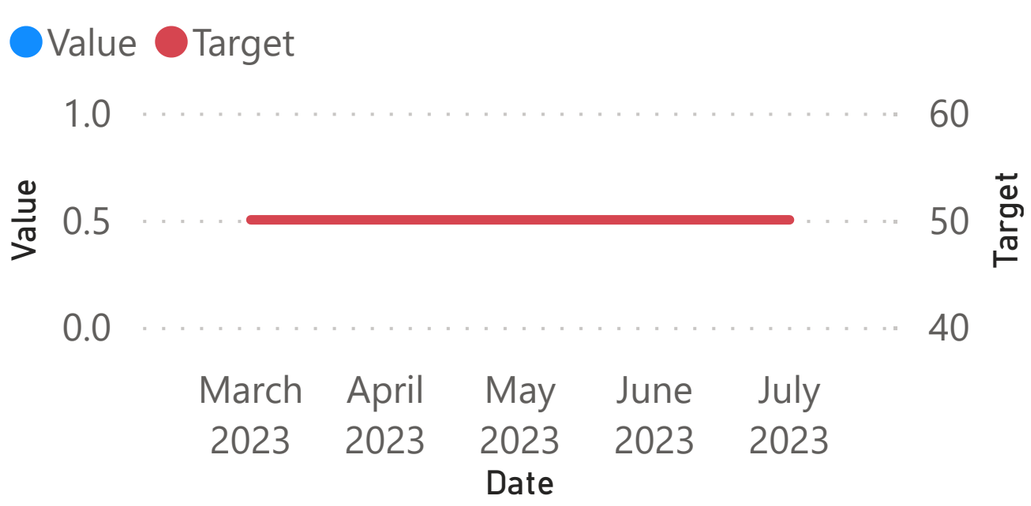


Technical Analysis:

Energy use still high driven by ROCK works

Actions:

Green Plan: Reduce Waste



Technical Analysis:

Compactors arriving next month

Actions:

Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

Improvement in FFT scores across the Division. Improvement in clinical correspondence sent within 10 days from 56% in Dec 22 to 70% for Aug 23. Staff turnover across Division continues to decrease. 2 x Rapid improvement events in SALT.New CAMHS/ADHD MDT established to review complex cases. Sunflower House won team Star of the Month. Launch of Community & Mental Health Division star awards.

Areas of Concern

Increase in no of incidents of minor harm due to a small number of patients in Sunflower House self-harming. National alert for shortage of ADHD medications impacting on service. Impact of absence within Neurodevelopmental medical team on statutory services including timeliness of adoption medicals and Adult Health Clearances. Lighting and surface of temporary carpark supporting Sunflower and Catkin Centre.

Forward Look (with actions)

Continued improvement in clinical correspondence being sent (Director priority). Improvement to carpark and lighting planned with map of safe routes to be circulated to all staff, children, young people and families attending appointments at Catkin Centre and Sunflower House. Recruit to temporary Medical Advisor roles to support capacity for safeguarding team. Safety huddles regarding ADHD medication alert.

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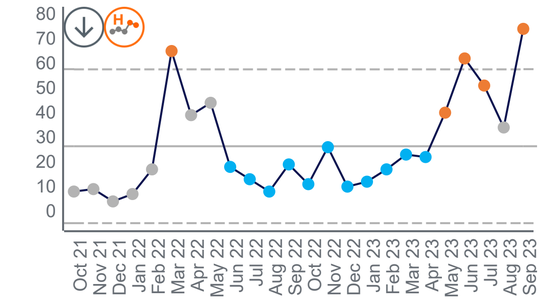
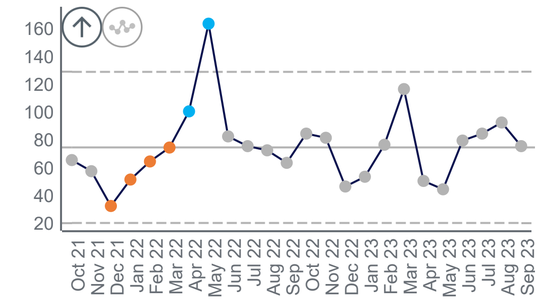
Divisional Performance Summary - Community & Mental Health

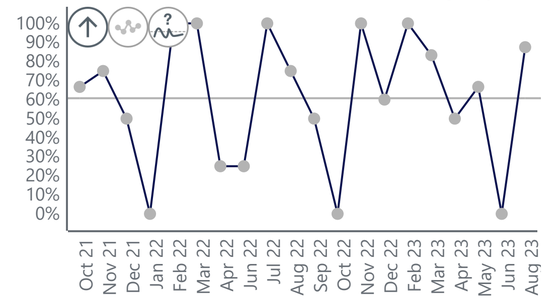
Number of Incidents rated Minor Harm and above



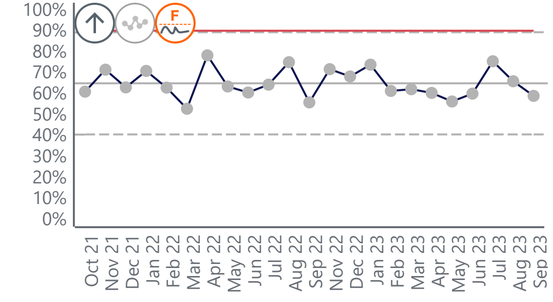
Number of Incidents rated No Harm and Near Miss



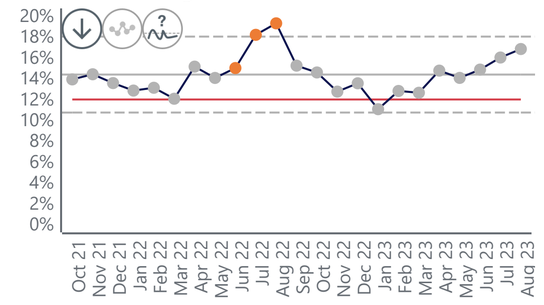
% Complaints Responded to within 25 working days



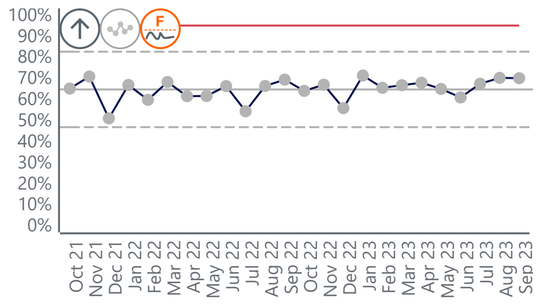
% PALS Resolved within 5 Days



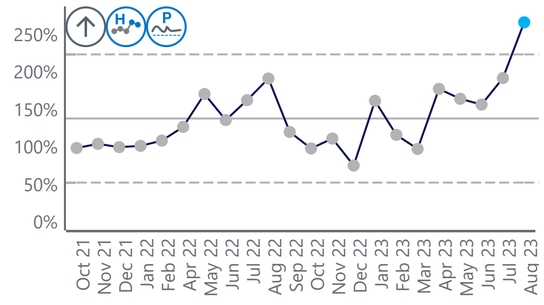
% Was Not Brought Rate (All OP: New and FU)



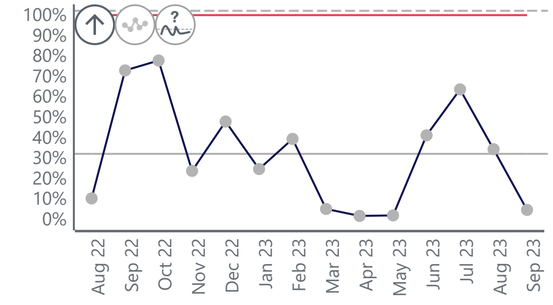
% of Clinical Letters completed within 10 Days



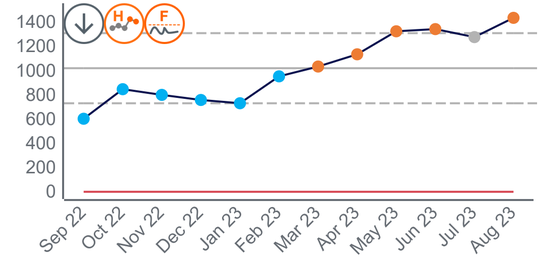
% Recovery for OP New & OPPROC Activity Volume



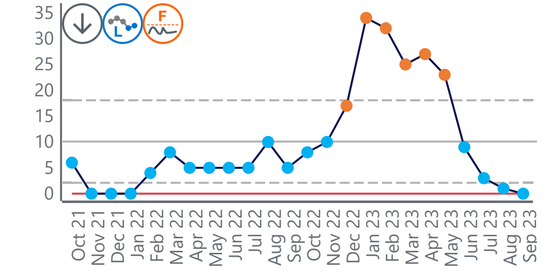
IHA: % complete within 20 days of referral to Alder Hey



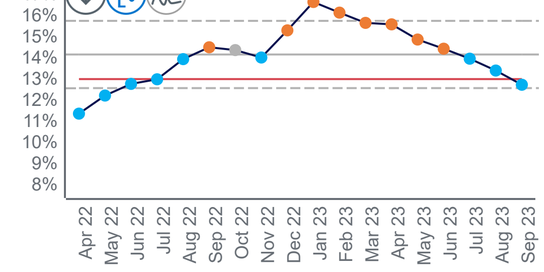
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



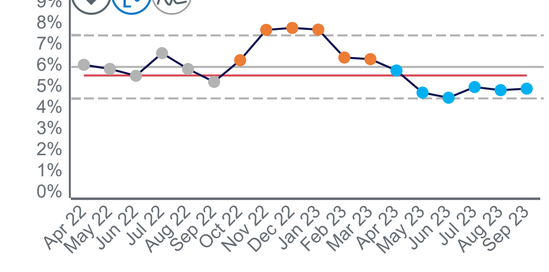
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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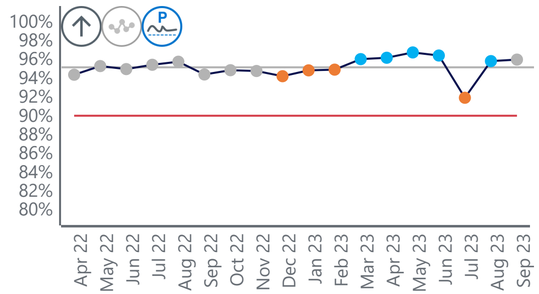
Divisional Performance Summary - Community & Mental Health

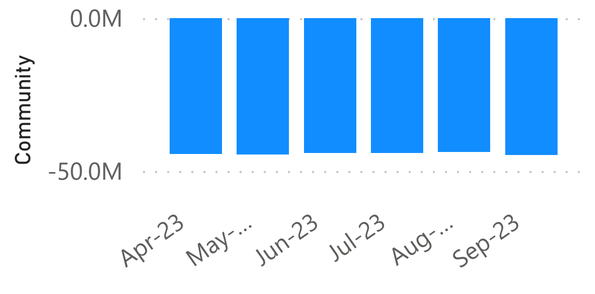
Mandatory Training



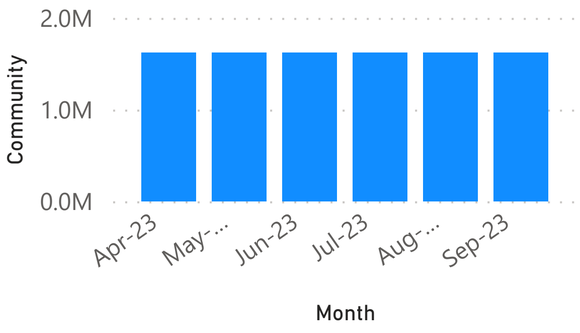
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

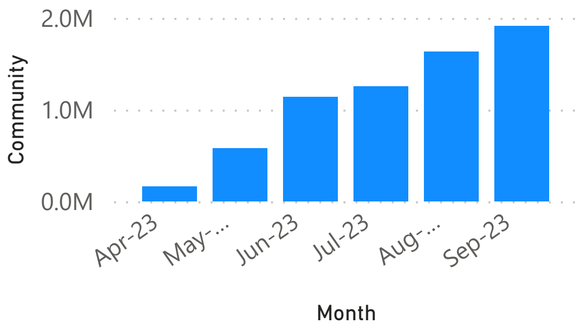
Revenue Position (Year End Forecast)



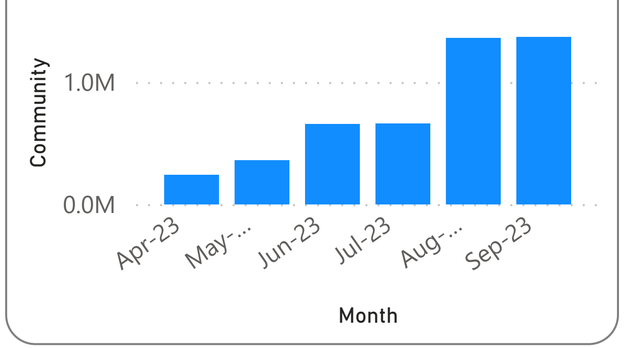
CIP Position (Recurrent Full Year Effect)

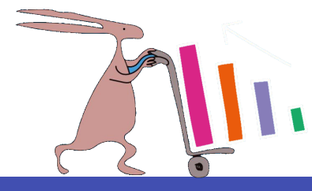


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

PAU pilot continued to September, focusing on improving direct assessment for GP and others to a Paediatric assessment. Sustained compliance with all standards for cancer care. Maintained response rate for PALS. Maintained reduction in staff turnover rates. Delivery of over 2.5mil CIP YTD. Managed safe deployment of Alder Care, noting extensive preparation and responsiveness from Pharmacy, Labs and ED

Areas of Concern

ED performance is 78% seen within 4 hours in month, impacted by increased attendances, Alder Care, industrial action and staffing absences. Increase in patients waiting over 65 weeks owing to reduction in capacity with Alder Care roll out and reduced theatre capacity. Despite a positive CIP position at M5 (£2.5m) the Division is challenged in delivering recurrent savings.

Forward Look (with actions)

Divisional Health and Wellbeing week scheduled in November. Continued enhanced financial controls in place. Continue to develop recurrent CIP plans in line with the trust strategy. Challenges to elective plan remain due to reduced activity from Alder Care, likelihood of ongoing industrial action and reduction on theatre capacity. Revised recovery plans under review by clinical and operational teams.

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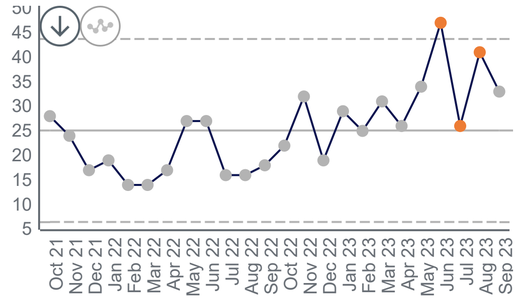
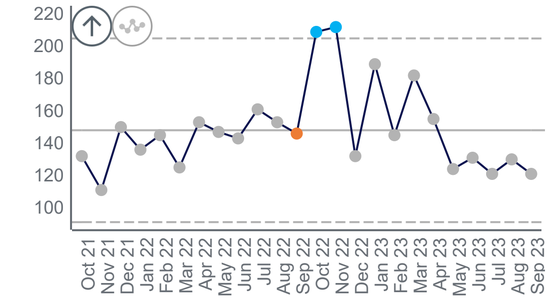
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

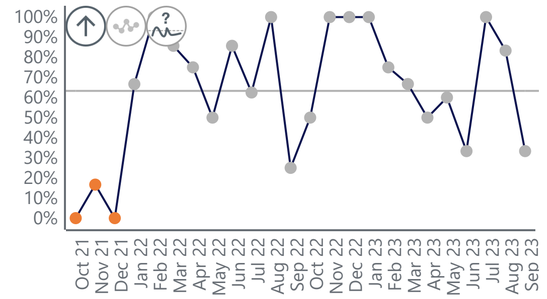
Number of Incidents rated Minor Harm and above



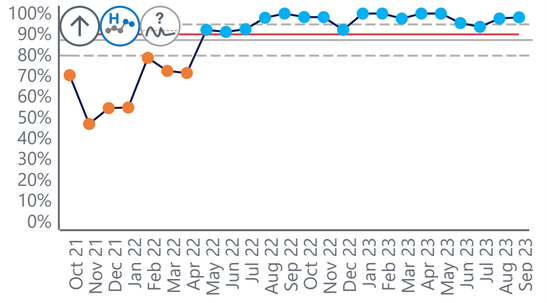
Number of Incidents rated No Harm and Near Miss



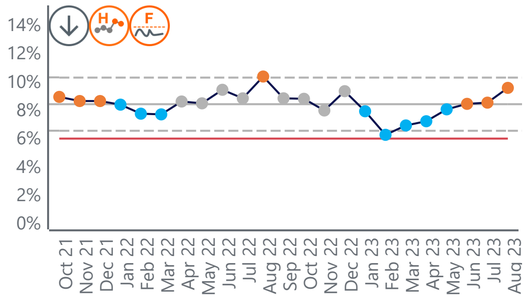
% Complaints Responded to within 25 working days



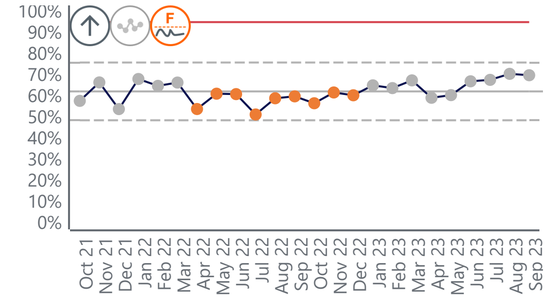
% PALS Resolved within 5 Days



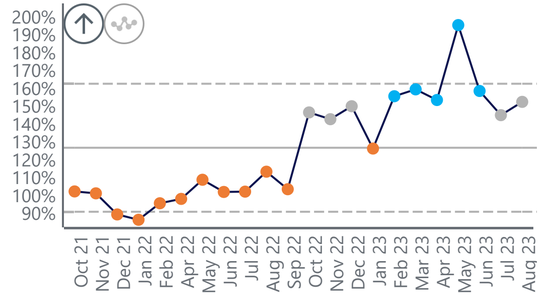
% Was Not Brought Rate (All OP: New and FU)



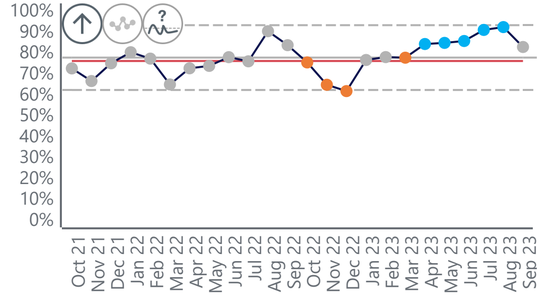
% of Clinical Letters completed within 10 Days



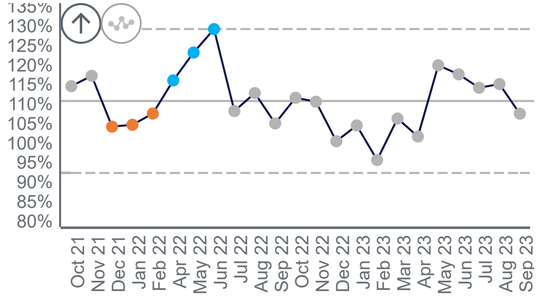
% Recovery for OP New & OPPROC Activity Volume



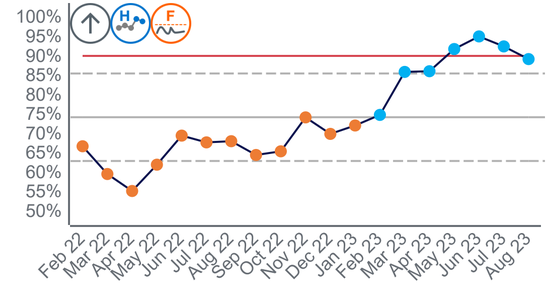
ED: % treated within 4 Hours



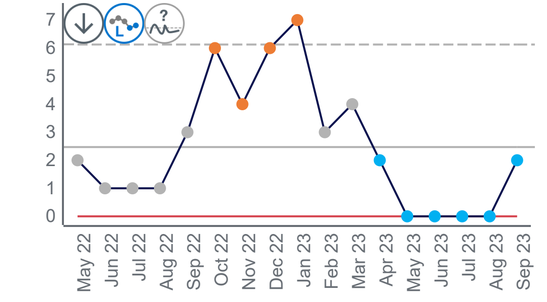
% Recovery for DC & Elec Activity Volume



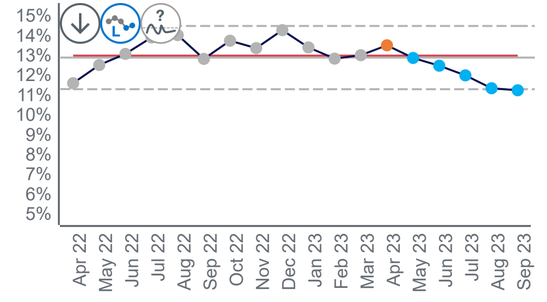
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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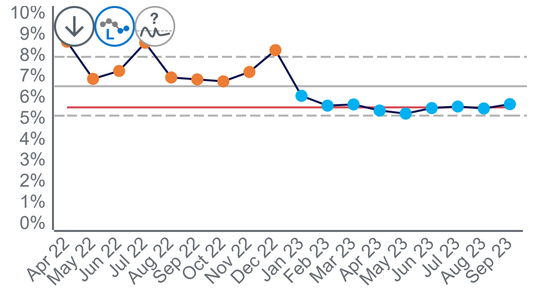
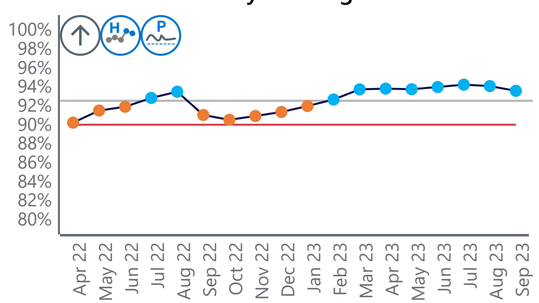
Divisional Performance Summary - Medicine

Sickness Absence (Total)



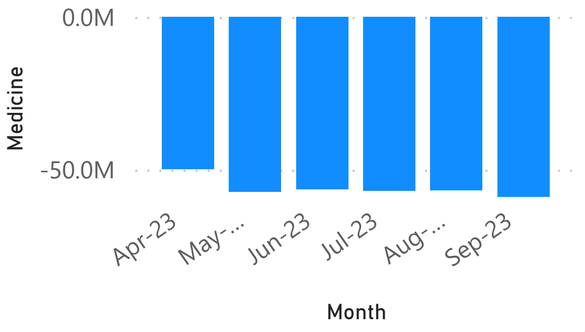
Mandatory Training



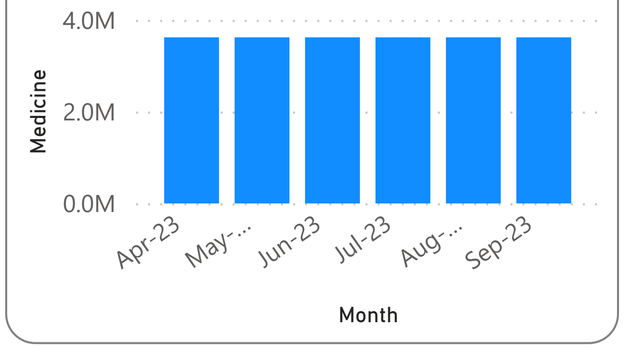
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

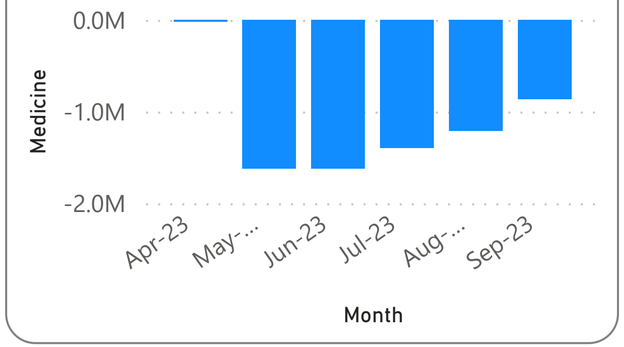
Revenue Position (Year End Forecast)



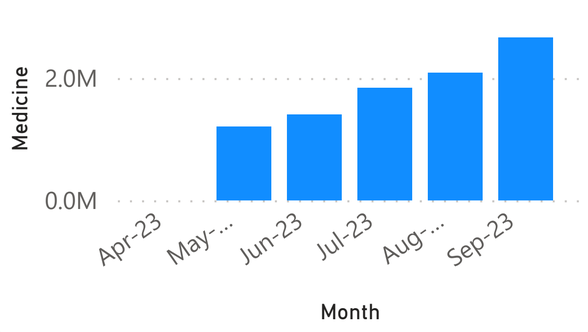
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

Maintained 100% compliance with all PALS and formal complaints responses. 106% recovery for OP new & OPPROC activity (M5 activity). Reduction in sickness absence rates for 2nd consecutive month. Continued reduction in staff turnover although work ongoing to reduce this rate further. Mandatory training remains above trust target at 94%.

