Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 8th February 2024, commencing at 9:00am
Lecture Theatre 4, Institute in the Park
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
YOUNG GOVERNORS (9:00am-9:15am)							
1.	**23/24/254**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/255**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/256**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **11th January 2024.**	**D**	Read enclosure
4.	**23/24/257**	**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.	**23/24/258**	**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.	**23/24/259**	**9:30 (10 mins)**	**Collaborate for Children and Young People: Partnerships Update.**	D. Jones	To receive an update on the current position.	**A**	Read report
7.	**23/24/260**	**9:40 (10 mins)**	**System Wide Update.**	D. Jones	To receive an update on the current position.	**N**	Presentation
8.	**23/24/261**	**9:50 (10 mins)**	**Terms of Reference:** • **Women's Hospital Services in Liverpool Programme Board**	L. Shepherd	To receive the Terms of Reference for: Women's Hospital Services in Liverpool Programme Board, Women's Hospital Services in Liverpool Committee and the C&M Children's Board.	**N**	Read enclosures

			Terms of Reference. • **Women's Hospital Services in Liverpool Committee Terms of Reference.** • **C&M Children and Young Peoples Committee.**				
9.	**23/24/262**	**10:00 (10 mins)**	**Transformation Programme.**	N. Palin	To receive an update on the current position.	**A**	Read report
Operational Issues							
10.	**23/24/263**	**10:10 (60 mins)**	• **Integrated Performance Report for M9, 2023/24.** • **Finance Update for M9, 2023/24.** • **Digital, Data and Information Technology Update.** • **M10 Flash Report/ Operational Overview.**	Executives/ Divisions R. Lea K. Warriner A. Bateman	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M9 position. To receive an update on the current position. To receive an update on the current position.	**A** **A** **A** **A**	Read report Presentation Read report Read enclosure
11.	**23/24/264**	**11:10 (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							
12.	**23/24/265**	**11:20 (10 mins)**	**Response to the Thirlwall Inquiry Terms of Reference – Updated organisational Governance Assessment.**	N. Askew/ E. Saunders	To take a balanced review of what is working, how improvements can be made and to receive an update on the work that is taking place around the organisation's culture.	**A**	Read report
13.	**23/24/266**	**11:30 (10 mins)**	**Gender Development Service (North Programme) Update.**	L. Cooper	To provide an update on the current position.	**A**	Read report

14.	**23/24/267**	**11:40 (5 mins)**	**Learning from Patient Safety Incidents.**	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
15.	**23/24/268**	**11:45 (5 mins)**	**PALS and Complaints Report, Q2.**	N. Askew	To receive the PALS and Complaints report for Q2.	**A**	Read report
16.	**23/24/269**	**11:50 (10 mins)**	**Organ Donation Annual Report, 2022/23.**	C. Thomas	For approval.	**A**	Read report
17.	**23/24/270**	**12:00 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 17.1.24.** - **Approved minutes from the meeting held on the 18.12.23.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 18.12.23.	**A**	Read enclosures
Lunch (12:05pm-12:25pm)							
Game Changing Research and Innovation							
18.	**23/24/271**	**12:25 (5 mins)**	**Research and Innovation Committee:** - **Chair's verbal update from the meeting held on the 18.1.24.** - **Approved minutes from the meeting held on the 6.11.23.**	S. Arora	To escalate any key risks, receive updates and note the approved minutes from the 6.11.23.	**A**	Read enclosure
The Best People Doing Their Best Work							
19.	**23/24/272**	**12:30 (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

20.	**23/24/273**	**12:40 (10 mins)**	**Freedom To Speak Up – Update.**	K. Turner	To receive an update on the current position.	**A**	Read report
21.	**23/24/274**	**12:50 (5 mins)**	**People and Wellbeing Committee:** - **Chair's highlight report from the meeting held on the 24.1.24.** - **Approved minutes from the meeting held on the 22.11.23.**	F. Marston	To escalate any key risks, receive updates and note the approved minutes from the 22.11.23.	**A**	Read enclosures
Strong Foundations (Board Assurance)							
22.	**23/24/275**	**12:55 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 16.1.24.** - **Approved minute from the meeting held on the 20.12.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the .	**A**	Read enclosure
23.	**23/24/276**	**13:00 (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
24.	**23/24/277**	**13:10 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 25.1.24.** - **Approved minutes from the meeting held on the 12.10.23.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 12.10.23.	**A**	Read enclosures
Items for Information							

25.	**23/24/278**	**13:15 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
26.	**23/24/279**	**13:19 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 7th March, 9:00am to 2:00pm, Venue TBC							

REGISTER OF TRUST SEAL
The Trust seal was used in January 2024: • 409: Lease - 700 Mandarin Park (9.1.24). • 410: Licence for Alterations – 700 Mandarin Park (9.1.24)

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M9, 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 11th January 2024 at 15:00**
Lecture Theatre 3, Institute in the Park

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

23/24/231 Welcome and Apologies

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

23/24/232 Declarations of Interest

There were none to declare.

23/24/233 Minutes of the previous meeting held on Thursday 7th December 2023
Resolved:
The minutes from the meeting held on the 7th December were agreed as an accurate record of the meeting.

23/24/234 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Staff Story *(Discussion to take place about CYP/music therapy at Alder Hey to support a conversation with the Arts Council in January)* – A strategic discussion has taken place and the outcome will be shared with the Arts Council to see if they are able to support a number of Trusts in terms of music therapy for patients. **ACTION CLOSED**

Action 23/24/175.1: *Learning from the Letby Case (Systems and Processes - Discussion to take place around confidentiality versus openness)* – A revised report is to be submitted in the private element of February's Board on employee relation cases and the learning from these cases. **ACTION CLOSED**

.

Action 23/24/202.1: *Integrated Performance Report (Include details in January's IPR on the high financial risks that are included on the risk register)* – This information will be included in February's iteration of the Integrated Performance Report following the completion of the additional work that is required. **ACTION CLOSED**

23/24/235 Chair's and CEO's Update

The Chair advised the Board of the visit to the Trust on the 11.1.24 by the Leader of the Labour Party, Sir Keir Starmer and the Shadow Secretary of State for Health, Wes Streeting MP. The aim of the visit was to discuss the launch of the Labour Party's 'Child Health Action Plan' and to hear about the Trust's assessment of the challenges facing today's children and young people (CYP) and what it is doing to tackle them. It was reported that the visitors appreciated the time that everyone gave, the preparation that took place and were truly inspired by the work that Alder Hey is doing. The Chair offered congratulations and thanks to all those involved in making the day such a success.

Louise Shepherd felt that the visit was a great opportunity to draw attention to key messages. During the day Sir Keir Starmer met with senior staff and participated in an interactive Q&A session with staff members. Following this Sir Keir Starmer visited Ward 1C to meet some of the families and the staff who care for them. Wes Streeting also paid a visit to Alder Hey's Innovation Hub where he met with key members of staff who have been helping to deliver the organisation's leading edge programmes in recent years.

The Trust shared details of some of the important work that it is conducting to tackle the growing health challenges faced by CYP and their families, and there was a focus on prevention, working with communities, CYP, and innovation. The outcome of the day highlighted the challenges that CYP are experiencing in the North of England which the Labour Party are hoping to address via the development of a strategy for children's health in the future.

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

23/24/236 Operational Issues

Integrated Performance Report (IPR), M8

The Board received the Integrated Performance Report (IPR) for Month 8. An update was provided on the following areas of the IPR:

Unrivalled Experience – *Safety*

- The Board was advised that the category of harm has been changed therefore the reporting of near miss incidents is starting to stabilise.
- Attention was drawn to the hospital acquired organisms' metrics which indicate that hospital acquired infections remain low. It was felt that this is really positive.

Unrivalled Experience – Caring

- There has been a reduction in performance in terms of complaints being responded to in 25 working days. It was confirmed that this area of work remains a focus for the Trust.

Community and Mental Health Division

- It was reported that a GP pilot has gone live to enable ASD/ADHD assessments to take place by GPs in surgeries.
- It was confirmed that recruitment will commence in the next week to appoint a named doctor for Safeguarding.

Division of Medicine

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

Division of Surgery

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

Smartest Ways of Working – *Finance Sustainability:* Well Led

- In M8, the Trust is reporting a £1.5m surplus (£1.5m ytd) which is in line with plan.
- The Trust is forecasting to achieve a £13m surplus following the revised H2 plans and subject to the Cost Improvement Programme (CIP) risk.
- CIP is £1.3m behind plan ytd. It was reported that an overall £13.8m CIP has been transacted with £3.9m in progress.
- Recurrent CIP is also an area of concern given the gap recurrently is £11.9m. It was reported that a lot of work has taken place with the Divisions which has resulted in a £5.6m improvement being posted.
- There is a revised plan in place for M9 with a caveat that no further industrial action takes place. The result of the planned strike action in December had a £480k impact for the Trust as well as an increase in costs. It was reported that the Trust is £0.5m off plan for M9 due to industrial action and is too large a figure to mitigate.

Fiona Marston drew attention to the graphs on page 17 of the IPR and asked if additional information could be included to make them more meaningful.

23/24/236.1 Action: RL

Resolved:

The Board received and noted the content of the IPR for Month 8.

Operational Plan Progress/M9 Flash Report

An update was provided on the progress that has been made on the Trust's 2023/24 operational priorities, as detailed in the Operational Plan progress summary as

follows: 1. Delivery of the Patient Safety Strategy. 2. Increase people availability and wellbeing. 3. Advance the clinical research portfolio and innovation pipeline. 4. Handover of Springfield Park to the community. 5. Improve access to care and reduce waiting times. 6. Financial sustainability. 7. Safely deploy the Alder Care Programme.

Reference was made to the approval of the investment case for the 3rd MRI scanner and it was pointed out that thought is being given to the opportunities that this scanner will bring in terms of delivering pioneering new studies.

It was reported that the Urgent and Emergency Care metrics as at the 11.1.24 indicate that the Trust has the second highest performance figures in the country.

Elective Care – The Trust has signalled that it will eliminate the long RTT waits for CYP waiting over 65 weeks by the end of March, with the caveat that there is no further industrial action.

Resolved:
The Board received and noted the Operational Plan Progress and the Flash Report for M9.

23/24/237 Gender Development Service (North) Update

The Board was provided with a progress update on the implementation of the nationally commissioned Children and Young People's Gender Service (North) ahead of the planned service go live in Spring 2024. Attention was drawn to the following key areas of the programme:

- *Estates* – A suitable premises for the service has been identified in Warrington, which is based within the Northwest and benefits from access to national, regional and local transport links. The building is a standalone, two-story property which the service will have full and sole use of. The ground floor will be open in April 2024 following renovation/changes and likewise the top floor will be open in June 2024. Working groups are planned with stakeholders to discuss the interior décor of the building which will include sensory environments.
- *Workforce Recruitment* – There is a workforce risk within the Community and Mental Health Division as a result of the recruitment process for the new service which Alder Hey is leading. There is to be a focus on this matter.
- *Finance and Contracting* – The North programme's business case was approved by NHS England (NHSE) on the 28.11.23 and relates to the mobilisation of the service. Discussions are ongoing with NHSE about the potential transfer of an open caseload to the service from the current provider and the management of risks associated with this transfer.
- *Governance Arrangements* – The new service will sit within the Community and Mental Health Division at Alder Hey and follow the divisional and Trust governance processes embedded across the division. There are clear lines of accountability to the Director of Community and Mental Health Services for the service. In addition, the necessary processes in relation to the Care Quality Commission (CQC) will be in place prior to the service going live.

The Board was informed of the associated risks that relate to the additional request from NHSE about the new service taking on the open caseload from the current provider. It was reported that a workshop has been scheduled to look at addressing

this matter and resolving the risks. It was confirmed that NHSE and commissioners are involved in this workshop. Discussions have taken place with CQC around their expectations as well as the General Medical Council (GMC).

It was reported that the Trust has been briefing the Chair and CEO of the Integrated Care Board who have acknowledged the complexity of this matter. The Trust will continue to update the ICB going forward.

Shalni Arora queried as to whether there will be a national involvement with the communications plan for the new service. The Board was advised that this will be discussed during next week's workshop. The Chair highlighted the importance of giving thought to the security of staff and communications.

In terms of going forward, it is felt that it needs to be emphasised that the new Gender Development Service is a national service and therefore it is imperative to have continuity across the country. With regard to staff safety and security, the Board was informed that this was one of the main priorities for the Trust when looking to acquire a new building for the service.

The Chair highlighted the importance of including clinical governance as part of the governance process. It was reported that existing patients from the current provider will be assessed using the new protocols therefore the Trust may see a rise in complaints as a result of this.

Resolved:
The Board noted that the programme continues to progress at pace and remains on track for implementation of the nationally commissioned specialist, tertiary Gender Service for children and young people.

23/24/238 Serious Incident (SI) Report

The Board was provided with oversight of incidents that are considered as serious, following the guidance from the NHS England Serious Incident (SI) Framework (March 2015), and associated learning for the reporting timeframe from the 1st of November to the 31st of December 2023. The following points were highlighted:

- Alder Hey will transition from the SI framework to the Patient Safety Incident Response Framework (PSIRF) on the 2.1.24. As a result, the format and content of future Board reports will change from providing lessons learnt to providing assurance and oversight in relation to trends, themes, and areas for improvement. A suggestion was made about a Board development session taking place in April on the new PSIRF system.
- There was one SI open during the reporting period (StEIS ref: 2023/18692). An RCA investigation was completed and sent to commissioners on the 3.11.23. The outcome of the investigation was also shared with the family.
- Three SI action plans remained open during the reporting period and are within their expected date of completion.
- All Duty of Candour responses were completed within the expected deadlines during the reporting period.

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

23/24/239 Mortality Report, Q2

The Board received the Mortality Report for Q2. The following points were highlighted:

- The Medical Examiner process will go live in April 2024. Alder Hey has appointed two paediatric medical examiners to join the Liverpool University Hospitals NHS Foundation Trust's (LUHFT) Medical Examiner team.
- It was reported that a mortality dashboard has been created that provides granular detail on deaths and offers considerable potential going forward to scrutinise the organisation's mortality data.
- A new section is to be included in future reports that will provide details on neonatal mortality across the Liverpool Neonatal Partnership.

Fiona Marston felt that the graph on the first page of the report wasn't very helpful. Following discussion, Alfie Bass agreed to arrange for Fiona Marston to liaise with Julie Grice so that this matter could be discussed.

23/24/239.1 Action: ABASS/FM

23/24/240 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 15.11.23 were submitted to the Board for information and assurance purposes.

Resolved:
The Board noted the approved minutes from the meeting held on the 15.11.23

23/24/241 People Plan Highlight Report

The Board received and noted the People Plan update that provided a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during December 2023.

The Chair commended the leadership that ensured the hospital was safe during the periods of industrial action.

Alder Hey Staff Survey 2023 – Initial Results

The Board received an overview of the initial results of 2023 Staff Survey. A number of slides were shared that provided information on the following areas:

- Overview;
  - 60% of colleagues completed the 2023 survey.
  - The Trust sends the survey to all staff members each year and has done so for many years.
  - Quality Health has shared the organisation's raw data with the Trust, alongside a comparison of the data from the 60 Acute and Community Trusts they also survey.
- The progress that has been made.
- New question for 2023.

- Areas for further enquiry.
- Next steps.

Garth Dallas pointed out that the raw data verifies that more individuals are answering questions on discrimination and felt that this information will enable the staff networks to conduct deep dives. The Chair suggested that the establishment of the staff network groups is giving staff the confidence to complete the survey.

Resolved:
The Board noted the update on the People Plan and the 2023 Staff Survey.

23/24/242 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 27.11.23 were submitted to the Board for information and assurance purposes.

Resolved:
The Board noted the approved minutes from the meeting held on the 27.11.23.

23/24/243 Board Assurance Framework Report (BAF)

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

- It was felt that December's BAF report, which is now in its new format, provides a good reflection of the Trust's risks and it was confirmed that all updates have been included.
- The Board was advised that work is taking place by colleagues this month on the gaps in controls of their respective risk/s.

A question was raised about whether Quality Assurance Rounds (QARs) will be taking place on a face to face basis in the near future. It was reported that a hybrid model is to be proposed with some sessions taking place virtually and some on a face to face basis. A formal paper is to be submitted during a NED briefing session for discussion purposes.

Kerry Byrne drew attention to the importance of Non-Executive Directors addressing the CYPF risk that sits under BAF risk 1.1. It was confirmed that BAF risk 1.1 is still evolving but attention will be paid to this matter.

23/24/243.1 Action: NA

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

23/24/244 Any Other Business

There was none to discuss.

23/24/245 Review of the Meeting

The Chair advised that the agenda had been kept very focussed due to having a condensed Board meeting but pointed out that February's agenda would see the return of the usual format.

The Chair queried as to whether a session should take place for the Trust's CYP to discuss the Gender Development Service. It was reported that the service will have its own forum but to engage outside of this is an idea.

Date and Time of Next Meeting: Thursday the 8th February at 9:00am in Lecture Theatre 4.

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for February 2024							
11.1.24	23/24/239.1	Mortality Report, Q2	Arrange for Fiona Marston to liaise with Julie Grice to discuss the possibility of including more detail in the graph on the first page of the Mortality report.	A. Bass	8.2.24	On track Feb-24	
Actions for March 2024							
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	7.3.23	Mar-24	**7.11.23** - A meeting is in the process of being scheduled. An update will be provided in February. **30.1.24** - A meeting is in the process of being scheuled. An update will be provided in March **ACTION TO REMAIN OPEN**
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	
7.12.23	23/24/203.1	Alder Hey in the Park Campus Development Update	Share the Detect presentation with the Board that provides an overview of what the park will look in the next few years.	D. Powell/ J. Halloran	7.3.23	Mar-24	
Actions for April 2024							
9.11.23	23/24/173.2	Digital, Data and Information Technology Update	*External Reporting* - Discuss the possibility of compiling a report that focusses on the Trust's robust reporting processes and the lessons that have been learnt nationally, for submission to the Board.	J. Grinnell/ K. Warriner	11.4.24	Apr-24	**3.1.24** - This item will be included on February's agenda. 11.1.24 - This action has been deferred to April 2024. **ACTION TO REMAIN OPEN**
7.12.23	23/24/210.1	Neonatal Governance Review.	Meeting to take place between Dame Jo Williams, Louise Shepherd, the Chair and CEO of LWH before the Away Day session goes ahead, to look at developing a framework for the partnership. Alfie Bass to provide a briefing ahead of the meeting, detailing the Trust's thoughts for progressing the partnership, for discussion purposes.	Dame Jo Williams/ L. Shepherd/ A. Bass	11.4.24	Apr-24	**5.1.23** - Contact has been made with the CEO of LWH. An update will be provided in February. **30.1.24** - A meeting has been scheduled for the 10.4.24. An update will be provided during April's Trust Board. **ACTION TO REMAIN OPEN**

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
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	Closed	**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. **1.12.23** - This action has been deferred to January 2024. **3.1.24** - This action has been deferred to February 2024. **30.1.24** - Section 4 has been removed from the BAF. The next phase of risk appetite work will support better understanding of underlying scores. **ACTION CLOSED**
9.11.23		Staff Story	Discussion to take place about CYP/music therapy at Alder Hey to support a conversation with the Arts Council in January.	L. Shepherd/ M. Thomas/ V. Greenwood	7.12.23	Closed	**5.1.23** - An update will be provided during January's Trust Board. **11.1.24** - A strategic discussion has taken place and the outcome will be shared with the Arts Council to see if they are able to support a number of Trusts in terms of music therapy for patients. **ACTION**
9.11.23	23/24/175.1	Learning from the Letby Case	*Systems and Processes* - Discussion to take place around confidentiality versus openness .	Exec Team	7.12.23	Closed	**11.1.24** - A revised approach is to be submitted to the Trust Board on people practices and challenging staff. A report is also going to be submitted in part two of February's Board meeting on employee relation cases and the learning from these. **ACTION CLOSED**
9.11.23	23/24/175.2	Learning from the Letby Case	Board to return to this item in February 2024 to take a balanced review of what is working, how improvements can be made and to receive an update on the work that is taking place around the organisation's culture.	N. Askew/ A. Bass/ E. Saunders	8.2.24	Closed	**30.1.24** - A report is being submitted to the Board in February. **ACTION CLOSED**
7.12.23	23/24/202.1	Integrated Performance Report	Include details in January's IPR on the high financial risks that are included on the risk register.	R. Lea	11.1.24	Closed	**5.1.23** - An update will be provided in January. **11.1.24** - This information will be included in February's iteration of the Integrated Performance Report following, completion of the additional work that is required. **ACTION CLOSED**

11.1.24	23/24/236.1	Integrated Performance Report	*Smartest Ways of Working – Finance Sustainability: Well Led* - Include additional information in the graphs on page 17 of the IPR to make them more meaningful.	R. Lea	8.2.24	Closed	**30.1.24** - All finance graphs have been updated and included in the January's IPR. **ACTION CLOSED**
11.1.24	23/24/243.1	Board Assurance Framework Report	Further attention is required to BAF risk 1.1 to enable the NEDs to look at the CYP&F risks that sit under risk 1.1.	N. Askew	8.2.24	Closed	**30.1.24** - A meeting is to be arranged with Kerry Byrne, Nathan Askew and Erica Saunders to discuss this matter. The review will be managed via SQAC. **ACTION CLOSED**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	Vision 2030 – Collaborate for Children and Young People: Partnerships Update
Report of:	Dani Jones, Chief Strategy and Partnerships Officer
Paper Prepared by:	Dani Jones, Chief Strategy and Partnerships Officer Abby Prendergast, Associate Director of Strategy and Partnerships Jenny Dalzell, Strategic Partnership Lead (Place) Dr Liz Crabtree, "Beyond" Programme Director

Purpose of Paper:	Decision **Assurance X** **Information X** Regulation
Background Papers and/or supporting information:	Link to Board Assurance Framework Risks 3.2 Strategy Development 3.5 System working to deliver 2030 strategy.
Action/Decision Required:	**To note X** To approve
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Strategic Goal: Collaborating in Communities • CYP Areas of Need: Get me Well, Personalise my Care, Improve my Life Chances
Resource Impact:	N/A

Vision 2030: Collaborate for Children and Young People – Partnerships Update

Introduction

Achievement of Alder Hey's Vision 2030 - healthier, happier, and fairer futures for children and young people (CYP) - is dependent on working with our partners in the communities we serve, in a collaborative health and social care system that has a shared focus on the needs of CYP.

Under the Health and Care Act (2022) Provider Trusts have new duties to collaborate, work as part of the local Integrated Care System (ICS), and contribute to addressing the impact of health inequalities. Addressing the wider determinants of health has a key role to play in reducing health inequalities and improving CYP health outcomes; this requires a system approach.

As both a specialist healthcare provider with a global reach and a local provider for CYP, we have recognised our unrivalled opportunity to shape and advocate for children's healthcare through our range of key partnerships and enshrined this in Vision 2030.

The purpose of this paper is to provide the Board with assurance and information relating to the core relationships and system partnerships in which the Trust are engaged.

These system relationships and partnership arrangements are core enablers to the delivery of Vision 2030. They provide our health and care system with the architecture, connections and communities required to meet the needs of CYP and families.

This quarterly Board assurance update (previously titled 'Growing Great Partnerships') was refreshed in October 2023 to align with the Trust's agreed Vision 2030.

1. Cheshire and Merseyside Integrated Care System (C&M ICS) – Collaborating for Children and Young People

ICSs consist of several types of partnership and delivery structures including Integrated Care Boards (ICB), Integrated Care Partnerships (locally this is the C&M Health and Care Partnership), Provider Collaboratives and Place-based Partnerships (see diagram[1]).

Alder Hey play a leadership role for CYP within C&M. The Trust is actively working to ensure CYP are effectively represented and served at each of these levels. This is a work in progress, but great progress has been made with partners in bringing together a collaborative health and care system focused on the needs of CYP.

The partnerships and partner programmes described below are important vehicles to enable setting and achievement of joint objectives across one system with the needs of CYP at the heart. They aim to address the key issues facing CYP's health and care today, influence strategic decision making and allocation of resources, share knowledge and

[1] https://www.kingsfund.org.uk/audio-video/integrated-care-systems-health-and-care-act

expertise, bring together the networked CYP workforce and share innovations to revolutionise care delivery. This is necessary to improve CYP outcomes, experience, and to make system efficiencies.

Q3 23/24 has seen momentum in establishing key aspects of the collaborative CYP system in C&M, detailed below. The system's agreement to establish these key functions shows recognition of CYP as a priority population cohort by C&M ICS, the Provider Collaboratives and partner organisations.

All newly established forums work in harmony with existing forums where there is sustained focus on building and simplifying the CYP system architecture and workplans. In Summary, the core components are:

Forum	Focus
C&M Health and Care Partnership (HCP)	CYP are one of 3 agreed priorities for the HCP, alongside delivery of All Together Fairer[2] (Marmot) recommendations.
ICB CYP Committee	Single line of sight and CYP strategy for the whole C&M system.
Beyond CYP Transformation Programme	Whole-system (health & care) integrated transformation/ delivery programme.
Directors of Children's Services (DCS) Network	9 Local Authorities leading on both DCS shared priorities and integrating on system-wide partnership priorities with Beyond.
CMAST CYP Alliance	Improving CYP acute services across C&M.
MHLDC Provider Collaborative – CYP work stream	Improving CYP mental health and learning disability services across C&M.
Place Level Partnerships	Beyond works with all 9 C&M Places. Alder Hey are partners in Liverpool, Sefton, and Knowsley Places.

As these functions embed and mature, there will be an increasing need and ask for Alder Hey and partners to contribute to system resource across multiple work programmes, alliances, and strategies to achieve system objectives for CYP. New ways of working will be required to achieve this, and Alder Hey will need to continually review capacity to meet these requirements.

1.1 The C&M Health and Care Partnership

CYP are a key priority area for the HCP and a CYP focussed session was held by the HCP Board on 14th November 2023. This session supported consideration of the system approach needed for CYP in C&M and had 4 key areas of focus:

- Introduction to Children's Services including the role of DCS / lead member, statutory legislation/ guidance, and the role of the Corporate Parent: Jenny Turnross (DCS Liverpool)
- Overview of Beyond Programme: Liz Crabtree (Programme Director, Beyond)
- Update on the new CYP ICB Committee: Dani Jones (Chief Strategy and Partnerships Officer, Alder Hey)

[2] https://www.instituteofhealthequity.org/resources-reports/all-together-fairer-health-equity-and-the-social-determinants-of-health-in-cheshire-and-merseyside

- Appropriate Places of Care: Progress update, work to date, forward plans and presentation of a case study: Liz Crabtree/Amanda Perraton (DCS Warrington)

Following presentations, breakout groups were held to discuss the needs of CYP and consider how the HCP can support the CYP agenda, influence joint funding models and what other areas of health and social care integration for CYP can be explored.

The HCP Board demonstrated strong support for the ongoing work to improve outcomes for CYP. There was commitment to continue to work collectively to address issues through the HCP membership, the All Together Fairer recommendations and a focus on addressing the impact of poverty, and through the CYP Committee (see below).

1.2 C&M ICB Children and Young People Committee

C&M ICB have put CYP right at the heart of the ICS's strategic priorities and established the new CYP Committee. Chaired by the C&M ICB Chair, the CYP Committee met formally for the first time in December 23 (following two informal meetings in September and November 23), with a core aim of developing a system wide approach to better outcomes for CYP.

Initial strategic priorities for the CYP Committee include a focus on major cross-cutting issues for CYP such as Neurodiversity, Mental Health / Appropriate Places of Care, Oral Health and CYP Edging Towards Care. December's meeting explored a system approach to improving outcomes for children edging towards care, a highly impactful trauma informed awareness session, an exploration into experiential governance, and the Committee received its first 'single line of sight' report for CYP across the C&M system, including key updates from:

- Place Delivery
- Directors of Children's Services (DCS) Network
- Beyond CYP Transformation Programme
- CYP Voice and Participation
- C&M CMAST CYP Alliance
- Statutory Health Delivery (e.g., SEND / Safeguarding)
- MHLDC – CYP Programme
- Voluntary Community Sector (VCS) and the C&M CYP VCS Network

Membership of the CYP Committee includes representation from all the above, including both C&M Provider Collaboratives (detailed below) to ensure all efforts are coming together to achieve a single line of sight for CYP within C&M.

The CYP Committee is ambitious, and motivated to drive a movement for CYP, listening to their voices and meeting their needs by bringing together key partners, stakeholders, and programmes of work. It will have a key role in ensuring the voices and needs of CYP are prominent in discussions and decisions taken by the ICB. The Committee will oversee development and delivery of the C&M CYP Strategy and ensure an effective system focus on CYP as a population cohort. The Committee will be responsible for oversight of the delivery of the CYP ambitions and priorities within the C&M Joint Forward Plan.

1.3 Beyond CYP Transformation Programme – Leading CYP Transformation in C&M

In Q3, C&M ICB confirmed recurrent funding for the Beyond programme, demonstrating strong system confidence and putting Beyond on a solid footing to deliver against key transformation programmes that will improve outcomes for CYP over the coming years. The programme is also funded through NHSE Long Term Plan monies (awaiting confirmation of this funding for 24/25).

Key developments in Q3 also include:

- Beyond is convening system partners to deliver key pieces of complex system working including **Appropriate Places of Care; meeting the needs of CYP with complex needs; Speech, Language and Communication Needs; and a system approach to neuro-disability pathways** – details of each can be found in Beyond's Q3 Newsletter (see Appendix 1) – as well as supporting the new C&M ICS CYP Committee.
- **Beyond continues to support the CYP Health Equity Collaborative (HEC), a collaboration between Barnardo's, the Institute for Health Equity and 3 ICSs** (C&M, South Yorkshire, and Birmingham & Solihull). The evidence-based HEC framework has been further developed following feedback from over 300 CYP and is due for publication in February 2024. This, and the developing data tool, will inform the interventions to address the impact of health inequalities.
- **Four CYP HEC champions have been recruited** from C&M and will be supporting the development of interventions; they are introduced in Beyond's Q3 Newsletter (Appendix 1). These young people will provide input over the lifetime of delivery, and codesign pilot interventions.
- Beyond is also linked with the "***All Together Fairer***" (Marmot) programme. **Core20PLUS5** for CYP aligns closely with Beyond objectives and key deliverables will be included in workstream objectives. Three members of the Beyond team have successfully applied to become CORE20+5 CYP ambassadors.
- **Oral Health:** 8 of our 9 C&M Places are worse than the England average for dental decay in 5-year-olds. The ICB is supporting an upstream, evidence-based, population health programme across C&M. This 3-year programme will include increasing access to toothbrushing and pastes to targeted children most at risk of dental decay, and developing a supervised toothbrushing scheme, at scale across the sub region. This will be focussed on the Core20 population across C&M. The ICB has agreed that this programme of work will be delivered via Beyond and recruitment is underway for key roles to support delivery.

1.4 Cheshire and Merseyside Acute and Specialist Trust (CMAST) CYP Alliance

C&M CMAST Provider Collaborative Chief Executives agreed a proposal in Summer 2023 to take a proactive and planned approach to improving access to children's acute services, delivered through a CMAST CYP Alliance.

The recently established CMAST CYP Alliance met for their inaugural meeting in mid-November and again monthly thereafter, bringing together senior CYP leadership from CMAST member trusts.

The CYP Alliance will:

- Ensure the quality of acute care is standardised so that all CYP in C&M have the same high standard of care whichever service or hospital they use.

- Proactively and collaboratively tackle underlying problems and/or identify opportunities to share best practice and innovate.
- Bring together a breadth of experience, expertise, and perspective from across the paediatric hospital system into one forum known as the CMAST CYP Alliance.

The Alliance will drive service improvements for all CYP in the region by collaboratively delivering against the agreed core priorities of:

- Elective recovery
- CYP diagnostics
- Paediatric workforce
- Urgent care systems (shared innovation and best practice)

Working groups will be established in February 2024, identifying key stakeholders from partners across the region to agree target outcomes and drive forward improvements in the agreed priority areas.

1.5 MHLDC Provider Collaborative – CYP programme

The MHLDC provider collaborative has begun to co-design a CYP workstream with senior colleagues from member Trusts. Initial priorities will be focused on neurodiversity services (including attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD) and Speech and Language Therapy (SALT)), and mental health services (including eating disorders, and mental health support in emergency departments and on wards).

Work will continue into Q4 and beyond to further establish and embed the MHLDC priorities for CYP, developing key objectives and a project initiation document. Trust Board will be kept appraised of these developments as they arise.

2. Place – Collaborating with our Local Communities

Place-level Partnerships are developing positively, with each local area shaping their plans with some emphasis on CYP needs and priorities. Alder Hey are committed to maximising our opportunities to work at Place which is crucial for both central and clinical functions within Alder Hey, and to the alignment of our Vision 2030 priorities, engagement, and development of local-level plans.

Place-level engagement is a necessity and given that Alder Hey works across several Places, it is also resource heavy. Place partnerships can only be effectively developed to deliver our Vision 2030 ambitions with the right relationships, resource, and capacity – strategically, clinically, and operationally. Sustainable, consistent, and appropriately skilled engagement at Place(s) is required to ensure aligned plans, delivery of agreed programmes of work, attraction of local funding and management of reputational risk. This is a current resourcing challenge, recognised in BAF 3.2, and options to be resolved will be explored within the Executive Team.

2.1 Development of a Trust Wellbeing Offer

Significant progress has been made in our plans to create an Alder Hey '*Wellbeing Hub*' that will co-locate health and wellbeing services to support and assist CYP, parents,

and carers in promoting equality in access to health care and tackling health inequalities in services across the Trust. The proposal links directly to Vision 2030 and will have up-to-the-minute understanding and access to poverty proofing and wellbeing offers for our CYP, carers and their families. The Alder Hey Charity is working with the Trust on the model.

Our vision is for this to evolve into a one-stop-shop grounded in offers of practical support available from partner organisations akin to the current Staff Advice and Liaison Service (SALS) – a "just drop in and we'll help" approach.

Feedback from several pieces of project work in this sphere confirm that the service needs to:

- **Be accessible at Alder Hey**, recognising that a child's health and life chances are not set in isolation but are shaped by the socio-economic conditions in which they are located.
- **Take a holistic approach** to improving healthcare access and linking people with partner organisations to improve for these families.
- **Be staffed by people who know where and what services are available** in the community and within Alder Hey. They would act as an intermediary, introducing families to the services.
- **An availability of trained staff who can empower parents/patients to tackle barriers systematically**. Available to provide much-needed access and support for appropriate housing, financial welfare, employment rights, advice, and guidance. For example, a Service Level Agreement with the Citizens Advice Bureau would provide staff knowledge of benefits and to be able to assist in completing applications, or at least introduce families to people that can help.
- **Tackle digital inclusion** by assisting with accessing and completing relevant forms online and online training, e.g., Disability Living Allowance (DLA) forms – Increasing parental and staff skills.
- **Link to local community groups and social expertise** to manage the holistic needs of parent/carer wellbeing. For example, access to community projects, food support, social networks, parent mental health support etc.

Our Wellbeing Offer

With leadership from the Health Inequalities and Prevention (HIP) Steering Group and reporting into the 2030 Strategy Leadership Group, this plan has made significant progress and is now able to present the delivery model to the Executive Team early in the new year with a view to going live in late spring 2024. The Board will then be furnished with a detailed report of the model and mobilisation plans.

2.2 One Liverpool Strategy

Work to refresh the One Liverpool Strategy has commenced, with all Liverpool Place Partners, including Alder Hey and Liverpool City Council, involved in co-producing the

strategy. The content will be informed by national strategy and the C&M five year forward plan. It forms the health and care chapter of the Liverpool City Plan, which is also due to be refreshed. The strategy will be approved by the One Liverpool Partnership Board and Liverpool Health and Wellbeing Board, as well as being endorsed by the boards/governance of all partners, by March 2024.

The One Liverpool objectives are being reviewed to ensure we reflect current and future challenges as a health and care system. The strategy will be ambitious but also realistic in terms of outcome improvements, informed by a clear baseline, as many of our key outcomes, such as life expectancy and healthy years of life, have deteriorated since the Covid pandemic and the cost-of-living crisis, which has impacted disproportionately on areas of high deprivation such as Liverpool. There will be a continued strategic focus on population health approaches to improve outcomes; health creating communities; service improvement and integration, as well as an objective around financial sustainability.

In the interim, work continues apace in the 'Healthy Children and Families' Population Segment, led by the Trust's Chief Strategy & Partnerships Officer who is joint Senior Responsible Officer (SRO) with the Liverpool City Council Associate Director Public Health – CYP & Health Improvement. **In addition to work on the mobilisation of Family Hubs across the City, driving the Mental Health and Emotional Wellbeing plan, a Lung Health approach is in development across the city with all partners.** This brings the City plans together with Vision 2030; aligning the approach for those CYP in the 'Get Me Well' cohort and our internal plans to review the Trust's service delivery model for CYP with respiratory conditions.

2.3 *Sefton*

Bringing together Sefton Council, local NHS, voluntary, community and faith (VCF) groups and other organisations involved in improving health and care in the borough, Sefton Partnership has a shared vision: "***To deliver a confident and connected borough that offers the things we all need to start, live, and age well, where everyone has a fair chance of a positive and healthier future."*** Sefton Partnership will shape and support the delivery of health and care for the borough, engaging with and involving local people in how best to meet their needs.

At the recent Sefton Partnership Board, Vision 2030 was shared, the content well received and the alignment with Sefton's priorities for CYP welcomed. Alder Hey is committed to supporting this partnership. Sefton's CYP Partnership Board, chaired by the Chief Executive of Sefton Council, a further commitment for the Trust, is also currently undergoing a refresh of its agenda, and will develop a three-year plan for all CYP and their families living in Sefton. This work is in addition to other fora supporting the regular contracting and commissioning agenda for the physical and mental services for the Borough and, we continue to be an engaged partner in several other Boards and Committees supporting the Sefton Place agenda.

3. North West – Collaborating for Excellent, Resilient Specialist Services

3.1 Children and Young People Specialist Services – Delegation to Integrated Care Systems

On 7th December 23 the NHS England Board approved plans to fully delegate the commissioning of appropriate specialised services to ICBs from April 24 in the East of England, Midlands, and the North West regions of England.

These commissioning arrangements apply to 59 specialised services deemed suitable and ready for greater ICB leadership by the NHS England Board.

Regional NHSE teams who commission services being delegated from April 2024 will come together in 'commissioning hubs', hosted within one ICS on behalf of a wider region. To ensure that there is stable support for the delegation of services, the hub teams will continue to be employed by NHS England during 2024/25, after which they will transfer to ICSs and discharge delegated responsibilities in April 25.

The impact in 24/25 is expected to be minimal, as the arrangements are in shadow format, with no intended change to funding allocations or service delivery. As further information is made available from NHSE, Alder Hey will ensure individual services and divisions are fully assessing the impact of any changes and will continue to work with regional colleagues on the necessary and appropriate CYP strategy for the region, particularly given most delegated paediatric services will be commissioned on a multi-ICB footprint. Alder Hey's Managing Director represents the C&M Provider Collaboratives on the NW Specialised Services Joint Working Group.

The next discussion with system colleagues (Alder Hey, Royal Manchester Children's Hospital (RMCH), Lancashire and Cumbria ICS and North West NHSE) is scheduled in February, and the Board will be kept updated as this evolves.

3.2 Women's and Childrens Transformation Programme (Specialised Commissioning)

Full development of the North West Specialist Commissioning Women and Children's 'case for change' is due in July 2024 (Gateway 2), with a long list of proposed models of care for the following:

- the *Neonatal Transformation (Critical Care) Review*
- the *Paediatric Critical Care (Level 1 & Level 2) and Surgery Review*
- the *Children's Cancer service specification* (Primary Treatment Centres (PTC) and Paediatric Oncology Shared Care Units (POSCUs))

At the most recent NHSE Women's and Childrens Transformation Board (Nov 23), the following developments were shared:

- Creation of working groups: Workforce, Estates, Financial Principles and Methodology.
- Various clinical and non-clinical engagement events to take place from Feb 24 onwards.
- Commitment to Gateway 2 in July 24 including 12-week consultation on model options.
- Final business case to be ready July 25 for socialisation with regional oversight and scrutiny committees for C&M, Greater Manchester and Lancashire and South Cumbria.

All relevant hosted and jointly hosted Operational Delivery Networks (ODNs) (by Alder Hey and RMCH) are engaged and expected to be a vehicle to mobilise this transformation programme. NHSE are currently reviewing the capacity of Clinical Leadership within ODNs to support this Transformation Programme.

Alder Hey continue to be actively engaged in this programme of work to support the development of the content of the case for change. Appropriate representation from Alder Hey

will play into the work streams as they develop, and we will be kept informed on progress, influencing the strategic direction as appropriate.

The Trust has begun mobilisation of our internal response, dedicating a 2030 Strategy Leadership Group in November for a deep dive into the Transformation Programme. This was a clinically led session to understand the proposed changes and impact on the region and on Alder Hey as an individual organisation. In summary, the impact for different service areas could include:

- Neonatal
  - Change in designation of Level 3 intensive care and Level 2 high dependency care centres in C&M and the North West, to ensure minimum activity days are met.
- Paediatric Critical Care
  - Re-distribution of some Level 2 high dependency care from tertiary centres to District General Hospitals in C&M and the North West.
- Surgery in Children
  - Re-distribution of non-specialised surgical activity from tertiary centres to District General Hospitals in C&M and the North West.
- Children's Cancer
  - Re-distribution of some cancer activity from tertiary centres to District General Hospitals designated as enhanced POSCUs in the North West.

The above headlines are preliminary ahead of any formal options appraisal; however, they support the need to create sustainable models of care across the region. Further work will take place in Q4, and into 24/25, to understand the impact, risks and engagement needed, and the Board will be kept updated as this evolves.

3.3 Operational Delivery Networks (ODN)

The Neonatal ODN, Paediatric Critical Care, Surgery in Children and Long-Term Ventilation (PIC/SIC/LTV) ODN and Cancer ODN continue to work with NHSE on the National Women's and Childrens Transformation Review (described above), which will consider the optimal model of care across the region for each of these services. Our ODNs will need to be appropriately resourced to lead this work alongside NHSE, and 24/25 workplans will reflect priorities against current capacity. Capacity to appropriately deliver against priorities is currently a risk for the ODNs.

The new NHSE ODN Service Specifications are due to be implemented from April 24, specifically referring to system wide transformation responsibilities. It is also confirmed they will state ODN budgets should be ringfenced and not be subjected to cost improvement plans by the Host Trust.

All North West ODNs that report through the North West Paediatric Partnership Board (NWPPB) will come together in March 2024 with Executive colleagues from Alder Hey and RMCH for a face-to-face networking day.

4. Childrens Hospital Alliance (CHA) – Collaborating Nationally with our Children and Young People's Hospital Partners

Alder Hey continues to play an active role in leading and supporting the workstreams of the Childrens Hospital Alliance (CHA) as the host trust for the partnership. This

network continues to support an active and growing range of peer-to-peer groups - including for CEOs, Chief Operating Officers, Chief Nursing and Medical Directors, Finance Directors, Comms Directors, Innovation leads, Pharmacists and Allied Health Professionals.

Priorities and programmes of work are currently centred on:

- Providing food for parents of children in hospital (linked to Sophie's Legacy – below)
- The national paediatric accelerator
- The 'was not brought' programme – predictive artificial intelligence and tailored interventions.
- Shared learning and support for child health leaders
- CHA virtual ward proposal
- CHA risk tool (CHART)

Specific updates for Alder Hey related to the work of the CHA are detailed below.

4.1 Sophie's Legacy

The Trust have been able to agree a future sustainable model for Sophie legacy in terms of free food provision for our resident parents. For physical and mental health, parents will have breakfast provided at ward level, a sandwich or soup and a roll for their lunch and either the chefs special or £2 reduction on a main meal. Our Alder Hey Charity continue to support the provision of hot drinks and snacks on all inpatient areas.

We continue to provide ward level catering for our families whose child is at end of life, has a learning disability or for other special cases. This has made a massive difference to our families who have provided great feedback in terms of this offer.

4.2 Martha's Rule

A task and finish group has begun to implement Martha's rule which has 3 parts:

1. A critical care outreach service is available to review patients 24/7.
2. Staff can access this resource for any concerns regarding deterioration.
3. Parents can refer directly to the same service.

Our response team, which is now operational 24 hours a day 365 days a year, will be the initial escalation point for review, referring to appropriate other services, including critical care, as required. We are currently exploring innovative technology to make this as accessible as possible for all parents and staff and hope to have a pilot in place early 2024.

5. Partnership Governance and Partnership Quality Assurance Rounds

It was agreed at the NWPPB in September 23, that the joint Cleft Lip and Palette service between Alder Hey and RMCH would undergo a partnership quality assurance round by end of 23/24; however, the Quality Assurance Round pack is currently under review at Alder Hey. Once this has been finalised and approved, the Partnership Quality Assurance Round pack will be rapidly updated to reflect any changes and then used to assess joint services.

Appendix 2 provides an assurance summary of the key joint services and strategic partnerships, demonstrating named executive leads, purpose, partners, governance/reporting arrangements, summary progress and any risks for escalation to Trust Board.

6. Risks and Issues to Highlight

The Board is asked to note:

1. The increasing requirement for strategy / system resource across multiple work programmes, alliances, and strategies (link to BAF 3.2).
2. The progress and momentum of the NW Case for Change for the three specialist reviews (Neonatal, PIC/SIC and Cancer) and the increasing need to galvanise Clinical and Operational leadership for this programme.
3. The increasing transformation priorities that are being placed on ODNs, at present, without additional resource from NHSE.

7. Recommendations

Trust Board are recommended to:

- Receive and note the content of this report including progress made.
- Take assurance that the strategic partnerships are currently appropriately managed and governed.
- Acknowledge the risks summarised, pertaining to requiring additional (or redistributed) resource and capacity to deliver on partnership / system priorities and Vision 2030. Executive colleagues are working with external system partners and internally within Alder Hey to identify this.

Appendix 1: Beyond Programme Q3 Newsletter

BEYOND NEWSLETTER Q3.pdf

Appendix 2: Joint Services / Partnership Assurance Summary

Purpose	Partners	Established	Governance/ Reporting Arrangements	Summary Progress 23/34	Risks / Issues for Escalation to Trust Board
Liverpool Neonatal Partnership Executive Lead: Adam Bateman					
Joint delivery of Level 3 neonatal service	Liverpool Women's FT (LWH)	2020	Liverpool Neonatal Partnership (LNP) Governance structure LNP Board (monthly) provides assurance to Trust Boards at LWH & Alder Hey LNP Integrated Governance (monthly) – assurance to Surgical Critical Care Board (Alder Hey) and Family Health Board (LWH) Internal – Division of Surgery	LNP governance structure is in the process of being reviewed and will be presented at Board in Jan 2024. LNP Board has moved to bi-monthly with leadership team meeting MD's between boards. Monthly risk and integrated governance meetings continue with feedback into Family Health Divisional Board and Surgical risk meeting. New programme board has been established with programme plan and this will be supported by both divisional teams, and report in to both divisional boards. Positive recruitment of nursing staff with good retention. ANNP recruitment has been difficult, however, fellow recruitment has supported this. Consultant recruitment continues. Build progressing in line with expected timeframes.	Managing the capacity and flow during the build period and the supporting of neonatal care outside the 1C environment. Recruitment of tier 1&2 medial team (inclusive of ANNP's). Procurement of equipment and increasing costs. Ensuring safe and effective governance across both sites.
Liverpool Adult Congenital Heart Disease (CHD) Partnership Executive Lead: Alf Bass					
Joint delivery of Level 1 adult CHD service	Liverpool Heart & Chest FT; Liverpool University Hospitals FT; LWH	2018 – revised Memorandum of Understanding (MOU) Sept 2020	External – Liverpool ACHD Partnership Board (quarterly) Internal – Division of Surgery	-North West wide delivery of seamless all-age CHD service in partnership -Joint governance with CHD ODN to remove duplication in the system fully embedded -Previous plans for a single patient treatment list have been superseded by the development of a CHD database which will have this functionality built in – database go live anticipated in Summer 2024	None for escalation.
NorCESS - North West Epilepsy Surgery Executive Lead: Benedetta Pettorini					
Joint delivery of Northern Epilepsy surgical service - aim to improve the uptake and access to epilepsy surgery in those children for whom	Royal Manchester Children's Hospital (RMCH)	2012	External – North West Paediatric Partnership Board (NWPPB - Alder Hey & RMCH) Internal – Division of Surgery	-NorCESS is a long-standing specialist commissioned service by NHS England, receiving regular funding and serving CYP across the North West - the multidisciplinary team (MDT) review children with epilepsy who meet the criteria for evaluation	Ongoing risks re: persistent problems with specialist recruitment (e.g., neurology and neurophysiology).

surgical control or amelioration for their epilepsy is a possibility				for surgical intervention, provide a comprehensive pre-surgical evaluation and co-ordinate epilepsy surgical procedures for children for whom it is identified as appropriate.	These are logged within the joint service and escalated via an agreed escalation plan to NWPPB.
North West Obesity Tier 3 service **Executive Lead: Urmi Das**					
Joint delivery of level 3 obesity hub & spoke model	RMCH	Nov 21	External - NHSE monitoring & C&M CYP Programme Board (quarterly) Internal - Division of Medicine	-Service running across 2 hubs (AH & RMCH) and spoke in Preston. -Inequalities uplift in funding for 23/24 -Led for Alder Hey by Dr Senthil Senniappan. -Monitored through divisional routes and NWPPB as a joint service	Service remains in pilot phase with capped funding and capacity to meet growing demand. Issues are region wide and escalated to NHSE.
Alder Hey & Public Health Liverpool **Executive Lead: Dani Jones**					
Delivery of a shared work plan via collaborative resource	Liverpool City Council Public Health	May 21	Internal – Health Inequalities & Prevention Steering group à Safety & Quality Committee	-Collaborative funding with LCC for public health consultant identified and recruitment progressing -Health Inequalities and Prevention Steering Group continues - coalescing the -Trust's Health Inequalities activity – chaired by Public Health professional -Prevention Pledge commitments – in partnership with the ICS. Priority project work includes: -Prevention in pathways: supporting long waiters with access to preventative support e.g., Mental health, food insecurity etc -Dental / Oral Health -Smoking Cessation (CYP, families and staff) -Healthy Weight & Obesity – community/VCSE local delivery	None for escalation.
North West Paediatric Partnership (NWPPB) **Executive Leads: Dani Jones / Alf Bass**					
Joint oversight of NW ODNs & commitment to collaborative delivery of specific specialist / tertiary paediatric services as mutually agreed.	RMCH	2019	External – North West Paediatric Partnership Board NWPPB – biannually) Internal – Resource and Business Development – ODN assurance paper (biannually)	-Joint development and oversight of NW ODNs and joint services -MOU's/partnership agreements described on a case-by-case basis at a service/network level, following the principles set out in the NWPPB MOU approved by Trust Board in 2019. -Scoping future NW service models e.g. cardiology, neurology -Aligned models for NW delivery across e.g. Long Covid	None for escalation.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	Women's Hospital Services in Liverpool Programme Board Terms of Reference. Women's Hospital Services in Liverpool Committee Terms of Reference.
Report of:	Louise Shepherd, Chief Executive
Paper Prepared by:	Cheshire and Merseyside ICB

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☑ ☐ ☐
Action/Decision Required:	To note To approve	☑ ☐
Summary / supporting information		
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:	n/a	

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
1.1.	Inability to delivery safe and high-quality services	9

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
Cheshire and Merseyside

NHS Cheshire & Merseyside Integrated Care Board

Women's Hospital Services In Liverpool - Programme Board

Terms of Reference V1.0

Document revision history

Date	Version	Revision	Comment	Author / Editor
06.11.23	0.1		First draft	Clare Powell
06.12.23	0.2	Section 2 – duties regarding access, inequalities and lay perspectives added. Section 6 – equality, diversity and inclusion – more detail.	Feedback from shadow programme board members incorporated	Clare Powell
11.01.24	1.0	Deputy chair identified. LUHFT members increased from 2 to 3. AHCH and CCC added to reporting section.	Agreed as final at Programme Board on 10.01.24	Clare Powell

Review due:
November 2024

Women's Hospital Services in Liverpool - Programme Board

Terms of Reference

1. Purpose

The Women's[1] Hospital Services in Liverpool Programme Board is established by the Women's Services Committee (WSC), a subcommittee of NHS Cheshire and Merseyside Integrated Care Board (ICB) in accordance with its constitution.

The Programme Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The Programme Board's primary purpose is to:
Develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool.

This will involve:

- understanding all the clinical sustainability challenges hospital-based maternity and gynaecology services in Liverpool face;
- exploring potential solutions for how those challenges can be addressed and resolved;
- undertaking an options appraisal of the viable solutions for making these hospital services clinically sustainable for the future; and
- making recommendations to the Women's Services Committee of NHS Cheshire and Merseyside.

A wide range of stakeholders will be involved in the work to ensure that there are no unintended consequences for women, their families and other C&M providers and a full impact assessment will be completed on any future proposals.

[1] It is important to acknowledge that it is not only people who identify as women (or girls) who access women's health and reproductive services to maintain their sexual and reproductive health and wellbeing. The terms 'woman' and 'women's health' are used for brevity, on the understanding that transmen and non-binary individuals assigned female at birth also require access to these services. Delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

The programme will follow the process set out in the NHS England Guidance for Planning, Assuring and Delivering Service Change (2018)[2].

2. Responsibilities / duties

The Programme Board's duties are as follows:

- Develop the programme plan for the Women's Hospital Services in Liverpool Programme.
- Establish the operational arrangements for programme delivery including any working groups.
- Identify the key clinical risks and issues in women's hospital services in Liverpool.
- Explore the medium and long term solutions to managing the identified risks and issues.
- Lead the development of the case for change for women's hospital services in Liverpool.
- Lead the development of the future model of care for women's hospital services in Liverpool including identifying service dependencies.
- Lead the option appraisal process to identify potential solutions to delivering the future model of care.
- Lead the production of business case(s) as required.
- Complete equality, quality and sustainability impact assessments on proposals for the future delivery of women's hospital services in Liverpool.
- Ensure there is fair and equitable access to women's hospital services in Liverpool.
- Ensure the future model of care and options to deliver it seek to reduce health inequalities.
- Seek external clinical and professional advice where specialist or independent review is required, including involvement from an NHS Clinical Senate.
- Make recommendations to the Women's Services Committee about the future delivery of women's hospital services in Liverpool; proposals will be informed by clinical evidence, research, and intelligence, and will demonstrate how they meet the needs of women and their families.
- Communicate and engage with clinical services stakeholders such as clinical networks, the C&M local maternity and neonatal system (LMNS) and CMAST (C&M acute and specialist trusts provider collaborative).
- Communicate and engage with other key stakeholders e.g., Liverpool Providers Joint Committee, Place leads.
- Support consultation and engagement processes with staff, stakeholders, patients, and the public.
- Ensure that lay perspectives are considered and reflected throughout the work of the programme.
- Support the Women's Services Committee with the formal change assurance process with NHSE.

[2] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

- Manage the overall programme risks, issues and dependencies.
- Regularly report progress to the Women's Services Committee, escalating risks and issues as necessary.

3. Authority

The Programme Board will lead the development of a future care model for women's hospital services in Liverpool that will provide the best possible care and experience for all women, babies and families.

The Programme Board is authorised by the Women's Services Committee to:

- request further investigation or assurance on any area within its remit;
- make recommendations to the WSC;
- escalate risks and issues to the WSC;
- agree a programme plan to discharge its responsibilities;
- approve the terms of reference of any working groups that support the work of the programme board;
- delegate responsibility for specific aspects of its duties to working groups or individuals.

Decisions on areas, functions, or budgets outside of the authority or scope of the ICB is discharged through the authority that is delegated to the individual members of the Programme Board by their respective organisations.

For the avoidance of doubt, in the event of any conflict when making any decisions or recommendations, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the Programme Board being permitted to meet in private.

4. Membership & Attendance

Membership
The Programme Board membership shall be approved by the WSC.
When determining the membership of the Programme Board, active consideration will be made to diversity and equality.

The Programme Board Membership will be composed of:

- Programme Board Chair – Interim CEO of Liverpool Women's FT
- ICB Associate Medical Director – Transformation (Deputy Chair)
- An Independent Clinical SRO, from outside the Cheshire and Merseyside ICB footprint
- An Independent Programme Director

- ICB Head of Communications and Engagement
- x3 representatives from Liverpool Women's Hospital NHS FT (LWFT)
- x3 representatives from Liverpool University Hospitals NHS FT (LUHFT)
- x1 representative from Alder Hey NHS FT (AHFT)
- x1 representative from Clatterbridge Cancer Centre NHS FT (CCCFT)
- x1 representative of Liverpool Place (ICB)
- Leads of working groups if not covered by the membership above.

Attendees

Only members of the Programme Board have the right to attend Programme Board meetings, but the Chair will invite relevant individuals for all or part of a meeting as necessary in accordance with the business of the Programme Board.

The Chair may also invite specified individuals to be regular participants at meetings of the Programme Board to inform its decision-making and the discharge of its functions as it sees fit.

Participants will receive advance copies of the notice, agenda, and papers for Programme Board meetings. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5. Meetings

5.1 Leadership

The Chair of the Programme Board will be the interim Chief Executive of Liverpool Women's FT.

A Deputy Chair will be identified from within the standing membership of the Programme Board by the Chair.

The Chair will be responsible for agreeing the agenda with the Programme Director, ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

For a meeting or part of a meeting to be quorate a minimum of four Programme Board members need to be present, including:

- the Programme Board Chair or Deputy Chair
- at least one LWFT representative
- at least one clinically qualified member

Programme Board members may identify a deputy to represent them at meetings of the Programme Board when they are absent. Members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of any clinical members).When in attendance, a deputy of a member has the same right to vote as that of the member.

If any member of the Programme Board has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken within the remit of the Programme Board.

5.3 Decision-making and voting

The Programme Board will ordinarily reach its conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Programme Board may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair will hold the casting vote.

5.4 Frequency and meeting arrangements

The Programme Board will meet in private.

The Programme Board will seek to meet monthly. Additional meetings may take place as required.

Meetings may be conducted virtually using telephone, video, and other electronic means, when necessary.

5.5 Administrative Support

The Programme Board shall be supported with a secretariat function, which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the Programme Director.
- good quality minutes are taken in accordance with the standing orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept
- the Chair is supported to prepare and deliver reports to the WSC.

- the Programme Board is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

5.6 Accountability and Reporting Arrangements

The Programme Board is accountable to the Women's Services Committee of NHS Cheshire and Merseyside Integrated Care Board and shall report to the WSC about how it is discharging its responsibilities.

Regular programme reports will be produced and formally presented to the WSC. These reports will also be provided to the LWFT, LUHFT, AHFT and CCCFT Boards. Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

Members of the Programme Board have the responsibility to inform their respective organisations prior to and post the meetings with respect to the business undertaken by the Programme Board, and seek their support for any recommendations being considered by it.

6. Behaviours and Conduct

Benchmarking and guidance

The Programme Board will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

ICB values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Programme Board shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Management of Conflicts of Interest

All members shall comply with the ICB's Managing Conflicts of Interest Policy / their relevant organisation COI policy at all times. In accordance with best practice on managing conflicts of interest, members should:

- inform the chair of any interests they hold which relate to the business of the Programme Board.
- inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest

- inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, members should:

- Uphold the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary.

Equality diversity and inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of any recommendations and decisions they make.

The programme aims to improve equity and equality of access to women's hospital services in Liverpool; in particular, in access to other adult acute and emergency services.

The programme board will proactively seek to ensure that equality, diversity and inclusion is considered in the management and mitigation of clinical risks, in the case for change and in proposals for the future model of care.

The communications, engagement and involvement plan will detail how the programme will ensure that a diverse range of views are sought and included in the development of proposals.

Comprehensive impact assessments will be undertaken on proposals.

7. Review

The Programme Board will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required.

Any proposed amendments to the terms of reference will be submitted to the Women's Services Committee for approval.

NHS
Cheshire and Merseyside

NHS Cheshire & Merseyside Integrated Care Board

Women's Hospital Services In Liverpool Committee

Terms of Reference V2.2

Document revision history

Date	Version	Revision	Comment	Author / Editor
10.03.23	1.1		Revision following first shadow meeting of the Committee on 28.02.23	Matthew Cunningham
08.11.23	2.0	Revisions to reflect the programme definition and the establishment of a programme board		Clare Powell
06.12.23	2.1	Track changes accepted. Minor amends and revisions to membership section.		Clare Powell
20.12.23	2.2	Updates to membership and duties sections following feedback from the Chair		Clare Powell

Review due:
November 2024

Women's Hospital Services in Liverpool Committee

Terms of Reference

1. Purpose

The Women's[1] Hospital Services in Liverpool Committee (the Committee) is established by NHS Cheshire and Merseyside as a Committee of the Integrated Care Board (ICB) in accordance with its constitution.

The Committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The Liverpool Clinical Services Review report, published in January 2023,[2] recommended that a sub-committee of the ICB be established to oversee a programme of work to address the clinical sustainability of hospital services for women and the clinical risk in the current model of care. The Review was informed by and built on the considerable work undertaken by other reviews over several years. The recommendation to take a whole-system approach to addressing the clinical risks and sustainability challenges affecting women's hospital services in Liverpool was accepted and therefore NHS Cheshire and Merseyside ICB will be responsible for overseeing this programme of work.

The primary focus of the work will be hospital based maternity and gynaecology services and although these services are delivered in Liverpool they include tertiary services for Cheshire and Merseyside. Any proposed solutions may therefore impact on the care of patients across Cheshire and Merseyside and beyond and these populations will be fully considered in the programme.

The Committee will be established with a diverse membership, drawn from a variety of partner organisations, and will include other representatives in attendance, drawn from the NHS Trusts with a role in delivering these services.

Over the next five years, the Committee will oversee and assure the development and implementation of a future care model that will ensure that women's hospital services delivered in Liverpool provide the best possible care and experience for all women, babies and their families.

---

[1] It is important to acknowledge that it is not only people who identify as women (or girls) who access women's health and reproductive services to maintain their sexual and reproductive health and wellbeing. The terms 'woman' and 'women's health' are used for brevity, on the understanding that transmen and non-binary individuals assigned female at birth also require access to these services. Delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

[2] https://www.cheshireandmerseyside.nhs.uk/media/vz2na242/cm-icb-board-public-260123.pdf

2. Responsibilities / duties

The Committee, through delegated authority from the ICB, will develop recommendations for safe, high quality and sustainable services.

The Committee will:

- Ensure that a clinically led programme of work is established to identify options for delivery of safe, high quality and sustainable services. This will include:
    - approving the strategic case for change.
    - agreeing the programme governance arrangements, that ensures robust development of options and evidence of how conclusions have been reached.
    - establishing a programme board to lead the development of the case for change and future model of care for women's hospital services in Liverpool.
    - gaining assurance that proposals for future delivery of these services are clinically led, informed by clinical evidence, research, and intelligence, and can demonstrate that they meet the needs of women and their families.
    - approving the programme board's workplan.
    - receiving regular progress reports from the programme board and seeking assurance about programme delivery.
    - involving and engaging NHS and wider partners, managing strategic dependencies across Cheshire and Merseyside (and beyond) and resolving any conflicts.
    - ensuring the programme has sufficient resources drawn from all partners, with the right skills and capacity to deliver a large-scale, complex programme.
- Ensure that the voice of the patient, public and stakeholders is heard.
    - It will develop and maintain processes to ensure that there is meaningful involvement of the public, patients, carers, and stakeholders in the development of proposals.
    - It will ensure that OSC and appropriate local, regional and national bodies are engaged.
- Ensure that the financial impact of proposals / options is robustly assessed so that it can present costed recommendations to the ICB for decision.
- Ensure that all significant proposals undertake Health Inequality, Quality and EDI assessments so that their impact can be assessed against the objectives of the ICB.
- Ensure that the programme complies with statutory and regulatory requirements, in particular the duties of consultation should any major service reconfiguration be recommended.
- Make recommendations to the ICB, keep the ICB appraised of progress and identify significant risks to the delivery of the programme work plan.

3. Authority

The Committee will oversee the development of a future care model that will ensure that women's hospital services delivered in Liverpool provide the best possible care and experience for all women, babies and families.

The Committee is authorised by the ICB to:

- request further investigation or assurance on any area within its remit
- bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- make recommendations to the ICB Board
- escalate issues to the ICB Board
- approve an annual work plan to discharge its responsibilities
- approve the terms of reference of the programme board
- delegate responsibility for specific aspects of its duties to sub-groups, sub-committees or individuals.

Decisions on areas, functions, or budgets outside of the authority or scope of the ICB is discharged through the authority that is delegated to the individual members of the Committee by their respective organisations.

For the avoidance of doubt, in the event of any conflict when making any decisions or recommendations, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

4. Membership & Attendance

Membership

The Committee membership shall be appointed by the ICB in accordance with the ICB Constitution. Membership of the Committee may be drawn from the ICB Board membership; the ICB' executive leadership team; officers of the ICB; members or officers of other bodies in the wider health and social care system; other individuals/representatives as deemed appropriate.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Committee Membership will be composed of:

- Committee Chair - Chair of the ICB
- an Independent Clinical SRO, from outside the Cheshire and Merseyside ICB footprint
- the ICB Women's Services Programme SRO, who will be an ICB Executive
- the ICB Associate Medical Director (Transformation)
- an ICB Non-Executive member
- the ICB Director of Finance
- an ICB Primary (GP) Care Partner representative

- a representative from the Local Maternity and Neonatal System
- the Liverpool Place Director
- the Sefton Place Director
- the Knowsley Place Director
- a representative from CMAST
- lay representatives
- a representative from the NW Specialised Commissioning team

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair will invite relevant staff members for all or part of a meeting as necessary in accordance with the business of the Committee.

