BOARD OF DIRECTORS PUBLIC MEETING

Thursday 7th September 2023, 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
1.	**23/24/101**	**9:00 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/102**	**9:01 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/103**	**9:02 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **27th June 2023 and the 6th of July 2023.**	**D**	Read enclosure
4.	**23/24/104**	**9:04 (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.	**23/24/105**	**9:05 (10 mins)**	**Chair/CEO's Update; including:** • **Vision 2030 Strategy Update.**	Chair/ L. Shepherd J. Grinnell	To provide an update on key issues and discuss any queries from information items. To provide an update on the current position.	**N** **A**	Verbal Read report
Operational Issues							
6.	**23/24/106**	**9:15 (60 mins)**	• **M5 Overview.** • **M5 Flash Report .** • **Integrated Performance Report for M4, 2023/24.** • **Finance Update for M4, 2023/24.** • **Digital, Data and Information Technology Update; including:**	Executives/ Divisions R. Lea K. Warriner	To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues. To receive an update on the current M4 position. To receive an update on the current position.	**A** **A** **A** **A**	Slides Report Report Report/ Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- **Presentation on Aldercare.**				
7.	23/24/107	10:15 (10 mins)	**Alder Hey in the Park Campus Development Update.**	J. Halloran	To receive an update on key outstanding issues/risks and plans for mitigation.	A	Read report
8.	23/24/108	10:25 (5 mins)	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 30.8.23.** - **Approved minute from the meeting held on the 26.6.23 and 17.7.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 26.6.23 and the 17.7.23.	A	Read enclosures
PATIENT STORY (10:30am-10:45am)							
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
9.	23/24/109	10:45 (10 mins)	**Alder Hey Community Mental Health Services (Liverpool and Sefton) Proposed Changes to Waiting Times Standards and Reporting.**	L. Cooper	For noting and approval.	D	Read report
10.	23/24/110	10:55 (10 mins)	**Brilliant Basics Update.**	N. Palin	To receive an update on the current position.	A	Read report
11.	23/24/111	11:05 (5 mins)	**Serious Incident Report.**	P. Brown	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	A	Read report
12.	23/24/112	11:10 (5 mins)	**Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 19.7.23.** - **Approved minutes from the meeting held**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 21.6.23.	A	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			on the 21.6.23.				
Game Changing Research and Innovation							
13.	**23/24/113**	**11:15 (10 mins)**	**Update on Research.**	J. Chester	To receive an update on the current position.	**A**	Verbal
14.	**23/24/114**	**11:25 (5 mins)**	**Research and Innovation Committee:** - Chair's verbal update from the meeting held on the 10.7.23. - Approved minutes from the Innovation Committee meeting held on the 18.4.23.	J. Chester	To escalate any key risks, receive updates and note the approved minutes from the 18.4.23.	**A**	Read enclosure
The Best People Doing Their Best Work							
15.	**23/24/115**	**11:30 (10 mins)**	**Medical Revalidation Update.**	H. Blackburn	To receive an update on the current position.	**A**	Read report
16.	**23/24/116**	**11:40 (10 mins)**	**People Plan Highlight Report; including:** • EDI Update.	M. Swindell G. Dallas	To receive an update on the current position.	**A**	Read reports
17.	**23/24/117**	**11:50 (10 mins)**	**NHS North West Black, Asian and Minority Ethnic Anti-Racist Framework.**	M. Swindell	For discussion and approval.	**D**	Read report
18.	**23/24/118**	**12:00 (5 mins)**	**People and Wellbeing Committee:** - Chair's verbal update from the meeting held on the 11.7.23. - Approved minute from the meeting held on the 24.5.23.	F. Marston	To escalate any key risks, receive updates and note the approved minutes from the 24.5.23.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
19.	**23/24/119**	**12:05 (15 mins)**	**Freedom To Speak Up - Update.**	K. Turner	To receive a quarterly FTSU Guardian update.	**A**	Read report
Lunch (12:20pm-12:40pm)							
Strong Foundations (Board Assurance)							
20.	**23/24/120**	**12:40 (5 mins)**	**Board Assurance Framework Report; including:** • **Corporate Risk Register.**	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 reports
21.	**23/24/121**	**12:45 (10 mins)**	**Fit and Proper Person Test Framework for Board Members.**	E. Saunders	To receive the new Fit and Proper Person Test framework published by NHSE in August 2023.	**N**	Read report
22.	**23/24/122**	**12:55 (5 mins)**	**Governor Election Results.**	E. Saunders	To receive the outcome of the 2023 summer elections.	**N**	Read enclosure
23.	**23/24/123**	**13:00 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 13.7.23.** - **Approved minutes from the meeting held on the 22.6.23.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 22.6.23.	**A**	Read enclosures
Items for information							
24.	**23/24/124**	**13:05 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
25.	**23/24/125**	**13:09 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal

Date and Time of Next Meeting: Thursday 5th October 2023, 11:00am, Lecture Theatre 4, Institute in the Park.

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

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M4, 2023/24	R. Lea
Register of Shareholder Interests	R. Lea

EXTRAORDINARY PUBLIC MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on **Monday 27th June 2023 at 10:00am**
via Microsoft Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Dr. F. Marston	Non-Executive Director	(FM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 23/24/70	Mr. D. Spiller	Ernst and Young	(DS)
Apologies	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)

23/24/68 Welcome and Apologies

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

23/24/69 Declarations of Interest

There were none to declare.

23/24/70 Draft Annual Report and Accounts for 2022/23

Annual Report

The Board received the Trust's Annual Report for 2022/23 which was prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. The Board was provided with an overview of the report which it was felt captures both the essence of Alder Hey and reflects the organisation's challenges/achievements in the previous year. It was pointed out that it is a fair reflection of the Trust's activities over the period and covers the breadth of requirements of the ARM to provide a level of accountability to the Trust's members and the wider public. Tribute was paid to those involved in compiling the Annual Report, in particular, Erica Saunders and Jill Preece.

The Annual Report has been checked for consistency by Ernst and Young (E&Y) along with the Annual Governance Statement, of which, it was confirmed that there were no material differences found.

It was reported that the Audit and Risk Committee approved the 2022/23 Annual Report and Accounts on the 22.6.23. The date of submission to NHS England (NHSE) is the 30.6.23 and thereafter the Trust will lay the Annual Report and Accounts before Parliament either ahead of the summer recess or in September.

Annual Accounts

The Committee was provided with an overview of the 2022/23 Annual Accounts and the supplementary finance report. It was reported that the Trust's year end position for 2022/23 was £5.5m surplus, £800k favourable to plan. It was confirmed that there aren't any material changes to the organisation's control total that would change the Trust's financial performance for the year.

Attention was drawn to a small number of high level points, as detailed in the supplementary finance report; **1.** £49k adverse impact on the performance against the control total. **2.** The full revaluation of the Trust's estate and the reversal of impairments. **3.** Adjustments to accruals. It was pointed out that both the Finance team and E&Y have worked well together but there have been a number of lessons learnt as a result of the audit. It was confirmed that the Trust is in a position to meet the 30.6.23 submission deadline.

'ISA 260'

The Board received the external Audit Results Report for year ended the 31st of March 2023. The following points were highlighted:

- It was confirmed that E&Y are proposing to issue a clean audit opinion which it is felt is a positive position for the Trust.
- *Assessment of Control Environment* – In the testing of PPE, E&Y identified items of equipment recorded in the Fixed Asset Register (FAR) that had actually been disposed of previously without an update made to the FAR. E&Y have extrapolated a difference of £1.7m overstatement of the Net Book Value of PPE in the disclosure note. This doesn't affect the bottom line but the adjustment will have to be signed off by the Managing Director and the Chair of the Audit and Risk Committee.
- There are a small number of control recommendations detailed in the report but it was pointed out that the report doesn't lend itself to provide detail of the significant improvements that have been made.
- It was confirmed that the audit is coming to a close and there are no significant points to raise. There are a couple of items that the Trust need to address but this won't affect the opinion.
- A wash-up will take place once the audit has concluded, of which E&Y will participate with.

Letter of Representation
Resolved:
The Board noted the Letter of Representation.

The Chair of the Audit and Risk Committee, Kerry Byrne informed the Board that there were a number of items outstanding when the Annual Report and Accounts were

submitted to the Committee on the 22.6.23 due to challenges experienced by the Trust and E&Y, but overall the Committee felt that the Trust's position is a positive one.

The Chair pointed out that 2022/23 has been a challenging year for the Trust but there has also been a huge level of achievement for Alder Hey. In terms of the accounts, the Finance team have done a wonderful job and the Trust has ended the financial year with an unqualified opinion which is something to be very proud of. The Chair recommended that the Annual Report and Accounts for 2022/23 be approved. The Board confirmed its agreement.

Resolved:
The Board approved the Annual Report and Accounts for 2022/23.

23/24/71 Committee Annual Report

The Board received the following Committee Annual Reports for 2022/23, noting that each Committee had fulfilled its Terms of Reference and managed its governance processes during the year; it also acknowledged the 2023/24 priorities for each Committee:

- Audit and Risk Committee (ARC).
- Safety and Quality Assurance Committee (SQAC).
- Resources and Business Development Committee (RABD).
- People and Wellbeing Committee (PAWC).
- Innovation Committee.

The Chair thanked each of the Assurance Committee chairs for their leadership during the year. The Chair pointed out that there is some excellent work taking place across all of the Assurance Committees and felt that the level of scrutiny and debate provides the Board with assurance that actions are being progressed and substantiated with evidence/data.

Resolved:
The Board received and noted the contents of the 2022/23 Annual Reports for each of the Assurance Committees.

23/24/72 Board Self-Certification of Compliance with the Provider Licence

The Board received the 2023 Board annual self-assessment and self-certification of compliance with the NHS provider licence.

It was reported that a modified provider licence and new guidance came into effect on the 1.4.23 and there is to be a fresh focus on this area of work going forward.

Resolved:
The Board received and approved:
- NHS Improvement Provider Licence Self-Assessment
- The declarations in relation to general condition 6 and the corporate governance statement, AHSC's and Governor Training.
- The declaration in relation to general condition 6 (systems for compliance with licence conditions) and service condition 7 of the provider licence (continuity of services).

23/24/73 Any Other Business

The was none to discuss.

23/24/74 Review of the Meeting

The Chair concluded that Alder Hey has ended the year in a good place and conveyed thanks to the Executive Directors, the teams and everyone involved in achieving this position.

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

PUBLIC MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on **Thursday 6th July 2023 at 11:15am**
via Microsoft Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mrs. S. Owen	Deputy Chief People Officer	(SO)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Staff Story	Ms. C. Hill	Senior Divisional Manager, Pathology	(CH)
	Dr. W. Simmons	Consultant Paediatric and Perinatal Pathologist	(WS)
Item 23/24/81	Ms. J. Halloran	Acting Deputy Development Director	(JH)
Item 23/24/84	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Apologies	Mr. N. Askew	Chief Nurse	(NA)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mr. D. Powell	Development Director	(DP)
	Mrs. M. Swindell	Chief People Officer	(MS)

Staff Story

The Chair welcomed Dr Will Simmons, Consultant Paediatric and Perinatal Pathologist and Christine Hill, Senior Divisional Manager who were invited to attend July's Board to provide an overview of the work that is being conducted by the Trust's Pathology department.

A number of slides were submitted that provided the following information:

- Scope of Paediatric Pathology.
- The aims of pathological assessment.
- Paediatric pathology activity.
- Alder Hey pathology service users.
- The Northern Ireland Service.
- Perinatal pathology nationwide.
- *The future* – Super Hub model, digital and molecular pathology, training, upskilling non-medical staff, increased utilisation of non-invasive techniques.

The team responded to a question that was raised about what a Super Hub model would look like, and attention was drawn to the funding that is required to progress this model in terms of additional equipment, a training centre, capacity, and resilience.

Louise Shepherd paid tribute to the team and felt that it is extraordinary as to what has been achieved. Louise Shepherd highlighted the importance of wrapping around the team to offer support and resources. Following a conversation, it was agreed to liaise with the team to discuss this matter further.
Action: LS/JG

The Chair thanked Christine and Will for their presentation and the fantastic work that is taking place.

23/24/75 Welcome and Apologies

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

23/24/76 Declarations of Interest

There were none to declare.

23/24/77 Minutes of the previous meeting held on Thursday 8th June 2023
Resolved:
The minutes of the meeting held on the 8th of June were agreed as an accurate record of the meeting. .

23/24/78 Matters Arising and Action Log

Matter Arising

Liverpool Trusts Joint Committee Terms of Reference (approved version)

The Board received the final approved version of the Liverpool Trusts Joint Committee Terms of Reference and noted the minor changes from the version previously approved at the June board meeting. Erica Saunders reported that a summary set of minutes will be produced on behalf of the LTJC that the Liverpool NHS provider trusts can share with their Boards and Council of Governors.

Action Log

It was confirmed that all actions are on track.

23/24/79 Chair's and CEO's Update

Workforce Plan – The Chair provided an overview of the webinar that was conducted on the 3.7.23 by the Chief Executive of NHS England (NHSE) Amanda Pritchard on the national Workforce Plan. It was reported that there are going to be a number of opportunities as a result of the NHS plan which the Government has agreed should be published. The Board was advised of the £2.4b funding in place to support the rollout of the plan but it was pointed out that this doesn't include the cost of training.

Louise Shepherd spoke about the next phase of the Workforce Plan in respect to the Mental Health workforce for paediatrics which is a national issue. It was also pointed out that the System will need to support the Integrated Care Board (ICB) with the development of a Workforce Plan for Cheshire and Merseyside (C&M).

National Children's Transformation Programme – Louise Shepherd reported on the national work that she is involved in as part of her new role. The following points were highlighted:

- Work is taking place on the rollout of the NHS Workforce Plan.
- A medium-term NHS strategy is to be developed. The children and young people (CYP) element of this is being developed with a focus on a shift into Community Services. The plan is being developed in partnership with the National Mental Health, Learning Disability and Community Teams who have been very supportive.
- Connections are also being made with the Children's Commissioner and the Department of Education to further develop a cross government approach.

Louise Shepherd agreed to provide a quarterly update to the Board on the progress of national children's transformation work.

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

23/24/80 Operational Issues

Operational Plan Progress

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

Alder Care - The Board was advised of the progress that has been made with the project, and attention was drawn to the issue relating to reports not being available to staff. The Trust has escalated this matter to Meditech and has requested a response by the 7.7.23. Detail was provided on the opportunity to access national funding and it was reported that the Trust has submitted a bid for resources to enable Alder Hey to commission the services of a consultancy to deal with this risk. The Board confirmed their support in terms of using the services of a consultancy. It was confirmed that Alder Care training has commenced but there is an increase in booking for training required (48%).

Industrial Action – The Board was advised of the strike action that junior doctors are taking from the 13.7.23 to the 18.7.23, and the 48 hour strike action that hospital consultants will be taking from the 20.7.23. Mitigations are in place to cover the junior doctors' strike but it will be more challenging due to consultant annual leave.

During the period of time that consultants take strike action the Trust will not conduct elective work but will provide emergency cover. Alder Hey will support the organisation's consultants who have agreed to work as well as those who wish to take strike action. The Chief Medical Officer, Alfie Bass was confident that the Trust will be safe during the periods of strike action in July.

M3 Flash Report
Resolved:
The Board received and noted the Flash Report for month 3 (*June 2023*).

Integrated Performance Report (IPR), M2

The Board received the Integrated Performance Report (IPR) for Month 2. An update was provided on the following areas of the IPR:

Community and Mental Health Division

- ASD/ADHD: There has been an increase in CYP waiting over 65 weeks to complete assessments for ASD and ADHD. A report is in the process of being compiled to detail the current position. It was reported that the C&M ICB has confirmed that an amount of non-recurrent funding will be transferred to support the teams to continue to work on improvements and work collaboratively across C&M.

Division of Medicine

- Two Serious Incidents (SIs) were reported to StEIS that required RCAs, as detailed in the SI report.

Division of Surgery

- Sickness absence is high within the Division but short-term actions have been implemented to manage this issue. It was confirmed that a recruitment Away Day took place recently.
- Outpatient waiting lists are increasing therefore the team is looking at alternative ways of working to try and address this problem. Rates of pay are also being discussed and approved to enable the Division to increase activity.

The Chair referred to the work that is taking place on WNB by the Division of Surgery and queried the extent of the deep dives/analysis and asked as to whether enough learning is being shared. It was reported that following a deep dive into long waiters it was found that a number of appointments were not required anymore.

Louise Shepherd advised of the interest from the region with regard to waiting lists for CYP. It was confirmed that the ICB has shared a briefing on this area of work following a request from the North Regional Director for NHS England, Richard Barker.

Resolved:
The Board received and noted the content of the IPR for Month 2.

Finance Report for M2, 2023/24

The Board was informed of the redesign of the Finance report, which is presently evolving, therefore the new version of the document will be submitted during September's meeting along with detail of the Trust's five key risks that are being monitored by the Resources and Business Development Committee (RABD).

A number of slides were shared with the Board that provided the following information:

- For May (M2), the Trust reported a deficit of £0.5m which is in line with its plan.
- The YTD position is a £1m deficit in line with the plan approved.
- CIP delivery is £1.7m behind plan YTD. Overall, £3.2m CIP has been transacted with £3.5m in progress. There is a gap of £11m to be identified but includes £6.5m transformation schemes.
- Cash has remained high in line with plan and capital is largely in line with expectations.

The Board was advised of the end of year stock take that took place which identified five risk areas:

- *Impact of Industrial Action* – The estimated impact of industrial action on performance YTD is £400k. It is unsure as to whether organisations will be compensated for this loss therefore this risk has been ranked as a high risk for the Trust.
- *Inflation* – Energy markets have settled during Q1 (*financial upside* for the Trust) and organisations are to receive funding to cover the cost of the recent pay rise.
- *System Position* – C&M remains under considerable pressure, with some trusts already falling behind their plans. It was confirmed that this is a high risk for the Trust.
- *CIP* – There has been an improvement in year. It was reported that work is underway on the strategic initiatives which has a £6.5m transformation and Trust wide transactional target assigned in 2023/24.
- *Capital* – The Trust is seeing cost pressures as a result of the Campus projects and it was reported that the ICB are yet to commit in terms of capital funding for incentive models. A further NIHR bid is being progressed, and the Finance team are conducting a forecast of capital for 2024/25 to enable the Trust to manage this medium risk to the organisation.

Resolved:
The Board noted the finance update for M2, 2022/23.

23/24/81 Alder Hey in the Park Campus Development Update

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

- *Park Reinstatement* – A forum for the local community took place recently with Liverpool City Council and Alder Hey in attendance. It was reported that the outcome of the meeting was positive with steady progress being made. Attention was drawn to the delay to the demolition of the old Catkin Building due to asbestos and it was confirmed that work is taking place on a plan to maintain the programme. The Board was advised that a large team of people are addressing this matter.
- *Neonatal and Urgent Care Development* – It was confirmed that progress is being made. The blue light road is to be diverted on the 17.7.23 and preparation work is taking shape. Further programme workshops are to be undertaken, and additional survey work commenced on the 26.06.23. A mitigation proposal is to be submitted to RABD on the 17.7.23.

The Chair queried as to whether Alder Hey is maintaining channels of communication with the Friends of Springfield. It was confirmed that the Trust is and that discussions now have a more joined up feel to them. Garth Dallas pointed out the benefits of involving the wider members of the Friends of Springfield Park.

Lisa Cooper drew attention to the need for proper signage for the new Catkin Building/ Sunflower Centre and queried the progress that is being made with the undercroft car park. It was reported that the Trust is expecting a quote w/c 10.7.23 for the sprinkler system that needs to be installed in the car park, but it is possible that it may take up to eight months before the work is complete. It was agreed to discuss these two issues outside of the meeting.

23/24/81.1 Action: LC/JH

Resolved
The Board received and noted the Campus Development update provided on the 6.7.23.

23/24/82 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 22.5.23 were submitted to the Board for information and assurance purposes. The Board was advised of the introduction of the quarterly deep dive review sessions that will take place with the Divisions in order to have more granular conversations about impact to operations so that informed financial decisions can be made.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 22.5.23.