Areas of Concern

Increase in total patients waiting over 65 weeks, impacted by reduction in activity due to Alderc@re. % clinical letters signed within 10 days remains static and below trust target. In month CIP was a challenge, predominantly based on impact of Alderc@re on available data- unable to post planned income CIP.

Forward Look (with actions)

Monitor lost activity via divisional tracker due to ongoing Industrial Action. Action plans around increasing capacity for Spinal, ENT and Dental long waiting patients which includes insourcing support. New theatre schedule which accounts for reduction in sessions- actions to ensure improved producitivity. Improvement work continues within Diagnostic areas to bring division to compliance by November.

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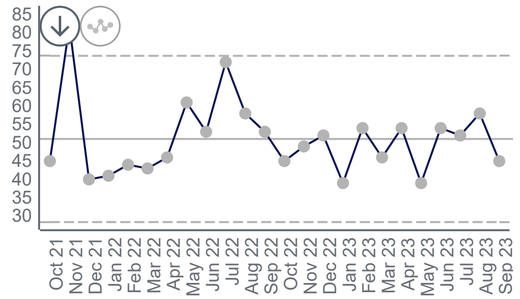
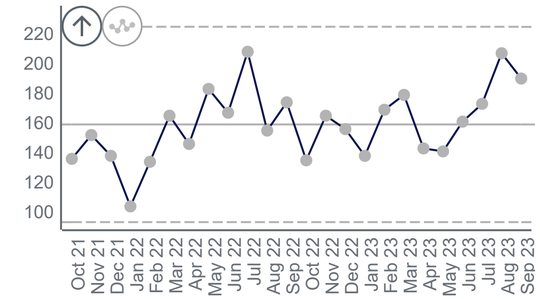
Divisional Performance Summary - Surgery

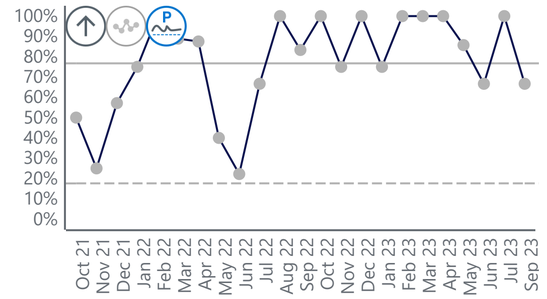
Number of Incidents rated Minor Harm and above



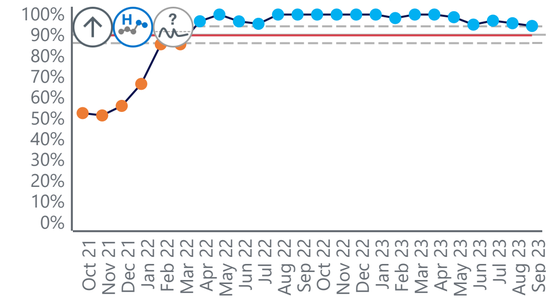
Number of Incidents rated No Harm and Near Miss



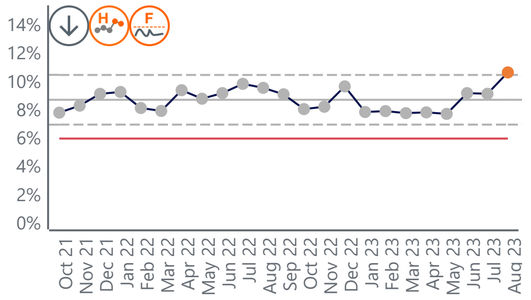
% Complaints Responded to within 25 working days



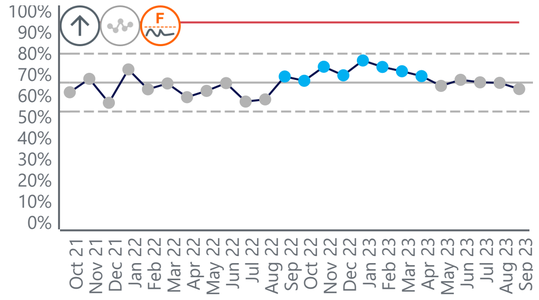
% PALS Resolved within 5 Days



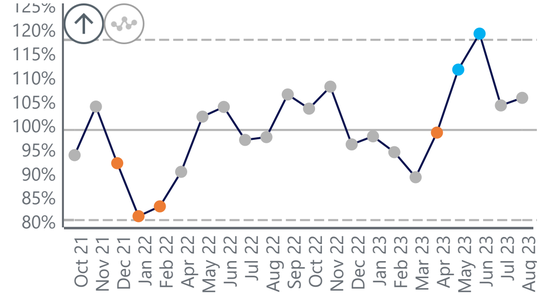
% Was Not Brought Rate (All OP: New and FU)



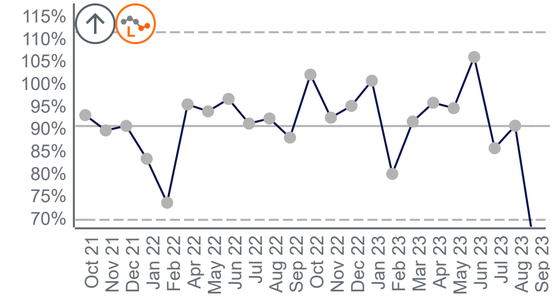
% of Clinical Letters completed within 10 Days



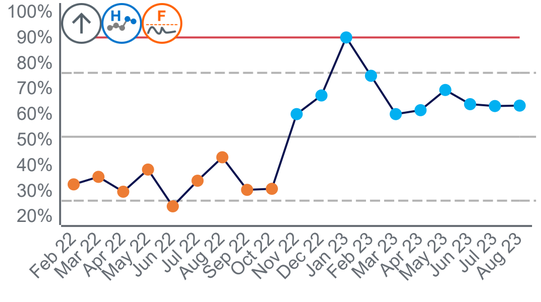
% Recovery for OP New & OPPROC Activity Volume



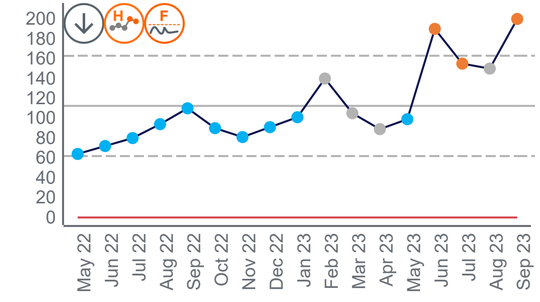
% Recovery for DC & Elec Activity Volume



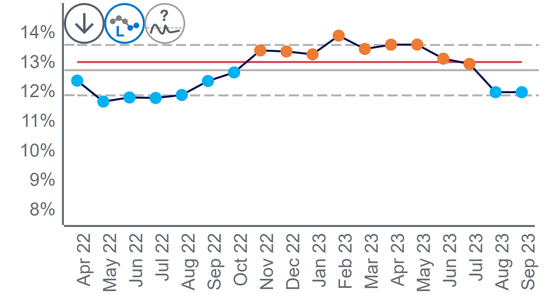
Diagnostics: % Completed Within 6 Weeks of referral



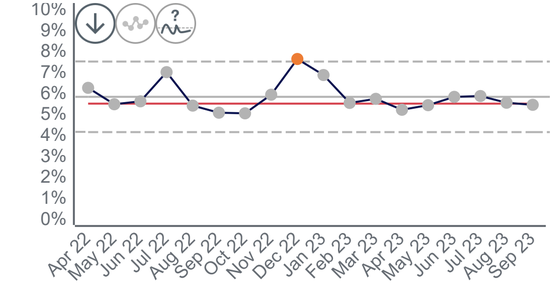
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)



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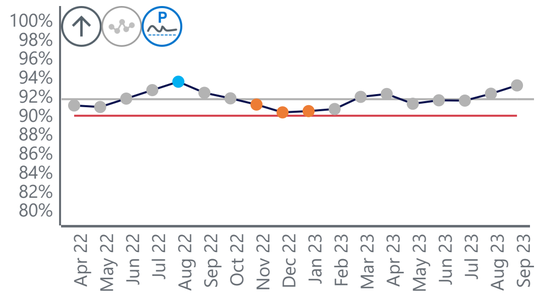
Integrated Performance Report | October 2023

Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

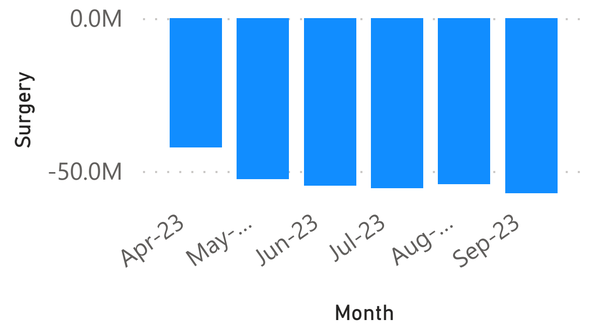
Mandatory Training



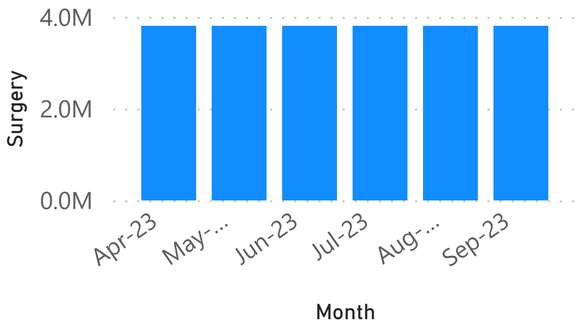
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

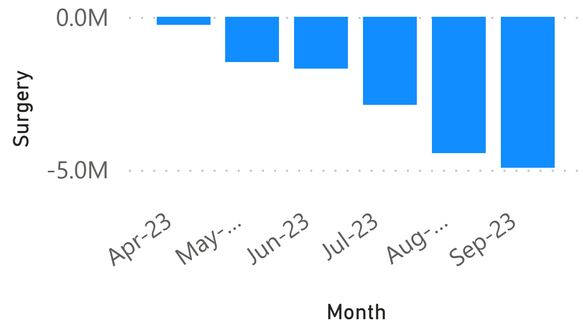
Revenue Position (Year End Forecast)



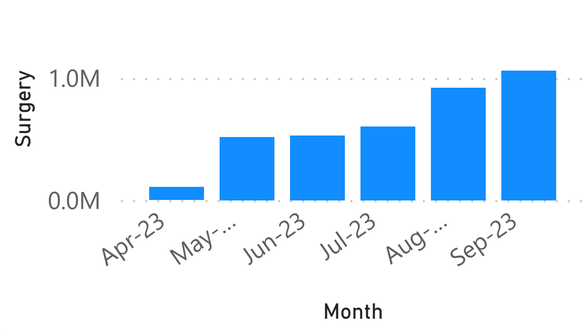
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

Research strategy in final stages of development. Recognition for meeting national commercial recruitment target. Increase in patient feedback and engagement activity within the division. Positive feedback from staff about improvements in research education and learning from incidents.

Areas of Concern

Reduced capacity of study support services continuing to delay new studies from opening. Predicted reduced study recruitment due to end of large-scale study now occurring. Further clinical incidents (no harm) relating to muscle biopsy procedures for research. Potential organisational change at HEI partner impact on PIs.

Forward Look (with actions)

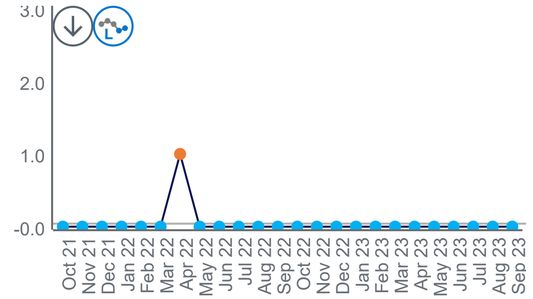
Research strategy submitted to R&I Committee. Research MRI staffing business case submitted. Improved research portfolio performance.

Integrated Performance Report | October 2023

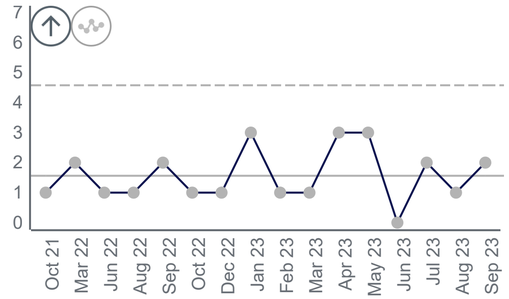
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

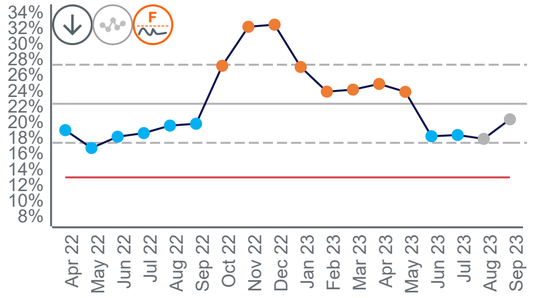
Number of Incidents rated Minor Harm and above



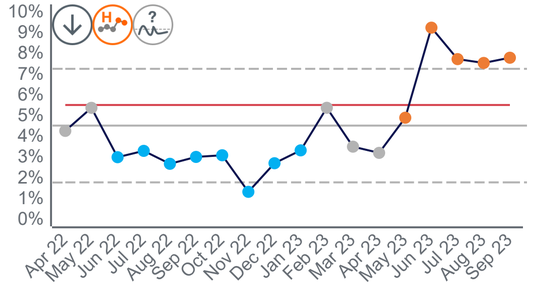
Number of Incidents rated No Harm and Near Miss



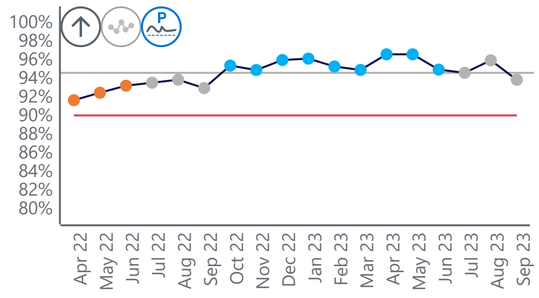
Staff Turnover



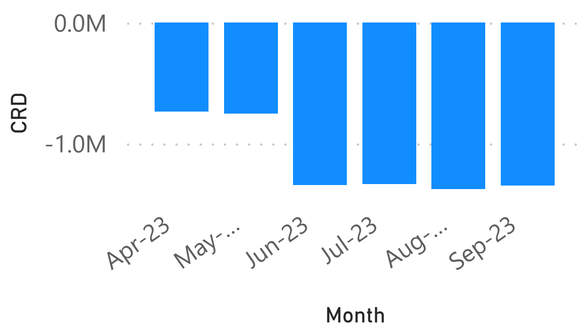
Sickness Absence (Total)



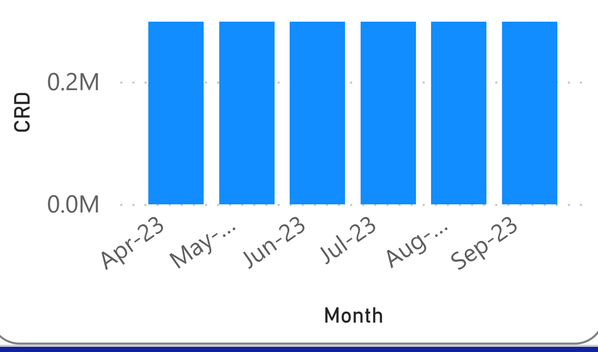
Mandatory Training



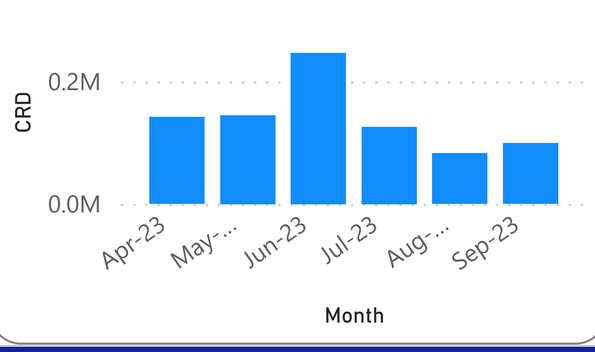
Revenue Position (Year End Forecast)



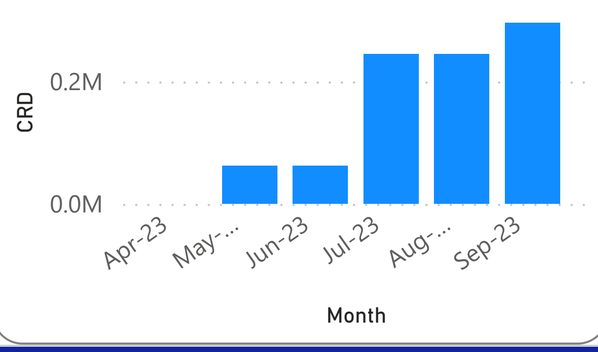
CIP Position (Recurrent Full Year Effect)



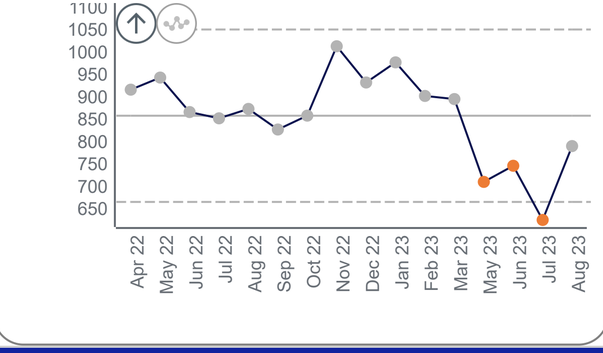
Revenue Position (Variance to date)

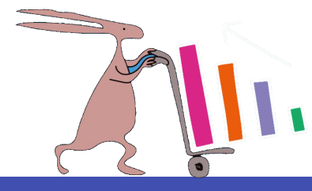


CIP Position (Delivered to date)



Number of Patients Recruited into Research Studies





Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative continues to meet monthly with good attendance. Highlights from the meeting held on 18th Sep are: Mandatory training for Corporate Services remains above the 90% target at 94%, CIP delivery at M5 was £1.5m against a Trust target of £1.8m, Despite a small increase in-month (and since January 2023), short term sickness absence remains below trust target at 2%.

Areas of Concern

Overall sickness absence has risen to 6% in month (previously 5%). Average time to hire has risen in-month to 40 days (previously 29 days). Staff turnover currently sitting at 13%. PDR compliance for B7 and above was reported at 57% against a target of 90% at the end of August. Bank and agency spend continues to be an area of interest.

Forward Look (with actions)

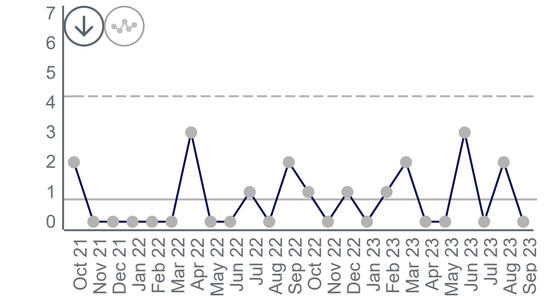
Continued focus on: Bank and agency spend, Our Plan 2030 – Supporting our People, Green Plan, Zero Tolerance training programme for corporate services with a particular focus on hotspot areas such as security, Proportion of BAME staff in post, BIG Conversations.