Members of the Programme Board will be routinely invited to attend to provide progress reports and to be part of the Committee discussions. These attendees can include but are not limited to:

- the ICB Associate Medical Director – Transformation
- Representative(s) from Liverpool Women's Hospital NHS FT
- Representative(s) from Liverpool University Hospitals NHS FT
- Representative(s) from Alder Hey NHS FT
- Representative(s) from Clatterbridge Cancer Centre NHS FT
- Women's Services Programme Director
- Programme Support Officer(s)

The programme director and any other dedicated staff will support the operation of both the Committee and the Programme Board.

The Chair may also invite specified individuals to be regular participants at meetings of the Committee to inform its decision-making and the discharge of its functions as it sees fit.

Participants will receive advance copies of the notice, agenda, and papers for Committee meetings. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. Named regular participants may include:
a) a Director of Public Health.
b) a representative from Healthwatch Liverpool on behalf of all the Cheshire and Merseyside Healthwatch organisations.
c) an individual bringing knowledge and a perspective of the voluntary, community, faith, and social enterprise sector.
d) individual(s) representing the Local Medical Committee.
e) individual(s) representing Primary Care (Pharmacy, Dentistry).
f) a representative from the University of Liverpool.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5. Meetings

5.1 Leadership

The Chair of the Committee will be the Chair of NHS Cheshire and Merseyside ICB.

A Deputy Chair will be identified from within the standing membership of the Committee by the Chair.

The Chair will be responsible for agreeing the agenda with the Senior Responsible Officer for the Programme, and the Programme Director, ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

For a meeting or part of a meeting to be quorate a minimum of five Committee members must be present, including:

- the Committee Chair or Deputy Chair
- at least one clinically qualified member
- at least one ICB Executive member.

Committee members may identify a deputy to represent them at meetings of the Committee when they are absent. Committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of any clinical members). When in attendance, a deputy of a Committee member has the same right to vote as that of the member.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken within the remit of the Committee.

5.3 Decision-making and voting

The Committee will ordinarily reach its conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.4 Frequency and meeting arrangements

The Committee will meet in private.

The Committee will meet at least four times each year. Additional meetings may take place as required.

In normal circumstances, each member of the Committee will be given not less than one month's notice in writing of any meeting to be held. However:

- the Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
- a majority of the members of the Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting.
- in emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

As a Committee of the ICB, meetings maybe conducted virtually using telephone, video, and other electronic means, when necessary.

5.5 Administrative Support

The Committee shall be supported with a secretariat function, which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the SRO of the programme;
- good quality minutes are taken in accordance with the standing orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- the Chair is supported to prepare and deliver reports to the Integrated Care Board;
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

5.6 Accountability and Reporting Arrangements

The Committee is accountable to the Cheshire and Merseyside Integrated Care Board and shall report to its Board on how it discharges its responsibilities.

A summary of key issues discussed and concluded shall be produced and formally submitted to the Integrated Care Board. Reporting will be appropriately sensitive to personal circumstances and will not contain personally sensitive or personally identifiable information.

The Committee will provide the Integrated Care Board with an Annual Report for each year it is in place. The report will summarise its conclusions from the work it has done during the year.

Members of the Committee who are not ICB members have the responsibility to inform their respective organisations prior to and post the meetings with respect to the business under-taken by the Committee and seek their support for any recommendations being considered by the Committee and the Board.

6. Behaviours and Conduct

Benchmarking and guidance

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

ICB values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Management of Conflicts of Interest

All members shall comply with the ICB's Managing Conflicts of Interest Policy / their relevant organisation COI policy at all times. In accordance with best practice on managing conflicts of interest, members should:

- inform the chair of any interests they hold which relate to the business of the Committee.
- inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest.
- inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, members should:

- Uphold the Nolan Principles of Public Life.
- Attend meetings, having read all papers beforehand.
- Arrange an appropriate deputy to attend on their behalf, if necessary.

Equality diversity and inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of any recommendations and decisions they make.

7. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required.

Any proposed amendments to the terms of reference will be submitted to the Integrated Care Board for approval.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	Children and Young Peoples Committee – Terms of Reference
Report of:	Louise Shepherd, Chief Executive
Paper Prepared by:	Cheshire and Merseyside ICB

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☑ ☐ ☐
Action/Decision Required:	To note To approve	☑ ☐
Summary / supporting information		
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:	n/a	

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
1.1.	Inability to delivery safe and high-quality services	9

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
Cheshire and Merseyside

NHS Cheshire & Merseyside Integrated Care Board

Children and Young Peoples Committee

Terms of Reference

v1.1

Document revision history

Date	Version	Revision	Comment	Author / Editor
08.09.2023	1.0	First draft presented to informal CYP Committee		Matthew Cunningham
	1.1	Amendments made following Informal CYP Committee 08.09.23		Matthew Cunningham

Review due:
(add date)

V (add) approved by the Board of NHS Cheshire and Merseyside (add date)

Children and Young Peoples Committee

Terms of Reference

1. Introduction

The Children and Young Peoples Committee (the Committee) is established by NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') as a Committee of NHS Cheshire and Merseyside in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the website of NHS Cheshire and Merseyside, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board of NHS Cheshire and Merseyside

The Committee is a sub-committee of the Board of NHS Cheshire and Merseyside and its members, including those who are not employees or members of NHS Cheshire and Merseyside, are bound its Standing Orders and other key policies.

When referring to 'children and young people' throughout this document, this covers ages 0 to 25 and refers to babies, children and young people.

It is anticipated that the Committees scope, purpose, authority, membership and governance arrangements will evolve over time as it is established and as a Cheshire and Merseyside Children and Young Peoples Strategy is produced and implemented.

2. Role and Purpose

The Committee's main purpose is to have oversight of, shape and provide assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (children and young people), including looked after children.

The Committee will oversee the development and delivery of the Cheshire and Merseyside Children and Young Peoples Strategy and ensure effective system focus on Children and Young People as a population cohort. The Committee will also be responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People.

The Committee will have a key role in ensuring that the voice of and needs of Children and Young People are prominent in the discussions and decisions of the Board of NHS Cheshire Merseyside.

The Committee will provide, seek and receive assurance and intelligence from other key forums and Committees which have a role in the oversight of, assurance or planning

delivery of services for Children and Young People across Cheshire and Merseyside, including:

- Cheshire and Merseyside Health and Care Partnership
- Cheshire and Merseyside ICB Quality and Performance Committee
- Cheshire and Merseyside ICB Women's Services Committee
- Cheshire and Merseyside ICB Finance, Investment and Our Resources Committee
- Cheshire and Merseyside ICB Transformation Committee
- Place Safeguarding Childrens Partnerships
- Cheshire and Merseyside Beyond Childrens and Young Peoples Transformation Programme Board
- North West Children and Young People Transformation Programme.
- CMAST Provider Collaborative
- MHLDC Provider Collaborative
- Cheshire and Merseyside DCS Network
- Cheshire and Merseyside Population Health Board (Marmot link re Start Well etc, Core20+5CYP)
- Strategic Clinical Network(s)
- North West NHSE Specialist Commissioning Women and Children's Transformation Board.

Whilst established as a formal committee of NHS Cheshire and Merseyside, its membership will be drawn from a variety of system partners with the ambition that the Committee will harness and help co-ordinate a collective system focussed approach to improving the health, wellbeing and care of Children and Young People. Whilst the Committee itself does not have the authority to make binding decisions on the duties and functions of partner organisations in relation to Children and Young People, representatives of these organisations who are members or who are in attendance will be encouraged to use the meetings of the Committee to seek a collaborative and consensual view to help inform their decisions.

3. Responsibilities / duties

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Committee's duties for and on behalf of NHS Cheshire and Merseyside and its functions can be categorised as follows:

- set out and agree the steps NHS Cheshire and Merseyside is taking to address the needs of children and young people, with a focus on improving their physical and mental health outcomes and reducing inequalities, and as included within the Cheshire and Merseyside Joint Forward Plan
- ensure there is visible and effective leadership for addressing issues faced by the groups outlined as in scope of the Committee
- ensure that NHS Cheshire and Merseyside has resources in place so as to champion and work in co-production with children, young people and their families so that the Board of NHS Cheshire and Merseyside is informed by and understands the issues which affect children and young people.

- ensure that NHS Cheshire and Merseyside plays a pivotal role in leading relationships with key partners across the Integrated Care System as regards children and young people, and their families
- ensure that NHS Cheshire and Merseyside plays a pivotal role in delivering on the strategy and priorities of the Cheshire and Merseyside Health and Care Partnership as regards children and young people, and their families
- develop Cheshire and Merseyside key performance indicators for the quality of services for children and young people, and the impact these services have on outcomes for children and young people and their families/carers
- have oversight of and make plans to mitigate any associated risks identified against the delivery of the ICBs functions and responsibilities for Children and Young People. The Committee will be responsible for any associated risks that feature on the Board Assurance Framework of NHS Cheshire and Merseyside.

4. Authority

The Committee is authorised by the Board of NHS Cheshire and Merseyside to:

- have oversight of and approve the strategy and priorities for NHS Cheshire and Merseyside with regards Children and Young People
- have oversight of, agree and approve the prioritisation of ICB funding and allocations for Childrens and Young Peoples functions and services that NHS Cheshire and Merseyside has responsibility for, as agreed and outlined within the Scheme of Reservation and Delegation, and as approved within the Financial Plan and Budget book, and in line with the ambitions of the NHS Long Term Plan
- have oversight of and agree recommendations to the Board of NHS Cheshire and Merseyside with regards the further delegation of responsibility and authority to individuals or forums within NHS Cheshire and Merseyside to make decisions on and commit funding in relation to the Children and Young Peoples functions and responsibilities of NHS Cheshire and Merseyside
- consider and make recommendations to the Board of NHS Cheshire and Merseyside regarding the delegation of functions, budgets (including pooled budget arrangements) and responsibilities in the relation to Children and Young People to any parties outside of NHS Cheshire and Merseyside.

In making its decisions the Committee is acting on behalf of the Board of NHS Cheshire and Merseyside.

In making its decisions the Committee will also be mindful of and be informed by the corresponding statutory duties, functions and funding requirements of partner organisations in relation to Children and Young People.

5. Membership & Attendance

Membership
The Committee membership shall be approved by the Board in accordance with the Constitution.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Committee Membership will be composed of:

- ICB Chair
- ICB Executive Director of Nursing and Care
- ICB Assistant Chief Executive
- x1 ICB Non-Executive Director
- x1 NHS England representative
- x2 Provider Collaborative representatives
- x4 ICB Place representatives
- x1 Local Authority Chief Executive
- x2 Local Authority Director of Children Services representative
- x2 Beyond Board Representative
- x1 Director of Public Health representative / Population Health representative
- x1 Healthwatch Representative
- x2 VCFSE Representatives
- x2 Youth Board Representatives.

It is expected that members will prioritise these meetings and make themselves available. Where this is not possible a nominated deputy may attend of sufficient seniority. Deputy attendance needs to be agreed in advance with the Chair.

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair may invite other relevant staff to all or part of a meeting as necessary in accordance with the business of the Committee. Such attendees will not be eligible to vote. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

It is expected that there will be a number of regular attendees to meetings of the Committee, including Senior Responsible Officers leading on core work programmes in relation to Children and Young People.

6. Meetings

Leadership
Committee members may appoint a Deputy Chair from amongst the standing members.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Quorum
For a meeting or part of a meeting to be quorate a minimum of 50% of the membership must be present, including the Chair or Deputy Chair:

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision-making and voting
The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

Frequency and meeting arrangements
The Committee will meet in private.

The Committee will meet up to six times per year. Additional meetings may take place as required.

The Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Administrative Support
The Committee shall be supported with a secretariat function. Which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the lead Executive for the Committee
- good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- a log of stated conflicts of interests is kept
- the Chair is supported to prepare and deliver reports to the Board of NHS Cheshire and Merseyside
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

7. Accountability and Reporting Arrangements

The Committee is accountable to the Board of NHS Cheshire and Merseyside and shall report to the Board on how it discharges its responsibilities, as delegated by, and authorised by the Board.

A Committees Chair Summary Briefing will be collated and issued to all members of the Committee following each meeting so that the discussions and decisions of the Committee can be readily communicated to partner organisations within the Integrated Care System.

A Committees Chair Report which summaries key issues discussed and concluded shall also be produced and formally submitted to the Board of NHS Cheshire and Merseyside following each meeting of the Committee. The report will be structured to alert, assure and advise the Board. The Chairs Report will also be provided to meetings of the Cheshire and Merseyside Health and Care Partnership.

The minutes of the meetings shall be formally recorded by the Committee secretary and also submitted to the Board in accordance with the Standing Orders. Minutes and assurance reports of a confidential nature from the Committee will be reported to a subsequent meeting of the Board in private.

Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. Behaviours and Conduct

The Committee shall conduct its business in accordance with any national guidance. The seven Nolan Principles of Public Life shall underpin the committee and its members.

Members should:

- inform the Chair of any interests they hold which relate to the business of the Committee.
- inform the Chair of any previously agreed treatment of the potential conflict / conflict of interest.
- abide by the Chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- inform the Chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- abide by the Chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.
- abide by their own respective organisation's Code of Conduct.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- attend meetings, having read all papers beforehand
- arrange for their substitute to attend on their behalf, if necessary
- act as 'champions', disseminating information and good practice as appropriate

- comply with the Committee administrative arrangements including identifying agenda items for discussion, the submission of reports etc.
- consider the equality, diversity and inclusion implications of the discussions they undertake at Committee meetings.

9. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board of NHS Cheshire and Merseyside for approval.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	**Transformation Programme**
Report of:	Natalie Palin, Director of Transformation and Change
Paper Prepared by:	Natalie Palin, Director of Transformation and Change Natalie Deakin, Head of Service – DMO Colin Beaver, Deputy Director of Marketing and Communication Rachel Lea, Director of Finance and Development

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	**Trust Board 22/23/06**: Operational Plan 22/23 Trust Integrated Performance Report **Strategy Board** – Strategic Scorecard (July 23) **Transformation Programme (Report Dec 2023)**
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 ☐

If "No", is a new risk required? Yes ☐ No ☐

Risk Number	Risk Description	Score
	Please note that work is ongoing to develop our BAF to mirror the integrated delivery approach.	

Level of assurance (As defined against the risk in In Phase)	☑	**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

This report aims to update the Trust Board on the progress made in the implementation of our Vision 2030 Strategic Plan (23/24), specifically focusing on developments since the last update to Trust Board in December 2023. Despite the challenges posed by the Christmas break and the ongoing industrial action, which inevitably led to some loss of momentum, we have diligently worked to balance the demands of a long-term, multi-year programme while implementing the recommendations outlined in the last update paper (Trust Board – Dec-23).

Areas of focus: This report aims to provide a comprehensive overview of the following key areas:

- ✓ Initiation and Delivery of our Strategic Initiatives
- ✓ Benefit Realisation – Integrated Plan (2024/25)
- ✓ Review of Change Resources
- ✓ Communication Plan
- ✓ Highlighting Areas of Progress and Good Practice

Key Risks and Recommendations:
A significant risk associated with the development and deployment of the Vision 2030 Strategic Plan is the potential constraint imposed by traditional organisational silos. To address this, the following key recommendations are proposed.

To continue development of: -

- Benefit Realisation and Integrated Plan for 2024/25
- Alignment of wider Trust Change Resources

2. Background and Current State

Initiation and Delivery of our Strategic Initiatives

Background: With the endorsement of Vision 2030, we have embarked on a transformative journey, redefining our approach to address CYPF (Children, Young People, and Families) needs. Central to this transformation is an integrated programme of change, underpinned by name strategic initiatives, all of which are in direct alignment with our overarching vision and are imperative for the realisation of our long-term objectives.

In March 2023, we established the strategic initiative mandates, laying out a blueprint for the desired future state across a multi-year timeline. The Trust Delivery Management Office has been instrumental in this phase, setting up the necessary frameworks for these strategic initiatives to evolve into formal programmes. This evolution is guiding our transition from the current state towards the envisaged future state.

Current State: The table below provides an overview of where we stand in the initiation phase of our strategic initiatives as of January 24. It reflects the diverse stages of each programme within their respective project life cycles. This diversity underscores the need for a strategic and flexible approach in managing our portfolio of programmes, allowing us to adapt and respond effectively to varying requirements and stages of development.

Table 1: Strategic Initiative Initiation Phase

PHASE 1 INITIATION					
Strategic Theme	Senior Responsible Officer (SRO)	ID	Strategic Initiative	Initiation Date	Initiation Phase Completion
Unrivalled Experience	Chief Nurse and Experience Officer	1.1	CYP&F Engagement & Experience	Qtr 1 (23/24)	100%
Supporting our People	Chief People Officer	2.1	Thriving at Alder Hey	Qtr 1 (23/24)	100%
Supporting our People	Chief People Officer	2.2	Professional Development Hub	Qtr 4 (23/24)	20%
Supporting our People	Chief People Officer	2.3	Future Workforce	Qtr 4 (23/24)	10%
Pioneers Breakthroughs	Chief Futures Officer	3.1	Futures	Qtr 4 (23/24)	50%
Collaborating for CYP	Chief Strategy and Partnerships	4.1	Collaborating in Communities	Qtr 1 (23/24)	100%
Revolutionising Care	Chief Digital and Transformation	5.1	New Models of Care	Qtr 4 (23/24)	50%
Revolutionising Care	Chief Digital and Transformation	5.2	Digital	Qtr 1 (23/24)	100%
Revolutionising Care	Chief Digital and Transformation	5.3	Insight Led Decisions	Qtr 3 (23/24)	40%

Now that some of our strategic initiatives have completed the initiation phase, it is timely to report on those that have made headway on delivery (the implementation phase). The table below summarises the progress made for those strategic initiatives now in the implementation phase.

Table 2: Strategic Initiative Implementation Phase

PHASE 2 IMPLEMENTATION					
Strategic Theme	Senior Responsible Officer (SRO)	ID	Strategic Initiative	Implementation Commenced	Implementation Phase Completion for 23/24
Unrivalled Experience	Chief Nurse and Experience Officer	1.1	CYP&F Engagement & Experience	Qtr 3 (23/24)	70%
Supporting our People	Chief People Officer	2.1	Thriving at Alder Hey	Qtr 4 (23/24)	40%
Collaborating for CYP	Chief Strategy and Partnerships	4.1	Collaborating in Communities	Qtr 1 (23/24)	50%
Revolutionising Care	Chief Digital and Transformation	5.2	Digital	Qtr 1 (23/24)	90%

Our Benefit Realisation approach

Background: As highlighted in the Transformation Report (Dec 23), our **Benefit Realisation Approach** was redesigned during the third quarter of 2023/24. A pivotal development in our approach is the creation of a **Benefit Case framework.** This framework is instrumental in pinpointing the baseline position and expected benefits derived from our transformational changes. It establishes a solid foundation for monitoring the benefits realised, including those leading to cash releasing savings, enhanced productivity, income generation, and social value return.

The importance of organisational financial sustainability cannot be overstated, especially considering the expected £17 million cost improvement requirements for 2024/25. Moving forward, every investment decision and change initiative will necessitate the formulation of a benefit case. Progress in advancing our benefit realisation approach is being reported through RABD.

Current state: We are continuing to advance the suite of 'benefit cases' which require significant work in identification of appropriate measures, baselines, and targets. One notable achievement in this process has been the increasing involvement of our colleagues from various departments. This collaborative effort has led to a deeper and more comprehensive understanding of 'productivity opportunities'.

This collaborative and cross-divisional approach is not only enhancing our understanding of where and how we can improve productivity but also paving the way for a more unified and coherent annual plan for the financial year 2024/25. By adopting this integrated approach, we are moving towards a genuine system-wide strategy for improvements, breaking down silos and fostering a more cohesive and efficient management of CIP.

We have arranged for Senior Responsible Officers (SROs) to present their benefit realisation cases at the RABD committee meeting in February 24. This presentation will be for the purpose of seeking sign-off and approval. This step underscores the importance of the committee's role in our governance structure and its influence in shaping our benefit realisation approach. Diagram 1 details the benefit cases that we are currently developing (Appendix 1 – includes an example benefit case).

Integrated Annual Plan 2024/25

Background: Our benefit plan is directly aligned to the developing integrated annual plan for 2024/25. This step aligns with recommendations from previous Trust Boards, which highlighted the importance of creating a unified, comprehensive plan. Consolidating our objectives and resources into one plan ensures a more efficient use of our resources and provides clearer direction. This integration represents a significant advancement in our continuous improvement journey and the embedding of our BB improvement system. This integration facilitates the smooth transition of improvement strategies into practical actions, ensuring divisional, service and departmental alignment. The plan will include measurable targets, defined timelines, and clear accountability structures, which are crucial for effective management.

Current State: The annual planning for 24/25 is underway internally, however the full national guidance is yet to be published. The current timetable is detailed in table 3, however this is subject to change once the national timetable and dates are known.

Task	Date	Status
First draft financial templates submitted by departments/divisions – WTE/Activity/£	25th January	Complete
Senior finance review of templates	31st January	Complete
Initial draft plan submitted to RABD **Benefit cases presented to RABD by SRO**	26th February	
Full annual planning template complete by all department divisions including CIP plans	End of February	Underway
Draft submission to ICB	TBC – likely end Feb	
Executive review of annual planning templates	w/c 4th March	
Final plan submission to RABD	25th March	
Final submission to ICB	TBC – likely end of March	

Review of our widest Change Resource

Background: In our Trust Board meeting (Dec 23), we approved a vital recommendation concerning the alignment of our broader change resources. Our current centralised Delivery Management Office (DMO) comprises of 4.5 Full-Time Equivalents (FTEs) and is dedicated to supporting the implementation of our Vision 2030 strategic plan. The recommendation we approved calls for a comprehensive review of our Trust-wide resources, with the aim of ensuring that they are appropriately aligned with our strategic goals.

Current State: Throughout January 2024, we have engaged extensively with our Executive Team and Divisional Leadership teams. This engagement has led to an assessment of our broader change resources, revealing a total of 37.5 Full-Time Equivalents (FTEs) across various corporate and divisional services. This process has facilitated the co-creation of a proposal in its early stages, focusing on four key elements:

1. Aligning our HR/Organizational Development and Transformation Resource (BB / DMO), to foster team-based improvements utilising our effective '@ Its Best' methodology. This integration acknowledges the importance of addressing cultural enhancements in tandem with transformational change.

2. Aligning crucial support resources necessary for executing strategic programmes, encompassing areas such as Digital Transformation, Communication, Business Intelligence, and Finance.

3. Creating agility in aligning our broader change resource specialists to aid the delivery of specific projects, including Safety, Divisional PMO, and Innovation initiatives.

4. Establishing a unified access point and a dedicated physical location (Innovation Hub). This will provide teams with one way in to access centralised support for improvements and universal access to change resources.

These core elements are designed to offer a platform for team-based improvements, coordinated allocation of specialist resources, and to propel our transformation programme forward. While there is no intention to alter the existing line management structures regarding the execution of work, an equal reporting line will be established for project oversight (objectives, project management). Maintaining the current organisational structure is expected to facilitate a swifter adoption of the new integrated approach.

It is recommended that work continues to develop this proposal further, throughout February 24; with an aim towards implementation during April 24. We will be opting for a "learning by doing" approach, as opposed to crafting an overly detailed plan; the advantages of this approach include flexibility, enhanced innovation, real time problem solving across the change resource and faster implementation of actions; and most importantly team engagement.

Communication Plan

A plan has been developed to support communication around Vision 2030, what it is and what it sets out to do. It focuses on communications to staff and stakeholders.

A narrative for Vision 2030 has been developed and is covered in full in the Vision 2030 brochure. A summary version of this narrative will be developed for use in other spaces.

Other tactical activity includes:

- Replace the old plan on a page ('four trees') throughout the Trust with the new 'sunflower' version. This includes current environmental branding e.g., on the mezzanine which will be removed and updated in line with the refreshed look and iconography of Vision 2030.
- Intranet resource and associated: Create a dedicated space on the intranet for Vision 2030 comms, feat. news, updates, discussion and resources to view and/or download, incl. the plan on a page, brochure, videos, creative assets (templates/graphics).
- A monthly highlight email bulletin will be published by the Marketing & Communications Team linking to the news and updates on the intranet.
- A monthly, virtual open meeting dedicated to each of the strategic initiatives, providing updates on activity and taking questions. This will be led by the Programme Teams to ensure authenticity.
- Broadly accessible highlights summary of progress towards the objectives of Vision 2030; 'Vision 2030: Our Journey So Far…'.
- For stakeholders, in addition to ongoing face to face engagement, create a regular Stakeholder Bulletin, linked to a dedicated space on our website where other resources will be available, e.g.: a 'flip book' version of the 2030 brochure, videos.
- Launch: Whilst Vision 2030 is very much underway, we can mark the shift to the new organisational plan, fully aligned to Vision 2030, from 1 April by, for instance, some engaging PR activity such as the planting of a sunflower garden on site.

3. Assessment of Progress

Substantial progress has been made in a relevantly short period of time, sustaining, and signaling a more fundamental shift in our approach to the management of change and our journey towards Vision 2030. Table 3 highlights key achievement and good practice, against our milestone plan.

In accordance with our continuous improvement approach (Brilliant Basics), we are always seeking excellence; with that in mind this section also identifies opportunities to enhance our internal systems of control, to further advance our strategic deployment.

9066

Table 3: Key Achievements and Area of Good Practice

Goal	Baseline / Target	Highlights	Area of good practice
Experience & Engagement	Target – 95% CYPF Satisfaction Score (FFT) 23/24 YTD – 93% (FFT)	**Experience driving the entire organisation** - - Filming has commenced in the development of phase 1 of the Alder Hey virtual tour with a first reveal to the project team scheduled for March 24. - Experience and Engagement Week scheduled (12th Feb –16th Feb 24) featuring the launch of our warm welcome standards (co-developed with our CYP). - Alternative WhatsApp supplier identified and due diligence progressing with the view to pilot in March 24 with the soft launch of Martha's Rule.	✓ Year 2 programme planning started. ✓ Exploring expertise in house to deliver customer training. ✓ Utilised external knowledge and expertise to enhance CYPF feedback using AI to draw out emotional sentiment at no additional cost. ✓ Currently testing the concept of an effort score as a new measure.
Our people	1% reduction in staff sickness rates 5.5% 1% reduce staff turnover to 13% YTD - 11%	**Thriving Leaders** ○ 14 core topics agreed, leads assigned, content creation in progress – go live Feb 24. **Preceptorship** ○ Preceptorship Policy written and submitted– final submission beginning of March 24 ○ Seeking ratification of policy through Education Governance (8 Feb) and PAWC (end of Feb) then engagement through PRG. ○ AHP lead & practice educator business case approved at IRG Dec 23 – going to AFC panel and exec panel for approval Feb-March 24. ○ Current cohort of nurses are reporting very positive feedback on their preceptorship journey thus far.	✓ Pivoting the collective resource around Preceptorship and Development of a Managers Essentials Offer. ✓ Initiating induction workstream 31 Jan – with completion of A3. ✓ Staff thriving index question agreed and in development.
Futures	No. Of solutions deployed to care +/- to market	○ Futures Leadership Group established and meeting regularly. ○ Engine room progressing well with baseline data collected. ○ 1st commercial partnership agreement developed and signed. ○ Programme structure established and recruitment of workstream leads commenced.	✓ 124 staff members contributed to our thinking around the Futures strategy via engagement sessions.

Goal	Baseline / Target	Highlights	Area of good practice
Collaboration in communities	Generate Social Value across LCR 23/24 Baseline: 0 Target: £189k YTD – £107k Reduce variation in health care outcome- CORE20+5CYP metrics in development	**Family Hub:** ○ CAB and Health Junction partnership in development. ○ Exec Approval Feb, Business case to Charity March 24, mobilisation April 24. **Advocacy:** ○ Working group in place, year 1 focus agreed. (Respiratory, lung health) **Employment and education** ○ £107k social value generated to date. ○ 2300 CYP across 78 schools joined broadcast on caring for your teeth- partnership with Children's University ○ 2 x B5 roles secured to progress work. **CYP System:** ○ C&M Cheshire and Mersey ICS CYP Committee established - 5 core themes agreed. ○ C&M CMAST CYP Alliance and associated working groups established. **Greener:** ○ Energy optimisation project ongoing with SPV – focus on fixing heating. ○ Waste - compactors now in. ○ Finalising bid with LUHFT for innovation funding. ○ ICS level energy work started. **Air quality / housing / Respiratory:** ○ Warmer homes team visited AHFT and ran a stand in atrium. Keen to support our Family Hub. ○ Fed into LCC's new housing strategy being presented March 24.	✓ Engagement with youth forum to develop Family Hub idea and approach. ✓ Respiratory project presenting to Liverpool NHS execs in Feb. Housing/ environment proposed as workstream. ✓ Reviewing respiratory' 'high consumer / costs' by postcode and reviewing with LCC team to identify common suppliers & issues. ✓ Following up Marmot housing group work. Opportunity to combine TORUS air quality findings with LCC Net zero plans. Funding bids available in March.
Revolutionising Care	Efficiency / productivity Clinical Capacity (Elective Capacity) To be baselined	○ Development of the Alder Hey Anywhere at testing phase **Operational Improvement:** ○ Virtual ward pilot started, following successful lobbing to invest in paediatric care £200k investment secured. ○ Development of PAU – aligned to 'Get Me Well' ○ Agreement with system partners Alder Hey will host a CYP UEC workshop (provisional dates shared) **Virtual Urgent & Emergency Care:** ○ Technical configuration discussions underway to allow 111 to directly booked into our UTC slots. ○ Alder Hey agreement to support Pharmacy First Service (going live 1st Feb 24). **Personalise My Care:** ○ Deeper process mapping in progress. ○ PDSA cycles drafted and provisionally agreed. ○ Data trawling in progress to identify the various CYP complex care cohorts. ○ CYPF co-design SOP approved – engagement starting on Friday, 2nd Feb 24.	✓ Virtual ward, contributing to our areas of Need for both Get me Well and Personalised Care. Biggest paediatric virtual ward in country and consistent achieving 80% occupancy. ✓ Clinical Summits (2) ✓ **Personalised Care**: Clinical workshops (3) consensus on the definition of the level of complexity that warrants coordination as a starting point. Appreciative inquiry in progress – gathering learning and benchmarking.

0068

4. Conclusion

In conclusion, this report provides the Trust Board with a comprehensive update on the advancements made in the Vision 2030 Strategic Plan (23/24) since our last update in December 2023. This report covers the initiation and delivery of strategic initiatives, the integration of our 2024/25 plans for benefit realisation, the alignment of our wide-ranging change resources with strategic priorities, the communication strategy for the upcoming quarter, and the identification of areas of progress and best practice.

However, we recognize the risks associated with traditional organisational silos, which could impede the development of the Vision 2030 Strategic Plan. To mitigate these risks, we emphasise the importance of continuing to develop our Benefit Realisation and Integrated Plan for 2024/25, along with aligning our broader Trust Change Resources with our strategic goals. This approach will ensure cohesive and strategic alignment in our efforts, harnessing our diverse talents and resources.

4. Recommendations & proposed next steps

The key recommendations arising from this paper is to note the significant progress made to date. To approve the below areas, with reporting of progress to be included in the next board report.

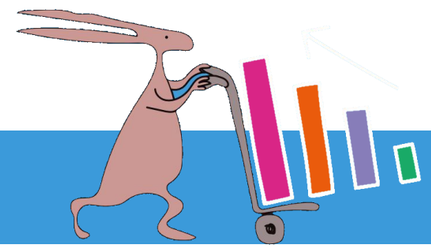
To continue development of: -

a) **Benefit Realisation and Integrated Plan for 2024/25**: This plan will encompass both strategic and operationally important change areas, ensuring alignment and coherence in our efforts.
b) **Alignment of wider Trust Change Resources**: Ensuring that our resources are optimally aligned with our strategic priorities.

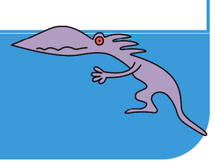
NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: January 2024



Contents



Icon Definitions

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

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

XmR chart

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

Process limits

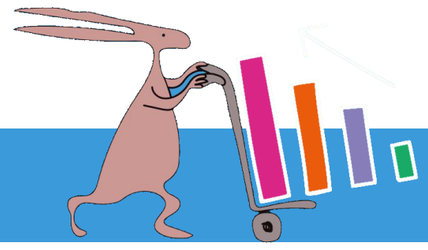
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

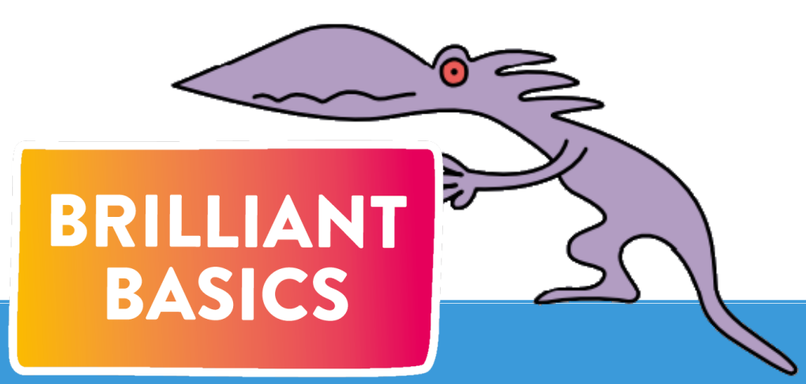
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Cancer 2-week referrals & C.Difficile demonstrates performance is consistently achieving target with an improving trend	Staff Turnover, OP New/OPPROC recovery, Mandatory training, Virtual Ward Bed Days, Level 1 patient safety training are inconsistently achieving target with an improving trend	Theatre Utilisation, ED Sepsis, Diagnostics, CAMHS >52 wks, are not achieving targets but demonstrating improvement
	Common Cause	Cancer and MRSA metrics are achieving targets	ED 4hrs, EL/DC Recovery, Cancelled Operations, WNB, Stranded patients, F&F Trust & ED, PALs, Sickness & ERF are inconsistently achieving target and are yet to evidence statistical improvement	Complaints, Deteriorating inpatients, Clinic Letters completed, Medical Appraisal, Long Term Sickness & PDRs are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern			RTT >65 Weeks & >65 Wk waits ASD/ADHD are not achieving targets

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
- 61.4% of our metrics are inconsistently achieving target
- We are not achieving the target for 22.7% of our metrics but experiencing improvement in 3 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.



Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety

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

Highlights:

No serious incidents or Never Events reported. Incidents initially reported as Moderate or above are reviewed by the Division and the PSIRF panel and validated. 93% of inpatients and 91% of ED patients received antibiotics within 60 minutes for sepsis. No hospital acquired infections; No Category 3 or 4 pressure ulcers

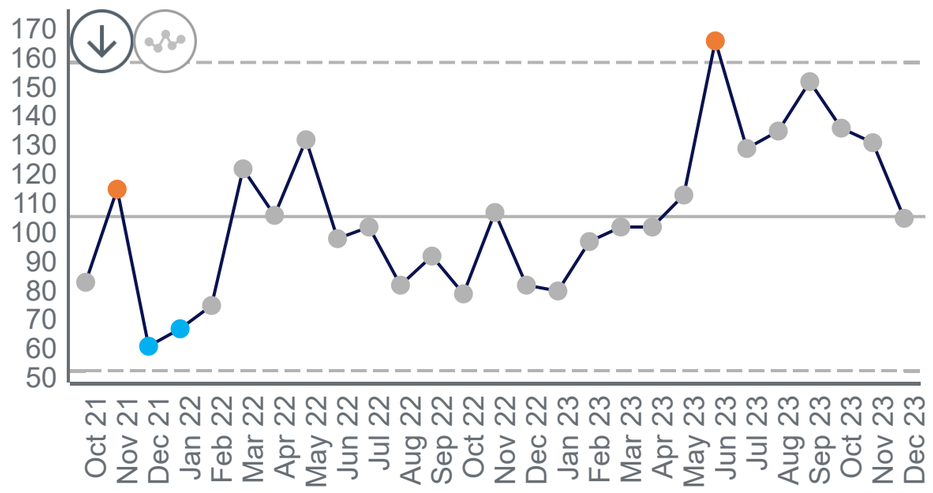
Areas of Concern:

Significant increase in the number of unplanned admissions to Critical Care from inpatient beds to highest number in a year. It is reported that acuity and occupancy were high at the time on both the inpatient wards and Critical Care.

Forward Look (with actions)

Deep dive is currently underway by the Response Team to understand the increase in unplanned admissions to Critical care from inpatient beds in more detail and identify whether any opportunities arise to inform practice. This will be reported on in February

Number of Incidents rated Minor Harm and above



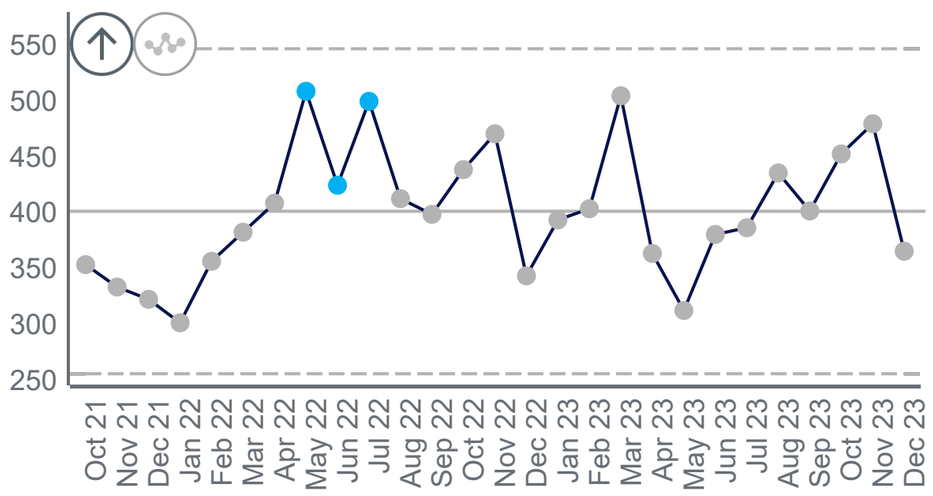
Technical Analysis:

This is interim measure of number of incidents instead of per 1,000 bed days due to data accessible at month end. December 2023 shows 105 patient safety incidents rated as harm which is 3rd consecutive reduction. No common cause variation however recent months are higher than average of 105 across the period although a new system was implemented May 2023.

Actions:

Decreased number of incidents reported; this is synonymous with previous trend in December due to reduced bed occupancy and staff annual leave during the holiday period. All staff encouraged to continue to report. Weekly PSIRF panel review meetings now in place and well attended

Number of Incidents rated No Harm and Near Miss



Technical Analysis:

This is interim measure of number of incidents instead of per 1,000 bed days due to data accessible at month end. December 2023 shows 366 patient safety incidents rated as no harm which is decrease following 3 consecutive month increasing, although volumes are inline with December 2022 of 344. No common cause variation.

Actions:

Decreased number of incidents reported; this is synonymous with previous trend in December due to reduced bed occupancy and staff annual leave during the holiday period. All staff encouraged to continue to report. Weekly PSIRF panel review meetings now in place and well attended

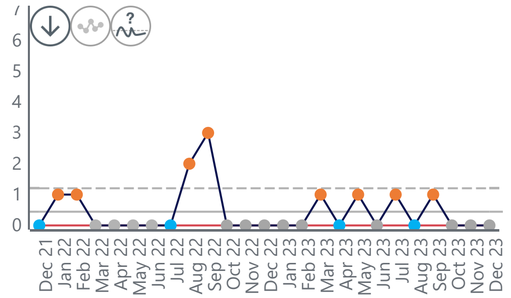
0074

Integrated Performance Report | January 2024

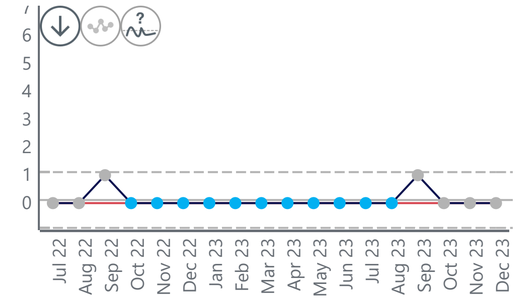
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

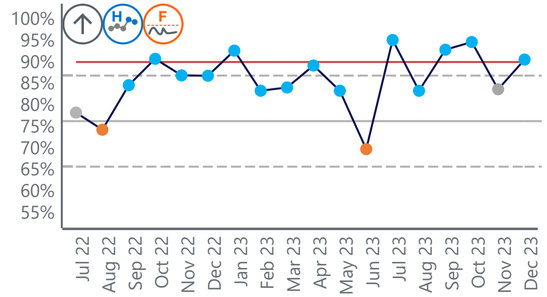
Number of Serious Incidents (Steis reported)



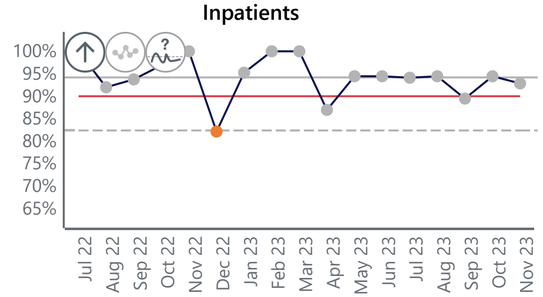
Number of Never Events



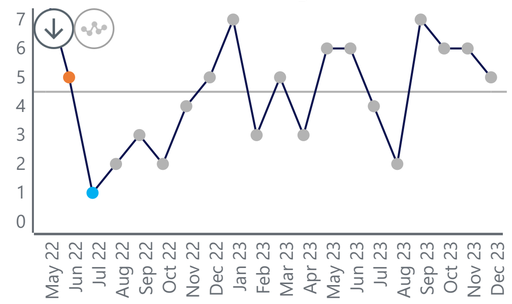
Sepsis % Patients receiving antibiotic within 60 mins for ED



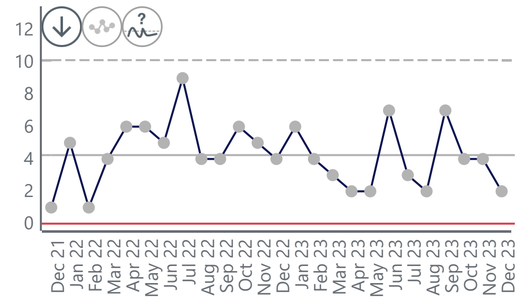
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



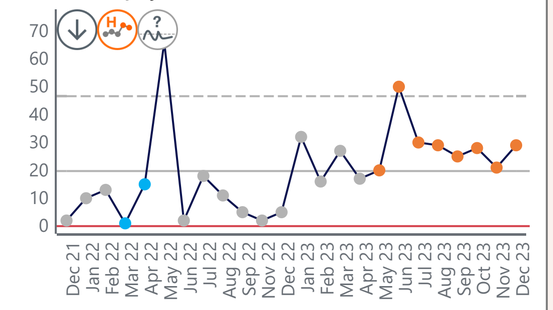
Medication Errors resulting in Harm



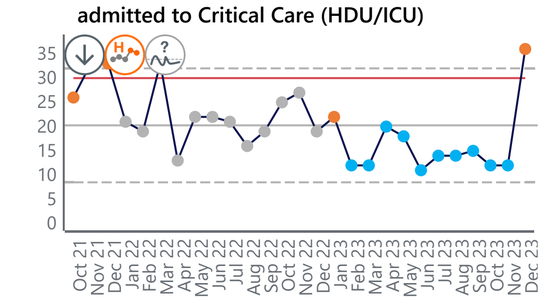
Pressure Ulcers G2-4



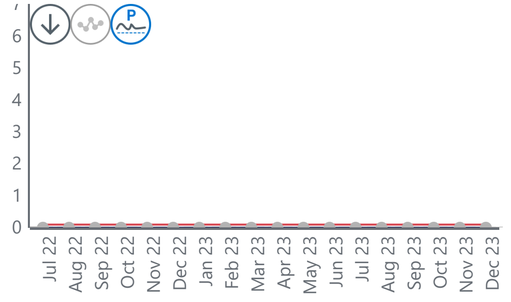
Use of physical restrictive intervention



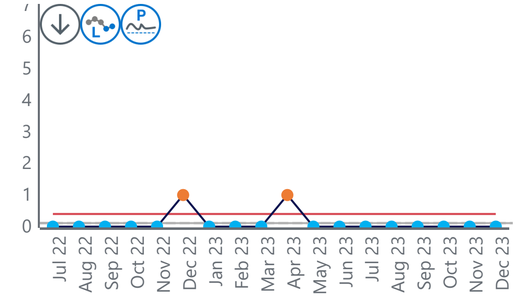
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



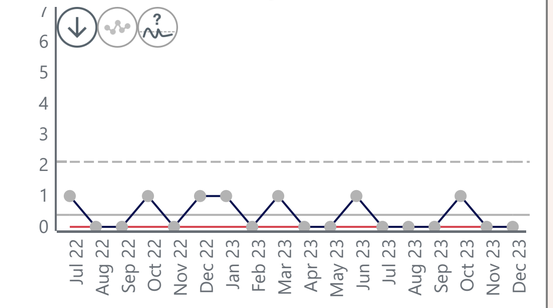
Hospital Acquired Organisms - MRSA (BSI)



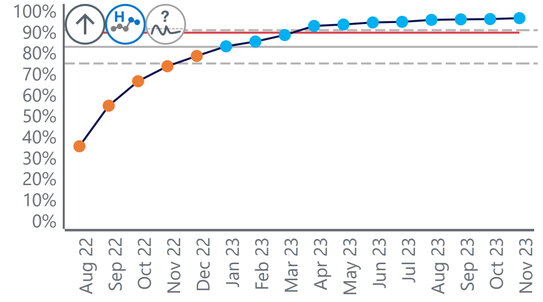
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Integrated Performance Report | January 2024

Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring

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

Highlights:

Decrease in the number of informal PALS concerns received in month. Continued approach of local resolution at the first point of contact. Increase in the last 2 months of families who would recommend the Trust and who would recommend ED

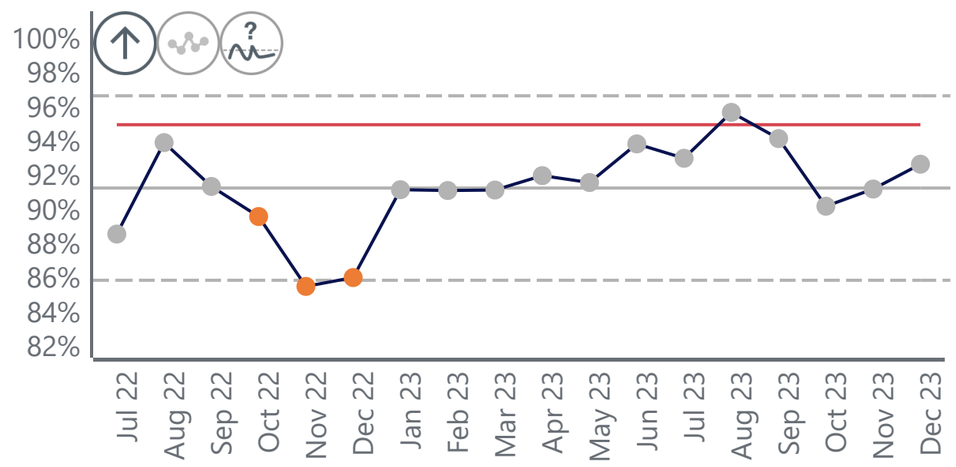
Areas of Concern:

Significant decrease in compliance reported in regard to responding to families who make a formal complaint; this is the lowest reported compliance rate for 2 years

Forward Look (with actions)

Deep dive underway with Divisions to understand the low compliance rate and this will be reported back on in February and in the Quarter 3 Complaints report to Trust Board and SQAC. Expectation that all complaints are resolved in line with the policy and extension requests must be approved by the Chief Nurse

F&F Test - % Recommend the Trust



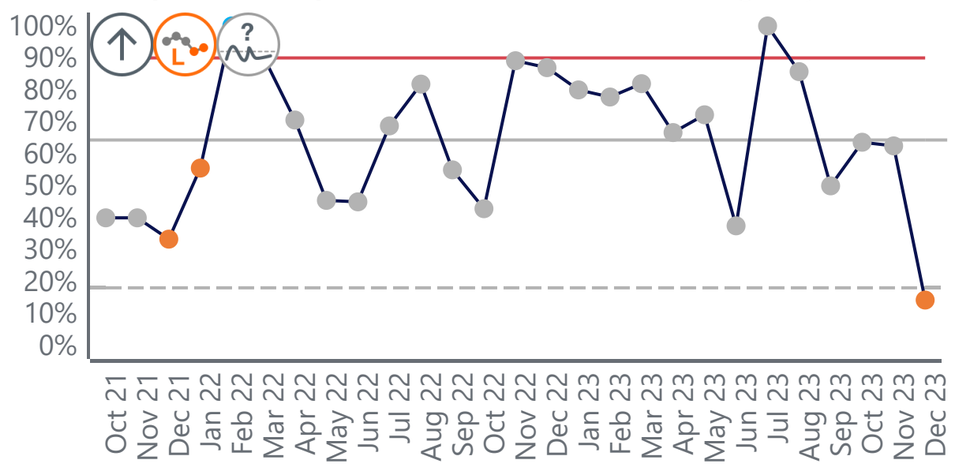
Technical Analysis:

Consistently not achieving the 95% target. December performance of 93% represents increase from November performance of 91% and represents consecutive back to back months of improvement. However December 2023 is 7% higher than December 2022

Actions:

Review of FFT questions and methodology underway by the Patient Experience Strategy group led by the Chief Nurse

% Complaints Responded to within 25 working days



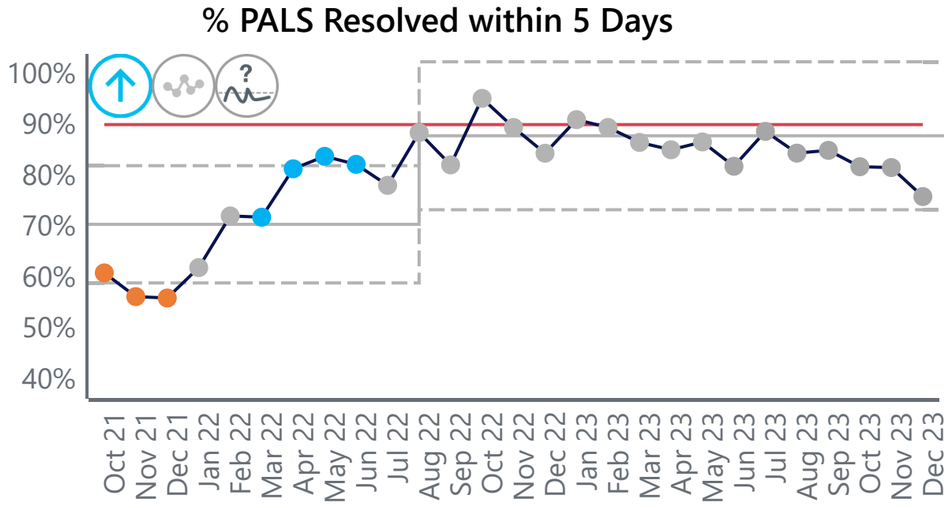
Technical Analysis:

Inconsistently achieving the 90% target with an average of 64% which shows significant fluctuation from month to month. Performance in December 2023 was 14% which represents 6 breaches out of 7 complaints due in the month.

Actions:

Deep dive underway with Divisions to understand the low compliance rate and this will be reported back on in February and in the Quarter 3 Complaints report to Trust Board and SQAC. Divisions to respond to formal complaints within 25 working days in line with the policy

% 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. December 2023 performance was 76% and will cause special cause varation if current trend continues.

Actions:

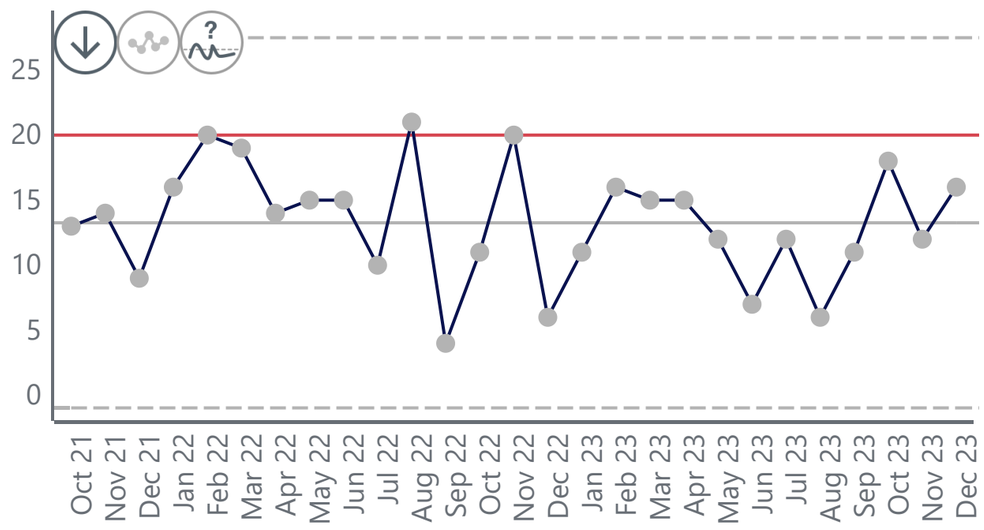
Divisions to respond to PALS within 5 working days in line with the policy

Integrated Performance Report | January 2024

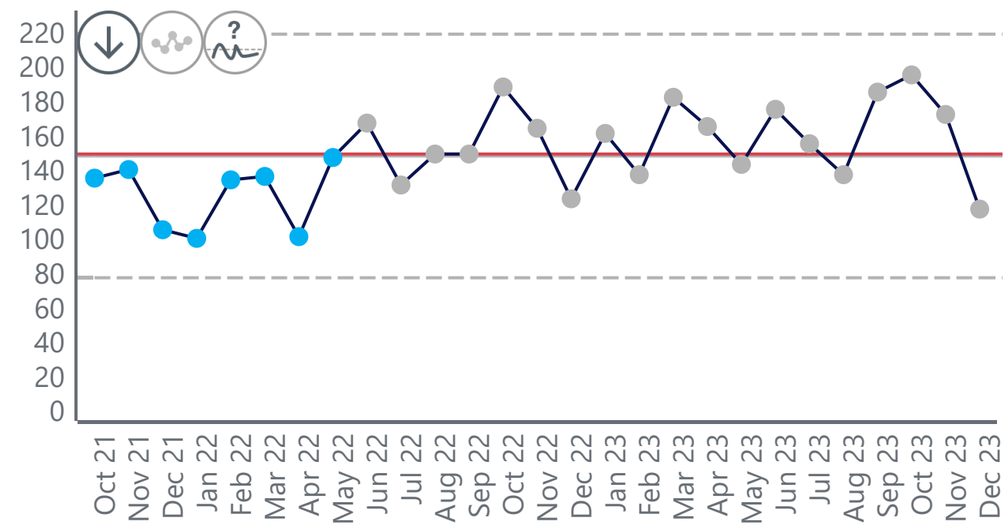
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

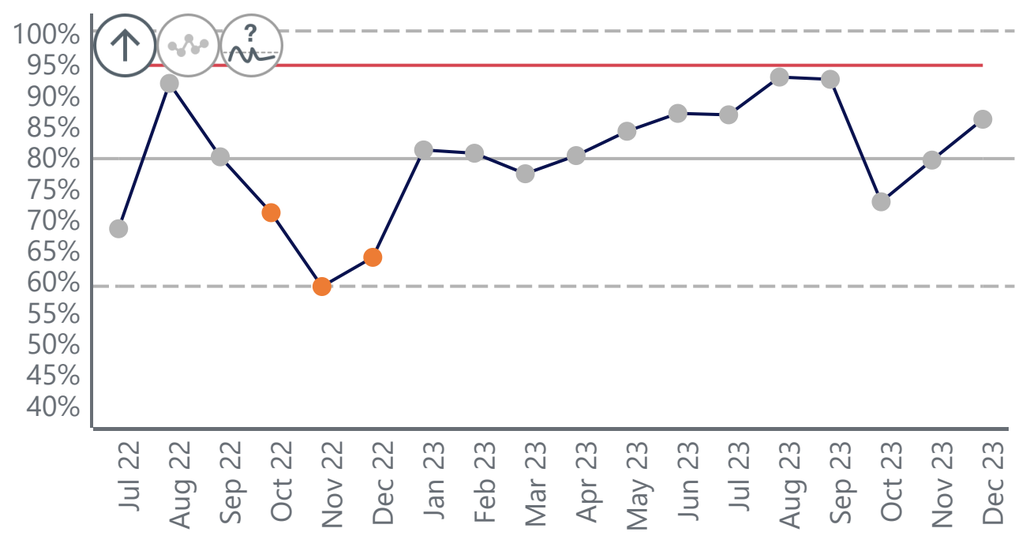
Number of formal complaints received



Number of PALS contacts



F&F ED - % Recommend the Trust



Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

Firstly, Emergency Department treated 85% of patients within 4 hours. In December, we are ranked the second best performing ED in the country for timeliness of care. Secondly, high utilisation of the virtual ward.

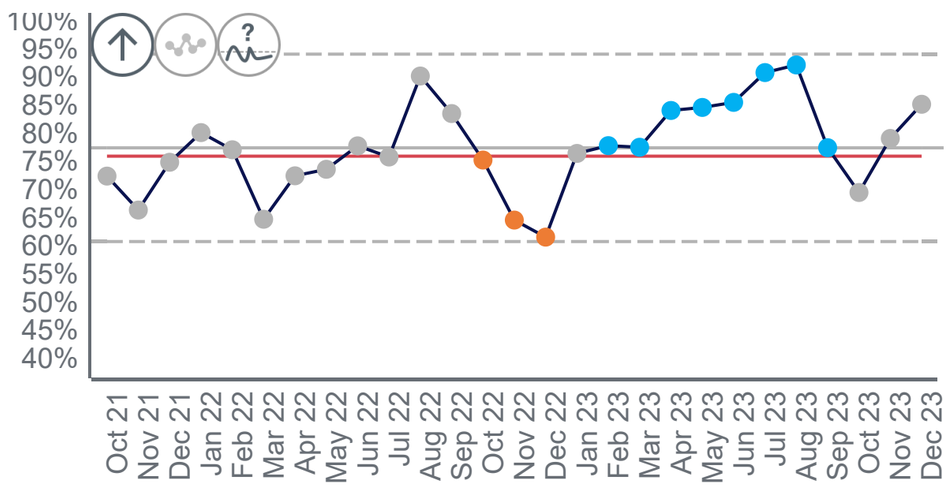
Areas of Concern:

Rate of WNB is not improving statistically

Forward Look (with actions)

Improvement projects in WNB including transport support and families being given greater control and choice of appointments in high WNB services. Action taken in Surgery Division to target significant outlier in WNB performance- Community Ophthalmology- currently running a partial booking pilot.

ED: % Treated within 4 Hours



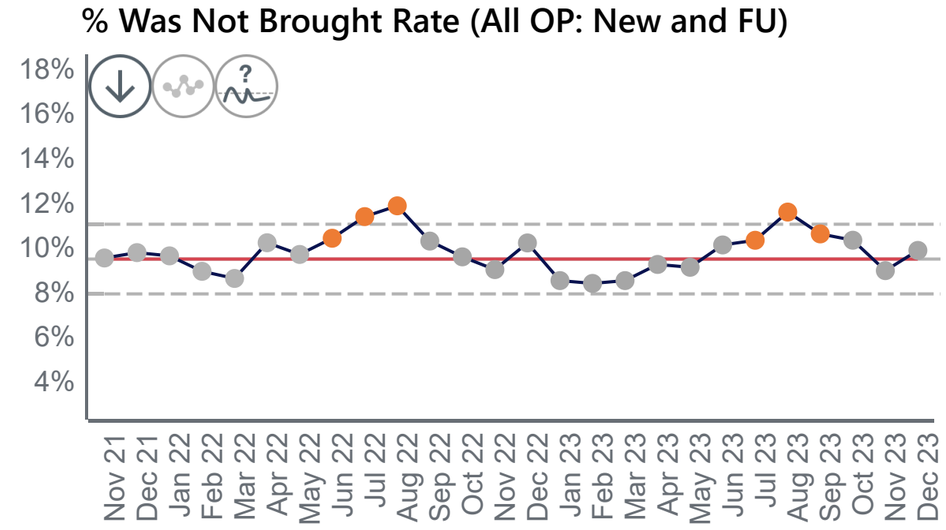
Technical Analysis:

Common cause variation has been observed with performance of 85.2% which is 2nd conscutive increase following two consecutive months of reduction in performance. Trust achieving the national target (>76%) in December 2023, with December 2022 at 62%. 2023 calendar year had 11 months achieving the target.

Actions:

ED treated 85% of patients within 4 hours, continued improvement month on month. In December, we are ranked the second best performing ED in the country for timeliness of care. A number of measured are in place to continue to stive for this performance including- increase utilisation of UTC appointments, launch virtual urgent care pathways with system partners, analysis of PAU pilot.

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



Technical Analysis:

WNB rates demonstrates common cause variation. Performance in December 2023 of 9.9% is inline with when compared to December 2022 (9.8%) and now the second consecutive month below the target of 10% since May 2023 although a number of bookings are still be actioned for the month which could alter December 2023 position.

Actions:

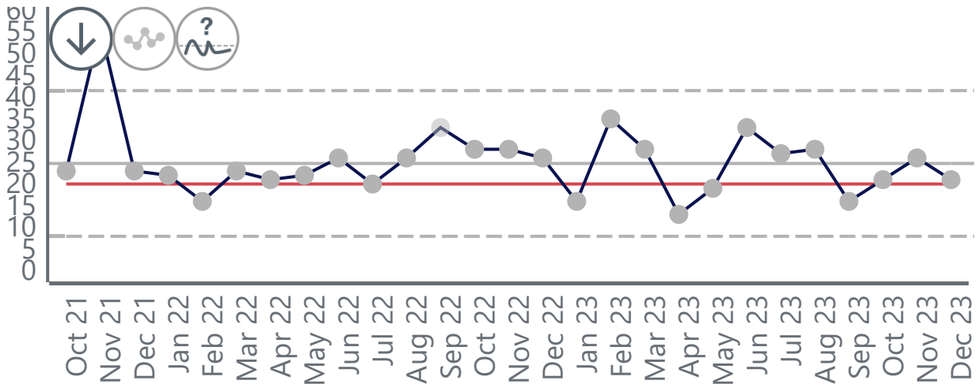
Was Not Brought rate at end of December was 10% which is 1% higher than previous months although still below the higher levels seen earlier in the year. Focussed work in community CAMHS, ADHD and community ophthalmology in Q4 is planned to support continued improvements in rates to attendance.