23/24/83 Use of Restrictive Physical Interventions Annual Report 2022/23

The Board was provided with assurance of activity in relation to the use of restrictive physical interventions across the Trust for the reporting period from the 1.4.22 to the 31.3.23. The following points were highlighted:

- The Trust reported 163 incidents in respect to the use of restrictive physical interventions of CYP accessing services at Alder Hey. The reporting of the use of restrictive interventions reflects the continuing work undertaken across the Trust to support appropriate recording.
- The recorded incidents detailed in Table 1 relate to CYP with eating disorders.
- The sixty-eight incidents reported via the Tier 4 Children's Inpatient Unit relate to the care provided to one child who required Nasogastric feeding as part of their planned care when least restrictive options were ineffective. The child was detained under Section 3 of the Mental Health Act.
- Nineteen incidents were recorded reporting minor/non-permanent harm to CYP and staff.
- *CALM Training* - The Trust has successfully recruited a Consultant Nurse in Mental Health who will train to become a CALM associate and an accredited trainer for the Trust.

Kerry Byrne pointed out that the vast majority of incidents occur in the Division of Surgery and on Ward 3A and queried as to whether these figures have been compared to Trust wide restrictive physical intervention figures. The Board was informed that the Division of Surgery figures relate to one or two patients and a number of incidents. With regard to the incidents on Ward 3A, these relate to one or two patients who have needed restraining on a number of occasions.

Kerry Byrne referred to last column in Table 2 (*harm to other*) and asked as to what this relates to. It was confirmed that InPhase are looking into this from a reporting category perspective.

Resolved:
The Board received and noted the content of the Use of Restrictive Physical Interventions Annual Report for 2022/23.

23/24/84 Director of Infection, Prevention and Control (DIPC) Report, Q4

The Board received a presentation that provided an update on Infection, Prevention and Control (IPC) for the Q4 reporting period. A number of slides were shared that

provided information on the following areas:

- Targets set and the outcomes for 2022/23.
- Increase in patients with HAI multi-antibiotic resistant organisms; six cases of Hospital acquired CPE in 2022/23 and seven cases of Hospital acquired VRE in 2022/23.
- Data reflecting the increase in GNB/BSI and patient acquisition of Pseudomonas.
- Recommendations and next steps;
  - Revision of IPCC and governance processes for IPC
  - Reinstatement of IPCC in Q1 2023/24.
  - Develop IPC workplan for 2023/24 based on the Board Assurance Framework (BAF).
  - Consideration to be given to IPC software to support the work of the IPC service.
  - IPC to report on incidence of Pseudomonas cases and their management to be produced for the Water Safety group.
  - Implementation and dissemination of the Trust's new Isolation Policy.
  - Review of IPC policies for the management and screening of multi-antibiotic resistant organisms and dissemination of policy.
  - Working with the Brilliant Basics team to change the way the department works to provide a more effective service for patients, staff and visitors.

The Executive Lead for IPC, Alfie Bass drew attention to the long-standing issues and challenges that have been experienced by the department. The Board was advised of the recruitment plan that is in place which is being managed and progressed by Bea Larru and Veronica Greenwood. It was pointed out that the department requires IT support going forward therefore a package will be developed to support the work of the service. Although IPC is currently a challenged area if was confirmed that the department is keeping the Trust safe.

The Board was advised that Alder Hey is looking to invest in IPC/Infectious Disease Control (IDC) and the Microbiology service therefore, with the permission of the teams, the Trust will arrange for an external organisation to facilitate a discussion that will enable a plan to be developed to move these departments/services forward.

Bea Larru pointed out that IPC vision and mission has developed and thanked the Board for supporting the team through challenging times.

Resolved:
The Board noted the Q4 DIPC update.

23/24/85 Serious Incident (SI) Report

The Board was provided with oversight of incidents that are considered as serious following the guidance from the NHS England Serious Incident Framework (March 2015), and associated learning for the reporting timeframe from the 1.5.23 to the 31.5.23. The following points were highlighted:

- Zero Never Events were declared during the reporting period.
- The Trust declared one StEIS incident during the reporting period; reference number 2023/10739. This incident related to a delay in diagnosis of bone malignancy.
- Two initial Duty of Candour responses were required and completed within expected deadlines during the reporting period. It was confirmed that the Trust is compliant with Duty of Candour.

- One SI action plan remained open during the reporting period which is within the expected date of completion.

Resolved:
The Board received the Serious Incident report for the period from the 1.5.23 to the 31.5.23.

23/24/86 Safety and Quality Assurance Committee (SQAC)

The approved minutes from the meeting held on the 17.5.23 were submitted to the Board for information and assurance purposes. During June's meeting the Committee Received the Annual Organ Donation Report which demonstrated the work that has taken place over the last twelve months and the potential for the organisation to do more. It was pointed out that there is a real opportunity for Alder Hey to raise the profile around organ donation internally and externally. Attention was drawn to the forthcoming 'Organ Donation Day' and it was suggested that a comms plan be compiled to highlight the work that is taking place and help people feel more comfortable about conversations on organ donation.

23/24/86.1 Action: ABASS/Communications Team

The Chief Medical Officer, Alfie Bass advised that the Trust is looking to do more around education, recognition, and proactive messaging.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 17.5.23.

23/24/87 People Plan Highlight Report including; EDI Update

The Board was provided with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during May and June 2023. The following points were highlighted:

- Total sickness absence in May is 5.2% and below the 5.5% target, for the second consecutive month. Sickness absence levels have been falling consecutively, month on month since December 2022.
- Turnover remains high at 15%, however has remained stable since December 2022. Retention is a key workstream to be addressed in the Trusts People Plan.
- *PDR's* – There has been a reduction in the month of May with a completion rate of 76%.
- *Industrial Action* – The Royal College of Nursing (RCN) has announced that they have not reached the turnout required to undertake further industrial action. Radiographers have confirmed that they will be taking action but further detail in terms of strike dates are being awaited.
- *Nursery* – It was reported that the Trust received a 'good' Ofsted grade following an inspection of the Alder Hey's nursery.

On behalf of the Board, the Chair thanked all those involved in helping the Trust to achieve a 'good' Ofsted rating following a recent inspection of the nursery.

EDI Update

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

- *NHS EDI Improvement Plan* – The Trust will use the NHS EDI Improvement plan to identify targeted actions that align with its people commitment. The improvement plan will provide a framework that will guide the organisation to successfully implement the six high-impact interventions whilst working alongside key stakeholders and staff networks to improve and enhance staff experiences, thus establishing an equitable and inclusive working environment.
- *Equality System Delivery (ESD) 2022* – Work is taking place via the EDI Steering Group to look at how the organisation can successfully implement the ESD 2022 and address the outcomes of the recent workshop that took place.
- *Staff Networks* – It was reported that developing staff networks are growing from strength to strength and have been welcomed by the Trust's workforce.
- *Armed Forces* – The Armed Forces Staff Network celebrated Reserves Day on the 21st of June, which recognised the organisation's Reservists' valuable contribution to the countries Armed Forces, ahead of Armed Forces Day on Saturday the 24th June.
- *Training* – The Network Chairs and Co-Chairs have commenced the development-training programme that will provide them with skills and resources to build successful networks that will deliver positive changes for the Trust's staff.

Garth Dallas drew attention to the cultural change that is taking place across the organisation and highlighted the importance of the EDS tool which will enable the Trust to showcase Alder Hey as an organisation that is supporting the NHS approach in terms of EDI operations.

Resolved:
The Board noted:
- The contents of the People Plan Highlight Report.
- The update on EDI.

23/24/88 Revised Constitution

The Board received a report that proposed changes to the Trust's Constitution required by the Health and Care Act 2022.

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

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

The proposed changes were approved by the Council of Governors at its meeting on the 7th of June 2023 and the Board was advised that the Trust has been working collectively on the changes with the CMAST Governance Group. Following discussion, the Board approved the proposed changes to the Trust's Constitution.

Resolved:

The Board approved the proposed changes to the Trust's Constitution required by the Health and Care Act 2022.

23/24/89 Board Assurance Framework Report (BAF)

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

- The Board was advised of the issues that are being experienced around functionality and obtaining data from the Trust's new Incident and Risk Management System, InPhase which is creating a problem in terms of providing assurance reports to the Board and Committees. It was confirmed that the BAF is continuing to be updated manually until a full report can be produced via the system.
- Internal facing work has taken place with the Assurance Committees to look at associated risks to the delivery of the Visions 2030 Strategy and think about how risks are described and assessed in this new context.
- It was highlighted that the Committees continue to remain focused on the specific BAF risks allocated to them.

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

23/24/90 Audit and Risk Committee

The approved minutes from the meeting held on the 20.4.23 were submitted to the Board for information and assurance purposes. The Chair of the Audit and Risk Committee (ARC) drew attention to a report that was submitted to ARC on the 22.6.23 regarding a bank mandate fraud that occurred in May. It was confirmed that work is taking place to strengthen internal controls.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 20.4.23.

23/24/91 Any Other Business

There was none to discuss.

23/24/92 Review of the Meeting

The Chair advised that the next Board meeting will take place on the 6.9.23 due to having a recess in August. It was felt that July's agenda covered the majority of the issues being experienced by the Trust which Alder Hey is addressing. Attention was also drawn to the progress that is being made in terms of driving the organisation's Vision 2030 Strategy forward.

Date and Time of Next Meeting: Thursday the 7th of September at 9:00am in LT3, Institute in the Park.

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for October 2023							
27.10.22	22/23/176.1	Research and Innovation Committee Terms of Reference	*Alignment to RABD ToR* - RABD ToR to be submitted to the Board with the proposed amendments for alignment, following approval of the R&I TOR.	R. Lea	26.1.23	Oct-23	**19.1.23 -** This item has been deferred to February's Trust Board. 29.3.23 - This item has been deferred to May's Board. **27.4.23 -** This item has been deferred to June's Board. **3.6.23 -** The ToR will be submitted to the Board in September once they have been reviewed by RABD. **1.9.23** - The ToR will be submitted to the Board in October once they have been reviewed by RABD. **ACTION TO REMAIN OPEN**
27.10.22	22/23/182.2	Board Assurance Framework Report	Look at presenting the monthly trend in section four of the Board Assurance Framework Report in a more dynamic/meaningful way.	E. Saunders	15.12.22	Oct-23	**15.12.22** - A piece of benchmarking work is taking place to ascertain a response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **29.3.23** - This action is linked to new risk system and is unchanged pending the go live of InPhase in April. **27.4.23** - The new risk system is due to go live on the 10.5.23 therefore an update will be provided in June. **1.7.23** - This action has been deferred until September. **1.9.23** - This action has been deferred to October. **ACTION TO REMAIN OPEN**
27.10.22	22/23/185.1	Review of Meeting	Invite a black member of staff to present to the Board during 'Black History Month'.	K. McKeown	26.10.23	On track Oct-23	
6.7.23		Staff Story	Meeting to take place with Will Simmons and Christine Hill to discuss the support/resources that the Pathology Service requires to progress the Super Hub model.	L. Shepherd/ J. Grinnell	7.9.23	Oct-23	**1.9.23** - A meeting is in the process of being scheduled. **ACTION TO REMAIN OPEN**
4.5.23	23/24/21.2	Board Assurance Framework Report	Meeting to take place between Melissa Swindell, Garth Dallas and Angie Ditchfield to discuss EDI risks from a CRR/BAF perspective.	M. Swindell	8.6.23	Oct-23	**1.7.23** - An update will be provided during July's Trust Board. **1.9.23** - A meeting is in the process of being scheduled. **ACTION TO REMAIN OPEN**

Status	
Overdue	(red)
On Track	(green)
Closed	(blue)

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
				Closed Actions			
4.5.23	23/24/09.2	Operational Issues	Exec Team to challenge itself to find solutions for access, performance, turnover and finances in terms of the complex issues that the Trust is experiencing, whilst ensuring there is the right oversight at Assurance Committee/Board level. Initial thoughts to be shared on this matter during June's Trust Board.	J. Grinnell	8.6.23	Closed	**1.7.23** - An update will be provided during July's Trust Board. **1.9.23** - This action is an evolving and ongoing one. Updates will be provided via regular reporting processes. **ACTION CLOSED**
4.5.23	23/24/21.1	Board Assurance Framework Report	A piece of work is to take place on the risks that fall out of the 2030 Strategy.	E. Saunders	6.7.23	Closed	**1.9.23** - This work took place during a BAF development session on the 6.7.23. **ACTION CLOSED**
8.6.23	23/24/41.1	Vision 2030 Strategy Update	Discussion facilitated by Louise Shepherd and John Grinnell to take place to enable NEDs to publicise the strategy autonomously.	J. Grinnell/ L. Shepherd	6.7.23	Closed	**1.9.23** - This action has been addressed. **ACTION CLOSED**
8.6.23	23/24/41.2	Developing a CYP Strategy for Cheshire and Merseyside	Meeting to take place with Paul Sanderson re his reference to funding for the national community of medicine to discuss the importance of connecting with the ICB and other leads nationally regarding this matter.	D. Jones	6.7.23	Closed	**1.9.23** - This meeting has taken place. **ACTION CLOSED**
8.6.23	23/24/46.1	Alder Hey in the Park Campus Development	Look into the issues that are causing a delay to the opening of the Catkin car park and provide an update.	D. Powell	6.7.23	Closed	**1.9.23** - This action has been superseded by 23/24/81.1. **ACTION CLOSED**
6.7.23	23/24/81.1	Alder Hey in the Park Campus Development Update	Liaise with Jayne Halloran regarding the signage for the new Catkin Building/Sunflower House and the queries relating to the car park.	L. Cooper	7.9.23	closed	**1.9.23** - This action has been addressed. **ACTION CLOSED**
6.7.23	23/24/86.1	Safety and Quality Assurance Committee (SQAC)	*Annual Organ Donation Report* - Develop a Comms Plan for this year's 'Organ Donation Week' which takes place from the 18.9.23 to the 24.9.23 to highlight the work that is taking place at the Trust and help people feel more comfortable about conversations on organ donation.	A. Bass	7.9.23	Closed	**1.9.23** - This request has been shared with the Comms team and Carla Thomas for actioning. **ACTION CLOSED**

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	**Vision 2030 – Strategic Plan Mobilisation Progress Qtr. 1-2**
Report of:	Dani Jones, Chief Strategy and Partnerships Officer John Grinnell, Managing Director / CFO
Paper Prepared by:	Natalie Palin, Director of Transformation and Change Kate Warriner, Chief Digital and Transformation Officer Natalie Deakin, Head of DMO

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	March 2023, Strategy Board Paper April 2023, Strategy 2030 Board Paper Board Strategy workshops across 22/23 Integrated Performance Report
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 detailed within this paper

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
	Work is on-going to align the Vision 2030 risks, alongside the Board Assurance Framework.					
Level of assurance (as defined against the risk in InPhase)	☑	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Purpose

The purpose of this report is to provide the Board with oversight of progress of the mobilisation phase against our 2030 vision. The report will provide an assessment of the mobilisation phase of the 2030 vision based on the current state, highlighting key findings, areas of concern and positive areas of progress.

The key message from this report is that progress has continued to be sustained during quarter two and early deliverables from our strategic initiatives will be delivered imminently.

2. Background and Current State

The Trust Board approved the Strategy 2030 (March 23), with next steps of evolving our governance arrangements, pivoting our change programme, and reviewing our leadership approach and arrangements. The table below provides an update on the progress of the outstanding milestones against the mobilisation plan. Completed milestones have been reported in previous Board reports and are excluded from table 1.

Table 1: Vision 2030 Mobilisation Milestones – remaining milestones

Mobilisation Milestones	By when	B/R/A/G Status*
1. Establishment of 'CYPF Areas of Need'	Qtr. 1-2	On track
2. Initiation of Strategic Initiatives – 10 Strategic Initiatives (4 have been Initiated in Qtr. 1)	Qtr. 1-2	At risk
3. Delivery of our Financial Strategy	Qtr. 2	On track
4. Our 2030 – Narrative and Communication Plan (Stage 1 – Qtr. 1), Stage 2 (Qtr. 2)	Qtr. 1-2	On track
5. Development of our Strategic Outcomes – Strategy Exec dashboard	~~Qtr. 2~~ Reprofiled Qtr. 3-4	On track

**BRAG status: Blue - complete, Green - on track, Amber - at risk, Red - off Track, Blank - not started*

As outlined in table 1 above, all milestones are on track for completion by the end of September 23 (Qtr 2) with the exception of one (*initiation of all 10 strategic initiatives*). Assuming that the 'on track' milestones will be delivered to time, this paper will explore the reasons for the delays of the 'off track' milestone and explore mitigations in place for delivery.

The criteria for completion of mobilisation milestone 2 'Initiation of Strategic Initiatives' as per the above are as follows:

- ✓ Engagement workshops complete.
- ✓ Project working group identified and mobilised.
- ✓ Outcomes and measures defined.
- ✓ Milestones and associated actions identified.
- ✓ Risks identified and monitored.
- ✓ 1st draft of EIA/QIA
- ✓ Initial financial assessment undertaken.

Table 2 below summarises the completion status of initiation for the 10 Strategic Initiatives.

Table 2: Strategic Initiatives Initiation Status

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	95%
Supporting our People	Chief People Officer	2.1	Thriving at Alder Hey	Qtr 1	95%
Supporting our People	Chief People Officer	2.2	Professional Development Hub	Qtr 2	20%
Supporting our People	Chief People Officer	2.3	Future Workforce	Qtr 2	10%
Pioneers Breakthroughs	Chief Futures Officer	3.1	Futures	Qtr 2	30%
Collaborating for CYP	Chief Strategy and Partnerships	4.1	Collaborating in Communities	Qtr 1	95%
Collaborating for CYP	Chief Strategy and Partnerships	4.2	CYP'S System	Qtr 2	10%
Revolutionising Care	Chief Digital and Transformation	5.1	New Models of Care	Qtr 2	40%
Revolutionising Care	Chief Digital and Transformation	5.2	Digital	Qtr 1	95%
Revolutionising Care	Chief Digital and Transformation	5.3	Insight Led Decisions	Qtr 3	10%

*It has been agreed that the strategic initiative ‘Insight Led Decisions’, will be initiated in Qtr 3 rather than Qtr 2 however, delivery of the strategic scorecard which forms part of this initiative is in progress and will continue.

Positive Progress:

- We have remained on track to have formalised the initiation of two Strategic Initiatives as planned by the end of Qtr. 2 (3.1 Futures and 5.1 New Models of Care).

- Overall, a high percentage of delivery milestones and enabling actions within the strategic initiatives that have mobilised are on track or in progress. This demonstrates the organisational commitment to both effective programme management, ability to deliver within expected timelines and our wider organisational assurance to ‘Make it Happen’. Appendix 1 outlines the current high level milestone plan for the mobilised strategic initiatives.

- There are many positives and learning that will inform the continued deployment of our 2030 Vision, not least the importance of making it real through tangible deliverables. In the last month our people and CYP have had opportunities to engage in a range of engagement and co-design of elements of the 2030 vision.

- The creation of a single programme of change has progressed through the portfolio change with Delivery Management and Quality Hub, now reporting to the Chief Information and Transformation Officer.

- Table 3 provides details of the early deliverables, key milestones due to completed during the reminder of September 2023. What can be seen through the below table is the significant progress that has been achieved, and the shared commitment to make it happen.