Integrated Performance Report | October 2023

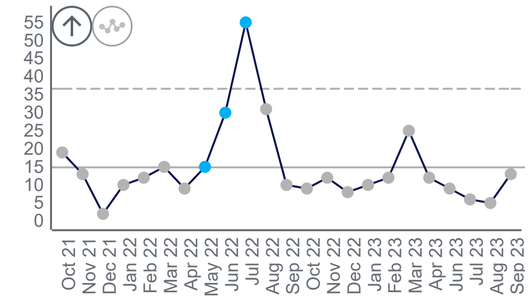
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

Number of Incidents rated Minor Harm and above

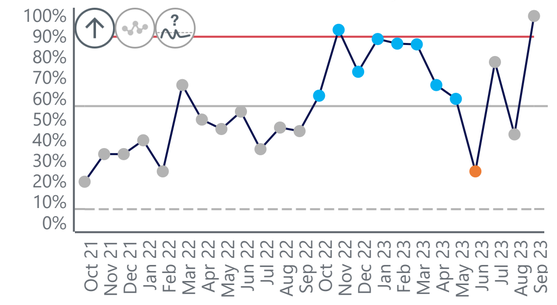


Number of Incidents rated No Harm and Near Miss

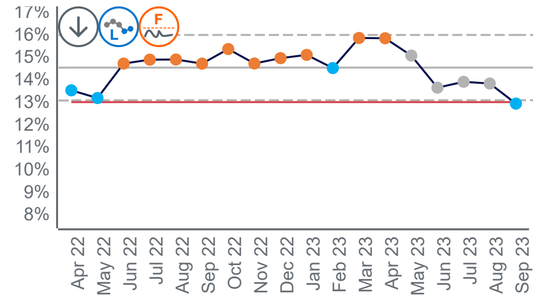


% Complaints Responded to within 25 working days

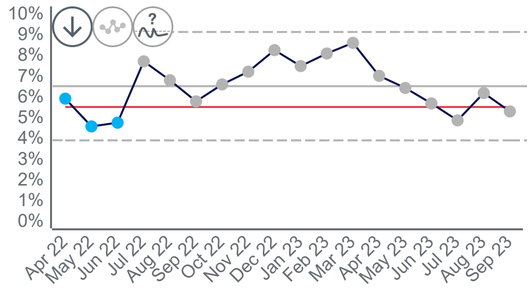
% PALS Resolved within 5 Days



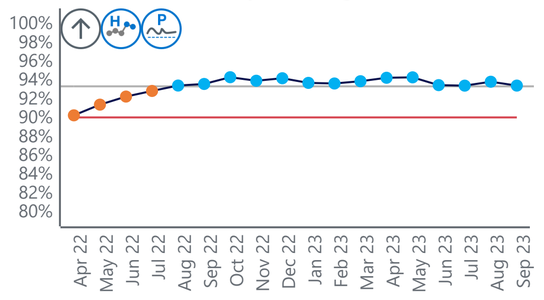
Staff Turnover



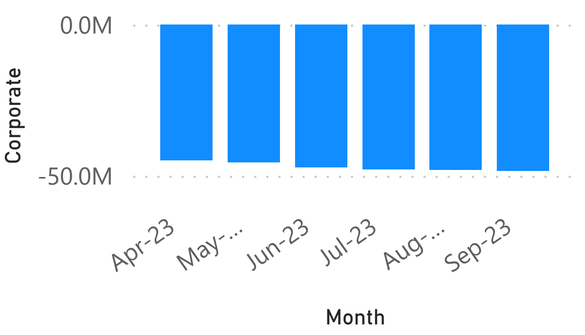
Sickness Absence (Total)



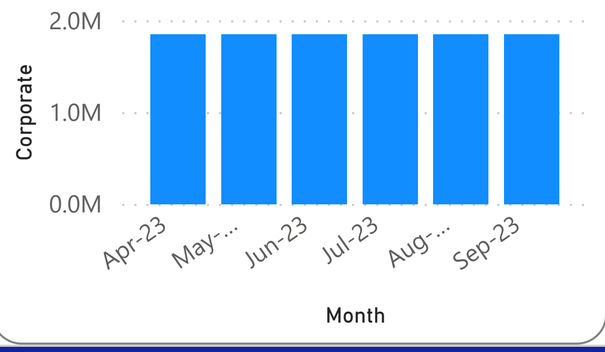
Mandatory Training



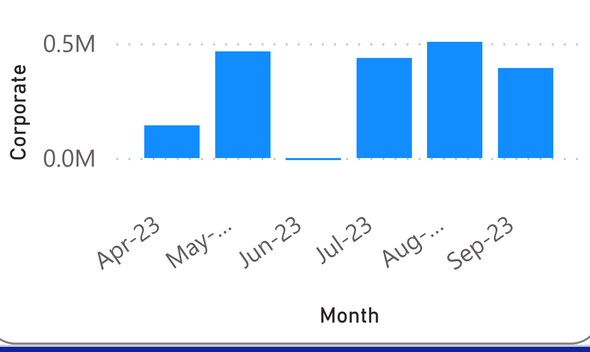
Revenue Position (Year End Forecast)



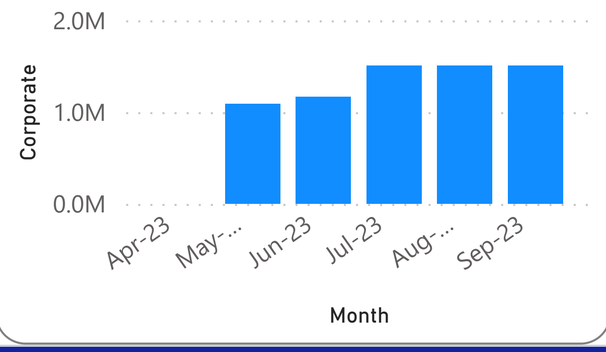
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



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

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Vacancy		Turnover (Leavers)		Sickness		Medication incidents		Staffing Incidents		FFT			
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total	Total count of Patients at Midnight	CHPPD Rate		RN - %	HCA - %	RN - %	HCA - %	RN - %	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good	Pals	Complaints
Burns Unit	99%	-	100%	-	2017	**103**	19.58	14.87	-1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0	17	0	1	10	80%	0	0
HDU	62%	89%	60%	77%	6654	**323**	20.60	32.22	11.00%	0.00%	0.00%	0.00%	11.89%	0.00%	6	35	0	2	4	100%	0	0
ICU	80%	140%	81%	69%	17309	**374**	46.28	32.22	7.00%	-4.00%	0.40%	0.00%	5.49%	0.00%	12	65	0	1	3	100%	2	0
Ward 1cC	84%	93%	84%	82%	6622	**538**	12.31	12.31	7.00%	-4.00%	1.82%	0.00%	6.98%	8.44%	3	27	0	6	21	100%	1	0
Ward 1cN	64%	7%	68%	-	2956	**225**	13.14	13.14	15.00%	5.00%	0.00%	0.00%	0.96%	0.00%	5	16	0	7	6	100%	0	0
Ward 3A	93%	63%	92%	134%	7435	**713**	10.43	10.27	-11.00%	3.00%	1.17%	0.00%	4.48%	11.56%	2	22	1	5	53	98.11%	0	0
Ward 3B	77%	90%	82%	-	4986	**382**	13.05	7.28	0.00%	-6.00%	0.00%	0.00%	6.71%	45.58%	5	8	0	5	14	92.86%	1	0
Ward 3C	88%	76%	75%	118%	7853	**681**	11.53	10.31	6.00%	1.00%	0.00%	0.00%	7.68%	6.64%	13	48	0	0	17	94.12%	0	0
Ward 4A	72%	96%	73%	107%	7432	**747**	9.95	10.19	7.00%	-2.00%	0.00%	0.00%	9.60%	14.71%	1	28	0	1	58	94.83%	1	0
Ward 4B	62%	78%	47%	79%	7089	**438**	16.18	10.28	16.00%	-20.00%	0.00%	2.94%	8.27%	18.54%	1	43	0	1	20	95%	1	0
Ward 4C	91%	92%	85%	110%	7173	**691**	10.38	10.36	15.00%	-1.00%	2.02%	0.00%	3.51%	18.15%	14	103	0	2	42	100%	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.

<u>Medicine</u>

The over establishment on 3B for unqualified vacancies are the additional supernumerary staff who are awaiting a pin or occupational health clearance which has impacted the fill rate for registered as they are not yet counted in the numbers. HCA sickness equates to 0.93WTE who were off for the whole of June. During this month the ward has had to cover a high number of maternity leave posts.

Ward 3C vacancies gaps in June equates to 3.08WTE due to maternity leave and secondments covering the ward manager on an interim basis. HCA sickness has reduced from May. The ward is also supporting an RN 1:1 and HCA 1:1 on a long-term basis.

Ward 4B RN sickness levels have reduced to less than 10% in June, however the HCA sickness has increased to 18.54% which equates to 5.29WTE. 2.0 WTE RNs were also seconded to cover maternity leave roles on the ward. HR drop-in sessions commenced w/c 13th February and a task and finish group has started to focus on staff wellbeing and retention. The over establishment on 4B for unqualified vacancies, includes the international nurses awaiting a pin or occupational health clearance which has also impacted the fill rate for registered as they are not yet counted in the numbers. The ward has also had to cover a high number of maternity leave posts, 6.53 WTE RNs and 1.53 WTE HCA.

Ward 4C continue to have a high RN vacancy rate at 15% due to a high turnover over the last few months, however this has reduced from May. 9.0WTE new staff have been recruited starting from October so this will slowly start to improve over the next few months. HCA sickness has increased in June but equates to 1.3WTE.

A weekly forward look meeting is established within the Division of Medicine to proactively move staff within the division to ensure safe staffing across all wards.

Surgery

Ward 1cCardiac fill rate continues over 80%, however there is a high number of vacancies. New staff have been recruited but won't be reflected in the numbers until the end of October. The over establishment on the HCA line is due to the band 2 to 3 uplift and funding not yet being received in the budget line. RN LTS increased during June to 5.0WTE and HCA sickness equates to 1WTE.

Ward 1cNeo staffing is overseen by safer staffing and supported by the Liverpool Neonatal Partnership, with nurses being deployed from LWH if required. Recruitment for the new neonatal unit is ongoing, and supernumerary staff are allocated on to most shifts during the initial training period. Issues relating to staffing are discussed with the Surgical Matrons and support is offered where needed. All patients are nursed in line with BAPM standards, acuity information shared at all safer staffing meetings to ensure that staffing levels are supportive of patient acuity.

Ward 3A RN fill rate continues over 90%, however they are over recruited on the RN line due to covering 6.44WTE maternity leave posts. 2.0WTE staff are international nurses awaiting a pin or occupational health clearance. Long term sickness equates to 2.0WTE RN & 1.0WTE HCA which is being managed with support from HR and in line with policy. The ward has also had to cover a high number of 1:1 patients, with additional shifts not always being picked up.

4A has had vacancies, LTS and maternity, this is expected to be a consistent theme until November. To mitigate, there are new starters commencing in post in October, following a period of induction and supervision they will commence in the numbers from November. STS remains quite low and LTS is being managed with support from HR and in line with policy.

A weekly forward look meeting has been set up in Surgery to proactively move staff within the division to ensure safe staffing across all wards.

Critical Care

HDU continue to have a number of international nurses that are working as band 4 prior to gaining NMC registration. 3 international nurses that started in April were still supernumerary in June, 2 of them have gone into the numbers in September and one of them is still training. An additional 3 international nurses started in July and will be supernumerary for some time. HDU have ongoing RN vacancies that are slowly filling which is largely why the fill rate is 60%. 9.0WTE RNs start in October but will be supernumerary until December. STS was 2.84% and LTS was 8.57%.

ICU continue to have both short and long-term sickness. Vacancies remain high in June but are improving from August.

Summary

There are some differences in CHPPD benchmarks for the month of June. Burns, ICU, HDU and wards 3B and 4B are notable.

Burns CHPPD remains higher than the national benchmark, this is explained by Alder Hey incorporating a day case clinic nurse within the unit and numbers which is being addressed.

HDU CHPPD continues to report lower than the national benchmark, to note there are significant vacancies.

ICU during the month of June had reduced activity and patients resulting in higher-than-average CHPPD.

The national benchmark for ward 3B is significantly lower than previous months. The CHPPD for Alder Hey remains consistent with previous months, however due to the decrease national, appears that Alder Hey is an outlier for the month of June.

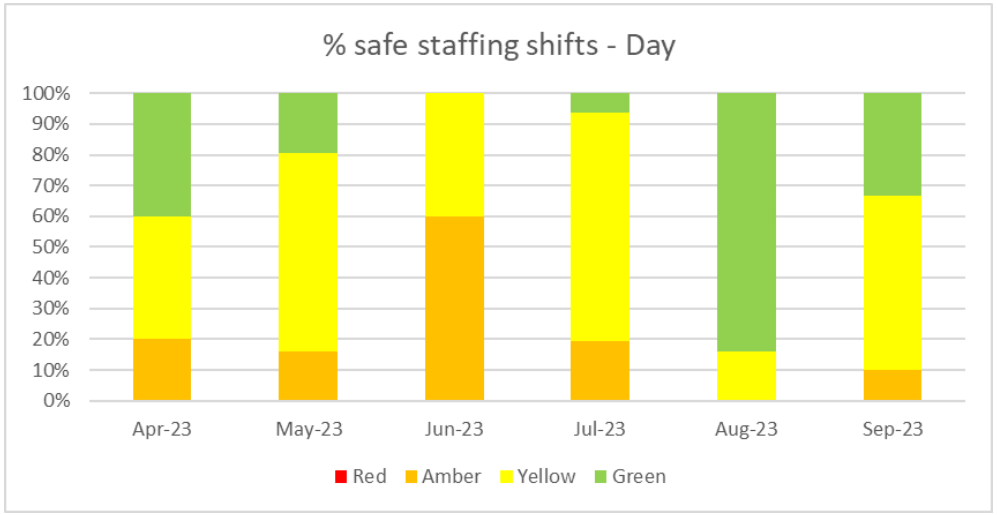
There is a consistent difference from the National benchmark for Ward 4B. Ward 4B has been consistently higher over the last few months. Deep dive into capacity and staffing has been undertaken and a full review of the nursing model is currently being undertaken with the aim to changing the nursing patient ratio. This is being piloted in August for a 3 month period.

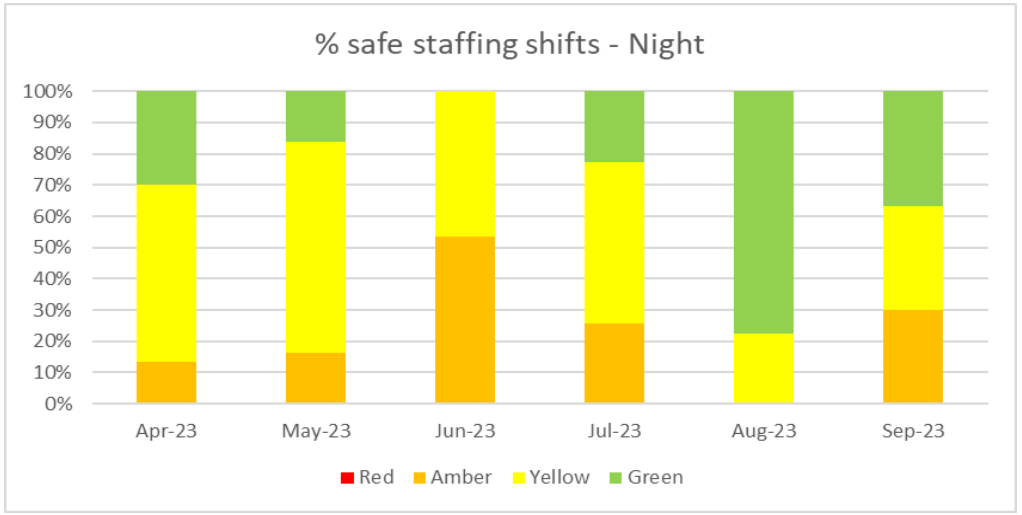
Ward 4C has significantly improved during June, reporting nearly the same as the national benchmark.

During this period reported, staff moves on NHSP were not recorded on E-Roster.

<u>Summary of September staffing</u>

There has been an increase in yellow and amber days during the month of September. 0 red days have been recordered since November 2022.





Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 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:

- National Digital Update
- AlderC@re Update
- Good progress with Digital and Data Futures/2030 Strategy
- Good Operational performance

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

2.0 National and Regional Updates

2.1 National Digital Leadership

NHSE have undergone some changes within the digital and transformation directorate. Colleagues were introduced through the inaugural joint CCIO/CXIO multidisciplinary meeting, which brings together digital and clinical leaders across the country.

The leadership team have signalled their key priorities for the next 12 months:

- Improvements to the NHS App to include better appointment management functionality and integration with 111
- Frontline Digitisation – Ensuring all Trusts have or are working towards full electronic patient records
- Shared Care Records – joining up patient records across multiple diverse regions
- Population Health Management including the launch of the federated data platform

AH will continue to engage with the group and keep the Board of Directors abreast of progress and further developments.

3. Digital and Data Futures Progress

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

The development of the Alder Hey Anywhere platform is progressing well. iDigital are working in close partnership with Innovation to further develop and test the solution to ensure that all technical integrations are functional. A two week series of development and test sprints are scheduled to commence at the beginning of November, with the estimate timescale to deploy the platform at the end of November 2023.

3.2 Outstanding Records and Safe Systems

Blood Transfusion Consent has now live electronically and the team are working to improve compliance in line with April 2024 deadline. The medical leads are working to transition all medical procedure builds that are outstanding for full compliance with eConsent.

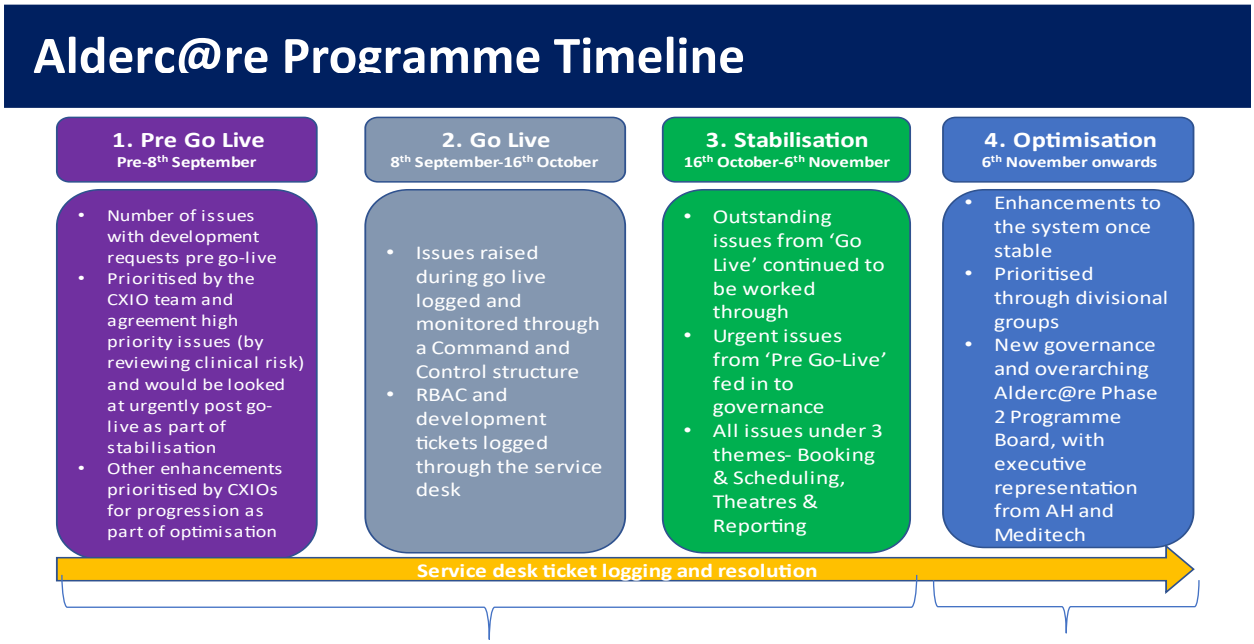
The new Risk and Incident Management system InPhase is steadily progressing. The reporting workstream is scheduled to complete imminently having encountered a number of challenges.

3.2.1 AlderCare

Phase 1 of the AlderC@re programme, which involved the deployment of Meditech Expanse 2.1, went live in Alder Hey in September 2023. This phase of the programme included a complete rebuild of the system to allow the move to version 2.1, allowing web-based functionality for some users.

A command-and-control structure was in place throughout the Go Live period. There was digital, operational, and clinical cover 24 hours a day for the initial period. Superuser and floorwalking was available in all areas within the hospital and community services. An AlderC@re service desk was enabled to allow staff to log tickets and have them resolved efficiently. A multidisciplinary drop-in service was also available for staff seeking support.

During the Phase 1 of the programme, it was acknowledged that there would need to be a Phase 2 which would encompass optimisation of the system including future upgrades. AlderC@re Phase 2 which is due to commence early November represents a considerable programme of work of optimisation which will require robust governance and significant resources from across the organisation. It is proposed that the governance of this work is aligned appropriately through the 2030 vision and programmes of work.



3.3 Healthier Populations through Digital, Data and Analytics

The main focus for the team has been supporting the reporting element of AlderCare. This entailed ensuring Operational Teams around the Trust have suitable mitigation reports in place during the transition whilst full reporting capability has not been available.

Progress has been made with the Patient Tracking Lists which are currently in validation. All other reports are also in validation and full reporting capability is due to be delivered in early November. Weekly oversight in partnership with NHS England continues with regards to the reporting workstream.

In parallel, work is ongoing to support the development of the ‘Trust 2030 Scorecard’ which will be a key mechanism for monitoring the progress and impact of the new strategy.