Integrated Performance Report | January 2024

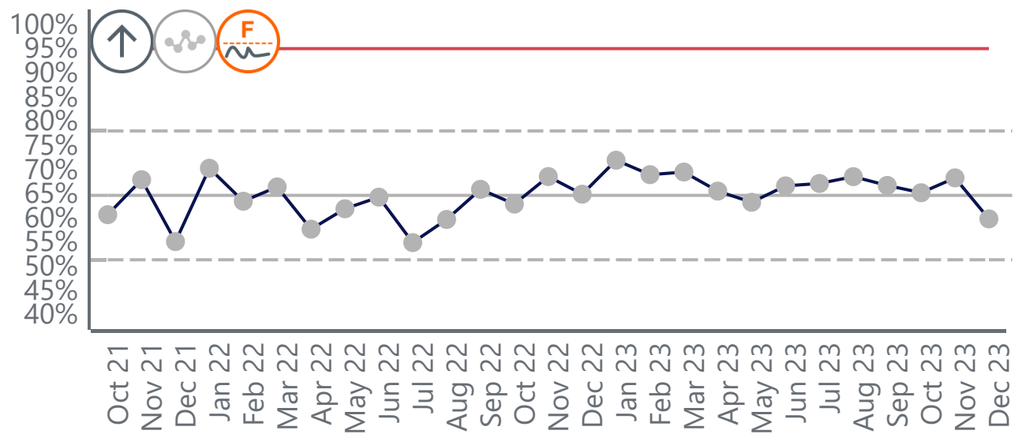
Alder Hey Children's NHS Foundation Trust

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

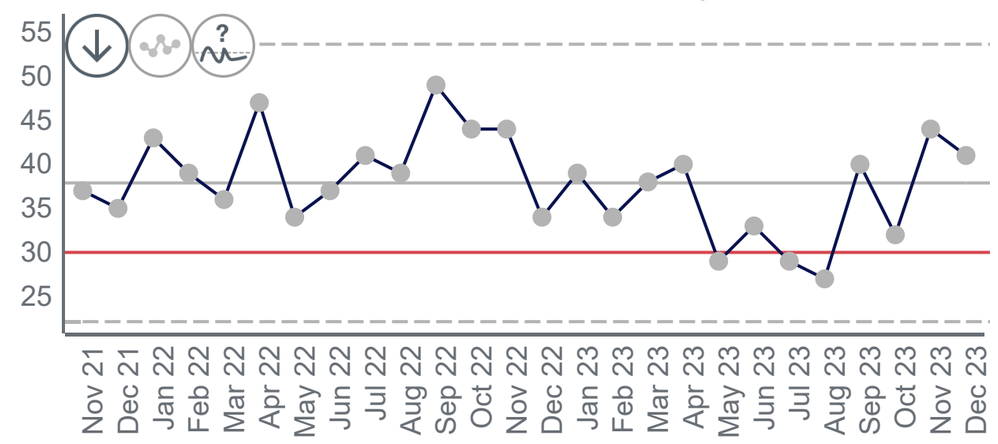
Number of Cancelled Operations (on day of admission for a non-clinical reason)



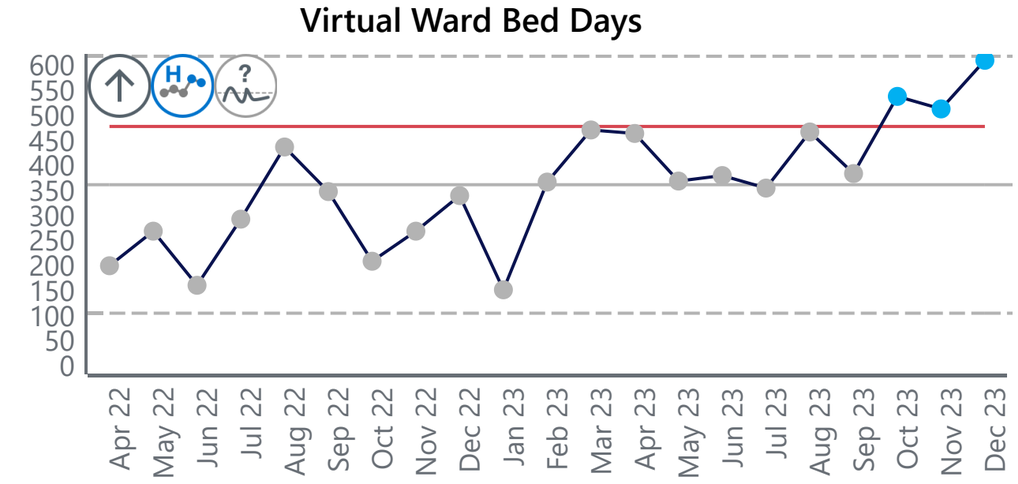
% of Clinical Letters completed within 10 Days



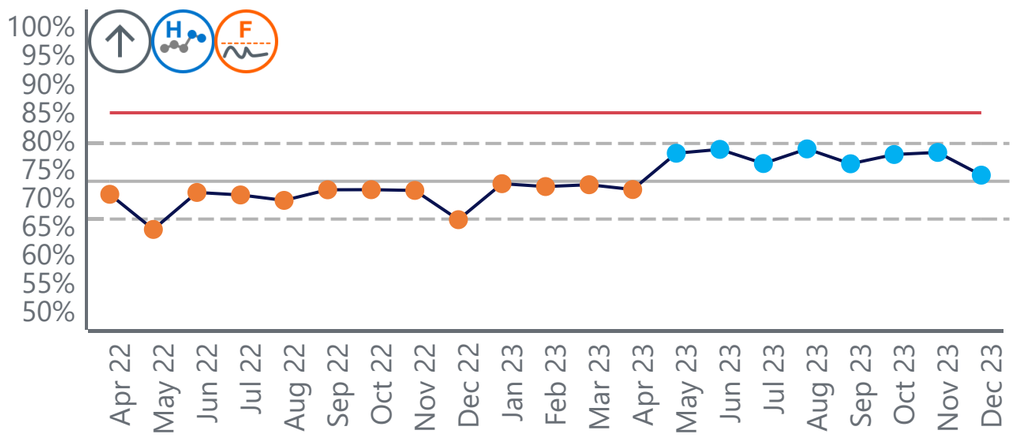
Number of Stranded Patients (21 Days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

Strong elective recovery performance (volume) relative to 2019 and despite industrial action. Sustained improvement in access to diagnostic care. High volume of outpatient recovery. Excellent access to cancer care. Improvement in reducing the CAMHS backlog of patients requiring treatment to be completed.

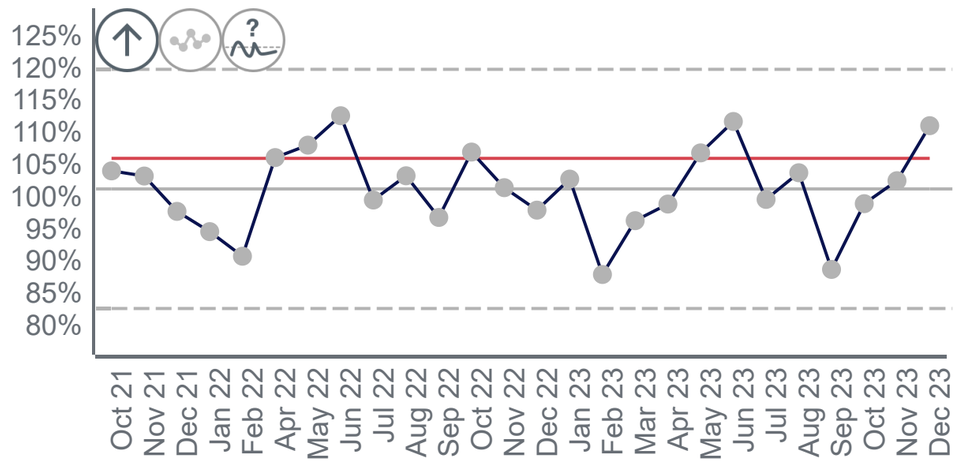
Areas of Concern:

Challenge to deliver the 65 week standard in elective care. Extremely high demand and large number of patient awaiting a neurodiversity diagnosis.

Forward Look (with actions)

Delivering zero 65 weeks by the end of March 2024 with a focus on productivity improvements, additional weekend operating and 'super week' in Dentistry. Looking to role out additional 'super week' approach in Spine an ENT. Delivering the elective hub capital project is the medium-term plan to enhance recovery, capacity and productivity.

% Recovery for DC & Elec Activity Volume



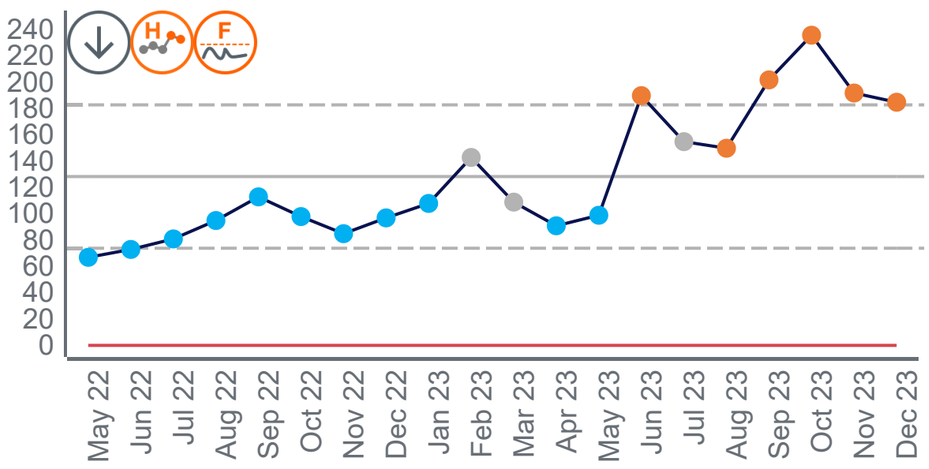
Technical Analysis:

December performance of 111% is the third consecutive month of improvement. The data series continues to demonstrate common cause variation.

Actions:

Increase in activity run rates in Q3, both day case and elective pods despite further IA/reduced theatre schedule. Phased restoration of theatre sessions (following recruitment) will follow a planned approach based on demand and utilisation. Overperformance against M8 forecast in elective ERF, mainly due to an increase in Spinal activity. Currently significant backlog in inpatient coding impacting income position.

Number of RTT Patients waiting >65 weeks



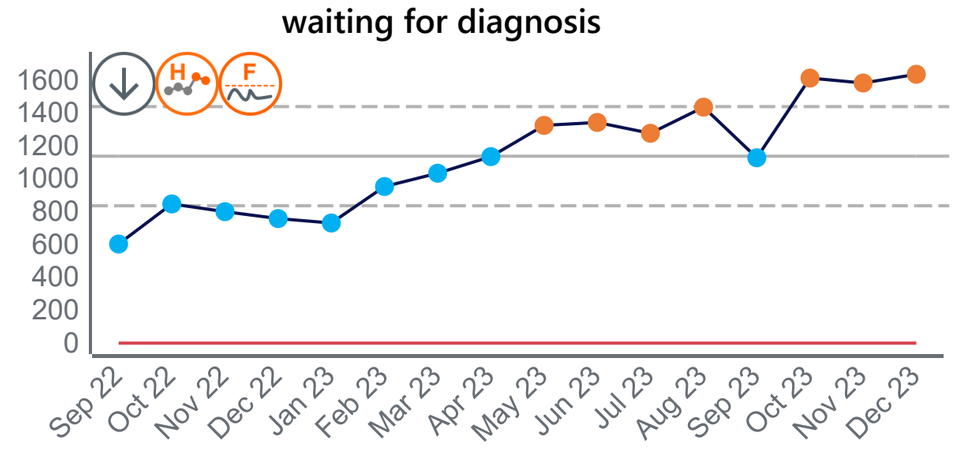
Technical Analysis:

Number of patients waiting > 65 weeks has slightly increased to 196 in December (192 in November). The current trend is showing special cause variation with an increase in breaches over the last 6 months. Dentistry (n=88) and ENT (n=82) make up 86.7% of the Trust total.

Actions:

'Super week' held in Dentistry in January with a focus on new patients and high volume clinics to treat long waiting patients. Additional weekend operating and clinic sessions in ENT, Dental and Spinal in Q4 2023-24.

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



Technical Analysis:

On average 1138 patients are waiting for an ASD or ADHD diagnosis per month. December shows 1636 patients which is above the outer control limits, now showing special cause variation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

Actions:

ASD and ADHD collaborating with colleagues across C&M as part of a system wide Neurodiversity improvement project, this was launched in December and follow up work planned for remainder of Q4. Weekly meetings in place with ADHD team to manage impact of medication shortages which is imapcting on capacity and waiting times.

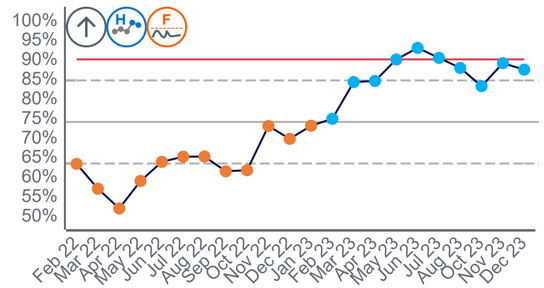
0080

Integrated Performance Report | January 2024

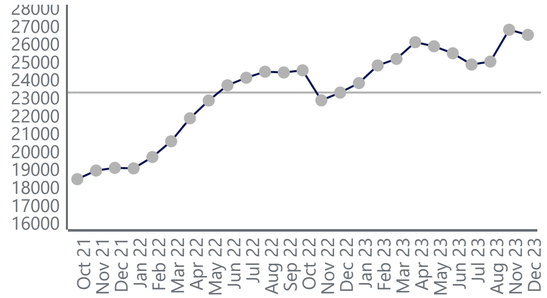
Alder Hey Children's NHS Foundation Trust

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

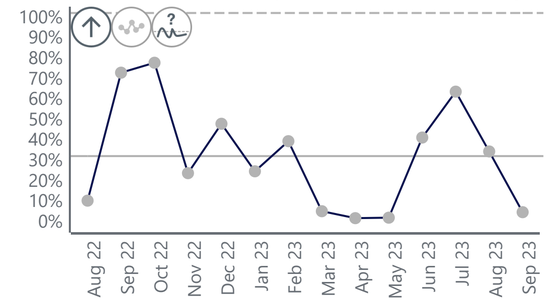
Diagnostics: % Completed Within 6 Weeks of referral



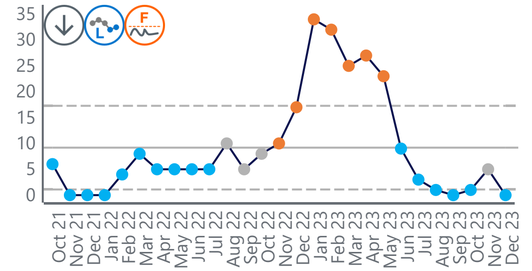
Waiting List Size



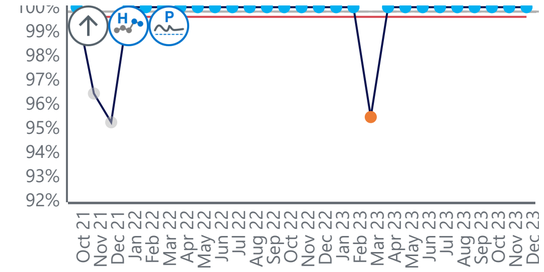
IHA: % complete within 20 days of referral to Alder Hey



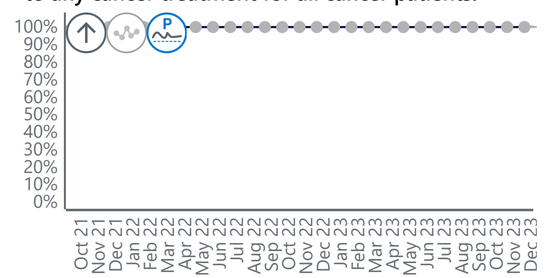
CAMHS: Number of children & young people waiting >52weeks



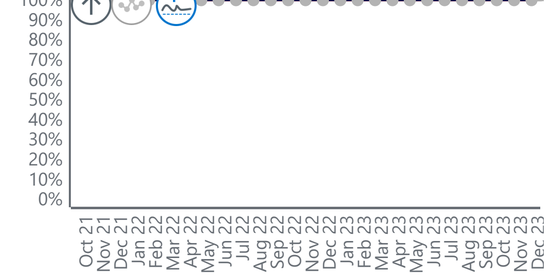
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



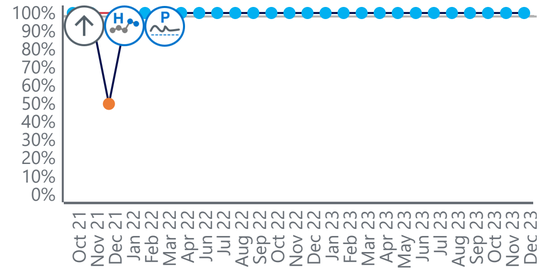
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



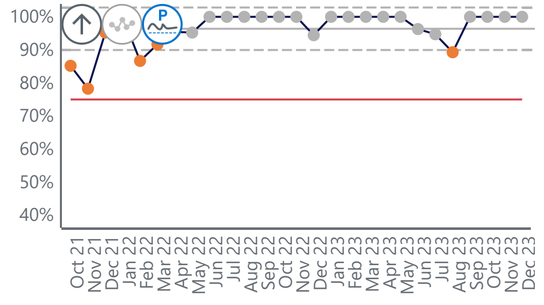
All Cancers: 31 day wait until subsequent treatments



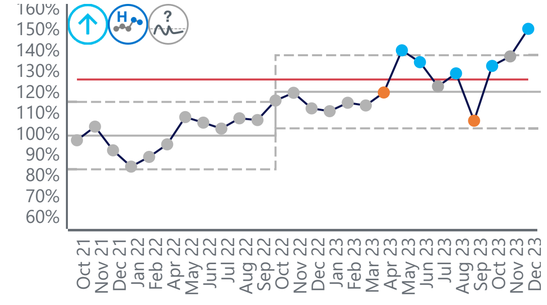
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Integrated Performance Report | January 2024

Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

A continued reduction in staff turnover for the 8th consecutive month, with an 11% turnover in December 2023. Work continues in respect of stay conversations and initiatives to improve retention. Ongoing and improved activities within Divisions to effectively reduce long Term sickness with focus on increased qualitative return to work meetings and reduced Occupational health DNA'S to improve sickness absence.

Areas of Concern:

PDR compliance remains and area of concern at only 69% compliance against a target of 90%. Given the importance of the PDR discussion both in respect of retention and development needs, this needs to be escalated. The PDR compliance is managed by L&D, which reports to the Academy.

Forward Look (with actions)

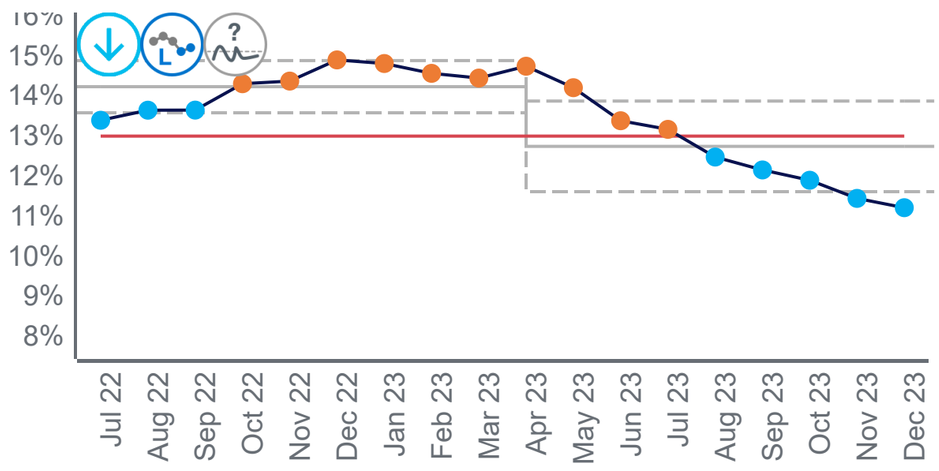
Review data on PDR completions per division and provide support to the Academy to improved compliance, achieving target of 90%

Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

Staff Turnover



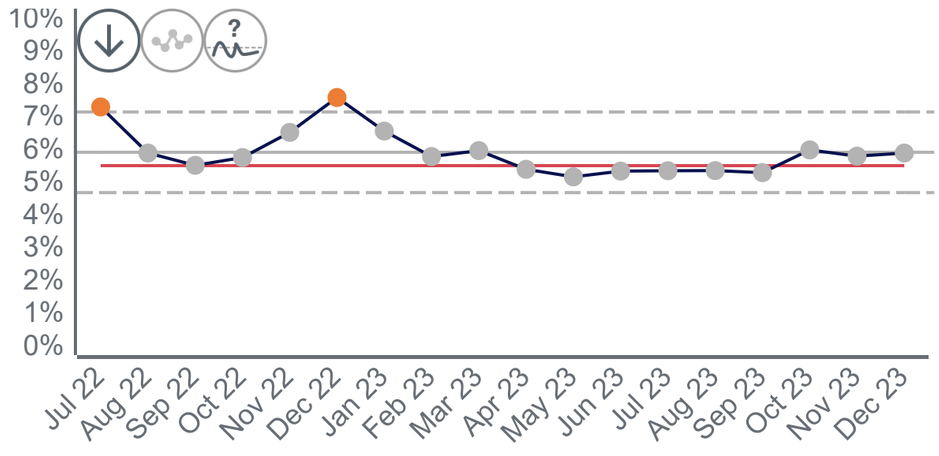
Technical Analysis:

Staff Turnover has demonstrated special cause variation , 11.2% is the 8th consecutive month with a reduction and 5th consecutive month within target.

Actions:

There is a continued reduction in turnover (11%), this is now below the annual target of 13%. A review of the Target will be set prior to April 2024. On going analysis and external benchmarking in place to improve the position. Quarterly reporting to PAWC.

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in December is 5.88% which is over the 5.5% target. A slight increase from November at 5.79%. Although a significant decrease compared to December 2022 (7.58%). December 2023 performance comprises STS at 1.77% and LTS at 4.11%. Still demonstrating common cause variation, third consecutive month above target since March

Actions:

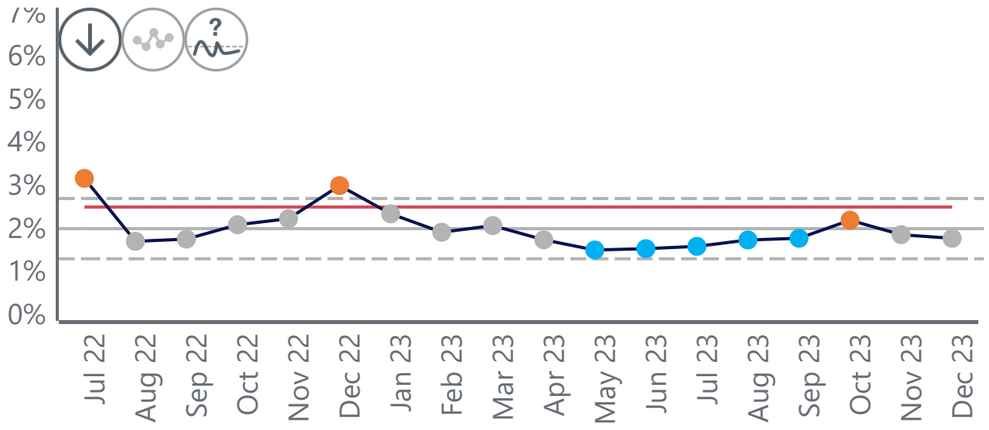
5.9% in December 23, which is an anticipated increase over the winter. The following remain in place • Discussions at Divisional Boards • Management meetings • Divisional wellbeing activities • Focus on Stage 3 LTS • Return to Work discussions are being reinforced and new online form now in place • Proactive winter vaccine programme (flu/covid) continues onsite

Integrated Performance Report | January 2024

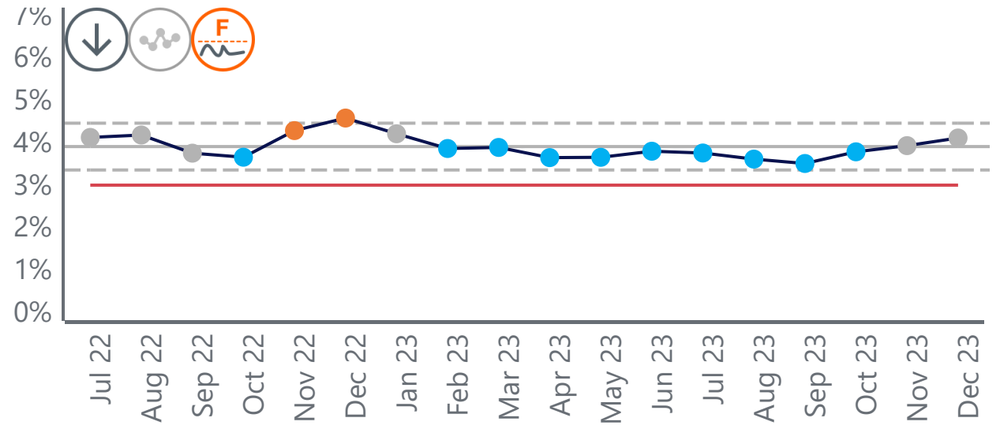
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

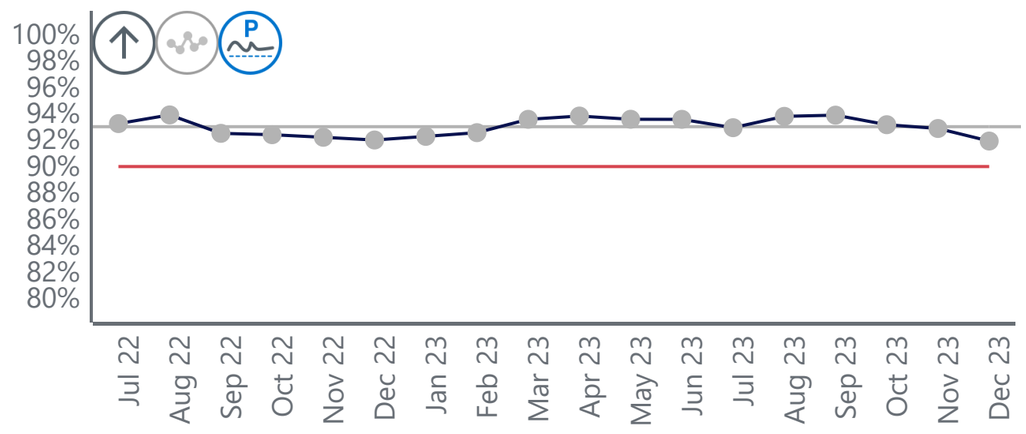
Short Term Sickness



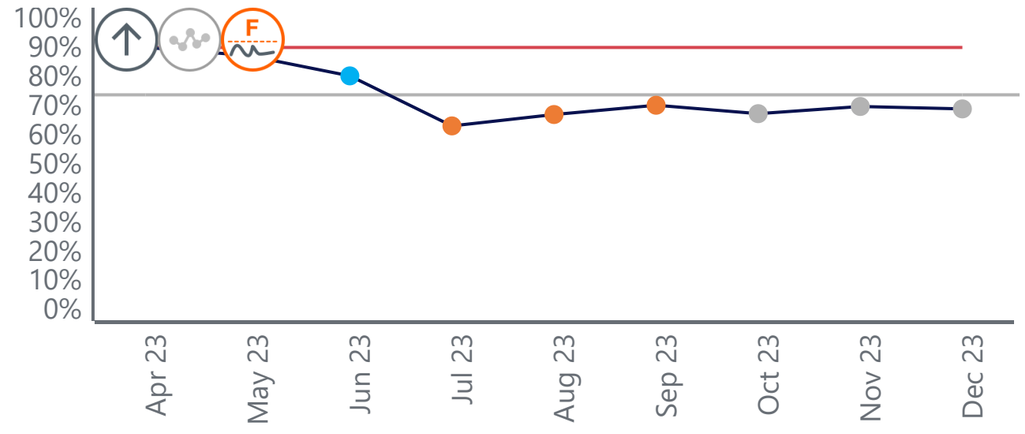
Long Term Sickness



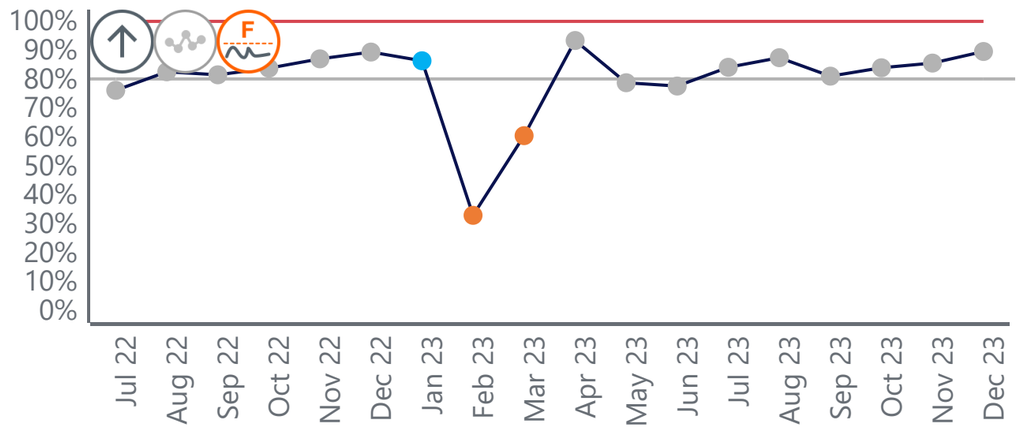
Mandatory Training



% PDRs completed since April



Medical Appraisal



Staff movement / Churn rate - In Development

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

In December (M9), the Trust is reporting a position £0.5m adverse to plan (£3m surplus against a plan of £3.5m ytd), due to industrial action. Forecasting to achieve £11.5m surplus. This is £1.5m away from the revised forecast submitted in November. This is due to industrial action and subject to CIP risk. CIP £1.5m behind plan ytd. Overall, £14.2m CIP has been transacted with £3.5m in progress. On track to deliver subject to red & amber schemes. Recurrent CIP has increased in month from £5.8m in M8 to £11.7m in M9. Cash has remained high in line with plan & capital in line with expectations.

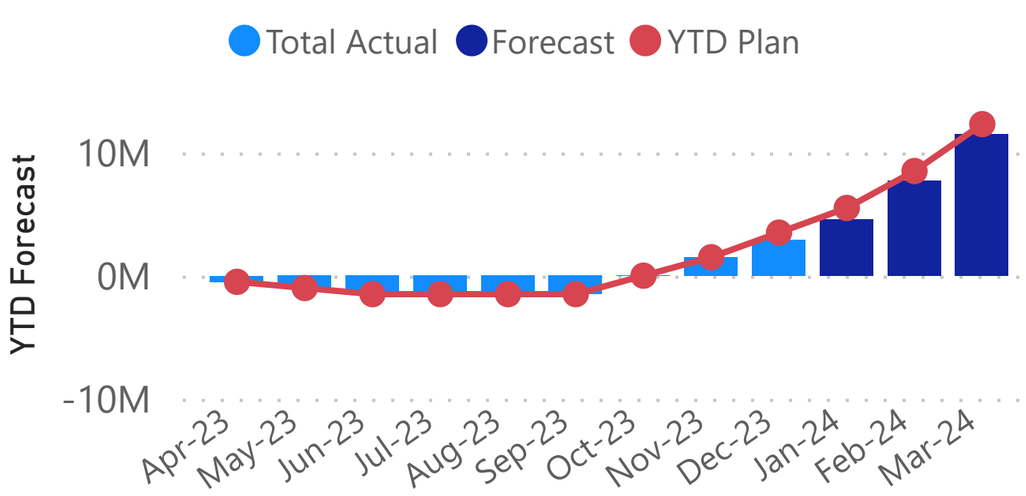
Areas of Concern:

CIP gap closed in year subject to delivery of red & amber schemes £3.5m. Whilst recurrent CIP has improved significantly in M9 (£11.7m now identified recurrently up, from £5.8m in M8) this remains an area of concern given the gap recurrently is £5.9m which will be carried into 24-25 if not identified. Challenging £13m revised forecast plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets. No confirmation to date that the cost of IA in Dec and Jan will be funded/targets adjusted

Forward Look (with actions)

Continued cost control to reach the year end position and continued focus required on recurrent efficiency. Work also continues with divisions on transformation schemes to identify recurrent changes and benefits to be reported to RABD.

Revenue Position (Year End Forecast)



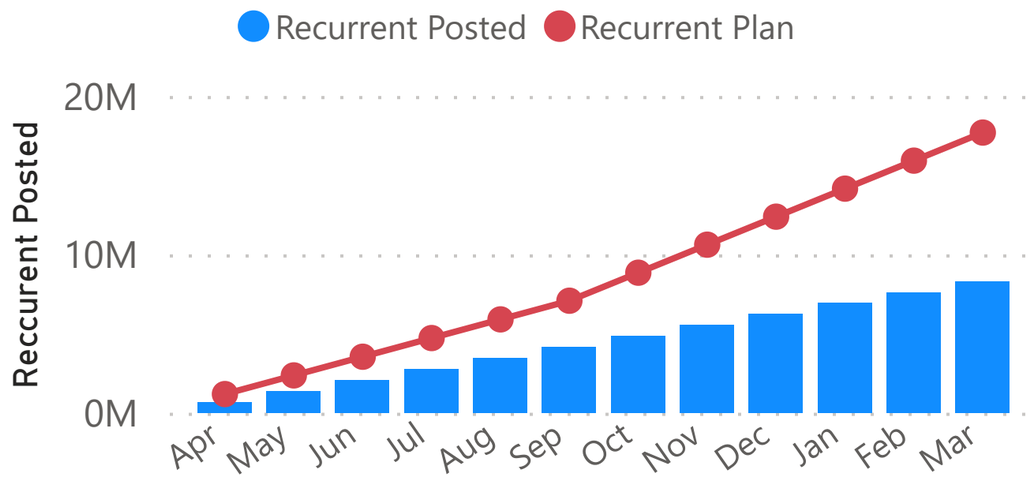
Technical Analysis:

Current forecast is £1.5m off plan due to industrial action. However, further risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures including further industrial action.

Actions:

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

CIP Position (Recurrent Full Year Effect)



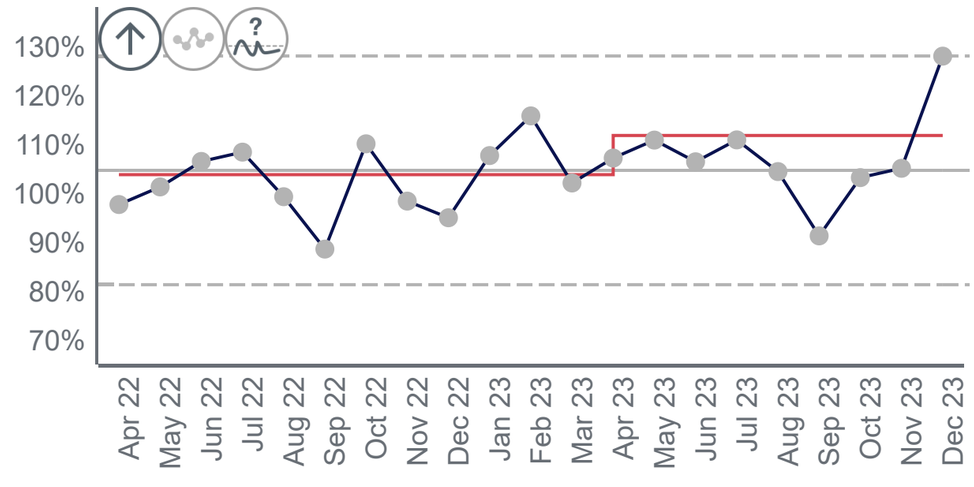
Technical Analysis:

In year CIP identified and in progress is £17.7m so achieved in full. Of this, £11.7m is recurrent up from £5.8m last month.

Actions:

Support required with exec leads and transformation to identify the large-scale opportunities. Work continues on wider change programmes to be reported to RABD in Feb. Still large gap recurrently of £5.9m although this has reduced from prior month

% ERF Value (Income)



Technical Analysis:

December performance estimated at 128.2%. YTD performance estimated at 107.1%.

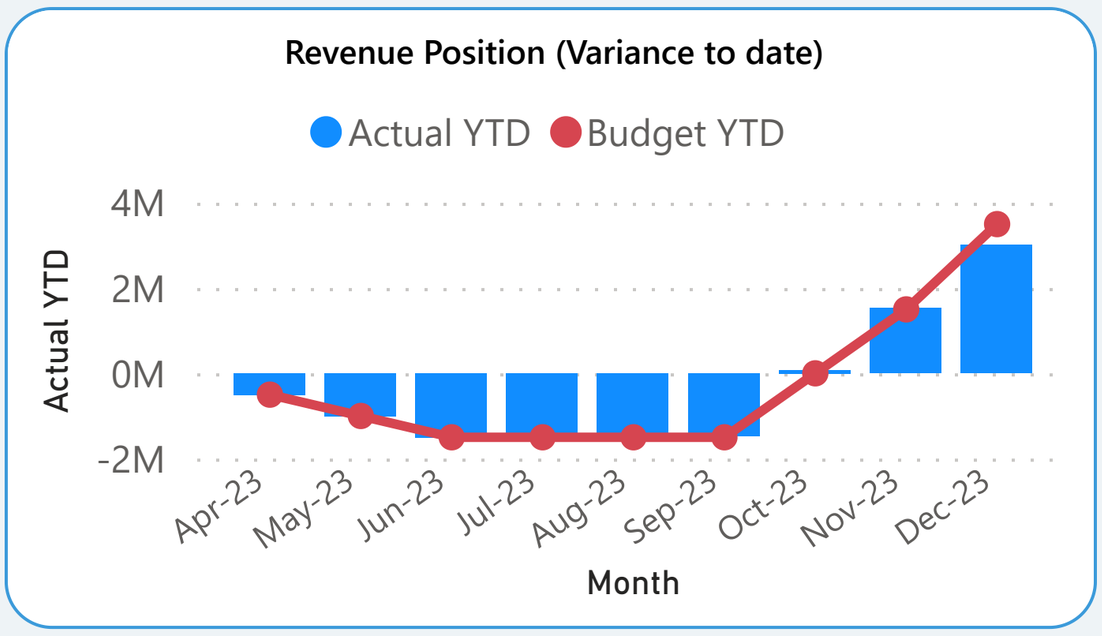
Actions:

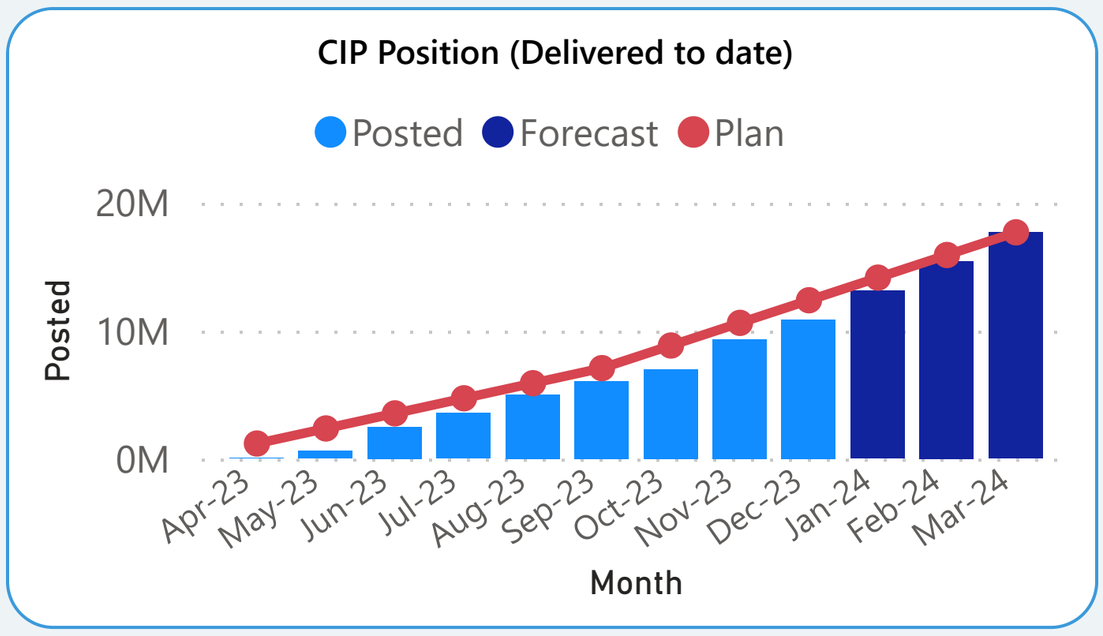
Continue to monitor those areas (at POD and speciality level) that are under performing versus plan.

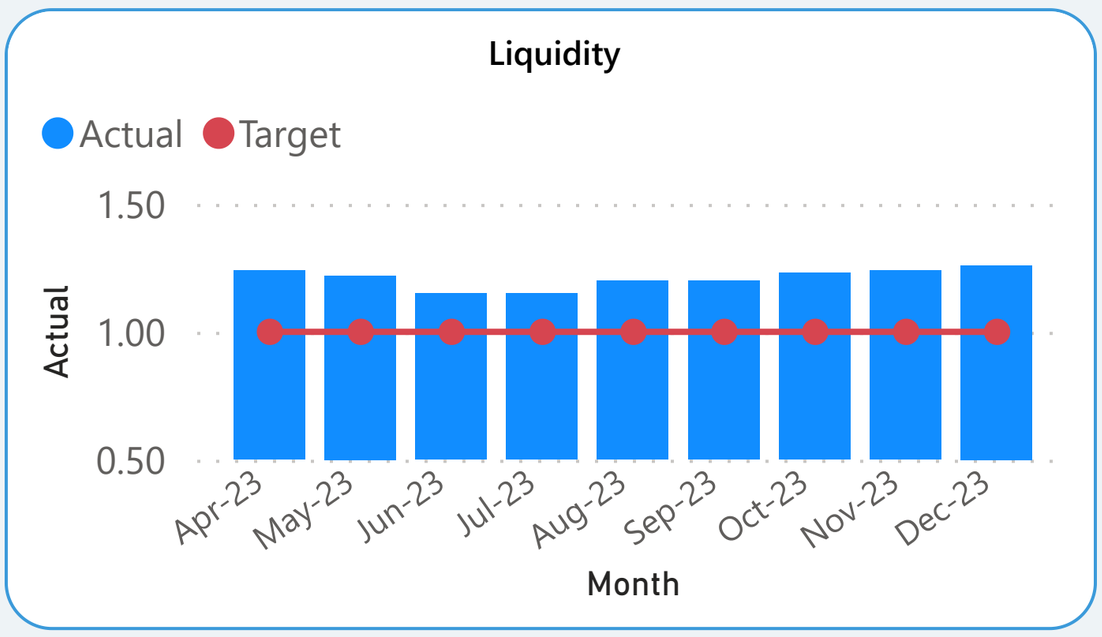
Integrated Performance Report | January 2024

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 continues regarding ongoing development of risk reports within InPhase Weekly sitrep in place regarding reporting functionality. Meeting planned end Jan 24 with digital leads to continue to develop the reporting functionality and report visualisation development. Risk 2746 patient harm due to lack of clear guidance/training in chest drains has decreased score from 15 (5x3) to 12 (4x3) following approval of business case

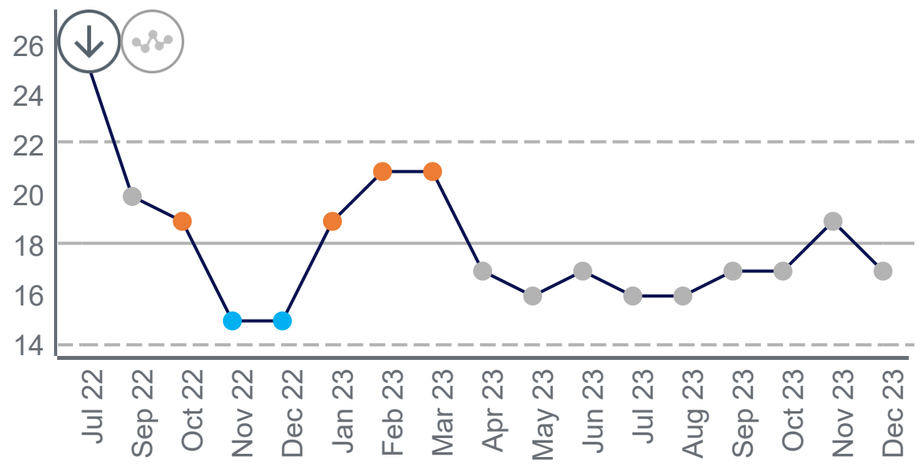
Areas of Concern:

Technical functionality issues identified impacting on report functionality escalated directly to InPhase CEO. InPhase interim solution in place via a configuration change. InPhase long term fix will be a code change forming part of their next version release. Awaiting confirmation of release date from InPhase.

Forward Look (with actions)

Further development of the Heatmap visualisation. Future workshop scheduled for 29/01/24. Meeting with King's College to review their dashboards in advance of at the visualisation workshop 29/01/24. Work underway to generate board papers automatically through SQL Server Reporting Services. Continue to oversee and escalate overdue high risks to relevant division and risk lead

Number of High Risks (scored 15 and above)



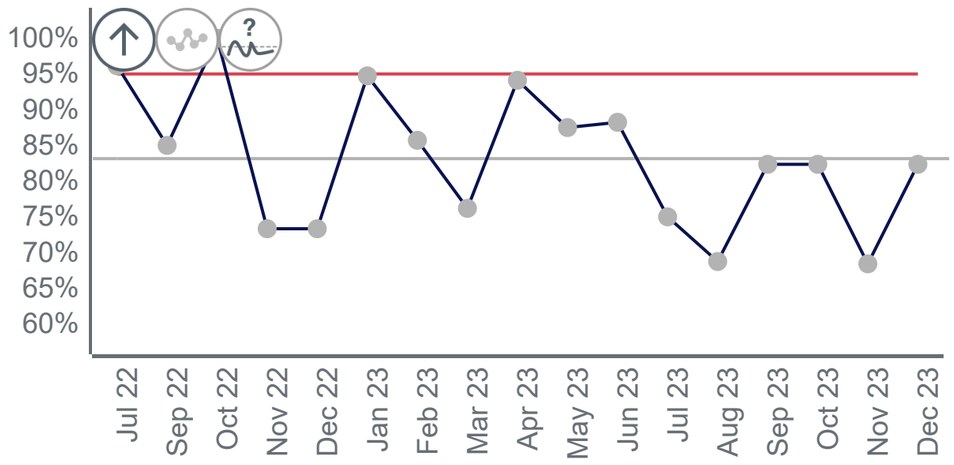
Technical Analysis:

The 17 high risks are identified and themed as follows : Quality – Safety (5 risks), Workforce / Staffing & HR (5 risks), Compliance and Regulatory (3 risks), Financial (1 risk), Operational (1 risk), Quality - Effectiveness (1 risk) and Reputation (1 risk).

Actions:

17 high risks at end of Dec 23. All high risks are monitored via presentation of the above presented via the Corporate Risk Report at the Risk Management Forum

% of High Risks within review date



Technical Analysis:

82.35% (14/17) of risks are within their expected review date.

Actions:

82.35% (14/17) of risks within expected review date.

3 overdue high risks have been escalated to the relevant risk owner and division as follows: 2332 C&MH Division (Staffing), 67-H&S Corporate Division (Compliance & Regulation) & 2719 Surgery Division (Quality Safety)

Smartest Ways of Working - Safe Digital Systems- Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

A formal announcement has been made and Alder Hey have been successful in obtaining national funding to support the development of AlderHeyAnywhere. 9 out of 14 priority developments were delivered through AlderCare Optimisation in December, with 4 emergency requests also delivered in month. Insight Led Care stakeholder engagement workshop was held in December to assist in developing the PID.

Areas of Concern:

Small number of reports remain to be validated post Aldercare but good progress is being made and will be completed during January.

Forward Look (with actions)

Insight led PID to be approved in January, further delivery of AlderCare Optimisation priorities and the completion of AlderHeyAnywhere Business Case. Alignment of Digital programmes to 2030 strategy to also be completed.

New Metric Under Development	Technical Analysis:	Actions:
		New metric under development

New Metric Under Development	Technical Analysis:	Actions:
		New metric under development

New Metric Under Development	Technical Analysis:	Actions:
		New metric under development

Integrated Performance Report | January 2024

Alder Hey Children's NHS Foundation Trust

Collaborating for CYP - Green Plan: Well Led

SRO: Mark Flanagan, Director of Marketing and Communications

Highlights:

Bid for NEEF2 funding of £ 2m capex prepared with MITIE&SPV

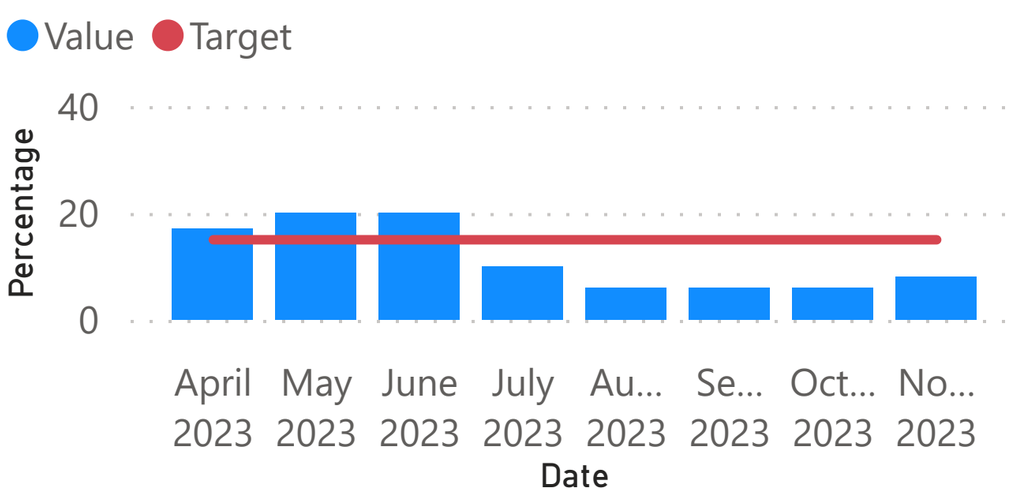
Areas of Concern:

CHP reliability declined to 5% in December with no maintenance contract in place. ROCK works lasting longer than expected to heating still forced on.

Forward Look (with actions)

NEEF2 results on 16/01. Vercity report on heating problems completed by 20/01. Bid for Circular economy project (£ 2m across all partners) being completed this month.

Green Plan: Reduce Carbon Footprint



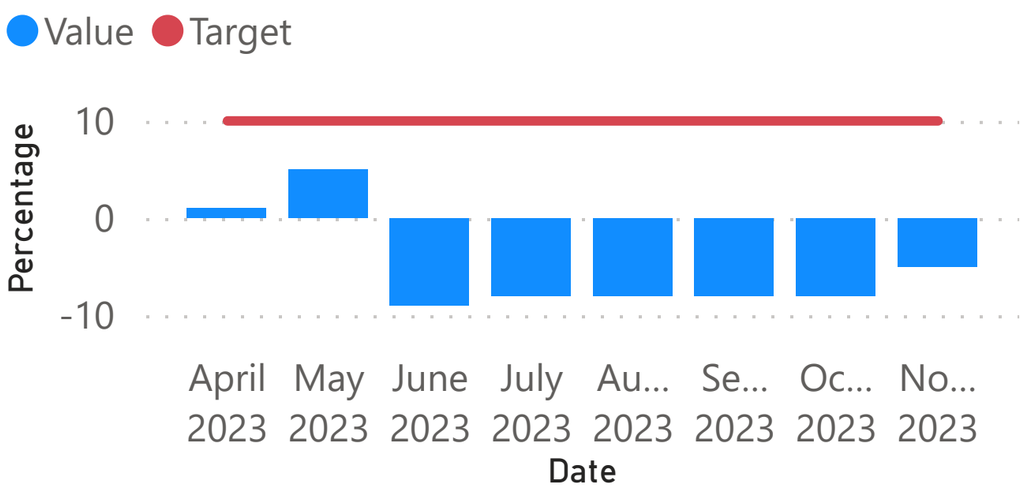
Technical Analysis:

8% saved in December 2023 compared to December 2022

Actions:

PV project with NEEF2 money

Green Plan: Reduce Energy Usage



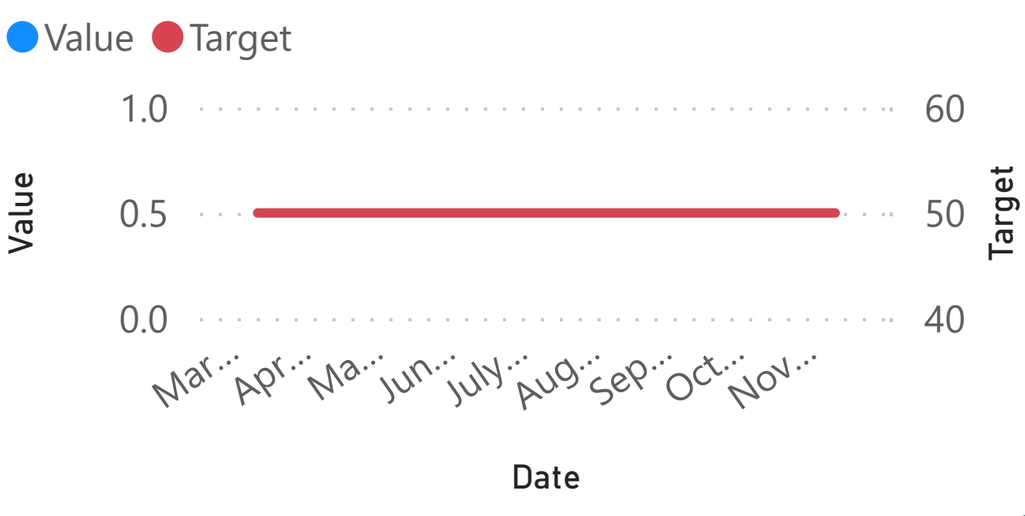
Technical Analysis:

Energy use less adverse. Heating forced on in winter having less impact than in Summer

Actions:

4 LED projects in NEEF2 including Police station. Office / corridor area can be included to test LEDs in main site.

Green Plan: Reduce Waste

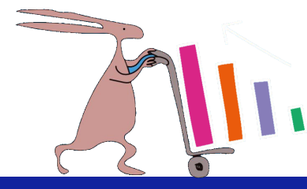


Technical Analysis:

Compactor and baler now on site. No reduction in performance visual.

Actions:

Reviewing savings data



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

•Number of minor harm incidents continues to reduce

•Compliance with mandatory training continues to remain high

•Further continued reduction in staff turnover to 12%

•Zero young people waiting over 52 weeks for CAMHS

•Transforming Care funding secured to provide Sensory e-learning package across Cheshire & Merseyside

•Alder Hey Charity funding secured by Complex Care team to provide support for parents/carers of inpatients to support their health and wellbeing

Areas of Concern

•Continued impact of national ADHD medication alert and reduced capacity to complete diagnosis pathway for complex young people

•Continued risk relating to lack of a Named Doctor Safeguarding within safeguarding team

•Capacity for long waiting young people in Mental Health services is under review due to ongoing challenges with vacancies in teams

Forward Look (with actions)

•Focused work on Psychiatry waiting times within CAMHS and plan agreed with team to reduce waiting time to access Psychiatry review

•Project launched to support move into Police Station as part of relocation of staff from 3SM

•Task and finish group commenced to review pathways for NHS 111 Support for young people experiencing mental health crisis

•Bi-directional text messages to be implemented for HCA clinics

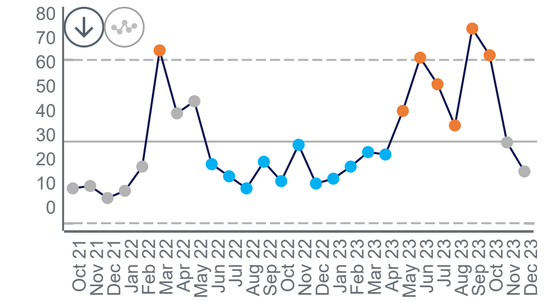
•Piloting questionnaire for young people who had confirmed attendance but subsequently didn't attend to understand reasons for non-attendance of outpatients appointments

Integrated Performance Report | January 2024

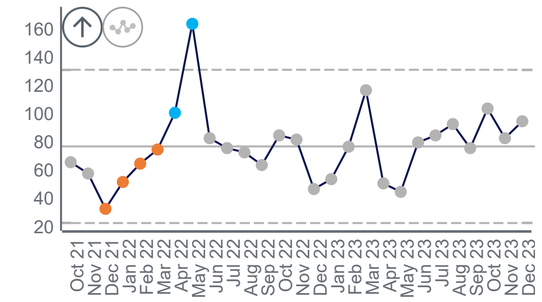
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

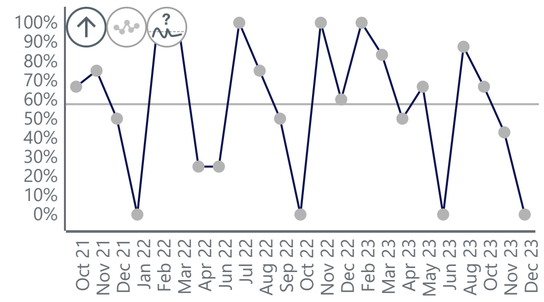
Number of Incidents rated Minor Harm and above



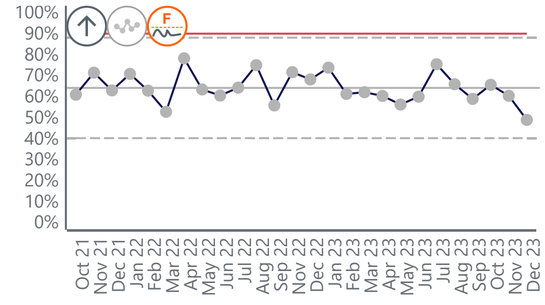
Number of Incidents rated No Harm and Near Miss



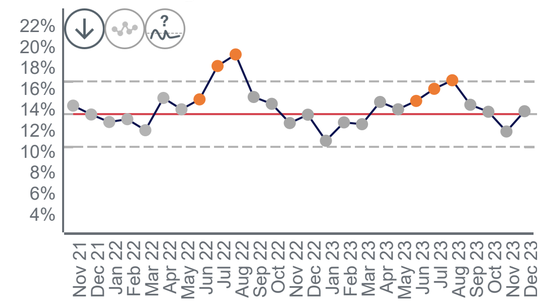
% Complaints Responded to within 25 working days



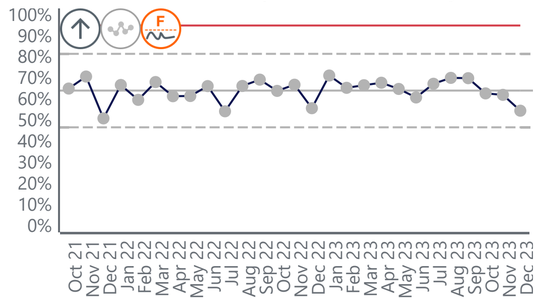
% PALS Resolved within 5 Days



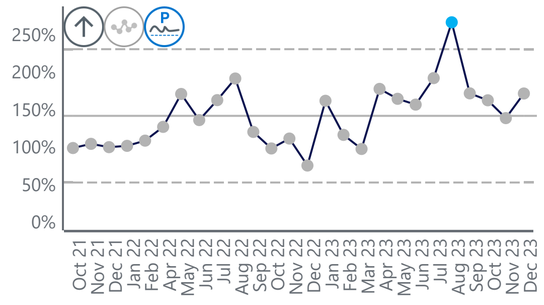
% Was Not Brought Rate (All OP: New and FU)



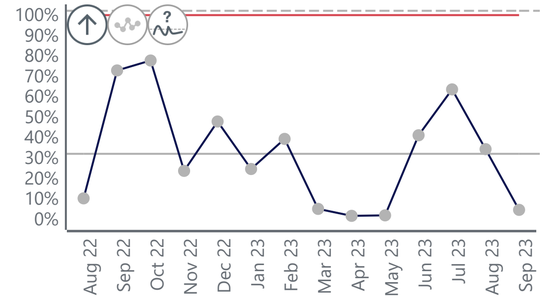
% of Clinical Letters completed within 10 Days



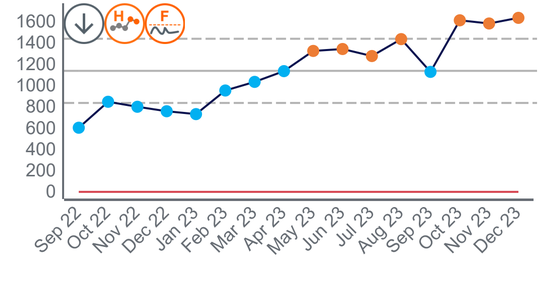
% Recovery for OP New & OPPROC Activity Volume



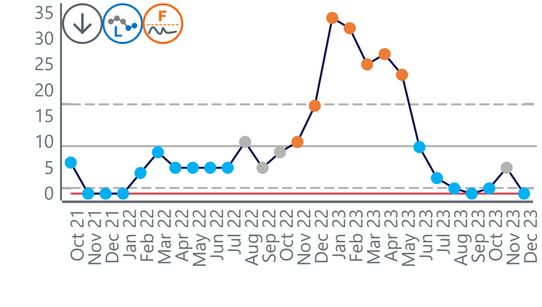
IHA: % complete within 20 days of referral to Alder Hey



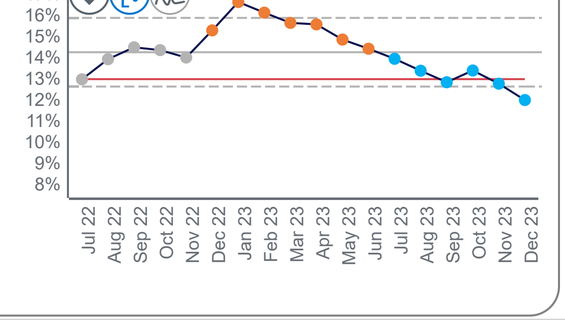
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



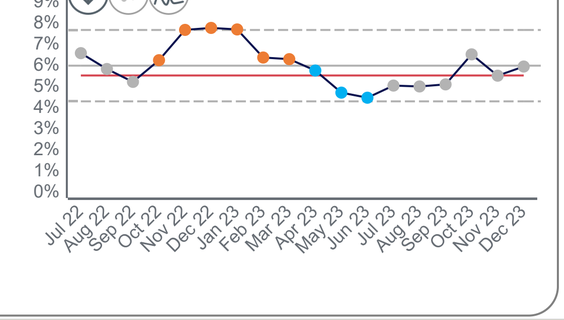
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)

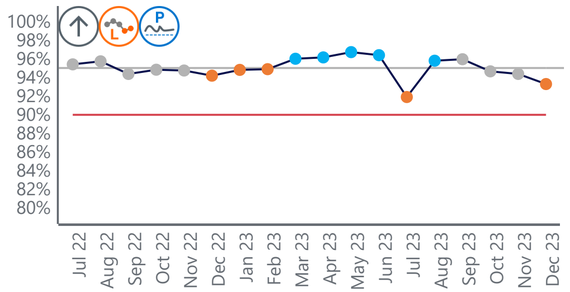


Integrated Performance Report | January 2024

Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

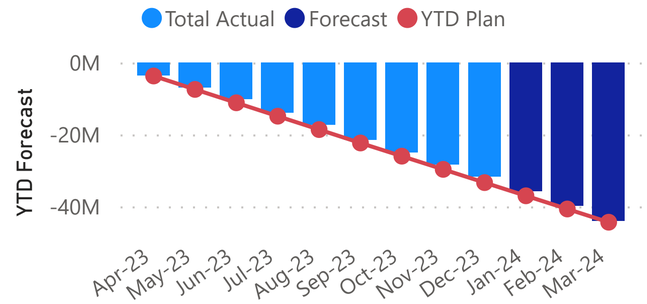
Mandatory Training



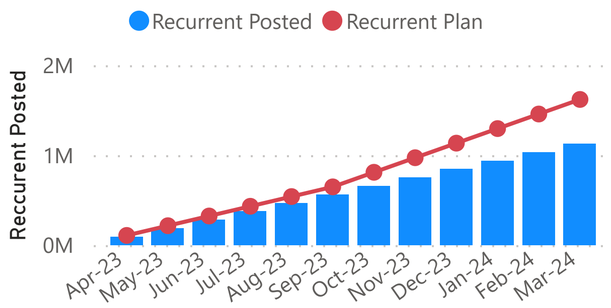
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

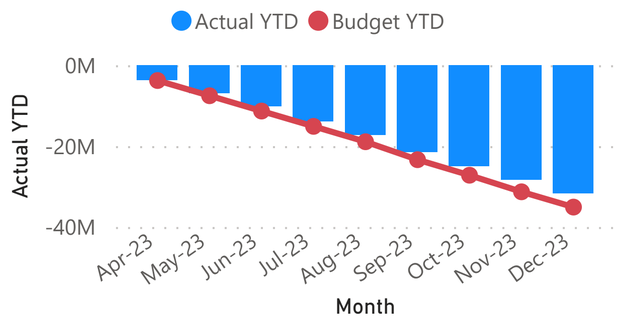
Revenue Position (Year End Forecast)



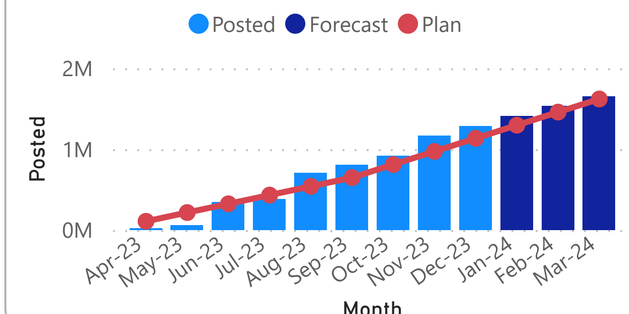
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

•Further improvement in ED 4 hours performance to 85%, achieving national standard and the 2nd highest preforming ED in the country during December
•Sustained reduction in WNB rate, now 7% achieving the Trust target. For new appointments the division currently has a 5% WNB rate
•Recovery of OP and OPROC activity highest YTD at 217%, significantly supported by increased UTC appointments from ED
•Diagnostic compliance remains stables despite challenges and impact of Industrial action and reduced capacity during the Christmas period, key actions in place to ensure continued improvement and achieve 90% measure, currently performing at 87%
•Improvement in waiting list size and number of patients waiting over 65 weeks for treatment
•Sustained compliance with all standards for cancer care
•Continued reduction in staff turnover now at 10%
•Improvement in PALS closed within 5 Days, achieving Trust target
•Delivery in year CIP 3.6M and recurrent 2.3M posted
•ERF income over preforming by 1.2M
•Sustained sickness rates at 5.5%
•Improved Emergency Department Sepsis, delivery of antibiotics within 60 minutes, achieving 90% target, all delays were reviewed by the clinical team
•Improvement in ED F&F associated with reduction in waiting times
•Delivery in year CIP 3.6M and recurrent 2.3M posted
•ERF income over preforming by 1.2M
•Sustained sickness rates at 5.5%
•Improved Emergency Department Sepsis, delivery of antibiotics within 60 minutes, achieving 90% target, all delays were reviewed by the clinical team
•Improvement in ED F&F associated with reduction in waiting times

Areas of Concern

•Significant reduction in clinic letters completed within 10 days, impacted by industrial action and the Christmas period, improvement anticipated next month owing to a number of targets initiatives

•Reduced Neurology consultants cover impacting the level of on-call provision offered until further recruitment secured

•Slight reduction in mandatory training figures which teams are reviewing with targeted approaches per area

•Reduction in incidents reported for minor harm & above and no harm & near miss, in line with Dec 22 reporting, anticipated owing to reduction in activity and occupancy, however will continue to monitor

•Despite a positive CIP position at M5 (£2.5m) the Division is challenged in delivering recurrent savings and achieving the full £3.6m in year, procurement review underway

Forward Look (with actions)