Table 3: Key highlights and deliverables

Vision: A healthier, happier and fairer future where every child and young person can achieve their full potential.		
CYPF Areas of Need	Key Highlights	Milestones on track for completion Qt.2
CYPF Areas of Need	✓ Personalised Care, Patient Story makes real the need for change. ✓ Our people, sign up, to be actively involved in 'Get me well, and Personalised care' new models of care. ✓ Development of the mobilisation	✓ Establishment of Get me Well, and Personalised Care oversight and scrutiny groups.
Strategic Initiatives: *Delivering beneficial change, for CYPF, our people and communities.*		
	Key Highlights	Milestones on track for completion Qt.2
1.1 Experience & Engagement	✓ Standards co-developed with Youth Forum, and CYP Warm welcome Quality Round ✓ Expert Customer Experience Master Class delivered. ✓ Warm Welcome Workstream Lead Opportunity (recruited and advertised)	✓ New Experience Promises and Standards ✓ Call me Initiatives – digital functionality implemented
2.1 Thriving	✓ Additional OD Leadership Capacity ✓ Preceptorships Survey and development of workstream specifics	✓ Development of Specific Value Propositions ✓ Our people targeted engagement
3.1 Futures	✓ Futures Engagement Sessions	✓ Completion of PID
4.1 Collaborating in Communities	✓ Development of a Social Value, reporting Index and methodology	✓ Social Value Scorecard
5.1 Digital	✓ Alder Care Implementation	
5.2 New Models of Care	✓ 2 Clinical Summits delivered	✓ Completion of New Models Initiation documentation
5.3 Insight Led Decisions	✓ Outcome and Benefits framework approved to standardise approach, and alignment to the overarching vision 2030 Strategic Plan	✓ Define the programme governance framework (part 1)

Areas for improvement focus:

It can be concluded from the assessment in table 2 that,

- **At Risk:** There are delays in the initiation of three of our Strategic Initiatives by the end of Qtr. 2. The specific Strategic Initiatives that are off track include: -
    - 2.2 Professional Development Hub,
    - 2.3 Future Workforce and
    - 4.2 Children and Young People's System.

- **Mitigation actions for 2.2 and 2.3**: The risks of 2.2 and 2.3 are both known, and recruitment is on-going to address gaps. In addition, work is continuing with Strasys as part of our partnership to provide additional resource capacity to support the mobilisation of specific 'value propositions'. This risk will

continue to be managed through the Strategy Leadership Group, who will assess the likelihood of achievement in Qtr. 2 (through the mitigation actions).

- **Mitigation actions for 4.2:** An options paper is scheduled to be discussed at the Strategy Leadership Group in September with potential options for the best way forward to achieve the intended outcomes.

- At this stage a full assessment of the delays and how these will affect the strategic 23/24 plan both in the short and medium term is not fully understood.

3. Proposed Governance and Assurance Arrangements

Assessments of programme governance have continued to be undertaken on pre-existing programmes prior to the development of the 2030 vision. Some of these programmes have since closed, others are deemed as enablers to the 2030 vision whilst others have a direct mapping over to one of the 10 strategic initiatives. The current assurance assessments of these pre-existing programmes are outlined below in Table 4 and from Qtr 3, the assessments for the remaining 10 initiated strategic initiatives will be added.

Table 4: Current Governance Ratings for Pre-Existing Programmes

Programme *(SRO)*	Driver *	Governance rating	Overall Delivery rating
Patient Safety *Chief Medical Officer / Chief Nursing Officer and AHP/HCP Lead*	25% Reduction in harms		
Brilliant Basics Chief Nursing Officer and AHP/ HCP Lead			
Workforce Planning Chief People Officer	>80% of staff recommend a place to work		
Digital – Aldercare Chief Digital and Information Officer	100% Safety Compliance		
Genomics Medical Director, Liverpool Women's Hospital (LWH)	Delivery of outstanding care and Ground-breaking Research & Innovation		
Greener Director of Marketing and Communications	Net zero by 2035		

The overall position for the governance ratings of the pre-existing programmes is positive and good levels of programme governance have been indicated, risks are being managed and milestones remain on track.

These ratings will be available to the Strategy Leadership Group (Chaired: MD/CFO) as it is this group that is accountable for the effective management, change management, programme oversight and risk mitigation of strategic deployment. This group will then report into the Strategy Board which has oversight of the Vision 2030 outcomes.

4. Conclusion

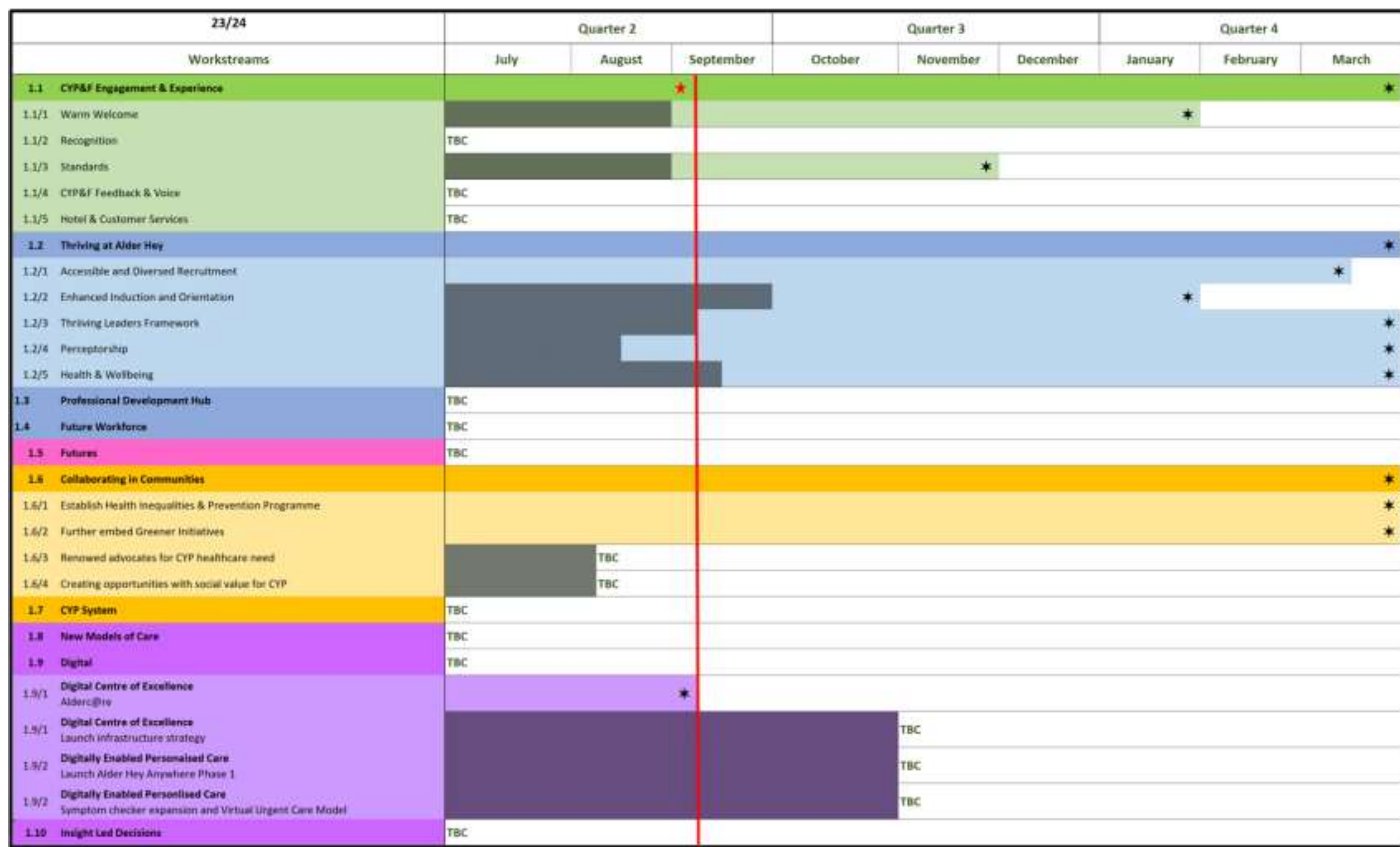
In conclusion this report has provided a comprehensive overview of the status and assurance against the high-level plans approved as part of the 2030 Vision: Strategic Plan 23/24 and Mobilisation Milestones. The report findings highlight significant strengths and progress; whilst detailing areas for improvement to ensure the successful delivery of our strategic objectives. The recommendations detail the proposed management of the areas requiring further improvement.

Our commitment to provide appropriate support, transparency and accountability is evident in our thorough assessment of areas of concern and milestone progress. While the majority of our mobilisation milestones are on track, there are milestones ot risk milestones (Strategic Initiatives). By addressing at risk milestones promptly and effectively we will reinforce our commitment to Vision 2030.

5. Recommendations & Proposed Next Steps

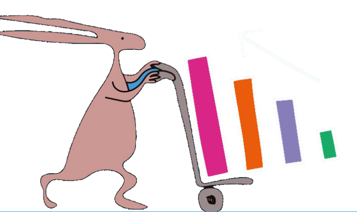
1. To note the findings and assessment.
2. To manage the highlighted risk around delays for 2.2, 2.3 and 4.2 through the Strategic Leadership Group and provide an updated position to the Strategy Board (Oct 23).
3. To continue delivery of our Strategic Plan 23/24.
4. To provide governance ratings for all strategic initiatives by end of Qtr 3.

Appendix 1: Strategic Initiatives Milestones Plan



Alderc@re
Go Live ★
8th Sept 23

Integrated Performance Report | August 2023



Flash Report -August 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for August
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	**0**
		FFT - % Recommending Trust	> 95%	**95.8%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Staff Turnover	*<13%*	***12.5%***
Collaborating for CYP	Handover Springfield Park to the community	Return Springfield Park to Liverpool City Council	By Nov 2023	**Completion for new park is now Dec 23 and residual works to existing park are scheduled for end of March 24**
Smartest ways of Working	Improve Access to Care and Reduce Waiting Times	ED: % treated within 4 Hours	> 76%	**92.2%**
		Number of RTT Patients waiting >65weeks	0	**150**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,436**
		Elective Recovery (Vol)	> 106%	**104%**
		Diagnostic Performance	> 90%	**87.3%**
	Financial sustainability	Revenue position – Year End forecast	12.3m Surplus	**£12.3m surplus**
	Safely Deploy Alder C@re	Alder C@re deployed	By Sept 2023	**On Track with risks**

Operational Plan Progress Summary

Published 5 September 2023

Strategic Goals	2023-24 Operational Priorities	Progress in August 2023	Areas of challenge
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• First meeting of Clinical effectiveness and outcomes group and co-chairs appointed • PSIRP and governance process developed and pending sign off • Development of our CYP, families and staff standards based on trauma informed care being tested with CYP and refined	• Defining the role of patient safety partners in paediatrics – work ongoing with other CYP trusts
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Finalising PID's • Thriving Leaders framework: actions and timescales agreed and workstream meetings set and have commenced. Significant early focus on partnership work with Strasys to identify areas for potential early scale and spread accelerated by recent IHF award and opportunities created by this internationally. • Needs based HWB: meetings in place to commence 6th Sept with work underway on Staff Thriving Index. Actions and timescales set	• Resource remains an ongoing concern, to be able to accelerate at pace
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• New partnership with Roche to explore children's acceptability of minitablets mixed with food • AH Charity award to fund books to help children to be 'Ready for Research'	• National decline in commercial research • Reduction in recruitment of participants to studies
Collaborating for CYP	**4. Handover Springfield Park to our community**	• Site handed over to the contractor to enable construction of the playground and football pitches. • The Multi-Use Games Area was opened for use 07.08.23. • Meeting held with Friends of Springfield Park (FOSP) and Liverpool City Council (LCC) – the preferred location of trees and planting was agreed.	• Existing infrastructure works to be completed. • Follow up meeting planned for 24.08.23 to be rescheduled due to unavailability of LCC – date to be confirmed. • Concerns raised by FOSP in relation to the size and depth of the swales, and the size of the football pitches agreed within the planning approval.

Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• ED continue improved performance against 4 hour target with 92% in August • Successful launch of PAU model with positive engagement from staff to share learning and improve pathways • 18% reduction in >52week waits from 1,004 (June) to 824 (Aug) • Diagnostic 6 week performance dipped due to Industrial Action, but Sleep Studies now at 86% within 6 weeks.	• Ongoing Industrial Action, safe management of activity levels and managing impact on access and waiting times. • Significant waiting times in neuro-developmental pathways (>65wks); investment agreed by commissioners but demand remains exceptional. • Implementation of Winter plan, to optimise benefits from Virtual Ward, UTC and PAU.
Smartest ways of Working	**6. Financial sustainability**	• Reporting an in-month surplus of £10k in August (M5) and £1.49m deficit year to date (Q2). This is in line with the plan. • Industrial action is impacting on delivery of activity and incurring additional costs with an ongoing risk to the plan. • Financial assessment underway on strategic initiatives to quantify savings. • Improved CIP identified to 84% in year.	• IYE CIP improvement however risk on recurrent with less than 40% identified. • Ongoing initial action, risk to delivery of plan in Q2.
Smartest ways of Working	**7. Safely deploy Alder C@re**	• Programme activities significantly ramped up to support go live over 8th-11th September • 2/4 Go/No Go decisions supported to proceed with programme • Good progress with outstanding P1s • Critical clinical criteria signed off • 86% of colleagues booked onto training • Good feedback from NHSE assurance review	• Sign off of any outstanding P1s • Continued drive on training • Ensuring access issues are anticipated and resolved ahead of go live where possible • Continued completion of reporting recovery plan and managing any post go live reporting issues

BOARD OF DIRECTORS

Thursday, 7th September 2023

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

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

Integrated Performance Report

Published: August 2023

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Well Led -

Supporting Our People — Page 14

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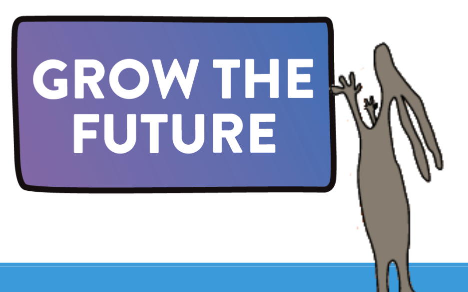
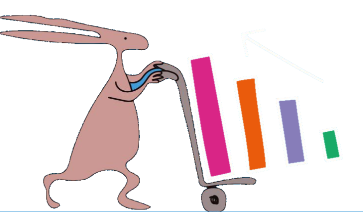




Icon Definitions

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

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

XmR chart

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

Process limits

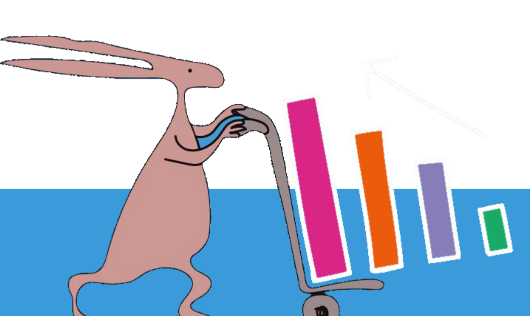
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

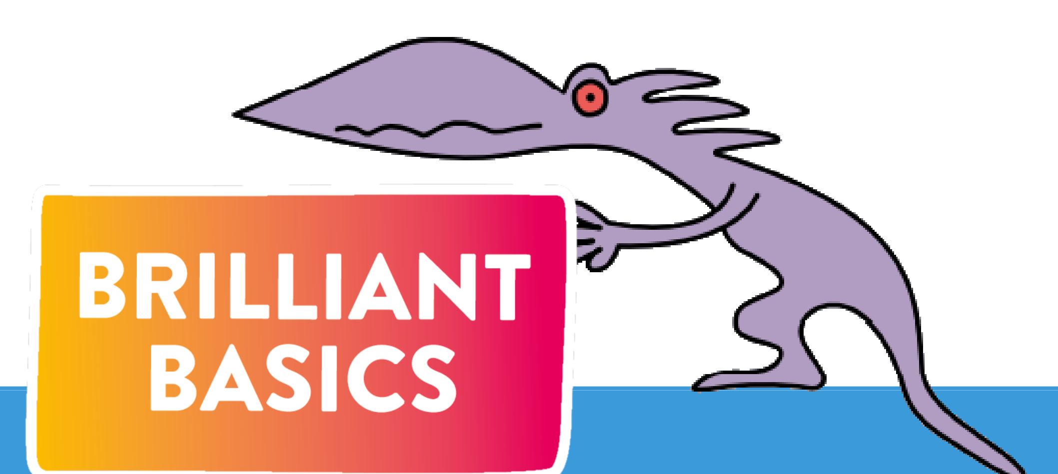
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

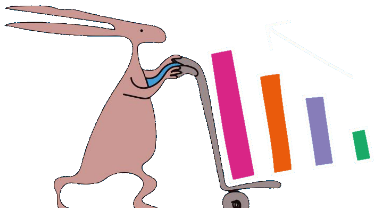
Variation		Assurance: Achieving Target	Assurance: Inconsistently Achieving Target	Assurance: Not Achieving Target
	Special Cause - Improvement	Cancer 2 week referrals demonstrates performance is consistently achieving target with an improving trend, Level 1 patient safety training & C.Difficile	Complaints responded to in timeframe are inconsistently achieving target with an improving trend	Staff Turnover and Diagnostics, are not achieving targets but demonstrating improvement
	Common Cause	Cancer and MRSA metrics are achieving targets	PALS, Sepsis, EL/DC/OP Recovery, Cancelled Operations, ED performance, WNB metrics and ERF are inconsistently achieving target and are yet to evidence statistical improvement	F&F recommend (Trust & ED), Theatre Utilisation, Clinic Letters completed, Medical Appraisal, LTS, CAMHS >52 week and Oral Health >52wks are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern			>65 Wk waits (RTT & ASD/ADHD are not achieving targets with a declining trend

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

- 16.3% of our metrics are consistently achieving target
- 59.2% of our metrics are inconsistently achieving target
- We are not achieving the target for 24.5% of our metrics but experiencing improvement in 2 of these metrics.

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





Unrivalled Experience - Safety

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

Highlights:

ED and In-patient sepsis screening has improved above target for this month. Reduction in medication errors and pressure ulcers. Unplanned admission to critical care continue to reduce.

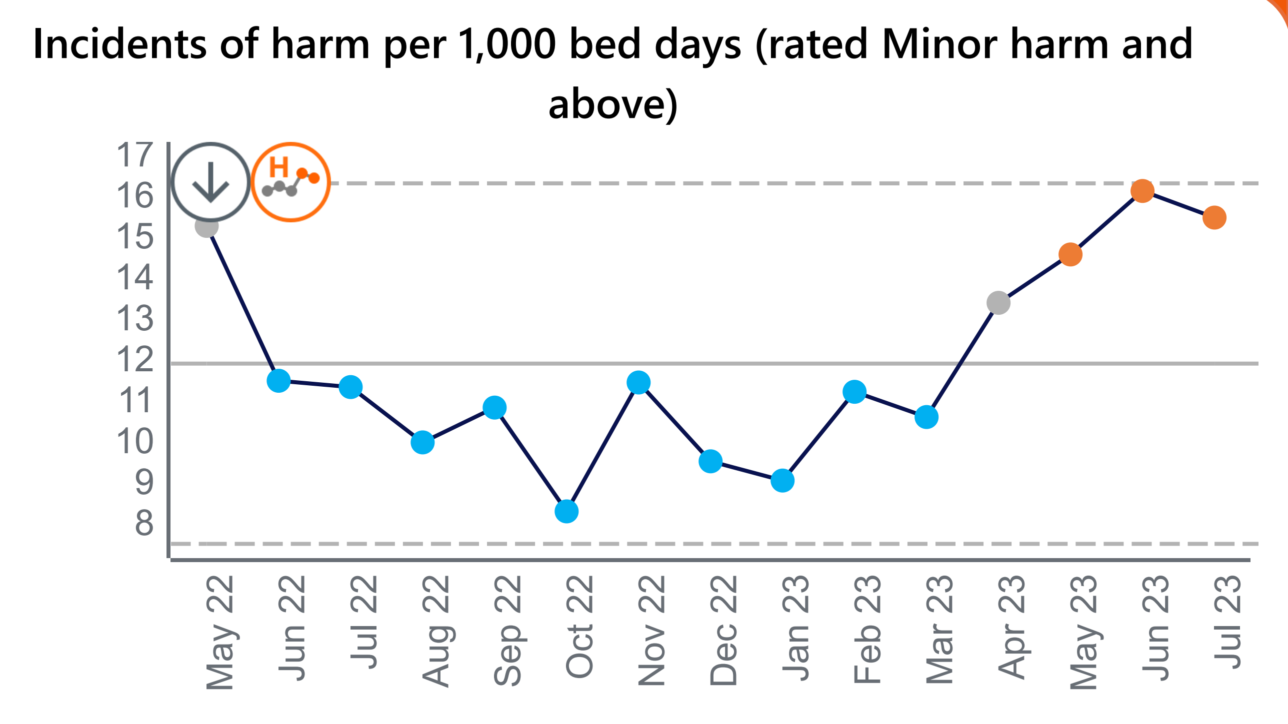
Areas of Concern:

Whilst reducing the number of restrictive interventions continues to be above target

Forward Look (with actions)

To maintain the improvements seen this month in relation to sepsis in both the in-patient and ED, along with reducing unplanned admissions to critical care.