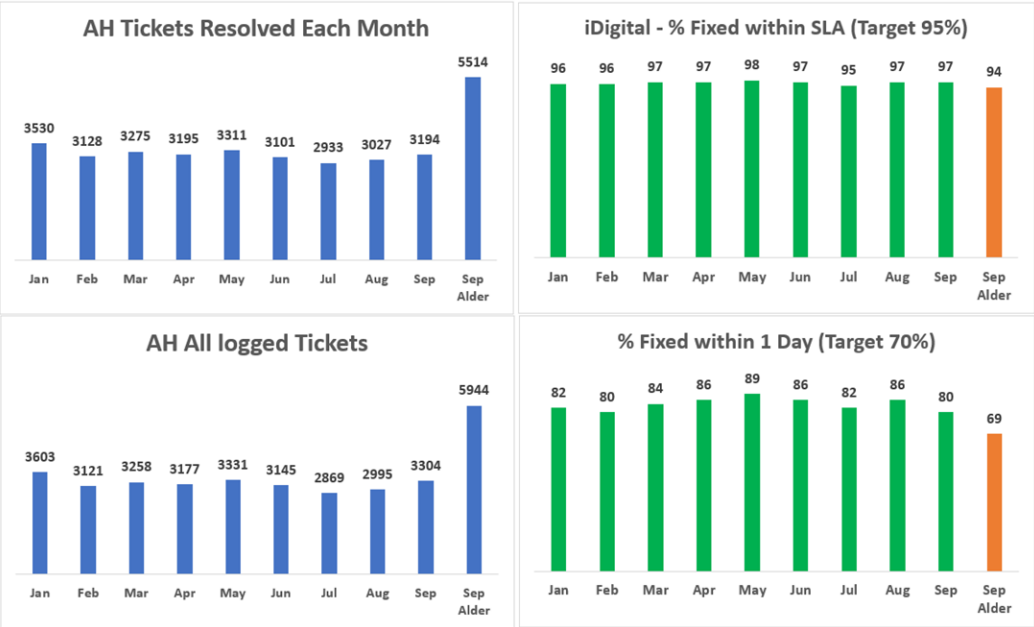
3.4 Technical roadmap and Operational Service Excellence

During this reporting period the service have been supporting centralising PACs across Cheshire and Merseyside, which will also include a new and improved network to increase the speed at which images can be shared across the region.

3.4.1 Operational Performance

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

- The AlderCare upgrade resulted in September seeing an uptick in tickets with a total of 5514 raised. This increase was broadly in line with planning assumptions
- The most common themes were:
    - Requests for access
    - Requests for Training
    - Printing support
    - System Development requests
- In relation this month also saw the highest number of resolved tickets in month (5514)
- Fixed within SLA performance was 97% for business as usual tickets and slightly under target at 94% including AlderCare tickets



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.

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

Alder Hey Children's NHS Foundation Trust

PART 1

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	**Development Directorate - Projects Update**
Report of:	**Development Director**
Paper Prepared by:	**Acting Deputy Development Director** **Jayne Halloran**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide a Campus and Park progress update. The Board is asked to confirm acceptance of the update and advise if reassurance has been provided.
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

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
BAF Risk 3.1	Failure to Fully Realise the Trust's Vision for the Park					3x4
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development Report on the Programme for Delivery

November 2023

1. Introduction

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

The content of this report has been altered from this month to include: (1) the overall number and score of risks being managed and reported, and (2) a detailed position for each element of critical path and associated project programmes.

The budget position for each project is being updated and refined. This will be included in future Trust Board reports from December 2023.

2. Key Risks

The tables below show the number and rating of key/high risks managed locally for each project.

Project	Project Manager	Open Risks	Low	Med	High (15+)
Park	KO	4	2	2	
Eaton Road Frontage	KO	2	2		
Fracture/ Dermatology OPD	KO	6		6	
Police Station Refurb	Day PM	15	7	9	
Neonatal & UCC	JOB/Hive	9	2	6	1
Alder Park Phase 1: EDYS	JVH/Day PM	Risk Register being developed			
Elective Surgical Hub	JVH/Day PM	Scope of project TBD			

KO - Kieron O'Toole
JOB - Jim O'Brien
JVH – Jayne Halloran

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Park	Failure to deliver long term vision for park	BAF 3.1	12	Majority of Phase 3 to be available early 2024 with seeding of pitches to take longer.
Neonatal & UCC	Inflation risk on project due to contract sign delay	Part of overall inflation risk (RL)	20	Weekly meetings with contractor to assess and maintain current inflation risk contingency. Separate paper to be shared with RABD 07.11.23.
SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Trust has responded to CEs received. No formal claim or arbitration yet submitted by contractor.

* There is an existing inflation risk on InPhase

3. Programme Delivery Timetable (Critical Path)

Project	Deliverable	2023			2024												2025												2026+
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	
Park	Phase 3 Reinstatement																												
	Histo Building Demolition																												
Police Station	Refurbishment																												
	Decommission & Removal 3SM																												
Neo-Natal & UCC	Service Diversions																												
	Main Construction Period																												
	Morgan Sindall Offices																												
	Morgan Sindall Welfare Cabins																												
SFH/Catkin	Sprinkler System Solution																												
Eaton Road Frontage	Phase 1																												
	Phase 2 TBD																												

4. Programme Delivery Timetable (Associated Projects)

		2023			2024											2025												2026+
Project	**Deliverable**	Oct	No	Dec	Jan	Feb	Ma	Apr	Ma	Jun	Jul	Aug	Sep	Oct	No	Dec	Jan	Feb	Ma	Apr	Ma	Jun	July	Aug	Sep	Oct	No	Dec	
Base Camp	Install																												
Alder Park	Construction Phase 1 (EDYS)																												
	Construction Phase 2 TBD (Therapies & Sefton CAMHS)																												
Elective Surgical Hub	Refurbishment TBD (scope of works under review)																												
Fracture/ Dermatology OPD	Dermatology Refurb																												
Fracture/ Dermatology OPD	Fractures Refurb																												
SG Garden	OPD Extension TBD																												
SG Garden	Garden Refurb TBD																												
Nursery	Construction																												
Rainbow Centre	Rainbow Suite Refurb TBD																												
PALS	Refurb Feasibility TBC																												
North-East Plot	TBD																												

5. Project Updates

Neonatal and Urgent Care Centre

Deliverable	RAG	Risks/Issues	Actions/Next Steps
The service diversion works commenced on 02.10.23.		Nothing to escalate.	Works will take up to 6 months to complete.
Phase 2 of contract to be signed by 30.11.23.		Increased construction inflation & SPV costs. Delay to unit opening.	Detailed cost, programme and risk paper shared with RABD 07.11.23. Agree EDU design and decant plan.
Phase 1 of the neo-look patient monitoring system has been signed off by the clinical team.		Coordination of technologies and flow of patient data between neo-look at the vital signs monitoring systems.	Philips workshop scheduled for November 2023 with a demo booked for 29.11.23.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Trust response to contractor re: Compensation Events 13.10.23. • No formal claim or arbitration yet submitted by contractor.		Possible contract claim.	Trust to review next steps with legal advisors.
Sprinkler System Under-Croft Car Park: • Tender issued 06.10.23, returns submitted 06.11.23. • A range of 'off the shelf' and bespoke systems will be considered compliant. • Qualitative submissions will be assessed and scored by the panel who approved the technical submission, with input requested from Merseyside Fire & Rescue. • Business case completed. • Final works completion estimated 8-12 months.		Fire compliance. Potential loss of overall car park numbers.	Proposals to be reviewed upon receipt, and costs available for RABD approvals November 2023.

Deliverable (Catkin & Sunflower Cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Water Safety Issues: Remediation of water mains and back fill completed. Internal works (pipework replacement & removal of any jointing compound) complete. RADA and anti-ligature showers & taps reprogrammed in accordance with Water Safety Group recommendations.		Continued contamination.	Monitor and re-sample.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Immediate priorities are being progressed, and will be shared/proposed at 05.12.23 LNC meeting: • Capacity and environment review of 2A, 2B & 2C in the main hospital. • Environmental review Institute in the Park. • Revised governance & reporting arrangements. • Allocation of desk numbers for priority staff groups. Accommodation for Morgan Sindall contractor offices agreed within Histopathology building. Budget and scope of works to be agreed.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for minor works/kit.	Develop action plan for each project and establish reporting / approvals mechanism.
Former Police Station Refurb: • Site set up meeting held 16.10.23. • Construction completion expected May 2024, a delay of one month since last reported due to delay in completion of the sale of the building & handover to the Trust which has now been achieved. • The lease of the 3-storey modular building (3SM) was extended for an initial 3-month period.		Operational date currently assessed as May 2024. Increased cost c£200K to further extend lease for 3SM.	Any further extension to the lease for 3SM to be confirmed with Laing O'Rourke by 22.11.23.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: Meeting with Friends of Springfield Park 07.11.23. Public meeting scheduled for 06.12.23.		Inconsistent communications.	Future meeting dates to be agreed. Continued and maintained input & communications from all key stakeholders.
Completion Works: Challenges with completing drainage and seeding of the pitches due to ground conditions. Supplier delays on installation of the play area now due to be fitted end of October. Ongoing programme reviews to mitigate delays where possible but given the tight programme, the issues are impacting on the overall completion date. Existing Infrastructure works are still present in the park area.		Delays in completion of preparation, soil and seeding of complete football pitches.	Continued bi-weekly coordination meeting to closely monitor infrastructure and park development site works to maintain the park programme.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Programme: Following a robust review of programme by the new Project Manager for Mitie and the Trust, the completion date is assessed as December 2024. This has been discussed with the Division.		Delay to completion, impact on operational running of the services.	Regular meetings. Close monitoring of critical risks. Programme to be agreed upon selection of a construction contractor.
Tender Process: Mitie addressing first part of TVE (to complete design, & tender documentation): • Proposed Tender Period: December 2023 – January 2024. • Tender Submission Returns: mid-January 2024. • Appoint Construction Contractor: Spring 2024.		SPV/Mitie have not achieved dates set out in the programme. Timely appointment of a construction contractor.	Regular SPV meetings continuing.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Phase 1 - High level programme to be fully agreed. Phase 1 completion August 2024.		Phase 1 – planning approval, interface with Catkin/Sunflower building (works and access), and cost certainty. Budget to be identified for phases 2 &3.	Finance to confirm funding options. Update presented at Executive Design Review 26.09.23. Further develop wider site master plan for Alder Hey and Alder Park in line with 2030 Strategy.

Elective Surgical Day Case

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Budget and scope review, led by Divisional senior leadership team supported by Development Team and Day PM.		Programme, available budget.	Revised scope of works to be determined with potential options.

Nursery

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Planning consultation period closed, no significant objections noted. Construction currently forecast January – October 2024, based on an affordable scheme.		Confirmed programme.	Regular meetings continue.

Rainbow Centre Refurbishment

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Room layouts signed off by clinical / leadership team 15.09.23.		Programme, available budget.	Design pack issued and TVE to be submitted to SPV for costing and programme.

6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 9 November 2023.

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	**Learning from the Letby Case – Initial organisational governance assessment**
Report of:	**Chief Medical Officer** **Chief Nursing Officer** **Director of Corporate Affairs**
Paper Prepared by:	**Chief Medical Officer** **Chief Nursing Officer** **Director of Corporate Affairs**
Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this paper is to provide a position paper with regard to learning assimilated to date from the outcome of the Letby trial and the terms of reference of the upcoming public inquiry
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:	Not yet identified

Does this relate to a risk? Yes ☐ No ☑

Risk Number	Risk Description	Score

Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

LEARNING FROM THE LETBY CASE – INITIAL ORGANISATIONAL GOVERNANCE ASSESSMENT

1. Purpose

The purpose of this paper is to provide the Board with an initial overview of the Trust's current position in relation to the emerging learning from the Lucy Letby case from a wider governance perspective and to propose an initial range of actions based upon an analysis of our existing arrangements and agreed plans.

2. Context

The Board will be aware that the terms of reference for the Thirlwall Inquiry into the circumstances surrounding the actions of Lucy Letby were published on 19th October 2023. An annex to the terms of reference was also released by the government which posed a series of questions that the Inquiry may wish to consider. It is likely that these questions were framed by the families of the victims. Whilst we recognise that this list is not exhaustive, nor does it form part of the formal terms of reference of the Inquiry, it does provide an insight into the concerns expressed by the families of the victims and on that basis is a helpful aid to our learning and future thinking, which we clearly wish to be driven by those experiences so that we can reflect and improve upon our own arrangements and practice.

3. Initial assessment

The summary below is designed to be a live discussion document for the Board rather than a definitive set of actions. We are acutely conscious that the Inquiry's focus will shift as the proceedings progress and evidence is heard. Indeed, the Trust has already received advance notice from NHS England that we, along with all Neonatal units nationwide, will be asked to provide written evidence to the Inquiry by mid-December. It is proposed therefore to update the framework we set out below on an ongoing basis to ensure we are fluent with the issues that emerge for the families and are learning from the process in real time.

4. Recommendation

The Board is asked to endorse the approach suggested by the three Executive leads accountable for Trust clinical and corporate governance, to discuss and agree the actions and to sponsor an open learning approach to the public inquiry as it proceeds.

Theme 1: Experience	Current position	Proposed action
Adequacy of information provided to parents	We provide information about raising concerns (PALS) and making a complaint - this was recently updated on the website. We need to review information relating to concerns regarding clinical deterioration as part of Martha's Rule.	Information about clinical deterioration and pals / complaints is reviewed and revised as part of Martha's rule which will include 24/7 response via the Response Team.
Quality of response when concerns are raised by parents	In terms of formal complaints each response is reviewed at divisional, CNO and CEO stages. Regular MIAA audits undertaken include sampling.	Consider evaluation of process with parents.
Access to child's medical records	SAR process – levels of compliance with time frames monitored through Risk Management Forum and reported to ARC. Escalation process in place for urgent cases.	None
Information provided to parents on the death of their child	Managed via Snowdrop team and includes an offer to meet with the relevant clinical team. The parents are asked what question the HMRG should consider when reviewing a death and feedback is provided.	None
Application of Duty of Candour (reg 20)	Fully compliant and reported to Board through SI report monthly.	None
Experience of PALS	Monitored through the IPR monthly in terms of performance metrics. Steady improvement being seen. However, we are now reviewing under experience strategy.	Review of our PALS service is part of the experience strategy work.
Trust responsiveness to parents' suggestions	We capture actions arising from complaints but this could be done more systematically across a range of sources.	Parents' Forum being relaunched and will provide focus for suggestions/improvement work based on experience.
Theme 2: Governance		
Adequacy of recruitment checks	Audit has been completed by MIAA with actions agreed and follow up audit in process by HR team.	Review any remaining gaps following re-audit.

Early warning systems and use of data	DETECT in place and widely used. Response Team have 24/7 oversight. All sepsis cases reviewed by matron of the day. Work underway to develop a systemic analysis of data to take a 'heat map' approach to performance/emerging issues in teams and departments.	Need to move to national PEWS once released. Develop 'how do we know?' methodology across safety, workforce and performance metrics.
Effectiveness of speaking up mechanisms	Full time FTSU Guardian in place (dedicated resource) supported by team of champions. Quarterly reports to Board. MIAA audit in process as part of annual audit plan.	Await outcome of audit to inform wider review if appropriate.
Trust culture and its influence on speaking up	This is currently very team related rather than evaluated trust-wide. FTSUG is currently undertaking a whole organisation visibility programme including corporate and off site community teams to raise awareness and take temperature.	We are developing tools to measure safety culture
Robustness of monitoring systems eg. Security, access to drugs	Security - Electronic access to patient areas usually well-policed and staff vigilant. Drugs - Omnicell system in place which uses fingerprint ID / passcode for drug access.	Consider simulation/drilling for specific incident types.
Effectiveness of reporting to external bodies – CQC, NHSE etc	Good relationship with CQC – open and honest, where concerns are raised we provide evidence and have discussions. Also CQC talk to the teams involved directly which contributes to dialogue and is well-received.	None
Adequacy of information provided to the Coroner	No issues have been raised to us; the HMRG process will assist with provision of information due to coverage of local review (all deaths); 80% cases discussed with coroner, the rest go to ME.	None at present
Effectiveness of inter-professional relationships	This is service dependent; we recognise that there can be challenges for some teams at times and need to	Work is underway to develop our safety culture as part of our People Plan and Safety Strategy

	develop a range of support mechanisms and resources.	
Effectiveness of management structures in ensuring patient safety	This is something we plan to test out through the introduction of a structured accountability and performance framework; it is linked to the Trust strategy but will have a strong safety element.	Framework in development.
Quality of information provided to the board when concerns are raised.	The Board is provided with appropriate information and is able to request additional assurance if not satisfied; discussions take place in Part 2 if the matter is confidential. Such confidential discussions can assist with the development of solutions when concerns have been raised informally or are still emerging.	For consideration as part of next Well Led development review. Work is ongoing to develop more sophisticated triangulation of anonymous data between the different speaking up mechanisms.
Adequacy of board oversight of clinical and corporate governance	Board governance arrangements are kept under review and have been updated and flexed in response to events (eg. Covid pandemic) or national policy (eg. patient safety strategy).	For consideration as part of next Well Led development review.
Management of individuals when concerns are raised about their practice	There is a robust policy framework in place to manage individuals and keep the organisation safe. For medical staff the CMO chairs a monthly MHPS working group to ensure that cases are expedited effectively. Legal support is sought as appropriate.	Key employment policies are being reviewed to ensure best practice is reflected and to apply learning from recent experiences.
How information is shared with professional bodies	Shared through the clinical lead with oversight from the CMO and CNO. The CMO holds a quarterly meeting with GMC liaison officer for the Trust. Any requests for information are dealt with promptly and openly as far as possible.	None at present
Treatment of those who raise concerns	Trust has adopted the national Speaking Up policy and a supplementary guide for managers which uses scenarios to coach managers when concerns are raised with them. Dialogue is taking place with regard to what a Just and Restorative culture means for Alder Hey.	Conversations ongoing with regard to good practice in this arena. A focus of this will be how Alder Hey will adopt the Just and Restorative culture in the context of our patient safety strategy.

Theme 3: System issues		
Implementation of recommendations from previous national inquiries – specifically Redfern.	There is evidence of robust responses to previous inquiries including Ockenden, Lampard and Francis. Redfern was specific to Alder Hey and was of great focus for the Trust in the 2000's with dedicated resource.	Consider review of post Redfern report activities – subject to availability of information.
Effectiveness of regulation	As above, Alder Hey as a Trust works openly with its regulators.	None at present.
Management accountability	FPPT was implemented in 2014 and robust arrangements are in place for ongoing monitoring of individual directors. New guidance converted to policy and approved by the Board in October 2023.	Ensure all checks carried out as per updated guidance.

Nathan Askew, Alfie Bass and Erica Saunders
November 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	Serious Incident, Learning and Improvement report 1st – 30th September 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	☐ ☑ ☐ ☑
Action/Decision Required:	To note To approve	☑ ☐
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).	
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:		

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Purpose

The purpose of this paper is to provide the Trust Board with oversight of those incidents that are considered as serious incidents following the guidance from the NHS England Serious Incident Framework (March 2015), and any associated learning for the reporting timeframe 1st – 30th September 2023.

2. Background

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

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

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

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

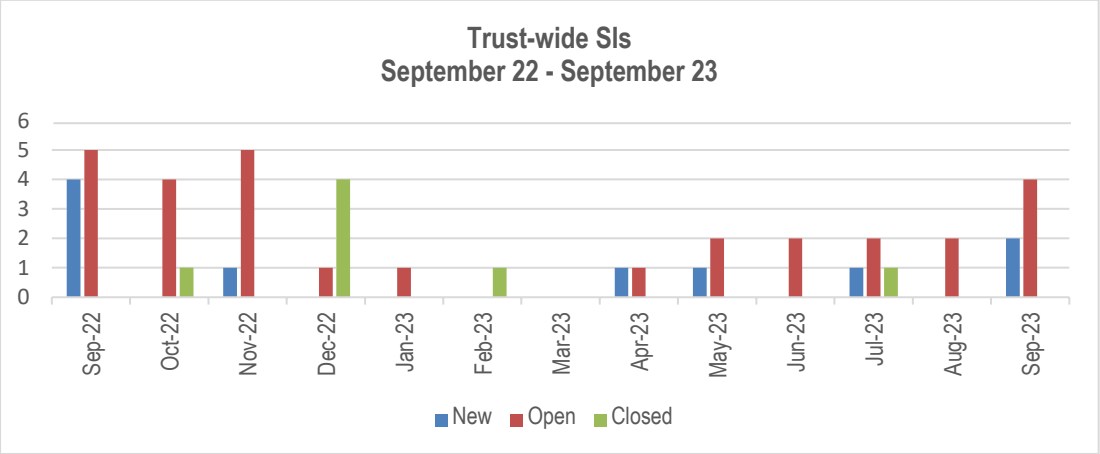
3. Local context

3.1 Never Events

The Trust declared **1** Never Event during the reporting period (1st – 30th September 2023).

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status September 2023



3.2.1 Declared Serious Incidents

The Trust declared **2** StEIS incidents during the reporting period (1st – 30th September 2023).

3.2.2 Open Serious Incidents

4 SIs were open during the reporting period as outlined in table 1.
0 SI investigations were completed in this reporting period (1st – 30th September 2023).

Table 1 Open SIs September 2023

StEIS reference	Date reported	Division	Incident	Summary
2023/10739	23/05/2023 (reported to StEIS 31/05/2023)	Medicine	Delayed diagnosis of bone malignancy.	Refer to appendix 1.
2023/12980	02/07/2023 (reported to StEIS 05/07/2023)	Surgery	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	
2023/17791	15/09/2023 (reported to StEIS 21/09/2023)	Surgery	Wrong implant / prosthesis used.	
2023/18692	30/09/2023 (reported to StEIS 06/10/2023)	Surgery	1 year 9 months female admitted for elective craniofacial surgery 29/09/2023. Cardiac arrest on ward post-operatively, transferred to PICU. Cardiac arrest secondary to tension pneumothorax. Patient sadly died 02/10/2023.	

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 30th September 2023):

0 SI action plans open.
1 SI action plan was completed.

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

3.3 Internal level 2 RCA Investigations

The Trust declared **0** internal level 2 RCA investigations during the reporting period (1st – 30th September 2023).

3.4 Duty of Candour

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

2 initial and 1 final Duty of Candour responses were required and completed within expected deadlines during the reporting period (1st – 30th September 2023).

4. Learning from serious incidents

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

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

1 SI action plan was completed during the reporting period (1st – 30th September 2023). Immediate lessons learnt from all SIs are outlined where applicable in this report.

Recommendations

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

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2023/ 10739 **InPhase ID - 783**	Delayed diagnosis of bone malignancy.	Limping child guidelines should be followed. Number of attendances should be reviewed and taken into consideration. Multiple attendances resulted in no clear diagnosis even though there were ongoing symptoms.	Referred to Orthopaedics. Child has now been referred to the oncologist for a biopsy, staging and subsequent treatment. Potential amputation required as the tumour is extensive. **September 2023:** Panel held 08/09/2023. RCA investigation completed and sent to commissioners 12/10/2023 pending approval.
2023/ 12980 **InPhase ID - 1802**	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	Escalation could have happened sooner. Line could have been removed sooner. Antibiotic usage was appropriate. Unclear escalation plan in place.	Review of escalation of patients in and out of hours so it is clear for the Neonatal Unit. Review as to why the line was not removed earlier. **September 2023:** Report being written by the Associate Chief Nurse for Surgery. Extension agreed to 10/10/2023. Second extension requested 10/11/2023 due to ongoing clinical discussions.
2023/ 17791 **InPhase ID - 3854**	Wrong implant / prosthesis used.	Request form needs to be visible to all staff (needs to be uploaded to EPR and printed as part of the preop paperwork). The Lines List Calendar should be more widely visible. Code/description for listing port and CVL on Meditech v6 were the same. On Expanse the procedures have their own descriptions on the ambulatory order. This process changed the Monday preceding the operation.	Separating out of consent forms for individual procedures. Making lines list calendar visible to all consultants and registrars completing the lines list. Include lines list request form as part of lines list huddle.