•Review of PDR plan to improve compliance by end of March 24

•Continue revised focus on forecasting and activity levels to improve waiting times and maximise income generation

•Review of PAU pilot to establish impact this winter and consider long term implementation

•Focus on coding review to support income and CIP opportunity

•Continued DMO1 working group to improve compliance

•Launch pilot of urgent and emergency care virtual pathways across Liverpool to reduce re-attendances aiming to provide CYP with the advice and care they need in their first interaction

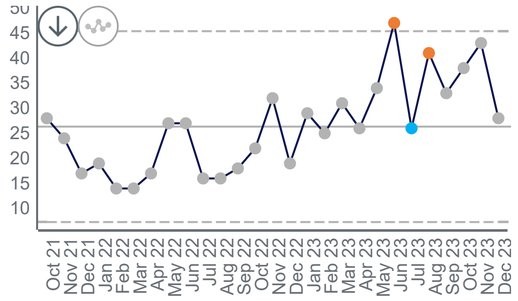
0092

Integrated Performance Report | January 2024

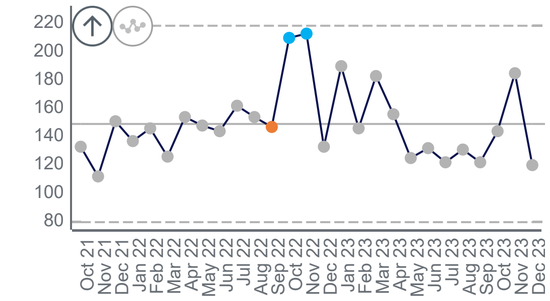
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

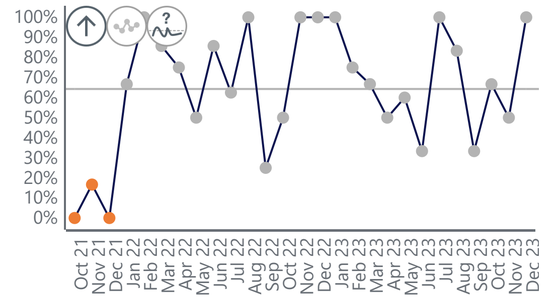
Number of Incidents rated Minor Harm and above



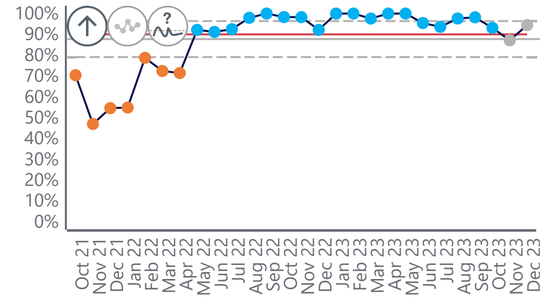
Number of Incidents rated No Harm and Near Miss



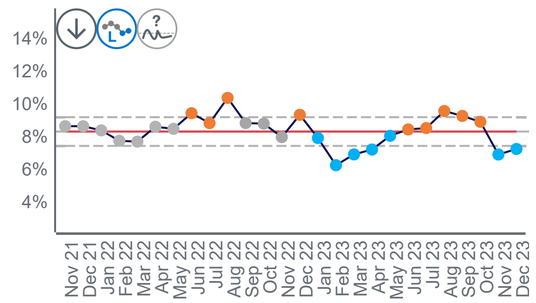
% Complaints Responded to within 25 working days



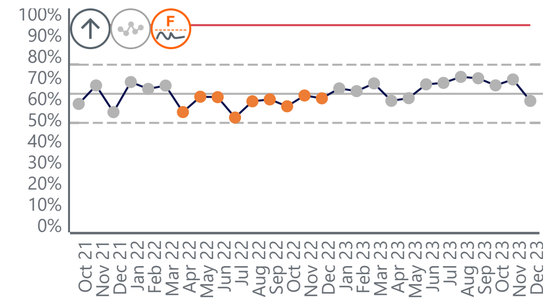
% PALS Resolved within 5 Days



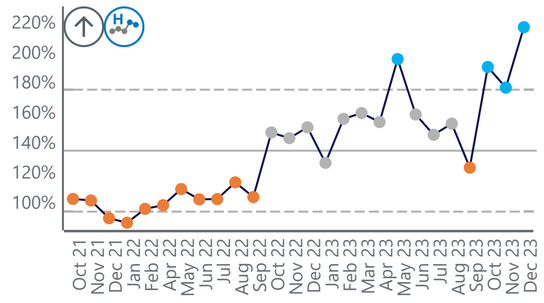
% Was Not Brought Rate (All OP: New and FU)



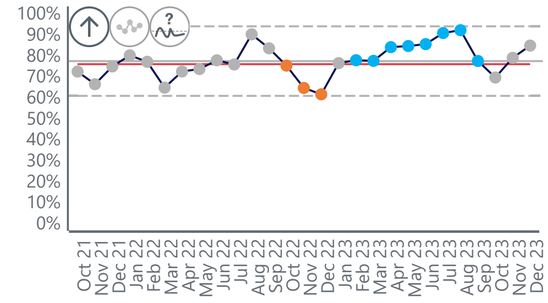
% of Clinical Letters completed within 10 Days



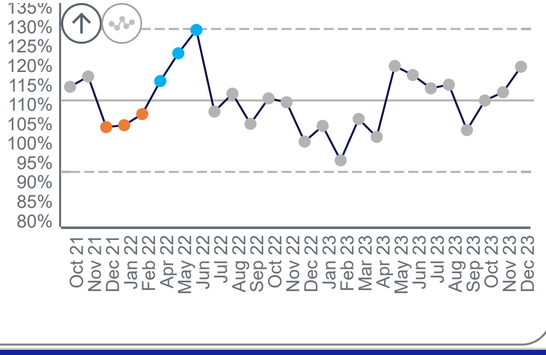
% Recovery for OP New & OPPROC Activity Volume



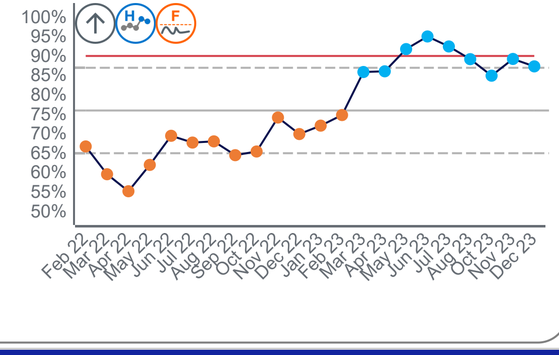
ED: % treated within 4 Hours



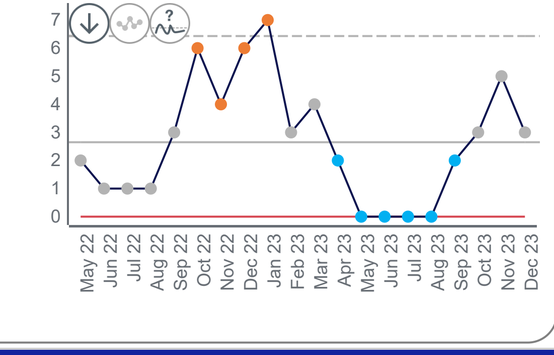
% Recovery for DC & Elec Activity Volume



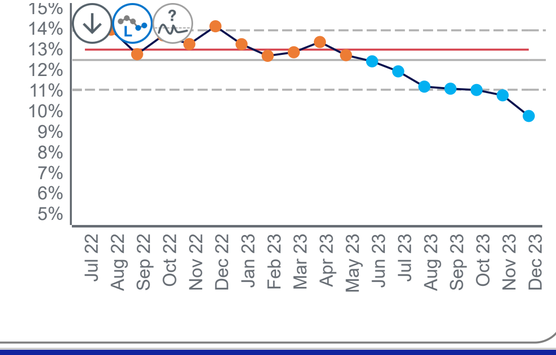
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



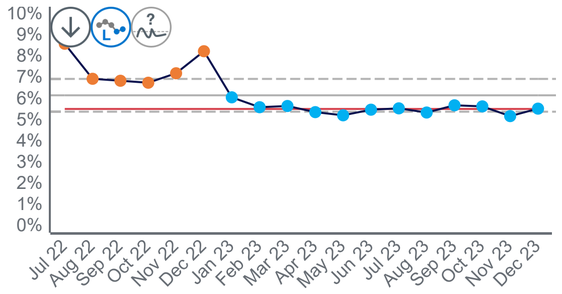
0093

Integrated Performance Report | January 2024

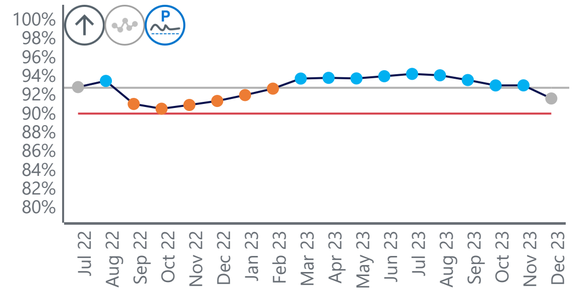
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

Sickness Absence (Total)



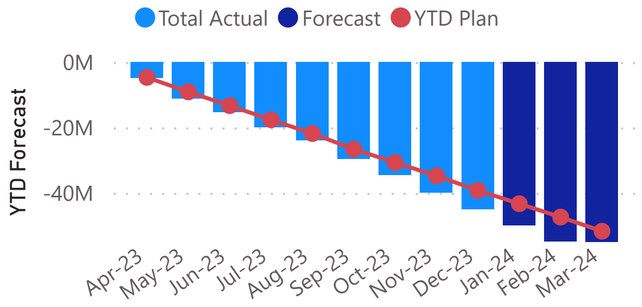
Mandatory Training



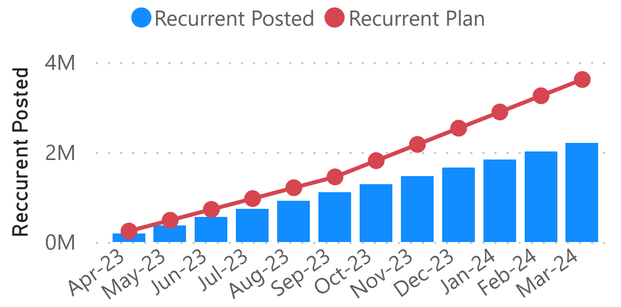
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

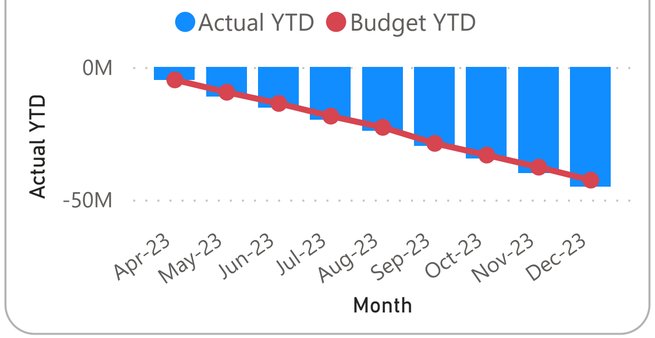
Revenue Position (Year End Forecast)



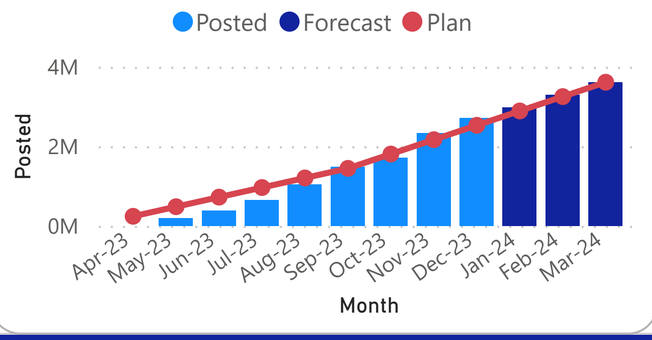
CIP Position (Recurrent Full Year Effect)

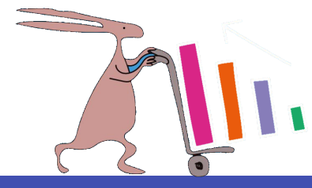


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

•% Recovery for DC & IP significantly increased in month at 102% with an ERF overperformance of £200k

•% Recovery for OPROC and OPNEW significantly increased in month at 114%

•100% DM01 compliance achieved in M9 with marked improvements made in Urodynamics and Cystoscopy

•Turnover remained below target at 11% and HR team working closely with areas of higher turnover to reduce further

Areas of Concern

•Number of patients waiting over 65 weeks increased slightly in month mainly due to IA impact and loss of capacity in ENT. Current trajectory looks to achieve 65 weeks however there is a risk to this position based on any future IA

•WNB rate increased in month at 9.9% with main outlier in community ophthalmology

•2 formal complaints breaches in M9 due to AL challenges and required amendments. Both were closed 7 days post due date. No PALS breaches for December, work undergoing on inphase to amend set up of targets due to data quality issues.

•CIP remains a key challenge within the division and cost reduction actions have been implemented to mitigate some of the risks.

Forward Look (with actions)

•Super week initiatives being held/planned in challenged access areas in order to mitigate potential risk and continue to work towards next years targets of clearing 52 week waits

•Hybrid booking pilot started in January for Community Ophthalmology to target high WNB rate, data shows that a reduction in this specialty will have statistical impact

•Continued work in those areas behind plan (IA aside) in order to increase run rates

•Productivity programme focusing on a number of GIRFT recommendations to increase elective recovery rates, inclusive of a review of clinic models to increase capacity

•Planned pilot of utilising some DGH capacity for backlog patients alongside trialling potential future models- to start utilising all day paediatric theatre list in Feb, weekly, at Warrington & Halton. Specialities will alternate between ENT and Paediatric surgery.

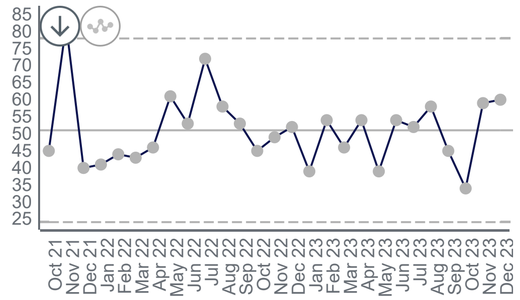
0095

Integrated Performance Report | January 2024

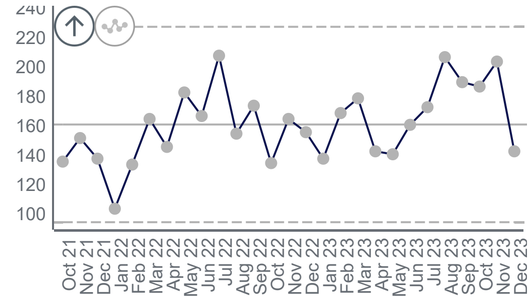
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

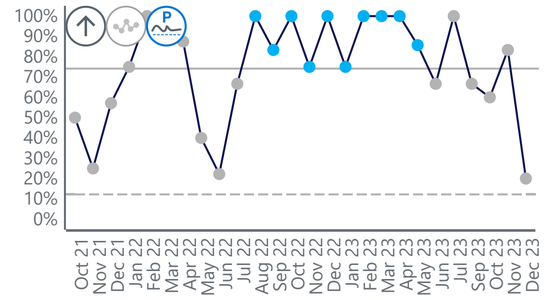
Number of Incidents rated Minor Harm and above



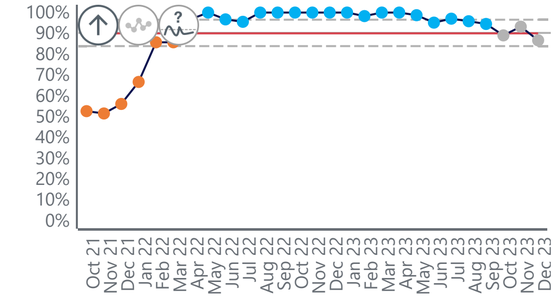
Number of Incidents rated No Harm and Near Miss



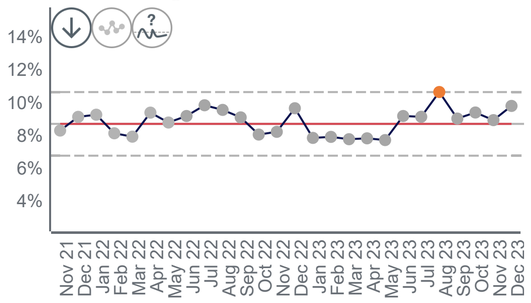
% Complaints Responded to within 25 working days



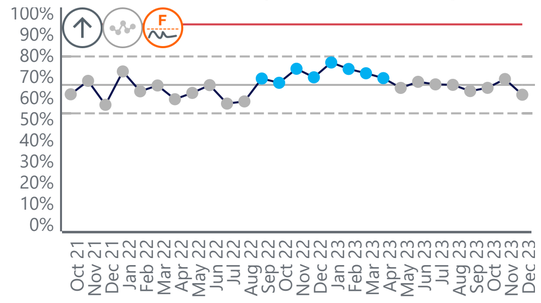
% PALS Resolved within 5 Days



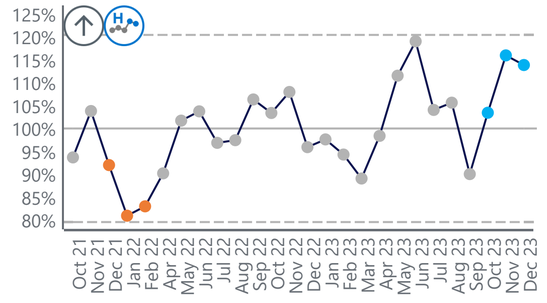
% Was Not Brought Rate (All OP: New and FU)



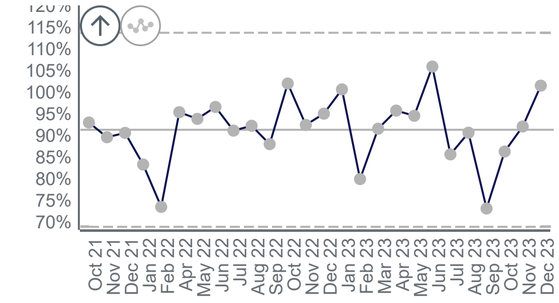
% of Clinical Letters completed within 10 Days



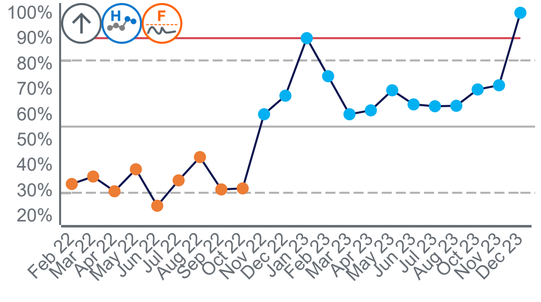
% Recovery for OP New & OPPROC Activity Volume



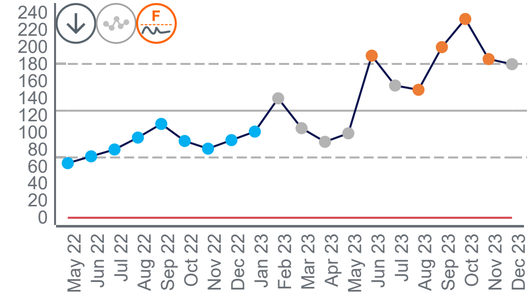
% Recovery for DC & Elec Activity Volume



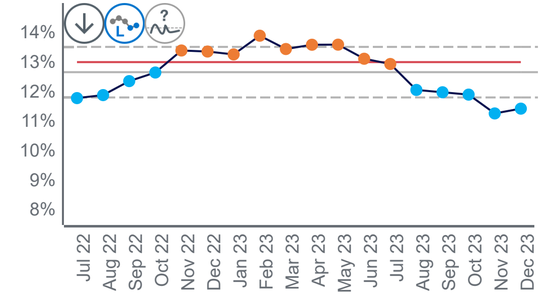
Diagnostics: % Completed Within 6 Weeks of referral



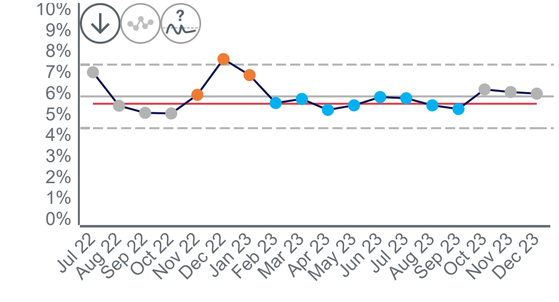
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)

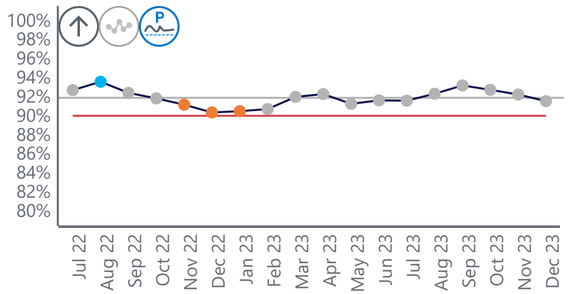


Integrated Performance Report | January 2024

Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

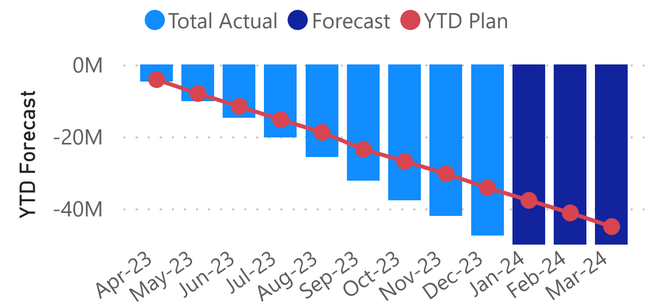
Mandatory Training



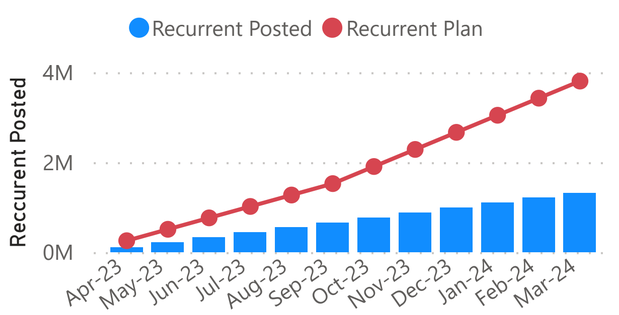
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

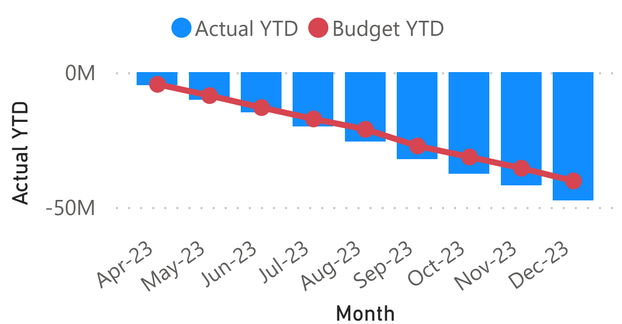
Revenue Position (Year End Forecast)



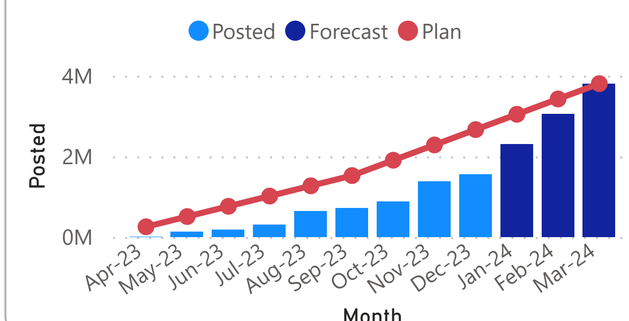
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

•Approval of investment case for 3rd MRI scanner which will be jointly led by Medicine and Clinical Research Divisions

•Successful collaborative meeting with University of Liverpool to develop plan for Institute of Child Health aligned with the Futures strategy

•Publication of scientific paper co-developed with Research Ambassadors (CYP 13-18 years old)

•Staff turnover remains low and below target

•Mandatory training remains on target

•No incidents of harm reported this mont

Areas of Concern

•Under-achieving against commercial income target and commercial study set up target (relates to national position as well as local challenges)

•Participant recruitment has remained at the expected level following the end of the DETECT study in August. Individual study performance is being monitored monthly to ensure we remain on target.

•Sickness absence has increased slightly due to an increase in short-term absences however long-term sickness continues to improve

Forward Look (with actions)

•Final draft of Alder Hey Research Strategy (2024-2030) being presented to R&I Committee on 18th Jan.

•CRD away day to finalise Research Strategy Implementation plan taking place on 31st January

•Work underway to install MRI scanner and implement new governance arrangements with Division of Medicine

•Awaiting outcome of expression of interest to host a Mobile Research Unit which would increase research opportunities for harder to reach populations

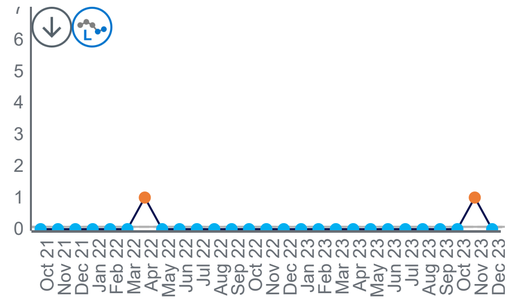
0098

Integrated Performance Report | January 2024

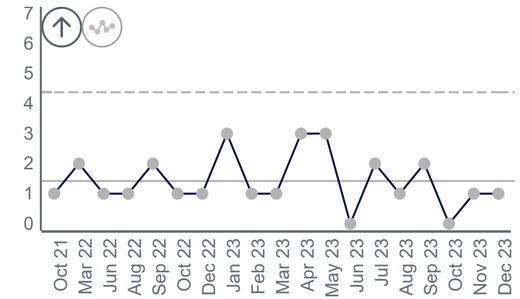
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

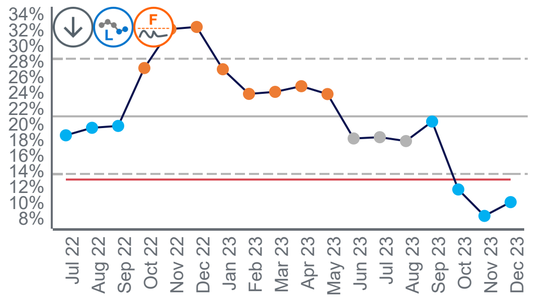
Number of Incidents rated Minor Harm and above



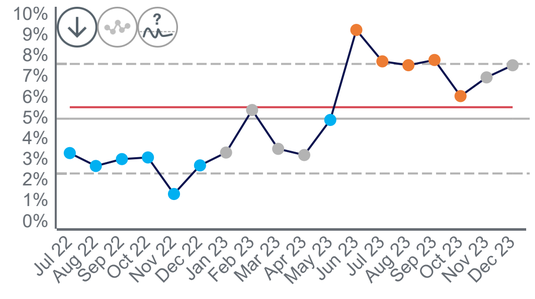
Number of Incidents rated No Harm and Near Miss



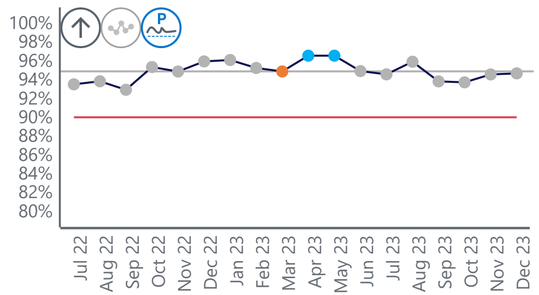
Staff Turnover



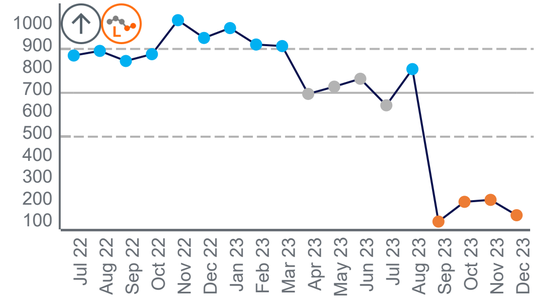
Sickness Absence (Total)



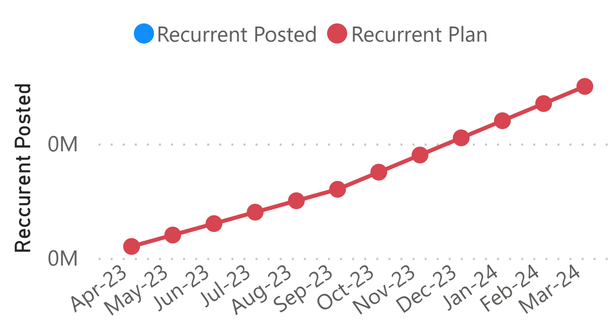
Mandatory Training



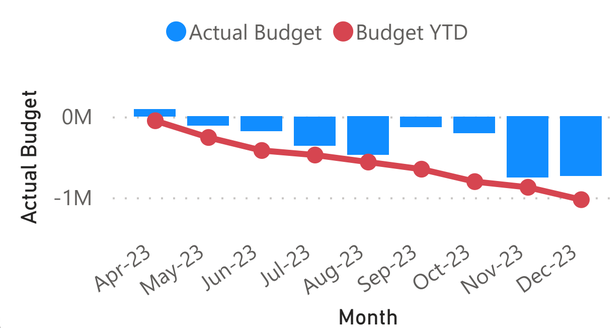
Number of Patients Recruited into Research Studies



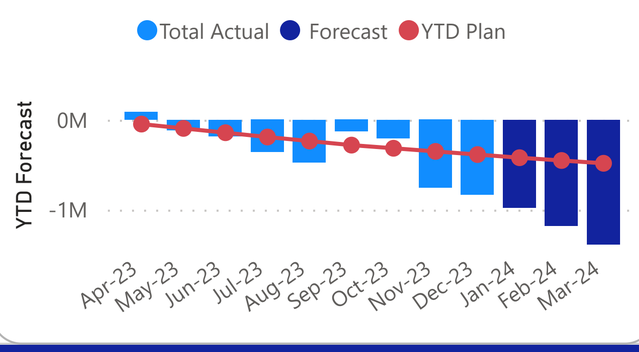
CIP Position (Recurrent Full Year Effect)



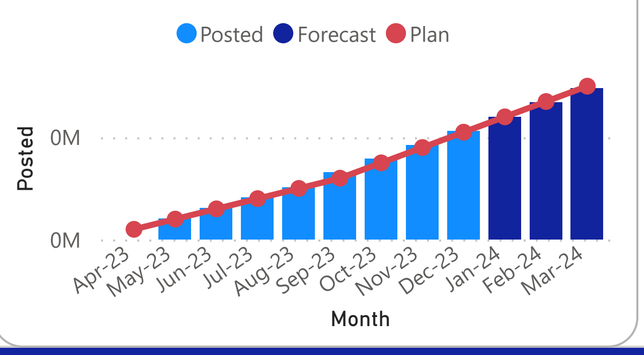
Revenue Position (Variance to date)

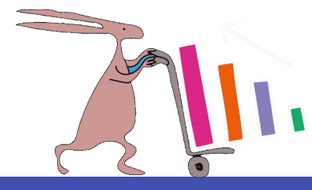


Revenue Position (Year End Forecast)



CIP Position (Delivered to date)





Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative did not meet in December due to the holiday season. The next meeting is scheduled on 23rd January 2024 to discuss the December position as follows:

• Mandatory training for Corporate Services remains above the 90% target at 91%.

• Staff Turnover remains at 12% which is below Trust target, however this remains an area of focus for HR with the formation of a T&F Group to review data and agree immediate actions.

• Short term sickness is 2% and is now below Trust target (2.5%)

• Positive engagement in all service areas in monthly review of risks and actions required regarding any overdue risks.

• All Recurrent CIP now identified and delivered at M8.

Areas of Concern

• Long term sickness has declined in-month and is currently sitting at 5%.

• Despite an increase in B7 PDR compliance to 70% this remains a focus for CSC.

• PDRs for all staff is at 67% the target of 90% in rolling 12-month period.

Forward Look (with actions)

• Outstanding Mandatory training to be addressed with individuals and escalated where there is any non-compliance

• Ensuring all risks are reviewed within timescale.

• Outputs from the Attraction and Retention T&F Group to be received by Corporate Services Collaborative for action.

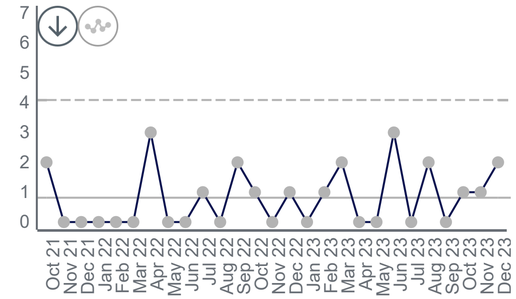
0100

Integrated Performance Report | January 2024

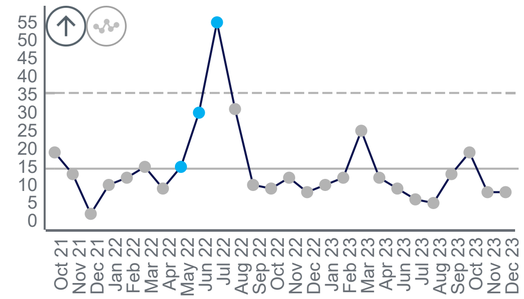
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

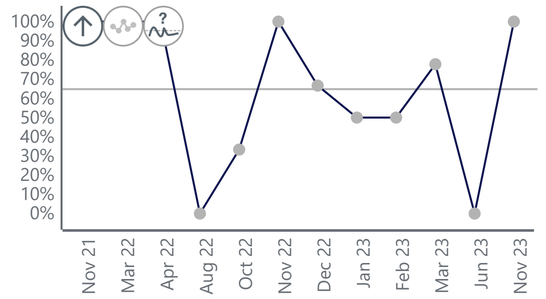
Number of Incidents rated Minor Harm and above



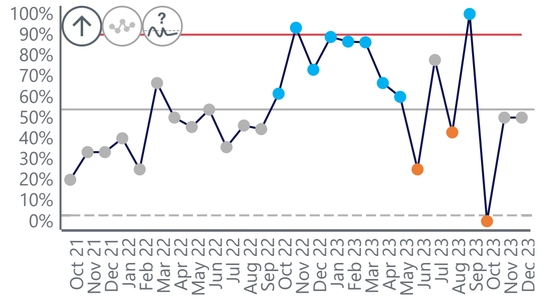
Number of Incidents rated No Harm and Near Miss



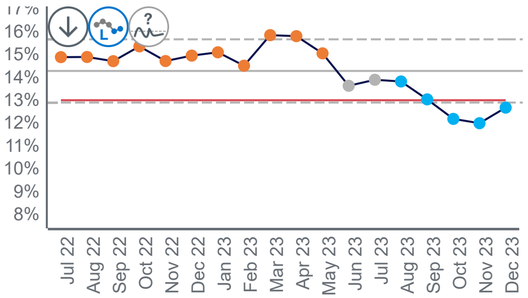
% Complaints Responded to within 25 working days



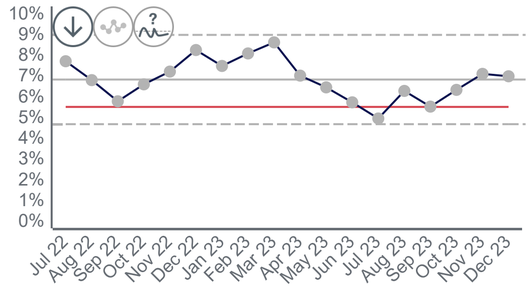
% PALS Resolved within 5 Days



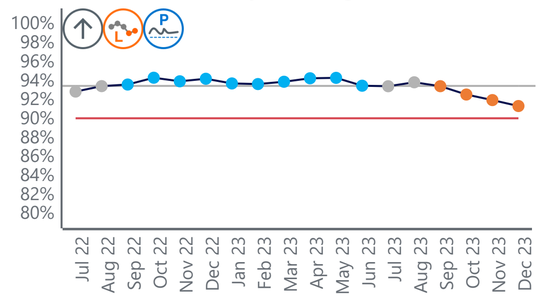
Staff Turnover



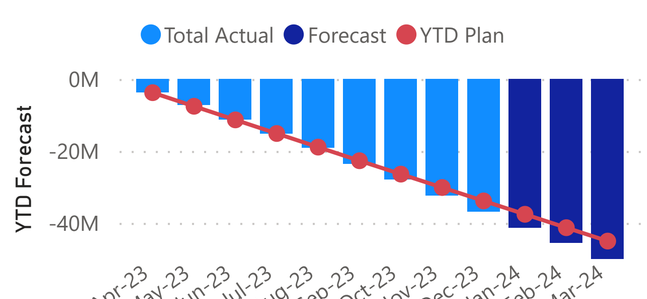
Sickness Absence (Total)



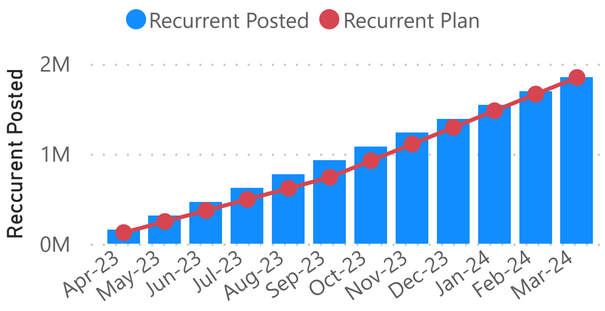
Mandatory Training



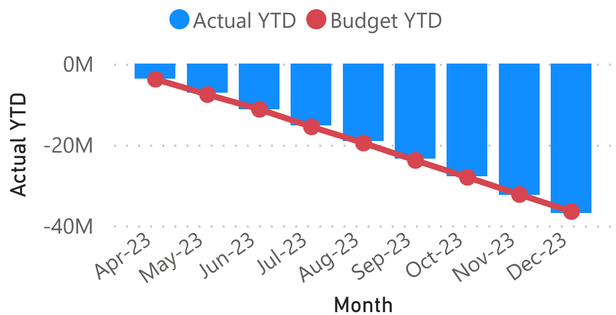
Revenue Position (Year End Forecast)



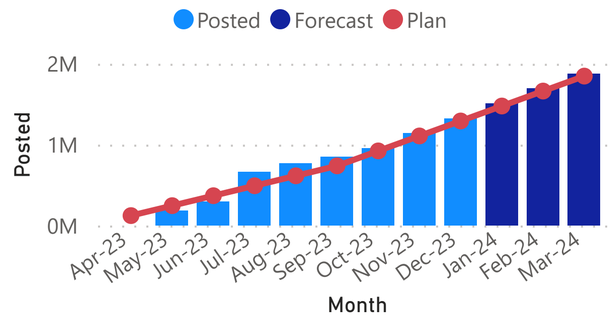
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



0101

Safe Staffing & Patient Quality Indicator Report
September Staffing, CHPPD and benchmark
January Board Paper

	Day		Night		Patients	CHPPD	National benchmark	Availablity				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate		RN - FTE	HCA - FTE	RN - %	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good		
Burns Unit	86%	-	100%	-	98	18.5	14.87	370.80	0.00	12%	0%	0.00	0.00%	0.00	0.00	14.20	3.83%	0.00	0.00%	2	24	0	1	14	100%	0	0
HDU	69%	103%	66%	110%	227	33.1	32.22	3,136.60	60.00	4%	2%	1.00	0.96%	0.00	0.00	97.37	3.10%	0.00	0.00%	8	55	0	3	5	80%	2	0
ICU	74%	73%	70%	61%	255	58.5	32.22	1,486.61	78.40	8%	0%	0.00	0.00%	0.00	0.00	85.79	5.77%	3.00	3.83%	19	100	0	1	1	100%	2	1
Ward 1cC	76%	83%	81%	86%	409	15.2	12.31	1,239.53	193.60	0%	-4%	1.92	4.57%	0.00	0.00	46.81	3.78%	26.40	13.64%	10	48	1	7	13	92.31%	0	0
Ward 1cN	66%	0%	66%	-	228	13	13.14	566.00	30.00	15%	-2%	0.00	0.00%	0.00	0.00	19.60	3.46%	27.00	90.00%	2	30	0	7	3	100%	1	1
Ward 3A	89%	80%	88%	146%	714	10.4	10.27	1,200.25	313.20	-7%	7%	1.53	3.76%	0.00	0.00	112.32	9.36%	27.60	8.81%	0	35	6	11	40	100%	0	0
Ward 3B	73%	120%	73%	-	375	12.7	7.28	791.20	117.60	20%	1%	1.92	7.33%	0.00	0.00	99.00	12.51%	27.60	23.47%	7	40	0	5	8	87.50%	1	0
Ward 3C	88%	84%	66%	113%	568	13.3	10.31	1,453.40	182.00	12%	1%	0.00	0.00%	0.00	0.00	98.77	6.80%	8.00	4.40%	11	82	1	1	11	100%	0	0
Ward 4A	82%	85%	80%	221%	701	11.9	10.19	1,466.72	177.20	6%	0%	1.53	3.13%	0.00	0.00	102.96	7.02%	0.00	0.00%	2	40	0	3	32	93.75%	1	0
Ward 4B	57%	72%	44%	67%	485	13	10.28	911.93	989.80	4%	6%	0.61	2.02%	0.00	0.00	70.45	7.73%	109.77	11.09%	2	56	2	3	11	100%	0	0
Ward 4C	93%	81%	85%	90%	598	11.6	10.36	1,228.64	299.60	14%	1%	1.00	2.43%	0.00	0.00	64.68	5.26%	80.96	27.02%	7	149	0	2	25	96%	2	0

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

Medicine

Ward 3b - The over establishment for unqualified vacancies are the additional supernumerary registered nurses who are awaiting a pin or occupational health clearance, this has impacted the fill rate for registered as they are not yet counted in the numbers. Fill rate of 120% for HCA's is due to several patients requiring 1:1 care. HCA sickness equates to 2.0 WTE who are currently on LTS.

Ward 3C - LTS continues to improve. The HCA sickness equates to 1.0 WTE but due to low numbers of HCA's within the overall ward establishment the percentage is high. The ward are also supporting an RN 1:1 and 3 x HCA 1:1 on a long-term basis due to safeguarding reasons. There was an increase in overall 1:1 for HCA's overnight.

Ward 4B - RN sickness levels continued to be monitored with significant improvements. 2.61 WTE qualified staff commenced in post therefore and remain supernumerary.

Ward 4C - continue to have a high RN vacancy rate equating to 11.89 WTE staff due to a high turnover over the last few months. 9.0WTE new staff have been recruited starting from October so this will slowly start to improve over the next few months.

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 1cNeo - staffing is overseen by safer staffing and supported by the Liverpool Neonatal Partnership, with nurses being deployed from LWH if required. Recruitment and training for the new neonatal unit is ongoing for the number of cots. 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 80%. The ward has also had to cover a high number of 1:1 patients, therefore contributing to the overfill on that line.

Ward 4A - has also had to cover a high number of 1:1 patients, therefore contributing to the overfill on that line

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 - average fill rate is less than 80% is due to the Band 4s that are in post awaiting NMC pins and other supernumery staff . In September there were 0.93wte RN on LTS, 14.6wte RN on short term sickness and 5.66wte RN on maternity leave.

ICU - patient numbers were low in September, therefore there were not as many staff on shift, this explains the lower fill rate. New starters commenced in post in October, following a period of induction and supervision they will commence in the numbers from January.

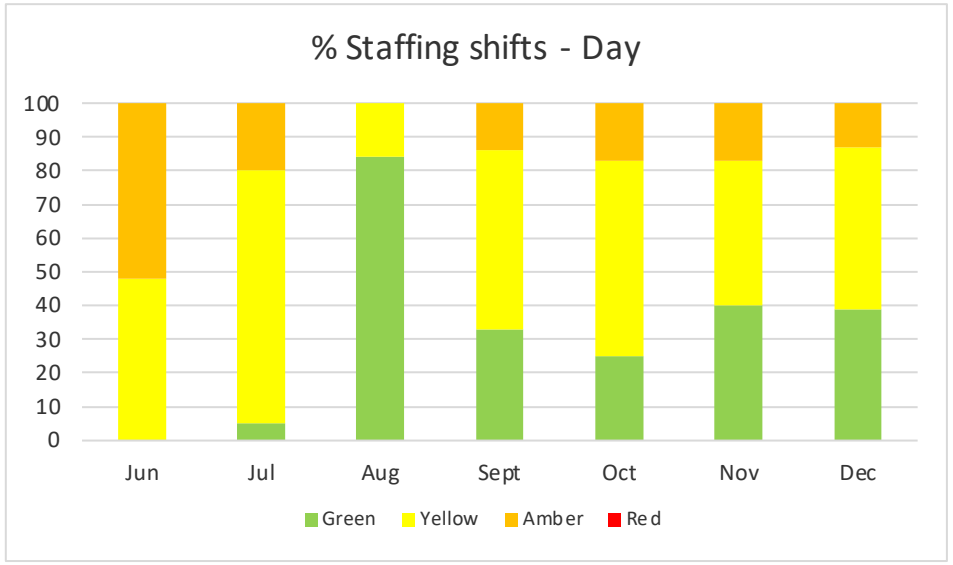
Summary

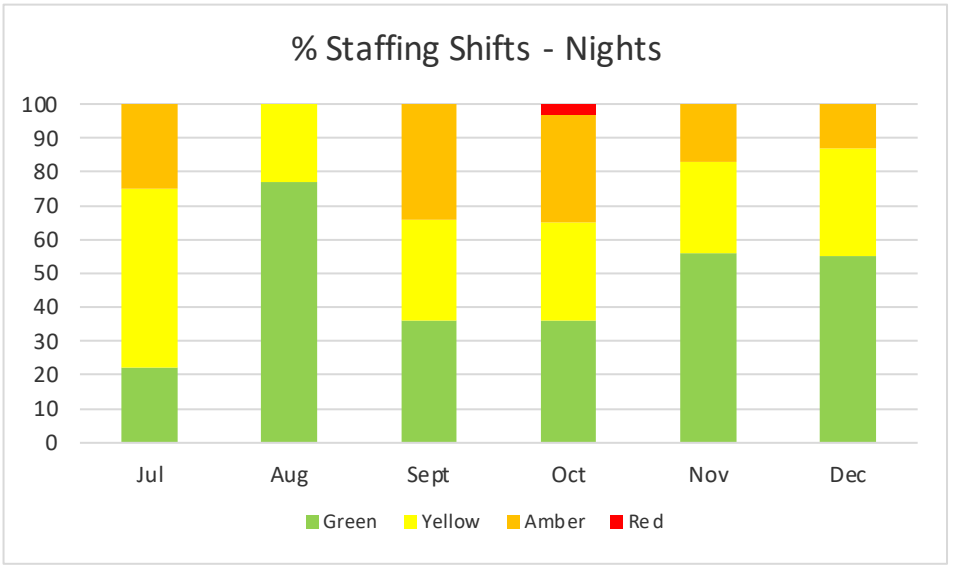
Unfortunately, the National benchmark data on model hospital for September is unavailable, therefore we continue to benchmark against the data available which is from June. Alder Hey are above the National Benchmark in all areas if comparing to this data. The national benchmark for ward 3B is significantly 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.

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 has been undertaken with the aim to changing the nursing patient ratio from 1-4 to 1-6 This was a successfully piloted in August 2023 for a 3-month period. Following review of the pilot and approved by Chief Nurse the qualified nursing staffing establishment on 4B will be 1-6. This will be reflected formally in the establishment and will commence April 1st .During this period reported, staff moves on NHSP were not recorded on E-Roster.

Summary of November staffing

No red days or nights reported since October. To note it is a positive improvement from previous years we have had no RAG red days during the winter months of November and December:





0103

Electronic Roster KPI Report

December Board Paper

E-rostering ensures staff are appropriately allocated in order to provide high quality and effective health care. Effective e-rostering considers factors such as patient needs, staff needs, organisational needs, the workforce and skills required to deliver services and workforce availability. Trusts are responsible for striking the right balance between patient safety, cost, and efficiency and used in the right way electronic staff rostering can help Trusts achieve this.

December KPI Table

RosterPerform 11 Overview

KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owes)		The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shits in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days (13 November - 10 December)	% Changed Since Approval	Net Hours (1 pro rated day per person)	Net Hours	Bank / Agency Use %	Bank / Agency Usage Hours	Additional Duties	Unfilled Roster %	Annual Leave %	Study Day %	Other Leave %	Sickness %	Parenting %	Total Unavailability %
Accident & Emergency - APNP (912201)	48	26%	80.00	401	0%	0	1	45%	20%	8.10%	0.00%	4.95%	0.00%	32.94%
Accident & Emergency - Nursing (912201	27	46%	720.00	334	17%	2192	16	15%	13%	1.94%	2.00%	8.19%	4.24%	30.67%
Burns Unit (915208)	32	46%	140.00	900	9%	220	2	8%	13%	3.00%	0.75%	4.38%	0.00%	25.36%
Critical Care Ward (913208)	44	29%	1200.00	6534	10%	2174	75	14%	14%	0.13%	0.19%	5.34%	4.86%	25.19%
High Dependancy Unit (HDU) (913210)	34	35%	640.00	5721	11%	1120	51	31%	13%	4.27%	0.37%	6.69%	8.49%	34.54%
Medical Daycase Unit (911314)	18	17%	50.00	83	6%	55	8	33%	20%	0.26%	0.00%	3.46%	0.00%	24.19%
Outpatients (916503)	25	46%	420.00	1096	16%	991	0	52%	17%	0.41%	1.00%	14.56%	4.14%	38.07%
Surgical Daycase Unit (915418)	30	35%	190.00	1255	9%	278	8	36%	14%	0.05%	1.00%	16.33%	0.00%	33.48%
Theatres - Cardiac & Cardiology (915405	28	27%	85.00	1361	10%	143	21	33%	20%	0.00%	10.00%	3.02%	0.00%	33.22%
Theatres - Emergency (915420)	20	35%	130.00	-46	6%	167	8	5%	16%	1.48%	1.00%	5.53%	0.00%	24.54%
Theatres - IP Anaesthetics (915423)	28	29%	230.00	192	5%	211	88	6%	20%	0.00%	2.00%	2.17%	0.92%	26.39%
Theatres - IP Porters (915435)	16	44%	82.00	-74	10%	171	6	23%	14%	0.00%	0.00%	8.03%	0.00%	22.64%
Theatres - IP Recovery (915422)	25	42%	101.00	611	11%	208	33	23%	16%	1.70%	7.00%	2.95%	0.00%	28.29%
Theatres - IP Scrub (915424)	28	33%	103.00	0.25	16%	276	0	22%	21%	0.44%	0.00%	13.51%	0.00%	35.26%
Theatres - Ortho & Neuro Scrub (915436	34	50%	128.00	28	20%	396	2	15%	24%	0.00%	0.99%	6.70%	2.01%	43.81%
Theatres - SDC Anaesthetics (915429)	33	21%	37.80	33	28%	234	1	31%	11%	2.27%	2.21%	12.49%	0.00%	28.79%
Theatres - SDC Recovery (915430)	23	27%	58.40	97	2%	19	8	36%	12%	2.51%	0.35%	5.95%	0.00%	21.77%
Theatres - SDC Scrub (915421)	44	38%	177.30	471	6%	165	36	60%	15%	0.81%	1.00%	19.99%	0.00%	38.87%
Ward 1C Cardiac (913307)	32	20%	532.00	2241	3%	241	0	23%	18%	0.53%	1.00%	3.11%	8.71%	39.07%
Ward 1C Neonatal (913310)	39	28%	361.00	321	0%	5	0	35%	14%	1.70%	0.56%	10.25%	1.78%	31.88%
Ward 3A (915309)	30	32%	556.00	28	9%	781	25	11%	16%	1.46%	1.00%	9.67%	3.28%	33.60%
Ward 3B - Oncology (911208)	34	36%	371.00	2852	22%	1364	40	21%	14%	0.00%	1.00%	8.31%	3.96%	30.98%
Ward 3C (911313)	35	28%	555.00	1894	19%	2084	33	20%	9%	1.09%	0.50%	8.12%	3.63%	23.32%
Ward 4A (914210)	25	29%	607.00	3186	12%	1009	18	27%	15%	2.74%	0.96%	9.36%	9.04%	39.18%
Ward 4B (914211)	31	26%	634.00	7619	7%	672	24	27%	12%	1.29%	1.00%	12.68%	8.08%	37.52%
Ward 4C (912207)	37	30%	533.00	511	8%	713	36	16%	12%	0.84%	1.00%	8.42%	1.23%	28.43%
Sunflower (912310)	19	52%	280.00	695.32	30%	1508.92	87	14%	10%	0.00%	0.00%	10.57%	10.22%	32.79%

KPI Dashboard - Patient Areas | Monthly Average Tracking - Med | Monthly Average Tracking - Surg | Monthly Average Tracking - C ...

0104

Summary Narrative

This is the first E Roster KPI data set and therefore no previous month is available to compare trend. Going forward there will be more of a focus on comparator data and trends at ward and Divisional level. The key elements that have been highlighted from the December KPI data are summarised below:

Lead time average is 30 days – Staff are only receiving on average 30 days' notice of shifts to be worked. There is the potential for impact on work life balance and the ability to reduce NHSP temporary staff bookings with good lead times. The Roster team continue to work with the Ward and Divisional leads to improve these lead times.

Net hours 38,344 – These are hours in the roster unaccounted for. The E Roster team are working with the departmental managers to correct any administrative errors so we can achieve full assurance that the data is correct, and a true reflection of what colleagues owe or are owed. These hours can be used in place of booking temporary staffing via NHSP when managers are confident that they are correct.

Bank/Agency use 11% - This figure relates to the fact that 11% of all shifts are identified through NHSP. The impact of this is twofold. Firstly cost, if it totals over the budgeted establishment. Also, it could impact on the quality of care if the fill is from staff that are not familiar with the ward, compared to regular workers. Managers are now only able to cancel and direct book shifts via roster.

Additional Hours 627 – These hours reflect staff booked over the funded establishment. The E Roster team are working with Managers to ensure additional duties are only being created in line with the temporary staffing policy.

Unfilled roster 25% - is high. This could indicate either the templates need to be amended or a safety issue with low fill rates. It is more probable the former as shifts are not removed to reflect occupancy. The E Roster team continue to work with Managers to review templates.

Sickness 8.3%- continues to be high but is managed by the senior ward teams and is used for Roster KPI purposes to reflect total unavailability.

Total unavailability is 31% - slightly over target. This could indicate there are too many people not on clinical duties/counted as being able to deliver care. This indicator covers sickness, suspension, maternity leave, study leave etc.

Progress

- Annual leave, other leave, maternity/paternity leave and study leave are generally within target.
- Roster sign off meetings are live in Surgery. Medical Division are in the process of setting them up, with Community next in line.
- Meetings are already in place with the E Roster team and Ward and Divisional Managers, to look at the quality of rosters and make changes as necessary, that will have a direct positive impact on the KPIs. Managers are developing an understanding of what the data is telling them and working towards rosters playing a key role in their workforce planning.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

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 ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
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 ☐

If "No", is a new risk required? Yes ☐ No ☐

Risk Number	Risk Description	Score
4.2	Digital and Data Strategic Development & Delivery	12

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 Digital, Data and Information Technology Update

1. Executive Summary

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

Key headlines include:

- Update on Cheshire and Merseyside Specialist Trust (CMAST) Alliance – Digital Workshop
- 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. National and Regional Updates

2.1 Cheshire and Merseyside Specialist Trust (CMAST) Alliance – Digital Workshop

In December, CMAST facilitated a Digital workshop and highlighted 4 areas of opportunity for collaborative development across the region, these are:

- Robotic Process Automation – System wide funding to support the sharing and development of automation processes across the region.
- Clinical System Maturity – Potential for a shared pool of digital resources to help improve consistency and standardisation to transformation programmes.
- Generative Artificial Intelligence – Opportunities for clinical and patient assistance and administrative support to help reduce burden and improve quality.
- Cyber Security – Outlining shared strategic objectives for the region.

Alder Hey will remain engaged with the group and seek to embrace any opportunities that could benefit the Trust.

3. Digital and Data Futures Progress

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

National funding has been made available to Specialist Trusts to support the expedition of development and delivery for Patient Portals. Alder Hey have been successful with a bid for £300k to help further develop the Anywhere platform. A Business Case will be developed to outline how the £300k will be utilised and this will be supported by a workshop with key stakeholders in February, to discuss areas of focus and deployment.

3.2 Outstanding Records and Safe Systems

Good progress has been made with the reporting templates for the new Risk and Incident Management System, InPhase. Work to automate the reports is underway and on track for February 2024. Scoping for the next phase which will include nursing audits and additional functionality to support the latest 'Learning from Patient Safety Events' accreditation from NHS England is underway.

There has been improved compliance with Blood Transfusion Consent following the electronic consent go live ahead of the April 2024 deadline.

3.2.1 AlderC@re

The programme has now moved into Phase 2, with a defined scope and refreshed governance and processes wrapped around it to support delivery. The scope of Phase 2 is centered around optimising the EPR and planning for future upgrades.

A clear and robust governance structure underpins Phase 2 of Alderc@re to ensure effective delivery. Alongside this, regular service meetings with Meditech have begun to take place with senior members of both organisations to review progress on developments and a forward look and ensure alignment between Trust and supplier. Divisional groups are meeting regularly to review and prioritise development requests.

The first development sprint was completed in December with 9 priority developments delivered alongside 4 emergency requests. There are currently 8 priority developments on track to be completed in January.

Good progress has been made with Aldercare Reporting with all national returns now being submitted. The majority of internal reports have now been validated with a small number scheduled to complete in January. External validation support is being sought to provide additional scrutiny on the process and outputs.

3.3 Healthier Populations through Digital, Data and Analytics

The Analytics Team have been predominantly focussed on the restoration of the Trusts reporting capabilities. The team have been working closely with the Divisions through Daily Huddles to manage the validation process.

A workshop took place in December to support the development of the Insight Unit, as part of the 2030 Strategy. This workshop brought together key stakeholders around the Trust to gather their thoughts and input into the future of more meaningful data and analytics provision at Alder Hey. This has been complimented with a survey for colleagues who could not make the session. Scope, priorities and plan for the Insights work is expected to be completed by the end of February.

Finally, a workshop is scheduled in January with Divisional Colleagues to review how the service is provided and to identify areas for improvement.

3.4 Technical roadmap and Operational Service Excellence

Replacement firewalls purchased and will be implemented throughout Dec/Jan. This will allow the consolidation of several technologies to allow for more efficient management and cost reductions over the lifetime of the contract.

Work remains ongoing support various estates projects, including the Police Station refurbishment and a new Community location. Finally, Multi Factor Authentication is being mandated nationally for remote working. Scoping and stakeholder engagement is currently underway to ensure the design of the solution meets the user's needs as well as keeping the Trust secure.

3.4.1 Operational Performance

The graphs below provide performance from December 2023. Key highlights include:

- Key Performance Indicators met consistently for previous 6 months.
- Service Desk resolved 42% raised in 2023.
- Tech Bar resolved 218 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 Board of Directors is asked to receive the report and note good progress to date.

Integrated Performance Report | January 2024

Alder Hey Children's NHS Foundation Trust

Flash Report -January 2024

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for January
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0	**0**
		Number of Serious Incidents (Steis reported)	0	**0**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**1 (MSSA)**
		FFT - % Recommending Trust	> 95%	**92.3%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Staff Turnover	*<13%*	***10.6%***
Collaborating for CYP	Handover Springfield Park to the community	Return Springfield Park to Liverpool City Council	By Nov 2023	**Final works will be completed by March 2024. This includes: lighting, paths, signage, and drainage / final seeding of the football pitches.**
Smartest ways of Working	Improve Access to Care and Reduce Waiting Times	ED: % treated within 4 Hours	> 76%	**82.0%**
		Number of RTT Patients waiting >65weeks	0	**163**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,745**
		Elective Recovery (Vol)	> 106%	***103.2%***
		Diagnostic Performance	> 90%	**82%**
	Financial sustainability	Revenue position – Year End forecast	13m Surplus	**11.5m**
	Aldercare optimisation	Optimisation of Aldercare	Optimisation programme has been scoped and is being initiated	**Metrics to be agreed through newly established governance**

Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary -

Published February 2024

Strategic Goals	2023-24 Operational Priorities	Progress in January 2024	Areas of challenge
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• Marthas rule implementation group continues to progress ready for pilot. • Medicinema planning underway with a launch towards the end of 2024	• Need to seek alternative What's app for business partner due to GDPR issues with initial supplier. • Increased unplanned admission to critical care needing further review and investigation
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Successful recruitment in theatre department which supports towards wellbeing amongst staff & the restoration of the theatre schedule	• Continued risk of industrial action • Increased level of sickness absence over winter
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• Islacare rollout in progress and AI pilot near completion. • CYP As One ICB funding approved and C&M rollout in progress. • Anywhere Expanse integration and testing complete. NHS E funding approved for NHS app and HCC integration. • LHAH scaling and adoption to other sites in progress. Additional feature development to begin. • Investment Zone final stage business case development in progress. Expected start delayed until June 2024. • Innovation hub refurbishment started. • 11 new ideas submitted to pipeline in January; 2 progressed to validate already.	• Ongoing CTO gap being addressed. 3 interviews carried out, 1 appointed. • Temporary gaps in leadership team due to secondment and sickness (MD & deputy MD). • Transition to Future's strategy and organisational structure in progress.

Collaborating for CYP	**4. Handover Springfield Park to our community**	• Tree planting continues. • Path works ongoing. • Playground: Benches installed. Surface works ongoing. Mid-February completion.	• Areas of residual Trust infrastructure works blocking full site possession for the park contractor. • Poor weather conditions.
Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Patients waiting > 65 weeks decreased to 163 (from 196 in Dec) • Delivered the national Emergency Department standard with 82% of patients seen within 4 hours • Sustained increase in utilisation of the virtual ward • Developed measles emergency preparedness plan	• The trust in on track to deliver zero patients waiting greater than 65 weeks by end of March, but further industrial action would affect this • Elective recovery levels in Surgery: plan to restore 7 sessions pw during February as per trajectory. Staffing skill mix remains a challenge in key areas • Diagnostic performance 82.2% based on challenges within Gastroscopy & LTV
Smartest ways of Working	**6. Financial sustainability**	• Reporting off plan in Month 10 by £1.5m reflecting IA in Dec and Jan. • Forecasting surplus of £11.5m, reflecting H2 reforecast (£13m) less IA for Dec and Jan. • Draft plan for 24/25 (high level) to be submitted to ICB 09/02/24	• Risk around CIP delivery for remainder of year. Forecast adjusted to prudent assumptions • Divisional pressures experienced in Surgery. Forecast currently assumes improvement in activity for remainder of the year – working through to gain assurance. • Working up CIP/Benefit plans for 24/25 • Confirmation of funding for 24/25 outstanding.
Smartest ways of Working	**7. Optimisation of Aldercare**	• 14 developments were prioritised through Clinical Digital Design Authority for Jan • 10 developments were completed in month • Highlights include Coding documents for Surgery, Abdominal Pathway, Measles immunisation and eProms	• Number of priority development requests outstanding with Meditech

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

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

February 2024

1. Executive Summary

The purpose of this report is to keep Trust Board informed of progress, risks and actions on the key capital projects as they arise. Budget position and forecast by project to be reported from Q4 2023/24.

Alongside a number of key projects and associated site works that will come to conclusion during the final quarter of 2023/24, and others due to commence in the new financial year, good progress has been made on other strategic projects:

- the estates solution for the Gender Development Services (GDS);
- a revised / prioritised scope of works for the Elective Surgical Hub project; and
- an agreed strategy for the refurbishment of the Lyndhurst Building (former Dewi Jones Unit) at our Alder Park site.

2. Key Risks

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

A review of the full Campus Development risk register was undertaken 10.01.24 by the Development Team to ensure all projects are being managed in accordance with the Trust's Risk Management Strategy, and to ensure clear and effective routes for escalation of critical path risks. The full risk register will be reviewed on a quarterly basis.

Since last month, a risk register has been developed for the GDS project.

Project	Manager	Open Risks	Low	Med	High (15+)
Park	KO	5	2	3	
Eaton Road Frontage	KO	3	2	1	
Fracture/ Dermatology OPD	KO	7	0	7	
Police Station Refurb	TJ/Day PM	15	11	4	
Neonatal & UCC	JOB	19	2	16	1
Alder Park Phase 1: EDYS	JVH/Day PM	Risk register to be developed			
Elective Surgical Hub	JVH/Day PM	Scope of project TBD			
Gender Development Services (GDS)	JVH/Day PM	4	1	3	

One risk (Neonatal & UCC) reduced from last month (20 to 16) to reflect RABD approval of inflation costs, and the signing of the main contract on 21 December 2023.