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



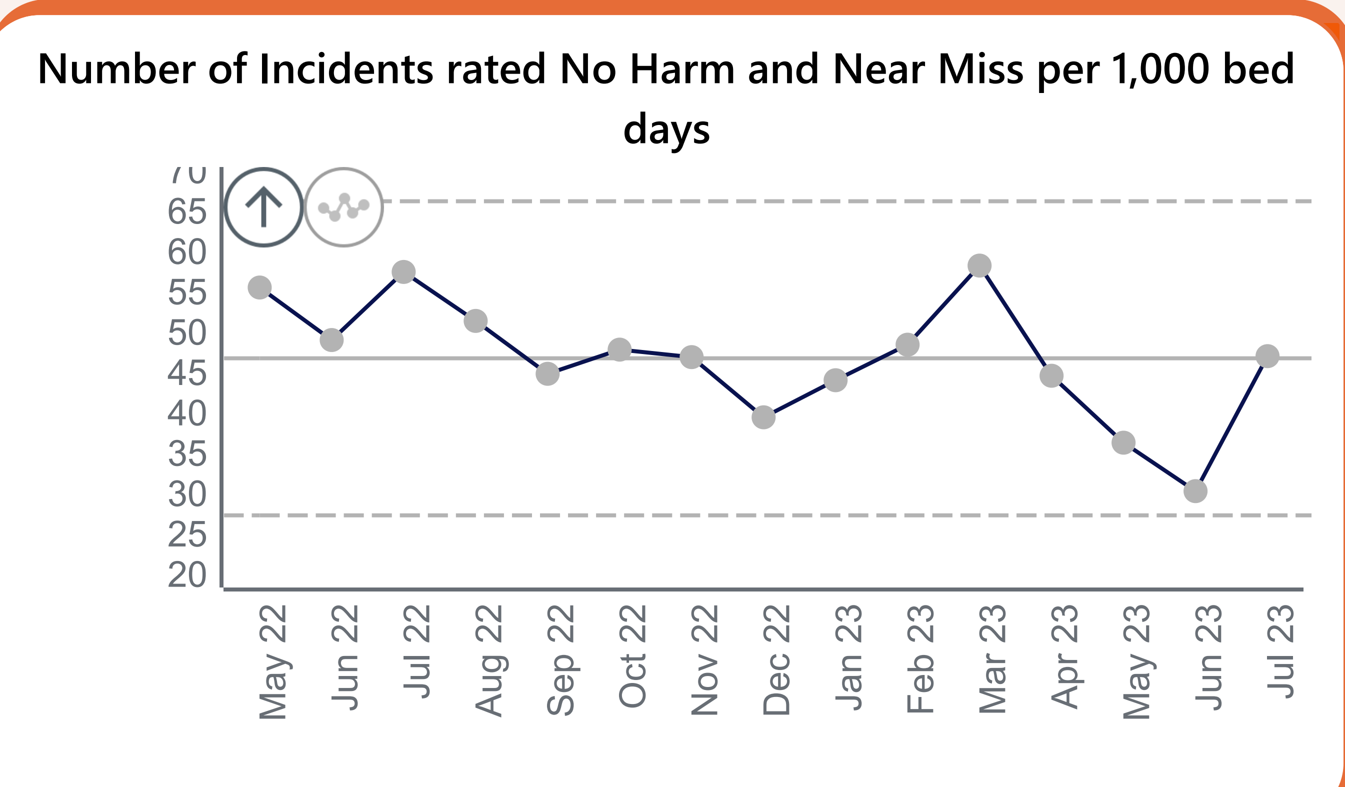
Technical Analysis:

Special cause variation has been observed which also correlates with InPhase going live May-23. Rates currently assessed on Physical Harm only.

Actions:

Continue to monitor any themes and trends in incident reporting

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



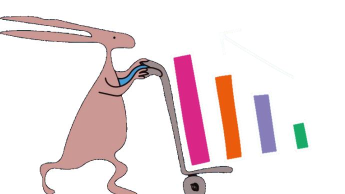
Technical Analysis:

Common cause variation has been observed with a 12 month average of 47 incidents per 1000 bed days. Rates currently assessed on Physical Harm only via InPhase.

Actions:

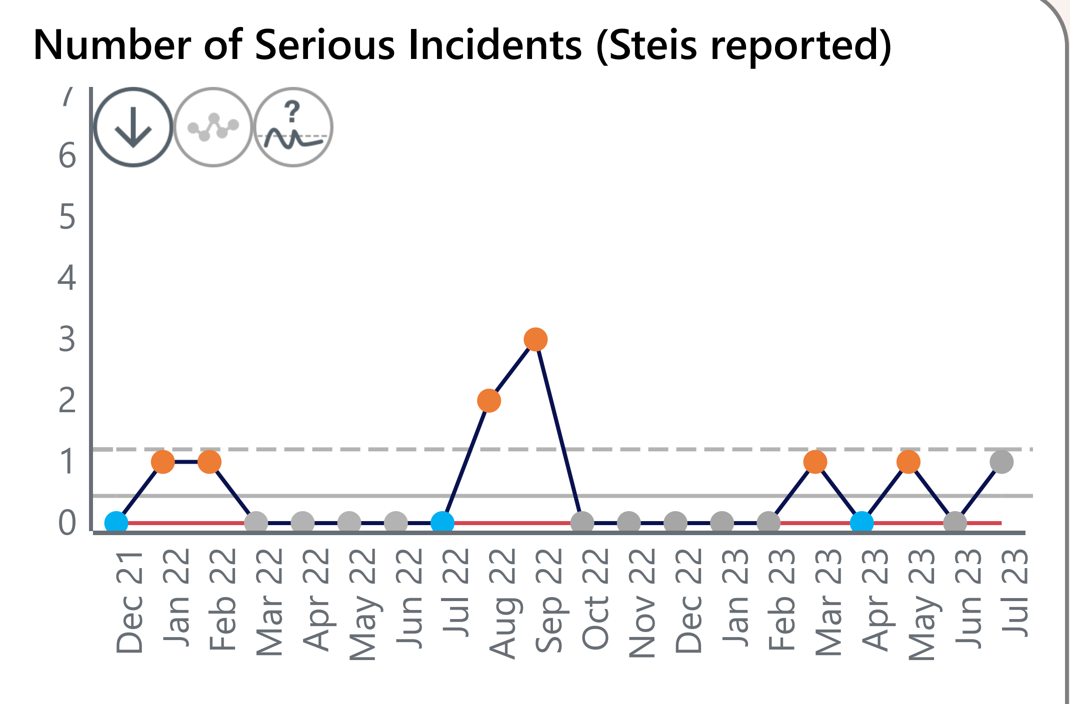
To continue to promote the recording of no harm and near miss incidents

Integrated Performance Report | August 2023

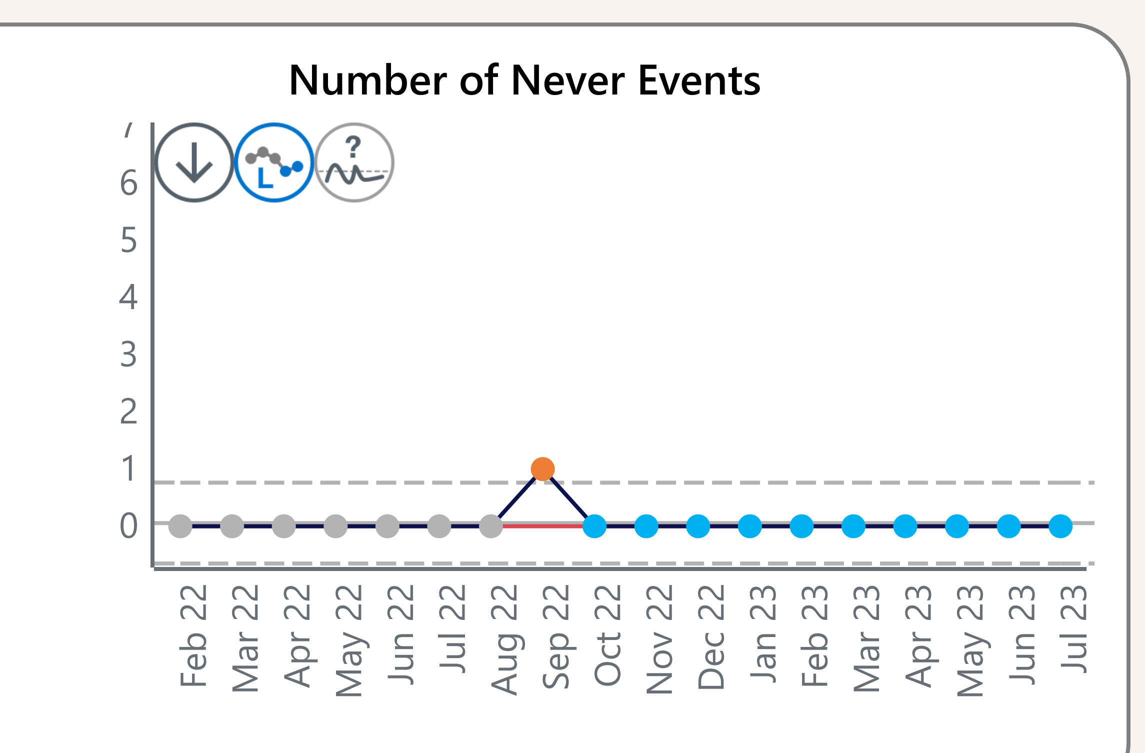


Unrivalled Experience - Safety - Watch Metrics

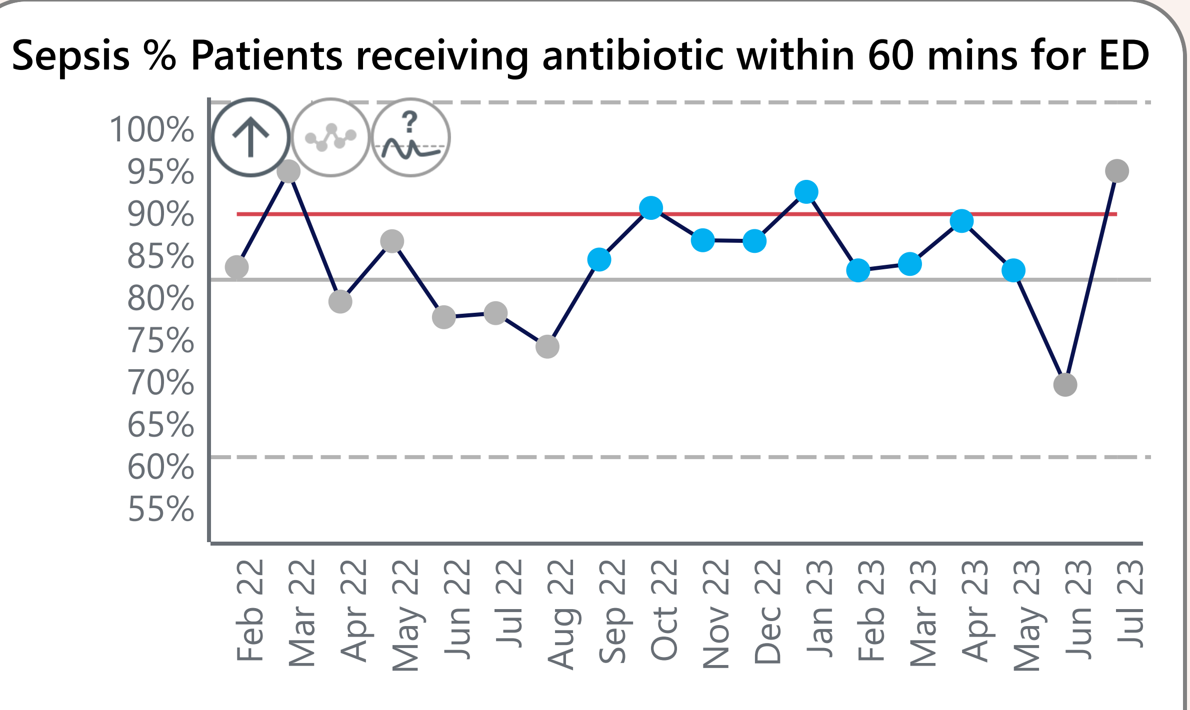
Number of Serious Incidents (Steis reported)



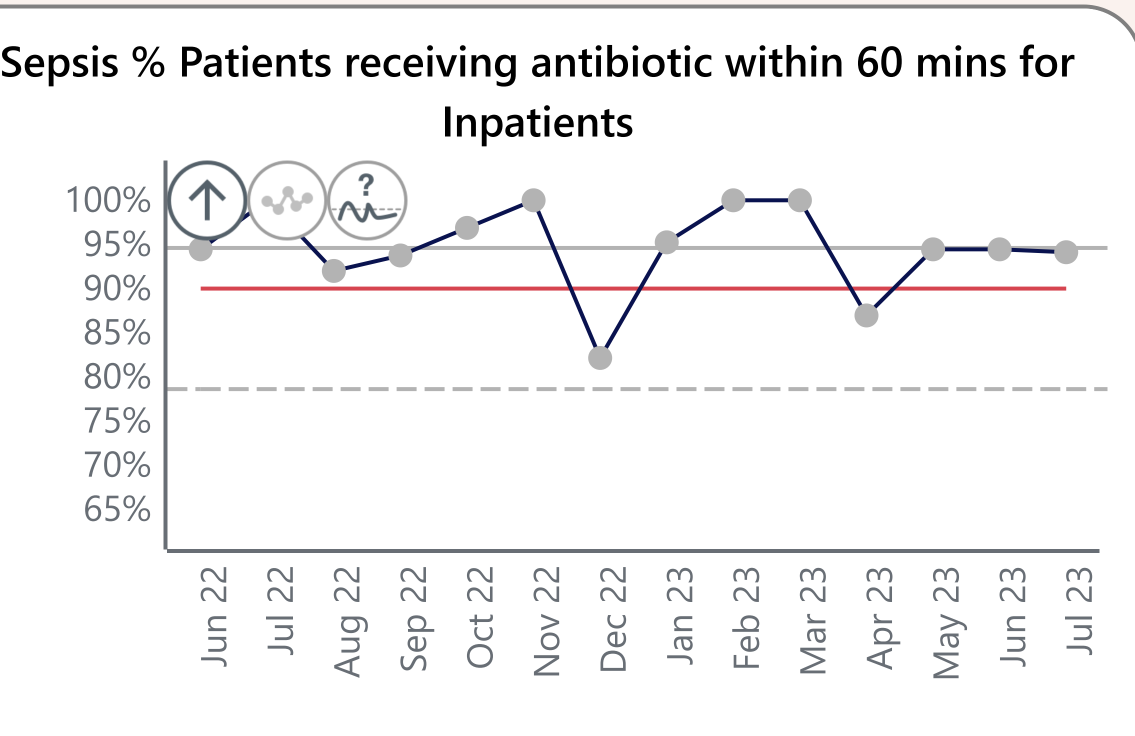
Number of Never Events



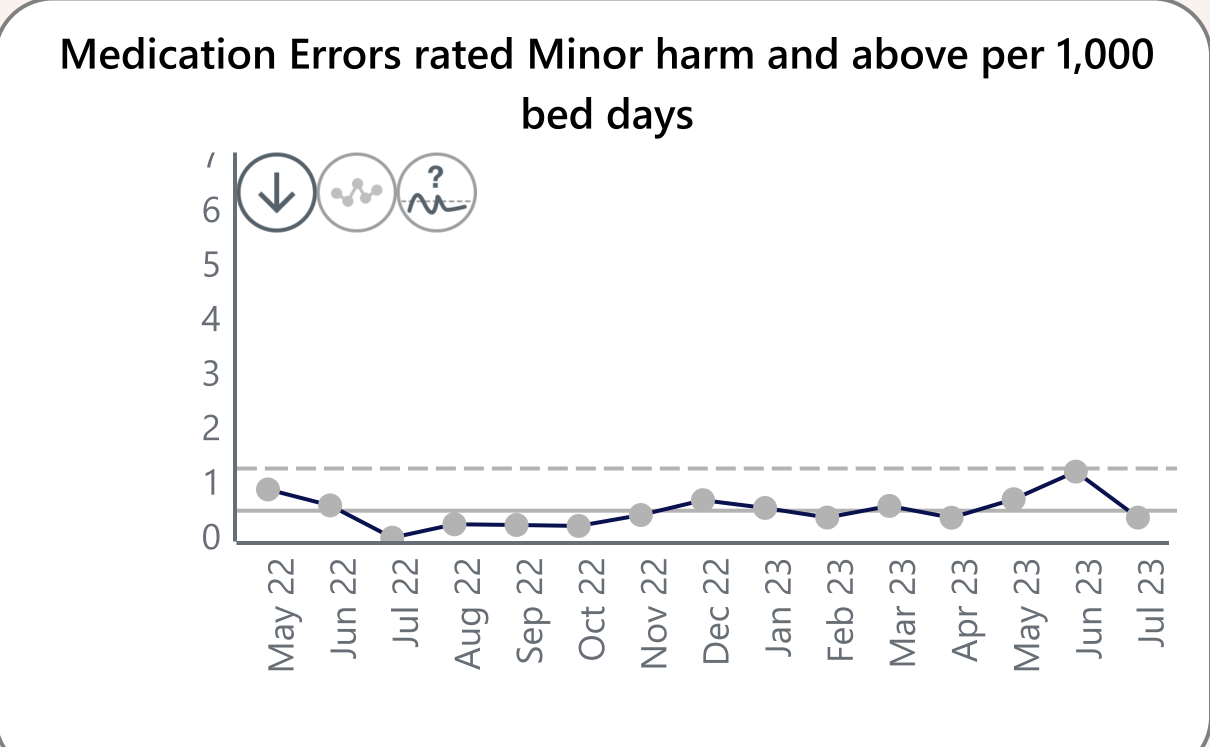
Sepsis % Patients receiving antibiotic within 60 mins for ED



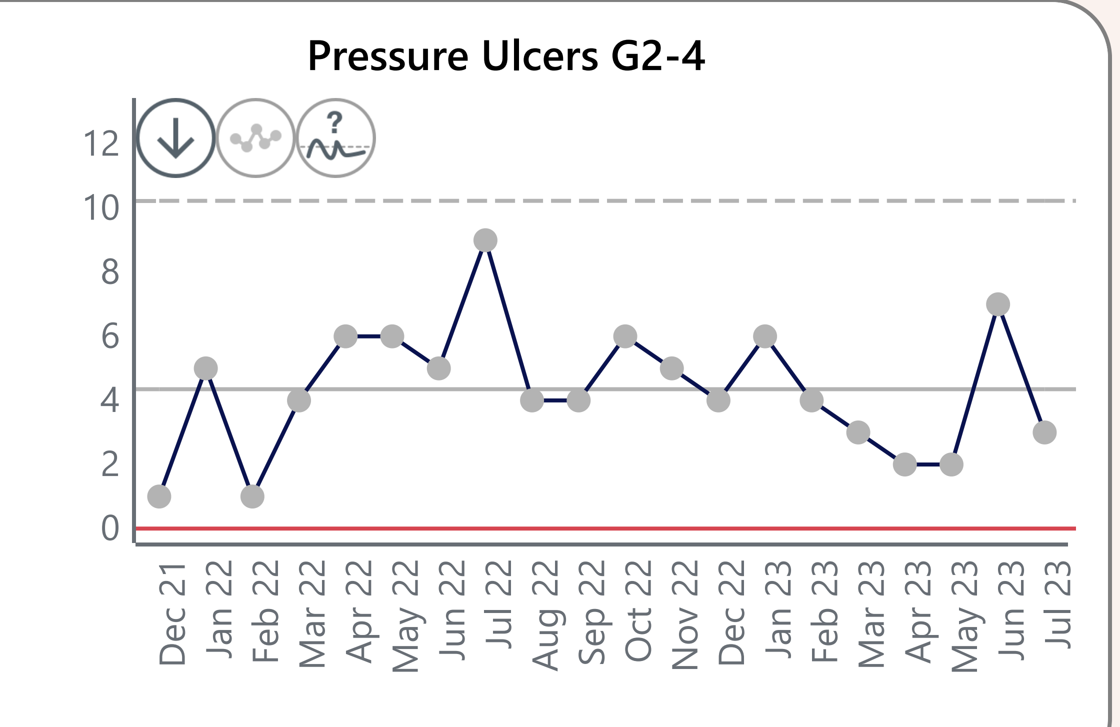
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