		Need separate E-consent form for tunnelled CVL/port/haemodialysis line. Better system for Line Requests necessary – Should be on Expanse with Ambulatory Order to allow for end-to-end audit of process. IT Equipment should be available for the forms to be viewed correctly. The Line Request forms should be easier to read. The selection should be more clearly visible.	**September 2023:** Never Event declared 19/09/2023. Initial Duty of Candour completed and RCA investigation in progress. Investigation panel completed on 11/10/2023. Draft report in progress.
2023/ 18392 **InPhase ID - 4287**	1 year 9 months female admitted for elective craniofacial surgery 29/09/2023. Cardiac arrest on ward post-operatively, transferred to PICU. Cardiac arrest secondary to tension pneumothorax. Patient sadly died 02/10/2023.	SUDIC protocol not triggered, safeguarding team since aware, social work referral made and discussion took place with Merseyside Police 04.10.23, log number 406041023. Airvo implemented but plan of care not documented. Inconsistency in completion and documentation of observations.	Planned debrief with medical and nursing staff scheduled. Joint morbidity and mortality meeting to be coordinated between medical teams caring for the patient. **September 2023:** Initial verbal and written Duty of Candour completed and RCA investigation underway.

Appendix 2

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	Safety Quality Assurance Committee
Report of:	Fiona Beveridge, Non-Executive Director
Paper Prepared by:	Fiona Beveridge

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 18th October 2023, along with the approved minutes from the 20th of September 2023 meeting.
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:	

Does this relate to a risk? Yes ☐ No ☐

Risk Number	Risk Description	Score
1.1.	Inability to delivery safe and high-quality services	9
1.2.	Children and young people waiting beyond the national standard to access planned care and urgent care	20
1.4.	Access to children & Young People's Mental Health	15

Level of assurance (as defined against the risk in Inphase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

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 a good **Inphase** update and agreed to receive a further update in November 2023. SQAC noted that the issues have been mostly with aggregate reports and that, though some manual intervention is required, reports of incidents continue to be made and actioned on the ground.
- SQAC received a **Patient Safety Strategy** update, and noted the growing maturity of the Reports, with the addition of a benefits realisation aspect before closure of workstreams noted. The positive feedback being gathered on the new system for acknowledgement of medical test results was welcomed, acknowledging that there are still some tweaks and that individual conversations would be pursued in some areas;
- SQAC noted the AMR software request; and
- SQAC noted the learning from litigation and discussed where this line of work might develop in the future.

- SQAC received the **ED monthly update report: MH attendances and ED @ its best** update and noted the ongoing pressures which are increasing. SQAC received an update on the plan to increase capacity which would be deployed in November 2023 as demand increases
- SQAC received the **DIPC report**, SQAC highlighted issues for future DIPC reports to assist with the navigation of the DIPC report and queried whether progress was being made to provide appropriate isolation for day-care patients with infections
- SQAC received the **Sepsis update** which included an ED Sepsis Deep, SQAC noted the progress being made with regards to Sepsis, however further improvements are required regarding Sepsis mandatory training. Divisions were requested to focus on improved Sepsis mandatory training compliance. SQAC noted that there had been 1 sepsis death. SQAC noted the push towards implementation of Martha's rule. SQAC noted that the meditech/expanse implementation had delayed progress in addressing a number of sepsis reporting improvements
- SQAC welcomed the **Drugs & Therapeutics Committee** Quarterly Report, and acknowledged the real sense of progress made in terms of establishing the Committee and the Drugs & Therapeutics Committee structure which is emerging.
- SQAC were delighted to receive the very positive report of the **Mental Health Act 1983 (MHA) Monitoring visit** following CQC visit to Sunflower House.
- SQAC received the belated **Complaints, PALS and Compliments** report which had previously been shared at the Board of Directors meeting
- SQAC received the **Patient and Family Feedback Quarterly** report. SQAC noted expanse issues impacting on the content of the report
- SQAC received **Divisional updates** which also included a deep dive regarding line infections that had occurred from September 2022 – September 2023. FB thanked

0107 colleagues for deep dive line infections.

- Community and Mental Health colleagues drew attention to work undertaken to address the number of open incidents, and risks being pro-actively managed with Pharmacy regarding ADHD medication availability. Discussion took place on the complaints arising from access delays to ADHD and AHD Assessment and Diagnostic service, and steps taken to keep patients and carers informed of their situation.
- Research division highlighted improved staffing position and focus on sepsis training.
- Surgery highlighted successful work with NHS England on a pilot study on ear health and hearing screening in residential schools, pointed to use of a patient input relating to a particular incident to highlight how the new PSIRF approach is being adopted.
- Medicine identified a number of challenges arising from growing winter pressures. Two particularly complex complaints are receiving input from legal advisers, so taking some time. The learning and action plans relating to line infections seemed specific and strong and appear to be having a positive impact.

- SQAC received the **Transition** report and noted the good progress made.

4. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 20th September 2023
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Clare Ellis	Head of Operations – Laboratory Medicine	(CE)
	John Grinnell	Managing Director/Chief Financial Officer	(JG)
	Rachael Hanger	Associate Chief Nurse, Surgery Division	(RH)
	Jo Revill	Non-Executive Director	(JRe)
	Jacqui Pointon	Associate Chief Nurse–Community & Mental Health Division	(JP)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Melissa Swindell	Chief People Officer	(MS)
	Catherine Wardell	Associate Chief Nurse – Medicine Division	(CW)

In Attendance:			
23/24/98	Will Weston	Medical Services Director	(WW)
	Kelly Black	Surgical Matron – Division of Surgery	(KB)
23/24/102	Julie Grice	Mortality Lead	(JG)
23/24/105	Natalie Palin	Director of Transformation and Change	(NP)
	Jill Preece	Governance Manager	(JPr)
	Laura Rad	Head of Nursing-Research	(LR)
	Jane Ratcliffe	Consultant, Complex Care	(JR)
	Peter White	Chief Nursing Information Officer	(PW)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)

Apologies:	Pauline Brown	Director of Nursing	(PB)
	Lisa Cooper	Divisional Director Community & Mental Health Services	(LC)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Paul Sanderson	Interim Chief Pharmacist	(PS)
	Erica Saunders	Director of Corporate Affairs	(ES)

23/24/93 Welcome and Apologies

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

23/24/94 Declarations of Interest

None

23/24/95 Minutes of the Previous Meeting

Committee members were content to APPROVE the notes of the meeting held on 19th July 2023.

23/24/96 Matters Arising and Action Log

The action log was received and updated.

Inphase update - SQAC **NOTED** that a comprehensive Inphase Report would be presented to Executive Team on 28th September 2023.

Aggregate Analysis of Incidents Complaints, PALS & Complaints – JR advised that she had liaised with divisions with regards to the fluctuations in data for self harm. JR stated that there had been no data anomaly, as the Trust does have to report any restraints pertaining to Mental Health or anyone who is restrained for feeding, such as a patient with an eating disorder and the Trust could have 3 or 4

incidents in one day for the same child. SQAC **NOTED** the update and agreed for this action to be closed and removed from the action log.

Sepsis Mandatory training compliance update:
Medicine Division – CW provided update:

- Overall Sepsis Mandatory training compliance is 87.16% with the Division on an upward trajectory.
- 3 wards are above 90% compliance, 3 wards are below the target. On review there had been issues regarding ESR, colleagues had since had training and CW is confident that compliance levels would now increase.
- Sepsis training remains a high priority within the Division of Medicine, Division had introduced the introduction of sims training which would be delivered in the ward areas, this would be undertaken in conjunction with the practice educator. Ward3B would be the first ward as this ward has the highest number of sepsis patients.

FB sought clarity regarding timeline of completion of sepsis training for those individuals who had been incorrectly exempted from Sepsis mandatory training. CW advised that she envisaged that this would be completed by the end of September 2023

Division of Surgery – RH provided update:

- Overall Sepsis Mandatory training compliance is 80.48%. RH had received assurance from all of the wards through review of the Division of Surgery challenge board. RH is confident of an improvement in Sepsis Mandatory training and that by 30th September 2023 all ward areas will be compliant.
- The Division had seen issues regarding individuals who are on long term sickness that are still displayed as requiring Sepsis mandatory training this accounts for a small number of staff within the Division.
- RH stated that there are a significant number of individuals within the Division of Surgery which stated that they are not required for training, despite these individuals requiring training – Division of Surgery colleagues are working with HR/ESR colleagues to address this issue, with potential impact on Sepsis mandatory training compliance in the short term whilst individuals attend Sepsis mandatory training.

Division of Community & Mental Health – JP provided update:

- Overall Sepsis Mandatory training compliance is 76% compliance in August 2023. Similar to the other Divisions there are some discrepancies regarding those staff who are requiring training, this issue had now been amended on ESR.
- In addition there had been technical issues accessing the Sepsis mandatory training module, this had been escalated to relevant colleagues and is continuing to be monitored through the Divisions Infection Prevention Control meetings and the Tissue viability sub group.

FB stated that there is mixed reporting regarding levels of compliance and issues being addressed and advised that SQAC would review this again, FB welcomed proposed timescale from NA. NA suggested a 3 month review. NA stated that the breakdown of wards was helpful, which highlighted the areas of focus, acknowledging the requirement for the data to be cleansed. NA advised that Sepsis mandatory training is not onerous.
Resolved: SQAC to receive update report on outstanding levels of Sepsis Mandatory Training compliance report at December 2023, to provide assurance on improved compliance, SQAC welcomed detail regarding the verification process for those staff on long term sickness to enable SQAC to receive assurance regarding levels of compliance.
Resolved: Divisions to promptly risk assess those high risk areas to ensure improved sepsis mandatory training compliance– i.e., neonatal compliance to enable those high risk areas to be reviewed
FB thanked all for Sepsis Mandatory Training compliance update.

23/24/97 SQAC data pack – 16th August 2023 – SQAC **NOTED** that there was no meeting held on 16th August 2023, SQAC had been requested to review the SQAC data pack circulated on 9th August 2023 and colleagues were requested to raise any questions by email. On review of the data pack by SQAC, no questions or significant issues were raised.

Assurance on Key Risks

23/24/98 *Delivery of Outstanding Care*

Safe

Patient Safety update

WW presented an update on the work of the Patient Safety Strategy Board:-

- There are 12 workstreams covering insight, involvement and improvement. In terms of success highlights since the last Patient Safety Strategy update Patient Safety colleagues continue to apply careful scrutiny to workstreams, 1, 2, 7, 13 & 16.
- No significant concerning trends to note.
- There are still strong intentions to incorporate measures of staff safety culture into the high level metrics.
- Patient Safety colleagues are looking forward to further business intelligence support following the completion of Inphase and Expanse data migration.
- Workstream 2 – colleagues had seen an increase in the amount of data being reported on Inphase, which is a reflection of increased reporting which is welcomed.
- Pharmacy team had successfully incorporated a dashboard, which includes a greater spotlight on medication safety, 10 times medication errors and TPN incidents
- Neonatal and new-born screening - All elements of the screening programme are now live and are on the relevant national systems. There is now oversight of the screening status of all neonates at Alder Hey and the associated outcomes, and in addition work continues with NHSE to evaluate patient pathways
- learning disabilities workstream- encouraging improvement in the proportion of appropriate referrals when comparing a figure of 92% in July, with earlier figures this year in April – when 66% of referrals were appropriate.
- A further significant success recently was highlighted by the Children and Young People as patient safety partners have a workstream because the Patient Safety Partners policy is now at the approval and ratification stage. The Job Description for the patient safety partners covering two age groups is now being finalised.
- There are a range of quality ward rounds which had taken place with the Children & Young People Forum and young volunteers.
- Assurance – Patient Safety colleagues had seen a slight decrease with regards to progression with programme assurance, mainly as a result of a temporary gap in project management. This had now been rectified and Patient Safety colleagues are keen to welcome a new project manager.
- When comparing the previous Patient Safety Strategy update colleagues would see improvements relating to stakeholder engagement and reporting of milestones.
- Further work is required with regards to defining benefits, quality impact assessments and equality analysis.
- Patient Safety colleagues look forward to approval of a patient safety business case, which involves the recruitment of two trained patient safety investigators. This is a national requirement and would further strengthen the patient safety approach. Patient Safety colleagues acknowledged that JR and CT had been working tirelessly in preparation for the implementation of PSIRF, which would help to ensure that the Patient Safety Strategy is aligned with both national requirements and the Trust vision for 2030.

KB alluded to a number of projects which had been both opened and closed already. KB stated that she assumed that Patient Safety colleagues had reviewed the benefits and sought clarity whether SQAC could receive a report detailing when a project had been closed, and detailing whether achievements had been met following those closed projects. WW provided assurance that programmes are only closed when the Patient Safety Strategy Board are happy that the milestones and benefits had been realised. WW confirmed that those benefits could be shared with SQAC for review going forward.

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

Resolved: SQAC received and **NOTED** the good progress in month and welcomed future Patient Safety Strategy updates. Patient Safety colleagues to consider how SQAC would receive insight into benefit analysis when closing down workstreams.

ED MH attendance & ED @ its best update report

UD presented the ED MH attendance & ED @ its best report:-

- During the month of August 2023 92% of Children and Young People were treated within 4 hours of attendance. For the ED department the ED stay for three patients was more than 12 hours, there had

been a deep dive into this time to triage which was around 7 minutes and time to clinician for consultant review was 42 minutes.

- There had been a decrease with regards to children and young people who had left before seen to 1%
- Friends and family shows a continuous improvement of around 93% recommending the service.
- ED department continue to be focussed on improving access within 4 hours, improving time to first clinic review, and reducing the number of breaches out of hours. There are several ongoing initiatives as part of the model of care which ABa is leading on, this remains in progress with ED colleagues supporting this and reducing breaches.
- The PAU pilot went live on 8th August 2023
- Division are reviewing winter plan schemes for 23/24 which include how to avoid ED, rapid assessment, treatment options and improved discharge pathways.

UD alluded to 5 children and young people who attended the ED with mental health concerns, and had not been referred to crisis care, following review of the 5 children and young people not referred all were considered to have received the appropriate care and input, of those 3 Children and Young people had physical health differential diagnosis with a plan for follow up with primary care, once physical health had been fully investigated. Once Child/Young person who had a eating disorder who was admitted and received mental health support on the ward and one child/young person was appropriately referred to safeguarding and social care for follow up.

FB sought clarity whether any comments or feedback had been provided to UD or CW from staff in terms of staff experience and morale during this period of time, UD stated that in general morale is good within the service, there had been a CQC visit on 19.9.23, and despite the ongoing Industrial Action and the deployment of Alder Care staff generally have improved morale.

CW stated that the Division are undertaking temperature checks and that generally staff are feeling more content, retention of staff had also improved.

UD stated that the leadership in ED is correct which is making a positive impact, particularly with regards to the Head of Nursing role.

FB welcomed the improvements and innovation and highlighted the importance of maintaining the progress over the winter period.

Resolved: SQAC received and **NOTED** the ED MH attendance & ED @ its best update report.

23/24/100 Board Assurance Framework

NA presented the Board Assurance Framework

- NA referred to 1.1 regarding the continued Industrial Action, which is being managed well, with strategic command and control in place. Junior Doctors and Consultants are both undertaking Industrial Acton together on 19/20th September 2023, the Trust has as much mitigation in place as possible. NA stated that there is recognition nationally regarding the impact regarding increased waits and the financial impacts on organisations.
- ES and JP are working hard on the transition of the current Board Assurance Framework to the 2030 vision Board Assurance Framework, with good progress made to date, first review of the Board Assurance Framework would be at the Strategy Board in 2/3 weeks' time.

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

SQAC referred to those SQAC risks and particularly risk 1.1 and stated that colleagues are going to see an increase in the gaps in control, due to the ambition of the 2030 strategy.

SQAC welcomed review of the new version of the Board Assurance Framework and those mitigations for those gaps in control.

23/24/101 Inphase Update

FB expressed concern with regards to the SQAC annual work plan which had been approved, and the immediate slippage on the annual workplan. FB welcomed an update/explanation for Inphase slippage.

PW presented Inphase presentation, which provided an overview on the current position:

PW expressed apologies to SQAC for not presenting the InPhase report to SQAC, due to the demands of the recent deployment of Alder Care.

- Aldercare had been safely deployed over the last week. An Inphase Report is due to be presented to Executive Team on 28th September 2023 and a further update could be presented to SQAC at October 2023 meeting if required by SQAC.
- 7 reports are under review, of which 2 are due to be signed off on 20.9.23 (BAF/Incident report).
- 5 reports require minor updates and internal testing for sign off by the end of this week.
- Inphase itself had been listed as a risk - risk number 22, with several mitigations in place, including manual extraction of data, as opposed to the automated reports feature, which is currently developing.
- Learning from the last 6 months since the InPhase system had been deployed, PW stated that the Trust's initial ask was too broad and that the Trust did not take the opportunity to review Alder Hey processes and have the idealised single source of Truth.
- Reports had since been streamlined, with only 7 reports required, which will be signed off by the end of this week.
- Assumption had been made by the Trust that InPhase would provide data that the Trust previously reported but this had not been requested. The Trust should have been very clear regarding the ask from the beginning, this is clear learning for other digital projects.
- Colleagues should have been implementing much earlier shared learning with those established sites, although discussions took place with other Trusts, colleagues were not liaising with directly with reporting teams or development teams, and were speaking with end users and governance leads who In phase next steps.
- All outstanding reports are due to be signed off by the end of this week.
- iDigital BI specialists to work directly with corporate/division governance leads to enhance reporting and dashboard infrastructure.
- Report with full action plan to be presented to Executive Team on 28.9.23, Executive Team had aided with delivery of the 7 core reports.

JG alluded to the risk module and queried whether colleagues had focussed particularly on the incident reporting element. PW stated that there are 10 core modules; and that the reports were retrieving data from several places, the aggregate work had been extremely challenging regarding legacy risks that had been brought forward, and the data mismatch, i.e risks that had been open for 12 months and ensuring that the data is consistent with previous reporting. Inphase team had been reviewing all modules, regarding triangulation needed, with ongoing work taking place.

FB expressed thanks to all.

Resolved: SQAC received Inphase update.

Caring
Effective

23/24/102 Mortality Report - JG presented the Mortality report:

JG advised that this time of year that the Trust is running higher than usual for the number of deaths, and the Trust had not seen a decrease during the summer period. JG envisaged that during the month of August 2023 that mortality cases would decrease, however there were 8 mortality cases, there are no concerning features for the Trust. JG had raised this issue with the Child Death Overview Panel on 19.9.23 and they also noted as a Region mortality figures had remained higher. Colleagues at the Child Death Overview Panel had discussions regarding any potential causes and across the deaths that had been reviewed by the Child Death Overview Panel to date which cover the whole of Merseyside and the Isle of Man and the outliers – those patients that had died whilst in the area, over half of the mortality cases are SUDIs/SDICS and requires discussion whether this is a national change, with no significant concerning issues for the Trust. FB requested clarity regarding SUDIs/SDICs, - unexpected deaths surprising, the Trust would have those expected deaths such as a child with chronic medical condition, however these are cases whereby babies have suddenly died at home. JG queried whether there is impact following covid and the impact of health visitor support that parents were receiving at home, and whether this is now impacting on the care provided in the community. The Child Death Overview Panel are aware.

Issues

- Change in LeDer reporting –as a Trust this will have little change, reporting is now going directly to the Child mortality database.

- JG alluded to whether looking at the number of cases, and with so many cases of death being inevitable, whether importing some kind of mortality into the Trust. JG stated this is difficult given if retrieval teams go out to different places in the country, it is then very difficult to not bring a child back, and there are parental expectations, and sometimes assessments need to take place to show that there are no options for care. This does not impact on care and there are no concerning themes.
- ME Pilot had been slightly delayed due to IT issues, this is being addressed following expanse introduction, with forms going onto meditech.
- ME Introduction had been delayed nationally until April 2024.
- Ongoing work regarding community deaths to ensure pathway is smoother.
- JG referred to the Lucy Letby case and the issues that arise from this, at present it is not clear on what guidance may change. JG envisaged that neonatal deaths are likely to have far more scrutiny and advised that a section within the report would be included to ensure this is clearer, to ascertain whether there are any neonatal themes. JG confirmed that the Trust does participate in PMRT but the Trust cannot undertake PMRT reviews ourselves as it covers obstetric care and Alder Hey Children's NHS Foundation Trust provide no obstetric care, the only way this Trust can participate is to aid the aspects of care the Trust provides, with close links with Liverpool Women's NHS Foundation Trust to ensure a two way process. JG is reaching out with colleagues in the Neonatal network. JG is expecting further family feedback into the Mortality Review Group and more questions asked as it has impact across Trust wide.

Learning

- Sharepoint is nearly ready
- Despite Industrial action HMRG had caught up with outstanding mortality reviews, had reviewed hospice reviews and have had extra mortality meetings.

Future

- Future ME examiner pilot
- Readily available learning points/newsletter
- Close links with Birmingham
- Update of Terms of Reference and policy
- Changes to HMRG and departmental forms
- Adapt according to feedback when appropriate**.**

Resolved: SQAC received and **NOTED** the Mortality Report

FB expressed thanks to JG for comments relating to L Letby case.
ABa congratulated JG in reaching 100% regarding standard reporting.

ABa alluded to neonatal deaths, and stated that although the babies at LWH are not AH babies our Trust do share a service and are joined in that responsibility. AB highlighted the importance of increased visibility across both Liverpool Women's NHS Foundation Trust and Alderhey neonates.
Resolved: JG & AB would discuss this offline at the next 1:1.

JG advised on the current process, that currently all of the PMRT reviews from LWH feed into the mortality process and vice versa, with good clear communication, with a good process for LWH, there is a less clear process for DGH such as Warrington and Whiston. JG advised that there had been an independent review in CDOP for Liverpool over the last year which highlighted that it is a legal requirement for a Designated doctor, a job advert is expected to be issued over the next couple of months.