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Park	Failure to deliver long term vision for park	BAF 3.1	12	Phase 3 to be completed by March 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)	16	RABD approval given 14.11.23 to fund inflation costs. Development team to identify mitigation plan for SPV/other costs. Main contract signed 21.12.23.
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	2024												2025												2026+
		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 TBD																									
Police Station (Reduced Scope)	Refurbishment																									
	Decommission & Removal 3SM																									
Neo-Natal & UCC	Service Diversions																									
	Main Construction Period																									
	Morgan Sindall Welfare Cabins																									
SFH/Catkin	Sprinkler System Solution																									
Eaton Road Frontage	Phase 1 (scope TBD)																									
	Phase 2 (scope TBD)																									

4. Programme Delivery Timetable (Associated Projects)

Project	Deliverable	2024												2025												2026+
		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 & Therapies)																									
	Construction Phase 2 TBD (Sefton CAMHS)																									
Elective Surgical Hub	Refurbishment TBD (feasibility study May '24)																									
Fracture/ Dermatology OPD	Refurb Construction																									
New Nursery	Construction																									
Rainbow Centre	Rainbow Suite Refurb TBD																									
PALS	Refurb Feasibility TBC																									
North-East Plot	TBD																									
GDS North Hub Estates Solution Design, Refurb, Commissioning & 'Go Live'	Phase 1 (First Floor)																									
	Phase 2 (Ground Floor)																									

5. Project Updates

Neonatal and Urgent Care Centre

Deliverable	RAG	Risks/Issues	Actions/Next Steps
The service diversion works commenced on 02.10.23. A small deposit of unexpected debris material was found 12.01.24 and removed 31.01.24 requiring a work around of planned activities.		Completion of works ahead of main construction. Management of noise and site access routes during peak works.	Construction Progress meeting established 30.01.24 to monitor programme of works, and any required mitigations. On-going site management plan, including enhanced communications to patients & families.
Full final phase of construction contract signed 21.12.23. Instruction issued to MSC to complete full ground floor layout works ie: to include construction completion of the 'shelled' space (Urgent Care Centre).		Increased construction & SPV costs. Delay to unit opening.	Development Team are working with the SPV and Mitie to identify mitigation plans in relation to increased SPV / other costs. Agree EDU design and decant plan.
Equipment Specification & Procurement: Incubator specification agreed, final quantities required to be confirmed.		Coordination of technologies and flow of patient data between component systems: incubator, monitoring, alarms and line of sight elements.	Workshop held 17.01.24 to conclude coordination elements. Programme Board February 2024 to present status update and to agree governance approvals route.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Trust response submitted to contractor: 13.10.23 (Compensation Events), 10.11.23 (associated position paper 1) and 15.12.23 (associated position paper 2). • No formal claim or arbitration yet submitted by contractor.		Possible contract claim.	Detailed update shared at 20.12.23 RABD.

Deliverable (Catkin & Sunflower Cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Sprinkler System Under-Croft Car Park: • Tender period closed 01.02.24. Submissions are currently being assessed. • Business case completed. • Final works completion estimated 8-12 months.		Fire compliance. Potential loss of overall car park numbers. Budget TBC.	Tender returns evaluation. Dates for funding approvals via IRG and RABD tbc.
Water Safety Issues: To ensure statutory temperatures are maintained. Valve replacement works to balance hot water temperatures are concluded.		Continued contamination.	Microbiological sampling will continue.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Immediate priorities are being progressed: • Complete utilisation study clinical office functions (levels 1 & 2 main hospital and Institute in the Park) 22.01.24 - 02.02.24. • Permanent solutions for those staff currently accommodated on a 'temporary' basis as the result of an arising shorter-term pressure. • Potential increased scope: meeting rooms and storage. • To agree the Governance framework and guiding principles for managing mid-long term space utilisation.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for minor works/kit.	Implement action plan agreed at 01.02.24 Executive Director's meeting. Continue to develop options for meeting rooms and storage. Budget and scope of works to be agreed.
Former Police Station Refurbishment: • Revised layout and scope of construction/infrastructure works agreed to manage out-turn costs. • Enabling works due to commence on site 05.02.24. • Car parking provision available as required to support patient/visitor overflow and potential additional staff spaces. • Main works due to commence 11.03.24 and complete June 2024.		Operational date currently assessed as June 2024.	Robust programme management. Contract signing. Establish user group to commence pre-move planning and operational commissioning.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: FOSP meeting w/c 19.02.24.		Inconsistent communications.	Continued and maintained input & communications from all key stakeholders. Quarterly newsletters and regular website updates.
Completion Works: On schedule: • Playground completion inspection 16 February 2024. • Lighting, planting, street furniture & signage, path works completion March 2024. • Drainage works and final seeding to the football pitches expected April 2024 (followed by 12-month establishment period).		Delays in completion football pitches. Completion of existing Infrastructure works.	Continued bi-weekly coordination meeting to closely monitor infrastructure and park development site works to maintain the park programme. Trust discussions on-going with LCC to confirm and gather required documentation for the handover of Springfield Park to LCC. Countdown to Handover meetings to commence this month.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Tender Process: • Tender Issue Date: w/c 12.02.24 • Tender Submission Returns: 15.03.24 • Appoint Construction Contractor: Spring 2024 • Start on Site: 03.06.24 • Construction Completion: 16.12.24		Timely appointment of a construction contractor. Delay to completion, impact on operational running of the services.	Regular meetings. Close monitoring of critical risks. Initial discussions with wider estates community re: potential short-term decant facilities to help manage patient activity during works.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

Deliverable	RAG	Risks/Issues	Actions/Next Steps
High level programme to be fully agreed. Phase 1 scope of works to be agreed. Planning consent condition (section 278) re traffic calming to be satisfied as part of Institute approval 2013. To be reviewed as part of the wider estate strategy (inc NE plot and boundary treatments) and development of site master planning options.		Phase 1 – planning approval, interface with Catkin/Sunflower building (works and access), and cost of works & section 278. Trust has identified a mitigation to satisfy 278 requirements, to be submitted as part of the planning consent. Phases 2&3 -Budget to be identified.	Finance to confirm funding options. LCC to continue and complete the current application for Eaton Road Frontage. Continue to 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
Trust Variation Enquiry (TVE) response received from the Special Purpose Vehicle (SPV). Feasibility study completion May 2024.		Programme, available budget.	Governance via Elective Surgical Hub Programme Board.

New Nursery

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Planning determination expected imminently to allow construction to commence: • Complete design & instruct main contractor – Feb 2024 • Start on site – Feb 2024 • Works complete – Nov 2024 • Operational – by Jan 2025		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.	TVE submitted to SPV for costing and programme.

Gender Development Services (GDS) – Estates Solution

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Furniture supplier selected. Children & Young People / staff engagement event 06.02.24 to comment on furniture colours, specifications and interior design options & proposals. Lease agreed and in place 23.01.24. LOI signed 01.02.24.		Programme, available budget. Supplier lead in times (eg: mechanical ventilation system).	Full design complete 09.02.24. Construction contract signing by 01.03.24. Equipment procurement. Construction works.

Alder Park – Refurbishment of Lyndhurst Building (former Dewi Jones Unit)

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Scope of works for Phase 1 approved at 01.02.24 Executive Director's meeting. This includes: • Eating Disorder Service (EDYS), a newly established service currently accessing facilities in Catkin building; and • Physiotherapy services currently provided at Burlington House, Crosby. Appoint construction contractor by 31.03.24. Construction completion Phase 1 anticipated December 2024.		Programme, available budget.	Final layout designs to be signed off by clinical/senior leadership team. Progress development of Phase 2 business case for Sefton CAMHS, currently based at Sefton Carers, Crosby. Develop wider site master planning.

6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 8 February 2024.

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	**Response to the Thirlwall Inquiry Terms of Reference – Updated 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

RESPONSE TO THE THIRLWALL INQUIRY TERMS OF REFERENCE – UPDATED ORGANISATIONAL GOVERNANCE ASSESSMENT

1. Purpose

The purpose of this paper is to provide the Board with a further update following the initial overview of the Trust's assessment of learning from the Lucy Letby case from a wider governance perspective. Since the focus has now moved to the upcoming Thirlwall Inquiry it is the intention to continue to mirror the terms of reference for that until such times as more information is released about the planned approach.

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. Further update

The summary below was designed in November 2023 to be a live discussion document for the Board rather than a definitive set of actions. We remain acutely conscious that the Inquiry's focus will shift as the proceedings progress and evidence is heard. Indeed, the Trust has already received a request from NHS England relating to the Neonatal ODN hosted by Alder Hey. We will continue 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.	Continue to monitor the number of second stage complaints as an indicator of the effectiveness of complaints management
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. Note: In terms of Experience theme, all areas are in scope of Experience Strategy work stream

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.	Remaining actions to be reported back to ARC re legacy issues. Process going forward assured.
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. Focus moving to measuring the right things, triangulation and disaggregation to deepen analysis and understanding
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.	Substantial assurance received from MIAA audit in December 2023. Recommendations to be followed up by FTSUG.
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.	Further discussions with regard to the development of a Just and Restorative Culture actively taking place
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.	Recent inquiry with regard to Neurology is a positive real-life example of constructive work with the regular to provide assurance
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	None at present

	of local review (all deaths); 80% cases discussed with coroner, the rest go to ME.	
Effectiveness of inter-professional relationships	This is service dependent; we recognise that there can be challenges for some teams at times and need to develop a range of support mechanisms and resources.	Work is underway to develop our safety culture as part of our People Plan and Safety Strategy
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.	Thematic review commissioned by Managing Director following recent case will look at leadership and cultural issues particularly out of hours
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. A revised People Practices report has been developed and submitted in the private board this month
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).	First post PSIRF implementation report at board this month – will be kept under review in terms of assurance levels to NEDs
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. Link to thematic review and accountability within Just and Restorative Culture
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
February 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	**Children and Young People's Gender Service (North): Programme Update**
Report of:	Lisa Cooper, SRO Gender Development Service (North) Dr Neelo Aslam, Clinical Lead Gender Development Service (North)
Paper Prepared by:	Emily Gardner, Programme Director Gender Development Service (North)

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Previous Trust Board papers (2023 & 2024)
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:	N/A

1. Purpose of report

The purpose of this report is to provide an update to Trust Board regarding progress with implementing the nationally commissioned Children and Young People's Gender Service (North) ahead of the planned service go live in Spring 2024.

2. Background

The current Gender Identity Development Service (GIDS) is commissioned by NHS England and provided by Tavistock and Portman NHS Foundation Trust, for children and young people who experience difficulties in the development of their gender identity. In 2020, NHS England commissioned Dr Hilary Cass to review gender identity services for children and young people, because of several factors including significant increased demand; long waiting times and lack of evidence to support clinical decision making.

In July 2022, in a letter to NHS England, Dr Cass recommended that the new regional centres for the re-named Gender Development Service (GDS) are led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services. Alder Hey Children's NHS FT and Royal Manchester Children's Hospital (MFT) have developed the GDS North Hub. Great Ormond Street Hospital for Children NHS FT (GOSH), Evelina London Children's Hospital (GSST) and South London and Maudsley NHS FT have formed the South Hub. Both Hubs are jointly known as the Phase 1 Providers.

Following a public consultation, the updated interim service specification has been released, along with the public consultation report. The final service specification is due to be released following the publication of the final report from the Cass Review, which is expected by the end of 2023.

3. Summary of progress

The programme is now within the implementation phase, with particular focus on critical requirements to enable a go live on 01 April 2024. Whilst the programme still operates with a substantial level of risk, there has and continues to be rapid development and significant progress made in all areas associated with the programme.

This paper provides an update on key areas of the programme:

- Estates
- Workforce and Recruitment
- Open Case Load
- Finance and Contracting
- Regulation

4. Estates

A 5-year lease is now in place for premises in Warrington, work will commence in February 2024 to create 13 clinical spaces. Sufficient clinical space is planned to be ready for the service opening in April 2024, with all work expected to be completed by July 2024. Interior design is also underway, and a session for children and young people to input into the selection of furniture is planned.

5. Workforce and Recruitment

The first wave of recruitment for the service has been completed, with a positive response particularly from internal staff. Senior clinical resource projected to be in place for April 2024 will be 5.4wte with a potential workforce establishment of 18.6wte by May 2024, including non-clinical staff. This cohort of staff will be sufficient to provide a safe transfer from the current service and ongoing risk management.

Whilst initial recruitment has been positive, sufficient clinical workforce continues to be a risk to service delivery. To achieve the full staffing complement, roles will continue to be readvertised and promoted through appropriate channels. The programme will also continue to review traction of recruitment campaigns including consideration of a range of potential incentives that could be utilised, in line with Alder Hey Trust policies.

Children and young people have been involved in recruitment processes for all senior leadership and clinical posts within the service.

6. Open Case Load

The capacity of the future service to support a cohort of the current open case load has remained a significant challenge for the programme. NHS England have confirmed that the priority for the service will be the children and young people on the current open caseload, who are not open to NHS endocrine services, rather than taking referrals from the national waiting list. The North programme has agreed a process with the current provider and NHS England to ensure the safe transfer of children and young people. Clinicians will triage children and young people who transfer to the service commencing from mid-February 2024, before the Trust assumes clinical responsibility from 01 April 2024.

The number of children and young people who will transfer to the new service may vary, as there will be an opportunity to ‘opt out’ of the transfer from the current service. The figure is currently 136 children and young people who will transfer. The service will not be able to receive referrals from the national waiting list until there is clear assurance that children and young people who have transferred are safely looked after, the timescale for this is currently unknown.

7. Finance and Contracting

To support programme costs and mobilisation of the service, the Trust has received £1 million to date and an additional £2.167m will be paid by local NHS England Northwest Specialist commissioning team in February 2024. Expenditure against this budget remains on track, with a small underspend in some areas. The programme has also received confirmation that the business case for £3.28m capital funding has been agreed, this represents an increased figure from the final mobilisation plan following further review on renovation works. Expenditure for this budget also remains on track.

Whilst the contractual framework is not yet fully agreed, this has been escalated to NHS England to ensure there is a shared ambition to have a contract in place ahead of service go live and reflects the operational reality of the service. The North programme has worked with Hill Dickinson to develop a detailed letter to NHS England to ensure maximum protection for the Trust.

8. Regulation

NHS England have assured the North programme that they are in consultation with the CQC regarding the transfer of the service. An update to Trust Board will be provided in due course regarding this. In addition, the Trust are liaising with the local CQC office regarding the new service and applicable registration processes.

9. Recommendations

It is recommended that Trust Board note the programme continues to progress at pace and remains on track for implementation of the nationally commissioned specialist, tertiary Gender Service for children and young people. Implementation is in line with the national interim service specification, the programme will continue to mitigate noted risks and challenges.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	Learning from Patient Safety Incidents 1st-31st January 2024
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	All NHS Trusts were contractually required to transition to the Patient Safety Incident Response Framework (PSIRF) prior to end of Q4 2023-24. PSIRF replaces the current Serious Incident Framework, and the Trust transitioned on the 1st of January 2024. The purpose of this report is to provide the Trust Board with a summary of activity following the transition to PSIRF and next steps, noting that this is the first report to Trust Board under the new framework and feedback is welcomed.
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	☐	**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

		applied and effective in practice				

1. Purpose

The purpose of this paper is to provide the Trust Board with a summary of activity following the transition to Patient Safety Incident Response Framework (PSIRF), including oversight of those incidents that have been reviewed in line with the Trusts and Patient Safety Incident Response Plan (PSRIP), highlighting any identified areas of learning and improvement for the reporting timeframe 1st – 31st January 2024 and next steps.

For the purposes of completeness any legacy Serious Incidents (SIs) completed and reported externally to commissioners in 2023 will be presented for learning.

2. Background

On 1st January 2024, the Trust transitioned from the National Serious Incident Framework (SI) (NHS England 2015) to PSIRF in line with national requirements.

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm.

The Patient Safety Incident Response Plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 months to January 2025. The plan is flexible and can be changed to consider specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

The Patient Safety Incident Response Policy sets out how the Trust will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

Both documents received Integrated Care Board (ICB) approval prior to transition. The Trust has ensured that the policy and plan meet the required standards outlined by NHS England and both have been published on the Trust's external website.

3. Local context

Informed by national and local patient safety priorities, our patient safety profile and those patient safety incidents that identify the most potential for learning and improvement, PSIRF replaces the methodology of root cause analysis with a systems-based patient safety incident investigation (PSII) approach or more locally a Patient Safety Response (PSR).

In line with our approved PSIRF governance process all incidents reported as moderate physical harm or above, plus any patient safety incident where it is felt that the opportunity for learning and improvement is significant, are presented and reviewed at the weekly Patient Safety Incident Response Investigation (PSIRI) Panel to determine the appropriate learning

response if required (PSII or PSR) plus any associated system wide learning or areas for improvement.

3.1 Patient Safety Incidents.

Table 1 below notes the number of patient safety incidents reviewed at PSIRI panel throughout January 2024. Table 2 notes the number of patient safety incidents presented and reviewed by division.

Table 1

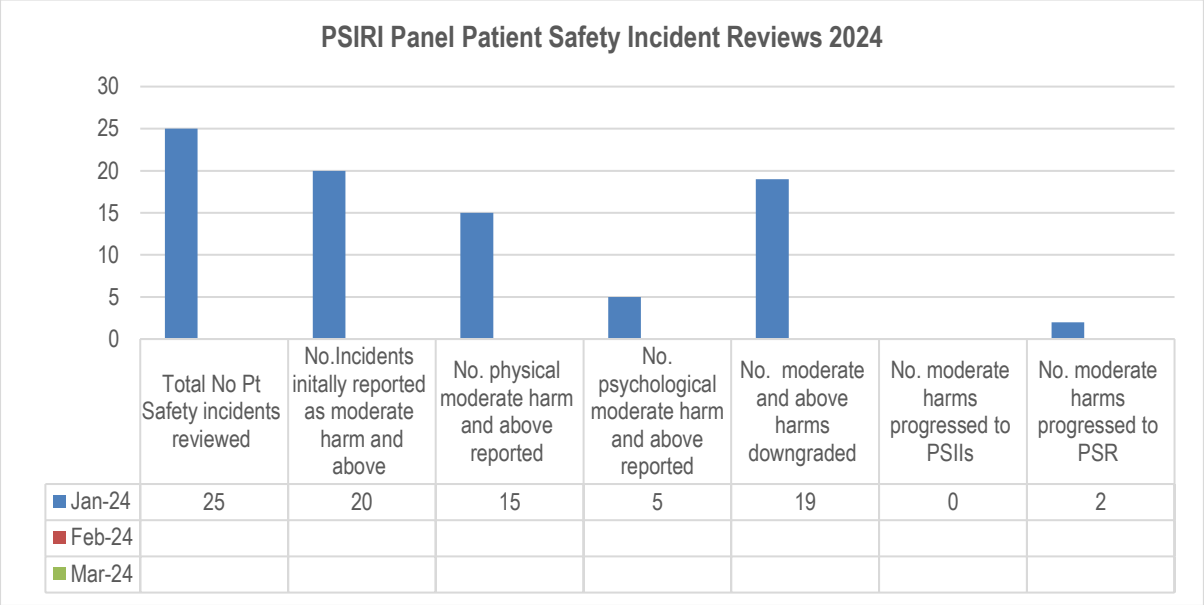
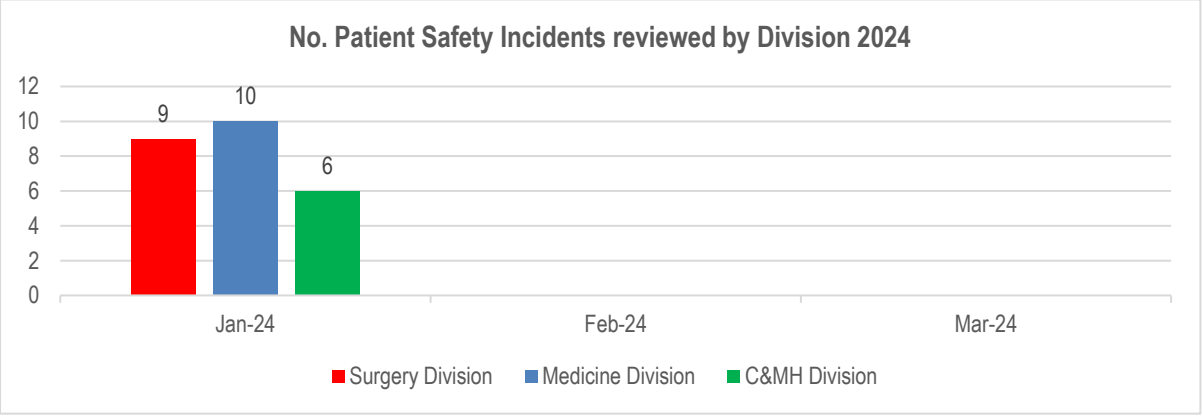


Table 2



A total of 25 incidents were reviewed at the weekly PSIRI panel during the reporting period 1st -31st January 2024, of which 20 incidents had been initially reported as either moderate and above physical or psychological harm. The remaining 5 had been presented by divisional leads for discussion or potential learning purposes.

Following discussion and review of the reported moderate or above harm incidents presented a collective decision was made by PSIRI panel and divisional leads to downgrade the initial reported moderate harm levels for 19 incidents based on incident findings, alignment to any

current Brilliant Basics quality improvement workstreams or patient safety improvement programmes and use of the NHS England harm grading table (Appendix 1).

3.2 Patient Safety Incident Investigations (PSIIs)

A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Line with the new PSIRF framework, Alder Hey's Trust Board are accountable for the approval and closure of all Patient Safety Incident Investigations (PSIIs).

To date, the Trust has not commissioned a PSII in relation to the local priorities outlined in the PSIRF plan.

3.3 Patient Safety Responses (PSRs)

2 PSRs were commissioned in January 24 to investigate the reported incidents as outlined below:

- #6771 moderate physical harm -*Gastro clinic review due to take place end of October but delayed by 4 months due to backlog of follow up appointments*) had not been reviewed by the clinical team and a PSR in the form of an SBAR (Situation Background Assessment Recommendation) was requested by the PSIRI panel to be completed and presented for reviewed at the next panel.

- # 7127 moderate physical harm - *Young person discharged from mental health inpatient unit out of area and transferred to Liverpool with no handover/contact from her local services)* occurred whilst the patient was under the care of another Trust. This incident was sent to the referring Trust for investigation and wider shared learning. Whilst an inpatient at Alderhey this incident was linked to a cluster of incidents involving the same young person. The PSIRI panel requested that a debrief needs to take place with the relevant CAMHS and ED teams to identify any issues and learning.

4. Duty of Candour

PSIRF does not change the duty to be open and transparent and the statutory duty of candour requirements Trusts are required to follow under Regulation 20(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 remain the same.

Zero Duty of Candour responses were required during the reporting period.

5. Learning from patient safety incidents

5.1 System learning

The PSIRI panel identified 3 incidents presented that would benefit from further system wide review to inform system wide learning or quality improvement as outlined below in table 2.

Table 2

Brief incident description	PSIRI Panel findings /Learning	PSIRI Panel Recommendations
No. 6552. Community death of 16yr SUDIC process not correctly followed.	Confusion over pathways in and out of hours for body to be taken to mortuary or AED. Previous incidents reported Summer 2023 regarding mortuary and lack of following SUDIC process which resulted in QI programme with Brilliant Basics	SBAR Rapid review to feed into the system wide review via Liverpool CDOP group. Revisit the Brilliant Basics Quality Improvement work undertaken re mortuary pathway in Summer 23
Nos 6786/6830. Self-harm assessment undertaken in AED. Historical risk taking behavior identified but not identify on the pre-admission risk assessment. Ward was not aware of risks. When attempting discharge patient had access to batteries and ingested them to prevent discharge.	Cluster of incidents noted at weekly Patient Safety Meeting relating to self-harm. Reminder to crisis care staff about the importance of capturing all relevant information on the risk assessment document even if it is already recorded in the clinical notes.	SBAR Rapid review completed. Improvements to the recording of risk assessments in electronic notes to be explored with digital leads. Self-harm risk assessments and associated staff training to be reviewed as part of the established community & mental health division suicide prevention group.
No. 6471 Patient brought back to the ward post cath lab and deteriorated - crash call put out. Patient resuscitated and transferred to ITU.	Cluster of incidents noted at weekly Patient Safety Meeting relating to deteriorating patient and recovery.	Incident to feed into established surgical division looking into pathways for recovery to ward discharges.

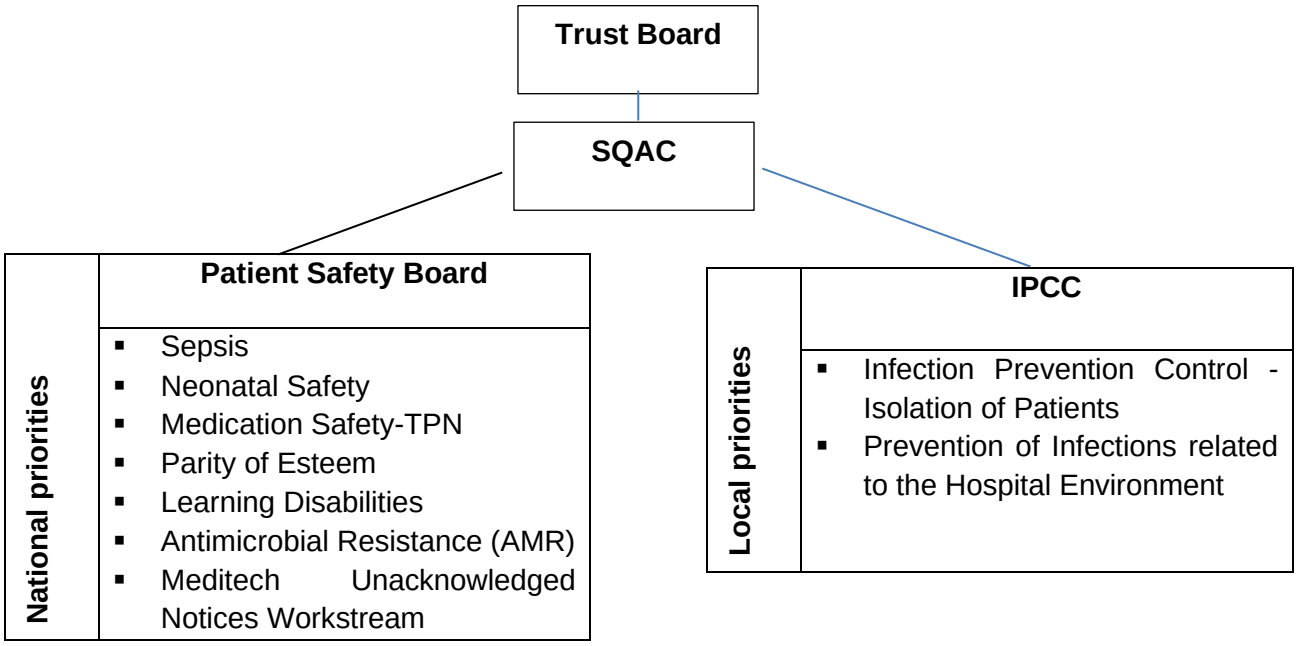
5.2 Quality Improvement (QI)

Our local patient safety profile outlines several existing patient safety quality improvement programmes and workstreams which are delivered using our Brilliant Basics Quality Improvement (QI) methodology and aligned to either national, local, or divisional priorities (Figure1).

Several workstreams report directly to Safety Quality and Assurance Committee (SQAC) via Patient Safety Board or Infection Prevention and Control Committee (IPCC), with others reporting directly through divisional governance structures.

In line with the Trusts PSIRP any reported patient safety incidents aligned to any of the patient safety improvement programmes outlined in figure 1 will not be reviewed separately but reviewed as part of the existing QI workstreams.

Figure 1



Divisional Reporting			
Surgery	**Medicine**	**Community & Mental Health**	**Corporate**
▪ Safer Theatres at Alder Hey (STAT) Programme ▪ Mini-STAT (Junior Doctor Induction)	▪ ED at its Best ▪ Safety Huddles in ED ▪ Urgent Treatment Centre (UTC) ▪ Hospital Optimisation Acute Medical Pathways	▪ Advancing Outpatients Care	▪ Zero Tolerance ▪ SUDIC process

6. Training and Education

6.1 Patient Safety E-Learning

The table below demonstrates the Trust compliance against two mandatory patient safety e-learning modules, introduced to support PSIRF.

E-Learning Modules	%Compliance
Level 1a Essentials for Patient Safety (All staff)	**97%**

Level 1b: Essentials of patient safety for boards and senior leadership teams	**100%**

Several staff members have completed the Health Services Safety Investigation Body (HSSIB) Level 2 – Systems approach to learning from patient safety incidents training prior to transition. Full details will be available from March 2024.

6.2 Engagement Sessions and Support

In December 23 three live Q&A sessions were broadcast to all staff in preparation for transition to PSIRF. Several engagement sessions have been held with different staff groups following transition with further sessions planned. Support will be provided to clinical and non-clinical staff to complete individual learning responses.

Attendance and discussion at a range of children and young person's forum events has also taken place.

A Patient Safety SharePoint site has also been developed and accessible to all staff.

7 Legacy Serious Incidents (SIs)

All legacy SI investigations have now concluded findings of which will be presented at SQAC. Please refer to appendices 2-4 for full details.

8 Next Steps

There is further work required as the Trust continues to navigate the new framework. As we move into adopting this new way of managing our patient safety incidents and learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to.

Areas of focus include the following:

- **Training and Education:** Training for staff on how to undertake thematic reviews and complete an SBAR review is being planned to mitigate cross division/team variability. Further training with all staff on the use of the harm guidance for clinical incident reporting is also planned.

- **Learning Response Templates:** A review of the learning response templates will be undertaken to ensure they are fit for purpose and provide the correct level of assurance.

- **Review of Divisional incident review meetings:** The Terms of Reference for these groups require a review to ensure that their duties reflect the new framework and incidents reviewed in a timely manner.

9 Recommendations

The Trust Board is asked to note the activity that has been undertaken following the Trusts transition to PSIRF and level of assurance provided in this first Learning from Patient Safety Incidents report under the new PSIRF framework.

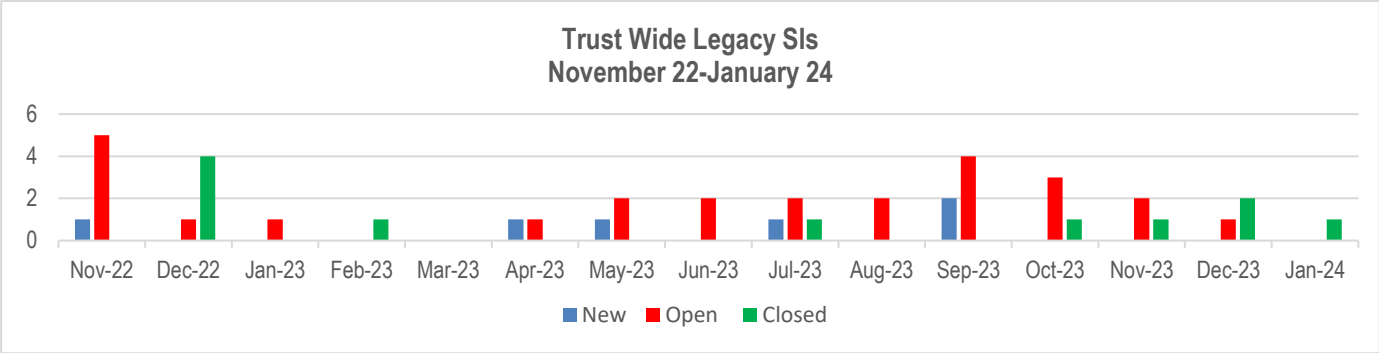
Appendix 1 Harm Grading Guidance for Clinical Incident Reporting

Harm Level	Physical Harm Sustained by the Patient	Psychological Harm Sustained by the Patient
	Your answer should be based on the information you have at this point and can be changed if further information becomes available.	Distress is inherent in being involved in any patient safety incident, but please select 'no harm' if you are not aware of any specific psychological harm over and above this. Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.
No Harm	The patient has sustained no physical harm as a result of this event.	Being involved in any incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.
Low Harm	Low physical harm is when ***all of the following*** apply: • minimal harm occurred - patient(s) required extra observation or minor treatment. • did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit. • did not or is unlikely to need further treatment beyond simple dressing changes or short courses of oral medication. • did not or is unlikely to affect that patient's independence. • did not or is unlikely to affect the success of treatment for existing health conditions	Low psychological harm is when ***at least one*** of the following apply: • distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit. • distress that did not or is unlikely to affect the patient's normal activities for more than a few days • distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition
Moderate Harm	Moderate harm is when ***at least one*** of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond simple dressing changes or short courses of medication, but less than 2 weeks	Moderate psychological harm is when ***at least one*** of the following apply: • distress that did or is likely to need a course of treatment or therapy sessions that extends for less than six months

	additional inpatient care and/or less than 6 months of further treatment, and did not need immediate lifesaving intervention • has limited or is likely to limit the patient's independence, but for less than 6 months. • has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm	• distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months
Severe Harm	Severe harm is when ***at least one*** of the following apply: • permanent harm / permanent alteration of the physiology • needed immediate live-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment • has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions. • has limited or is likely to limit the patient's independence for 6 months or more	Severe psychological harm is when ***at least one*** of the following apply: • distress that did or is likely to need a course of treatment that continues for more than six months • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months
Fatal* ***Previously documented as 'Death' in NRLS**	You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.	

Appendix 2 Legacy Serious Incidents (SIs)

Graph 1 Trust-wide StEIS reported SI legacy status January 2024



Legacy SI reports

1 legacy SI investigation was completed and submitted to commissioners during the reporting period (1st – 31st January 2024). *(2023/18692: Death of a patient on PICU 02/10/2023 – Elective craniofacial surgery 29/09/2023. Cardiac arrest on ward 4A post-operatively secondary to tension pneumothorax, transferred to PICU)*

1 legacy SI investigation RCA was presented and discussed with commissioners on 3 January 2024 and has now concluded. *(2023/12980: Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection)*

Immediate lessons learnt are outlined where applicable in appendix 3.

Legacy SI action plans: During the reporting period (1st-31st January 2024) **4** SI action plans remain open and within their expected date of completion. Full details of the SI action plan position can be found at appendix 4.

Legacy internal Level 2 RCA investigations: There are no legacy internal L2 RCA investigations outstanding. In line with PSIRF, internal level 2 RCAs will no longer be undertaken. Any reported moderate physical or psychological harm or above incidents will now be reviewed at the weekly PSIRI panel to determine the actual harm level and relevant learning response if applicable.

Appendix 3

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
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. **January 2024**: RCA presented at North Mersey SI panel -03/01/2024. Incident closed on StEIS 03/01/24 with an action plan completion by 31/01/24.
2023/ 18692 **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. 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. **January 2024:** RCA investigation completed sent to commissioners 18/1/24.Report shared with parents

Appendix 4

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
2022/10739	23/05/2023	31/05/2023	Medicine	Delayed diagnosis of bone malignancy	17 16 actions completed.	31/12/2023	29/02/2024 – Extension agreed to work with the ICS on the outstanding action. Trauma lead to attend ICS meeting planned February 2024.	1
2023/12980	02/07/2023	05/07/2023	Surgery	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	10 4 actions completed.	31/01/2024		0
2023/17791	15/09/2023	21/09/2023	Surgery	Never Event – Wrong implant / prosthesis used.	9 1 action completed.	01/05/2024		0
2023/18692	29/09/2023		Surgery	Death of a patient on PICU 02/10/2023 – Elective craniofacial surgery 29/09/2023. Cardiac arrest on ward 4A post-operatively, transferred to PICU. Cardiac arrest secondary to tension pneumothorax.	11 4 actions completed	29/02/2024		0

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	**Quarter 2 2023/24 Complaints, PALS and Compliments report**
Executive Lead:	Nathan Askew Chief Nurse
Paper prepared by:	Pauline Brown Director of Nursing

Purpose of paper:	The purpose of this paper is to provide Trust Board with an update and assurance on the performance against complaints and PALS targets in Q2 2023/24 and a thematic analysis of the top reasons for complaints and PALS
Summary and/or supporting information:	32 formal complaints received in Q2; this is consistent with preceding quarters. The main complaint theme continues to be in relation to treatment and procedure, and Access, Admission, Discharge and Transfer (ADT). This is consistent with the preceding quarters 84% compliance with the 3 working day acknowledgement standard was achieved in Q2; this is a downward performance and recommendations for improvement have been made 86% compliance with the 25 working day response time for formal complaints demonstrating the requirement for continued focus, action and commitment to ensure families receive a timely response to their concern 4 second stage complaints were received in Q2 No new referrals to the PHSO this quarter and no current investigations 478 informal PALS concerns raised in Q2; this is consistent with preceding quarters. The main themes relate to communication and waiting time for appointments 82% compliance with the 5 working day response time for PALS concerns demonstrating the requirement for continued focus, action and commitment to ensure families receive a timely response to their concern This report is correct based on the data available at the time of reporting
Financial Implications	None
Key Risks Associated	Reputational risk associated with not meeting the quality priorities and the Trust targets.

Quality Implications	Poor patient experience due to not meeting the required time frame for response and resolution and not having staff appropriately trained to locally resolve issues in their ward / department / service
Link To: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Delivery of outstanding care** **The best people doing their best work** Sustainability through external partnerships Game-changing research and innovation Strong Foundations
Resource Impact:	Yes
Action/Decision Required:	Trust Board are asked to note and approve the content of this report

1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our service users expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate, and compassionate response. Compliments, concerns, and complaints are an important measure of the quality of care we deliver and are used to learn and further improve our services.

The aim of the report is to provide assurance that the Trust is responding to the concerns raised by children, young people, and their families in line with Trust procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO); identifying and analysing themes that the Trust needs to address to make service improvements; and to highlight action taken.

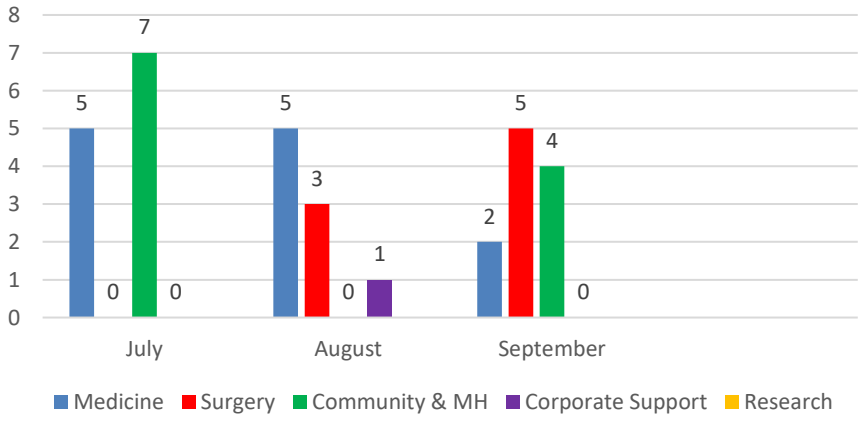
This report provides an overview of formal complaints and informal PALS concerns received and completed between July to September 20232 (Q2). This report is correct based on the data available at the time of reporting

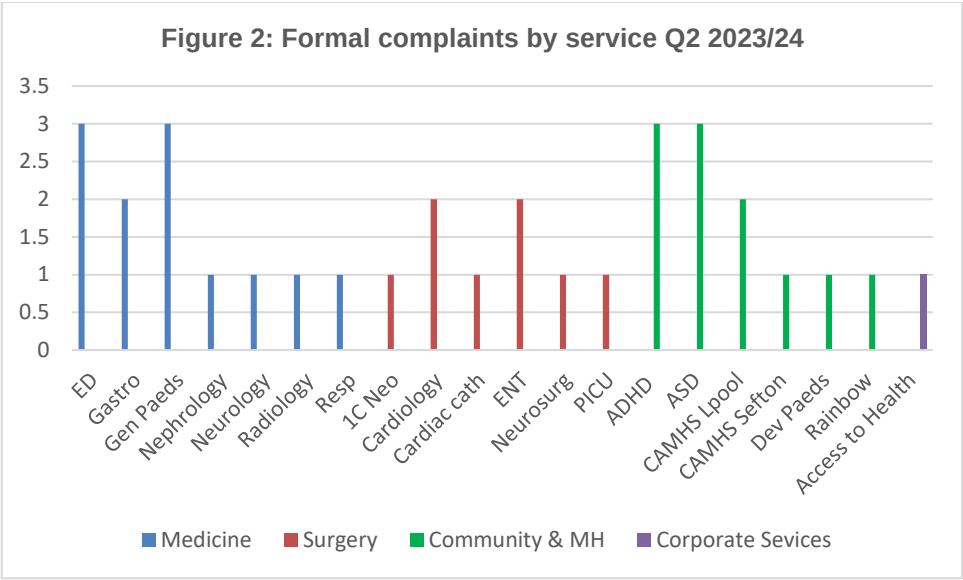
2. Formal Complaints

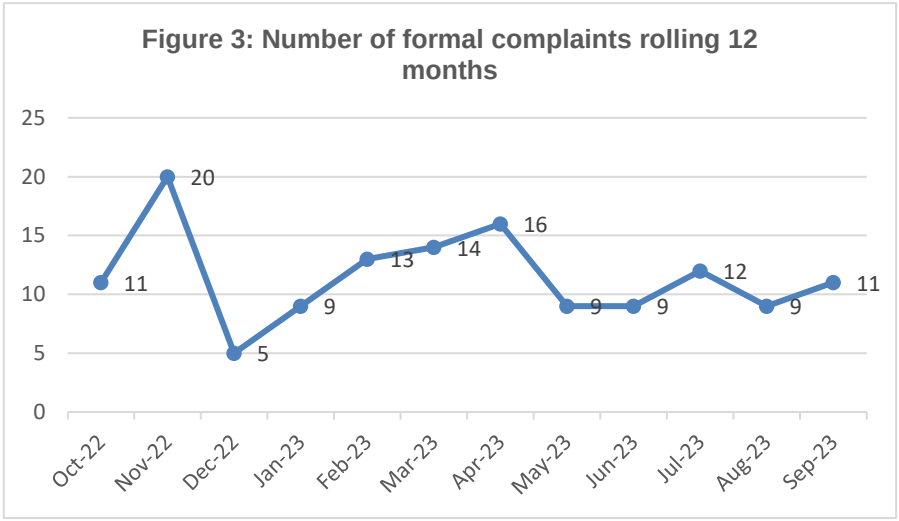
2.1 Number of formal complaints received Q2 2023/24

32 formal complaints were received in Q2; consistent with 35 in the previous quarter (Q1 2023/24). Figure 1 shows the breakdown of complaints received by Divisions in Q2; Figure 2 shows by Divisional services, and Figure 3 shows the complaints received by month (does not include withdrawn complaints) over a rolling 12 month period.

Figure 1: Number of formal complaints by Division in Q2 2023/24





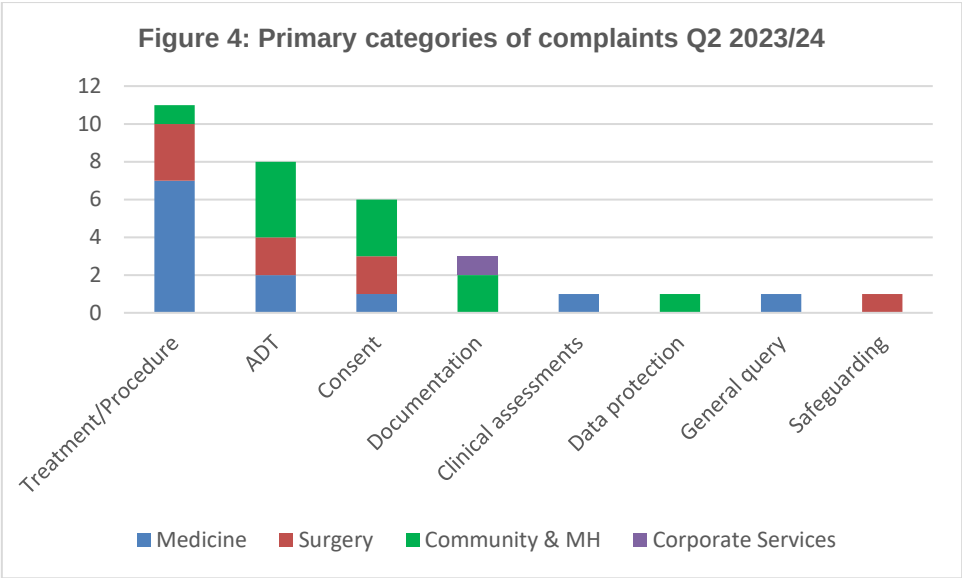


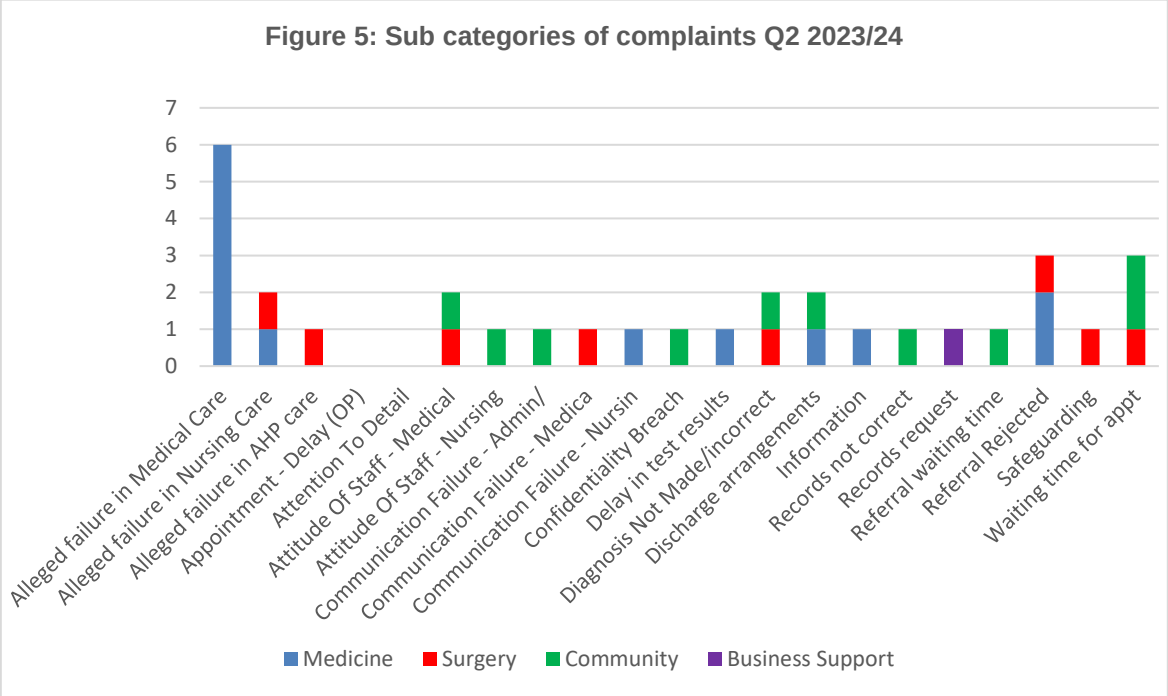
The trend over time is variable but demonstrates a reducing number of formal complaints.

2.2 Complaints received by category Q2 2023/24

The main theme (primary category) in this quarter continues to be in relation to treatment and procedure and ADT (Access, Admission, Transfer, Discharge)

Figure 5 demonstrates the main theme within the treatment and procedure category is in relation to alleged failure in medical care accounting for 6 of 11 complaints in this category (54%); this sub category is a continued theme in the last year.



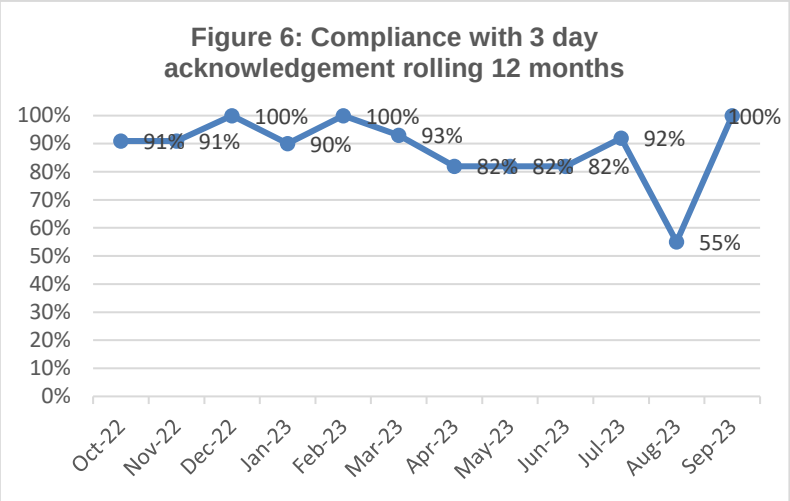


2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 Compliance with 3-day acknowledgement Q3 2023/24

In Q2, 84% (27 of 32) of the formal complaints received were acknowledged within 3 working days, with 10 being acknowledged on the same day. Of the 5 complaints which were not acknowledged within 3 working days: 3 were due to administrative errors and were acknowledged between 3-7 days; and 2 were due to complaints being received in other departments and not forwarded in a timely manner to the Complaints Officers; 1 was acknowledged at 14 days and 1 was significantly delayed and only acknowledged after 62 days. These delays have identified a gap in the process where complaints are received by other departments; this gap will be addressed through communication to teams disseminated through Divisional governance structures, and a review of the policy to ensure it is clear how

what action to take in the event of receiving a formal complaint. The process for cross covering annual leave will also be reiterated through Divisional governance structures. Figure 6 shows performance with this KPI over a rolling 12 months and demonstrates a downward turn. It should be noted that the months for Q1 are all reported as 82%; this is the mean percentage compliance over the quarter and monthly compliance will be shown in the next report



2.3.2 Complaints responded to and closed in Q3 2023/24

A total of 21 complaints were responded to and closed in Q2 (not inclusive of complaints closed due to withdrawn) of which 14 were received during Q2 and 7 were received in Q1. An additional one complaint was closed as withdrawn (Surgery)

2.3.3 Compliance with 25-day response

Of the 21 complaints responded to in Q2, 18 (86%) were responded to within 25-days as demonstrated in Figure 7. Medicine Division achieved 90% compliance (9 of 10); Surgery Division achieved 100% compliance (2 of 2); and Community and Mental Health Division achieved 77% compliance (7 of 9). Of the 8 complaints that remain open and under investigation at 1st October 2023 (all received within Q2), 4 were within the 25 day timeframe and 9 were overdue

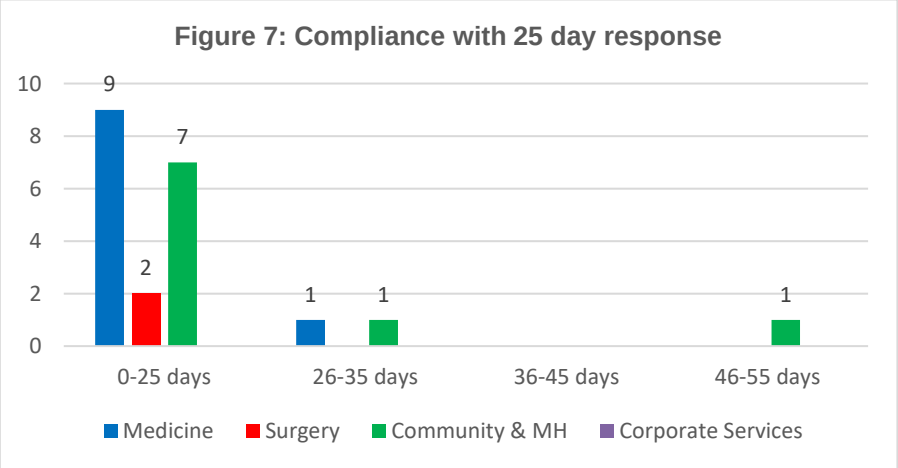
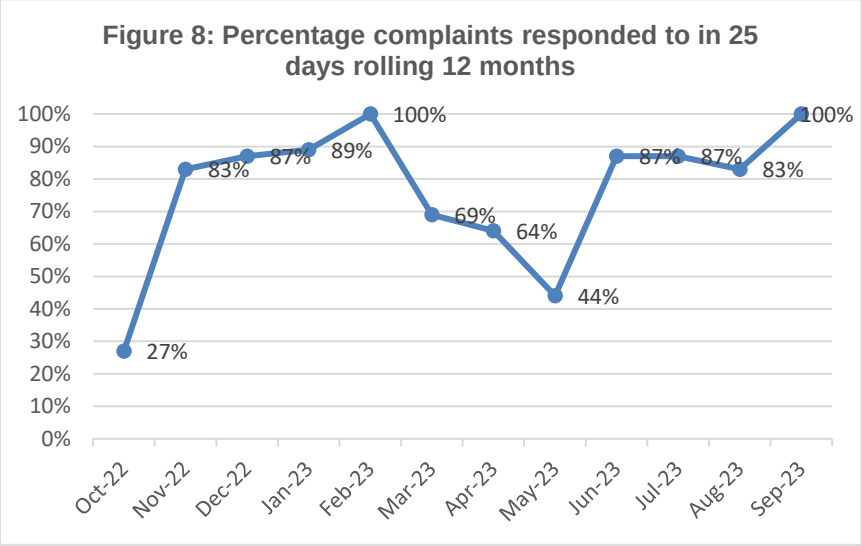


Figure 8 shows the compliance by month which depicts a fluctuating performance but improved performance in Q2 in comparison to Q1. Improving the time to respond to families in a timely manner is a continued Trust and Divisional priority.



2.3.4 Number of open and closed formal complaints by month

Table 1 shows the monthly numbers of complaints received and status of complaints being investigated. Data quality issues may have affected some of the data contained which will be reviewed and updated in the Q3 report. Complaints that are received in a month may not be responded to until the next month in line with the 25-day response timeframe.

Table 2: Formal Complaints received 2023/24													Cumulative to date
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Received (includes withdrawn)	14	11	9	12	9	11							**66**
Withdrawn and closed		4			1								**5**
New complaints (adjusted from withdrawn)	14	7	9	12	8	11							**61**
Open (first stage)		1	1	17		13							
Investigated, responded to and closed		6	8	8	11	2							**35**
Re-opened (Second stage)		1	3		1	2							**7**

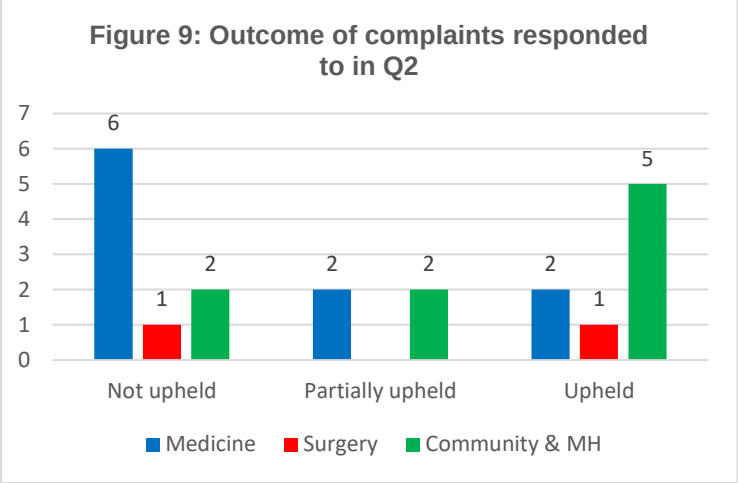
2.3.5 National complaint reporting: Review of the frequency of the KO41a secondary care complaints collection and publication

Submission of data compliant with the NHS Digital deadlines.

2.4 Outcome of the complaint

2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse or deputy. In Q2 9 (43%) of complaints were not upheld; 4 (19%) were partially upheld, and 8 (38%) were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether the majority of concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figure 9 shows the outcome of complaints closed in Q2 by Division



2.4.2 Second stage complaints

Second stage complaints are a rich source of valuable data and a key indicator of our performance. They can be triangulated to inform the Trust of how satisfied our families are with the quality of our response, and as an early indicator of families who may seek further resolution through the Parliamentary & Health Service Ombudsman. Second stage complaints are monitored on a monthly basis as a key performance indicator.

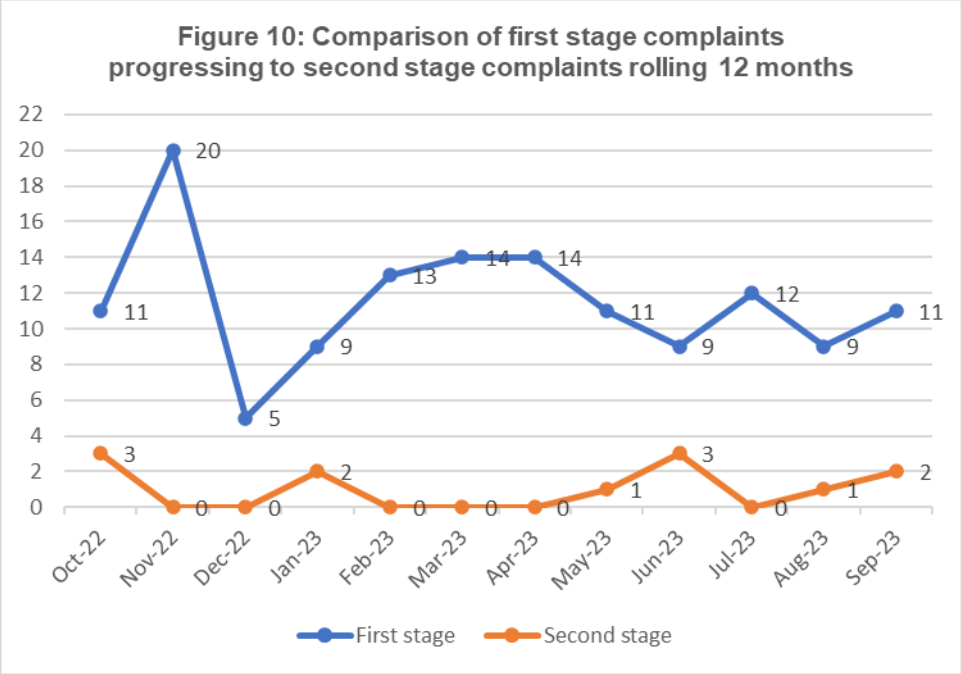
The initial response letter advises the complainant that, should they be dissatisfied with any part of the initial complaint response, or require further assistance, they should contact the Trust within 25 working days in order that the Trust can try to resolve any outstanding concerns.

In Q2, 4 families informed us that they were not satisfied with the outcome of their initial complaint response; one relates to Medicine and two to Community and Mental Health.

Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response. 1 was acknowledged within 3 working days (Medicine) and 2 were acknowledged at 4 working days (Community and Mental

Health). One was closed within 25 working days (Community and Mental Health) and 2 were closed at 34 and 38 days

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by Quarter however year to date in 2023/24, 10% of complaint responses have resulted in a second stage complaint (7 of 66 responses). Figure 12 shows the comparison of monthly initial complaints and monthly second stage complaints received for a rolling 12 months



2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There have been no new referrals to the PHSO this quarter and there are no other open PHSO investigations.

2.6 Actions and learning from complaints

It is essential that where things go wrong the Trust takes action to remedy any issues. Complaint response letters inform the individual complainant what action has or will be taken, and the Division monitor the actions through to completion. A clear breakdown of all actions is included in the response letter to the complainant.

Formal complaints are reviewed at the monthly Divisional Integrated Governance meetings to ensure senior divisional oversight of the current trends, to enable learning, to enable identification of specific areas of concern and any strategic actions, and ensure actions are fully disseminated, implemented and reviewed.

Examples of improvements made to services as a result of concerns raised are:

Concern:	Clinical information sent out to the incorrect school provider and information relating to another child in a letter
Action:	Delete letter from patient's record
Lessons learned:	1. Care and attention is needed when dictating letters/reports to ensure the correct patient is identified and the content of the letter relates to that patient only 2. Ensure only one patient's record is open when dictating letters/reports to minimise the risk of incorporating a different patients' information into letters/reports in error.
Concern:	Lack of communication regarding appointments and treatment for daughter with Down's Syndrome
Action:	To arrange a meeting with services involved in young person's care to discuss how as a Trust we identify clinical services that may be required in addition to the child/young person receiving services for Down Syndrome.
Lessons learned:	1. To ensure communication is made/returned with the parent/carer at all times 2. When a PALS and Complaints Officer is on leave, to ensure the email out of office / answerphone message gives the generic complaints email address, in order that any queries can still be responded to.
Concern:	Issues with communication and information in letters
Action:	1. All clinicians will be reminded to ensure that letters are thoroughly proofread before being sent, to minimise the chance of naming errors. 2. All administrators will be asked to check whether clinicians are in work when taking messages, and to inform families when there may be a delay in responding.
Lessons learned:	All assessment letters should include a full report of significant life events that families have shared.

2.7 Healthwatch

No formal complaints raised via Healthwatch in Q2 however Healthwatch Sefton shared a report with the Trust on behalf of Sefton Carers in regards to the availability of some medication. The Trust formally responded and the issue has been discussed at the Patient Experience and Engagement meeting. Representatives from the Trust will be meeting with Sefton Carers to gain a deeper understanding of issues and identify any specific action for specific families required.

3. PALS informal concerns

3.1 Number of informal PALS concerns received Q2 2023/24

There were 478 informal concerns received during Q2 consistent with the preceding quarters. Figure 11 shows the total number by month, Figure 12 shows the breakdown by Division for a rolling 4 quarters and Figure 13 shows the Divisional services with the highest number of concerns raised

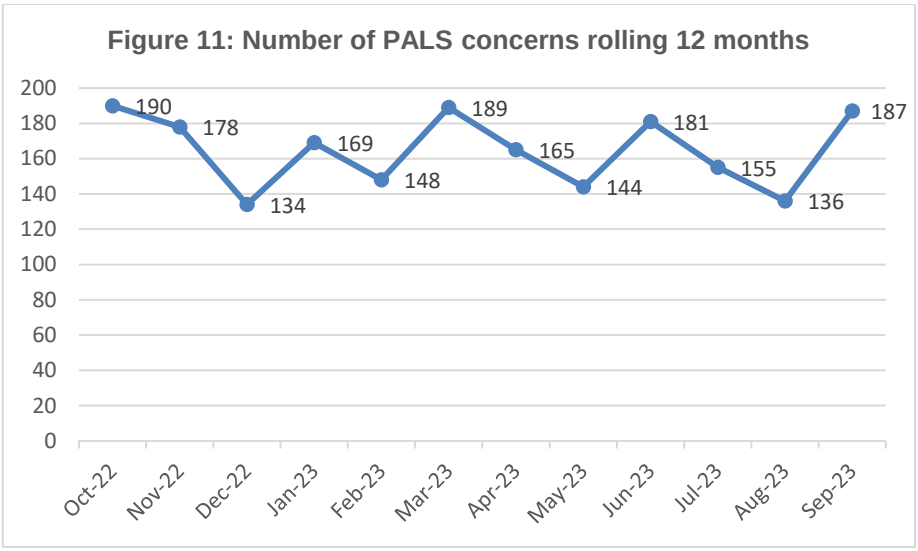


Figure 11: Number of PALS concerns rolling 12 months
200
180
160
140
120
100
80
60
40
20
0
190
178
134
169
148
189
165
144
181
155
136
187
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

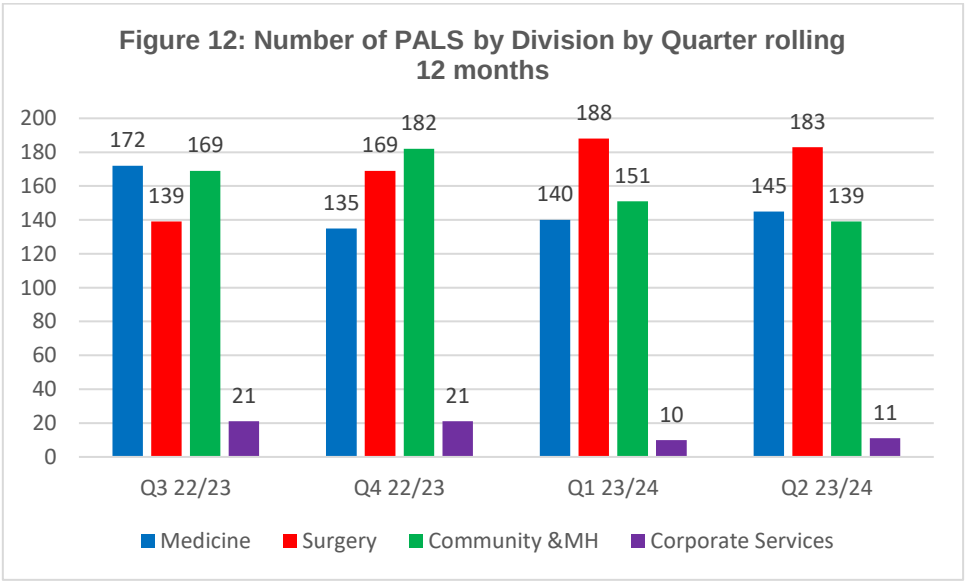


Figure 12: Number of PALS by Division by Quarter rolling 12 months
200
180
160
140
120
100
80
60
40
20
0
172
139
169
21
135
169
182
21
140
188
151
10
145
183
139
11
Q3 22/23
Q4 22/23
Q1 23/24
Q2 23/24
Medicine
Surgery
Community &MH
Corporate Services

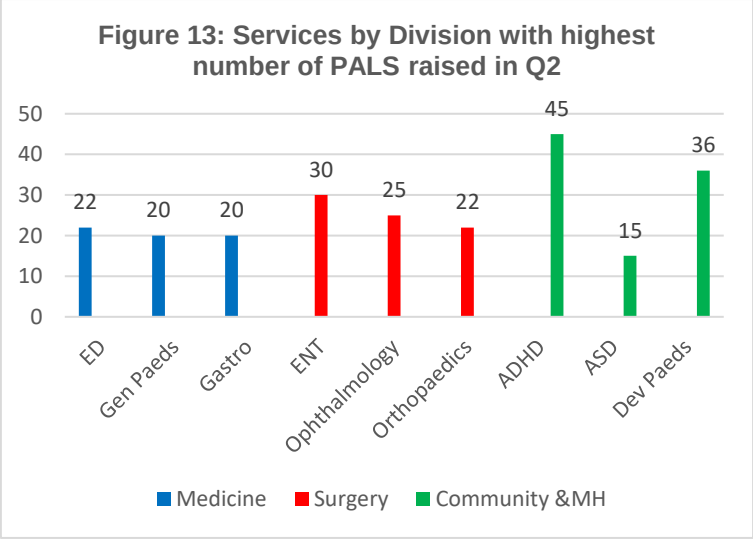
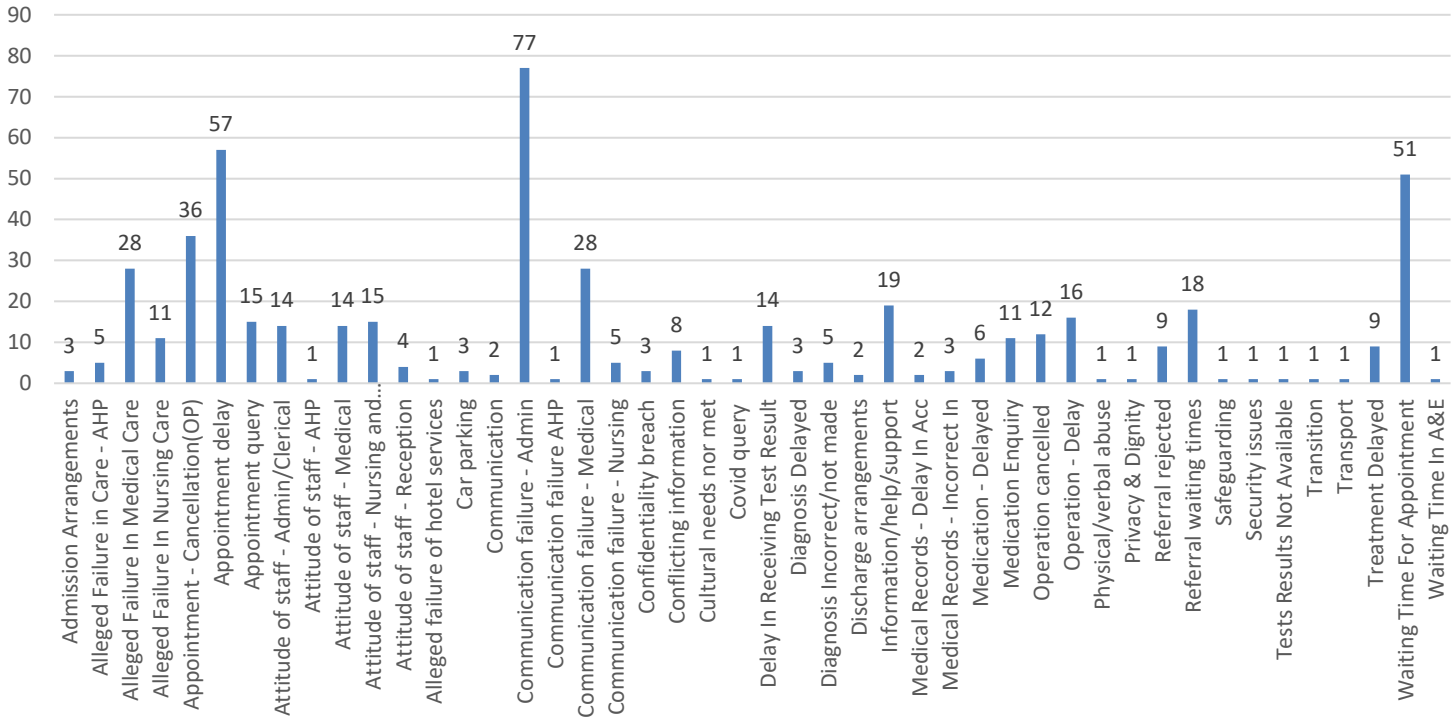


Figure 13: Services by Division with highest number of PALS raised in Q2
50
40
30
20
10
0
22
20
20
30
25
22
45
15
36
ED
Gen Paeds
Gastro
ENT
Ophthalmology
Orthopaedics
ADHD
ASD
Dev Paeds
Medicine
Surgery
Community &MH

3.2 Informal PALS concerns received by category Q2 2023/24

The main issues raised within Q2 continue to relate to communication, appointment waiting times and delays, and alleged failure in medical care as shown in Figure 14. This is consistent with the concerns that are raised as formal complaints and informal PALS concerns previously reported in the last 2 years.