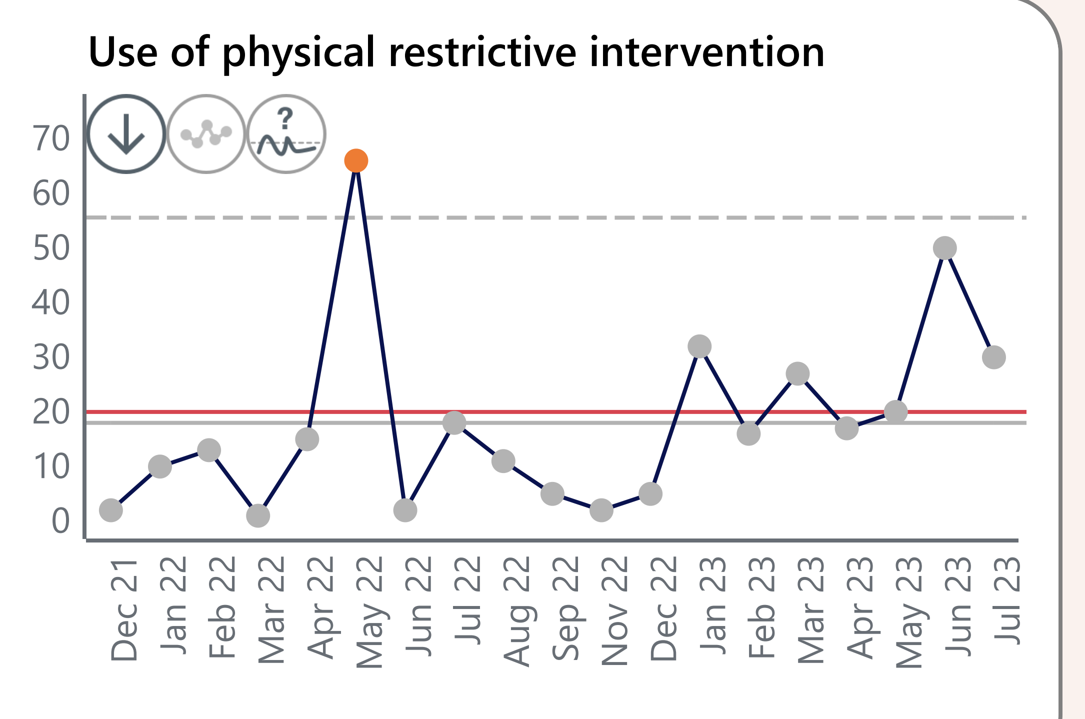
Medication Errors rated Minor harm and above per 1,000 bed days



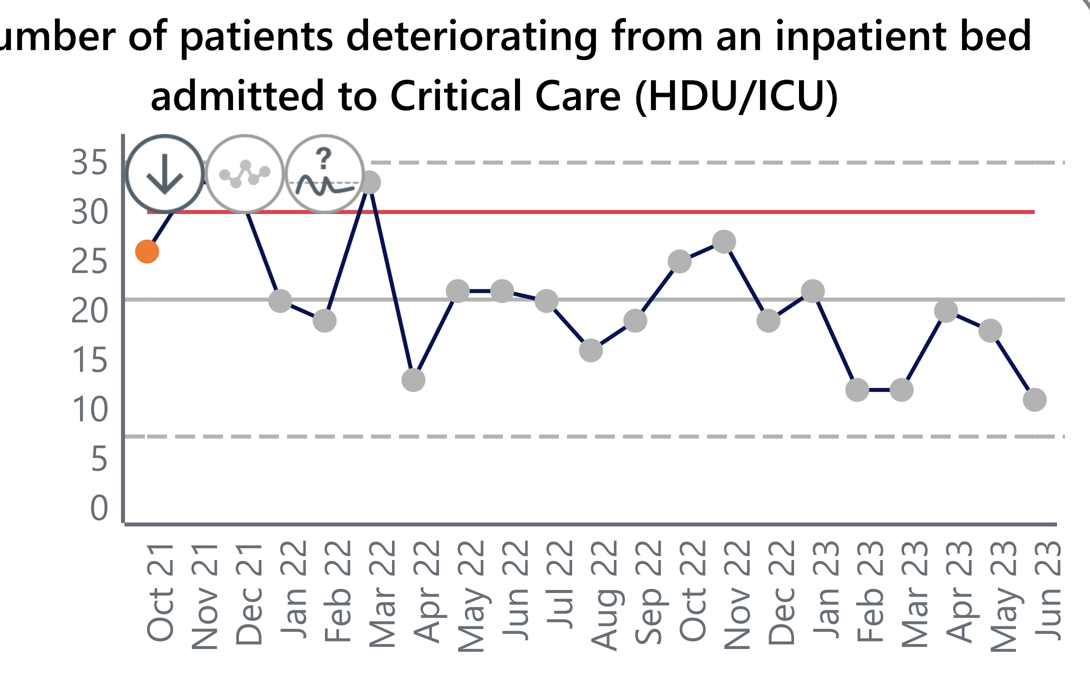
Pressure Ulcers G2-4



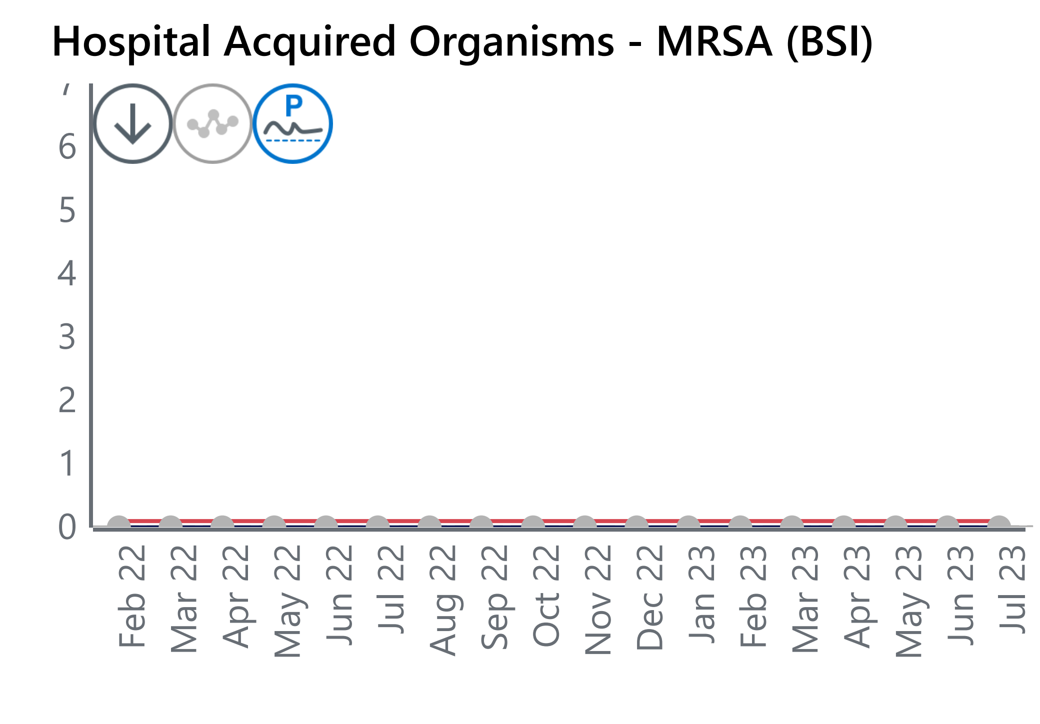
Use of physical restrictive intervention



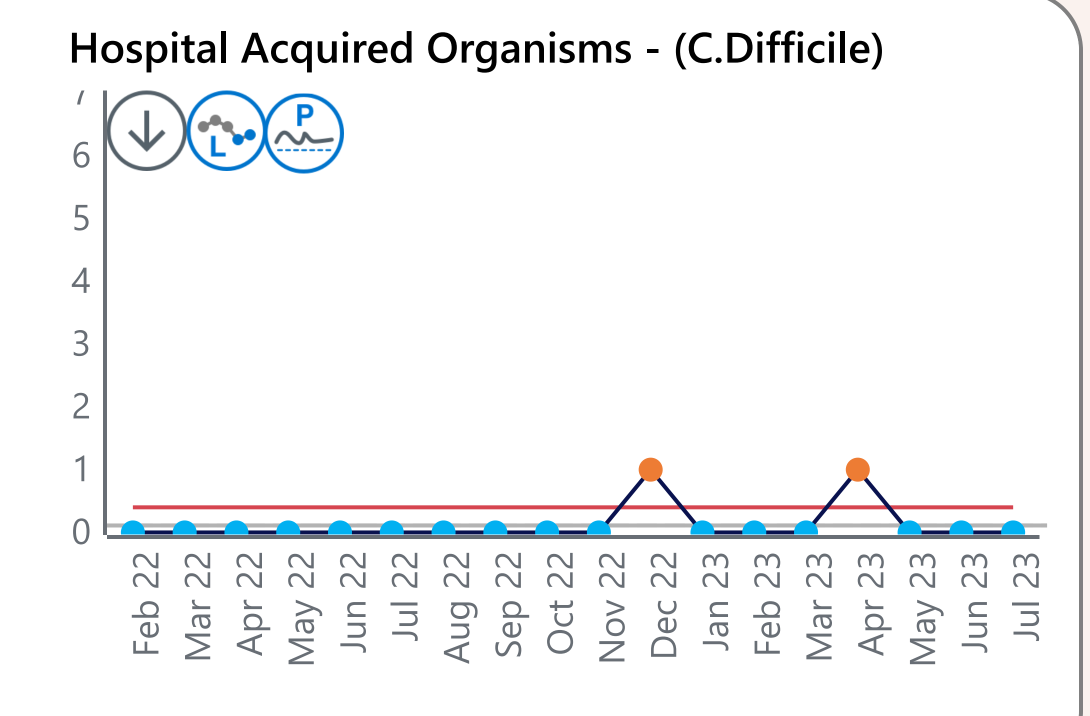
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



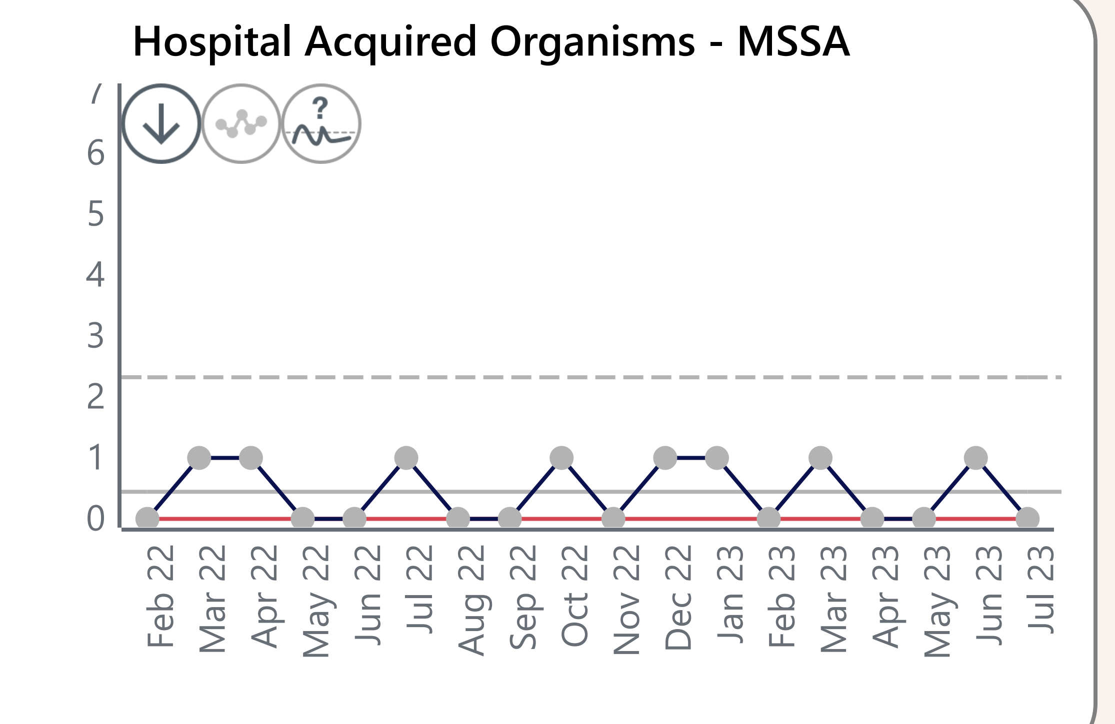
Hospital Acquired Organisms - MRSA (BSI)



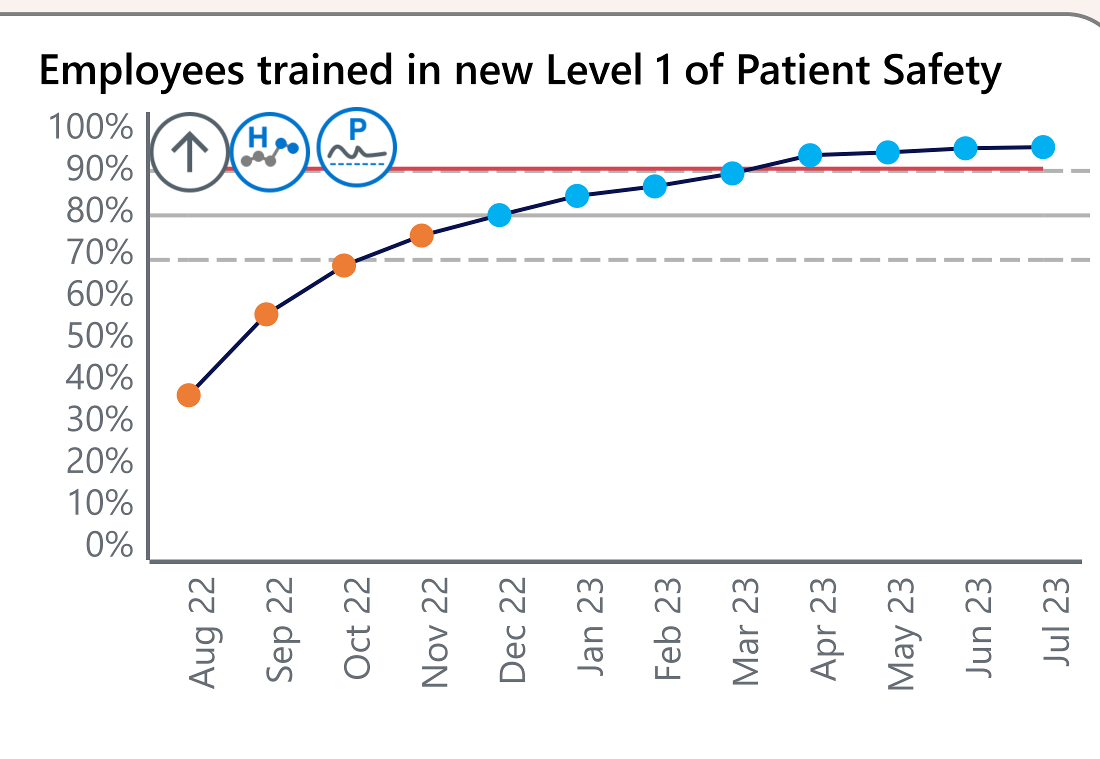
Hospital Acquired Organisms - (C.Difficile)

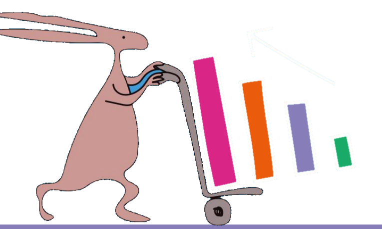


Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety





Unrivalled Experience - Caring

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

Highlights:

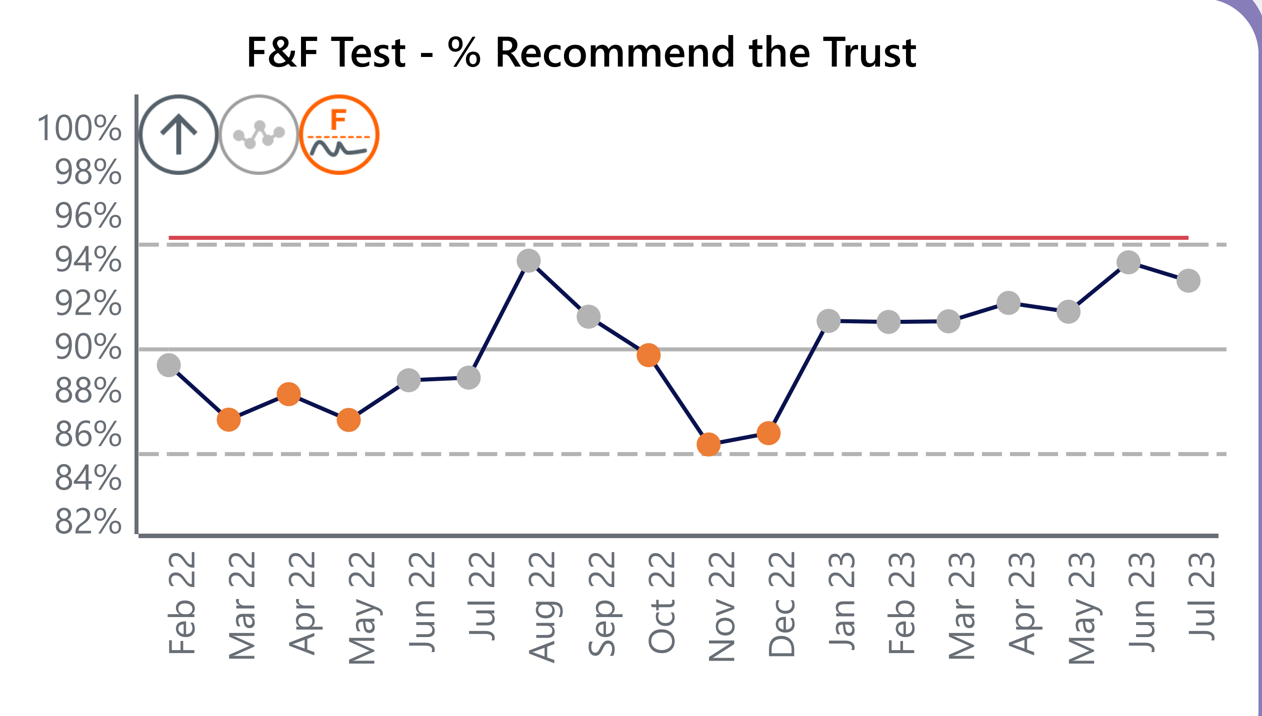
Complaints response rate within 25 days at 100% in month. FFT continues to be on an upward trajectory towards target.

Areas of Concern:

Responsiveness to Pals is improving but needs further attention to meet the target

Forward Look (with actions)

Divisional teams to ensure compliance with the response times for pals and for complaints.