ABa stated that it is difficult given that there are two trusts, two governance systems, and the two neonatal networks. ABa highlighted the importance of ensuring that all are really comfortable and all are aware of any emerging issues.
RH questioned how the Trust makes those links regarding PMRT and our own investigations process for the shared learning and highlighted the importance of alignment to ensure families only have to receive feedback once.

JR stated that she had recently had this discussion and that JR had reached out to the maternity network across the North West, JR stated that aligns into PSIRF regarding cross arrangements when incidences happen, across organisations. This is work in progress.

JRe sought clarity on how colleagues collect feedback from families and queried whether there is a report into SQAC or a different committee. JG advised that the Snowdrop team seek feedback from families at an appropriate time in their bereavement pathway but there is not a formal report that is shared with SQAC, any comments or recurrent themes are contained within the Mortality Report, often it is quite personal to families involved with any themes identified. JR is happy with this approach, SQAC recognised the sensitivities within the report.

FB expressed thanked to JG for comprehensive update, whilst recognising the outstanding work undertaken to move towards the new regime.

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

23/24/103 CQUIN Quarterly Report

The Trust has a total of 9 CQUINS agreed for this year, whilst many of the CQUINs are on trajectory there are a limited number of CQUINs that during the planning stage seemed fine, however in practically these CQUINs had proved challenging in the translation from adult specific CQUINS to a paediatric CQUIN.

The Trust is continuing to liaise and engage with commissioners, both specialised commissioning and the local commissioners regarding those specific challenging CQUINs. The other CQUINs are on trajectory.

Resolved: SQAC received and **NOTED** the CQUIN Quarterly Report.

23/24/104 Divisional Update and Deep Dive regarding Outstanding NICE Compliance

Division of Surgery: RH provided Divisional update:

- Division had launched ISLA care in the Surgical site surveillance team, which enables families to send in pictures of wounds to enable improved categorisation of infections, ensuring quicker assessment and appropriate treatment, which had proven to be one of the highest performing teams in Isla Care despite only being live for a 6 week period.
- Challenges – the Division had seen an increase in the lost to follow up patients, this is closely being tracked and monitored through the rapid review process, and liaising with the operational team within the division to continue safer waiting list management
- Division continue to have good number of incident reported, with low levels of harm. There was 1 moderate harm that was non clinical, this had been RIDDOR reported in the last month
- Investigations – there is currently a neurology missed follow up investigation, with harm identified this is being reviewed through the investigation process.
- Sepsis compliance in month is 100%
- The division had not seen any Grade 3 or Grade 4 Pressures ulcers for a sustained period of time, with ongoing work taking place to reduce Grade 1 and 2 pressure ulcers.
- Complaint responses remain good, division has had early intervention and discussions with families, and as a result had been able to downgrade a number of complaints into PALS with the agreement of those families.
- The Division have 4 high risks, RH alluded to risk 2712 relating to chest drains which also relate to a national patient safety alert, the division have a clear funded plan for a new chest drains within the Trust, therefore this requires implementation and training roll out, this risk can then be closed.

KB alluded to the data on those incidents relating to minor harm or above, and referred to the run chart and referred to October 2021 – April 2023 there are around 40-60 per month, and that in May onwards there are 0, with similar other run chart. RH stated that she suspected that this is due to how the data is being extracted through from the run charts, and queried whether there is a data issue in extracting the information through to the IPR.

NA advised that these are the two metrics that were changed to be measured in the per 1,000 bed days in the Integrated Performance Report, NA's stated that his assumption was that the work had not been undertaken within the divisional reports. NA advised that he would provide feedback to the BI team and would provide a further update outside of this meeting.

Jo R welcomed the good news on pressure sores, and sought clarity whether this involved more training and sought clarity whether this was embedded or susceptible to much busier periods.

RH advised that the division had seen a significant improvement in PICU, which came from a Grade 3 pressure ulcer approximately 12 months ago, part of plan was to have a daily tissue viability round on the unit, which has resulted in a real change in culture, reporting, escalation and tolerance for any low level signs that there is an issue with a patients pressure area, with a significant impact in PICU, which is one of the highest areas of reporting of pressure ulcers, with general raised awareness of pressure ulcers, with really good engagement, with continued focus and monthly reporting to Divisional Integrated Board.

ABA referred to dietician issue for 1C and stated that it is extremely frustrating regarding the lack of progress to address this issue. AB stated that this is requirement and standard for cardiac services and sought clarity regarding whether there is a plan in place to address. RH stated that there are ongoing discussions with the Dietician team. RH agreed to consult with C Lee to address this issue to enable improvement, RH would provide update to SQAC at October 2023 meeting. AB stated it would be helpful to understand what it preventing this been actioned.

FB alluded to the lost to follow up patients and sought clarity whether there are any emerging themes with regards to this increase. RH stated that following the rapid review colleagues had reviewed whether there are any links, RH stated that they are all slight nuances, however they tend to relate to not having their next follow up being booked. RH envisaged this is due partly to do with validation of pathways, and some cases relate to the discharge process through the ward. RH stated that some areas are impacted by the waiting lists, and that there is a process to clinically review those long waiters, divisional colleagues are aiming to undertake a review by the end of September 2023, with the expectation that RH would be able to provide SQAC with high level detail at the October 2023 meeting. AB stated that the root causes are two fold and that some of the Trust processes when patients are discharged through a ward, however with Alder Care there is a new e form to reduce that error, this will enable analysis whether this is working and stopping any user error, second issue related to the mis match between the demand for follow up appointments, and how many patients are actually seen, as in some departments colleagues are listing far more patients that could possibly be seen, therefore there are a number of patients who will wait beyond the time that the clinician would want for follow up, this is an acute and systemic issue, with a programme of work to be deployed to address this issue, and adopt PIFU and other safeguards to put in place. AB had requested Ronnie Viner who led the Safe Waiting List Programme to take a leadership role on this. AB stated that when the Safe Waiting list update is provided in the future focus should be made on follow ups to provide SQAC with assurance. AB had requested RV to liaise with clinicians, with the intention to establish a programme to reduce those risks in follow up care.

Community & MH – JP provided Divisional update:

- Successes – Specialist speech and language for the deaf had been involved in co production to change the name of the service, and develop a logo. Point is around BSL and the name of the service
- Challenge regarding managing the working environment and finding confidential quiet space for dictation or private telephone discussions in a busy open space, this is being constantly reviewed to enable any improvements, however this is creating challenges for staff and decreased morale.
- Inphase Division are experiencing some teething issues with regards to closing risks and some misunderstanding regarding how the form was set out, this has now been adjusted by the Inphase team, and hopefully people will not be closing risk accidentally when closing the screen. Division are still experiencing challenges with regards to manually retrieving reports from InPhase.
- Largest majority of PALS originate from developmental paeds service and challenges experienced regarding getting these PALS cases closed within 5 days, colleagues had been collaborating with team

to improve compliance, there had been issues relating to people being off work and the division are looking at how to support staff.

Medicine – CW provided Divisional update:

- CW referred to Sepsis and ED and advised that the Division continue to see inconsistencies. The division had undertaken a deep dive to review the cause, effects and the impact, findings are currently being reviewed. CW would present findings to October SQAC.
- PALS and complaints continue to be at 100%.
- Friends and Family Test – the Division had worked hard to increase response rates and improved responses and as a result the Division had received an increase in responses.
- CW referred to pressure sores, with continuous improvement and consistency across the division for patients, the division had no cases of pressure sores, with ongoing work with tissue viability team.

KB alluded to the Risk action and stated that the description had been included in the report and advised when talking about risks at ARC there are 2 as a minimum – i.e the risk appears from nowhere and colleagues can deal with the risk internally and this risk is never seen again, then there are other, risks that have appeared, and are not in the Trusts control to address, and the risk can be long standing. KB queried whether there could be additional columns with a yes/no for two questions within the report that details whether it is one of the risks that can be managed, with sufficient actions identified, and that the risk is on trajectory, or whether the risk is going to be more long standing and challenging issues. JR referred to the risk appetite which is work in progress.

Resolved: NA advised that the template would be reiterated again for next month, resulting in an improved template for next month.

FB stated that it is notable that there are no scores following mitigation, separate from the score on the risk, KB advised that this is the score after mitigation.

UD stated that the Division of Medicine Audit work states 39, and at the beginning of the month this was 15, and the Division currently have 7 which are overdue, with the Division continually focussing on audit and risks.

Research Division

- Research Division had made substantive team leader positions, with shared clinical oversight of the Clinical Research Facility Ward.
- There are a number of staff engagement activities across the division, with patient facing events and key advances within patient experience. The division had launched the Alder Hey Research platform in July 2023, from previous years of having less than 1% the division have had 13% feedback over the last two months, with detailed feedback received.
- Challenges – the division are continuing to support staff through the changes, LR advised that there would be a decline in activity not necessarily connected to safety and quality and raises the question regarding opportunities for research that are given to children given the DETECT ceasing in August 2023 and the commercial studies delay nationally, and various compounding factors i.e., Industrial Action with and a decrease in activity evident.
- There are no issues to escalate in terms of incidents, PALS or pressure sores. Risks are being well managed.
- Deep dive NICE Compliance – there were no NICE compliance issues to report from Research Division.

Outstanding NICE COMPLIANCE – Medicine

CW advised that the Division of Medicine had a much improved position following the last presentation to SQAC. The Division have 29 guidance, 9 are ongoing and 20 completed guidance. There had been 5 challenges requiring a deep dive, 4 had been completed with a baseline assessment completed. 1 is outstanding which relates to pharmacy- NG209 – Tobacco: preventing update, promoting quitting and treating dependence, with challenges experienced as this was provided to the wrong lead and a delay in sending this to the correct person, PS and AG are reviewing this.
The division have a much improved position, with only 1 outstanding NICE guidance overdue.

Resolved: SQAC received and **NOTED** the Divisional update and the improvements relating to the Deep Dive regarding Outstanding NICE Compliance

23/24/105 Clinical Effectiveness and Outcomes Group Chairs Highlight report.

JR, Interim Chair of Clinical Effectiveness & Outcome Group presented the Clinical Effectiveness and Outcomes Group Chairs Highlight report.

JR reported that there had been two substantive chairs appointed Dr. Gavin Cleary and Professor Ian Sinha. JR is meeting weekly with them. There had been 2 Clinical Effectiveness and Outcomes Group meetings to date, with presentations provided at meetings to demonstrate quality of those people undertaking audits, all audit projects would be approved by the Divisional Governance leads to ensure oversight, and quality and relevance to the Trust. JR is currently supported by JR, Linda Wain and the Audit Team.

FB sought clarity regarding escalation to SQAC. JR stated that this is work in progress to embed the culture to ensure audit is a significant feature for all staff, and to ensure that all central guidance issued is addressed, JR reiterated that this is work in progress with work ongoing to improve the profile of audit.

Resolved: SQAC received and **NOTED** the Clinical Effectiveness and Outcomes Group Chairs Highlight report, SQAC were content to support the work of the Clinical Effectiveness and Outcomes Group.

FB expressed thanks to JR and welcomed the positive news regarding the Chairs who had been appointed.

23/23/106 *Well Led*

Patient Safety Incident Response plan and governance process

JR advised that in line with the National Patient Safety Strategy the Trust will be transferring from the Serious Incident Framework to the Patient Safety Incident Response Framework by autumn this year, one of the requirements is to have a published PSIRF plan and policy.

The plan outlines the Patient safety data and the patient safety areas which the Trust would focus on for learning purposes, which is underpinned by Patient Safety profile and review of retrospective data over the last four years. Plan outlines the methods utilised for investigation and learning as the Trust moves away from root cause analysis and the move towards learning and shared learning for improvement in collaboration with the Brilliant Basics Team. Format is very prescriptive from NHSE, methods to utilise for wider learning are outlined within the plan. JR undertook a Quality Round on 1st September with a number of young people and staff reviewing how we start to share learning from safety incidents, as the Trust moves to embedding how learning could be shared Trust wide. Within the report there is supporting detail outlining internal and external governance processes required, both plans had been developed in collaboration with wider stakeholders including children and young people and families and had been presented at numerous forums, these were also approved at August Patient Safety Strategy Meeting.

JR requested ratification from SQAC, prior to submitting to Board of Directors on 5th October 2023, JR is due to then present to PLACE Commissioners and would then be signed off by the ICS and uploaded onto Alder Hey Children's NHS Trust public facing website.

FB sought clarity whether the weekly meeting cycle is mandated for the panel - JR stated that it is not mandated but is good practice, JR stated that Trust is changing culture and mindset and moving away from root cause process. JR stated that there is no harm in undertaking weekly meetings. FB suggested that it may be prudent to include 'normally weekly', JR would amend to reflect FB comments.

NA stated that the papers do not do justice to the phenomenal work and expressed thanks to JR, WW and CT, NA stated that the process would be illative, and if improvements are needed to be made this would regularly be reviewed. NA alluded to weekly meetings and advised that this does provide a good level of scrutiny and oversight.

NA stated that although details had been captured regarding safeguarding reviews in the table, the Trust is not changing any of the safeguarding processes in place.

FB expressed thanks to JR for ongoing support.

Resolved: SQAC received, **NOTED** and RATIFIED the Patient Safety Incident Response Plan and governance process

23/24/107 **Quality Assurance Rounds Reports –** JR presented the Bi Annual Quality Assurance Round report for the period of 1st March 2023 – 31 August 2023

- 13 Quality Assurance rounds across the Trust
- 8 Quality Assurance rounds had been cancelled and had since been rescheduled.
- Top five challenges, related to staffing issues, staff resilience, waiting list backlog, recruitment and workforce issues and increasing referrals, with a significant amount of issues relating to the covid backlog.
- Top five successes include the services are very proud of showcasing best practice, and are very proud to take part in the Quality Assurance Rounds, with staff continually going over and above on their actions, improved reporting of incidents and a great deal of proactive research and audits being undertaken in some services.
- Over last 12 months those recurring challenges and successes remain similar to those published over the last 6 months, JR had included in the report a triangulation of challenges of risks and actions which is noted in section 6.1 of the report.
- Risk management continues to be an area of focus and improvement across all Quality Assurance Rounds with additional training of staff at the time of presentation.
- Next steps - oversight and assurance of progression with risks continues to be reviewed and monitored by the Risk Management Forum.
- Risk Training continues to be provided by the Governance Team, on a team by team basis, JR is looking to review risk management process including training, report would be presented to ARC at the October 2023 meeting.
- The current template utilised for the Quality Assurance Rounds is under review, JR is trying to align this to the CQC single assessment framework, this form will change going forward, once the single assessment framework is in place by CQC.
- JR encouraged on site visits by Executive Team and Non Executive Directors to the teams as the teams enjoy face to face visits.

FB alluded to the new template and sought clarity regarding how long this work is expected to take. JR stated that the piece of work had been completed and this had been put out for consultation with some Executive Team colleagues, JR is wanting to streamline, however focus is being given to addressing issues relating to InPhase and implementation of PSIRF in the interim with focus on this in 2024, this is very much aligned to when CQC come live with the single reporting framework.

FB referred to the issue of in person visits and as a NED, NEDs do not receive any signals whether face to face is possible or whether this would be an imposition on staff, FB welcomed further thoughts on how this would be possible, and considering space requirement and those colleagues who need to travel a distance. FB welcomed further work to understand when the face to face Quality Assurance Rounds would be welcomed. JR advised that LC would liaise with NEDS and Executive Team colleagues offline to review whether the Quality Assurance Rounds could be coincided with NEDS on site meetings.

ABa advised that Executive Team colleagues had met with CQC on 19.9.23 and that CQC had informed colleagues that the South would be going first with regards to the new reporting Framework potentially in November, with the North to follow with a tentative date of March 2024.

Resolved: SQAC received and **NOTED** the themes and associated actions for the Quality Assurance Rounds over the last 6 months.

23/24/108 **Ward Accreditation Report**

NA presented the Ward Accreditation Report, key issues as follows.

- The Trust continue to expand Ward Accreditation to additional wards and departments, there had been a number of departments that had unannounced inspection, which had been really helpful.

Overall there is good improvement, particularly those who were bronze moving to silver.

NA alluded to page 197 of the pack, and the scores broken down against the CQC domains, as this highlights areas of concern regarding safety and well led for some areas, and for divisional leadership teams to think about engagement and engagement with ward managers regarding how this can be improved.

NA alluded to the assessment process and the non negotiable Safety criteria that are not met and trigger white and a reinspection, NA stated that the leaders within the Division would be addressing.
Next steps are to continue to expand the number of areas assessed, improve and would be realigning the criteria that sits within the ward accreditation with the new CQC oversight framework criteria.

ABA stated that it is really helpful to see this information divided by the domains.
ABA referred to the narrative regarding the previous award, latest awards and comments why on day of assessment and sought clarity. NA stated that within the ward accreditation framework there are a small number of non negotiables, and that if departments fail these that they are graded as white on the day of assessment, and then the team revisit for an unannounced visit to assess whether the issue resulting in white status had been addressed. NA stated that there are a number of wards that despite achieving gold or silver rating that actually the day to day housekeeping of fundamental safety standards need to be improved.

FB stated that there are large significant areas across the hospital that are white, NA stated work is required regarding expectations and fundamental safety criteria. FB echoed that this is a fundamental safety issue.

CW stated that she does agree with NA comments, and that these fall below compliance levels. CW welcomed the breakdown of information which is more helpful. Ward managers and matrons present information to colleagues to ensure detailed scrutiny and oversight for Medicine leadership colleagues.

RH stated that there are some ways in which improvement processes can be achieved. Surgery Division have weekly and monthly ward managers and matrons audits, and whether some of these parameters could be incorporated to receive assurance, RH stated she is happy to work with JR in this regard. RH referred to the escalation process, and how colleagues escalate and embed processes and utilise matrons more effectively, with work to do to improve assurance.

NP stated that the report was really helpful and alluded to the visibility of this data. NP sought clarity how this information is being used routinely to direct attention corporately and those targets and objectives, and how these are tracked and what colleagues could we do to support this to ensure directed attention on areas of focus.

NA advised that all Ward Accreditation is published on the intranet and alluded to prevalence audits, aim to undertake all wards/department in a year. NA stated that Wards and Departments should never fail on white areas, which is a fundamental safety issue. NA reiterated that this does need to be owned by managers or leaders in the team to lead teams to ensure teams are safe.
ABA stated that this is about the attention to detail on a daily basis, safety issues should be brought to immediate attention.

NA advised that he planned to address this with his Senior Leadership Team on 26th September 2023.
NA advised on 24/7 accountability for ward managers for the safety of patients and staff in a clinical area, as the Trust should never accept this as white on the day of assessment.

FB reiterated the importance of proactive checking of areas across the organisation and demonstration that it has been reviewed and checked. NA stated that accountability does sit with those who are running the shifts. Questions would be realigned as part of new work, with discussions held regarding how this would be embedded at ward level.
NA stated that there is a lot of good work within the report, whilst recognising that this is an ongoing improvement journey.

Resolved: SQAC received and **NOTED** the Ward Accreditation Report
Clinical Governance Effectiveness

23/24/109 Any other business - None received

23/24/110 Review the key assurances and highlights to report to the Board.
Agenda items received, discussed / approved at the meeting.

- SQAC noted the issues with Inphase and understood the plan to address issues.
- SQAC received a good update on Sepsis mandatory training compliance, with the expectation that Divisions would continue to monitor trough their governance meetings and present a further report to SQAC in December 2023.
- SQAC received a Patient Safety Strategy update, with good progress noted across all of the workstreams.
- SQAC received an ED monthly report: Mental Health attendance and ED@ its best update, which demonstrated improvements in ED, and improvement with ED reporting, with positive impact evident. as a result of changes made with regards to management of patient flow within ED.
- SQAC received a comprehensive and thorough mortality report, with discussions held regarding the move to the new system, and when working collaboratively or in partnership with other organisations to understand how this works and ensuring that the necessary processes are in place.
- SQAC received the CQUIN quarterly report and noted that the report is work in progress with the system to understand the full impact of all of the standards within the Trust.
- SQAC received good divisional updates, and in addition received a Deep Dive regarding NICE
- compliance in Medicine. SQAC welcomed progress made.
- SQAC received the Clinical Effectiveness and Outcome Group Interim Chair's Highlight report, SQAC was pleased to note that two Clinical Effectiveness and Outcome Group. Chairs had been appointed, whilst noting the ongoing focus on audits across the organisation.
- SQAC received, noted and approved the Patient Safety Incident Response plan and Governance. processes and approach. FB expressed thanks on behalf of SQAC to all involved for ongoing support regarding the introduction of the new Patient Safety Incident Response Plan.
- SQAC received and noted the Quality Assurance Rounds Report, with good discussion held.
- SQAC received the Ward Accreditation report, and discussed the need to separate out the key safety issues from the ward assurance process to ensure safety is business as usual. SQAC noted the safety issues reflected within the report and the suggestions for different approaches to be developed to proper ongoing accountability around these.
- The Quarterly Infection Prevent Control Report and the PALS & Complaints report was deferred to 18th October SQAC meeting, with SQAC acknowledging that the 18th October 2023 SQAC meeting would be a busy meeting.

FB expressed thanks to SQAC.

Date and Time of Next Meeting: 18th October 2023 at 9.30 -11.30 via microsoft teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 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 August/September 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 for the month of September was 5.33% in line with the Trust Target of 5.5%
- Staff Turnover has had its 6th consecutive month of reduction, a 2nd month within target, and has dropped to 12% from 13% in July.
- A focused effort from across the Trust is beginning to show improvement in respect of PDRs with a September position of 70% against the target of 90%, which represents an increase of 7% since July

3. Industrial Action

Though no future strike dates are currently known, further BMA strike dates for November and December 2023 are expected to be announced after 3rd November 2023 (unless agreement is reached between BMA and the government). Further Society of Radiographer (SoR) strike dates are also pending.

As a strike mandate only runs for a finite period, the BMA have notified the Trust that they are re-balloting consultant members, seeking to extend their current mandate for strike action for a further 6 months, to Monday 17th June 2024. This ballot closes at noon on 18th December 2023. For the first time the BMA are also balloting SAS doctors (Specialty, Specialist & Associate Specialist) for strike action, with the closing and mandate dates matching those of the consultants.

The previous junior doctors' re-ballot, which closed on 31st August 2023, was successful, extending their mandate for strike action for a further 6 months from that date.