Figure 14: Sub categories of PALS concerns in Q2



3.3 Trust performance against Key Performance Indicators (KPI): compliance with 5-day response

There has been downward turn in compliance with the 5 day response to PALS in Q2 based on the data available at the time of reporting. Figure 15 shows compliance between 69% to 82% (mean 71% for Q2). Please note that compliance is depicted as 85% for the months in Q1, as reported in the Q1 report, rather than the actual monthly compliance; this will be corrected in the graph in the Q3 report

Figures 16 to 19 show the monthly performance by the Divisions; Corporate Services percentages are affected by the small number of PALS concerns

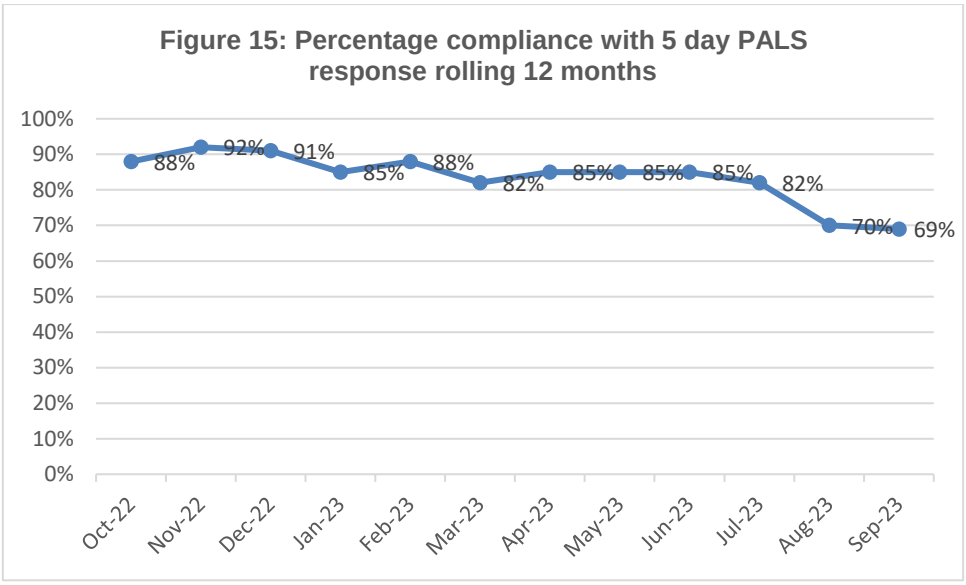


Figure 15: Percentage compliance with 5 day PALS response rolling 12 months
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
92%
91%
85%
88%
82%
85%
85%
85%
82%
70%
69%
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

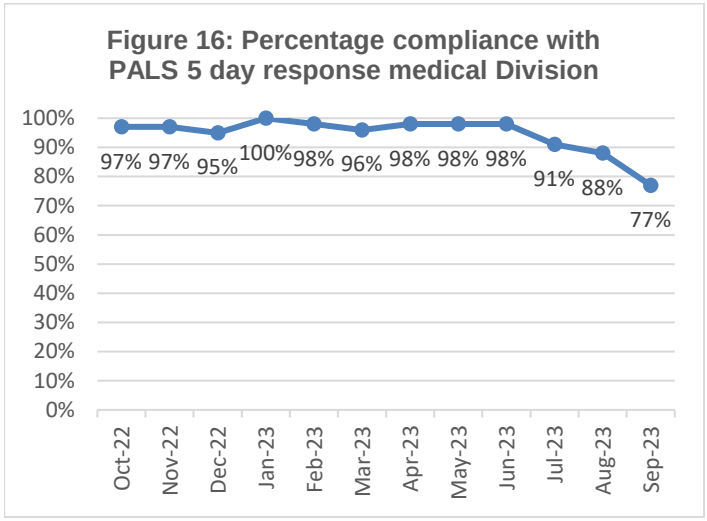


Figure 16: Percentage compliance with PALS 5 day response medical Division
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
97%
97%
95%
100%
98%
96%
98%
98%
98%
91%
88%
77%
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

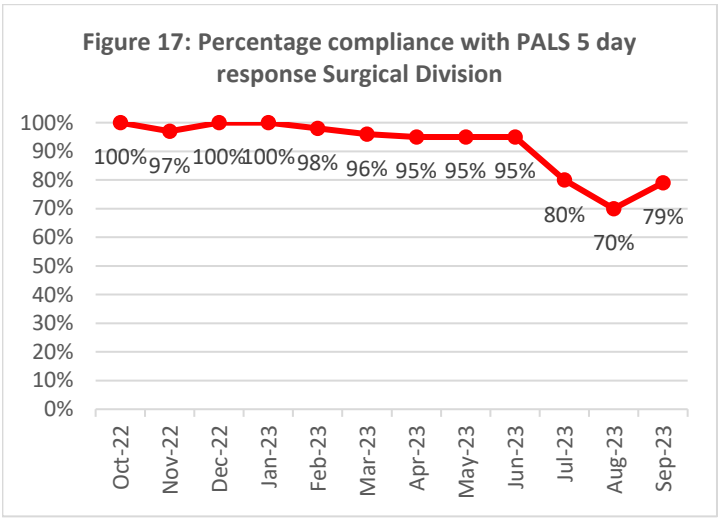


Figure 17: Percentage compliance with PALS 5 day response Surgical Division
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
97%
100%
100%
98%
96%
95%
95%
95%
80%
70%
79%
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

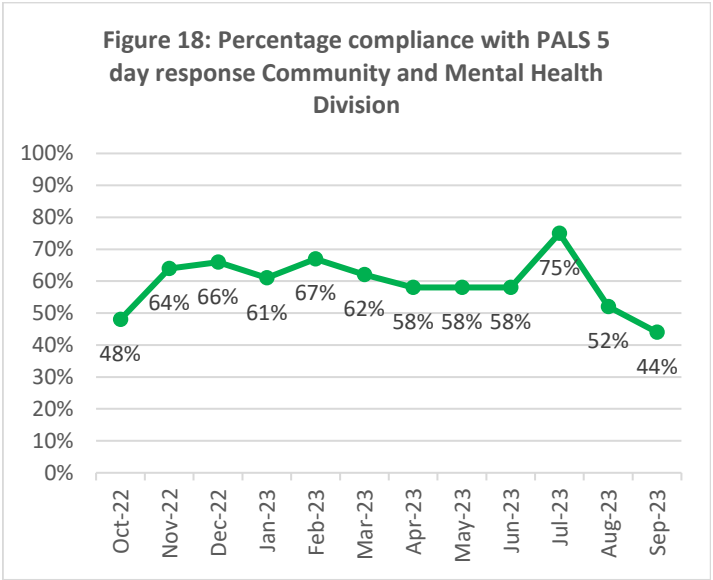


Figure 18: Percentage compliance with PALS 5 day response Community and Mental Health Division
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
48%
64%
66%
61%
67%
62%
58%
58%
58%
75%
52%
44%
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

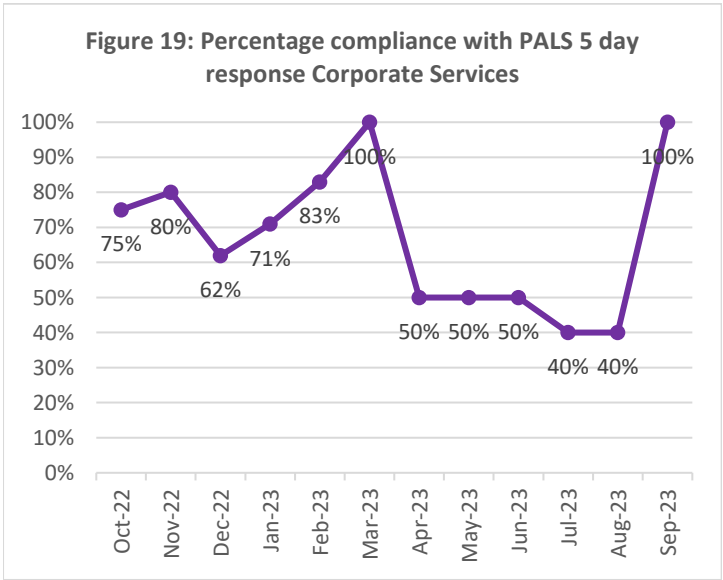


Figure 19: Percentage compliance with PALS 5 day response Corporate Services
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
80%
62%
71%
83%
100%
50%
50%
50%
40%
40%
100%
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

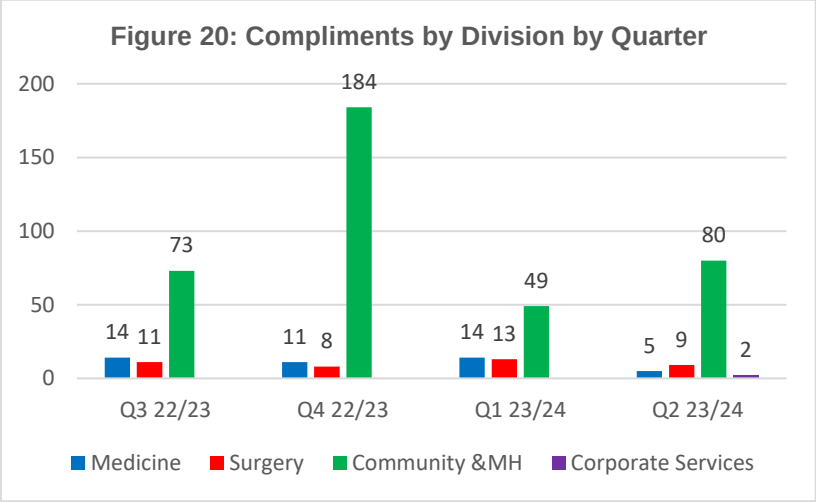
Divisions are asked to review their data and strive to resolve concerns within 5 working days from day of receipt of a concern; it is noted that many issues are resolved on the 6th working day

4. Compliments in Q3

Compliments are an equally important measure of the quality of care, treatment and service the Trust delivers, providing powerful, impactful and valuable feedback, and demonstrating that a child, young person or their family feel compelled to voice and share this with us by taking precious time to share what has been good about their experience and the impact that care and treatment has had on their lives. This feedback also provides important balance with concerns raised.

There is currently limited information recorded in the central InPhase system regarding compliments although it must be noted that the Community Division continue to input the majority of compliments as shown in Figure 20 below. It is acknowledged that the Trust receives many more compliments which have not been centrally recorded and Divisions are encouraged to submit.

.



5. Recommendations

- Trust Board are asked to note the content of this report
- Work will continue within the Divisions to improve performance in all KPIs
- Divisions must provide appropriate cross cover arrangements for annual leave to ensure a timely acknowledgement to the complaint and enable prompt commencement of the compliant investigation
- All services must forward any complaint received to the Complaints Officers to ensure a timely acknowledgement to the complaint and enable prompt commencement of the compliant investigation
- Work must continue to improve the data quality in the Complaints and PALS InPhase dashboard to ensure correct reporting and end the need for manual data extraction and analysis

Appendix 1: Examples of compliments received

Community Speech & Language Therapy Service: Parent gave SALT (and other language resource staff) a thank you gift at the end of term at the Early Years Language Resource where the child has had speech therapy this term (the child has been on the therapist's caseload prior to this in clinic too). A thank you card was received that read: *"To my Bryony. Where do we begin? Thank you for all your hard work and dedication over the last year +. You have believed in me every step of the way and you make my learning journey extra special and fun. "World's best speech therapist"*

School Mental Health Support Team – Sefton: *Melissa has been a huge support to me at a really difficult time. I have built a fantastic relationship with her over the last few months. I feel like I have been listened to and guided in the right way and Melissa shared some amazing tools/ideas that I will carry with me forever. Melissa has made me feel so much more positive about the future and taught me so much. I cannot thank Melissa enough. A great service!! Melissa is an absolute credit to her profession and I will truly miss working with her.*

Community Physiotherapy & Occupational Therapy: *I am a teacher on summer hols sorting out my files and I came across your email address in relation to a child in my last class. I wanted to say that Ang is amazing and the fact that she was familiar to x from previous therapy blocks really helped x respond and feel safe and confident. She struggles to process information and follow instructions so having Ang again was a massive help as she knows how to speak with and to x. x was fond of her and I myself have worked with Ang a few times now and she is always an incredible therapist. I just wanted you to know how much x has benefited from her*

Integrated Children's Community Nursing Team: x is now transitioned to adult services. the parents sent a card from her whole family thanking CCNT from the bottom of their hearts for all the amazing work we all do. thank you for always giving x the best care.

CAMHS – Liverpool: *Since started his CAMHS sessions with his Case Manager [Employee], I have already observed a shift in [Patient's] overall approach and attitude to life. [Patient] is demonstrating strategies that he is learning in sessions and using these at home and, for the first time, is displaying calmness in challenging situations and a willingness to seek solutions. He is learning to compromise. He is also showing signs that he is learning how to communicate & interact effectively and appropriately with his younger sibling both when conflict arises, and indeed to avoid unnecessary conflict. Their relationship is strengthening. He has started college this week and is showing much more enthusiasm acceptance and tolerance in a learning environment. He is becoming excited about his future possibilities. [Patient] has been able to establish a good rapport with his [Employee] and looks forward to their time together in sessions. He recognises the value of the support he is being given and talks about his therapist and sessions at home. He also feels valued by [Employee] and is truly grateful for the ongoing support he is receiving - not only during sessions but between sessions. [Employee] has a bright positive, manner. He is non-judgmental, professional and has demonstrated great empathy for [Patient] and our family situation. Long may this therapeutic relationship continue. :)*

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	Organ Donation Annual Report, 2022/2023
Report of:	Clinical Lead Organ Donation
Paper Prepared by:	Dr. Carla Thomas

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
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 ☐

If "No", is a new risk required? 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		

Context

Organ and tissue donation saves and improves the lives of thousands of UK citizens every year. It can offer comfort to the families of donors through the knowledge that something remarkable came from their loss.

Following implementation of the Organ Donation Taskforce recommendations in 2008, UK deceased donation has risen and the transplant waiting list has fallen. However, although significant positive steps have been taken, there remains a mismatch between donation and transplantation. Furthermore, in children, deceased donation has not grown at the same rate and the same transplant benefits have not occurred.

National Strategic Plans

UK Paediatric and Neonatal Deceased Donation – A strategic plan [2019]

- Aim to significantly increase the rates of paediatric and neonatal deceased donation in the UK.
- Aim to normalise practice, minimise variation and promote excellence in care, ensuring that donation is considered a routine part of end-of-life care on PICU.

Organ Donation and Transplantation 2030: Meeting the Need – A ten-year vision for organ donation and transplantation in the UK [2020]

- Living and deceased donation will become an expected part of care, where clinically appropriate, for all in society.

Organ Donation at Alder Hey Children's Hospital

Every death on PICU is audited by NHS Blood and Transplant (NHSBT) to assess if best practice is followed in relation to the identification and referral of potential organ donors [Potential Donor Audit].

2022-2023 Performance

Audited Deaths = 64
Neurological death testing rate = 40% [The percentage of patients for whom neurological death was suspected that were tested for death by neurological criteria.]
DBD [Donors after brain death] NHSBT Referral Rate = 100% [88.8% 2021/2022]
DCD [Donors after cardiac death] NHSBT Referral Rate = 84% [43.3% 2021/2022]
Family Approach involves SNOD = 50% [20% 2021/2022]

1 Organ donor, resulting in 4 transplants; 2 kidneys, 1 liver, 1 heart
No missed potential organ donors

Progress

1. Established Alder Hey Children's NHS Foundation Trust Organ and Tissue Donation Committee.
2. Deceased organ donation training incorporated into the Paediatric Intensive Care – Postgraduate Certificate in Critical Care.
3. Organ donation grand round presentation 23/09/22.
4. Organ donation promotion at Alder Hey Children's NHS Foundation Trust during organ donation week (26th September - 2nd October 2022).

Recommendations

1. Ensure deceased organ donation national policies, guidelines and best practice implemented and followed consistently within the Trust.
2. Ensure staff within the Trust are adequately trained.
3. Champion and promote organ donation at Alder Hey Children's NHS Foundation Trust.
4. Events to promote organ donation during organ donation week (18th – 24th September 2023)

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

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 17th January 2024, along with the approved minutes from the 18th December 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

0164 **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 an update regarding progress in relation to resetting the Quality Assurance Rounds, with some clear actions to be presented to Executive colleagues and to Non Executive Directors to approve, to enable a degree of face to face Quality Assurance Rounds throughout 2024.
- SQAC received a positive Patient Safety Strategy update, which provided good evidence of progress within the workstreams that had been detailed in the report, with good assurance that the Programme is progressing well, and is on trajectory.
- SQAC received the ED monthly report: MH attendances and ED @ its best update. SQAC noted the challenges regarding the data. SQAC clarified the additional deep dive information that had previously been requested at the 18th December 2023 meeting, and welcomed the deep dive information to be presented at the 21st February 2024 SQAC meeting.
- SQAC received the Sepsis Quarterly Report update, with a robust discussion held, focusing on two issues 1) The data issues and the need for these issues to be resolved - Executive Team colleagues agreed to review this offline to enable support in addressing the issues as a matter of some urgency. 2) SQAC agreed to receive clarification on what the training data is demonstrating– SQAC agreed they would receive this update at the 21st February 2024 meeting.
- SQAC received the Drugs & Therapeutics Quarterly Report. SQAC agreed that the cycle of reporting would be reviewed to ensure that the Drugs & Therapeutics reports are shared more promptly with SQAC.
  SQAC noted that there would be some quality improvements coming through via Inphase with further thought by Pharmacy colleagues on how the Drugs & Therapeutics Report could be further enhanced in the future.
- SQAC received the Board Assurance Framework, SQAC noted the move within the Board Assurance Framework to focus more on the strategic risks, and to incorporate in the future a risk regarding Experience. Actions would be addressed offline.
  SQAC noted the issues regarding coding issues.
  FB, ES and KB would discuss offline regarding reviewing the list of highly scored risks pertaining to SQAC.
- SQAC received the Confidential Enquiries/National Guidance Assurance Report and noted the good level of assurance within the report.
- SQAC received the Clinical Effectiveness & Outcomes Group – Chair's Highlight Report and noted the good level of assurance within the report.
- SQAC received the Divisional updates and the deep dive regarding ENT cancellations. SQAC noted that the Medicine Division had achieved a good compliance level regarding the 4-hour waiting time despite the challenges due

0165 to Industrial Action and the high levels of attendance. SQAC noted this was attributed by the Team to good collaborative working.

- SQAC received an overview of the ongoing work regarding low harm incidents and the potential to learn from them, particularly the low harm incidents that were linked to patients' accidents.
- Discussion was held regarding closing incidents and risks and the need to remain focused on this.
- SQAC received an update from the Community & Mental Health division regarding the national leadership in neurodevelopmental work and the ongoing work that is progressing within the division to ensure that the division are ready for PSIRF.
  SQAC received an update on detailed work regarding prescriptions.
- SQAC received the Transition Report, noting clear progress regarding the transition work.
- SQAC received, noted, and Ratified RM49 Hospital Cleaning Policy.

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
Monday 18th December 2023
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Dame Jo Williams	Chair	(DJW)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(ABa)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	John Grinnell	Managing Director/Chief Financial Officer	(JG)
	Beatriz Larru	Director of Infection Prevention Control	(BL)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RH)
	Jacqui Pointon	Associate Chief Nurse–Community & Mental Health Division	(JP)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Paul Sanderson	Interim Chief Pharmacist	(PS)
	Melissa Swindell	Chief People Office	(MS)
	Catherine Wardell	Associate Chief Nurse, Division of Medicine	(CW)
	Peter White	Chief Nursing Information Officer	(PW)
In Attendance:			
23/24/155	Kate Warriner	Chief Digital & Transformation Officer	(KW)
23/24/156	Will Weston	Medical Services Director	(WW)
23/24/159	Julie Grice	Mortality Lead, AED Consultant	(JG)
23/24/162	Dr. Matthew Neame	Locum Consultant General Paediatrician, Chief Clinical Information Officer, Division of Medicine	(MN)
	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	(NO)
	Natalie Palin	Director of Transformation and Change	(NP)
	Jill Preece	Governance Manager	(JPr)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)
Apologies:	John Chester	Director of Research & Innovation	(JC)
	Lisa Cooper	Director of Community & Mental Health Services	(LC)
	Urmi Das	Director of Medicine Division	(UD)
	Laura Rad	Head of Nursing - Research	(LR)
	Jo Revill	Non-Executive Director	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)

23/24/152 Welcome and Apologies

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

23/24/153 Declarations of Interest

None

23/24/154 Minutes of the Previous Meeting

Committee members were content to **APPROVE** the notes of the meeting held on 15th November 2023.

23/24/155 Matters Arising and Action log

Safeguarding Mandatory training compliance for Corporate Services

JP advised that an updated report was presented to the November 2023 Corporate Services collaborative meeting and advised that there is a call for action of all services to increase mandatory training compliance. JP confirmed that this would remain on the corporate services collaborative agenda until compliance is improved.

DJW sought clarity whether each Division have an Accountable Officer for Safeguarding. NO advised that the Trust had recently established a Safeguarding Operational Group which each of the Divisions have representation at. NO stated that there is no actual dedicated named officer within the Divisions, however this could be considered by Safeguarding and Divisional colleagues. FB welcomed an update on Divisional Safeguarding Accountable Officer once this had been considered, SQAC would receive an update at the January 2024 SQAC meeting.

Resolved: Divisional Safeguarding Accountable Officer update to be received at January 2024 SQAC meeting.

Update regarding what actions are being taken to directly address those staff to ensure completion of mandatory training

NA advised that each of the Divisions had provided an update and a future forward look and that individuals are booked onto the mandatory training sessions until May 2024. Colleagues would continue to monitor compliance. NA advised that the Divisional Mandatory Safeguarding compliance is currently on trajectory, with continued focus on those staff who need to complete Safeguarding level 3 mandatory training.

NA advised that the Safeguarding Team provide ample opportunity for all staff to adhere to the Safeguarding mandatory training. NA alluded to level 3 safeguarding training compliance and stated that he is confident that there would be a significant increase in staff attending safeguarding mandatory training as we move towards the end of this financial year.

Resolved: SQAC received and **NOTED** the update regarding what actions are being taken to directly address those staff to ensure completion of mandatory training.

Alder Care Reporting update

KW alluded to the Alder Care Reporting comprehensive update report contained within the SQAC meeting pack. KW referred to the 3 elements regarding reporting - External reporting, internal report and the patient tracking list, KW advised that this had been managed through RABD.

- As at 18.12.23 there is 1 outstanding external report linked to Theatres which is currently undergoing internal validation.
- Internal reporting: there are currently 46 signed off which equates to approximately 70%, with a significant amount to be followed up week commencing 18.12.23.
- Patient tracking list had been signed off week commencing 11.12.23, these would go live week commencing 18.12.23.
- 2 items are outstanding which relate to the Sepsis dashboards – in patient dashboard and ED dashboard, both are currently with the service awaiting sign off, this had been escalated through to the Divisional Leadership Team. KW stated that she anticipated improvement week commencing 18.12.23.

KW acknowledged the good progress made to date and stated that it had been an extremely complex and lengthy process. KW stated that there are some lessons learned, particularly with regards to Trust timeframes that colleagues had originally aimed for. KW advised that there had been benchmarking undertaken with other Trusts and that normal recovery following this type of work is usually around 6-15 months.

FB expressed her thanks to KW and IT team and acknowledged the comprehensive report which is extremely clear.

Resolved: SQAC received and **NOTED** the Alder Care Reporting update

Safety Incidents associated with the upgrade of Meditech V6.08 to Expanse/Aldercare 2023

CW presented update, key issues as follows:-

CW advised that staff were requested to report any incidents on Inphase during the cut over process. Colleagues had agreed that the deep dive undertaken to identify issues were via

meditech, Expanse and Alder Care. The review undertaken was across the whole Trust which highlighted that there were 73 incidents reported during 1st September 2023 and 28th November 2023 on the Inphase system, and following collective and collaborative review was related to the roll out of Expanse.

- The highest number of incidents reported were during the first week of September 2023.
- Medication had the highest number of incidents reported, particularly in September 2023.
- Documentation was the second highest theme; documentation was also the highest category in October 2023 and November 2023 when medication tended to reduce then.
- There was no moderate harm or above incidents reported.
- Overall, the data demonstrates a good reporting culture within the Trust.

Recommendations and next steps – colleagues continue to report any issues relating to Expanse to ensure any areas of improvement continue to be identified.
CW alluded to the positive collaboration between clinical and digital colleagues, which must continue as the Trust progresses with the next phase.

FB referred to page 6 of the report, and stated that documentation seemed to be a degree of overlap or lack of clarity between the different categories and welcomed feedback from CW. CW stated that as issues had been reported colleagues had aligned them to the best fit category.
PS stated that this is reflective of Patient Safety Strategy Board and Medicine Safety Committee and reflects a robust reporting culture throughout the Trust and that this should be recognised.

FB stated that the Trust does have good evidence of a good reporting culture and alluded to the need to continue the robust reporting culture in the future.

FB thanked CW and colleagues for comprehensive report.
Resolved: SQAC received and **NOTED** the Safety Incidents associated with the upgrade of Meditech V6.08 to Expanse/Aldercare 2023 update.

Inphase Highlight report
PW presented the Inphase Highlight report and confirmed that the majority of reports had been completed, colleagues are continuing to work on the PALS & Complaints report. PW stated that the majority of the reports are awaiting SSRS completion which is the conversion into a word document to allow utilisation.

PW expressed his gratitude to colleagues' perseverance and resilience during this challenging time, with particular thanks expressed to J Rooney's team for ongoing additional support.

PW referred to the modules within Inphase which are now live, with the exception of the nursing audits which are due to be completed at the end of February 2024 which is in line with the tendable contract renewal which is due for renewal at the end of March 2024. PW advised that there are several elements still being developed.

PW shared the Liverpool Heart and Chest heatmap visualisation of the risks and provided an update/overview on the functionality of the heatmap

FB expressed her thanks to PW for comprehensive update.

KB welcomed the 'bullseye' report for the Trust. KB alluded to the conversion of the SSRS to word and sought clarity whether this is relating to the visualisation issue and sought clarity regarding timescale for completion. PW stated that the SSRS system would allow the move from current screen capture to automatically bring these reports into word therefore colleagues would not need to copy and paste, resulting in standard templates to be able to be used for various committees. This should result in a decrease in transcribing and additional work. PW advised that there had been significant work ongoing to ensure that the data quality and validation is safe and standardised throughout.

KB referred to Audit Committee timings and welcomed a lessons learned report for January 2024 Audit Committee. PW stated that he would be delighted to provide an update to Audit Committee at January 2024 meeting.

KW stated that the January Audit Committee may be too early as the SSRS work is landing in January 2024.

KB stated that she would be guided by KW and her team to consider. KB stated that she would not want a lessons learned report being presented to Audit Committee any later than April 2024.

FB alluded to the new governance architecture and stated that there is great visualization and development that would present the data, and highlighted the importance of colleagues being able to see where the data had been considered, as it would always have been to another group or committee prior to being presented to SQAC, this enables SQAC to see what reflections and conclusions had been drawn, and what actions had been put in place. FB highlighted the format of the report to ensure the function of the report to provide SQAC with assurance that the data is being viewed, and that it is being acted on, and that SQAC may want to see a draft of the templates, to enable appropriate colleagues to review templates offline to ensure that they meet all the necessary requirements.

NA stated that colleagues should share the drafts with SQAC, and advised that it is going to take another 6-12 months of continuous improvement, NA advised that colleagues could ensure that every time one of the reports are presented to committees that any feedback would be collected to ensure continuous improvement.

NA expressed his thanks for continued support and welcomed the lessons learned approach. NA stated that the Trust is now starting to see the reasons why the Trust had made the change, and to see the potential of what the system has to triangulate and move forward.

Resolved: SQAC to receive draft templates of reports as available as part of the usual cycle of work..

Resolved SQAC received and **NOTED** the Inphase highlight report.

Assurance on Key Risks

23/24/156 *Delivery of Outstanding Care*

Safe

Patient Safety update

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

- Patient Safety Strategy colleagues had applied careful scrutiny to workstreams 1, 6,7,8, 10,15 and 22.
- WW alluded to Safety metrics workstream 1 and advised that there was concern previously that there was an upward trend in the incidents of harm per 1,000 bed days metric, this however has subsequently reduced therefore colleagues are now more assured in this area.
- Patient Safety Strategy Board had received a positive update from the Negligence and Litigation workstream which described a new process whereby claims data can be used to share learning across the Trust.
- CYP and families as patient partners workstream reported that it is near completion of its associated policies and job descriptions.
- Education & Training workstream - confirmed additions to the trust wide training prospectus with specific HSSIB courses available for staff across the organisation to enrol upon.
- Parity of Esteem had demonstrated several areas of progress including recruitment of new posts, agreement of training levels and the establishment of Mental Health Champions and Suicide Prevention workstream.

- Unacknowledged notices had also demonstrated a more robust process by which divisions can monitor completion of compliance.
- Progress had been made since the last Patient Safety Strategy meeting regarding workstreams benefits, with further work to do regarding milestones.
- Patient Safety Strategy Board had maintained a good level of governance, resulting in a Green overall rating for the programme.
- Go live implementation date for PSIRF remains as 1st January 2024, WW and JR had recently met with representatives from Liverpool PLACE and advised that the PSIRF policy and plan was approved from their perspective.

WW expressed his thanks to SQAC for ongoing support and constructive suggestions received over the last few months.

JG sought WW reflections on when colleagues would extract the benefits, i.e., such as learning from families, and sought clarity regarding the overall dashboard that the overall programme is having and the level of impact. WW stated that for each workstream that there is a benefits tracker and advised that the Patient Safety Strategy Board ensure that the benefits are realised prior to being closed down. WW advised that he would discuss this further with Patient Safety Strategy colleagues with regards to the wider higher level benefit tracker and that he would update SQAC in due course.

JR alluded to PSIRF versus Serious Incident Framework and alluded to how colleagues measure benefits. JR referred to the significant benefit regarding changing culture and people being able to safely stand up and speak without recourse, with the Trust having a really good reporting culture, with good discussions held at weekly Patient Safety meetings.

NP stated that colleagues have time scheduled in the new year to meet with the Patient Safety Strategy Team to review the wider benefit work aligned to the approach across the whole strategic initiatives, this would be a starting position to enable this to be iterated over time to help answer the broader questions regarding how the Trust knows this is making an impact and knowing what the 'so what' is.

Resolved: SQAC received and **NOTED** the Patient Safety Strategy update and welcomed the good progress made in month. SQAC **NOTED** the continuous improvement across an array of patient safety workstreams. SQAC welcomed future Patient Safety Strategy updates.

FB expressed thanks to WW and Patient Safety colleagues for the comprehensive update and for the ongoing support provided to SQAC throughout the year.

23/24/157 ED MH attendance & ED @ its best update report

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

- During the month of December there was a slight decrease in attendance, however ED performance improved by 7% compared to previous month and is above the national standard, with continuous improvement.
- Consultant winter rota is in now in place.
- ED Escalation Policy is in place, further work is required to communicate this to colleagues.
- Significant improvement with regards to working with system partners this winter compared to previous winter periods.
- Sepsis compliance had reduced to 84% compared to previous two months when compliance was above 90%. Division had undertaken a deep dive in September 2023 and the Division are continuing to work through the action plan. Division are aiming to see an improved position in 2024.
- Friends & Families test are dependent on the Divisions waiting times, with responses tending to improve as waiting times are reduced. The Division are continuing to aim to increase the number of responses.
- PAU continues to be in action and continues to have an impact. A full analysis is envisaged in January 2024 to review, in comparison to winter 2022 the Trust had reduced the number

of medical outliers by almost 400 bed days and had increased turnaround from PAU EDU by 350 bed days. Division need to undertake a detailed analysis however the current position is good. Colleagues are seeing less patients admitted to 4C, with 4C seeing sicker patients who remain on the ward for longer periods.

Resolved: Division of Medicine would provide a comprehensive overview to SQAC on PAU at February 2024 meeting.

DJW welcomed the comprehensive update. DJW referred to working with the system and sought clarity whether the Trust is undertaking any heat mapping on post codes with regards to where patients are presenting from, and sought clarity whether Trust colleagues are then using this information to consult with GP colleagues and community based services.

CW stated that this is being reviewed and that significant education is taking place with GP'S and that the postcodes that use Alder Hey more frequently are being targeted for education. CW advised that a comprehensive update would be provided in the New Year.

JG alluded to admissions regarding mental health attendance, and queried whether this could be evaluated in future reports with regards to whether patients have physical issues and needs. CW stated that due to BI issues colleagues do not have the current data, CW envisaged that the data would be available for January 2024.

Resolved: CW would follow this up offline to enable an update to SQAC in the new year.

JP queried whether there is a process to triangulate diverted visits to ED as part of crisis care, and sought clarity whether there is any other data available to highlight any other improvements that could be made. CW stated that there is an opportunity to review this further in the new year.

FB thanked CW for comprehensive update and welcomed update at SQAC in January 2024 on the mental health patients and where they are presenting from together with post code analysis.

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

23/24/158 Quarterly DIPC Report

BL presented the Quarterly DIPC report, and provided an overview of the IPC Department and the sub groups who meet monthly. BL stated that the IPC committee had been relaunched to enable the Committee to be an enhanced forum for discussion.

BL referred to surveillance and stated that the majority of infections that are counted are gram negative blood stream infections with an Action plan in place regarding how to prevent such infections. IPC team are also working with NHSE to highlight that children and adults do have a different way of acquiring this infection and therefore the preventative methods are different. IPC colleagues had met with NHSE on 15.12.23 in this regard. IPC colleagues are also working with other paediatric Trusts (Sheffield, Bristol and GOSH) with the aim of nationally changing how these infections are reported, particularly in very young infants.

BL advised on the challenges within IPC related to receiving the data late, with fragmented data which is not linked with the clinical data and having an electronic surveillance system which would significantly assist the IPC team to be more proactive, as opposed to reacting to cases that had already occurred.
JG stated that this is critical that this would be moved forward with regards to the data.

FB stated that she really appreciated how the DIPC report was developing into the two separate sections. FB stated that a significant amount of work undertaken by IPC team detailed in part 2 of the report is extremely reactive, however what is being put in place within part 1 of the report is the apparatus that enables IPC to be proactive and to set the agenda regarding the

focus for IPC over the next 12 months, and whether IPC are meeting their goals and reacting appropriate to the incidents that occur. FB stated that this is obviously Quarter 2 report, however the Trust is almost nearing the end of Quarter 3 and would be receiving the Quarter 3 report, the Quarter 4 report and the Annual report. FB stated at such time it would be helpful for SQAC to receive some reflections from IPC regarding what the priorities need to be for 2024/24 hospital year and how the IPC team would implement those priorities and track progress against these priorities. FB welcomed a more reflective and proactive agenda setting report when the Trust reaches the end of the year.

KB stated that she is supportive of the DIPC report which details the graphs, however on review it appears that the Trust is breaching, or is at the maximum level for all of the indicators with the exception of 1, whilst only being 6 months into the year. KB queried whether the targets were too aspirational and whether they are going to be too demotivate.

JG stated that on review of the report it is difficult to obtain a sense of whether the target is too tight or whether the Trust is deteriorating and it is difficult to obtain a position statement regarding whether there is a broader issue.

BL advised that the targets are set up by NHSE which is a reduction of 50% of gram negatives that the Trust had the previous year. BL stated that the Trust have no control over the targets set, which had been set without considering the different patients that hospitals have. BL stated that IPC colleagues had been providing feedback to NHSE in this regard. BL stated that the targets are very useful and that the Trust has a zero tolerance to gram negative, and colleagues know that some infections are not preventable. BL stated that different divisions work in different ways on how to prevent central line blood stream infections, and it is important to have a trust process, a way to count these infections and ensuring all colleagues are working collaboratively. BL stated that the target is unrealistic. BL highlighted the importance of the relevant data being available.

JG sought clarity from BL whether the Trust was currently in an improved or worsened position compared to December 2022. BL envisaged that the Trust is in a slightly improved position and agreed that this would be included in future reports. BL stated that in 2022 there was 1 patient who had 12 episodes and queried whether this is a true reflection if comparing yearly comparisons.

FB highlighted the importance within the commentary of the data within the report and the nuance received through the commentary which is important, together with the general discussion. FB reiterated that it is important for SQAC to know the DIPC agenda in the year and what progress is being made.

AB stated that it is good to see the context against previous years and whether IPC are achieving the goals.

AB referred to Surgical Site infections and sought clarity whether this is shared at the Trust wide IPC Committee. BL advised that Surgical Site infections is governed by the Surgery Division and stated that a report should be shared with IPC committee which is not always shared. RP stated that the Surgery Division report into the Surgery Division IPC Committee and that given that the Trust wide IPC committee had not been re-established that long that Surgery colleagues had not been requested to report into this committee. RP stated that Surgery colleagues are happy to submit Surgical site infection reports if requested.

FB expressed her thanks to BL for IPC update and for colleagues for comprehensive discussion.

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

23/24/159 Mortality Report

JG presented the Mortality Report:

- JG reported that the Hospital Mortality Review Group is performing extremely well, and that the Mortality Group are a month ahead of trajectory. Earlier in the year JG highlighted that the Trust mortality rate was slightly higher than normal with regards to inpatient deaths, and on review of the current position for the year, the Trust would have the usual figure of mid 70's deaths for the year.
- The Medical Examiner Service Level Agreement had now been agreed, JG reported that she had envisaged that the Medical Examiners would commence Expanse training week commencing 11.12.23, however this was delayed due to access issues, colleagues are working to resolve this issue.
- Neonatal work – colleagues are finalising pathways linking PMRT and HMRG reviews working with neonatal network to ensure a clear process that is robust and resilient.
- There had been no avoidable deaths.
- There had been no concerning themes.
- Learning – HMRG are gaining insight into the neonatal processes to ensure comprehensive review in readiness for the expansion of the neonatal network.
- Increasing pressures on clinicians and the Trust due to concerns raised by families

JG stated that she had recently attended a national meeting at the end of November 2023, and that it was reassuring to meet with other Trusts and to assess Alder Hey against other Trusts nationally, JG stated that Alder Hey are not behind other Truss in terms of mortality. JG had made various contacts with other Trusts to provide mortality links with colleagues.

FB expressed her thanks to JG for succinct and comprehensive Hospital Mortality Review Group Report.

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

23/24/160 *Caring*
Effective
Board Assurance Framework
NA presented the Board Assurance Framework and advised that colleagues are continuing to align the risks to the 2030 vision and working with individual risk owners regarding any gaps in mitigation. NA advised that there are no significant changes relating to the risks pertinent to SQAC.

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

23/24/161 **NICE Compliance update on current position regarding those areas previously highlighted as a priority**
JR advised that following on from the previous SQAC meeting that she had met with both Community & Mental Health and Medicine Division colleagues regarding the overdue compliance NICE guidelines. JR stated that due to further scrutiny across all divisions has resulted in an improved trend of compliance for both baseline assessment and with completion of action plans.

- As at the end of November there were 13 NICE Guidance publications currently open across the Trust, of which 3 were baseline and on trajectory within the 3 month timeframe. 10 are at action plan stage, with full oversight.
- 1 guideline that was out of compliance within the three month timeframe had since been completed.
- Scrutiny of all NICE guidance is undertaken by the Governance team on a weekly basis, but also scrutinised through the monthly Clinical Effectiveness & Outcomes Group.

KB welcomed the significant improvement which had resulted in an improved position.

Resolved: SQAC received and **NOTED** the NICE Compliance update on the current position regarding those areas previously highlighted as a priority.

23/24/162 Divisional updates

Medicine Division - CW presented the Medicine Division update:

- Medicine Division Health and Wellbeing week had been extremely successful with over 800 staff who had participated, with good learning received which would be used for future Health and Wellbeing event.
- PAU 4C team of ACP's had won the Advance Practice Team of the year at the 2023 Cheshire & Merseyside Advanced Practice Awards, the award is expected to be presented during week commencing 18.12.23.
- Neurology on call service position continues to be a challenge for the Division, with a fragile team, with continued focus for the Division.
- Increased number of oncology and haematology patients that are outlines resulting in constant bed pressures on ward 3B, biggest impact being more robust working with patient flow to enable a forward look and appropriate planning in advance.

Community & Mental Health Division - JP presented the Community & MH Divisional update:

- The Community & Mental Health Division had recently gone live with a SharePoint page for the Division, whereby all information relating to governance would be included, with information regarding all of the learning from investigations would also be uploaded to the SharePoint page.
- Friends & Family Test– there had been 0 CAMHS responses in November 2023, this related to the auto text being issued and the connection not being made, this is being reviewed.
- Delays for treatment in Speech and Language Therapy, the Community & Mental Health Division had been working hard on reducing waiting times for first appointments for Speech and Language therapy patients, which had resulted in a delay for follow up patients which had increase to such a level that the time that the patient is being seen for a follow up appointment the reassessment is having to be undertaken, as a result the Division have increased the risk rating.

Surgery Division – RP presented the Surgery Update:

- PALS compliance remains at 100% for a period of 18 months.
- Patient experience sub group have great engagement with patients and families.
- The Division are still seeing issues regarding follow up and follow up booking of patients, and incidents relating to patients at a lower/moderate harm, work is ongoing to address.
- Division continue to experience challenges with not having the Sepsis dashboard overview which is extremely challenging with significant work for the matrons to manually extract the individual data set in the interim until such time that the dashboard is online.

KB requested if RP could include additional information in relations to risks >15 in future reports. RP confirmed that this detail would be included in future updates.

KB stated that there are a number of graphs in the reports within the IPR extracts whereby data does not exist for PALS and Complaints from April 2023 onwards and September 2023 regarding Alder Care. KB alluded to Complaints and PALS and stated that SQAC receive the detail on PALS & Complaints, however when this goes to Trust Board that Trust Board do not get this level of detail and sought clarity on timeline on when this would be resolved.
Resolved: KW advised that she would obtain a timeline offline for this and would follow up with the BI team and would provide an update to SQAC.

NA made a plea to the Divisions, with the exceptions of Clinical Research Division regarding the delay for timely review of incident forms and risks and requested the Division to focus on clearing those risks, and to ensure process for timely review of risks.

JR advised that as part of Inphase there are reports for the Divisions to show those risks that are overdue at 21 and 28 days which are available for the Divisions to extract from Inphase on a daily basis.

Clinical Research Division

NA advised that unfortunately LR was unable to attend SQAC and that NA had reviewed the Clinical Research Divisional update which was extremely focussed and clear. NA confirmed that he is happy to note any comments or feedback to relay to Clinical Research Division – no comments or feedback was shared.

Deep Dive regarding unacknowledged notices

Dr. Matt Neame, provided overview of diagnostic unacknowledged notices.

MN advised that the Unacknowledged Notices Project is being tracked through the Patient Safety Strategy Board and the Alder Care Programme with the aim of addressing risks and to provide the Trust with a safer system regarding acknowledgement of investigation results.

- The proposed updated SOP for managing these notifications was presented to SQAC in May 2023, and this is an update following the implementation of new SOP in September 2023, alongside deployment of Alder Care EPR in September 2023 the new SOP for managing diagnostic notifications had been implemented.
- The technical deployment had been successful, and the Trust is currently issuing 8,000 diagnostic notifications to clinicians each month. The system is extremely focussed on trying to help clinicians with the higher risk groups when patients are not in the hospital. The system is currently functioning well. There are good findings from the Community Division who have fewer than 20 notifications that had breached the standard of being acknowledged within 28 days.
- There is a stable trend towards improvement within the Medicine Division with approximately 800 unacknowledged notifications which had breached the 28 days threshold, with further work to do with the Medicine Division who use the day case wards more frequently – oncology and some medical specialities.
- There is an increasing trend within the Surgery Division, with ongoing work required to engage with Clinical Directors across the Division to encourage engagement with the SOP.
- There are no issues of concern with regards to the Clinical Research Division.
- MN stated that there is some concern regarding those unacknowledged notifications, however this is a recoverable position at present, with approximately 90% of clinicians with fewer than 10 unacknowledged notifications that are over 28 days. MN advised that there is an Action Plan detailed within the report to ensure improved performance. MN stated that there are monthly updates presented to the Chief Medical Officer and the Divisional Clinical Directors and Divisional Governance Leads to highlight performance within the Divisions and make plans to contact specific Clinical Directors. Patient Safety Strategy Board receive regular updates on the unacknowledged notices position.
- The analytics team had deployed a notifications dashboard, with a BI dashboard to ensure real time updates on clinicians and departmental performance. MN referred to the development of an updated training and communication plan. As part of this deep dive engagement with clinicians' feedback had been received regarding that the Trust could improve communicating the details of the SOP to clinical teams, MN advised of plans to engage with the comms teams to work on the updated communication plan.
- MN advised that there had been additional development requests from meditech to try and make the system more configurable to ensure that the higher risk notifications could be flagged in a different way, based on feedback received from teams.
- Ongoing work continues to develop specific SOP for medical teams who are using day case wards more frequently to ensure that the system could be even more useful for them.

AB expressed his thanks to MN for his ongoing support in driving this significant project forward.

AB stated that at present colleagues do not yet know what the steady state should be on a monthly basis as most clinicians would be checking the unacknowledged notices on a daily basis. AB stated that he does not want to see an increasing number of unacknowledged notices month on month. AB stated that there are some glitches in the system with individuals' teams, which MN is working through individually. AB stated that the plan is to contact clinicians directly for the next 6-12 month period following the monthly update discussions. AB stated that there is some information that clinicians need to input into their appraisal and queried whether a

consultant is provided with an individual report regarding unacknowledged notice, to make this a mandatory insert into their appraisal folder.

FB expressed thanks on behalf of SQAC to MN for ongoing support.
FB stated that it is clear to SQAC that people are continuing to work extremely hard on this project and it is clear that progress is being made.

JG reiterated AB and FB comments and welcomed the ongoing progress made.
JG queried whether there is any support that SQAC could provide to aid further improvement.
MT stated that there is ongoing work with regards to the required cultural change.MT advised that the monthly discussions with CMO and Divisions is really helpful.

JG stated that if there is an anomaly that needs to be flagged that the Trust should be able to collectively have something to make it unmissable.

AB advised that the Trust does have other data that looks at the length of unacknowledged notices, i.e. If notices not been reviewed 2 months and that perhaps the Trust need an escalation process regarding the longest unacknowledged notices.
FB acknowledged that this is going to be an ongoing project.

RP referred to the culture change and stated that the work that MT is undertaking to make the system more accessible is encouraging and highlighted the importance of engagement and that Divisionals needed to support and lead clinicians' engagement. RP referred to issues - e g automatic notification of an x ray undertaken during a procedure which is not reported, but possibly colleagues are still receiving a notification to indicated that the x-ray had been performed, however the x-ray had been reviewed during procedure and stated it would be helpful if such notices could be removed, and to look at the teams issues for those teams who do not regularly work at Alder Hey and for colleagues who work between Alder Hey and LWH i.e. neonatologist and ensuring teams notification.
MN stated that ED are using a really good process, with one nominated person reviewing all results, MN stated that he could definitely engage with relevant teams who would like to adopt a similar process.

FB sought comments from SQAC regarding the frequency of SQAC receiving future Unacknowledged Notices Reports, given that this is being addressed through other forums and that it is useful to know that progress is continuing and that the different nuances are being put in place.
Resolved: SQAC agreed that for the first 12 months SQAC would continue to receive Quarterly updates, and that once the programme is well embedded SQAC could review timelines of future reports.

Resolved: SQAC received and **NOTED** the Divisional updates
Resolved: SQAC received and **NOTED** the Deep Dive regarding unacknowledged notices and welcomed Quarterly updates for the next 12 month period.

23/24/163 CQUIN Quarterly Report

PB presented the CQUIN Quarterly Report.

- The Trust have 9 CQUINS, five CQUINS for the Integrated Care Board, and 4 CQUINS for Specialised Commissioning.
- All of the CQUINS are currently on trajectory, with the exception of two which the Trust are having additional discussions with Specialised Commissioning – regarding the Dreaming CQUIN which relates to eating, drinking and mobilising following surgery and Shared Decision making, with helpful discussions held with Specialised Commissioning with a plan for 2024.
- PB advised that all of the other CQUINS are on trajectory with regards to reporting.
- The Integrated Care Board had been pleased that the Trust had responded to the CQUINS this year in a very proactive way with regards to establishing local CQUINS as the CQUINS were very adult focussed this year.

- Flu vaccination at 40% compliance at the end of Quarter 2, PB reminded SQAC colleagues to encourage all teams to get obtain the flu vaccination.

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

23/24/164 Biannual aggregate analysis report

JR presented the Biannual aggregate analysis report which detailed the themes and trends for incidents, complaints, PALS, claims and inquest for Quarter 1 and 2 2023/24 (April – September 2023) providing assurance that the Trust is fully compliant with NHS Quality contract reporting requirements. JR stated that the caveat is that the report is a prescriptive reporting format based on the Quality Contract Requirements. Highlights from the report were provided to the group.

FB welcomed the succinct report and the consistency within the report.
KB alluded to page 12 of the report which referred to the highest incidents/cancelled operations in ENT and that she was surprised by this.

KB referred to Pages 3 & 4 of the report regarding incidents and referred to Ulysses duplications which were detailed as severe and fatal. JR alluded to the way in which the information is worded within Inphase and in the way it had changed in LFPSE as it is now called fatal. JP stated that the details are located within the appendix and related to a duplication. JP stated that one child death related to line sepsis, and one child death related to a patient who had undergone craniofacial surgery. KB stated whether the wording required review. JR stated that she would consult with NHSE regarding the wording of fatal. JR was unable to provide update regarding ENT. JR stated that future reports are envisaged regarding ENT via the Safer Waiting list team for the bimonthly commissioners' meetings.

JG stated that the 2 incidents are extremely serious fatalities that are being investigated and sought clarity on when - 4275 craniofacial investigation would be concluded. RP stated that this is due on 19th January 2024 and that this case was granted an extension as a 2nd panel was required due to extensive information to be reviewed.

RP referred to the other fatal case which had been closed and reported to ICB which was classified as potentially preventable, as sadly the Trust was not able to save this child due to overwhelming Sepsis.

FB referred to the difference of the implication of causation and stating what the patient outcome was, and that this report is just stating the patient outcome in a neutral way. JR stated that when these cases conclude they needed to be presented to SQAC as a full report.

DJW reflected on a number of the issues relating to PALS & Complaints, cultural issues and people accepting responsibility, and being held to account. DJW queried whether colleagues could undertake a longer look back, to review what the issues are, where the complaints are emerging from, whether the culture has changed, whether lessons had been learned, is there sufficient support in place and that a longer look back is likely to be helpful.
FB thanked DJW for helpful update and confirmed that SQAC would reflect on this.
NA recommended that it would be helpful to include this as a Deep Dive for February SQAC meeting to receive a Deep dive update across all of the divisions.

FB stated it would be helpful for SQAC to understand regarding the ENT cancellations, as there is also reference to other not requiring a procedure, and Task and Finish group is reviewing issues with the booking system.

NA recommended that Surgery provide a deep dive of ENT cancellations, which would include the reasons for cancellations at January 2024 SQAC meeting, this was supported by SQAC.

NA recommended SQAC receive a more detailed review of ED mental health presentations (including referral to crisis care), together with a detailed postcode analysis of end users at January 2024 SQAC meeting, this was supported by SQAC.

Resolved: SQAC received and **NOTED** the content of the Biannual aggregate analysis report and **NOTED** the assurance that the Trust is fully compliant with NHS Quality Contract reporting requirements. SQAC **NOTED** that this report would be presented to commissioners at the Quality Contract meeting in January 2024.

Resolved: SQAC to receive Deep Dive of ENT cancellations at January 2024 SQAC meeting
Resolved: SQAC to receive Deep dive of Medicine and Mental Health review of ED mental health presentations (including referral to crisis care) together with post code analysis of end users detailing what the Trust is doing to address this issue.
Resolved: SQAC agreed to receive deep dive on PAU at January 2024 meeting (this has since been deferred to February given the data won't be available).

23/24/165 Policy ratification

C37 – Medicine Management Policy
KB stated that C37 – Medicine Management Policy referred to Clinical Quality Steering Group which no longer exists. SQAC agreed that subject to this amendment being made to rectify this that SQAC were happy to ratify the policy.
Resolved: C37 – Medicine Management Policy – SQAC Ratified C37- Medicine Management Policy subject to removal of Clinical Quality Steering Group narrative.

C14 Hand Hygiene Policy
Resolved: SQAC received and Ratified C14 Hand Hygiene Policy.

RM49 Hospital Cleaning Policy
SQAC received RM49 Hospital Cleaning Policy. RP alluded to the cleaning policy and issues reporting environmental cleanliness with regards to clarity regarding who performs the audits and stated it would be helpful to see the reporting structure detailed within the policy to understand the process moving forward.
BL advised that this issue had previously been discussed at length at the Environmental group.
Resolved: SQAC were happy to Ratify RM49 Hospital Cleaning Policy in principle, with the expectation that the policy would be resubmitted with the appropriate appendix for January 2024 SQAC meeting.
BL stated that the appropriate paragraph could be expanded, however the detail is already included within the policy.
Resolved BL and RP would follow up offline to ensure the policy is meeting the needs of the Surgery Division.

RM73 Ventilation Safety Policy
Resolved: SQAC received and Ratified RM73 Ventilation Safety Policy.

C58 Screening & Management of Multi-Drug Resistance Organisms (MDRO) Policy
Resolved: SQAC received and Ratified C58 Screening & Management of Multi-Drug Resistance (MDRO) Policy.

C29 Toys & Play Equipment Policy
Resolved: SQAC received and Ratified C29 Toys & Play Equipment Policy.

C72 Prevention & Management of Pressure Ulcers Policy
Resolved: SQAC received and Ratified C72 Prevention & Management of Pressure Ulcers Policy.

FB expressed thanks to BL and team for updated Policies.

23/24/166 Any other business - None

23/24/167 Review the key assurances and highlights to report to the Board.

FB advised that it had been a good meeting with appropriate challenge, with good clear reports and good evidence of work in progress, with strong levels of assurance

- SQAC welcomed updates received following discussion at the previous SQAC meeting and on review of action log, to gain assurance to address risks and address some of the changes. SQAC welcomed comprehensive update on Alder care and Inphase reporting with improved reporting to SQAC. SQAC welcomed the progress made to develop the visualisation tools. SQAC agreed that a lessons learned report would be submitted to ARC in March 2024. SQAC were happy to see the new format of reports.
- SQAC received update on Patient Safety Strategy Board which highlighted the need to understand the wider benefits and further thought required regarding how the Trust measure and identify whether the wider benefits are being delivered.
- SQAC received the ED report with informative information, SQAC agreed to receive a deep dive at the January SQAC meeting regarding Mental Health ED attendances with the Medicine and Community & MH working collaboratively to deliver this.
- SQAC agreed to receive a review of PAU analysis of impact it is having at January 2024 meeting
- SQAC agreed to receive Postcode analysis at January SQAC meeting.
- SQAC received the Quarterly DIPC report and noted that it is a much improved report, SQAC identified that setting aims and goals for the year would be useful, particularly as the national targets set are not realistic or useful for the Trust and also to ensure that the data tables are able to demonstrate comparison to previous years, with some discussion whether actual incidents or patient days.
- SQAC received the Mortality report, with assurance provided.
- SQAC received the Board Assurance Framework
- SQAC received the NICE compliance update, which highlighted continued improvement with a clear system in place for receiving NICE updates into the Trust and ensuring implementation within a reasonable period of time.
- SQAC received an update on Unacknowledged Notices, with good discussion held regarding unacknowledged notices, with a clear system in place, SQAC noted that a cultural process is required, with various initiatives underway to ensure culture piece, SQAC are yet to see how this will level out, however clear progress is evident. SQAC agreed to continue to receive quarterly updates for a 12 month period.
- Divisional update highlighted challenge regarding sepsis notification/ sepsis data, and the challenges caused as a result of the absence of data.
- SQAC received CQUIN report which provided assurance
- SQAC received Aggregate analysis with good discussion held

Policies approval

- C37– Medicine Management Policy – SQAC Ratified this policy subject to the reference of Clinical Quality Steering Group being removed.
- C14 – Hand Hygiene Policy – SQAC Ratified this policy
- RM49 – Hospital Cleaning Policy – BL & RP to liaise offline with regards to clarity regarding structure of environmental cleanliness audits with the aim of ensuring this has appropriate information within the policy to meet the needs of the Surgery Division. SQAC Ratified the policy in principle with the expectation that the updated policy would be resubmitted at the January 2024 SQAC meeting.
- RM73 Ventilation Safety Policy – SQAC Ratified this policy
- C58 Screening & Management of Multi Drug Resistance Organisms (MDRO) Policy - SQAC Ratified this policy.
- C29 Toys & Play Equipment Policy – SQAC Ratified this policy
- C72 – Prevention & Management of Pressure Ulcers Policy – SQAC Ratified this policy

FB expressed thanks to all for ongoing support throughout 2023.

Date and Time of Next Meeting: 17th January 2024 9.30 -11.30 am via Microsoft teams.

Alder Hey Children's NHS Foundation Trust

Research and Innovation Committee

Confirmed Minutes of the meeting held on **Monday the 6th November 2023**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. D. Cole	Senior Project Adviser	(DC)
	Ms. A. Davies	Innovation Programme Manager	(AD)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Ms. S. Leo	Head of Research	(SL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. L. Rad	Lead Research Nurse	(LR)
	Ms. S. Sinnott	Deputy Business Partner	(SS)
	Mr. J. Taylor	General Manager, CRD	(JT)
Observing:	Ms. F. Ashcroft	CEO of the Charity	(FA)
	Ms. J. Preece	Governance Manager	(JP)
Item 23/24/42	Mr. R. Ellison-Smith	Strasys	(RES)
Apologies:	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Ms. K. Birch	Academy Director	(KB)
	Ms. L. Cooper	Director of Community and Mental Health Services	(LC)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. D. Hawcutt	Clinical Director of Research	(DH)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Dr. F Marston	Non-Executive Director	(FM)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mrs. L. Shepherd	Chief Executive	(LS)

23/24/36 Apologies

The Chair noted the apologies that were received.

23/24/37 Declarations of Interest

There were none to declare.

23/24/38 Minutes of the previous Meeting

0181 The minutes from the meeting held on the 10.7.23 were approved as an accurate record of the meeting.

23/24/39 Matter Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

Action 22/23/36.1: *Marketing and Communications Plan* (*MarComms plan to be finalised including innovation to submit a next steps report to identify the organisation's lead products, advise on the process for selling lead products, the positioning of innovation, potential customers, with a tactical plan to underpin this area of work)* – It was agreed to close this action as this item will be subsumed into the overall Futures agenda. Going forward, time will be set aside to think about marketing and branding for Futures. **ACTION CLOSED**

Action 23/24/28.2: *Data Access Committee (DAC) Terms of Reference Look into a process for assigning fair value to data for complex projects and provide a recommendation for a decision making/reporting process for DAC, from a finance, information governance and expertise perspective* – It was agreed to share the Terms of Reference for the Data Access Committee and the structure that wraps around it, during January's Research and Innovation (R&I) Committee meeting. **ACTION CLOSED**

Action: *Futures Strategy, Financial Plan and Business Model (1. Submit an investment case that provides detail on what needs to be done for innovation to enable the Trust to progress to the next stage. Provide information in the body of the report on the joint work that is taking place by R&I, and an overview of how both departments are being supported to deliver the Research Strategy. 2. Business Model - Task Force meeting to take place to finalise and agree a business model ensuring that it fits into the plans for the delivery of the Futures Strategy. 3. Task Force meetings to continue to discuss the Financial Strategy and the various models for commercial activity, taking into account the model recommended in the Consultancy Project Report* – An item has been included on November's agenda to discuss the strategy and financial plan for Futures. Following submission of the financial plan a meeting will take place to agree a business model that will fit into the plans for the delivery of the Futures Strategy. **ACTION TO REMAIN OPEN**

23/24/40 Research Strategy Update

A video was shared with the Committee to provide an update on the work that has been taking place to progress the Research Strategy. It was reported that multiple engagement events have taken place to obtain the views of staff, and the team has been liaising with young people to ensure their priorities are included in the Research Strategy. It was confirmed that a framework has been developed for the strategy which has been shared with senior academics/clinicians at the Trust and some of the organisation's higher education partners to make sure that the entire strategy is aligned with Vision 2030 and that the idea of pioneering breakthroughs is very much embedded.

The Committee was advised that the Research Strategy is fully compatible with the Futures initiative and the idea of working collaboratively across numerous sites. It's also aligned as much as possible with the research strategies of multiple partners in order to build on the strong work that is taking place locally. Reference was made to the domains/objectives that have been proposed to assess the strategy and

measure finance, activity, safety, etc. It was confirmed that the final version of the Research Strategy will be submitted to the Committee in January for approval.

An in depth discussion took place about the challenges of 1. Setting time aside to enable clinical staff to focus on research. 2. Having the headspace to work more effectively. It was felt that if these challenges aren't addressed it will hinder the Trust's expansion plans and ability to bid for external resources. John Chester provided an overview of the actions that are taking place in collaboration with the Charity and the University of Liverpool to try and address these issues. It was also acknowledged that there is a need to find new ways of generating income.