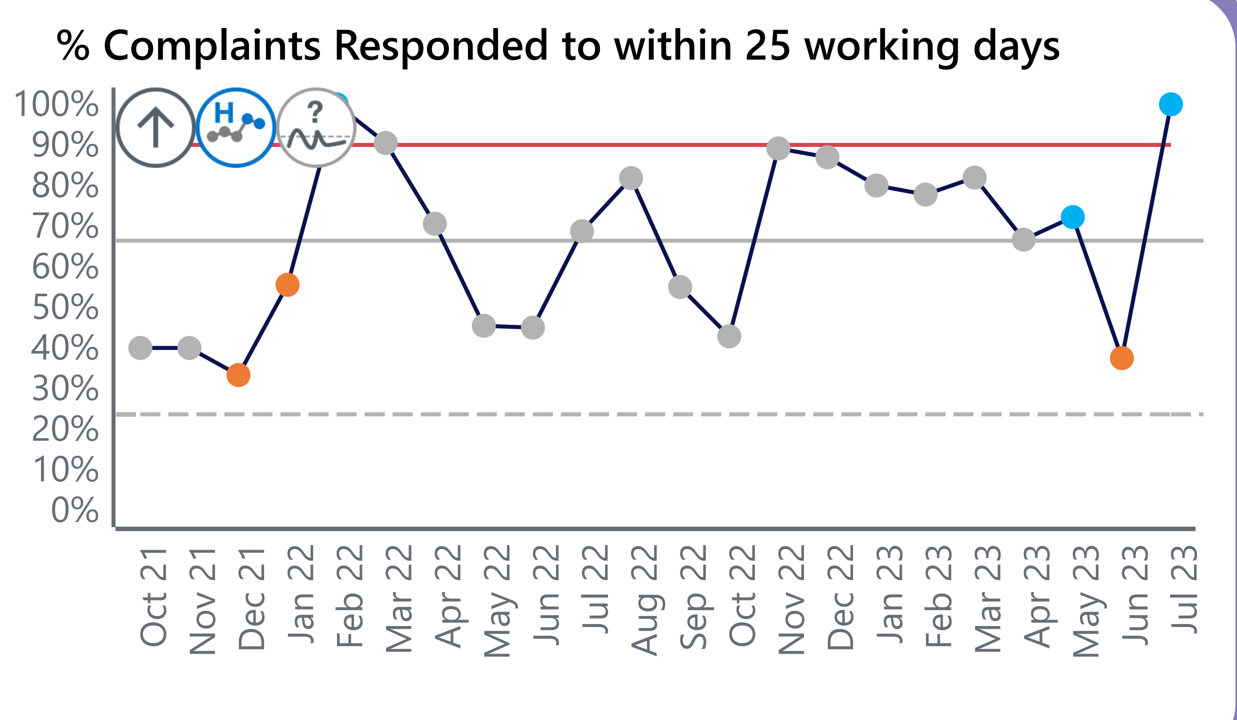


Technical Analysis:

Consistently not achieving the 95% target although 93% represents a 7th consecutive month above the 12 month average of 90%, which if continues would demonstrate special cause variation.

Actions:

Work continues to improve the FFT scores, improvement has been seen within ED and further work is on going in the department to increase satisfaction.

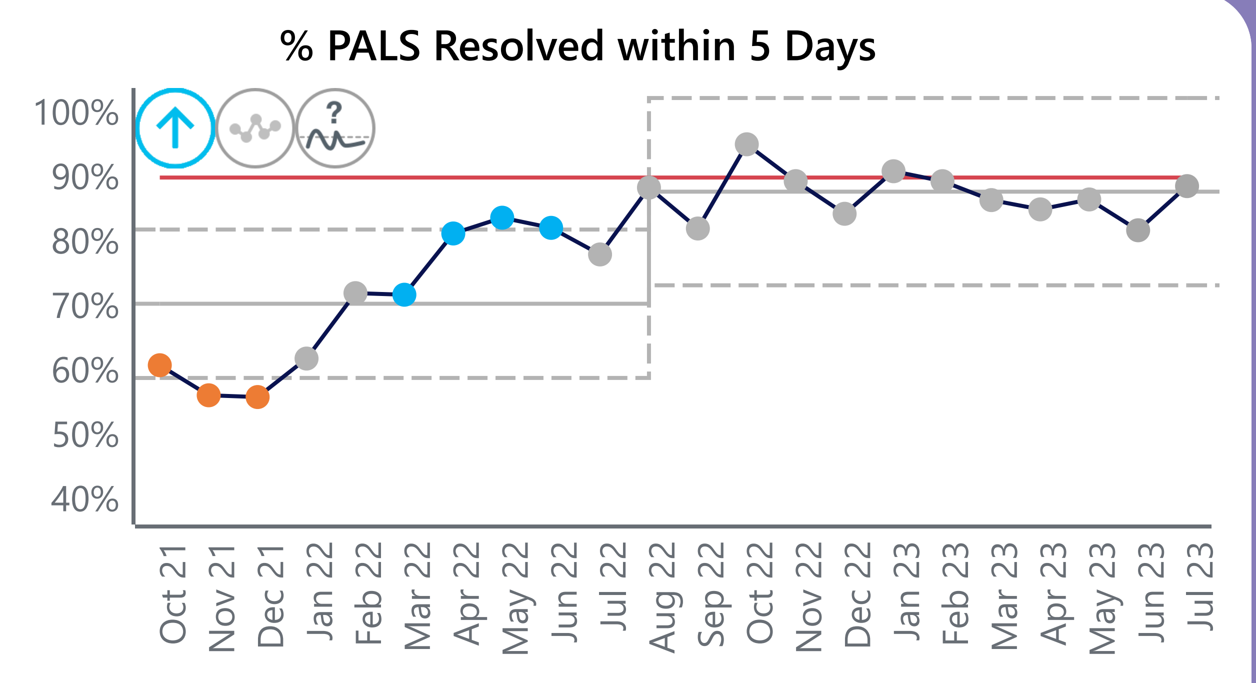


Technical Analysis:

Inconsistently achieving the 90% target with an average of 66% which shows significant fluctuation from month to month however Special cause variation has been observed with an increase from 38% in May 23 to 100% in July 23, which seen all 7 compliants due completed in date.

Actions:

To maintain the performance in relation to this metric



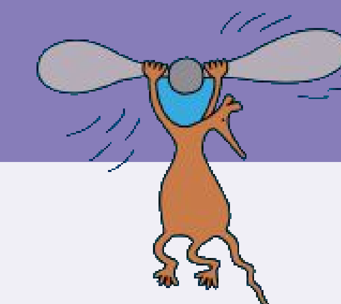
Technical Analysis:

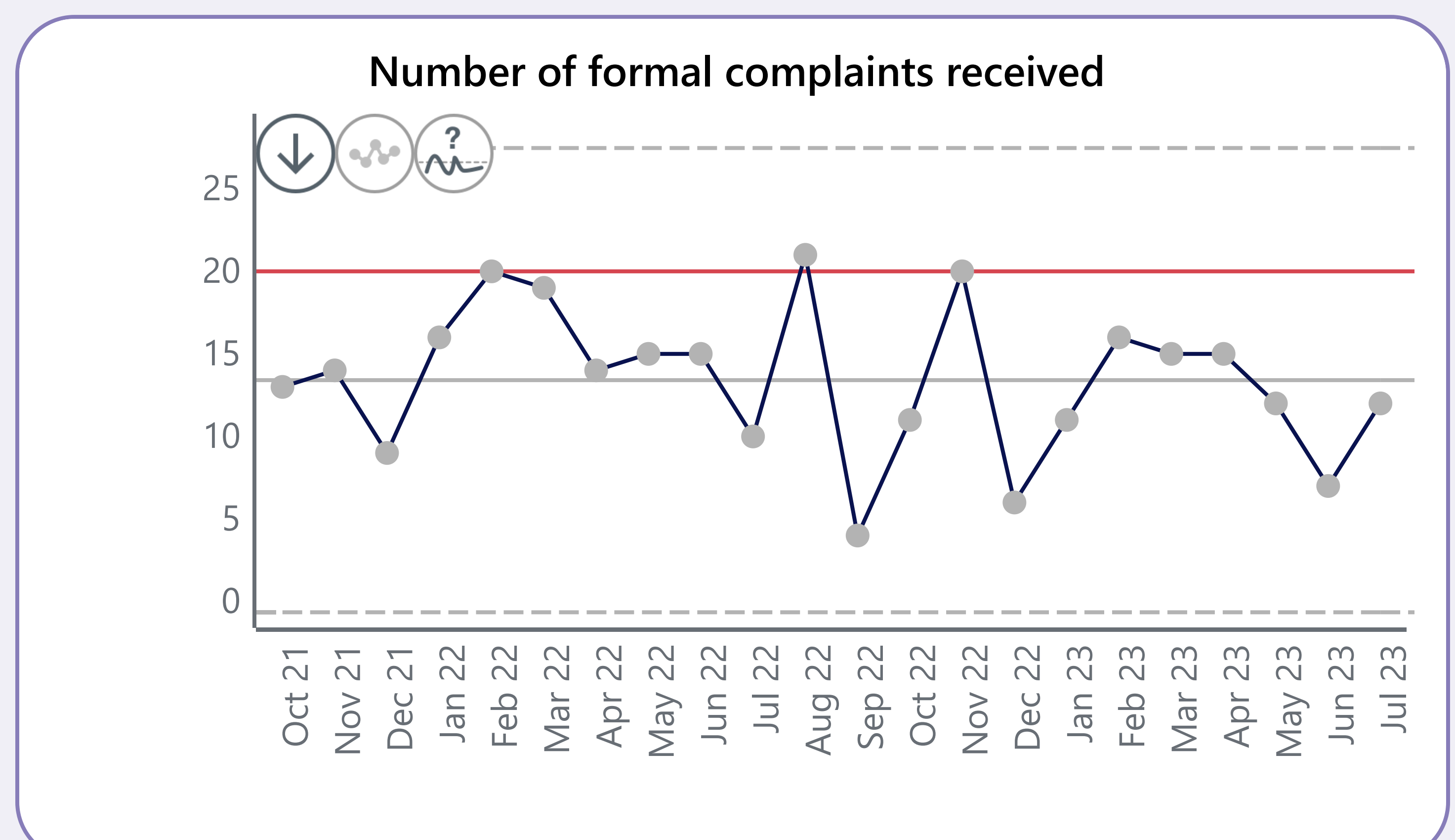
Common cause variation has been observed with a 12 month average of 88%. Inconsistently achieving the 90% target. July 2023 performance was 89%.

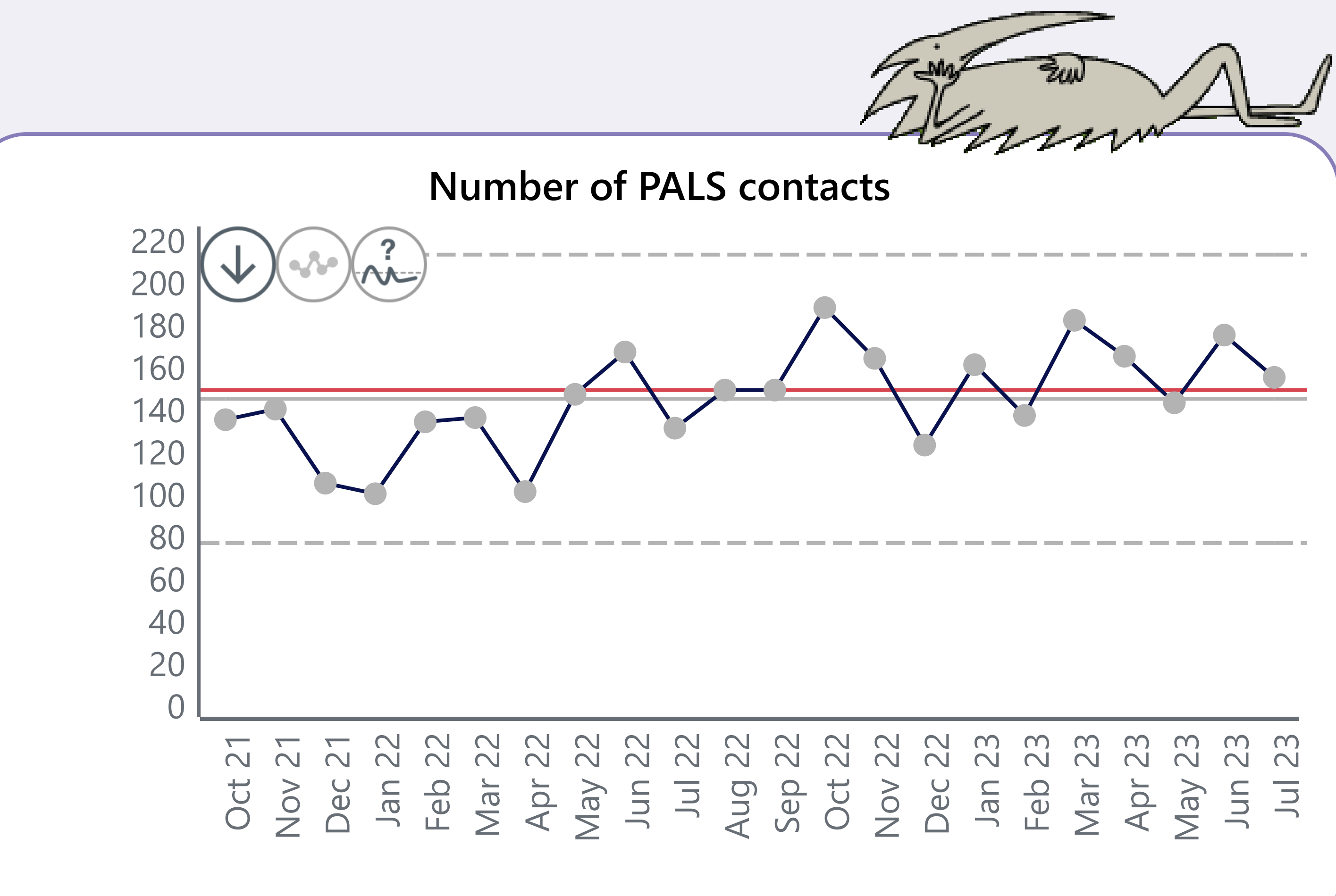
Actions:

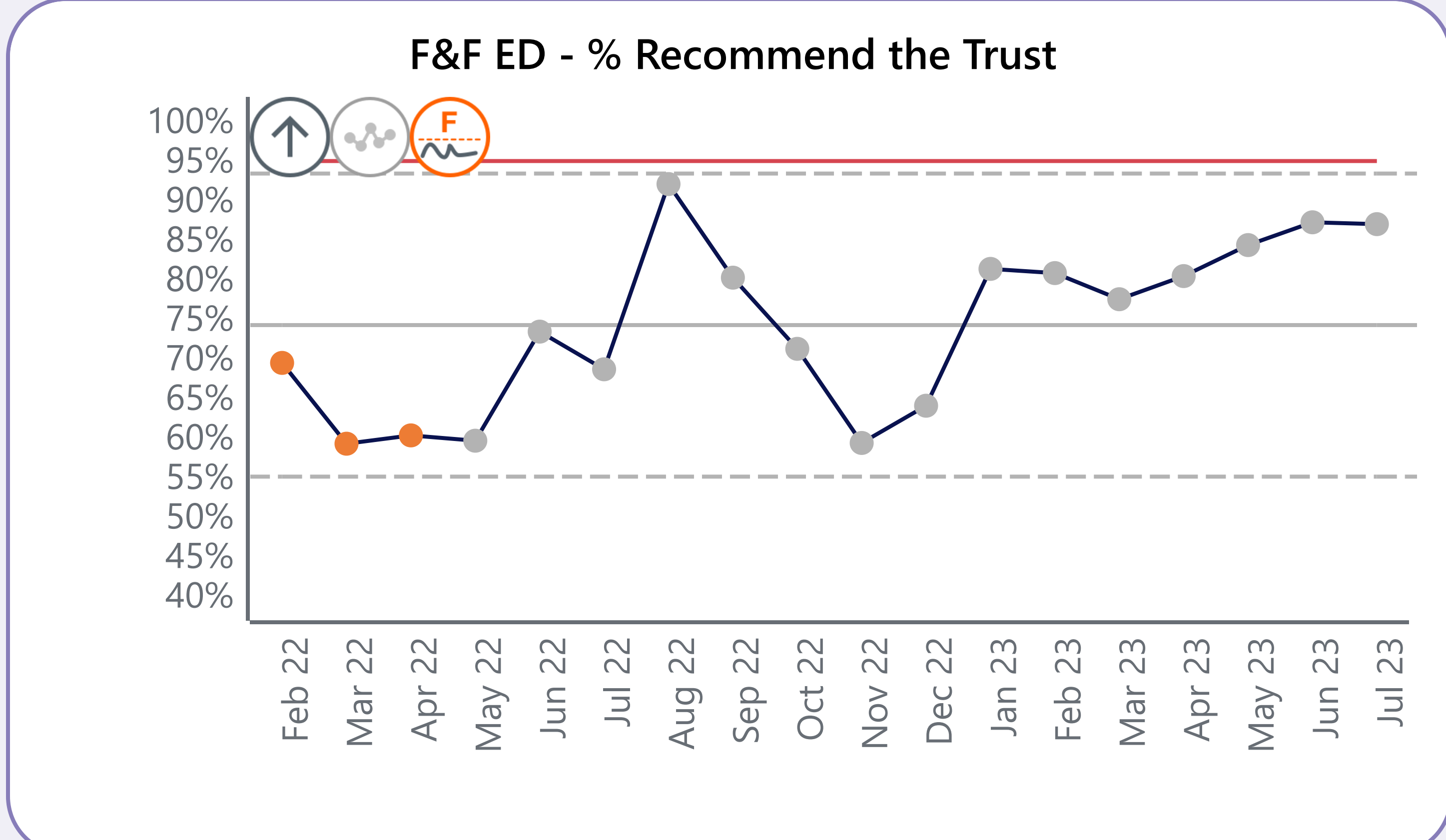
To ensure that divisional teams are responding in a timely way to PALS concerns, although this is on an upward trend

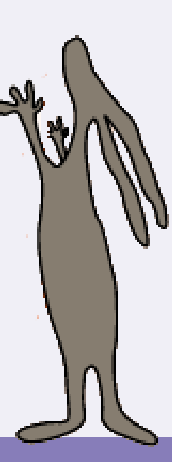
Unrivalled Experience - Caring - Watch Metrics

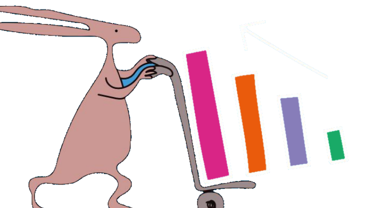












Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• ED consistently achieving the national standard, reaching 91% in July (target >85%) • Theatre Utilisation (touch time) continues to demonstrate improvement during May-July