The Trust continues to respond to industrial action through the tactical command structure, supported by Trust wide communications, FAQs, as well as ongoing and specific staff support (for admin colleagues for example) through SALS.

4. Annual Staff Survey 2023 (updated 26/10)

The annual NHS Staff Survey is open from from 11th September – 24th November 2023 (national window) and due to the launch of Alder Care, Alder Hey launched on 20th September 2023.

Notable changes are the removal of 3 COVID-19 questions, the addition of 2 Health and Wellbeing questions and inclusion of 3 local questions around Health and Wellbeing to allow benchmarking with other local organisations around the topic.

A working group has been set up to ensure that as many staff as possible complete the survey which includes OD, SALS, Communications and HR as well as Divisional and professional nominated leads.

The current response rate is 47% across the Trust (as of 26/10/23). A breakdown by Division is shown below. Under 10 staff is not reported as a statistic to reinforce anonymity of responses.

Division	Total	Completed	% Completed
Academy	29	21	72%
Alder Hey in the Park	14	7	50%
Capital	28	11	39%
Community & Mental Health	906	455	50%
Digital	171	84	49%
Executive	22	18	82%
Facilities	214	71	33%
Finance	45	40	89%
Human Resources	63	35	56%
Innovation	29	18	62%
Marketing & Communications	Under 10 staff		
Medical Services Directorate	Under 10 staff		
Medicine	1221	496	41%
Nursing & Quality	102	64	63%
Other	Under 10 staff		
Planning	11	9	82%
Research & Development	63	29	46%
Strategy	41	27	66%
Surgical Care	1290	590	46%
Total	**4263**	**1983**	**47%**

Sharon Owen
Deputy Chief People Officer
October 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

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

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	This report provides the board with a progress update on the Equality Delivery System 2022 and a summary of the staff network activity throughout July/August 2023
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Implications:	

1. Introduction

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

2. Equality, Delivery System 2022 update

We continue to work towards collecting evidence and insight to support the implementation of the EDS22. We aim to have the information by the end of November so that we can evaluate, score, and rate the evidence related to the three key domains:

- **Commissioned or provided services**
- **Workforce health and well-being**
- **Inclusive leadership**

Once the review is completed, we hope to engage stakeholders to support the development of recommendations, improvement plans and early impacts of the implementation of those plans.

3. North West BAME Assembly Anti-Racist Framework

Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role to be focused on tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems. Our ambition is to eradicate racism and we will work hard to create a culture that embraces inclusion. The Northwest BAME Assembly's anti-racist framework will support us on the journey to becoming intentionally and unapologetically anti-racist. Through the embedding of the recommended themes, deliverables and actions into our structures, processes, policies, and culture, we will start to create significant changes within our workforce and service delivery. The recommended framework is organised into three levels of achievement: Bronze, Silver, and Gold. Each level builds on the next, assisting organisations to make incremental changes and take consistent actions towards eliminating racial discrimination. We are currently working through the self-assessment tool developed by the Northwest BAME Assembly to identify gaps in our

current performance. Any gaps identified will allow us to formulate a robust action plan, prioritising activities that will help us achieve a bronze status in the next 12 months. We will work with the REACH staff network and trade union representatives to develop the plan. Once we achieve the bronze status, we will continue to measure our actions, helping us to progress to silver status. Alder Hey are working towards achieving bronze status and the Northwest BAME Assembly and the Integrated Care System (ICS) are supporting us in implementing the direct deliverables and achieving bronze status in the next 12 months. Working with the ICS will provide us with the opportunity to learn and share regional best practice.

4. Staff Networks

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

- **LGBTQIA+** Following the Navajo assessment which took place August/September the staff network celebrated Alder Hey being awarded the Navajo Charter Mark. Members of the network and wider team attended an awards event which took place at Liverpool College in October to receive the Award.

  The network members are committed to ensuring that the feedback provided by Navajo is acted upon and they are working with the Head of EDI and HR to develop an action plan which will address any key areas for improvement. They are also continuing to grow the network membership and on the 13th November will be hosting a drop in day which will be held in the Atrium to provide staff with information on the network and their exciting plans.

- **REACH** staff network has worked hard throughout October to bring Black History Month celebrations to Alder Hey. We have seen lots of fantastic communications and Blogs which have been written by several of our staff members, recognising and celebrating the impact many Black people have had on our communities over the years. We also saw a fantastic exhibition which was held in the Atrium. The Black History & Heritage Exhibition: Iceberg Month, which is part of World Museums History was created by Patrick Graham a UK-born writer, actor, and poet of Jamaican parents his Liverpool Black History display was a tremendous success, and the feedback has been overwhelmingly positive.
- **Armed Forces** staff network is working hard to put plans into place to celebrate Remembrance Day service in November. The network is being supported by our Chaplaincy Team and there will be a Remembrance Day service on Friday 10th November at 10:50am in the Atrium. This will be the first service of its kind with the local RAF cadets joining us to support this unique event.
- **ACE-Disabilities and Long-Term Conditions** staff network continues to grow. Some members of the group have supported the Domestic Operations Manager with a site review, providing insight how we could improve certain facilities to support staff with disabilities. The network members have also created a survey to gain insight into why some staff do not declare their disabilities and they are hoping to develop resources to guide staff on how to update their information on ESR. The networking is meeting to discuss plans for Disability History Month in November.

Angela Ditchfield

Head of Equality, Diversity, and Inclusion

October 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	**Chair's Highlight Report Resources and Business Development Committee - 23rd October 2023**
Report of:	John Kelly, Non-Executive Director
Paper Prepared by:	John Kelly, Non-Executive Director
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**
   To provide an update to the Trust Board on the previous Resource and Business Development Committee held on 23rd October 2023.

2. **Agenda items received, discussed at the meeting:**
   - Finance report M6
   - Integrated Performance report M6
   - Divisional updates for Surgery, Medicine, Community and Corporate Collaborative.
   - 23/24 Yearend Forecast
   - Campus update
   - Aldercare
   - PFI
   - Board Assurance Framework

3. **Key risks/matters of concern to escalate to the Board (include mitigations)**
   - Yearend Forecast: RABD discussed half year position and forecast scenarios including a number of risks and mitigations.
   - Cost Improvement Plan: RABD noted the risk and significant gap on the programme. It was agreed for the Benefit Realisation update to be presented next month linked to CIP.
   - Further potential Industrial Action dates.

4. **Positive highlights of note**
   - Workstream progressing in relation to coding of activity.
   - Was Not Brought, review within Community to continue to support families attending confirmed appointments.
   - Now in second phase of Aldercare.
   - Review Metrics on how we measure improvement and key areas that drive financial sustainability i.e. workforce, Was Not Brought, Service Line Review and productivity.

5. **Issues for other committees**
   None.

6. **Recommendations**
   To note progress and challenges to date.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Wednesday 25th September 2023 at 13:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	
	Rachel Lea	Director of Finance and Development	(RL)
	Fiona Marston	Non-Executive Director	(FM)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nurse	
	Colin Beaver	Deputy Director of Marketing and Communications	
	Audrey Chindiya	Medicine Accountant	
	Dani Jones	Director of Strategic Partnerships	
	Jane Halloran	Acting Deputy Development Director	
	Emma Hughes	Acting Manging Director for Innovation	
	Catherine Kilcoyne	Deputy Director Business Development	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Chris McNally	Deputy Costing Accountant	
	Clare Shelley	Associate Director Operational Finance	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
	Gary Wadeson	Associate Director – Income, Costing & Commissioning	
	Melissa Swindell	Director of HR & OD	(MS)
Agenda Item: 99	Katie Tooltill	Chief Procurement Officer	
	Richard Jolley	Procurement & Contract Manager	
102	Alex Pitman	Green Project Director	

23/24/87 **Apologies:**

Mark Flannagan	Director of Communications	(MF)
David Powell	Development Director	

23/24/88 **Minutes from the meeting held 30th August 2023**
The above minutes were approved as a true and accurate record.

23/24/89 **Matters Arising and Action log**
RL noted the action in relation to providing scenarios falling behind plan of the control total would be presented within the Finance paper M6.

All other actions had been included on the agenda.

23/24/90 **Declarations of Interest**
There were no declarations of interest.

23/24/91 **Finance Report**
Month 5 Financial Position
For M5 a £1k surplus was reported. Whilst year to date is a deficit of £1.5m which overall remains in line with the plan.

CS noted the implications of Industrial Action, the current cost is £2.8m.

The divisional position was noted for M5. CS gave an overview of the Trust position noting the aim is still to meet the £12.3m surplus at the end of the year. As noted above scenarios will be presented next month to provide assurances to RABD.

CIP is behind plan by 900k. CS highlighted the improvements since last month and the continued effort to close the £2.8m end of year gap.

JK noted the continued pressure of meeting the end of year target (£12.2) especially as continued IA is likely. RL added from national calls that it was hoped funding of around £200m was to be released further details around funding was to be confirmed, it is assumed that funding will not be committed to new spend.

JG highlighted a number transformation programmes with timescales that would need agreeing to support the Trust with the end of year submission. RABD discussed this in detail and agreed that an update would be give at the Divisional update RABD on 29th January 2024.
Action: Divisions/Finance teams

JK asked from next month onwards as part of the Service Line Reviews to include details on surplus/deficit and details for this.
Action: GW

Resolved:
RABD received and noted the M5 Finance report.

23/24/92 Month 5 Integrated Performance Report

AB highlighted risks for M5 included industrial action, 46 operations were cancelled as well as 367 outpatient appointments.

Neurodevelopmental pathways are taking over 12 months to complete diagnosis. Additional funding from commissioners has been approved.

Was Not Brought Rate reduction is being worked through the October Operational Board.

ED achieved 92%, diagnostic access 87% Elective Recovery is at 108%. AB noted thanks to the teams with the above successful targets during August with high industrial action.

Resolved:
M5 IPR report was received.

23/24/93 Monthly Write Off's

EK went through the £12,013k of bad debt relating to four salary overpayments that have been chased by CCI, but efforts have now been exhausted, and CCI have advised to close the file.

RABD noted continued efforts to stop overpayments.

Resolved:
RABD APPROVED the £12,013k bad debt write off's.

23/24/94 Service Line Reporting – a review of 22/23 Data

GW introduced the paper noting it had been split into two parts: part 1 National Cost Collection, part 2 Service Line Reporting.

National Cost Collection:
A discussion was held on benchmarking against other Specialist Trust's. CMc agreed to contact Sheffield to discuss areas that may be comparable. RL noted the next Children's Alliance meeting was due to take place Wednesday 27th September and would see if any other Trust's would be interested.
Action:CMc

NA asked if it would be possible to re-run the data against Trust's who are BAPM Compliant as the majority are not. RL noted the submission for next 23/24 review is due at the end of October and suggested benchmarking discussions were held to easier compare the data.

Service Line Reporting:
GW presented the above results. Priorities for 23/24 included: Divisional action plans for top 5 loss making services.

CMc presented on the SLR dashboard noting the financial profit/loss for each division and speciality. There was also a breakdown for patients, pod, consultant and length of stay. DJ asked if it was possible to include postcode of patients, CMc said this wouldn't be an issue and would look into. On behalf of RABD the Chair thanked CMc for the data, a discussion was held on using this going forward to review inefficiencies and Tariffs.

Resolved:
RABD received and discussed the National Cost Collection and Service Line Reporting Review.

23/24/95 **Cost Improvement Plan**
Resolved:
RABD received the monthly update for CIP, this was also discussed under M5 Finance report.

23/24/96 **Campus update**
Catkin Sunflower House:
JH reported on an incident at the Sunflower House yesterday noting an action plan had been developed to review further fencing and onsite presence, a huddle to review the incident was taking place later today.

An update was received on the contractor submission of Compensation Events, legal advisors are working through.

Neonatal and Urgent Care:
Building work due to start from the first week in October 2023.

Office Building:
Lease for the police station has now been signed.

Park Reinstatement:
Working alongside Friends of Springfield Park in relation to the size of the swales and football pitches.

The Chair asked for details on communication of the land bought back to the Trust. JG confirmed newsletter had been circulated to surrounding areas and updated on the community event held September 2023. Meetings are due to take place on

moving forward with the east plot. JH noted possible options for the plot include community areas and clinical, research development.

Fracture and Dermatology Outpatients:
A project manager has now been appointed for the scheme, it is likely that there will be at least a 2 month slippage on the March 2024 completion date.

Resolved:
RABD received the monthly position on Campus.

23/24/97 **Aldercare**

KW highlighted:
All clinical areas have now been live with the Aldercare programme for over 2 weeks.
Initial delays included pharmacy migration, outpatients and theatre migration. All services were live 48 hours later with decisions from command and control. KW went through the details for these delays noting both were unforeseen and the learning taking from this.
The delays have impacted reporting around 4/5 days delay. It was noted that there may be gaps in reporting for M6 RABD reports, commissioners have also been made aware of gaps within reporting for next month.
Post go live is in progress with additional support to areas including; ED, admin and access.
RABD noted the continued work from colleagues with go live and post.

The Chair asked for details on outstanding jobs logged. KW advised the response team continue to work through.

Resolved:
RABD noted details of Aldercare Go Live and post.

23/24/98 **Operational Delivery Networks**

DJ presented the paper with details of the 2 North West paediatric Operational Delivery Networks as well as the 3 networks with Manchester Children's Hospital.

RABD noted the new draft NHSE service specification 23/24. They are likely to be renamed 'Clinical Networks' and have specified responsibilities in relation to system wide transformation.

Resolved:
RABD received the bi annual Operational Delivery Network paper.

23/24/99 **Procurement Monitoring**

KT shared a summary of performance from August 2023 highlighting 32 schemes have been delivered against a plan of 53 a negative variance of 21 schemes to date. The schemes behind plan with the largest savings have been escalated to the Procurement Board.

The Procure Partnerships Construction Framework has now been awarded and runs from 01st September 2023 - 31st August 2027 and is an income-based contract for Alder Hey.

The Chair asked for details on supporting divisions with CIP targets. KT referred to a number of workshops that are being held in October to support divisions and agree a CIP plan moving forward.

FM asked how patient benefit is monitored through Procurement. KT noted any decisions on new products is made with clinical input against quality and social output.

NA noted the large number of clinical waste each month in relation to use by dates and appointment of an onsite post to monitor going forward. The Chair noted the possibilities for this to be under Brilliant Basics. KT and NA agreed to discuss further outside of the meeting updating RABD at the next quarterly Procurement update in December 2023.
Action: KT/NA

Resolved:
RABD received the quarterly procurement monitoring.

23/24/100 Innovation and Commercial Activity
EH presented the above quarterly report noting the first part is in relation to products developed with revenue prospects, the second section is co creation and partnership agreements.

KW queried one of the possibilities under Was Not Brought in relation to moving forward with an external company. EH confirmed no data has been forwarded at this stage and formal checks would be completed prior to moving forward.

FM noted the increase in WNB across other Trust's. EH advised from the pilot when interventions were put in place from the output of the algorithms the WNB was reduced.

A discussion was held in relation to updates being received at both RABD and Research and Innovation Committee. ES added that whilst a number of the projects proceed due diligence and transparency continue through both committees. ES agreed to discuss with both Committee Chairs, Emma Hughes and Fiona Marston outside of RABD.
Action: ES/EH/JK/SA/FM

Resolved:
RABD received the quarterly Innovation and Commercial Activity.

23/24/101 Communications
CM went through media interest for the month of August. Continued engagement with Springfield park and opening of the Multi Games Area (MUGA).

JG noted his thanks to the communications team with the height of media interest in a number of areas and the support with Aldercare.

Resolved:
RABD received the monthly communications report.

23/24/102 Energy

AP went through the paper in and gave an update on the energy procurement and buying strategy for 23/24 following the move to a flexible contract in April 23 – Mar 24.

A further updated will be provided to November RABD including tender options.
Action: AP

NP asked for details of plans to reduce internal energy waste i.e. lights on in areas not being used. AP said the team continue to review light and heating usage.

FM asked if there are any plans to increase solar panel usage at the Trust. AP said he has received a quote for additional solar panels and working through costs with finance.

Resolved:
RABD noted the current position on Energy with a further updated to be received at the November RABD.

23/24/103 PFI

GD highlighted:

- Energy consumption for the month of August was 13% over the monthly contractual target and 9% over the annual. In relation to cooling and energy usage one of the contributing factors is the number of windows that are open at any one time. Several communications have been circulated.
- The combined heating and power plant ran at almost 100% efficiency during August, this is for the first time in a number of years.
- Incorrect reporting was noted from Mite's reports, GD and RL are working through with Mite and the Trust's legal advisors.
- Commercial discussions have failed to resolve the mobile endoscopy payment, options are being worked through to resolve.

JG asked if Project Co would be able to provide a detailed updated on the pipe work position. GD agreed to discuss this with Project Co and update RABD once a response had been received.
Action: GD

Resolved:
RABD received the monthly update on PFI.

23/24/104 Board Assurance Framework

RABD received the above paper noting whilst Inphase reporting is being worked through current risks had been updated.

ES noted RABD discussions today in relation to potential data issues under SLR and Innovation projects. It was agreed this would discussed outside of the meeting to see if these risks were to be added to the BAF.

Resolved:
RABD received and noted the Strategic Risks.

23/24/105 Any Other Business

No further business was reported.

23/24/106 Review of Meeting

JK noted good discussions in relation to the second part of the financial year and implementation of Aldercare.

Date and Time of Next Meeting: Monday 23rd October, 1300, Rooms 2/3 Innovation Park.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	**Board Assurance Framework Report 2023/24 (September)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Monthly BAF Reports
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:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
As detailed in the report	This report provides an update against all Board Assurance Framework Risks for the month of September 2023.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2023/24

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives and delivery of Vision 2030.

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' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment	Trust Board
3.6	Risk of partnership failures due to robustness of partnership governance	Resources and Business Development Committee
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	Research & Innovation Committee

3. Summary of BAF at 9th October 2023

Ref, Owner	Risk Title	Board Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC PILLAR: Delivery of Outstanding Care				
1.1 NA	**Inability to deliver safe and high-quality services**	SQAC	3x3	2x2
1.2 AB	**Children and young people waiting beyond the national standard to access planned care and urgent care**	RABD / SQAC	**4x5**	3x3
1.3 AB	**Building and infrastructure defects that could affect quality and provision of services**	RABD	4x3	2x3
1.4 LC	**Access to Children and Young People's Mental Health**	RABD / SQAC	**3x5**	3x3
STRATEGIC PILLAR: The Best People Doing Their Best Work				
2.1 MS	**Workforce Sustainability and Development**	PAWC	**4x5**	3x2
2.2 MS	**Employee Wellbeing**	PAWC	3x3	3x2
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC	**3x5**	4x1
STRATEGIC PILLAR: Sustainability Through External Partnerships				
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	RABD	3x4	3x2
3.2 DJ	**Failure to deliver 'Our Plan' and developing 'Vision 2030' 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
3.4 JG	**Financial Environment**	RABD	**4x4**	4x3
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
3.6 DJ	**Risk of partnership failures due to robustness of partnership governance**	RABD	3x2	3x2
STRATEGIC PILLAR: Game-Changing Research and Innovation				
4.1 CL	**Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People**	Research & Innovation	3x3	3x2
4.2 KW	**Digital Strategic Development & Delivery**	RABD	4x4	4x1

4. Summary of September 2023 updates:

- ***Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. (DJ).***
  Risk reviewed in light of Vision 2030 BAF refresh; recommendation to change going to Strategy Board Oct 23. Current risk evidence, actions and controls assessed and no change to score in month.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed - in light of recommended BAF refresh scheduled for Strategy Board Oct 23, this will be refreshed to reflect Vision 2030 and associated delivery/execution thereof. No change to existing risk score in month.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Recommend close from BAF and move to BAU - in line with Vision 2030 BAF refresh and target risk rating met. ***SUGGEST TO CLOSE RISK*.**

- ***Workforce Equality, Diversity & Inclusion (MS).***
  All staff networks now live with leads recruited and action plans in development. Navajo charter mark assessment (LGBTQIA+) successful with the Trust achieving charter mark status in September 2023.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  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 ongoing with the program due to complete in October 2023. It is hoped that this will prevent further pipework from corroding.

  A larger water pump has been installed in ICU to see if it has any effects on water temperatures. This will be monitored over the coming days.

  Out-of-range water temperatures continue to be monitored and local mitigations are in place such as filters on water outlets, and later this year we will introduce a chemical dosing system across the site.

  We have received the full details of the proposed dosing system for cold water, and this was also discussed at the recent liaison committee with AB & GD in attendance.

  Chillers are currently undergoing commissioning and it is hoped they will be brought online before the end of the move with the temporary ones being removed soon after.

Works on the skylights will stand down in October and recommence April 2024.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in September was more challenging, due to Alder Care deployment, Industrial Action and increase in attendances. In month performance against the 4 hour target was 78%, which remains above national standard of 76% but below our aspiration of 85%.
  Key elements of the winter plan include Virtual Ward, PAU and UTC to support ED performance and access over the coming months.

  Diagnostic waits have been impacted by Industrial Action, but we expect to return to >90% compliance during October.

  Industrial Action and Alder Care also impacted capacity to reduce long waits (RTT) - with total number of 52ww stable at 812 (pending validation) but an increase in 65ww from 150 to 202 (pending validation). Division of Surgery continue to actively manage this with focus on ENT, Dental and Spinal, but ongoing Industrial Action is a significant threat to elimination of 65w by March 2024.

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk 1.1 has been reviewed. Gaps in assurance continue with controls in place. Progress continues to be monitored by SQAC and receptive subgroups. Gaps in assurance relating to industrial action continue to be regularly reviewed as part of the Trust command and control structure relating to industrial action with appropriate plans in place for each episode.

- ***Access to Children and Young People's Mental Health (LC)***
  Review undertaken and BAF risk remains the same. Uploaded Trust Board paper (September 2023) which includes changes to reporting metrics.

- ***Financial Environment (JG).***
  Risk reviewed in month - score remains rated 16. C&M ICB have now started work on a Liverpool PLACE financial strategy to ensure sustainability by 25/26. Alder Hey are a member of the group and will be taking updated through Trust Board and RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  Works to the new park are progressing as per the revised programme agreed with Liverpool City Council.

- ***Digital Strategic Development and Delivery (KW).***
  AlderC@re was successfully deployed by 12th September and the programme is now in its stabilisation phase. Prior to go live the Clinical Safety case was approved and all Critical criteria were met.

- ***Workforce Sustainability and Development (MS).***
  Risk reviewed. Small reduction in turnover and sickness seen in August 2023.