A number of points were raised by Committee members in relation to;

- The lack of clinical academics with an interest in digital health and paediatrics, which it is felt is a gap.
- The importance of ensuring that Artificial Intelligence (AI) is a core/enabling component of the Research Strategy to ensure the Trust remains at the vanguard.
- It was felt that the organisation needs to think about the recruitment process from a systematic perspective in terms of getting successful candidates with research and innovation capabilities into post quickly.
- It was pointed out that staff see time spent on innovation and research as additional work therefore it is necessary for the organisation to generate a system that enables staff who have an interest in technology, research, innovation, education, etc. to see the benefits/positives of dedicating their time. Attention was drawn to the importance of having lean structures in place to create the resources required to invest in Futures and people long-term.

John Grinnell felt that it would be beneficial to have an understanding of the current strengths and weaknesses in the UK market place to enable the Trust to combine its ambitions with the needs identified and asked for a market assessment to be included in the strategy document.

23/24/40.1 Action: DH

The Chair pointed out that thought needs to be given to determine the Trust's position on AI in terms of working with a partnership organisation of whether it will be part of the Futures Strategy.

23/24/40.2 Action: JC/AB

It was confirmed that the comments regarding the Research Strategy will be fed back to Dan Hawcutt so that they can be built into the next iteration of the strategy.

23/24/40.3 Action: SL

Resolved:
The Research and Innovation Committee noted the update on the Research Strategy.

23/24/41 Futures Strategy Update

The Committee received an update on the Futures Strategy. A number of slides were shared which provided information on the following areas:

- Recent progress.
- Delivering better futures.
- An overview of Futures.
- Branding for Futures.

Reference was made to the connectivity to the wider 2030 Vision and other strategic initiatives, especially in relation to Futures responses and some of the

priorities that have emerged from the new models of care around respiratory and care coordination. It was queried as to whether thought needs to be given to the
0183 design in terms of other programmes wrapping around the new models of care. It was acknowledged that connectivity is key and the Committee was advised that this area of work will be discussed during the first Leadership Group meeting on the 10.11.23 and will also be an item for discussion during team meetings.

Futures Finance Plan

The Committee received a report on the plans for developing a financial strategy to support the Futures Strategy, and the key steps that need to be taken to finalise the strategy. The purpose of the report was to provide information on the proposed methodology and seek feedback. Attention was drawn to the following key points, as detailed in the report:

- Current state (baseline financial analysis).
- Outline of the financial strategy (for Futures);
  - Securing external investment in Futures.
  - Diversification: New commercial revenue streams.
  - Enabling productivity and efficiency in the Trust.
- Start-up resources.
- Methodology and timeline for developing a financial strategy for Futures.

Following discussion a number of points were made:

- The report states that Futures will improve the Trust's productivity and efficiency which was very much around the clinical impact but this doesn't feature in the Futures diagram.
- It was felt that further detail is required in the funding diagrams to describe where the funding is coming from.

23/24/41.1 **Action EK**

- Attention was drawn to the importance of getting connectivity and productivity right especially in relation to recharges between the (R&I) Divisions, focussing on productivity as a whole and not just on individual treatment areas. It was also felt that further work needs to take place on the detail in the report that relates to innovation productivity.

A question was raised about the outcome of the Health Tech Research Centre grant. John Chester provided an update and agreed to circulate the provisional feedback received to the relevant people.

23/24/41.2 **Action: JC**

Resolved:
The Research and Innovation Committee noted the update on the Futures Strategy and the plans for developing a financial strategy to support the Futures Strategy.

23/24/42 **Strasys Partnership Update**

The Committee was furnished with a number of slides that provided an update on the partnership between the Trust and Strasys. Information was shared on the following areas:

- What the partnership is trying to achieve.
- Agreed formalities.
- What we said we will do;
  - Determining opportunities across R&I and other areas.
  - Building relationships.
  - Keen to start prioritising whilst being realistic about where contributions can be generated.

- Execute on scale in terms of priorities.
- Partnership Board taking place on the 10.11.23.

0184

- Achievements since September.

Committee members were asked for their feedback on:

- The support that Committee members can bring/offer to foster the partnership.
- The regularity of updates.
- The timeline and approach for a bigger Ventures Plan.

The Committee requested that an update on the partnership be provided on a quarterly basis via the submission of a formal report that includes figures to convey what is being achieved in terms of generated contributions, etc.

23/24/42.1 Action: RL

Reference was made to the Ventures Plan and it was pointed out that this will need to be worked up and then submitted initially to the R&I Committee and then the Trust Board for approval.

A discussion took place around the option to use the workforce segmentation internally and it was asked that this be wrapped into the partnership arrangement and access be provided.

23/24/42.2 Action: Strasys

It was reported that the Board has agreed a number of priorities around respiratory and care co-ordination and it was felt that these areas may provide opportunities for the Strasys partnership.

Resolved:
The Research and Innovation Committee noted the update on the Strasys partnership.

23/24/43 Innovation Strategic Inward Investment Update

The Committee received an update on the latest position of the Alder Hey Innovation Strategic Outline Case (SOC) that will aid and drive public inward investment. An update was also provided on the Investment Zone funding opportunity that the Trust is part of, as detailed in the report.

Claire Liddy responded to a question that was raised about the Trust's overall funding allocation for the Investment Zone programme and provided clarity on the SOC exercise which it was pointed out forms a baseline document and set of analyses that can be adapted and built out based on funding opportunities and funder audiences.

The Chair highlighted the importance of ensuring that the Trust remains in control of its most successful projects and is clear in terms of which projects are to be allocated to the Investment Zone Programme and the Strasys partnership.

Resolved:
The Research and Innovation Committee noted the Innovation Strategic Inward Investment update.

23/24/44 Innovation Finance - Management Accounts, Q2

The Committee received a Q2 finance update for the Innovation department. A number of slides were shared that provided information on the following areas:

- Financial summary (*key points*).

- Total innovation position for 2023/24 by spend type.
- Total innovation position for 2023/24 by capital/revenue split.

0185

- Innovation growth (*grants to date and 2023/24 growth forecast*).
- Growth (*grants and proposals tracker for 2023/24*).

Resolved:
The Research and Innovation Committee noted the Q2 finance update for innovation.

23/24/45 Research Finance - Management Accounts, Q2.

The Committee received a Q2 finance update for research. A number of slides were shared that provided information on the following areas:

- Financial summary (*key points*).
- Total research position for 2023/24 by spend type.
- Total research position for 2023/24 by activity.
- Research – Grants to date in 2023/24 that are successful and submitted.

The Chair felt that the financial information is becoming easier to understand and thanked Emily Kirkpatrick for the work that has taken place to enable this.

Resolved:
The Research and Innovation Committee noted the Q2 finance update for research.

23/24/46 Research Performance Report for Q2

The Committee received an update on the performance of the Clinical Research Division during Q2, 2023/24. An overview of the following areas was provided:

- Highlights and successes.
- Study and grant activity.
- Improvement priorities.
- 5-year trends in research performance.
- Research workforce.
- Research themes/units.
- The risk register.

Resolved:
The Research and Innovation Committee received and noted the Innovation Performance Report for Q1, 2023/24

23/24/47 Innovation Performance Report for Q2.

The Committee received the Innovation Performance Report for Q2, 2023/24. An overview of the following areas was provided:

- Operational scorecard.
- Divisional performance;
  - People Plan.
  - HR update and HR metrics.
  - Risks.
- Strategy deployment detail;
  - Pipeline performance data.
  - New into pipeline examples.
  - Programme delivery: Pipeline project from validate to deployed.

- Finance (including benefits).
- Grants.
- Commercial monitoring.
- Brand and marketing.

0186

The Chair referred to Alder Hey Anywhere and asked for clarity on the comments that were made about the risks relating to this area of work. Background information was provided on this matter along with the reasons for the delayed go live date. In terms of revised timelines for the platform there is a possibility that it will be live and operational by Q4 as long as all safety tests have been passed.

The Chair queried as to whether additional information on opportunities, market assessment and analysis could be included in the one page summaries for projects that have gone through the triage phase and have become active. Claire Liddy agreed to include this information going forward for the launchpad projects but pointed out that a market assessment wouldn't usually be conducted for automated solutions due to the nature of these projects. It was decided to have a further discussion outside of the meeting regarding this matter.

23/24/47.1 Action: CL/SA

Attention was drawn to the importance of setting some time aside to reflect on the Trust's ultimate strategy for personal digital space that Alder Hey wants to offer to children, young people and their families (CYPF). This is a large strategic project therefore it is important to articulate a proposed strategy and appraise the options available to enable a judgement to be made in terms of having a hybrid option or a gate way approach with Alder Hey Anywhere as a single go to place. It was felt that there are several things that need to be considered and mapped out in a real forward look. Following a discussion, it was agreed to progress the open action to conduct an options appraisal/proof of concept that was approved by the Programme Board pre implementation of the Alder Care Programme.

The Chair requested that the R&I Committee action relating to the strategy document/Alder Hey Anywhere be reinstated and updated with the outcome of the options appraisal/proof of concept, in preparation for April's meeting.

23/24/47.2 Action: CL/KW

A further suggestion was made about setting time aside during a forthcoming Committee meeting to reflect on the Healthcare Anywhere project in light of the busy market place.

Resolved:
The Research and Innovation Committee received and noted the Innovation Performance Report for Q1, 2023/24

Commercial and partnership monitoring update, Q2
Resolved:
The Research and Innovation Committee noted the update on the three main products detailed in the report.

23/24/48 Innovation Portfolio Review, Q2

The Committee received a report that provided a full deep dive and spotlight into the entire innovation pipeline in order to offer assurance that the pipeline and associated resources are being managed. Over the past twelve months, Alder Hey Innovation has received feedback that the pipeline is too disparate and not strategically aligned. In response to this, the report details the proactive action that has been taken to resolve these issues, demonstrate focus and commence the mapping of projects.

For noting

0187 This is the first report of this topic and is proposed going forward as a bi-annual review of the innovation portfolio strategy alignment and prioritisation. The Committee confirmed their agreement of this proposal.

The Chair requested an update on the Acorn Partnership risk. It was confirmed that the Trust has been working with its lawyers regarding the partnership but there has been a delay. Rachel Lea agreed to follow this matter up and circulate an update to Committee members via e-mail.

23/24/48.1 Action: RL

Resolved:
The Research and Innovation Committee received the Innovation Portfolio Review for Q2 and agreed that this report should be submitted to the Committee on a bi-annual basis.

23/24/49 Board Assurance Framework (BAF) Report

The Committee received the Board Assurance Framework Report (BAF) for September 2023. The following points were highlighted:

- Work is taking place on a further iteration of the R&I BAF risk therefore it is proposed to have a focus on this risk during January's meeting. It was agreed to provide the Chair with an update on the changes to the R&I risk ahead of January's meeting.

23/24/49.1 Action: JC/ES

- A full InPhase BAF report will be submitted to the Committee in January.
- A presentation on the risk management arrangements for R&I was submitted to the Audit and Risk Committee on the 12.10.23.
- The Committee was advised that the Data Access Committee will be instrumental in tightening the controls of the longstanding gap in assurance around data.
- The risk relating to the work of the Strasys partnership is to be included on the BAF.

Resolved:
The Research and Innovation Committee noted the contents of the BAF report for September 2023.

23/24/50 Any Other Business

There was none to discuss

23/24/51 Review of the meeting

The Chair felt that the meeting was very productive and thanked all those involved in compiling the reports and the video. It was confirmed that there is nothing to escalate to the Board.

Date and Time of the Next Meeting: Thursday the 18th of January, 1:00pm–5:00pm, Meeting Room TBC.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	People Plan highlight Report.
Report of:	Chief People Officer
Paper Prepared by:	Sharon Owen, Deputy Chief People Officer

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	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 December/January.
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 ☐

If "No", is a new risk required? Yes ☐ No ☐

Risk Number	Risk Description	Score
#2664 #16 (2.1 BAF)	Industrial strike action impacting staff availability. Workforce sustainability and Development	12 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 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 December 23/January 2024.

2. Current Position

2.1 Workforce Metrics

The monthly workforce metrics are provided in the monthly Integrated Performance Report (IPR). Complete sickness figures for January 2024 are not available at the date of this report writing but will be available for discussion at Trust Board through the IPR. However, it is important to highlight some key themes.

Sickness at 5.8% continues to be higher than the Trust target of 5.5%. This is largely driven by long term sickness absence. Divisional HR Business Partners are supporting divisions to ensure that there are action plans in place to support all staff on long term sickness. HR Advisors are currently undertaking a detailed review of areas of high sickness, identifying correlations with low levels of Return-to-work compliance and Occupational Health DNAs to explore bespoke interventions to improve the position.

Turnover at 11% has reduced month on month for the 10th consecutive month and below the Trust's annual target of 13%. Retention initiatives are proving successful in reducing high levels of turnover.

Personal Development Reviews (PDR's) The current rates of compliance are significantly below the Trust Target of 90%, at 66%. Review of the PDR position for each division will be undertaken to identify reasons for low levels of compliance and actions plans put in place to address this.

A review of workforce metrics will be undertaken to determine target KPI's prior to the next financial year.

2.2 Industrial Action

The BMA have rejected the Government's pay offer for **consultant** colleagues following a referendum where 51% of members voted to **reject** the offer. The BMA have taken the decision to enter discussions with the Government about another pay offer, instead of calling further strikes at this time. The re-ballot of consultant doctors for strike action (should it be required) that closed on 18th December 2023 and was successful. Each mandate is valid for 6 months.

Following negotiations between the BMA and the Government, a pay offer for **SAS doctor** colleagues is being put to members. The referendum will be open from 29th January - 28th February 2024. The recent ballot (closing 18th December) for strike action of SAS doctors was successful, however the BMA have confirmed that no SAS strikes will be called whilst members are voting on the proposal.

0190 The Society of **Radiographers** (SoR) have not yet announced further strike dates; their mandate for strike action ran until the end of December 2023. They have not yet issued a re-ballot of members to extend this.

2.3 Staff Survey

This year's staff survey saw 2537 (60%) colleagues complete the survey– up 6% from 2022 and the highest numbers of staff completing the survey at Alder Hey to date. The full national results are expected in late February.

2.4 Organisational Health and Wellbeing

The Health and Wellbeing Steering Group continues to meet 6 weekly to focus on Organisational HWB, as outlined by NHSE and to provide assurance against the 9 WB Guardian principles.

Following a baseline assessment against the NICE Wellbeing at Work guidance in 2023, Physical HWB was identified as a priority area and a task and finish group was set up. Addressing staff wellbeing following traumatic incidents has also been an area of focus leading to the development of a Debriefing Guidance and pathway, in collaboration with the EPRR lead to ensure that all staff know and have access to the opportunity for a group psychological debrief following a traumatic incident. There is also work underway as part of the new patient safety strategy to ensure that staff wellbeing is considered routinely when incidents are raised. Postvention support in the event of a suicide in the organisation, is a programme of work being led by the SALS Clinical Lead and Deputy Chief People Officer who are developing local guidance.

3 Conclusion and next steps

- A detailed review of areas of high sickness, identifying correlations with low levels of Return-to-work compliance and Occupational Health DNAs to explore bespoke interventions to improve the position.
- Review data on PDR completions per division with targeted action plans

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

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 activities related to equality, diversity, and inclusion throughout the months of December 2023 and January 2024, including a progress update on the Equality Delivery System 2022 and an update on the staff networks.
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 provide the Board an overview of the critical strategic and operational activity related to Equality, Diversity, and Inclusion (EDI) during the months of December 2023 and January 2024.

2. Equality, Delivery System 2022 update

The Equality Delivery System 2022 is almost complete and related action plans have been developed. The final assessment and scoring will take place over the next few weeks. The Equality Delivery System (EDS22) is a framework designed to help facilitate NHS organisations to assess and improve services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice. The analysis undertaken as part of the implementation of the EDS22 can go a long way to providing the information required by law to demonstrate compliance with the Public Sector Equality Duty.

3. Staff Networks

Our developing staff networks continue to go from strength to strength and have been a welcomed support amongst our workforce:

- LGBTQIA+ staff network is currently developing an Allyship training programme that will be piloted within the Finance department during February. This programme will provide our staff on how they can actively support the staff network and become Ally's. February is also LGBTQIA+ history month and the 2024 theme celebrates LGBTQIA+ peoples' contribution to the field of Medicine and Healthcare both historically and today. The staff network is developing plans to showcase the amazing work of LGBTQIA+ staff across the NHS and have a selection of events lined up to celebrate history month.
- REACH staff network continues to make some positive changes and it is growing in numbers. The network is exploring opportunities to develop a Leadership programme specifically for ethnic minority staff and they will be working in collaboration with OD and L&D to explore the options. The network

has also applied for a funding opportunity which is linked to the National retention programme Stay and Thrive. This NHS England led programme is offering regional Trusts £3000 to support projects linked to enhancing the experiences of internationally educated staff. The project proposal will celebrate all our international colleagues, providing them with opportunities to develop leadership skills and learn the Liverpool Dialect by introducing 'Scouse School'.

- Armed Forces staff network are making some exciting plans which will help provide support to armed forces staff as well as children and young people from armed forces families. They are engaging with the local Armed Forces community and are working with local cadets to seek opportunities to team up and support our children and young people. They are already planning the Remembrance service and will also be planning other events throughout the year to mark the armed forces community. The network is also putting plans in place to enable Alder Hey to apply for the Armed Forces Covenant Gold Award which is a fantastic achievement.
- The **ACE** Disabilities and Long-Term Conditions staff network held an engagement event in the Atrium in December to celebrate Disability History Month and it was a huge success and lots of staff made a pledge to support the ACE staff network in working towards enhancing the experiences of staff with disabilities and long-term conditions. The network also had a Christmas party which brought members together in a social environment to share food and celebrate the festive session. The last meeting held in January saw our Non-Executive Director Garth Dallas share his role as EDI Champion with the wider network members. The network also discussed their ideas and plans for 2024, developing actions to support the key deliverables set out in the Workforce Disability Equality Standard action plan.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
January 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 8th February 2024

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

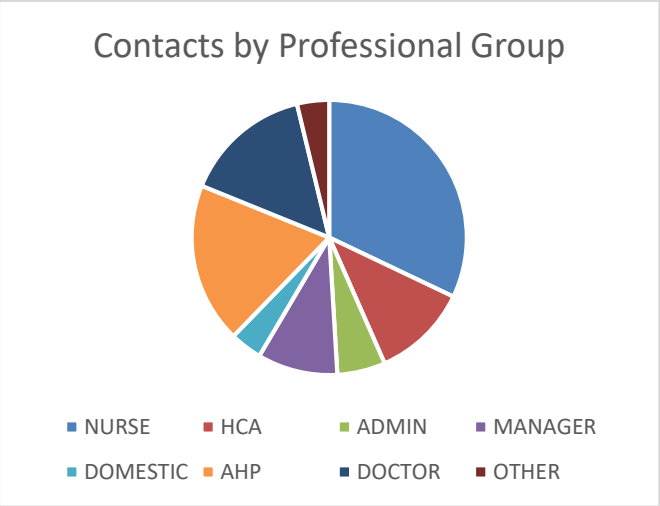
1. Purpose

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

2. Recommendation

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

3. FTSU Activity and Q2/Q3 Data



Contacts by Professional Groups

There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a range of worker/professional groups and levels of seniority.
A comprehensive definition for professional groups forms part of the updated guidance.

Recording Cases and Reporting Data (nationalguardian.org.uk)

Themes highlighted in bold are reported as part of the mandated quarterly data collection and returned to the National Guardians Office

Theme	Open	Closed	Total
Patent Safety and Quality	7	1	8
Worker Safety and Wellbeing	0	1	1
Inappropriate Attitudes and Behaviours	13	8	21
Policies, Processes, Procedures, Systems	15	6	21
Infrastructure/Environment	2	4	6
Cultural	1	1	2
Leadership			0
Senior Management Issue			0
Middle Management Issue			0
Total	38	21	59

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

Of the 38 cases that remain open in Q2/Q3, 2 is due to the individual currently being on sick leave and therefore unable to progress, 2 remain open at the request of the worker following changes made, there are 8 pending closure, this delay is due to the closure meeting not having taken place, of the remaining 26 cases, progress is being made and closure should occur in early 2024

Patent Safety and Quality

Concerns that relate to patient safety and quality are always escalated to the senior leadership team within the area. The concern raised in relation to patient safety in Q2, was escalated and actioned swiftly. The issue raised was in relation to adequate staffing numbers, skill mix and the ability to provide on-call cover out of hours, the staff members involved were assured by the proposed management action plan addressing these issues, that patient safety would not be compromised

and where happy for the case to be closed. Of the 7 cases remaining, 6 of these relate to one concern, in this case the issues have been escalated to a senior level and are being managed with clear action plans being formulated, there has been no harm to patients. The remaining case is relates to the management of a patient , this is also being escalated and managed at a senior level

Inappropriate Attitudes and Behaviours
There was a total of 21 issues raised in Q2/Q3, in this category where poor leadership behaviours are cited including, strained professional relationships; poor team culture and the development of 'cliques', creating toxic and divisive environments, lack of action to manage conflict and challenging situations; reported micro-management and communication. Staff are supported through coaching style conversations to manage expectations, explore options available and agree future actions. Actions may include facilitated conversations and mediation. While colleagues are accepting that the Trust is under severe operational pressure, several staff have expressed anxiety about returning to work after a period of ill-health or are seeking employment in alternative positions either internally or outside the trust due to their working environment.

Policies, Processes, Procedures, Systems
There were 21 issues or concerns raised in this category in Q2/Q3. These relate to policy and process and how this is interpreted and managed (by managers and Human Resources colleagues) impacting on the experience of workers and appearing to undermine the confidence in the aspirations of compassionate leadership and processes. Issues have been raised directly with HR within divisions to ensure they understand the reported experience and perspective. Specific queries relate to the application of the Sickness Policy, Flexible Working Policy, Disciplinary Policy and Procedure, and the perceived variance of job descriptions for similar roles across the organisation and subsequent Agenda for Change grading. Raising concerns relating to policies and procedures is ongoing and the FTSU Guardian and Champions are working with HRBP's to provide feedback on staff experience and support the continued reviewing, development and improvements of policies in line with our Trust values and Leadership Behaviours.

Infrastructure/Environment
The 6 issues raised in relation to infrastructure, were centred on the availability of resource, in terms of staffing, equipment and structure .In the 2 cases that remain open, 1 does have an agreed action plan to address the concerns raised, however to date it has not been possible to meet with the individual who raised the concern as they have limited attendance at the Trust, which has hindered progress.

Culture
In the 2 issues regarding culture, 1 was focused on an individual's journey following their appointment, the negative communications the individual received and the lack of support afforded to this person. The individual raising the concern, believed that this behaviour was as a result of their race. This concern was escalated to the Divisional lead who immediately addressed the issues raised, meeting the individual to elevate their concerns and developing a plan to move forward. The response to close the case was extremely positive regarding the support they had received and has mitigated the risk of this individual leaving the organisation due to these behaviours. The remaining open case relates to the management style adopted when addressing a concern with the member of staff raising the FTSU concern, there is a plan to meet with the lead involved to understand this in greater detail.

Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again and scored the process highly in terms of satisfaction. To view results from the questionnaire post closure please click on the link below

https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=OVmEMfpVb8x8dRhYPVxLZDFdyaHIx6lu&id=G888R1c5sE6Cur6KaqH2Sri2S89zA4NJtHQSSVjh0UBUQktJNk5OWUNCN01YUVNOWjlSTkVQSFBDMC4u

4. FTSUG Visibility Programme
This was developed to assure ourselves that staff understand the role and how it can support them to raise concerns, safely, that staff are familiar with the FTSU Guardian and to aid in the recruitment of FTSU Champions, so that our diverse workforce was truly represented, thus reducing barriers. To date the FTSU Champion group has increased by 9 as a direct result of the visibility programme, with a FTSU Champion training session scheduled for the 29th January 2024.

Currently 30 wards/Department have been identified, 20 with an agreed date and time of visit. The visits are not only aimed at our acute hospital but also in our community sites, so that staff, wherever they are, know their views and concerns are valued. Recently the FTSUG has attended the joint Liverpool and Sefton Physiotherapy and Occupational Therapy meeting and is scheduled to attend the Liverpool SALT face to face locality meeting, this attendance allows a wider reach to staff and this greater promotion. Contact is made with the department manager regarding the visit, this contact helps promote positive working relationships between manager and FTSUG, feedback post visit is provided to the manager.

5. MIAA Audit
The FTSU process has recently been subject to an audit by MIAA for the first time. The report was delivered in December 2023 with an overall assessment of 'substantial assurance'. There are five recommendations arising from the audit report, four of which were assessed as low risk and one as medium; the recommendations were presented as 'areas for improvement' given the overall findings with regard to the robustness of the controls in place. The audit findings provide an additional layer of assurance to the board that our speaking up arrangements are working as they should, with some

additional areas to consider to strengthen our processes further and these are being taken forward in the coming financial year. This include the recruitment of the deputy FTSUG which is subject to a business case for additional backfill resource for one of the existing Champions to take on the role.

6. FTSU Champions Matrix

As the FTSU Champions network grows, it is important to assure ourselves that we are developing a group that is representative of our workforce, that they reduce any perceived barriers to staff speaking up, such as job role, band, seniority, race, sexual orientation, disability, to name but a few. Below are our current FTSU Champions, job role, area of work and division.

Name	Job Title	Area of work	Division	Completed training
Joe Fitzpatrick	Internal Communications Manager	Communication	Corporate	yes
Paula Clements	Theatre Matron	Theatre	Surgery	yes
Julie Worthington	Clinical Systems Facilitator Chair Staff side	IM&T	Corporate	yes
Adam McNeill	PICU Education Facilitator	PICU	Surgery	No, scheduled 29/1/24
Karl Emmerson	Neuro Nurse Specialist	4B	Medicine	No. scheduled 29/1/24
Emily Kavanagh	Learning Disability Nurse Deputy Chair ACE	SEND Team	Community	No. scheduled 29/1/24
Paula Beazley	Medical Photographer	Medical Photography	Community	yes
Clare Rider	Project Manger			
Despina Forysth	HCA	4B	Medicine	No scheduled 29/1/24
Madeline Whelan	Lead Pharmacist	Pharmacy	Medicine	No. scheduled 29/1/24
Lisa Jones	Aseptic Technician	Aseptic Unit Pharmacy	Medicine	No. scheduled 29/1/24
Christopher Browne	Concierge Advisor	Patient Experience	Corporate	No. scheduled 29/1/24
Andrew Edogun	Resilience Officer	Emergency Preparedness	Corporate	No. scheduled 29/1/24
Suzie Hutchinson	Strategic Clinical Lead	Sefton MHST	Community	yes
Jane Attwood	Manager IDigital	IM&T	Corporate	No. scheduled 29/1/24
Carl Dutton	Specialist Mental Health Practitioner	CAMHS	Community	yes
Paul Sanderson	Interim Chief Pharmacist	Pharmacy	Medicine	No. scheduled 29/1/24
Clive Marlton	Clerical Officer/Admin	Physio School	Community	No. scheduled 29/1/24
Stephanie Taylor	Clerical/ Admin		community	No. scheduled 29/1/24
Connor Greenwood	Pharmacy Tech	Pharmacy	Medicine	No. scheduled 29/1/24
Zoe Mawdsley	Ward Manager 4A	Ward 4A	Surgery	TBC
Dave Walker	Charge Nurse	Ward 4A	Surgery	TBC

Gaps

The continuing recruitment of FTSU Champions, remains a priority, as to date we still have areas that do not have a FTSU champions, nor do we have significant representation from our consultant body, or our REACH, ACE and LGBTQ+ networks.

7. FTSU APP Development

Prior to the introduction of InPhase as a platform for staff to raise concerns, the FTSUG had started work with the Innovation Hub to create an App that staff can have on their mobile devices so that they can raise concerns via this route. The idea has been accepted for the next phase and a scoping document completed and signed off. The benefits indication element of the document are listed below.

- Implementing an efficient system for the FTSU guardian can streamline the reporting process to national offices and the daily management of staff data, contributing to smoother operations and improved support.

- Providing a user-friendly service and easy accessibility can enhance staff satisfaction, reduce workplace stress, and minimize the need for staff to take time off.
- Accessibility for both the FTSUG and staff.
- Enhanced transparency.
- Sharing quarterly generated reports with the board and the FTSU Guardian's Office on a national scale.
- Standardization of the FTSU approach and improved timeliness.
- Alignment with best practice guidelines.

There is nothing specific product for use by the FTSU mechanism, currently on the market so this would be introducing a new idea that Alderhey would pioneer, and which could expand across the NHS.

Kerry Turner
Freedom to Speak Up Guardian
January 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	People and Wellbeing Committee
Report of:	Fiona Marson, Non-Executive Director
Paper Prepared by:	Fiona Marston

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 People and Wellbeing Committee meeting held on 24th January 2024, along with the approved minutes from the 22nd of November 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
2.1	Workforce Sustainability and Development	15
2.2	Failure to deliver the best experience for Staff, Children and	9
2.3	Young People and their Families Workforce Equality, Diversity & Inclusion	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. Agenda items received, discussed / approved at the meeting

- Progress against the People Plan:
  Thriving @ Alder Hey continues to advance positively and governance is close to delivery. The committee were updated on the progress of activities relating to:
  - Preceptorship through which newly regulated professionals (nurses, nurse associates & allied health professionals) are welcomed and integrated into Alder Hey. The aim is to achieve more commonality for all staff categories in order to attract and retain staff. Policy to PAWC in Feb 2024.
  - Management Essentials: internal programme for development of leadership skills. Training plan is ready for rollout in Feb 2024

  Thriving metrics are (i) churn (net joining & leaving) and turnover, (ii) sickness and (iii) retention. In addition a staff thriving index is under development and questions to staff have been formulated with the aim of commencing a trial to test this metric, commencing in April 2024.

- **Divisional Metrics Update:**
  Divisional metrics show some good downward trends relating to sickness absence and staff turnover. Time to Hire & Return to work remains areas of concern with continued monitoring throughout departments with a view to taking actions.

  Trust Wide metrics were included and the Committee acknowledged the good progress made in this level of monitoring.

- **Staff Survey Update:**
  Approximately 60% of staff responded to this year's survey, with no division or department below a 50% response rate and the HR team were congratulated. Results across all themes and Alder Hey outscored all comparator Trusts. Areas of concern were noted with action plans to be developed and brought back to PAWC. Alder Hey is awaiting central data to be sent out (Feb), which will be used to create a dashboard, based on which Big Conversations can commence.

- **Freed to Speak Up Update:**
  A detailed overview was provided to the committee noting all ongoing developments remain on course:
  - There has been a large increase in the number of FTSU Champions in the Trust
  - An MIAA Audit was completed, outcome was substantial assurance with areas for further work identified
  - Visibility Programme has now launched and continues to make good progress.
  - A new App development remains underway. There are Apps in other Trusts but without all the features identified as needed by the FTSU Guardian

0201 There are now three FTSU Training modules for staff one of which is mandatory. Data on uptake will be shared quarterly.

- **Apprenticeship Update:**
  Assurance was provided to the committee on the latest apprenticeship developments, which continue to progress positively. Not all vacancies are apprenticeship opportunities but there is scope for increasing the number of apprenticeships offered by Alder Hey. A significant number of staff lack the required maths and English qualifications but there is scope to fund staff to improve their maths and English to the appropriate level.

  Apprenticeship Week will run from 5th – 11th Feb 2024.

- **EDI & Inclusion Plan Update:**
  The committee noted good progress on EDI and Inclusion in Alder Hey with the setting up of networks. The EDI lead is also work with the ICS. Work is ongoing on reporting and the plan is to provide more support for staff to complete the 2024 25 equality impact assessment. The staff survey provided good feedback and a basis for developing action plans.

  Additional resource has been awarded to recruit a new EDI Advisor role to continue to push project improvements forward.

- **Gender Pay Gap Update:**
  The Gender Pay Gap report highlighted that on average in Alder Hey women earn 27% less than men (median gap 19%). This is not a result of paying men and women differently for the same or equivalent role but a reflection on the proportion of women in lower grade roles. Nonetheless actions to achieve improvements by supporting female staff better. The stated long term goal is to attain gender balance across the Trust workforce especially at more senior levels

- **Board Assurance Framework Update:**
  The Committee membership noted the contents of the BAF report noting there are 3 remaining risks for which PAWC is responsible. The aim is to consolidate these under 2 risk headings.

  A Deep Dive on was undertaken on risk 2.3 (Quality Diversion & Inclusion) and the committee noted the current risk rate of 15 with a target of 4.

- **Minutes Received and Approved**
  - Health & Safety Committee (Sep 2023)
  - JCNC (Dec 2023)
  - LNC (Oct 2023)
  - Education Governance Committee (Oct 2023)
  - EDI Steering Group (Sep 2023)

2. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 22nd November 2023
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director **(Chair)**	(FM)
	Fiona Beveridge	Non-Executive Director	(FB)
	Garth Dallas	Non-Executive Director	(GD)
	John Kelly	Non-Executive Director	(JK)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MSW)
	Rachel Greer	Associate Chief Operating Officer, CAMHS	(RG)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
	Kelly Black	Matron – Surgery	(KB)
	Sarah Leo	Head of Research	(SL)
In attendance:			
	Kathryn Allsopp	Head of Operational HR	(KA)
	Katherine Birch	Director, Alder Hey Academy	(KB)
	Gill Foden	HR Manager	(GF)
	Amanda Harrison	Head of Human Resources	(AH)
	Alison Mellor	Workforce Systems & Information Manager	
	Phil McNamara	Internal Communications Manager	(PMc)
	Sharon Owen	Deputy Chief People Officer	(SO)
	Natalie Palin	Director of Transformation	(NP)
	Jo Potier	Associate Director of Organisational Development	(JP)
	Jill Preece	Governance Manager	(JP)
	Darren Shaw	Head of Organisational Development	(DS)
	Kerry Turner	FTSU Guardian	(KT)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Apologies:	Chloe Lee	Associate COO – Surgery	(CL)
	Rachel Hanger	Associate Chief Nurse – Surgery	(R
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(AB)
	Adam Bateman	Chief Operating Officer	(AB)
	Jason Taylor	General Manager – Research	(JT)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	Asia Bibi	ACOO – Service Improvement	(AB)
	Julie Worthington	Staff Side Chair	(JW)
	Urmi Das	Director, Division of Medicine	(UD)
	Jacqui Pointon	Associate Chief Nurse	(JP)
	John Chester	Director of Research & Innovation	(JC)

22/23/210 **Declarations of Interest**
No declarations were declared.

22/23/211 **Minutes of the previous meeting held on 13th September 2023.**
The minutes of the last meeting were approved as an accurate record.

22/23/212 **Matters Arising and Action Log**
Action log was updated accordingly.

22/23/213 **Strategy Progress Update**

People Plan – Thriving @ Alder Hey Children's NHS Foundation Trust

MS presented an overview on the progress of the 'Thriving' element of the strategy development which continues in line with progressing Vision 2030.

Recent focus has been on the benefits and efficiencies associated with the delivery of the people strategy.

NP delivered an overview of the deep dive undertaken to realise the full financial impact of staff turnover and sickness within the organisation i.e., agency spend, impact on colleagues, productivity etc NP explained that the presentation starts to illustrate some of the thinking and potential efficiency savings in relation to the Vision 2030 'Thriving' workstream.

FB commented that the turnover data has been cast in deficit mode as if all turnover is negative and reminded colleagues that some turnover is healthy. A huge focus of this piece of work needs to look at whether the right people leaving for the right reasons and staying for the right reasons. MS agreed that we need to utilise the demographic data from the Strasys review to understand these particular cohorts of staff and whether or not we are providing the right opportunities for staff. FM agreed and stressed the need to focus on where we can have the most impact on staff and staff wellbeing and a particular focus on succession planning is needed.

JK talked about the benefit case for reducing turnover and stressed the need to demonstrate the return on investment of each 1% reduction. He agreed with colleagues that 5% churn is healthy and market standard.

MS agreed that an ambitious cost reduction target of £2m had been set for year 1 of the Vision 2030 priorities which would continue to develop.
FB highlighted the importance of capturing all outsourcing costs for sickness, not just agency and bank spend.
CW talked about the financial impact of not having the correct skill mix which can be an issue within the Medical Division.

Resolved: The Committee received the Strategy Progress Update noting a further update scheduled in the New Year.

22/23/214 **Monitor Progress against the People Plan**

- **Divisional Metrics**

Medicine

The Committee received the Medicine Division metrics report (October 2023) data and noted progress to date. CW highlighted the following:

- Staff turnover showed a reduction of 2% since September.
- Sickness reported 6.36% which has decreased - plans in place to maintain all long term and short-term cases with support from divisional HRBPs.
- Return to work documentation compliance remains static and continues to be monitored in data inputting by ensuring all data is entered in a timely manner.

- PDR compliance is 80%. Medical appraisal compliance is at 81% and continues to be monitored monthly and discussed at Senior Management Meetings.
- Mandatory Training reported 93.45% and remains stable. Division aims to achieve 95% by deadline. Following an initial deep dive, various departments appeared just below the 80% target and priority training sessions are taking place.

Health & Wellbeing Week

In response to feedback from last year's staff survey, a Health and Wellbeing Week took place on 20th – 24th November involving a range of onsite activities throughout the departments displaying good engagement across departments in support of wellbeing week at Alder Hey. Fun packs had been delivered for staff throughout the hospital.

Staff Survey

Division of Medicine position has reached 51% compliance. All areas continue to be encouraged to complete the survey. All data continues to be monitored and reviewed.

Next Steps:

- Service provision remain stabilised and focused on activity.
- Top 4 areas have been identified with plans in place for each department with support from SALs when required.
- A Celebration & Recognition approach will be reenergised picking up from the previous year and will play a part in supporting and valuing our colleagues.
- Ask the Execs continues to be attended by members of the division and shared accordingly.

The Chair acknowledged good communication and engagement displayed across the division and noted there are good trends decreasing displaying positive progress being made.

Surgery

The Committee received the Surgery Division metrics report (October 2023) data and noted progress to date. KB highlighted the following:

- Staff turnover had declined in month and stood at 12% for the month of October.
- Exit Interviews; continue to conduct conversations with colleagues. New exit questionnaire will go live in due course available via trust intranet in the coming weeks.
- PDR compliance reported 53% to date for band 6 and below and 52% for band 7 and above – plans in place to address and monitor.
- Sickness absence current position reported 6.1% to date. Long term and short term continue to be well managed and supported throughout departments.
- Return to work continues to be monitored on data inputing. Division has formed a weekly assurance meeting Chaired via Head of Nursing supported by HR and the Roster Team.
- Staff Survey reports 53% with continued encouragement to complete.
- Mandatory Training reported 93% compliance to date. Plans for improvement continues to be reviewed and undertaken across the division. For face-to-face

training, non-compliant staff had been booked onto the next available session.

- A detailed temperature check had been undertaken with the ICU Nursing Team to consider any divisional improvements that can be driven by the team with a focus on wellbeing.

Health & Wellbeing Week

The division had also participated in a wellbeing week which was extended to AHPs and clinical teams aligned with wards and departments. Some really positive engagement between medical and nursing teams had come out of these activities. Follow up engagement sessions will continue to commence.

JP reflected on the level of engagement amongst teams during wellbeing week activities which had been impressive. Great to see that people are doing this in a way that suits their areas.

The Chair thanked KB for the detailed report noting areas of progression including the staff survey position.

Clinical Research Division

The Committee received the Research Division metrics report (October 2023) data and noted progress to date. SL highlighted the following:

- Turnover remains under 6% which shows a reduction.
- Short term sickness absence remains low at 1% with long term sickness absence reporting at 5%
- Return to work remains at 100% to date.
- Mandatory Training continues to be stabilised with plans to keep compliance steady.
- PDR for band 7 and above is at 85% and band 7 and below have continued plans for support.
- Wellbeing and staff survey is led by Laura Rad, Head of Nursing. Staff engagement sessions will continue to run accordingly.
- Star of the Month is highlighted in Team Briefing meeting for colleague recognition and shared learning.
- Staff survey response rate for Research reports at 63%.

The Chair acknowledged positive progress being made throughout the Research Division. Conversation ensued regarding presentation of the research and innovation metrics being presented together. FM undertook to pick this up with John Chester outside of the meeting.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (October 2023) data and noted progress to date. RG highlighted the following:

- Staff Turnover has shown a slight increase at 13% with plans to maintain

data.

- Sickness remains stabilised across areas (6.4%) with plans to align to winter.
- Return to work reported at 76% to date.
- Overpayments remains challenges across areas with action plans in place to address and manage. Training sessions for managers in relation to following policy & protocol are being arranged.
- Staf survey response rate currently sitting at 64% and rising and remains a focused priority.

Health & Wellbeing

The division held a breakfast morning for the Booking & Scheduling Team as part of staff experiences over the last 12 months which was a good success in communication and engagement. A workshop will be formed to help promote support for improvement for acknowledgment and recognition for colleagues at Alder Hey.

The Chair noted good progress being made throughout the division in particular to the staff survey reporting figure which is making good headway.

Corporate

The Committee received the corporate metrics report (October 2023) data and noted progress to date. ES highlighted the following:

- Staff survey response rate is at 57% to date.
- The Corporate Services Collaborative continues to meet monthly with good engagement across the organisation.
- Turnover position is at 12% which appears below trust target – shows a reduction in data.
- Sickness absence showed a slight increase for both long and short-term sickness cases; 4% and 3% respectively. Plans are in place to manage.
- Return to work has plans for improvement across the patch. Hot spots have been identified and initial piece of work will be undertaken to review and manage.
- Mandatory Training reported at 93% compliance to date. ES informed colleagues of the detailed discussion at the November SAQC meeting following presentation of the safeguarding report and mandatory training position which showed low compliance in some areas across the organisation. This had been added to today's CSC agenda for a deep dive into hotspot areas within corporate services.
- PDR positions remains on target to reach compliance with action plans in place to manage.
- Outputs from the staff survey 2022 BIG conversations were presented to the committee. JP doing work within corporate areas to respond to staff feeling that they are not listed to.

FB commented on the focus SQAC had been taking on sepsis and safeguarding training. She referred to the issue with sepsis training in that a lot of staff had been

exempted erroneously and that work was ongoing with the Academy to identify who is required to complete. As a result, compliance rates have been depressed but should see an increase in the coming months. Low compliance for safeguarding training is not an acceptable position in a children's hospital regardless of their role and this would be closely monitored by the committee on a monthly basis.

Next Steps:
Corporate metrics will continue to monitor and record all hot spots with internal focus on priority cases.

The Chair noted the slight rise in short term sickness across areas and highlighted good efforts are being made to complete targets including staff survey results.

- **Trust Wide Metrics**

Committee received and acknowledged data report and noted progress being made across the organisation.

The Committee acknowledged the Trust Wide Metrics is making good progress.

Resolved: Committee received and noted progress made to date from each division.

22/23/215 **Raising Concerns/FTSU**

The Committee received the Raising Concerns/ FTSU report and noted progress to date. KT highlighted the following:

KT reminded committee members of the purpose of the Freedom to Speak Up role, which is to provide colleagues with a safe route of raising and addressing concerns with Managers and to escalate as and when required to ensure appropriateness is being managed. She informed colleagues that there are on average 25-30 cases reported each quarter with the higher reported concerns being behaviours and relationships and process/policy issues. Staff also raise concerns via the SALS route. KT talked about the FTSU walkabout programme and its aim to visit every ward and department to raise staff awareness of the service and reduce barriers.
A full training programme is available for all FTSU Champions.

- GD took the opportunity to thank KT for the huge amount of work in this area and informed colleagues of the key relationship that formed with the EDI Steering Group Network Chairs. He went on to make a plea to make champions much more visible.
- JP echoed GD's comments and informed the committee that the model implemented at Alder Hey 'trauma informed FTSU' was unique to the Trust.

- Freedom to Speak up Guardian works in partnership with Senior Leadership, SALs and HRBPs to review any potential overlaps. This also allows key areas

of focus to be identified working in collaboration to highlight any rich data across the organisation to make any informal changes.

- National Guardian report continues to be presented quarterly to Board.

Next Steps:

- KT noted, once Champions have been identified, there will be a promotion of visible information made available across the trust with support from Communication Team.

Chair acknowledged progress within the report and noted good intentions to the creation of the Champion role.

Resolved: The Committee noted the FTSU update.

22/23/216 **2023 Staff Survey update**

The Committee received the Staff Survey report and noted progress to date. DS highlighted the following:

Staff Survey response rate reports at 59% to date.

Trust continues to encourage colleagues across the organisation to complete the staff survey ideally aiming to achieve up to 60%.

Final data expected by end of December 2023. BIG conversation packs will be issued once the data has been received by Quality Health

The Chair formally thanked DS for the work achieved to obtain Alder Hey's current figure which is making good progress. This was a great reflection on how Alder Hey works collectively together.

Staff Survey completion continues to push forward.

Resolved: the committee noted the 2023 staff survey update.

22/23/217 **Health & Safety Dashboard**

The Committee received the Health & Safety Dashboard for Quarters 1 & 2 (2022/23) and noted progress to date. AK highlighted the following:

- Mandatory Training reporting at 96% within the department
- Practical manual handling training L2 has decreased to 70% due to long term sickness of the trainer; team are monitoring with recovery plans in place to secure a trainer and develop a recovery plan to develop new key trainers.
- Manual handling training L1 remains above trust target at 98%.
- Risk Assessment Training: Health & Safety continue to provide training monthly. An application to the Education Governance Committee was made to have risk access training made as a mandatory module for band 5 and above; approval is pending.

- First aid training for staff and 'mini medics' – training continues to be rolled out both on and off site. In the process of exploring feasibility of a 'mini-medics' first aid training programme for CYP.
- Two RIDDORS reported to HSE.
- The Water Safety Group continues to monitor compliance with the Water Safety Plan.
- Health & Safety site inspections continue daily/weekly as required.
- Risk Register reports 8 open risks all within expected review date and with action plans in place.
- Non-Clinical Claims reports 12 reported in year. Team are working closely with Inphase to resolve all issues.
- Non-clinical incidents Q1 495 and Q2 567. An increase was reported due to a change in categorisation within the new InPhase system.

RAMS

Activity remains challenging with current capacity across Alder Hey totalling 89 sets of RAMS reported to date. All approved developments are conducted in line with site inspectors to ensure the trust is compliant with safety controls aligned to the control of contractor's policy.

The Chair thanked AK for the comprehensive update and noted good progress being made.

Resolved: The Committee received and noted the Health and Safety Performance Dashboard for Q1 & Q2 2023/24.

22/23/218 **North West BAME Assembly Anti-Racist Framework**

The Committee received an update against implementation of the North West BAME Assembly Anti Racist Framework and noted progress to date. AD highlighted the following:

- The NW BAME Assembly Anti Race Framework, supported by the ICS, has been adopted by the Trust and is being implemented as a region.
- A self-assessment has now been completed.
- action plan now developed and plans in place to implement the framework linking both the EDS22 including the WRES/WDES.

Next steps:

Engage with our REACH staff network and our trade union representatives to ensure they contribute to the development of the action plan. A quarterly update will be provided to the committee.

Resolved: The committee noted progress regarding becoming an anti-racist organisation applying the guidance and support from the North West BAME Assembly Anti-Racist Framework.

22/23/219 **Workforce Race Equality Standard**
Workforce Disability Equality Standard

The Committee received the WRES/WDES and noted progress to date. AD highlighted the following:

Workforce Disability Equality Standard There has been an increase in the number of staff declaring a disability which is a positive outcome. However, a number of staff don't declare so the team are working on this to provide necessary support for staff to declare. The EDI Team are working with the Network Chairs, Communications Team and FTSU Guardian including HRBPs to ensure we are promoting learning and presenting opportunities for our colleagues here at Alder Hey. Reasonable Adjustments Policy now launched.

Workforce Race Equality Standard Good progress. More staff employed from BAME backgrounds 11.5%. REACH network now in place. Teams continue to work closely for those remaining members by providing support and guidance. There is a decrease in the number of colleagues declaring bullying and a decrease in the number of concerns raised relating to bullying and harassment.

Next Steps

- Disability and Black History Month continues to be a main focus of achievement following previous feedback.
- On 4th December 2023 the Disability Team plan to talk to colleagues throughout the trust to provide awareness and assurance.
- Career progression will be a focus over the coming months along with starters/leavers data to try to make significant improvements.
- Future plans involve EDI improvement Plan aligning as one overarching action plan.

The Chair thanked AD and noted good progress made within the EDI Steering Group with good communication and engagement, but stressed the need for %ages to be moving toward zero. AD agreed that a change in culture is first step in achieving this.

Resolved: The Committee APPROVED the Workforce Race Equality Standard and Workforce Disability Equality Standard documentation.

22/23/220 **NHS Pre-employment Checks Audit**

The Committee received the HR Audit and noted for information. SO highlighted the following:

SO informed the committee that, following a recent MIAA audit which highlighted a number of gaps with recruitment procedures, and specifically qualifications evidenced on file, an additional piece of work had been requested by the Audit and Risk Committee to test compliance in this area.

The committee were informed that this work solely related to historical records and assurance provided that current record keeping was up to date. A stratified review of

historic records has now been undertaken looking initially at those required to have a statutory professional registration which were all fully compliant. Those undertaking clinical activities but not required to hold a professional registration would then be audited. Work remains ongoing with all actions on track. A final outcome report would be presented to Audit and Risk Committee and PAWC early in the New Year.

Resolved: PAWC received and noted the report in respect of employment checks audit.

22/23/221 **Overpayments**

The Committee received the Overpayments and noted for information. KA highlighted the following:

KA provided an overview on the current overpayment position at Alder Hey noting, the volume of overpayments reduced by 24% and compared to last year's figure.

Most frequent reason for overpayments was payroll error – late notifications.

Actions noted to improve position going forward – review, working closely with divisions, MIAA review, regular scrutiny and monitoring through RABD.

Position is the report will be submitted to RABD and subject to MIAA audit going to audit & risk in January 2024. Actions were taking is to see those improvements.

Impact on individuals always considered in terms of recovering monies – payment plan always agreed that reflects circumstances.

Resolved: the committee noted the overview of the Trust's overpayment position, current monitoring, and future actions.

22/23/222 **Trust DBS Renewals Programme Update**

The Committee received the DBS report and noted for information. KA highlighted the following:

KA reminded colleagues that in 2019 the Trust agreed a DBS renewal process subsequent to the Lampard review and NHSI/E recommendations (repeat every 3 years). KA clarified that international candidates join on a letter of police clearance as DBS does not check international records and are subject to a DBS check at the appropriate level following a short time period.

Current data review showed there are 93.4% of colleagues who have had a DBS check within the last 3 years. Anyone appearing outside of this will be reviewed on a risk basis i.e., clinical colleagues prioritised.

All action plans remain ongoing and are being managed accordingly.

GD asked about the Lampard review being primarily around Saville case and if the trust has anything in VIP visitors' policy? ES responded that a full-scale review of

recommendations from review was undertaken, and a full revamp of external visitors policy was undertaken. Assurance that JS did not visit AH.

Resolved: PAWC received and noted the update on the DBS renewals programme.

22/23/223 **Board Assurance Framework**

The Committee received the Board Assurance Framework for the month of October 2023. ES highlighted the following:

New version of the InPhase BAF Report noting that there were still some formatting issues to resolve over the coming months.

Work was underway to review the three current risks sitting within PAWC which were expected to reduce to two going forward to reflect 2030 Strategy. It was envisaged that the wellbeing risk would be replaced with a risk that describes the overall cultural conditions required to deliver the 2030 Vision.

Next Steps:

- Executive oversight remains focused on all open risks and in preparation ahead of winter. Executive colleagues continue to refine the BAF to reflect risks to delivery of the new Strategy – this will be presented to the December Board meeting.

Resolved: Committee received and noted the Board Assurance Framework for the month of October 2023.

22/23/224 **Nursery Ofsted Report – for Information**

The Committee received the Nursery Ofsted Report and noted for information. SO highlighted the following:

SO highlight to the committee good progress achieved following recent Ofsted inspection reporting an overall Good rating.

Resolved The Committee NOTED the report.

Ratify HR / Health & Safety Policies

22/23/225 **Social Media Policy**

The committee received the Social Media Policy which had been updated since the last meeting when feedback had been received regarding strengthening safeguarding elements of the Policy to ensure the safety of our staff safe. PMc had worked together with ES to ensure the Policy provides clear guidance to colleagues regarding the use of social medial platforms.

Resolved: The Committee Approved the Social Media Policy

Alder Hey Children's NHS Foundation Trust

22/23/226 **Health & Safety Committee (HSC) Minutes**

The Committee received the approved minutes of the HSC meeting held on 25th September 2023.

22/23/227 **Joint Consultative and Negotiation Committee (JCNC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on 18th October 2023.

22/23/228 **Local Negotiation Committee (LNC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on 8thAugust 2023.

22/23/229 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on (10th August 2023).

22/23/230 EDI Steering Group (Sept 2023)
The committee received the approved minutes from the EDI SG held on 17th July 2023.

22/23/231 **Any Other Business**

No further business was raised.

22/23/232 **Review of Meeting – Chair's Report to Board**

Strategy Update:
Progress towards delivery of the 2030 Strategy (People Plan) continues to progress. The Committee held a long discussion around staff churn and agreed to ensure we reflect the need to have a small amount of turnover and also a focus on whether the right people leaving/staying.

Going forward a focus on succession planning would be included in this piece of work as well as diversity.

Freed to Speak Up Update: A detailed overview was provided to the committee noting good progress is underway with making FTSU Champions more visible going forward.

Divisional Metrics Update: Divisional metrics – very encouraged by positive trends particularly in staff turnover.

Big conversations continue taking place in line with exit interviews / questionnaires.

Wellbeing Week was very well received by staff with really positive engagement throughout the trust and indeed on staff morale. It was really encouraging to see that people are doing this in a way that suits their areas.

Some emerging trends with regards to staff sickness which could be directly related to winter cold/flu.

Staff Survey Report: Staff Survey reported 59% to date with a trust target of achieving 60%.

Health & Safety Dashboard: a comprehensive overview of activities within the H&S department received with some really positive themes identified in terms of training and assurances was provided to ensure safety across Alder Hey.

North West BAME Assembly Anti-Racist Framework: Committee noted good progress being made to the Anti Race Framework with plans in place to support the next 12 months.

WRES/WDES Update: WRES/WDES reports highlighted good progress being made. The committee Approved both sets of documentation.

Date and Time of Next meeting

Wednesday 24th January 2024 at 2pm via MS Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Minutes of the meeting held on Wednesday 20th December 2023 at 15:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	John Grinnell	Deputy CEO/CFO	(JG)
	Rachel Lea	Deputy Director of Finance	(RL)
	Dame Jo Williams	Chair	(DJW)
In attendance:	Nathan Askew	Chief Nurse	
	Sian Calderwood	ACCO, Medicine	
	Audrey Chindiya	Accountant, Medicine	
	Ian Gilbertson	Deputy Chief Digital and Information Officer	
	Jane Halloran	Acting Deputy Development Director	
	Natalie Palin	Associate Director Transformation	
	Abby Prendegast	Associate Director of Strategy and Partnerships	
	Jill Preece	Governance Manager	
	Kieran O'Toole	Senior Capital Project Manager	
	Melissa Swindell	Director of HR & OD	
	Gary Wadeson	Associate Director Income, Costing & Commissioning	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda Item:	Russell Gates	Trust Contract and Commercial Advisor	
	Colin Beaver	Deputy Director of Communications	

23/24/144 Apologies:

Fiona Marston	Non-Executive Director	(FM)
Adam Bateman	Chief Operating Officer	(AB)
Emma Hughes	Acting Manging Director for Innovation	
Dani Jones	Director of Strategy and Partnerships	(DJ)
Erica Saunders	Director of Corporate Affairs	(ES)
Emily Kirkpatrick	Associate Director Commercial Finance	
Kate Warriner	Chief Digital and Information Officer	(KW)

23/24/145 Minutes from the meeting held 27th November 2023
The above minutes were approved as a true and accurate record subject to:

Agenda item 134 Third MRI Scanner resolved section amended to read:
RABD APPROVED the Third MRI Scanner subject to achieving stretch measures detailed in the paper.

Agenda item 136 Campus update neonatal section amended to:
A private RABD was held on 7th November 2023, approval was given to fund inflation costs of £1.4m subject to the team developing a mitigation plan in relation to increased SPV/other costs.

23/24/146 Matters Arising and Action log
All actions for this month have been included on the agenda.

23/24/147 Declarations of Interest
There were no declarations of interest.

23/24/148 Finance Report
Month 8 Financial Position

£1.5m surplus was reported for M8 as well as £1.5m year to date as in line with plan.

Divisional performance is varied with Surgery reporting a largely balanced position of £0.1m & Medicine £0.8m adverse, whilst remaining divisions reported a balanced position during November. Surgery has seen a benefit from the revised ERF baselines as part of H2 plans. Year to date Surgery (£6.4m) & Medicine (£2.1m) are adverse to plan. This is after the provision review as mentioned above has been actioned however the impact of industrial action is greatest within the surgery division.

RABD discussed the overall lower activity for M8 and ongoing concerns around coding. IG provided an update on Digital plans in place to improve the coding position including recruitment and priority of ERF. IG to take forward and include an update in the February 2024 Digital update.

CIP to date is behind plan by £1.3m, however forecast to achieve plans for full year subject to delivery.

Resolved:
RABD received and noted the M8 Finance report.

23/24/149 Underlying Position

For the financial year 23-24 the Trust has submitted a surplus plan of £12.3m which has recently increased to £13m surplus through the revised H2 planning submission.

As reported to RABD and Trust board in April 23, achievement of the surplus position was dependent upon a number of non-recurrent and one-off items that as a Trust we were asked to include to support the wider C&M system position.

Resolved:
In conclusion, the Committee are asked to note the underlying position of the trust as at month 8 and understand the movement from a surplus position in year to a likely exit run rate and starting point for 24-25 of c£2m deficit subject to the identification and delivery of recurrent CIP plans.

Further updates on the underlying position will continue to be reported to RABD through the planning updates in February.
Action: Finance Team

23/24/150 Month 8 Integrated Performance Report

RG highlighted:
ED performed restored to 79%, ie exceeding national standard of 76%, RG noted the good achievement with this and the continued effort to reach 80%. Was Not Brought (WNB) reducing 3 consecutive months, and now achieving target.

Elective Recovery was at 103%. Areas of concern continue to be around Industrial Action for January onwards.

Resolved:
M8 IPR report was received.

23/24/151 Cost Controls

In August 2023 all Organisations across Cheshire & Merseyside were asked to provide written assurance to the Integrated Care Board, of the steps being taken to comply with the controls set out from NHS England with regards to expenditure controls. The purpose of this paper is to provide an assurance update on actions taken thus far and proposed next steps for any ongoing actions.

Appendix 1 demonstrates more work completed to date along with further development and proposed deadlines for completion. The actions will then in turn provide more of an enhanced and robust approach to 24-25 Annual Planning recognising the increasingly challenging financial environment.

Resolved:
RABD are asked to note the contents of the report to provide assurance around mechanisms being put in place to proactively manage control of costs to support long term finance sustainability.

It is proposed a final update is provided to RABD in February as part of the Annual Planning update to provide assurance as we enter 24-25.
Action: Finance Team

23/24/152 Campus Update
RABD received a paper with current position for each of the projects:

The handover of Springfield Park to Liverpool City Council (LCC) in Spring 2024 marks a significant achievement for the Trust, and all those who have worked hard over the years to complete this exciting development.

Construction of the new Neo-Natal Unit/Urgent Care Centre will also start in Spring 2024, following completion of the service diversion works currently in progress. Another significant milestone for the Trust.

SA asked if it was possible to have a one-page summary showing the changes agreed to the scope of works for the Neo-Natal project from project inception to date.
Action: JH

An update was received on the Sunflower House sprinklers, as both tenders were disqualified AH is back out to tender.

Russell Gates provided an update on a number of ongoing claims, due to the sensitivity of this section it has not been captured in the minutes.

Resolved:
RABD received the current position of the Campus development.

23/24/153 Digital Futures Strategy
IG highlighted:
AlderCare programme has now moved into Phase 2, with a defined scope and refreshed governance and processes wrapped around it to support delivery. The scope of Phase 2 is centred around optimising the EPR and planning for future upgrades.

Good progress has been made with the Patient Tracking Lists (PTL). A robust approach to validation was agreed through Strategic Reporting Group and this commenced in early December.

A bid for £300K to support Patient Portal was approved and is hoped to be received April 2024.

Resolved:
RABD noted progress to date across Digital and IT programmes.

23/24/154 PFI

Contractual Position update
Due to the sensitivity of the above item this section will be included in the private RABD minutes.

Resolved:
RABD received and noted the current position.

23/24/156 Communications

RABD received the November Communications paper. It was noted that Communications update will be reviewed on the RABD Plan. S

Resolved:
RABD received and noted the communications report.

23/24/157 Board Assurance Framework

Resolved:
RABD received and noted the Strategic Risks.

23/24/158 Any Other Business

Clare Shelley
On behalf of RABD the Chair wished Clare well in her new role at a neighbouring Trust and thanked Clare for all her support and guidance over the last 2 years.

23/24/159 Review of Meeting

RABD noted good discussions and development of items discussed.

Date and Time of Next Meeting: Tuesday 16th January, Innovation Park Room 1, Edge Lane

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	**Board Assurance Framework Report 2023/24 (December)**
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 December 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	Failure to deliver the best experience for Staff, Children and Young People and their Families	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 and Alder Hey Campus	Resources and Business Development Committee
3.2	Strategy Deployment	Trust Strategy Board
3.4	Financial Environment	Resources and Business Development Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Research & Innovation Committee
4.2	Digital and Data Strategic Development & Delivery	Resources and Business Development Committee

3. Summary of BAF at 9th January 2024

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Delivery of Outstanding Care *(Outstanding care and experience)*				
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
STRATIC OBJECTIVE: The best People going their best work *(Support our people)*				
2.1 MS	Workforce Sustainability and Development	PAWC	**3x5**	3x2
2.2 MS	Failure to deliver the best experience for Staff, Children and Young People and their Families	PAWC	3x3	3x2
2.3 MS	Workforce Equality, Diversity & Inclusion	PAWC	**3x5**	4x1
STRATEGIC OBJECTIVE: Sustainability through external partnerships *(Collaborate for children and young people)*				
3.1 RL	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	RABD	3x4	3x2
3.2 DJ	Strategy Deployment	Strategy Board	3x4	4x2
3.4 JG	Financial Environment	RABD	**4x4**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	**4x4**	3x3
STRATEGIC OBJECTIVE: Game-changing Research and Innovation *(Pioneering breakthroughs)*				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Research & Innovation	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Digital and Data Strategic Development & Delivery	RABD	3x4	2x4

4. Summary of December 2023 updates:

- ***Strategy Deployment (DJ).***
  Risk reviewed; no change to score. Vision 2030 progressing as per agreed timeframes.
  Strategy Leadership Group have hosted two sessions for Get Me Well and Personalise my Care in Oct 23 and Dec 23, lead by our Clinical Leaders, to progress this agenda.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; Current risk evidence, actions and controls assessed and no change to score in month. Specific updates include:
  1. ICS commitment to CYP is taking shape through progression of the CYP Committee, which met informally in Sept and Nov 23, and formally for the first time in Dec 23.
  2. Various stakeholder engagement sessions took place in Dec 23 or are scheduled for Jan 24 to begin formal engagement and socialization of Vision 2030 with partners. Feedback so far has been very positive, and there is much system alignment on the priorities for CYP.
  3. On 7th December NHSE confirmed that the North West region would proceed with delegation of the first phase of specialised services in April 24.
  4. Place level capability and capacity within the strategy team remains a risk.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed; work continues to update in line with the 2030 Vision. No change to risk rating.

- ***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 has been extended to December. The SPV have issued a corroded pipework report to the Trust and both parties met on the 27th November to discuss. The Trust and Project Co reps undertook a walk round to verify report and found actions outstanding LOR and Project Co to mop up and re-issue to Trust end of Jan 2024.

  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.

  Further details on the online dosing system have been requested. P Co / Mitie have been slow to respond. site visit has taken place December 23. First pack of carbon filter pricing has been provided to WSG. Mitie to provide remaining parts prior to 22nd Jan joint safety meeting.

  Temporary chillers have been removed from the MSCP in December 23 the permanent ones are undertaking commissioning works in Jan Project Co to update end of Jan.

Works on the skylights will recommence April 2024.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in December was exceptionally challenging, with a significant increase in attendances and acuity and the department has increased the number of GP streams in response. However, in month performance against the 4 hour target for December was 85.2%, exceeding the national standard of 76%. Other 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 sustained and we delivered 89.90% compliance during December.

  Capacity to reduce long waits (RTT) remains a challenge, with agreement to reduce the number of sessions per week in the Theatre schedule from end of October to mitigate pressures including staff absence. However, there has been a decrease in 65ww (from 236 to 200) in month. Division of Surgery continue to actively manage this with focus on ENT, Dental and Spinal (all of which have protected theatre sessions). There is an ongoing risk regarding the potential for further Industrial Action which is a threat to elimination of 65ww by March 2024.

- ***Inability to deliver safe and high-quality services (NA).***
  BAF 1.1 has been reviewed and remains static. Further review and alignment to continue this year as we move to alignment with 2030 Vision. The risk is reviewed and monitored through SQAC.

- ***Access to Children and Young People's Mental Health (LC)***
  Review of actions completed and updated.

- ***Financial Environment (JG).***
  Risk reviewed and score remains at 16 due to some uncertainty on the 23/24 forecast with the recent industrial action impact and also the exit run rate and underlying position going into 24/25. Work has progressed on identifying and closing the recurrent CIP gap and significant improvement has been made in the month. The 11 benefit cases are in development using the new benefits framework and will be reported to RABD in February. Annual planning is underway for 24/25 and will be reported through RABD with the draft plan to Board in March.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed in month. No change to score. No new gaps/ issues identified. Countdown to handover of the Park to the Council now in progress. Contract for the main works on the Neonatal scheme has been agreed.