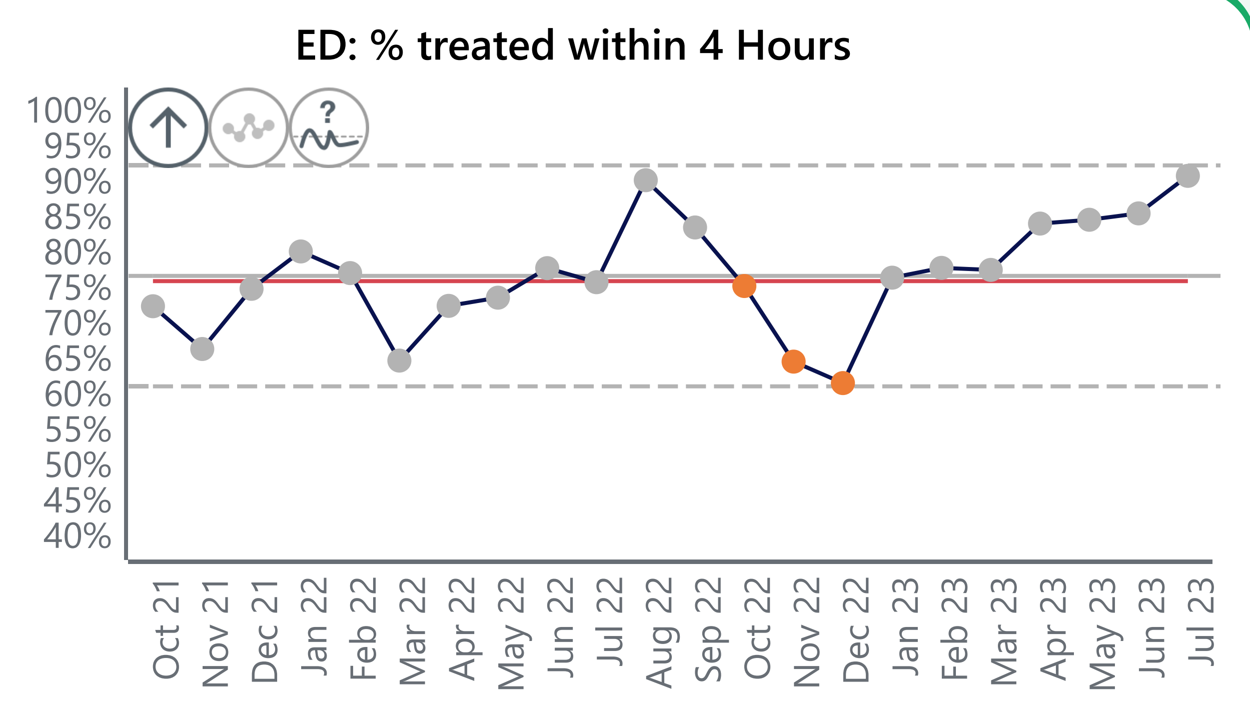
Areas of Concern:

• WNB rate is ow 10%, following Jan-May when performance was <10%. There is no statistical evidence to demonstrate sustained improvement in this area • Static performance regarding Cancelled Operations, Clinical Letters, Patients with LOS > 21 days and Virtual Ward occupancy

Forward Look (with actions)

• Developing and finalising our Winter Plan (mid-Oct) • Detailed benefit assessment of the WNB interventions and identify additional improvements if required • Increase the number of pathways connected to the virtual ward including, eating disorders and oncology and IBD (Oct). Project Manager now in place and recruiting a Clinical Lead, who will scope GP direct access into Virtual Ward

ED: % treated within 4 Hours



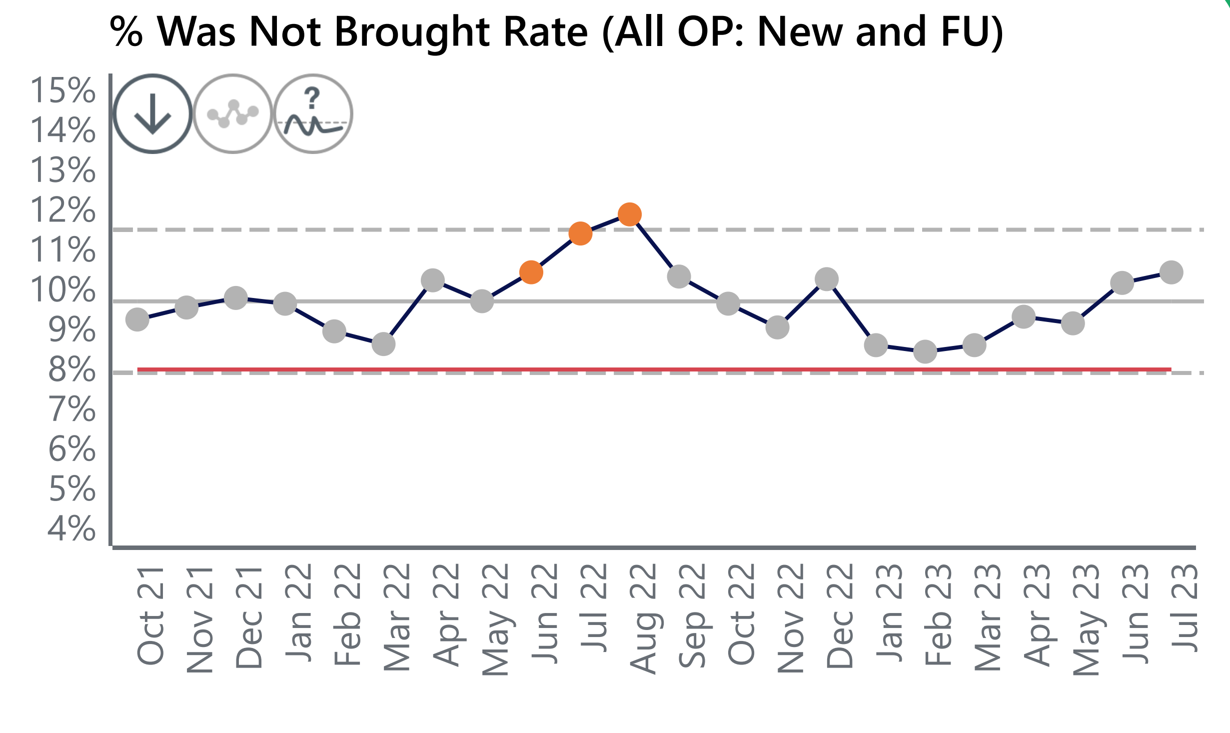
Technical Analysis:

Inconsistently achieve the new national target of 76%, common cause variation has been observed but the Trust has achieved the target for the past 7 months. Performance at 90.8% was increase on June 23 performance at 85.6%.

Actions:

• PAU pilot commenced 8 August 2023, offering direct assessment for GP and other health professionals to a Paediatric assessment.
• Measles preparedness plan and pathway
• Review out-of-hours medical cover

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

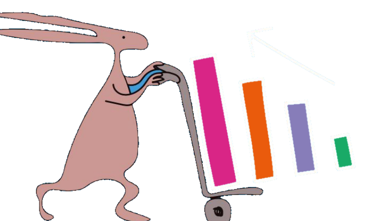


Technical Analysis:

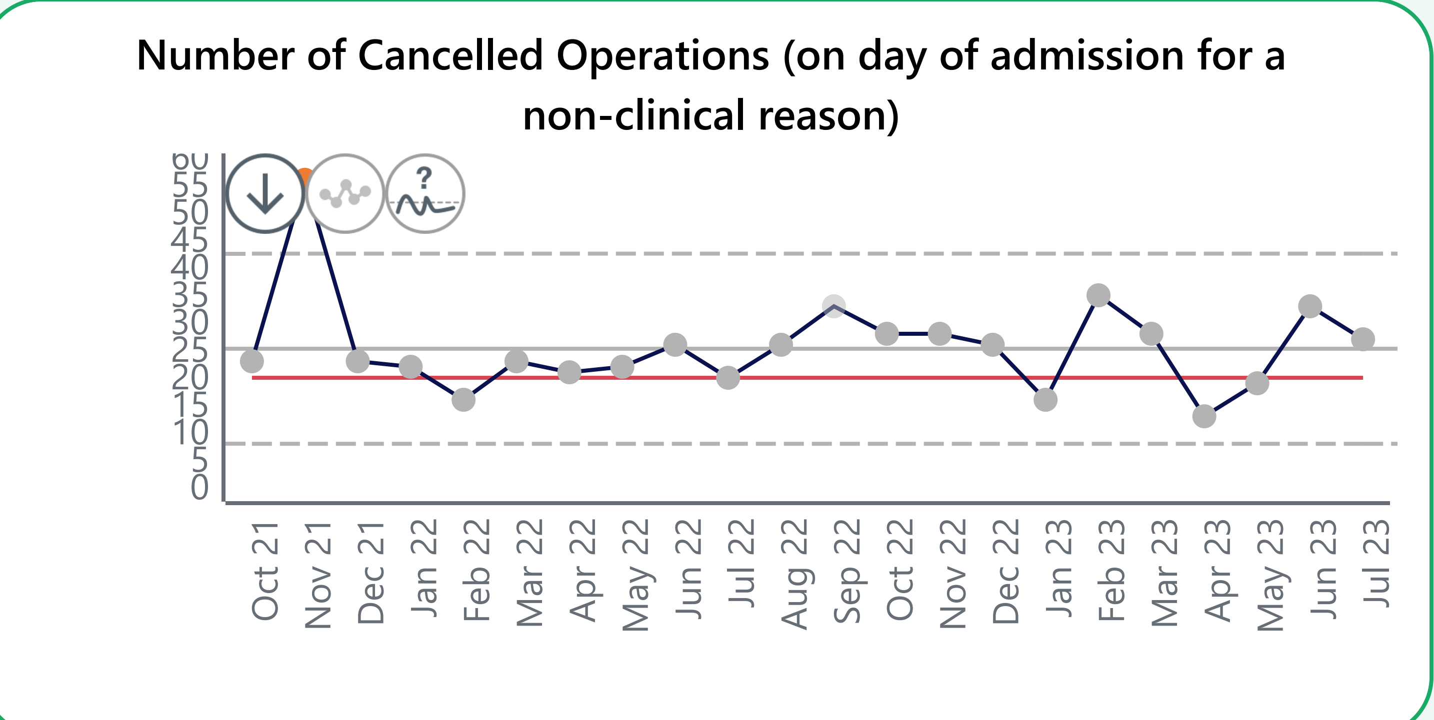
WNB rates demonstrates common cause variation. Performance in July 2023 of 10.3% is the highest rate since Dec-22, although is a decrease of 1% compared to July 2022 which was at 11.3% and mirrors the start of summer school holidays.

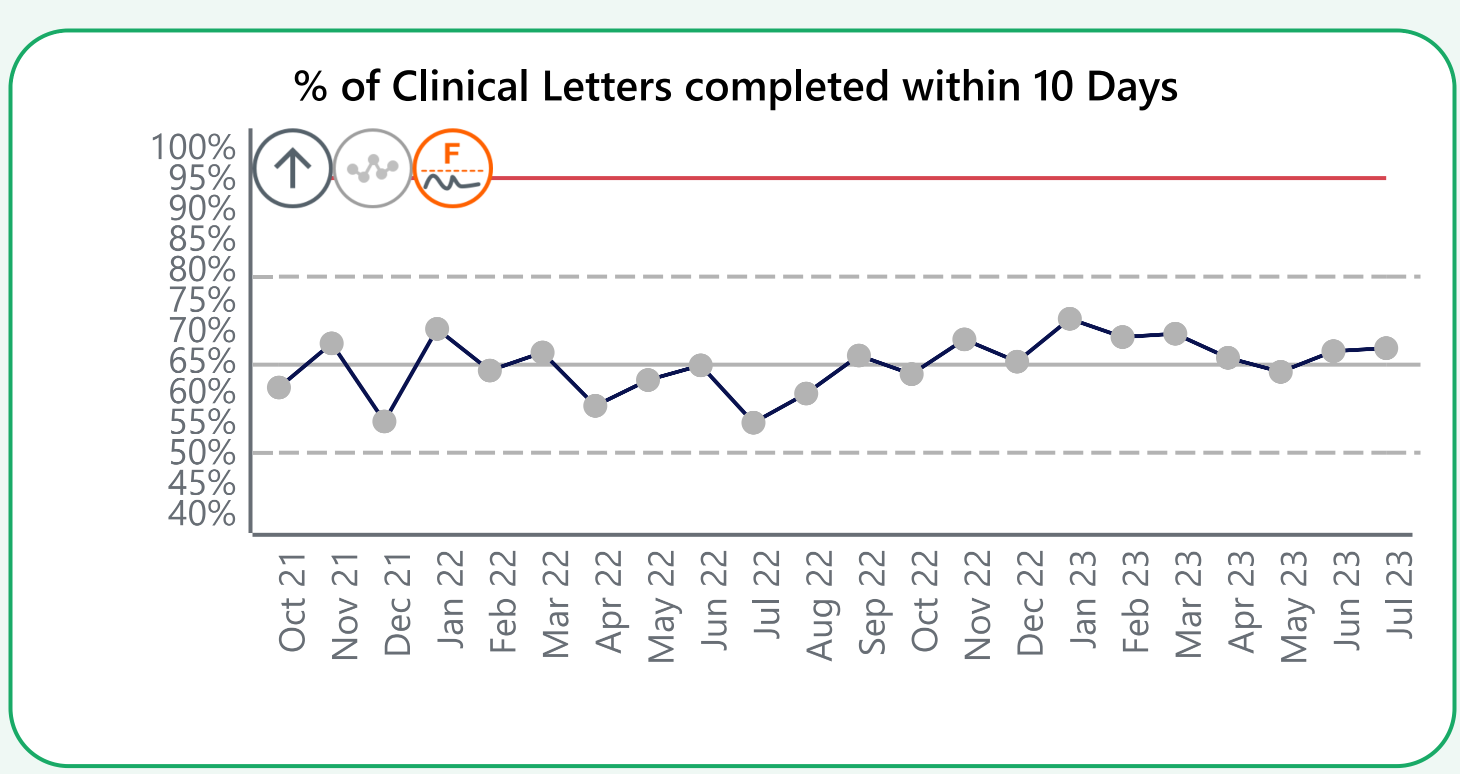
Actions:

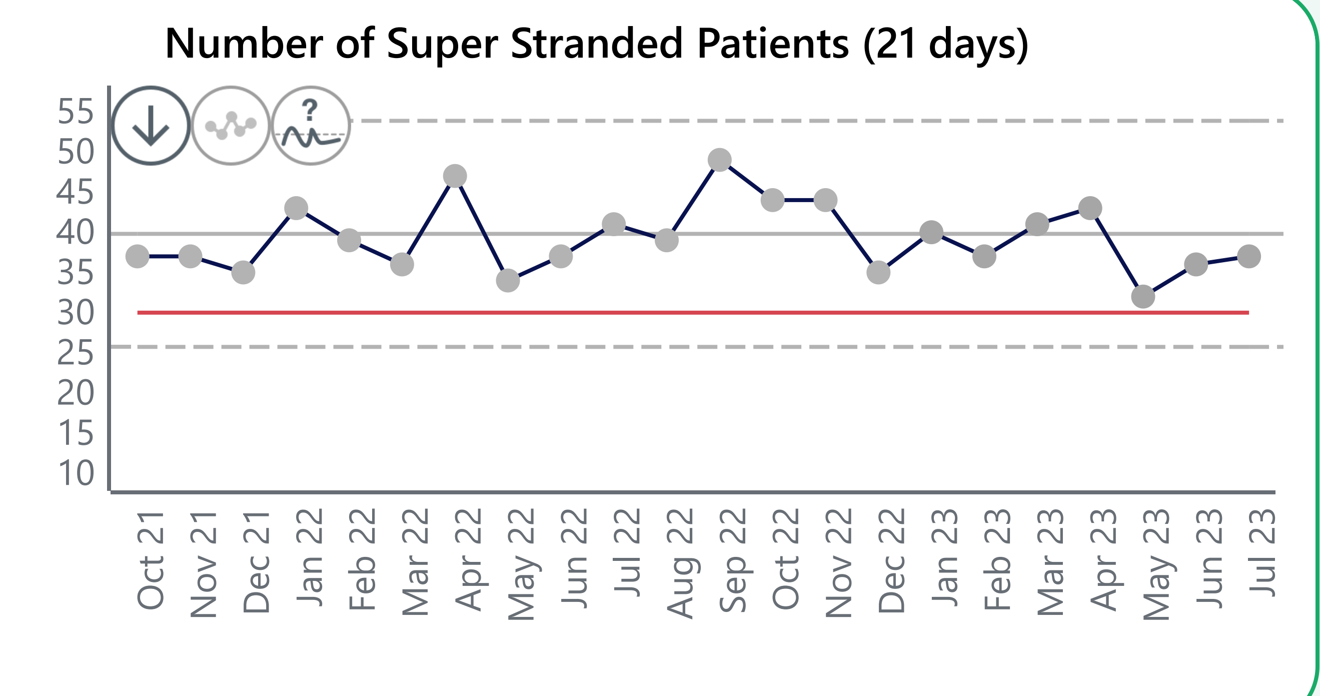
Targeting 9 clinical teams with highest %WNB. Making >500calls pcm based on AI predictor, although barriers to access (eg transport / child care) and language interpretation remain problematic. Benefit assessment is required during September, using PDSA cycle with attention on accurate capturing of call data, maximising re-use of appointments and signposting to help people attend.

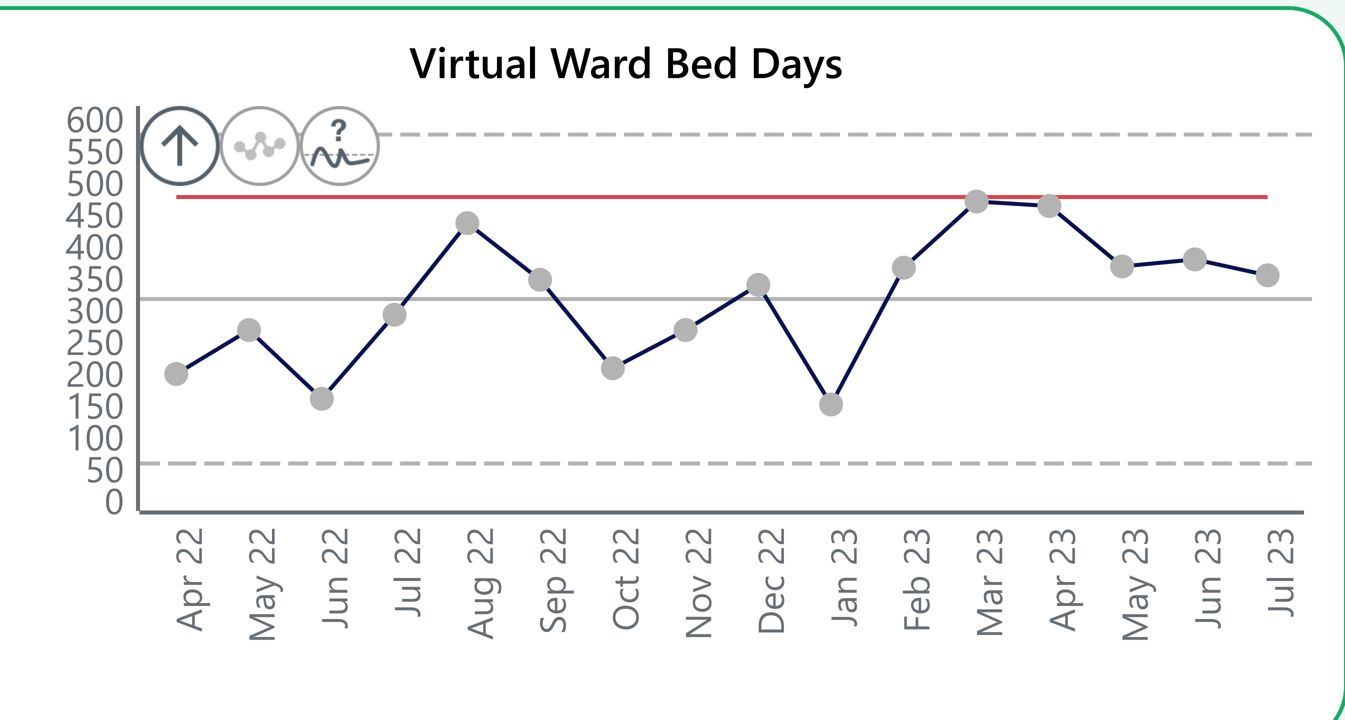


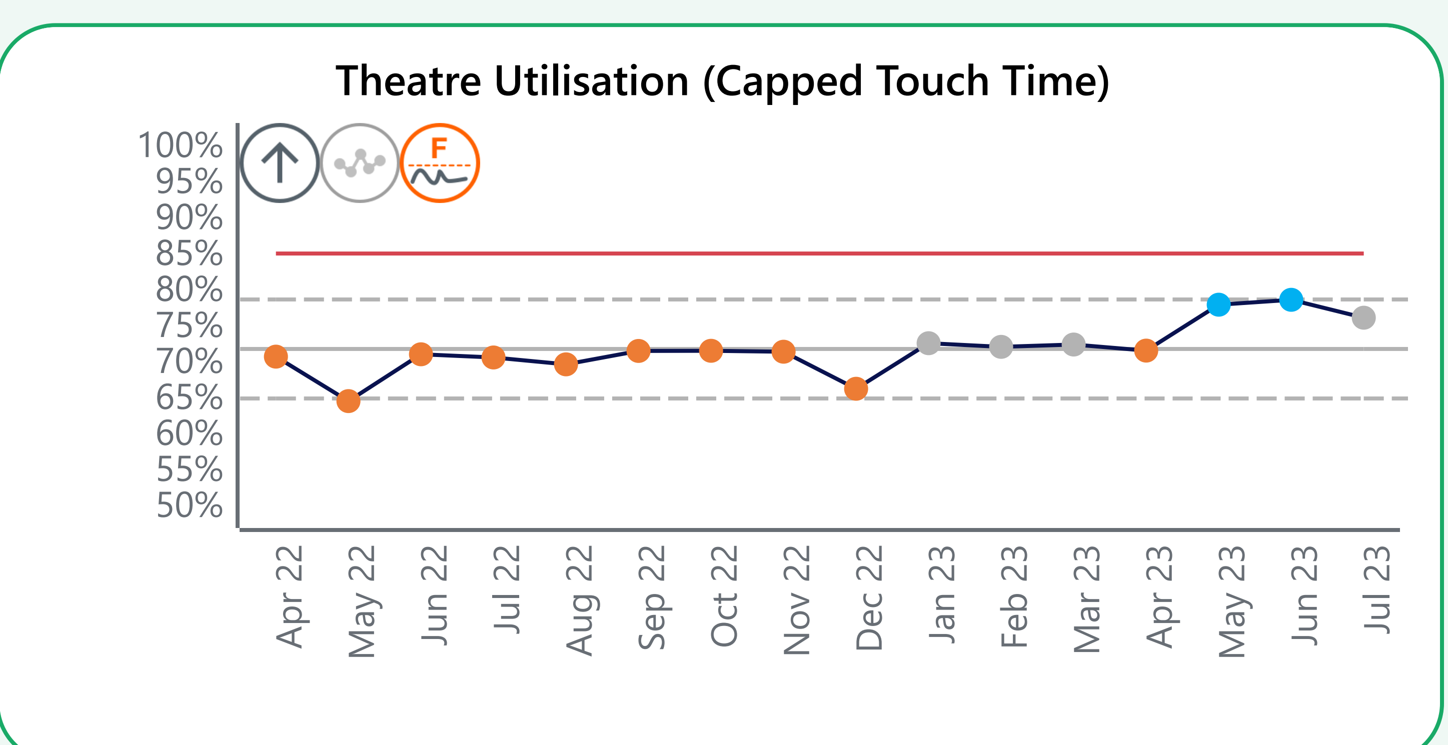
Smartest Ways of Working - Accessible Services - Effective - Watch Metrics