- ***Employee Wellbeing (MS).***
  Risk reviewed. Additional resource for SALS has been secured to deliver a more comprehensive service. Successful in bidding for seedcorn funding from research function to support a SALS research project into the impact and effectiveness of SALS. Risk reviewed in light of Vision 2030 BAF refresh; recommendation to change going to Strategy Board Oct 23.

- ***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).***
  Risk reviewed in light of Vision 2030 BAF refresh; recommendation to change going to Strategy Board Oct 23

5. Recommendation

The Board is asked to:

- note the updated position with regards to management of the BAF risks, and
- agree to close risk 3.6 Risk of partnership failures due to robustness of partnership governance.

Erica Saunders
Director of Corporate Affairs

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

Paper Title:	ARC – Chair's Highlight Report from the meeting held on the 12.10.23
Report of:	Jo Revill – Chairing on behalf of Audit & Risk Committee Chair
Paper Prepared by:	Kerry Byrne - Audit & Risk Committee Chair

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	ARC papers pack for 12.10.23
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 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

The October meeting was kindly chaired by Jo Revill on behalf of the ARC Chair.

- Update on the implementation of InPhase in relation to risk management
- Proposal from HR to undertake a comprehensive review of employee records to ensure evidence of pre-employment checks (by reference to the NHS Safer Recruitment Standards) are held on file
- Presentation from Research and Innovation on risk management processes within the Division
- Board Assurance Framework*
- Update from the Risk Management Forum including the Corporate Risk Register*
- Trust Risk Management Report*
- Risk Management Strategy, Risk Management Policy & Procedure and Risk Assessment Policy
- Report on risk management training throughout the Trust
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Update on the outstanding recommendations from the Consultant Job Planning audit
- Anti-Fraud Services Progress Report
- Request from EY for additional fees relating to the 22/23 external audit
- Clinical Audit Mid Year Progress Report
- Divisional Clinical Audit Plans for 23/24
- Quarterly update on compliance with the Data Protection Act and Freedom of Information Act
- Review of external audit
- Update on progress of the action plan from the ARC self-assessment
- Waiver Activity Report
- Corporate Governance Manual (approved)

* These reports were reduced contained limited information compared to those provided previously due to the ongoing lack of functionality in the InPhase system following implementation in May 2023.

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

As reported previously, key risk management reports usually presented to the meeting were prepared manually and were much reduced in detail due to the ongoing problems with InPhase post implementation. Significant progress has been made recently and is planned throughout October with a view to many of the outstanding issues being resolved shortly.

A report on the approach to risk management training throughout the Trust was presented by the Associate Director of Nursing and Governance (ADN&G). This training was previously mandatory, but it is not currently and consequently there is no ongoing and consistent training throughout the Trust. Risk awareness is fundamental to ensuring a positive risk culture therefore ARC has asked the ADN&G to look at the risk management training that is required and how it should be delivered and make a recommendation in this regard to the Risk Management Forum for taking to the Academy. This training is to include the risk appetite and tolerances (which are due to be finalised with assurance committees and Board across Q3&4) and the requirements of the Risk Management Strategy, Risk Management Policy & Procedure and Risk Assessment Policy (which are undergoing update in the same period).

A request was received from EY for a further £25,000 (on top of the agreed audit fee of £162,000) due to additional work required during the audit. The Finance Team is currently working through this request in detail with EY to understand the basis for the request and will report back to ARC.

4. Positive highlights of note

Following significant work of the ADN&G with the Divisions, and the introduction of the Clinical Effectiveness and Outcomes Group, greater understanding of the process of clinical audit throughout the Trust and reporting of it is being provided to both ARC and SQAC.

Each Division presents their risks and processes to manage them to ARC each year. For the first time, Research & Innovation presented and provided ARC with an opportunity to understand the more detailed risks that sit under the single R&I related risk in the BAF.

Following the first annual report on the level of compliance with the Data Protection and Freedom of Information Acts provided at the end of 22/23, the first quarterly reports showing ongoing performance were provided ensuring ongoing visibility of performance.

The outcome of a review of the performance of external audit was presented to the Committee. There were no significant areas of below expectation performance; areas for improvement were taken forward to the “wash up” meeting to review the 22/23 external audit process.

Following the ARC meeting, the ARC Chair attended a “wash up” meeting with the EY Partner and Senior Manager and senior members of the Finance Team to look back at the 22/23 external audit process. The aim was to identify any areas of improvement that can be introduced for this year’s audit, particularly

looking to reduce the number of issues that are outstanding at the June ARC meeting which then require resolution prior to Board. This was a positive meeting with several actions identified for both EY and the Finance Team.

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee
(Risk only meeting)

Confirmed Minutes of the meeting held on **Thursday 13th July 2023**
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 A Bateman	Chief Operating Officer	(AB)
	Ms. E. Kirkpatrick	Assoc. Director of Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager (minutes)	(JP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. L. Wain	Corporate Governance and Risk Manager	(LW)
	Mr J. Wilcox	Financial Accountant	(JW)
Item 23/24/51	Mr. I. Gilbertson	Deputy Chief Digital and Information Officer	(IG)
Item 23/24/52	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Item 23/24/53	Mrs. L. Cooper	Director of Community and Mental Health Services	(LC)
Item 23/24/57	Mrs. A. Kinsella-Andrews	Head of Health and Safety	(AK)
Apologies:	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JR)

23/24/48 Introductions and Apologies
The Chair welcomed everyone to the meeting and noted the apologies that were received.

23/24/49 Declarations of Interest
There were none to declare.

23/24/50 Minutes from the Meeting held on 22nd June 2023
Resolved:
The minutes from the meeting that took place on 22nd June 2023 were not ready due to the close proximity of the ARC meeting dates; these were later circulated by email on 4th September 2023.

23/24/51 Matters Arising and Action Log

Action Log

Local Proactive Exercise Overtime Review
KB referred to the review undertaken by Counter Fraud in relation to overtime which highlighted a number of issues with recruitment procedures. Seeking further assurance, the Committee had requested an additional piece of work selecting a small sample of staff checking compliance against five key employment checks. Twenty staff records were subsequently reviewed showing that nine staff did not have explicit qualifications evidenced on file. Assurance was provided that this evidence would be sought retrospectively.

Given that almost 50% of the sample didn't have a record of the required qualifications for their role, Committee Members felt that this posed a potential risk to the Trust and should be revisited on a wider scale as a mitigation. It was agreed that this piece of work should be undertaken on a risk stratified basis with clinically facing roles as a priority and then non-clinical roles. The HR department would be asked to develop a proposal using a risk-based approach and report back to October.

23/24/51.1 ACTION UPDATED ON LOG TO REFLECT PROPOSAL TO BE PRESENTED IN OCTOBER

EK assured the Committee that, within the finance department, in such circumstances where certificates had not been provided upon appointment, staff were being asked to provide them ahead of any promotion.

Expanse readiness review
KB confirmed that the Terms of Reference for the NHS Digital review had been received which was comprehensive and therefore an internal audit of this area was not required. **ACTION CLOSED.**

Annual Report
Kerry Byrne undertook to feed a small number of minor comments in relation to the Annual Report to JP**. ACTION CLOSED.**

Matters Arising

In-Phase
IG provided an update on the implementation of the Trust's new Incident and Risk Management System that went live during May 2023:

- Obtaining Data from the System
  In terms of reporting functionality, IG informed the committee that there were two reports outstanding from the list of reports that the Trust had requested from the InPhase development team. These were the BAF Report and Corporate Risk Register Report which were due for sign off imminently.
- Report Builder Training for Staff
  Uptake for InPhase system training was reported as low, however those that had completed the training had fed back on its effectiveness as negative. KB requested that this be looked into further to ensure that the training is fit for purpose. LW reported that a bespoke training session had been cancelled by InPhase which was due to take place the previous day. IG confirmed that this was due to the low uptake of report builder training and that bespoke sessions would only be provided to accredited staff members.

23/24/51.2 Action: IG

- System Notifications
  It was reported that the InPhase system lacked the functionality to issue automated notifications to staff alerting them when their risk is falling due for review. This was having an adverse impact on compliance. A solution was being tested with a view to implementing imminently.

  GD sought clarity on whether InPhase were fulfilling their contractual arrangements. IG undertook to examine the contract and report back outside of the meeting. He

went on to report that InPhase's lengthy response times to issues raised had been challenged directly with the CEO who he was now in direct communication with.

KB requested a written update to be circulated following today's meeting setting out current system status, gaps and impact. In addition, ES suggested a full written report to next Risk Management Forum.

23/24/51.3 **Action: IG**

23/24/52 **Key Financial Transactional Processing Controls Review**

KS presented a report outlining the suggested approach for the financial controls audit which will focus on the Trust's key transactional process controls. She informed the Committee that the audit would not look at budgetary control as this was heavily covered in last year's HFMA review. KB therefore suggested that coverage of this annual audit be kept under review periodically and requested that this audit explicitly looked at new supplier set up and change of bank details for existing suppliers given the recent fraud experienced. She went on to request that external auditors, EY are asked to confirm that there are no issues from their perspective on the revised scope.

23/24/52.1 **ACTION: KS**

Resolved: the Committee **APPROVED** the Terms of Reference for the Key Financial Transactional Processing Controls Review.

23/24/53 **Update on the Risk Management Process within the Community and Mental Health Division**

LC presented a number of slides on the risk management processes within the Community and Mental Health Division.

She talked about the key principles of risk and governance across the Division including cross-service challenge with a mantra of '*should it be on the risk register?*' which has been very much welcomed by the Division.

An update was provided against the priorities for 2022/23 (reported July 2022) with positive progress reported against all areas including additional resource within the Governance Team, collaboration across the Divisions to look at risk and increase in the frequency of a deep dive review of risk register from annual to 6 monthly.

Attention was drawn to the priorities for 2023/24 some of which related to the move to InPhase and ensuring the new system is up to date, embed risk review meetings and continue to review and refine governance and risk processes across the Division.

KB welcomed the cross divisional challenge regarding 'should it be on the risk register' and questioned the mechanism as to how we ensure that all staff are risk aware. LC reported that this is included within the local induction programme and on every single team meeting agenda. Staff are actively encouraged to challenge culture resulting in an improved quality of risks and volume within the Division.

LW took the opportunity to report that a fix had been made to the InPhase system (the previous day) regarding next review date for risks; if this was found not to be happening to report directly to LW for onward escalation.

KB thanked LC for the level of assurance provided in today's presentation.

Resolved:
The Audit and Risk Committee **RECEIVED** and **NOTED** the update on the Risk Management Process within the Community and Mental Health Division.

23/24/53 **Board Assurance Framework Report (May 2023)**
ES presented an update on actions being taken to mitigate the strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives.

She assured Committee members that despite not being able to extract the full BAF Report from InPhase, controls continue to be in place and progress against actions is monitored within the system monthly.

She went on to inform colleagues that work was being undertaken on the BAF to reflect the new strategic priorities/risks in terms of delivering Vision 2030. This would be presented to the October Trust Strategy Board for consideration prior to implementation.

Resolved:
The Audit and Risk Committee **NOTED** the Board Assurance Framework update for the month of May 2023.

23/24/54 **Risk Management Forum Update including the Corporate Risk Register and minutes from the last meeting.**
ES introduced the RMF Chair's report from 9th June 2023.

She reported that a deep dive into BAF risk 3.1 was due to be presented from the development team but did not take place due to sickness. This would be rescheduled to a future meeting.

A deep dive on the risk (2594) relating to adoption records was received from the Community and Mental Health Division which provided reassurance internally regarding a fix within the expanse system which has now been implemented and should see a reduction over coming months of pre-adoption records being routinely closed post adoption.

KB welcomed the challenge put forward at the meeting from the Chief Nurse on risks which was clear from the RMF minutes.

She went on to talk about the challenges with the InPhase system and impact on staff, and highlighted the need to ensure that staff are supported until all issues are resolved.

LW drew attention to the highlights from the Corporate Risk Register Report covering the period 1st April 2023 – 30th April 2023:

- 17 open high risks
- 2 closed within the period
- 1 increased in score
- 6 decreased in score
- 1 overdue review
- 3 risk with no agreed action plans
- 5 risks with action plans past expected date of completion
- 12 with static risk score

ES welcomed a collective review of high risks following resolution of reporting issues with InPhase including a check back with previous CRR and highly scored risks ensuring that these correlate with the new reports, once ready.

GD welcomed the format of the report which was very clear and comprehensive. KB supported this and stated that risks are now much better articulated which had been a particular focus for the Associate Director of Nursing and Governance since coming in to post, except for risk 2694, in this particular case it was not clear that this risk sat within the innovation department.

JR asked about ongoing strike action and whether this would potentially elevate some risks. In terms of monitoring, ES stated that industrial action was discussed in real time at weekly Exec meeting. AB referred to BAF risk 1.2 which captures the impact of IA in terms of access to care (cancellations and growth in waiting lists) which is already scored highly to reflect the current and ongoing position.

JR went on to talk about risks to safeguarding and again sought assurance that this was being effectively monitored during strike action. ES stated that the Director for Community and Mental Health Services was very much sighted on this matter which was more reliant on non-medical staff.

KB put forward a challenge in relation to the articulation of some of the 'people risks' and asked for consideration to be given to their actual impact, which for some, appear to be clinical. LW undertook to take this action away for review.

23/24/54.1 ACTION LW.

In relation to the long-standing risks table, KB asked for the inclusion of 4-5 reason codes for the lack of movement (rationale) for these risks. ES stressed the need to repeat the exercise to look at long standing risks and the justification for them not being closed.

23/24/54.2 ACTION LW/JR.

Resolved:
The Committee **RECEIVED** and **NOTED** the Risk Management Forum Update including the Corporate Risk Register and minutes from the last meeting.

23/24/55 Fraud Risk Matrix – update

EK introduced a report highlighting the outcome of the process undertaken with MIAA to review and update the Trust's fraud risks.

She informed the committee that a review of 120 risks that had been identified across the NHS by NHS Counter Fraud Authority. Using a risk rating methodology set out by the Government Counter Fraud Profession, the risks had now been condensed into 40 specific risks and 7 key thematic fraud areas.

Whilst the average scores for each thematic area was relatively low there were two trust specific risks rated 12 (bank mandate scams, and cyber enabled fraud) and one trust specific risk with a score of 10 (scams). These risks will be managed through risk 2309 on the risk register scored as 3x3=9.

EK sought views as to the appropriateness of managing these risks under one risk on Inphase. ES supported the current approach which required a level of pragmatism but

stressed the importance of proactively managing the mitigations in order to provide adequate levels of assurance.

It was pointed out that the system MIAA use to score risks is complex and therefore their 5x5 matrix may not necessarily produce the same outcome as the Trusts. The Chair advised of the four risks that the Trust has identified; bank mandate scams (12), cyber enabled fraud (12), scams (10), payroll (10.5) and asked as to whether a review of these risks could take place using the organisation's scoring matrix and if appropriate include them on the Trust's system as individual risks. It was agreed to conduct an exercise and share the outcome with the Committee during October's meeting.

23/24/55.1 Action: EK

GD asked as to why the Trust seems to constantly experience issues relating to payroll errors and queried as to whether these problems will eventually be eradicated. It was reported that a payroll review has been factored into the internal audit plan for this year, specifically looking at overpayments. RL went on to state that payroll was provided by third party (ELFS) and that an assurance report was routinely received from them, but they are only able to act on information provided by Alder Hey.

Resolved:
The Committee **RECEIVED** and **NOTED** the outcome of the process undertaken with MIAA to review and update the Trust's fraud risks.

23/24/56 Consultant Job Planning Position Update.

ES presented a report providing the latest position regarding actions taken to address the internal audit recommendations from the consultant job planning audit.

She reported that the percentage of job plans now on the L2P system was now over 80% and that General Managers remained very much sighted on ensuring that outstanding job plans were populated and added to the system. A process for Clinical Academics, which are joint appointments between the Trust and UoL, was yet to be agreed before the job planning process could commence.

KB welcomed the update report and assurance provided in terms of progress which has been a very complex process and asked if anything remained a particular challenge with outstanding actions. ES stated that improved compliance remained the area of focus for management and that the Chief Medical Officer was assured that this was now locally owned but will continue to review regularly through divisions and Local Negotiation Committee.

KB requested an update to October and January meetings on the last outstanding recommendations from the original audit with a view to try and close by year end.

23/24/56.1 ACTION ES.

Resolved:
The Committee **RECEIVED** and **NOTED** the Consultant Job Planning Position Update.

23/24/57 Non-Clinical Claims Report 2022/23

AK provided a summary of non-clinicals claims received during 1st April 2022-31st March 2023, with a comparison of claims received in 2021/22.

She referenced the previous claims culture within the Trust which saw escalated numbers of employee liability claims. Robust systems and safety processes for reviewing incidents and investigating accidents and organisational learning is now in place which has resulted in reduction of financial claims.

During 2022/23 a total of 4 claims were made against the trust which was a reduction of 10 from the previous year demonstrating a cultural improvement of health & safety practices embedded successfully across areas. This resulted in a reduction in financial contribution to Liabilities to Third Parties Scheme (which covers employers' and public liability claims from NHS staff, patients and members of the public) from 2022/23 for the first time in a number of years (saving of £25,270).

AK recognised that some challenges still remain regarding further areas for improvement specifically in relation to training, competencies and conducting of risk assessments in critical areas. Focussed activity for 2023/24 will concentrate on delivery of the Safety Strategy and continued ongoing improvements.

KB acknowledged and welcomed the improvement in this area and asked for trend graphs to be included in future reporting to show the positive trend.

Resolved:
The Committee **RECEIVED** the Non-Clinical Claims Report 2022/23 noting the improved position with regards to claims during 2022/23.

23/24/58 SFI Procurement Limit Update and Waiver Exemptions

EK presented a report requesting an increase in tender limits in the SFI to reflect inflationary increases, and to apply a small number of exemptions to the waiver process for conditions where this process does not add value and will not change the outcome.

She reported that a review of the requisition process had been undertaken with HPL and finance with a view to streamlining, where possible, and that the following changes were proposed:

- an increase in the quotation limit for requisitions in the SFIs from £10k to £20k in line with some other Trusts in the area. The risk around increasing this limit is perceived to be minimal given the value.
- a number of exemptions to the single tender waiver requirement are inserted into the SFI, in order that effort is not undertaken with waivers where it is unlikely that procurement would be able to influence the outcome of the purchasing activity Some of these exemptions may not be required going forward if expected changes to regulations around NHS clinical service spending with other NHS or Public Sector bodies being exempt from the public contract regulations come to fruition.

ES welcomed the changes to the single tender waiver process and requested that meeting statutory obligations i.e., CQC be included on the list.

KB asked if there were plans to review the new processes in the near future to ensure the release of capacity to undertake value added work. EK stated that the intention was to undertake a six monthly review in order to get a sense check, and report this to the January 24 ARC.

23/24/58.1 ACTION EK.

Resolved:

The Committee **APPROVED** the proposed changes to the SFIs and agreed that the Trust should instruct HPL to implement the changes above with immediate effect.

23/24/59 Policy for Engagement of External Auditors in Non-Audit Work

ES introduced the Policy for Engagement of External Auditors in Non-Audit Work for approval explaining that the Policy remained fit for purpose with no changes being proposed.

KB sought assurance that HPL are aware of our auditors in the event that a requisition was raised for them. RL informed the Committee that this was indeed the case but undertook to remind procurement colleagues.

RL took the opportunity to inform colleagues that the ICB are now regularly commissioning work from the 'Big 4' audit firms on behalf of the system making it likely that Alder Hey could become involved in non-audit work via this route. RL will retain oversight of this nuance. KB suggested the need to ask EY to advise the Committee of on an ongoing basis of any relevant work undertaken for the ICB and confirm their ongoing independence in relation to Alder Hey's audit.

23/24/59.1 Action E&Y/RL

Resolved:
The Committee **APPROVED** the Policy for Engagement of External Auditors in Non-Audit Work.

23/24/60 Any Other Business
There was none to discuss.

23/24/61 Meeting Review
The Chair thanked everyone for their contributions throughout the duration of the meeting.

Date and Time of the Next Meeting: Thursday 12th October 2023, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th November 2023

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

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The purpose of this paper is to set out a proposal to amend the Trust's Constitution.
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:	£13k per annum (NED salary)

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

COUNCIL OF GOVERNORS

Proposed Constitutional Change

1. Purpose

The purpose of this paper is to set out a proposal to amend the Trust's Constitution in relation to the composition of the Board with specific reference to Non-Executive Directors.

2. Recommendation

The Board is asked to approve an amendment to section 23, paragraph 23.2.2. of the Trust's Constitution to increase the maximum number of Non-Executive Directors (by one) to eight.

3. Rationale for proposed change

Recognising the increasing demands of the role, this proposal evidences the need to increase the number of Non-Executive Directors on the Board.

There have been some significant changes amongst the Non-Executive Directors (NEDs) during the last 18 months, including the appointment of two new NEDs as well as making new appointments to the additional roles of Vice Chair, Wellbeing Guardian and Senior Independent Director.

A review was recently undertaken of roles and responsibilities among the NEDs to ensure Committees are properly constituted with appropriate cross-cutting skills ensuring an even spread of duties. The time commitment for the NED role is notionally two to three days per month, however, it is becoming ever more apparent that NEDs are required to commit more days per month due to the increasing demands of the role, which is not a sustainable model going forward.

It would therefore be beneficial to increase the Board's capacity specifically in relation to the development of the Trust's strategic direction, Vision 2030, the emerging requirements for board members to engage with system level work and to ensure robust governance structures are in place.

4. Foundation Trust Constitution

The Trust's Constitution currently contains the provision that:

23.2 The Board of Directors shall be composed of not less than:

- 23.2.1. A Non-Executive Chair
- 23.2.2. Five-seven other Non-Executive Directors; and
- 23.2.3. Five-seven Executive Directors.

23.8 The number of Directors on the Board of Directors may be increased to seven [eight], provided always that at least half of the Board, excluding the Chair, comprises Non-Executive Directors.

5. Process and Next Steps

Under the terms of the Constitution any amendments must be approved by both the Council of Governors and the Board of Directors. The Council of Governors approved the proposal virtually on 1st/2nd November. The amended document must be submitted to NHS England to be published on its website and the amendment, as agreed, presented as part of the Governors' report at the next Annual Members' meeting.

Subject to the Board's approval, the Council will be formally notified of the final decision on 13th November 2023, with a view to presenting the update to the Annual Members' meeting on that date.

Jill Preece
Governance Manager
October 2023