- ***Digital and Data Strategic Development and Delivery (KW).***
  Risk reviewed, score remains static.

- ***Workforce Sustainability and Development (MS).***
  Risk reviewed and work continues to update in line with the 2030 Vision.

- ***Failure to deliver the best experience for Staff, Children and Young People and their Families (MS).***
  Risk reviewed and actions amended and updated. No change to risk rating. Agreed with CPO that risk will be reviewed and updated to reflect changed risk outline and description to broaden scope and include risks relating to organisational culture.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  Risk reviewed. No change to score in month. Actions remain on track.

5. Corporate risks (15+) linked to BAF Risks (as at 9th January 2024)

There are currently 18 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked
STRATEGIC OBJECTIVE: The best people doing their best work *(Outstanding care and experience)*				
1.1 Inability to deliver safe and high-quality services (3x3=9)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.4
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval	5x3	Surgery	
2672	Not compliant with national guidance with transferring and transcribing patient records following adoption	3x5	Community	
2657	As there is no consistent method for recording and communicating resuscitation decisions across the trust there is a child may be resuscitated inappropriately and receive inappropriate and potentially harmful treatment. A child may not receive resuscitation when it is in their best interests to do so.	5x3	Medicine	
67	NatPSA/2023/010/MHRA - Risk of death from entrapment or falls	5x3	Business Support	
91	Junior doctor staffing in general paediatrics	5x3	Medicine	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care (capacity).	4x4	Surgery	1.2 & 2.2
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	2.2
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	2.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	2.1 & 2.2
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	2.1 & 2.2

Risk	Risk Title	Score (IxL)	Division	Linked
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)				
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2
2019	Delay in treatment for Speech and Language Therapy	3x5	Community	1.2
2360	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18 week referral to treatment target for routine).	3x5	Community	1.2
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care (capacity).	4x4	Surgery	1.1 & 2.2
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)				
	None			
1.4 Access to Children and Young People's Mental Health (3x5=15)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.1
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.1
STRATEGIC OBJECTIVE: Delivery of Outstanding Care *(Support our people)*				
2.1 Workforce Sustainability and Development (3x5=15)				
91	Junior doctor staffing in general paediatrics	5x3	Medicine	1.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.2
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.2
57	Capacity/demand issues for the statutory Adoption Medical Advisor role	4x4	Community	2.2
2.2 Failure to deliver the best experience for Staff, Children and Young People and their Families (3x3=9)				
2741	The ability to maintain OFSTED ratios as a result of staff availability/turnover.	4x5	Business Support	

Risk	Risk Title	Score (IxL)	Division	Linked
	Health and Safety concerns operating the nursery in its current position in the centre of a building development			
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.1
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.1
57	Capacity/demand issues for the statutory Adoption Medical Advisor role	4x4	Community	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care (capacity).	4x4	Surgery	1.1 & 1.2
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1
2.3 Workforce Equality, Diversity and Inclusion (3x5=15)				
	None			
STRATEGIC OBJECTIVE: Sustainability through external partnerships *(Collaborate for children and young people)*				
3.1 Failure to fully realise the Trust's vision for the park and Alder Hey campus (3x4=12)				
	None			
3.2 Strategy Deployment (3x4=12)				
	None			
3.4 Financial Environment (4x4=16)				
2579	Risk of failure to achieve financial balance due to existing and emerging cost pressures, impact of Industrial Action on the delivery and recovery of NHS services, reduced effectiveness of services, inability to invest and innovate and potential of increased workforce pressures	3x5	Medicine	
3.5 System working to deliver 2030 Strategy (4x4=16)				
	None			

Risk	Risk Title	Score (IxL)	Division	Linked
STRATEGIC OBJECTIVE: Game-changing research and innovation *(Pioneering Breakthroughs)*				
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)				
	None			
STRATEGIC OBJECTIVE: Game-changing research and innovation *(Revolutionise Care)*				
4.2 Digital and Data Strategic Development and Delivery (3x4=12)				
	None			

6. Recommendation

The Board/Committee is asked to:

- note the updated position with regards to management of the BAF risks;
- note the ongoing issue with regards to target risk score colour not pulling off the system correctly. InPhase are continuing to investigate.

Erica Saunders
Director of Corporate Affairs

Inability to deliver safe and high quality services	
Risk Number	Strategic Objectives
1.1	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	Safety & Quality Assurance Committee

Description
Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

Jan 2024	
Control Description	Control Assurance Internal
The Trust has a quality improvement programme 'Brilliant Basics', where quality improvement is at the heart of everything we do and provides staff with the skills, knowledge and confidence to learn, lead and deliver in an improvement style.	Formal and informal training and coaching available to support departments to make positive changes. Outcomes shared through the SharePoint site and reported to board bi-annually against agreed plan.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through CQSG, learning bulletin produced and learning from RCA's shared at the meeting
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC

Gaps in Controls / Assurance
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis 2. Failure to comply with NICE guidance review and implementation in line with recommended timeframes 3. Robust reduction programme in the number of medication incidents and near misses 4. Impact of Industrial action in the safe delivery of care and progress against recovery 5. The CQC will move to a new oversight framework which may reduce our CQC ratings 6. The 2030 vision sees a shift to a consumer focussed experience with 5 workstreams with key deliverables for year 1, without any additional resource 7. The new models of care workstream will need to redefine the delivery of services whilst maintaining the principles of the strategy 8. Alder Care (Expanse) has been implemented across the organisation which poses risks until stabilisation.

Action	Description	January 2024	
		Due Date	Action Update
Alder Care (Expanse)	8. The risks to quality and safety need to be monitored during the period of stabilisation	30/11/2024	Command and control in place through the deployment which includes the monitoring of quality and safety data,.
Delivery of 2030 Vision	6. The programme will need to articulate resources required against impact of no additional resources being available. The experience focus underpins all other parts of the vision and key to the delivery of the overall strategy	31/01/2024	Resource requirement and impact assessment currently under development.
Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2024	There has been improvement in administrations times which continue to be monitored through SQAC to embed improved performance.
Industrial action	4. The ongoing industrial action by various unions has a potential impact on the safety and quality of our care. This is managed through the EPRR process to ensure the hospital is safe but does impact children and young people through cancelation and rearrangement of various services including OPD and elective surgery.	31/03/2024	IA planning group in place for the current Junior Doctors, consultant and recently reported radiographers IA. Managed through EPPR route and planning in place
Medication Errors and Near Misses	3. Proactive programme of work in place to reduce medication errors	31/03/2024	Dashboard in place with insight into the causes of medication errors and a proactive reduction plan monitored through Patient Safety board.
New CQC Assessment Framework	5. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2024	Key executive and corporate staff have undergone training in the new process and will continue to work with the CQC whilst change over date is pending
New Models of Care	7. Clinical leaders will need to be appointed to oversee the process and provide challenge on the principles of the strategy	31/03/2024	Clinical summits have been held which will prioritise the changes that will have the biggest impact.

Children and young people waiting beyond the national standard to access planned care and urgent care	
Risk Number	Strategic Objectives
1.2	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
■ Effective ■ Responsive		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
20	9	Resources and Business Development Committee

Description

Capacity and Demand modelling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care, and risk to achieve the national standard of eliminating waits >65 weeks by March 2024. Our challenged specialties include ENT, Dental, Spinal Surgery, ASD/ADHD and CAMHS. In addition, unprecedented demand for urgent care has increased the wait for clinical assessment and reduced the percentage of patients treated within 4 hours. These factors combine to create a risk that waiting times for elective and urgent care will exceed national standards, with potential detriment to experience and outcomes for Children, Young People and their families.

Jan 2024	
Control Description	Control Assurance Internal
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	Daily reports to NHS England -@ Daily Performance summary -@ monthly Performance report to Operational delivery group -@ Performance reports to RABD Board Sub-@Committee -@ bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	Corporate report and divisional Dashboards -@ Performance reports to RABD Board Sub-@Committee -@ Use of electronic patient pathway forms to signify follow-@up clinical urgency and time-@frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	Significant decrease in waiting times for Sefton SALT -@ Corporate report and divisional Dashboards -@ Performance reports to RABD Board Sub-@Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	monthly Performance report to Operational delivery group -@ Corporate report and divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	monthly oversight of project delivery at Programme Board -@ bi-@monthly transformation project update to SQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - SDG forum to address challenged areas and approve cases for investment where access to care is challenged.
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

Gaps in Controls / Assurance

1. Reduce to zero the number of C&YP waiting over 65 weeks for treatment to reduce the long-wait backlog for planned care
2. In urgent and emergency care, consistently exceed national standard of 76% of patients treated within 4 hours (aspire to 85%) and a time to clinical assessment of 60 minutes

Action	Description	January 2024	
		Due Date	Action Update
Reduce the long-wait backlog for planned care	Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	31/01/2024	Investments in capacity including insourcing have been deployed with reduction in number of long waiters in ENT and dental
Urgent and Emergency Care Standards	Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	31/01/2024	Actions implemented to date have led to improved access to A&E, which is now exceeding the 85% national standard

Building and infrastructure defects that could affect quality and provision of services	
Risk Number	Strategic Objectives
1.3	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Resource And Business Development Committee

Description
Building defects that remain unresolved by Project Co could impact on patient services, reputation and financial sustainability

Jan 2024	
Control Description	Control Assurance Internal
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations. Review of the action plan takes place monthly to ensure all remains on track.	
Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.	
Regular oversight of issues by Trust committee (RABD)	Monthly report to RABD on progress of remedial works
Trust Board aware of the ongoing status and issues.	Monthly report to Board on mitigation and remedial works

Gaps in Controls / Assurance
Remedial Works not yet completed; lack of confidence in timescales being met.

Action	Description	January 2024	
		Due Date	Action Update
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	30/11/2023	
Remedial Works to be completed	Undertake regular inspections on known issues/defects. Inspections continue on all areas via a weekly walk around.	31/12/2023	Inspections underway

Access to Children and Young People's Mental Health	
Risk Number	Strategic Objectives
1.4	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	9	Resource And Business Development Committee

Description

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

Jan 2024	
Control Description	Control Assurance Internal
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)
Business case for investment submitted to Liverpool and Sefton CCG's. This is also included in the Cheshire & Merseyside ICB submission.	Business case (attached)
Weekly performance monitoring in place for operational teams which includes: • Weekly Tuesday/Wednesday meeting with PCOs • Divisional Waiting Times Meeting each Thursday • Trust Access to Care Delivery Group each Friday This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: • Monthly contract statements • Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software

Gaps in Controls / Assurance

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to legacy waiting times and recruitment issues as a result of national workforce shortages.

Action	Description	January 2024	
		Due Date	Action Update
Action plan to reduce was not brought rate	Action plan to reduce was not brought rates across Liverpool and Sefton CAMHS including: - using WNB predictor to identify CYP at higher risk of non attendance - A3 exercise to monitor improvements - Transport pilot - ongoing, due to commence 31.10.2023	31/03/2024	
Continued workforce planning	Continued workforce planning including: - introduction of new roles - continued representation at C&M workforce meetings - review of all job descriptions and person spec to ensure consistency and ability to progress - development of preceptorship/development pathway	31/03/2024	
Data / BI - case load monitoring	Case load size reporting and monitoring to be improved including: - BI dashboard to be created - validation of data	31/03/2024	Open caseload report has been validated and clinicians are reviewing this in MDTs and reporting any issues.
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/03/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/03/2024	- Decision has been made to take PIFU Discharge to parent/carer forums and participation groups before implementation. Implementation takes at least 28 days. The initial delay will be taking it to the groups for discussion and then the 28 days for implementation will create a further delay. - Jo M to discussed with Kate W 03.11.23 to agree a new due date
Proceed with changes to CAMHS internal waiting times measures	Proceed with changes to CAMHS internal waiting times measures including: SOP/Pathway to be created Training plan for clinical and admin staff to be created and rolled out Data and reporting	31/03/2024	
Recruitment - timely recruitment to vacancies using 2023/24 funding	Timely recruitment to vacancies to include - meet with finance to review skill mix for services	31/03/2024	
Referral triage process to be reviewed	To review referral triage process across CAMHS	31/03/2024	
Review of KPIs and Reporting Measures	Review of KPIs and reporting measures for Sefton & Liverpool place	31/03/2024	
Review of standard booking processes	Review of booking and discharge processes across Liverpool and Sefton CAMHS to ensure consistency in approach, and management in line with trust processes.	31/03/2024	Choice booking now 4 weeks in advance which is supporting reduction in DNA/Cancellations and wasted appointment slots. Date extended to end of March to ensure this is embedded and consistent before action is closed.

Workforce Sustainability and Development	
Risk Number	Strategic Objectives
2.1	The Best People Doing Their Best Work

CQC Domains	Linked Risks	Owner
▪ Safe ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	6	People & Wellbeing Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation.

Jan 2024	
Control Description	Control Assurance Internal
Monthly Ops Board monitoring	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
People Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Apprenticeship Strategy implemented	Annual update to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to Board and PAWC
Nursing Workforce Report	Reports to PAWC, SQC and Board
Nurse Retention Lead	Bi-monthly reports to PAWC
Recruitment Strategy currently in development	progress to be reported PAWC
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation

Action	Description	January 2024	
		Due Date	Action Update
1. Not meeting compliance target in relation to some mandatory training topics	Process in place to monitor take up of training by topic; subject matter experts engaged in the process	31/03/2024	Work continues to monitor sickness absence through the divisions and will all of the relevant support through OH and SALS
3. Workforce Planning	3. Workforce planning across the organisation.	30/04/2024	Establishment control project close to completion before commencing the wider workforce planning project
5. Lack of a robust Trust wide Recruitment Strategy	5. Recruitment Strategy currently being developed in line with the actions set out in the NHS people plan	30/06/2023	Action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased. A Business Case has been shared with Exec Team - outcome awaited.

Workforce Equality, Diversity & Inclusion	
Risk Number	Strategic Objectives
2.3	The Best People Doing Their Best Work

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	4	People & Wellbeing Committee

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

Jan 2024	
Control Description	Control Assurance Internal
PAWC Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PAWC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by EDI Manager	monitored through PAWC
People Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	Diversity and Inclusion Action Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked until Nov 2020
EDI Steering Group now established - Chaired by NED	Minutes reported into PAWC

Gaps in Controls / Assurance
EDI under resourced to deliver significant EDI agenda

Action	Description	January 2024	
		Due Date	Action Update
EDI resource	Business case requires further development	31/03/2023	

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	
Risk Number	Strategic Objectives
3.1	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
		Rachel Lea

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Resource And Business Development Committee

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

Jan 2024	
Control Description	Control Assurance Internal
CEO Campus Highlight Update Report	Fortnightly Report
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board and RABD Stakeholder events / reported to Trust Board and CoG
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
Development Team monthly meetings	Outputs reported to RABD via Project Update
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision.
Weekly Programme Check.	The Development Team run a weekly programme check.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
Exec Design Group	Quarterly Minutes of Exec Design Reviews
Programme and plan (agreed with LCC and LPA) to return the park back by March 2024 (phase 3).	Updates on progress through Campus report .
Meetings held with Liverpool City Council at key stages	public meetings held
Planning application for Neonatal and Urgent Care	Full planning permission gained
Neonatal Programme Board	monthly meeting
Strategic Estates and Space Allocation Group	Chaired by Exec, meets quarterly

Gaps in Controls / Assurance
PARK: 1. Adoption of the SWALE by United Utilities 2. Residual infrastructure works delaying possession of land 3. Weather conditions causing potential delays CAMPUS: 1. Planning approvals for modular buildings to allow continuation of park works. 2. Successful realisation of the moves plan. 3. Funding availability and potential market inflation.

Action	Description	January 2024	
		Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	31/03/2024	
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2024	Regular updates continue to be provided to RABD and Trust Board as appropriate
Infrastructure works	Weekly coordination meetings, site walkarounds, RAMS, mitigation measures identified	05/12/2023	
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	31/03/2024	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves	30/04/2024	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell

Financial Environment	
Risk Number	Strategic Objectives
3.4	Strong Foundations

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		John Grinnell

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	12	Resource And Business Development Committee

Description

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

Jan 2024	
Control Description	Control Assurance Internal
Organisation-wide financial plan.	Monitored through Corporate Report and the monthly financial report that is shared with RABD and Trust Board.
NHSi financial regime, regulatory and ICS system.	Specific Reports submitted monthly and anually as part of business plan process (i.e. NHSI Plan Review by RABD)
Financial systems, budgetary control and financial reporting processes.	Daily activity tracker to support divisional Performance management of activity delivery -@ Full electronic access to budgets &@ specialty Performance results -@ Finance reports shared with each division/@department monthly -@ Financial in-month and forecast position reported through SDG, Exec team, RABD, and trust Board -@ Financial recovery plans reported through SDG and RABD -@ Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend 5 Year capital plan ratified by Trust Board
Divisional performance discussed at RABD with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting with divisional leads ('3 at the Top')
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / RABD and SDG for the relevant transformation schemes
RABD deep dive into any areas or departments that are off track with regards to performance and high financial risk area	RABD Agendas, Reports & Minutes
Financial Review Panel Meetings	Any area/division that is off plan is expected to attend a financial review panel meeting with DDOF with action plan detailing mitigation to bring back into budget.

Gaps in Controls / Assurance

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

Action	Description	January 2024	
		Due Date	Action Update
Changing financial regime	1. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2024	
Delivery of 5 year programme	4. Five Year capital plan	31/03/2024	23/24 Capital plan submitted in final plan. Due to changes in CDEL limits for the future years, further work is ongoing on the next 3 years including a review with each capital lead. This work will be complete and presented to executive team early June and reported back through RABD and TB once full risk is known.
Devolved specialist commissioning	3. Regular reporting to strategic execs and assurance to RABD and Trust Board Financial Analysis required to understand risk	31/03/2024	
High risk recurrent CIP programme	6. Ensure procurement processes followed to obtain value for money	31/03/2024	
Inflationary Pressures	7. Monitor closely impact of inflation increases	31/03/2024	Target date extended as action will need to be re-monitored in 23-24 as risk continues.
Inflationary pressures	7. Monitor closely impact of inflation increases	31/03/2024	
Shortfall against LTP	5. Long Term Financial Plan	31/03/2024	Annual planning process complete and bridge completed by division. However further delays to the completion of the LTFM and the productivity work has resulted in this not being completed in the time-frame initially set. This will form part of the 2030 financial strategy to be completed in Q2.
Underfunding of Long Term tariff arrangements for complex children	2. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2024	

Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.					
Risk Number			Strategic Objectives		
4.1			Game-Changing Research And Innovation		
CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
Well-Led		John Chester	9	6	Research & Innovation Committee

Description
Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries. Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities. Risk of exposure to ethical challenges and national and international reputational risks.

Jan 2024	
Control Description	Control Assurance Internal
Resource and Business Development Committee (RABD) Additional oversight of financial and commercial aspects of R&I activity	Reports to Trust Board
Research Management Board and Innovation Management Board (and subsidiary committees - Sponsorship Oversight Committee, Data Access Panel etc) Delivery and performance measurement of various R&I activities	Reports to R&I Committee
Clear management structures and accountability within each of CRD and IC	Reports to Operational Board
Protection +/- exploitation of intellectual property	Reports to R&I Committee
Strategic commercial partnerships with industry partners and commercial vehicles	Reports to Strategy Board and RABD
Staff probity - via online declaration of interests portal (gifts & hospitality, sponsorship etc.)	Adherence to Trust Policies, Declarations of Interest Register and digital audit trail to audit committee
External communications via internet, social media etc facilitated through Marketing and Communications team	Communications Strategy and Brand Guide
Data governance via Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOP
Risk registers	Reports to Risk Management Forum

Gaps in Controls / Assurance
1. Integration of R&I activities into Futures not yet fully determined. 2. Levels of activity targeted at maintaining and enhancing reputation not yet sustainable. 3. Financial model and levels of income not yet consistent with growth and sustainability. 4. Capacity and capability of clinical staff and services to participate in R&I activities. 5. Comms Strategy for Futures not yet fully described.

Action	Description	January 2024	
		Due Date	Action Update
1. Integration of R&I activities into Futures	Completion of Research Strategy.	31/03/2024	Starting
2. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2024	
3. Activity Levels	Review of CRD trials portfolio	31/03/2024	
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	
5. Financial Model	Case for internal and multi-sector inward investment.	30/06/2024	
6. Financial Model	Development of new commercial partnerships	30/06/2024	
7. Capacity and capability	Greater engagement with and education of R&I communities	30/06/2024	
8. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy	31/03/2024	

Failure to deliver the best experience for Staff, Children and Young People and their Families	
Risk Number	Strategic Objectives
2.2	The Best People Doing Their Best Work

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Safe ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	6	People & Wellbeing Committee

Description
Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision.

Jan 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2021 Staff Survey Report - main report, divisional reports and team level reports
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Thriving Leadership Planning	Strategy implementation as part of the People Plan
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Alder Hey Life Newsletter - keeping staff informed	Internal communications updated to PAWC
Spiritual Care Support	
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC monthly
Health and Wellbeing Conversations launched	HWB Conversations now embedded as part of the PDR process supported by training and support from SALS, OD and Wellbeing Coaches where needed. Key metric currently is %PDR completed but value of HWB conversations also assessed via Quarterly People Pulse
NICE Mental Wellbeing at Work Guideline issued and baseline assessment complemented	Baseline assessment
Regular Schwartz Rounds in place	
Network of SALS Pals recruited to support wellbeing across the organisation	
Staff support plan for all staff to manage social and emotional impacts of strike action. Plan reviewed and communicated as part of tactical command and developed in consultation with nursing community and local strike committee	

Gaps in Controls / Assurance
1. Increase in self-reported rates of burnout and work-related stress as assessment via 2022 Staff Survey and consistent with national picture for NHS staff. 2. Our people have the time, space and opportunity to improve

Action	Description	January 2024	
		Due Date	Action Update
Management essentials training	Develop a Thriving Leaders Framework for the organisation beginning with a management essentials training programme for all new managers to cover core HR and management knowledge and skills and to complement Strong Foundations leadership programme already running	30/05/2024	Management essentials programme in development and to be launched this month to the organisation. Currently 80% of content complete. Group meeting weekly to review and implement
Stress risk assessments	Skills and capacity gap to conduct good quality stress risk assessments for staff affected by work-related stress	28/02/2023	Stress Risk Assessment training to be added into Management Essentials training as part of new Thriving Leaders Framework (Vision 2030)
Suicide Postvention planning and process	Suicide Postvention guidance and team to be developed and established to provide effective and compassionate response in the event of the death by suicide of a staff member.	11/03/2024	Meeting with Chief People Officer and Deputy CPO on 8.1.24 to discuss next steps. Associate Director of OD/SALS Clinical Lead and Deputy CPO to develop local SOP on 30th January together for consultation with wider group of stakeholders prior to policy amendment and training plan. CPO to table for information at the PAWC. Update to be given to WBG.

Digital and Data Strategic Development & Delivery	
Risk Number	Strategic Objectives
4.2	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Resource And Business Development Committee

Description
Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.

Jan 2024	
Control Description	Control Assurance Internal
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Achieved Informatics Skills and Development Accreditation Level 3.
Formal change control processes in place	Weekly Change Board in place
Executive level CIO in place	Commenced in post April 2019, Deputy CDIO in place across iDigital Service
Quarterly update to Trust Board on digital developments, Monthly update to RABD	Board agendas, reports and minutes
Digital Oversight Collaborative in place & fully resourced - Chaired by Trust CCIO	Digital Oversight Collaborative tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
External oversight of programme	Strong links to system, regional and national digital governance via internal and external relationships.
Digital Strategy refreshed in 2022. Digital Data and Insights key components of Vision 2030 and associated governance and plans	Digital PID. Digital Oversight Committee. Relationship with Futures. Digital and Insights link as part of revolutionising care strategic initiative.
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Monthly digital performance meeting in place	iDigital performance meeting in place. Performance reported as part of Corporate Collaborative.
Capital investment plan for IT including operational IT, cyber, IT resilience	Capital Plan
iDigital Service Model in Place	iDigital Service Model and Partnership Board Governance
High levels of externally validated digital services	HIMSS 7 Accreditation

Gaps in Controls / Assurance
1. Cyber security investment for additional controls approved - dashboards and specialist resource in place 2. Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs 3. Issues securing experienced resources in some services 4. Alignment with other 2030 initiatives

Action	Description	January 2024	
		Due Date	Action Update
1. Maximising opportunities of collaboration through iDigital	Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	12/12/2023	
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	12/12/2023	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023 Date Entered : 01/09/2022 08:28 Entered By : Kate Warriner ---------- Some issues highlighted with programme, risking dates to delivery. Review underway Date Entered : 02/12/2021 16:45 Entered By : Kate Warriner ---------- Programme progressing, a number of work streams with challenges being progressed. Date Entered : 06/05/2021 08:51 Entered By : Kate Warriner ---------- Programme progressing well against Plan. Progress monitored through digital reports at RABD Date Entered : 11/01/2021 14:20 Entered By : Jill Preece
4. 2030 Initiatives	Ensure programme alignment into new models of care and Futures	12/12/2023	

System working to deliver 2030 Strategy	
Risk Number	Strategic Objectives
3.5	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	9	Trust Strategy Board

Description
Risk of inability to control execution of 2030 Vision due to system complexities and evolving statutory environment. Risk of failure to secure sign up from partners to engage in a new Strategy for CYP given the wider NHS context and competing priorities. Potential failure to land our 2030 Strategy with key partners within the wider system impacting on our reputation and long-term sustainability. Risk of poor relationships and strategic connection at Place, leading to mis-alignment of priorities and inability to execute Vision 2030.

Jan 2024	
Control Description	Control Assurance Internal
Membership of CMAST & MHLDC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST Committee in Common in place and working CMAST - CYP alliance established. MHLDC committed membership from Alder Hey and establishment of a CYP workstream.
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	Beyond Programme recurrently funded by ICS. Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board.
Impact of changing NHS finance regime, commissioning intentions (described in BAF 3.4)	See BAF 3.4 (financial environment)
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.
Joint development of new models of care on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board and Strategy Leadership Group
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings
Maintain effective existing relationships with key system leaders and regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually).
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Reporting through Strategy Board
Implementation of Vision 2030 is dependent on building capability and capacity to deliver in the new system environment. This requires both additional capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	Assessment of central team capacity along with a 24/25+ plan to address gaps to be undertaken with MD & CSPO in December 23. Linked with COO and divisions for wider capacity and capability across clinical teams.

Gaps in Controls / Assurance
1. Uncertainty over future commissioning intentions (see BAF 3.4 re finance) 2. Future delegation of Specialist Commissioned services into ICSs – shadow arrangements under definition 3. Executing the comprehensive Stakeholder Engagement Plan 4. National mandates forcing us to prioritise unexpected programmes of work 5. There is currently no sustainable arrangement for Place level capability and capacity within the strategy team, and a need to identify additional clinical leadership in Get Me Well - which is closely linked to the Place agenda. Delivery of 2030 Vision is highly dependent on system working, and an integrated local system partnership approach. Sustainable, consistent and appropriately skilled engagement at Place(s) from clinical and partnership perspectives is required to ensure aligned plans, delivery of agreed programmes of work, attraction of local funding and management of reputational risk.

Action	Description	January 2024	
		Due Date	Action Update
3. Partner Engagement	Complete partner engagement	12/12/2023	
4. Horizon Scanning	4. Horizon scanning	12/12/2023	
Capacity and capability to deploy Vision 2030 at Place(s)	Assessment of central team capacity along with a 24/25+plan to address gaps to be undertaken with MD & CSPO in December 23. Linked with COO and divisions for wider capacity and capability across clinical teams. Capacity and capability for Place especially for Get me Well is needed both in partnerships/strategy team and clinically	28/02/2024	
Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/08/2023	Conversations with NHSE and colleagues within Greater Manchester and South Cumbria continue to support a North West Children's Strategy for delegation of services.
System Developments	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/08/2023	Now have agreement for a Children's Board under the Cheshire & Mersey ICS which will include a children's health network. This will include key stakeholders from across the region with the ability to influence and transform children's services. It will act as a Forum for sharing information across the system to help us keep abreast of the changing landscape.

Strategy Deployment	
Risk Number	Strategic Objectives
3.2	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Trust Strategy Board

Description
Risk of failure to: - translate the 2030 Vision into operational plans and systematically execute. - deliver on the strategic ambitions to make a difference to CYP impacting on the delivery of the NHS Long Term Plan and Trust's reputation.

Jan 2024	
Control Description	Control Assurance Internal
Collaborating in Communities is a key theme in the 2030 Change Programme: assurance received through Strategy Leadership Group and Strategy Board	
2030 Vision: Alder Hey strategy refresh - Q4 23/24 - delivery of brochure and final comms collateral	Council of Governors strategy session (full overview) (Jan 2023) Strategy 2030 - Approved at Trust Board (March 2023) Strategy 2030 wider Staff Launch (May 2023)
CYP System update report to Strategy Board, incorporating partnership assurance periodically throughout the year.	Building upon Growing Great Partnerships report
Operational Plan incorporates Vision 2030 deliverables (2024/25)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
SRO Group established	
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	

Gaps in Controls / Assurance
1. Completion of 2030 Vision communication collateral 2. 2030 delivery programme and plan in development 3. Failure to develop capacity for delivery 4. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy 5. Failure to deprioritise to enable requisite focus on areas of need and transformational change 6. Risk of 'mission creep' associated to the Strategy

		January 2024	
Action	Description	Due Date	Action Update
1. Partner and stakeholder engagement on Vision 2030	Ongoing engagement programme as it is developed, and appropriate circulation/engagement following Board sign off.	30/11/2023	We are in the process of developing an external partner video and working with an external agency on a Vision 2030 'Sales Brochure' which will come to Board in September 2023.
2. 2030 delivery programme and plan		12/12/2023	
3. Developing skills and capacity to deliver the new Strategy		12/12/2023	
4. Sharp focus at Strategy Board on core mission		12/12/2023	
5. Focus on transformational change	Oversight through Strategic Leadership Group and Strategy	12/12/2023	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th February 2024

Paper Title:	**Chair's Report from ARC on 25th January 2024**
Report of:	**Kerry Byrne**
Paper Prepared by:	Kerry Byrne

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
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 ☑
If "No", is a new risk required? 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. 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

- National Employment Check Standard Audit Update
- Briefing on National Cost Collection Exercise
- Update on the implementation of InPhase in relation to risk management
- Presentation from Medicine on risk management processes within the Division
- Risk Appetite & Tolerances Update
- Board Assurance Framework
- Update from the Risk Management Forum including the Corporate Risk Register
- Trust Risk Management Report
- Draft Internal Audit Plan 24/25
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Anti-Fraud Services Progress Report
- Quarterly update on compliance with the Data Protection Act and Freedom of Information Act
- Briefing Paper from the Finance Team on accounting issues for the 23/24 audit
- Results of ARC self-assessment desktop review and proposal for effectiveness questionnaire
- Proposal to review the effectiveness of the internal audit service
- Private meeting with the Associate Director of Nursing and Governance

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

Peter White and Jackie Rooney provided an update on the implementation of InPhase relating to risk management. End user issues are now largely resolved, whilst some issues in extracting data for committee reports continue to be progressed. Due the upheaval and challenges of the implementation on users there are now more risks and actions overdue review than pre-implementation. It was agreed that the ARC Chair would write to senior staff within Divisions and Services to request that attention now be given to bringing risks and actions up to date, as well as ensuring other key risk management practices are reinvigorated.

In reviewing and approving the Internal Audit Plan for the last few years, the Committee has noted the increasing proportion of the days in the Plan that are required to meet externally mandated audits, leaving only a small number of

0244 days to be focussed on areas of importance or priority for the Trust. MIAA have been asked to provide benchmarking information on the days provided across their client base across Cheshire & Merseyside so that a judgement can be made by ARC in consultation with relevant Execs as to the ongoing suitability of the days in the Plan with a proposal in this regard to be presented to the April 24 ARC meeting.

4. Positive highlights of note

ARC was pleased to receive confirmation of the addressing of all recommendations resulting from the Consultant Job Planning audit. This has taken a number of years to progress, during which senior staff and systems have changed. Thanks are expressed to Alf Bass and Urmi Das for the significant progress in this area in the last couple of years.

5. Issues for other committees

ARC has requested that PAWC undertakes a deep dive review of BAF risk 2.3 relating to workforce equality, diversity and inclusion to assess whether sufficient progress is occurring to mitigate this risk.

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 12th October 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)
	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Ms. E. Kirkpatrick	Assoc. Director of Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRo)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
	Mr J. Wilcox	Financial Accountant	(JW)
Item 23/24/68	Mrs. S. Owen	Deputy Chief People Officer	(SO)
Item 23/24/69	Mr. J. Chester	Director of Research and Innovation	(JC)
Item 23/24/69	Mr. D. Hawcutt	Clinical Director of Research	(DH)
Item 23/24/69	Mrs. C. Liddy	Managing Director of Innovation	(CL)
Item 23/24/69	Mr. J. Taylor	General Manager, CRD	(JT)
Apologies:	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Miss. J. Preece	Governance Manager	(JP)

23/24/64 Introductions and Apologies

The Chair welcomed everyone to the meeting and acknowledged the apologies that were received. It was noted that the Chief Operating Officer, Adam Bateman will leave the meeting once the risk element of the agenda has been addressed.

The Committee was advised that Non-Executive Director, Jo Revill would be chairing the majority of the meeting on behalf of Kerry Byrne.

23/24/65 Declarations of Interest

There were none to declare.

23/24/66 Minutes from the Meeting held on 13th July 2023
Resolved:
The minutes from the meeting that took place on the 13th of July were agreed as an accurate record of the meeting.

23/24/67 Matters Arising and Action Log

Matters Arising

The Committee was advised of the reports that were submitted to the Resources and Business Development (RABD) Committee in August 2023 relating to two pieces of work that the Integrated Care Board (ICB) has asked the Trust to do in respect to expenditure controls and the National Cost Collection exercise. RABD have formally requested that the Audit and Risk Committee (ARC) consider conducting an internal audit on expenditure controls. KB explained that a comprehensive self- assessment against the ICB requirements has been completed by the Finance Team and actions have been agreed to address the gaps for the small number of non-compliant areas. KB was of the opinion that an internal audit does not need to take place as 1. Audits are conducted across the finance processes which produce solid assurance and 2. The ICB does not require the Trust to conduct an audit, therefore it was proposed that the action plan should be submitted to each ARC meeting until it has been signed off as delivered. A discussion ensued and it was agreed to submit a position update to the Committee in January and circulate the report that was received by RABD in August 2023.

23/24/67.1 Action: RL

Attention was drawn to the national cost control exercise that the Trust is required to carry out annually as part of the organisation's provider licence remit. The Trust has been asked to provide assurance that processes are in place to produce cost collection data. As there has not been independent assurance of this area in recent years it was suggested that the Committee seek assurance independently via MIAA. It was agreed to discuss this matter outside of the meeting.

23.24.67.2 Action: MIAA/KB

Action Log

Action 22/23/84.1: *Waiver Activity Report (Provide additional information in the next Waivers Report following a drill down to establish the reasons/themes for the lack of a reduction in waivers during the last reporting period. Include two line graphs in future reports (number/value) in order to track figures. (Linked to 23/24/25.1)* – It was agreed to liaise with HPL to request that graphs and trends be included in April's report.
ACTION TO REMAIN OPEN

Action 23/24/25.1: *Waiver Activity Report (Liaise with Health Procurement Liverpool to request that information in the report be presented in a more helpful format. (Linked to 22/23/84.1)* – It was agreed to liaise with HPL to request that each update covers a six month reporting period. **ACTION TO REMAIN OPEN**

Action 22/23/98.1: *Anti-Fraud Progress Report (Local Proactive Exercise Overtime Review - Include the recommendations from the overtime review in the next Anti-Fraud Progress Report and provide an update on the implementation of actions)* – It was confirmed that all three recommendations relating to the implementation of procedures and including a fraud declaration within time sheets have been actioned. **ACTION CLOSED**

Action 23/24/04.2: *MIAA Follow-up Report (Include the outcome of the IT Assets Hardware follow up review conducted by MIAA in October's Follow-up Report)* – It was confirmed that this information will be included in January's Follow Up report.
ACTION TO REMAIN OPEN

Action 23/24/52.1: *Terms of Reference for the Revised Key Financial Controls Audit (Liaise with E&Y to ensure that there is nothing else that needs to be included in the audit from their perspective)* – It was agreed to liaise with E&Y and provide an update during January's meeting. **ACTION TO REMAIN OPEN**

Action 23/24/54.2: *Corporate Report (*Create four to five codes for longstanding risks to provide rationale as to why a risk is still outstanding) – A meeting has been scheduled to think collectively about a standardised approach for codes. **ACTION TO REMAIN OPEN**

Action 23/24/59.1: *Policy for Engagement of External Auditors in Non-Audit Work (E&Y to advise the Committee on an ongoing basis of any relevant work that they undertake for C&M ICB and to confirm their ongoing independence in relation to AH's external audit)* –
It was advised that E&Y have consulted their independent processes internally and it was confirmed that the work undertaken on behalf of the ICB will not have any impact on the Trust and there are no issues as a result of the output of that work. In the event an issue arose E&Y would bring this to the Trust's attention as they are unable to conduct work that would have an impact Alder Hey. **ACTION CLOSED**

Action 23/24/54.1: *Corporate Report - Conduct a review of the 'People Risks' to determine whether they are people risks or clinical risks, for example, for some of the risk the impact is appears to be clinical but the "cause" is people)* – Work is taking place with risk holders to determine risk categories so that they can be included on the new InPhase system. This work is ongoing. **ACTION CLOSED**

Action 23/24/76.1: *Internal Audit Progress Report (The score has been reduced following the Financial Controls Audit. Kath Scott agreed to liaise with E&Y to confirm their agreement of this change)* – Kath Stott agreed to liaise with E&Y re this matter.
ACTION TO REMAIN OPEN

23/24/68 NHS Employment Check Standard Audit.

The Committee was provided with a report on the outcome of the recruitment and selection process audit that took place to review the Trust's recruitment processes that subsequently enabled an individual to fraudulently gain employment at the Trust in February 2019. Following a discussion about the report findings, the Chair requested that a further sample be audited against the NHS Safer Recruitment Standards for assurance purposes.

The Committee was advised that the audit confirmed that whilst there were no gaps found in the right to work in the UK, professional registration, work health assessments, and DBS check records, it was recognised that there are some gaps related to evidence on file of qualifications and references. A full review of the organisation's historic files will be undertaken over the next 12 weeks in order to gain maximum assurance around pre-employment checks for all staff. It was reported that an assessment has been conducted in respect to clinical staff who are required to have statutory and professional registration and it was confirmed that all respective individuals are compliant. The next area to be reviewed relates to clinical staff who aren't required to have a professional registration. The plan is to obtain all outstanding checks and update ESR accordingly. It was reported that there may be some residual risk in relation to references but following assessment an approach will be determined to mitigate this risk.

Once the audit has been completed a report will be submitted to the People and Wellbeing Committee and ARC in due course.

The Committee was informed that corporate services related audits are usually conducted by MIAA but it was felt that it is timely to reflect upon whether there are some corporate services audits, such as an ongoing check on a sample of recruitments against the NHS Safer Recruitment Standards that should be incorporated under the clinical audit umbrella.

Following discussion it was agreed to:

- Look at the possibility of having a more explicit risk on the risk register appertaining to residual risks.

23/24/68.1 **Action: SO/JRo**

- Consider whether ongoing checks against the NHS Safer Recruitment Standards should be added to the Clinical Audit Plan.

23/24/68.2 **Action: SO**

- Outcome of the additional audit to be submitted to ARC in January 2024 (*refer to action 23/24/51.1*).
  Action: SO

Resolved:
ARC noted the report on the NHS Pre-employment Checks Audit.

23/24/69 Update on the Risk Management Process within Research and Innovation

The Committee received a presentation of the risk management process within the Division of Research and Innovation. A number of slides were shared that provided information on the following areas:

- Clinical Research Division (CRD) risks.
- Innovation risks.
- Corporate governance arrangements for Research and Innovation.
- Key governance structures for assurance, approval, decision-making and monitoring within Research and Innovation.
- Revised risk management approach for Research and Innovation.
- Summary position for October 2023;
  - Total of 13 risks items currently on the register all with a relatively low score *(4 relate to CRD and 9 relate to Innovation - only 1 risk ranked as >12).*
  - Trends over time.

Jo Revill thanked John Chester for the presentation and asked how the team felt about the whole process of thinking about risk management in this way. It was pointed out that there are two sets of different factors across Research and Innovation; for example, there are a large number of clinical trials that are tightly governed and therefore risk is proactively managed. In terms of Innovation there are unexpected risks, but both teams have embraced this and have adopted a joint approach.

Jackie Rooney informed the Committee that it has been difficult to describe risks especially those relating to Innovation, but both teams have been very receptive in terms of trying to articulate risks and explain how they interface with the overall governance process so that non-Innovation/Research people can understand them. From a Research perspective the team has described how risks are managed from a research/ethics point of view and have

advised that they are in agreement to embrace any changes and be supportive in what they do.

KB queried as to whether a similar presentation will be shared with the Research and Innovation (R&I) Committee and asked if there were any issues that came out of the report compiled by Fiona Marston that need to be reflected in the risk register. It was confirmed that this presentation will be submitted to the R&I Committee.

KB drew attention to the importance of setting time aside over the next few months to reflect on how ARC receives ongoing assurance around R&I and also think about when a formal audit should be undertaken. It was pointed out that elements of R&I are not well established or understood therefore there may be periods of time when the Committee will ask for further detail. John Chester advised that CRD and the Innovation Team are committed to being held to the same standards as other Divisions and providing the relevant information requested by Committees, but conveyed the importance of having an innovation process and theme that is agile and not overburdened with paperwork/reports to enable the team to focus on the good work that they do.

A question was raised about whether the Trust needs to give some thought as to how it relates to the early stage of risk in terms of the innovators it works with. It was reported that a Standard Operating Procedure (SOP) has been produced to address governance when moving an idea out of the initial idea phase. This information is shared with the R&I Committee to provide transparency on the projects that are being progressed and detail on the level of risk that the Trust will be handling as a result of this. This enhancement to the process was introduced approximately six months ago to ensure visibility of the whole pipeline.

AB offered feedback following the presentation and raised the following points:

- *Workforce Risk (Biochemistry Team)* – It was felt that a risk relating to patient safety should be included on the risk register from an experimentation and discovery perspective, even if it has been heavily mitigated. The Committee was advised that CRD don't undertake any studies that are high risk. It was also pointed out that risk reviews and mitigations are conducted throughout each research study which is one of the reasons as to why they don't appear on the risk register.
- *Research Strategy* – It was felt that time is a huge factor in terms of growing and expanding therefore it is necessary for the organisation to address the funding required to recruit people with a research interest to ensure it fulfils its Research Strategy and ambitions for Futures. The Committee was advised of the expression of interest that has been submitted for Charity funded Programmed Activities (PAs). If successful, this will help the Trust develop its research active clinicians for specific tasks to earn additional grants and grow the organisation's research base.
- *Alder Hey Innovation* – Attention was drawn to the financial challenges and dependences on short-term contracts within Alder Hey Innovation. It was queried as to whether this should be reflected in the risk register as a pressure that the Innovation team are trying to address.

Resolved:
ARC noted the update on the risk management process within Research and Innovation.

23/24/70 InPhase Update

The Committee was provided with a current position of the InPhase Risk and Incident Management project and action plan for resolution of outstanding challenges and actions. Attention was drawn to the following key points:

- Since Go Live, several challenges continue to be highlighted within the reporting functionality of InPhase. Initially there were 21 reports requested by the Trust in relation to assurance reporting with priority not being given to the most important reports. This has been reviewed and streamlined to 7 priority reports.
- *Report Builder Training* – Internal IT champions are assisting with the report build facility and will continue to do so until all reports have been developed and signed off.
- It was reported that there are coding issues within the system that are outside of the Trust's control. This issue has been escalated to InPhase and their CEO who are now in the process of addressing the problem.
- Issues relating to the InPhase helpdesk have been raised by the Trust as responses directly from the supplier are not always actioned within the 10-day timeframe which is hampering progress. In order to mitigate this issue the Trust has requested onsite presence from InPhase personnel to address technical issues and reduce the number of helpdesk requests. It was confirmed that the Trust is working closely with the provider to resolve this problem and this issue has been included on the risk register.
- The Trust is now live with all nine modules. It was reported that the Trust's Medication Dashboard demonstrates the benefits realisation of the system as a whole.
- A review of the service specification and procurement of InPhase will be undertaken to review and benchmark the request outlined in the service specification versus the current delivery of provision.
- There is a clear action plan in place to address reporting issues, with Analytics Leads assisting with the report builds. This area of work should be fully completed by the 13.10.23.
- All reports, with the exception of complaints and PALS, have been signed off and are ready for use.

A question was raised about the length of time it will take to fix the coding issue. It was reported that discussions are taking place twice a week with the CEO of InPhase but at the present time there is no end date for resolving this matter.

Reference was made to the importance of conducting a post project review as it was pointed out that this will be beneficial for future software specifications.

A query was raised about whether the Trust is assured that it is in a safe place. It was confirmed that the organisation has a manual back up system in place that can supply a high level of detail if required.

Resolved:
ARC noted the update on the InPhase system.

23/24/71 Board Assurance Framework

The Committee received the Board Assurance Framework (BAF) report for August 2023.

It was reported that time has been set aside to think about strategic risks associated with the Vision 2030 Strategy. On the 5.10.23 the Strategy Board received a version of the BAF that had been updated to reflect the developing position. It was confirmed that work is ongoing and the Committee will start to see the changes that have been made when it receives the next iteration of the BAF.

Resolved:
ARC noted the content of the BAF report for August 2023.

23/24/72 Risk Management Forum (RMF) Update including the Corporate Risk Register (CRR) and minutes from the last meeting

The Committee was provided with an overview of the key points and areas of concern that were discussed during the RMF meeting that took place on the 30.8.23. The Chair of the RMF advised that a high quality robust conversation took place during the meeting and pointed out that time was set aside to review the trends of high corporate risks. It is felt that the Forum continues to address fitting topics and raise questions/challenges where appropriate, and a deep dive is conducted during each meeting where risk owners are held to account. The Chair of the RMF felt that it can be demonstrated that the Forum continues to be used as a principal way for feeding operational risks through to ARC.

Corporate Risk Register

The Committee received the CRR for the reporting period from the 16.8.23 to the 15.9.23.

KB referred to risk 2441 (*patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval)* and queried the reason for this issue ongoing especially as it had been reported six months ago that this matter was on the cusp of being addressed. The Committee was advised that this is a symptom of there being two different age groups and two different providers. The risk relating to neonates has been resolved as there is a new protocol in place with transport providers in the Midlands. In terms of non-neonatal transfers, negotiations are ongoing with a different transport team and therefore this element of the risk hasn't been mitigated as of yet. It was agreed to appraise risk 2441 to see if the likelihood has gone down based on progress.

23/24/72.1 Action: AB

It was pointed out that risk 25 (*defective ventilators*) is a new risk and further detail was requested on this matter. It was reported that this risk has been mitigated via funding from the Trust and the Charity which enabled replacement ventilators to be purchased. Jackie Rooney agreed to check that the risk has been closed on the InPhase system.

23/24/72.2 Action: JRo

Attention was drawn to risk 2627 (*not compliant with national guidance with transferring and transcribing patient records following adoption* due to pre-adoption records not being routinely closed post adoption) and a question was asked as to whether an audit should take place on historical records to ensure the eradication of any issues going forward. The Committee was informed that system checks take place each time an incident occurs plus there is a functionality in the Expanse system where data issues can be recorded and rectified. Robust mitigations have also been implemented to address the issues relating to adoption medicals not being completed. It was agreed to liaise with Lisa Cooper to see whether it would be beneficial to conduct an audit on this area of work.

23/24/72.3 Action: ES

Resolved:
ARC received and noted the RMF update, CRR and the approved RMF minutes from the meeting held on the 9.6.23.

23/24/73 Trust Risk Management Report

The Trust Risk Management report was submitted to provide the Committee with the opportunity to scrutinise the effectiveness of risk management throughout the Trust. The assurance presented in the report is a direct reflection of the evidence available on InPhase at the time of reporting. The following points were highlighted:

- The Committee was asked to note that there are 257 risks on the Trust Risk Register for the reporting period; 16.8.23 to the 15.9.23. This is a decrease compared to the previous reporting period (269).
- In the reporting period 4 new risks have been identified, 17 risks have been closed, 60 risks are overdue a review, 36 risks are without an ongoing action plan, and 52 risks are overdue an action. Some of this relates to an issue with risks and actions not being saved in the functionality on InPhase. It was confirmed that problem has since been rectified.
- Scrutiny of all overdue corporate risks is being undertaken by the Corporate Services Collaborative in addition to being addressed via monthly risk oversight meetings and the RMF.

Resolved:
ARC noted the content of the report.

23/24/74 Risk Management Strategy and Policies

The Committee received the Risk Management Strategy, the Risk Assessment Policy, and the Risk Management Policy and Procedure, for ratification purposes. Attention was drawn to the minor changes that have been made to the suite of documents, and it was pointed out that they may need to be re-written as a whole due to the journey that the Trust is on in terms of risk awareness and risk appetite.

KB advised that the documents had been submitted early following a request from the Committee but felt that it would be beneficial to re-ignite the risk appetite/risk tolerance discussions over the next three to six months so that this area of work can be finalised and included in the relevant policies ahead of re-ratification. Once the risk appetite/risk tolerances has been agreed it will be necessary to relaunch refresher training for staff. The Committee confirmed their agreement of this approach.

Resolved:
ARC approved the proposed approach.

23/24/75 Risk Management Training Throughout the Trust

The Committee was provided with an overview of the current approach to risk management training for all Trust staff upon commencing employment and on an ongoing basis. It was explained that there are several ways in which risk management is being addressed currently, as detailed in the report. Attention was drawn to the following key issues:

- It was reported that mandatory risk management training ceased during Covid and there are no plans at the present time to reinstate it as part of the induction programme. There is also no refresher training managed by Learning and Development.
- Further progress on risk appetite has been temporarily paused following the update of the BAF to align with the 2030 Strategy but it is imperative that this work recommences as risk appetite and risk tolerances need to be included in policies, etc. going forward.
- *Quality Assurance Rounds (QAR)* – The Committee was advised that teams are clear about the issues their departments are experiencing but when asked as to whether the matter has been included on the risk register a number of staff members reported that they didn't recognise it as a risk.
- There are teams and staff who are noted to be risk aware but it was pointed out that this tends to be demonstrated by staff in senior positions. There are gaps with a large number of staffing groups, but again this depends on role/seniority in the Trust.
- Attention was drawn to the detail included in the report appertaining to the gaps in the organisation's risk management training and the solutions to resolve them.

Following discussion, it was proposed that the Governance team:

- Take a phased approach to risk management training and review the current content of the Managers Toolkit.
- Establish whether risk management training forms part of the local induction programme for managers.
- Work with the new Head of Learning and Development to refresh the contents of the Managers Toolkit; to include risk management oversight and training.
- Suggest a risk stratified approach to risk management training based on level of seniority within a team and across the Trust.
- Present the findings to the RMF for further discussion on how the organisation approaches risk management training going forward and further engage with the wider stakeholder group to progress this area of work.

ES agreed to sponsor this approach as Chair of the RMF thus ensuring the Trust has an effective system going forward.

Resolved:
ARC noted the content of the report and acknowledged that whilst there are limitations there are also opportunities to talk about risk management awareness and risk appetite across the Trust. The Committee approved the proposal put forward by the Associate Director of Nursing and Governance.

23/24/76 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the 2023/24 Internal Audit Plan during the period; July 2023 to September 2023. The following points were highlighted:

- There were three reports finalised in the reporting period;
  - Data Quality *(Substantial Assurance).*
  - Payroll *(Substantial Assurance).*
  - Data Security Protection Toolkit *(Substantial Assurance).*

- *Cyber Review* – Additional information has been shared offline with Committee members to advise as to why a Cyber review is to be undertaken at the Trust and to request approval for this amendment to the Internal Audit Plan. It was pointed out that there is a place holder in the Plan for an IT audit therefore MIAA have looked at a whole range of IT audits and for a particular reason, as described in the e-mail that was circulated by MIAA, have recommended that a Cyber review take place.

For noting

ARC approved the amendment to the Internal Audit Plan.

KB referred to the Data Protection Security Tool audit and pointed out that it was explained to her that the report doesn't currently include the findings on the basis that it would highlight the organisation's security vulnerabilities which would become a risk in the event the report was posted in the public domain. MIAA acknowledged that it's difficult to read the report without the supporting detail and it was agreed to discuss this matter outside of the meeting to discuss an alternative approach going forward.

23/24/76.1 Action: KB/ES/GB

Rachel Lea drew attention to the payroll audit and pointed out that there was no reference in the report to the overpayments that the Trust has had to write off due to a change forms being submitted after the payroll date. MIAA advised that further overpayment testing is going to take place and an update will be provided during January's Committee meeting.

Reference was made to the reduced score following an audit of the Trust's key financial controls. It was requested that MIAA liaise with E&Y to make them aware of the change and acquire their agreement of this amendment.

23/24/76.2 Action: KS

Resolved:
ARC received and noted the contents of the Internal Audit Progress Report.

23/24/77 Internal Audit Follow Up Report

The Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been between April 2023 to September 2023. The following points were highlighted:

- MIAA are currently tracking 47 recommendation from 11 reviews.
- Of the five recommendations which have fallen due in this reporting period; 2 consultant job planning recommendations have been implemented and one recommendation relating to project management has been implemented. 1 consultant job planning recommendation has been superseded and one recommendation relating to the Consent audit remains partially implemented with approval requested from ARC for a further extension to enable detail to be included in the Clinical Audit Plans.

Attention was drawn to the importance of having routine auditing of consent processes as it has been an issue for CQC in past inspections therefore it is essential that they take place. The Committee approved the extension but it was asked that a request be submitted to CEOG asking that auditing of consent processes feature in all Divisions.

23/24/77.1 Action: JRO

Resolved:
ARC received and noted the content of the Internal Audit Follow Up Report**.**

23/24/78 Consultant Job Planning Position Update

A report was submitted to the Committee to provide an update on the three outstanding MIAA recommendations relating to consultant job planning. Background detail was provided along with an overview of the current status. It was confirmed that significant progress has now been made towards all of the Trust's job plans being available on the L2P system, and work will continue towards achieving 100% compliance with the MIAA recommendations.

KB explained that MIAA's report concluded that all recommendations have been implemented, whilst the Trust has taken a more cautious approach in concluding the level of implementation to ensure processes continue to be built upon and become embedded. MIAA advised that both positions are correct. From a system and process perspective the Trust has everything that it requires in place therefore MIAA are in agreement to sign off the recommendations. The Committee was informed that MIAA conduct this audit across a number of organisations and to achieve 89% of job plans compliance is a very positive outcome.

MIAA advised that due to the length of time it has taken to reach the current position and the various points in time that actions have been signed off, it has been agreed to consolidate this information into one report to provide detail on the original recommendations, how they were addressed and the date they were signed off. It was also reported that the Chief Medical Officer, Alfie Bass has suggested that a full audit take place in the next financial year. Jo Revill asked as to when the Committee can expect to see the consolidated report. It was confirmed that it will be submitted to the Committee during January's meeting.

23/24/78.1 Action: KS

In order to manage Committee expectations, it was pointed out that it will be very difficult for the Trust to achieve 100% compliance as at any one time there may a number of consultants who are on restricted duties, on long-term sick leave or maternity leave. In addition to this, clinical academics have to have an agreed job plan with the university which can take some negotiation at times. To conclude on the report, the reference to the Pay Progression Policy was not agreed by the LNC on the 11.10.23. It is assumed that there will be a more pragmatic approach in terms of having a procedure that sits behind the job planning policy to address incremental rises.

Resolved:
ARC noted the Consultant Job Planning position update.

23/24/79 Anti-Fraud Services Progress Update

The Committee received the MIAA Anti-Fraud Progress Report that sets out the work undertaken during the period from the 1.4.23 to the 2.10.23. Attention was drawn to the following key points:

- The annual Counter Fraud Functional Standard Return (CFFSR) submission against the national counter fraud, bribery and corruption standards (Government Functional Standard 013 for Counter Fraud) was submitted on 30.05.23 via the NHS Counter

Fraud Authority (NHSCFA) online portal. The Trust received a Green rating overall for the 13 Components which comprise the CFFSR. The return was reviewed and approved in advance of its submission by the Director of Finance and the ARC Chair.

- The NHSCFA has published a new Strategy 2023-2026 and Business Plan 2023-2024, which details how the NHSCFA intends to work collaboratively with the health sector over the next three years to understand, find and prevent fraud in the NHS.
- The NHSCFA have also launched a new Fraud Hub for the AFS community which will focus on supporting, enabling, assisting, and guiding health bodies on fraud and bridging the gap between the national fraud response and the local counter fraud response.
- The government is intending to create a new 'failure to prevent fraud' offence to hold organisations, including NHS organisations, to account if they profit from fraud committed by their employees. Under the new offence, an organisation will be liable where a specified fraud offence is committed by an employee or agent, for the organisation's benefit, and the organisation did not have reasonable fraud prevention procedures in place. The penalty for this will be an unlimited fine for the organisation and not the individual if the organisation is unable to prove that if had reasonable fraud prevention in place at the time the offence was committed.
- The Anti-Fraud Specialist (AFS) has issued 39 Fraud Prevention Checks (FPC) to the Trust for intelligence and preventative purposes.
- The Trust has been notified of the MIAA production of a series of 'Talking Fraud Podcasts' covering a range of topics to raise awareness of fraud, bribery and corruption.
- The AFS has issued the Trust with a Bank Mandate Resource Pack of materials, produced by the NHSCFA and have used this to review the new supplier set up process which was undertaken with Health Procurement Liverpool and also provided a detailed awareness raising session for relevant staff around bank mandate and the risks.
- *Hold to Account* – Following advice, it has been agreed to leave INV/23/01034 (bank mandate fraud) open until MIAA receives the outcome of the investigation from the Police so that it can be recorded on the national case management system.

Resolved:
ARC received and noted the Anti-Fraud Progress Report.

23/24/80 Additional Fee Proposal

The Committee received a report which outlined the proposed additional fee of £25k for the 2022/23 external audit and which provided a breakdown of the areas that it relates to.

A discussion took place regarding the additional fee and it was felt that further detail is required in terms of the breakdown for each category to understand the cause of the delay, the input from both external audit and the Finance Team, and whether the additional cost is a fair figure. It was pointed out that a wash up meeting is scheduled to take place, which the Chair of ARC will be attending, where issues/challenges can be raised and discussed. Hassan Rohimun advised that E&Y did make the Trust aware of the possible additional costs before the audit closed.

For noting
It was agreed that approval of the additional fee request should be addressed following the wash up meeting.

Going forward it is felt that it is imperative that potential overruns and the costs associated are raised at the time; issues affecting deadlines should be flagged during closure meetings and time should be set time aside ahead of the 2023/24 audit to reflect on timetables.

ES felt that a separate report should be compiled for the Trust's governors to provide transparency on this matter and an evaluation of what has been done.

KB drew this item to a close and provided a summary of the actions that need to take place to address this matter:

- Wash up meeting to take place to discuss the finer details.
- Greater level of information required on the proposed additional fee.
- Trust to provide challenge before approving the additional fee.
- Submit a report to the Council of Governors to advise of the additional fee, once approved.

23/24/80.1 **Action: ES**

Resolved:
ARC noted the additional fee proposal from E&Y

23/24/81 Clinical Audit Mid-Year Progress Report; including: Divisional Clinical Audit Plans.

The Committee was provided with oversight and assurance that the Trust's clinical audit activity is progressing to support improvements in patient care and outcomes. The review period covers clinical audit activity across the Trust for the reporting period from the 1.9.23 to the 30.9.23 and the mid-year clinical audit position. The following points were highlighted:

- At the time of reporting a total of 20 national mandated audits are included on the Trust's Clinical Audit Annual Plan for 2023-2024. It was confirmed that all audits are progressing and are on schedule. There were no regional mandated audits registered during the reporting period and there are 14 local trust priority audits.
- A total of 17 audits were registered within the reporting period. Of those, 10 audits were completed which were an even spread between the Division of Medicine and the Community and Mental Health Division. The audits completed were a mix of regional, national and local audit priorities.
- The Committee was advised of the process that has been implemented to address audits that have been registered but not completed and feedback hasn't been received in terms of an update. In the event there is no response the matter is escalated to the respective Clinical Governance Leads within the Divisions to decide as to whether the audit should be removed from the Plan. This area of work is monitored by the Clinical Effectiveness and Outcomes Group (CEOG).
- There is a system in place whereby it has been established that each Division has devolved the decision of local audit plans to teams and some specialities without oversight. It was reported that the Governance Team return registered audits to the Divisions to ensure they have oversight of what is being proposed within their teams thus enable audits to be included on local audit plans, and compliance data to be submitted to CEOG.
- Attention was drawn to the Divisional and Corporate audit plans in the report which have been signed off by the Safety Quality Assurance Committee (SQAC). The audit plans align to Divisional themes, professional registration, interests that clinicians

may have, CPD and revalidation. It was confirmed that this area of work is an iterative process.

Jo Revill asked as to whether the organisation is starting to see delays in the carrying out of audits due to industrial action taking place. The Committee was advised that the compilation of the Quality Account highlighted that the Trust hadn't submitted some of its nationally mandated case notes when it was asked to. This was due to a number of reasons but mitigations have since been implemented to ensure that the Trust meets its deadlines in terms of submitting national audit data.

KB felt that ARC and SQAC are receiving a greater level of insight/understanding of clinical audit and are now in a better position to ask questions. It was acknowledged that improvements will continue to take place but confidence is increasing as a result of visibility.

Resolved:
ARC noted the Clinical Audit Mid-Year Progress report which included the Divisional Clinical Audit Plans.

23/24/82 CIO Quarterly Update
Resolved
ARC noted the content of the Data Protection quarterly report and Freedom of Information quarterly report.

23/24/83 Review of External Audit (effectiveness survey)

The Committee received a report that set out the anonymised responses to the External Audit Effectiveness Survey based on the framework developed by Deloitte. The purpose of the Survey is to review the effectiveness of external audit provision, as well as any gaps in understanding amongst committee members.

Responses were received from two of the three ARC Members as well as a combined response from the Chief Finance Officer and the Director of Finance. The response was broadly positive, with a small number of areas highlighted for further focus; audit rotation, early engagement, timetabling as a larger than expected number of issues were flagged in the later stages of the audit, and bespoke training to new committee members as part of the annual cycle.

It was reported that a focus on these areas will take place during the wash up meeting between the Trust and Ernst and Young. KB asked that a brief discussion take place ahead of the wash-up session.

23/24/83.1 Action: EK/KB

The Committee was informed that this is the first time the Trust has conducted a review of External Audit. It was pointed out that there are some areas that both parties need to address in terms of strengthening processes. Thanks were offered to those who completed the survey and it confirmed that reflection will take place to look at how information is gathered and subsequently shared ahead of the next review.

Hassan Rohimun advised that E&Y welcomed the feedback and the opportunity to reflect on the outcome of the review and respond to the points made.
Resolved:
ARC noted the response to the effectiveness survey.

23/24/84 Update on Progress Against Actions from the ARC Self-Assessment

The Committee received an update on the progress that has been made against actions arising from the 2022 ARC self-assessment exercise.

It was felt that the self-assessment is a worthwhile piece of work which prepares the Trust for the future year end and thanks were offered to KB for leading on this.

Resolved:
ARC noted the update on the progress that has been made against actions arising from the 2022 ARC self-assessment exercise.

23/24/85 Waiver Activity Report

The Committee received a report on the tender and quotation waivers for Q2. The total value of waivers raised in Q2 was £1,875,535.88.

It was reported that the Trust has a robust system in place and is receiving waivers in the appropriate manner and for the rights reasons. Attention was drawn to the lack of comparisons included in the report in terms of highlighting trends but this will be rectified ahead of the Q3/Q4 report being submitted to the Committee in April. It was felt that it is important to include graphs and trends in the report to provide more oversight and detail, for example, a large portion of the waivers submitted in Q2 relate to Innovation but the report doesn't provide this information.

Resolved:
The ARC received and noted the Q2 tender and quotation waivers.

23/24/86 Corporate Governance Manual

The Committee received v7 of the Corporate Governance Manual for ratification purposes due to a number of amendments that were made following an annual review, which included the impact of cost control requirements outlined by NHS England, and decisions taken in Board Sub-Committees.

The key changes to the Manual are as follows:

- Job titles updated to reflect current structures.
- The People and Wellbeing Committee has been included under section 4.1.
- Update to sign off requirement for Non-Clinical Agency and Revenue Consultant spend in line with NHSE guidance.
- Business Case sign off limits updated in line with current business case guidance.
- Update to requisition limits following internal review.
- Update to procurement and tender limits in line with previous agreement by ARC in July 2023.
- Addition of waiver exemption section in line with previous agreement by ARC in July 2023.

ES thanked all those involved in updating the Corporate Governance Manual, especially Jill Preece.

Resolved:
ARC noted the amendments and ratified version 7 of the Corporate Governance Manual.

23/24/87 Any Other Business

There was none to discuss.

23/24/88 Meeting Review

It was felt that the papers supported the discussions that took place during the meeting and that the Committee covered some major points.

Date and Time of the Next Meeting: Thursday 25th January 2024, 2:00pm-5:00pm, Meeting Room 7.