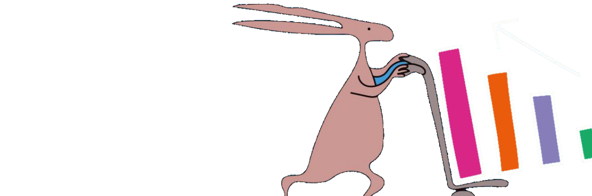












Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• Significant improvement in CAMHS with only 3 young people waiting >52 weeks (reduced from 34 in January) • Diagnostic waits continue to achieve target of >90% within 6 weeks • Continue to achieve national access standards for cancer care • IHA completed within 20 days of referral was 41% in July (still well below target but up from 2%)

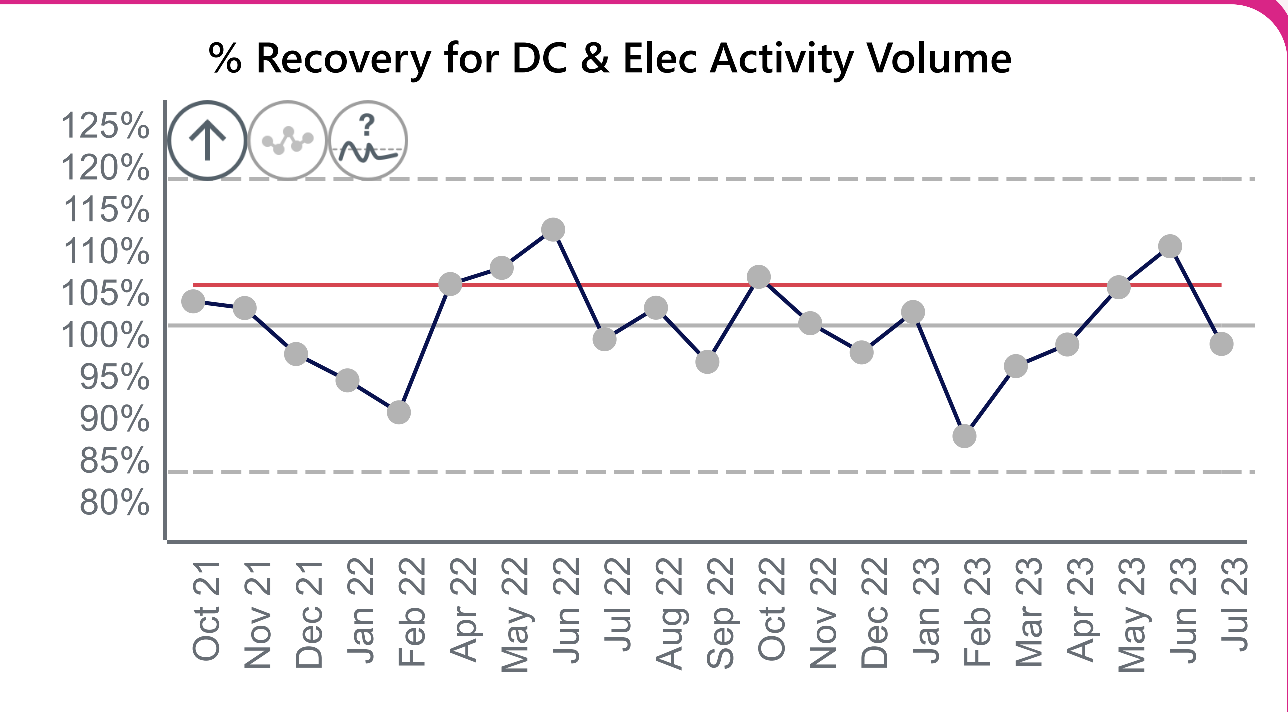
Areas of Concern:

• We still have 155 RTT patients waiting >65 weeks – primarily in ENT and Dental • Waiting times for ASD and ADHD are showing special cause variation with >1200 children and young people waiting for diagnosis • Levels of activity recovery for DC&IP and OP have dipped in July, with Industrial Action causing significant impact

Forward Look (with actions)

• Enhanced approach to activity forecasting & recovery plans in place for challenged specialities although this remains a significant risk due to ongoing IA • Development of recruitment plan for ASD and ADHD in line with agreed investment and reprofiling of waiting time improvement plan (Sept 23)

% Recovery for DC & Elec Activity Volume



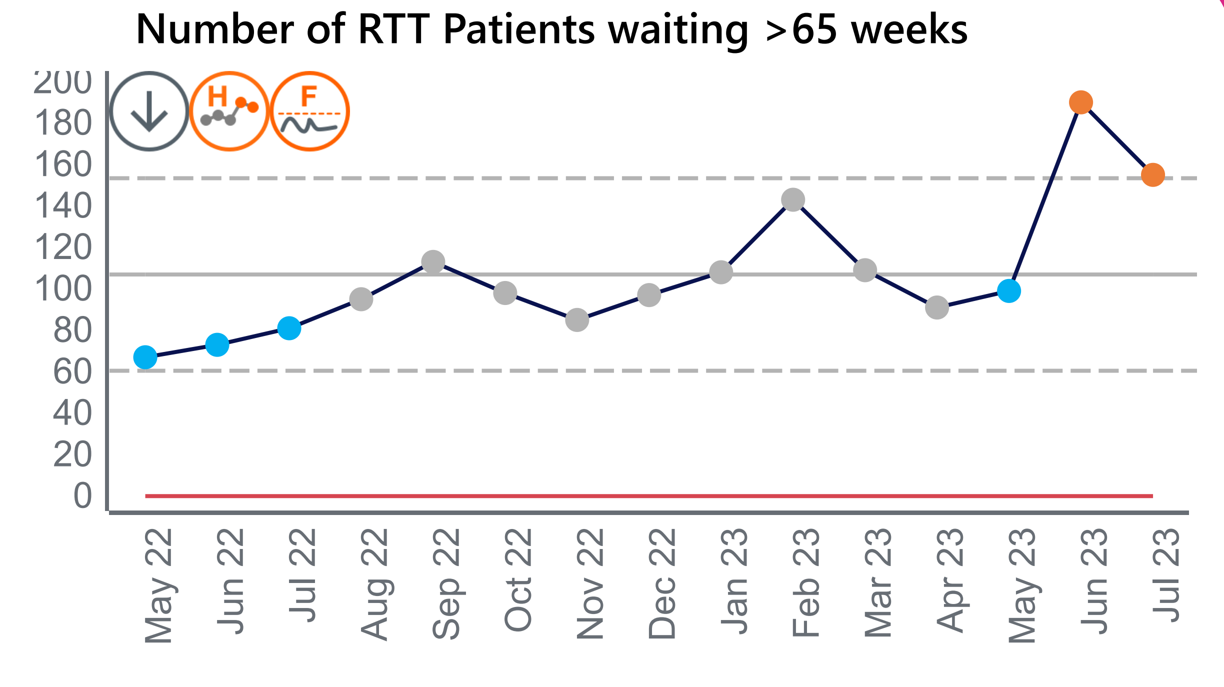
Technical Analysis:

July 23 performance of 99% by volume is below the target and reduction of 12% compared to June 2023. July experienced 9 calendar days of industrial action with 76 operations cancelled in advance for the strikes, in addition 27 operations cancelled on the day for non-clinical reasons. Monthly variation continues to demonstrate common cause variation.

Actions:

Activity levels will continue to be managed safely during ongoing Industrial Action. Number of theatre sessions per week is being managed pro-actively by Surgery to support staff and avoid burn out, with review of agency staff and removing under utilised lists. Revised agreement for extracontractual rates of pay by 1 September to increase weekend work.

Number of RTT Patients waiting >65 weeks



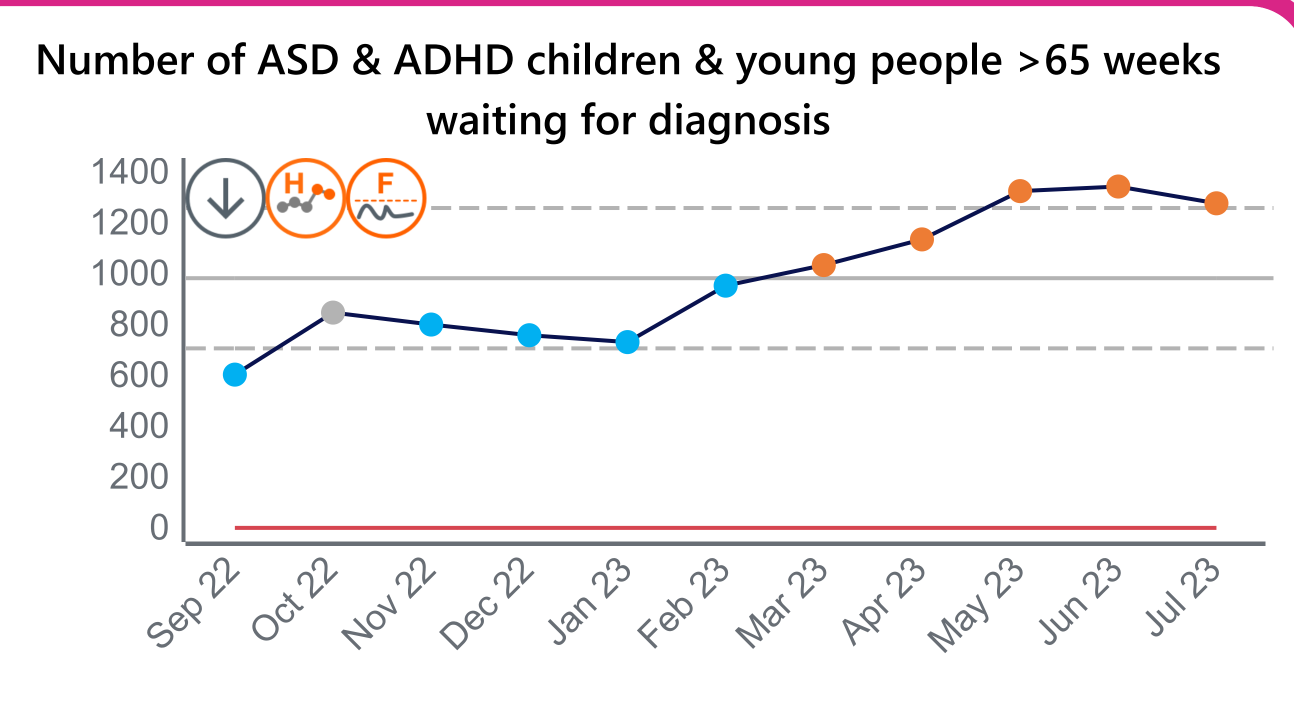
Technical Analysis:

Number of patients waiting > 65 weeks has decreased in July to 155 patients from 190 in June. Dentistry (n = 60) and ENT (n=85) have 145 patients >65 weeks, 94% of the Trust total.

Actions:

Enhanced approach to activity forecasting & recovery plans in place for challenged specialities although this remains a significant risk due to ongoing IA. Actions include in-sourcing, "opt-in" model, weekend lists, revised agreement for extra contractual lists by 1 Sept

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



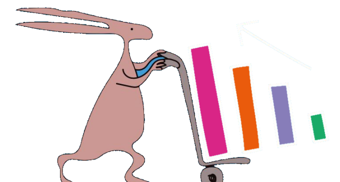
Technical Analysis:

On average 982 patients are waiting for an ASD or ADHD diagnosis per month. July shows 1277 patients which is above the outer control limits, now showing special cause varation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

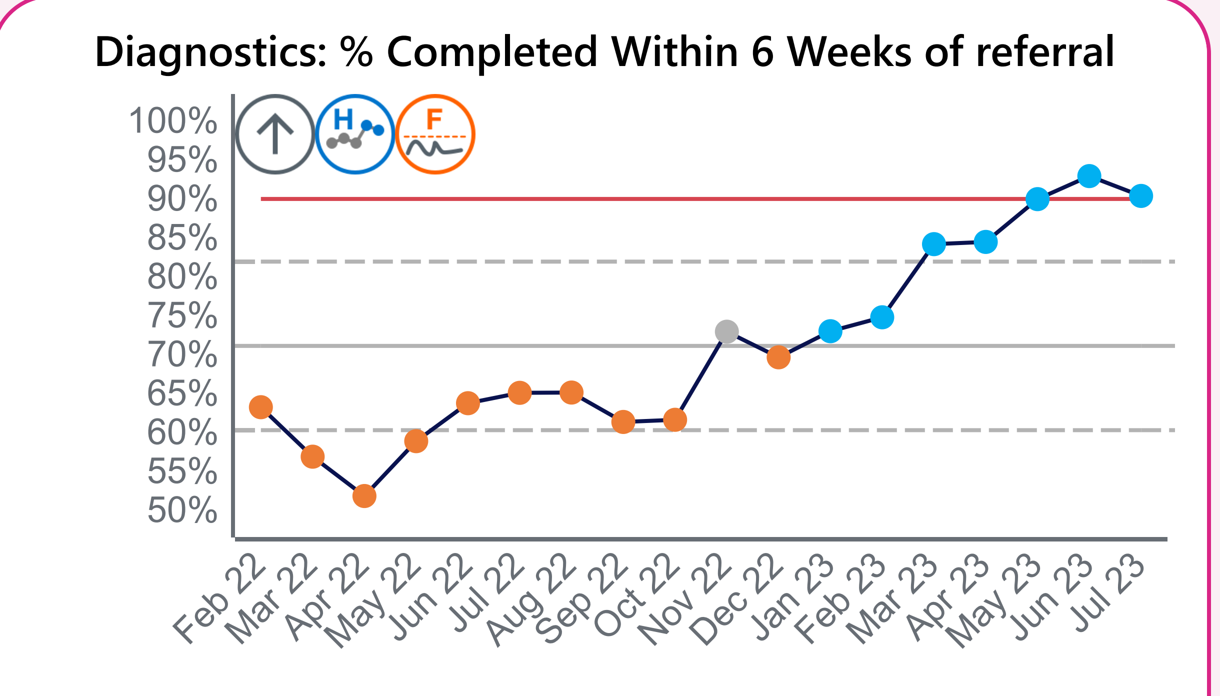
Actions:

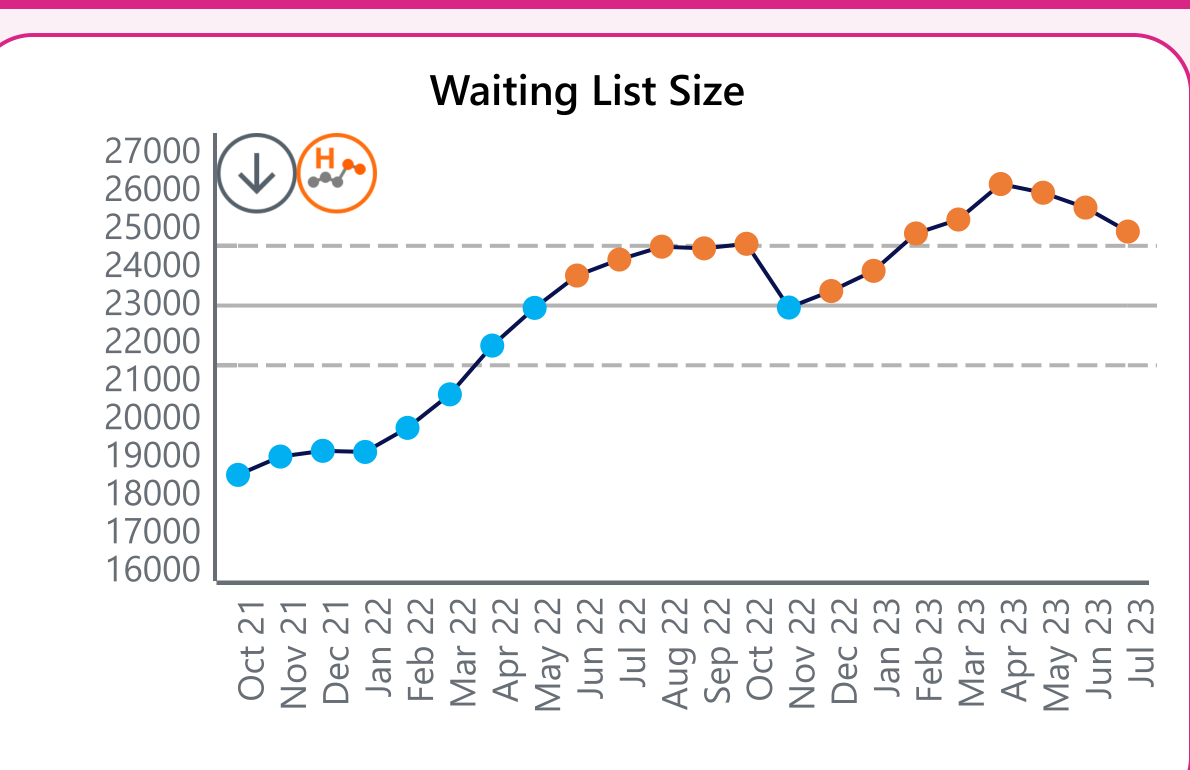
Development of recruitment plan for ASD and ADHD in line with agreed investment and reprofiling of waiting time improvement plan (September 2023)

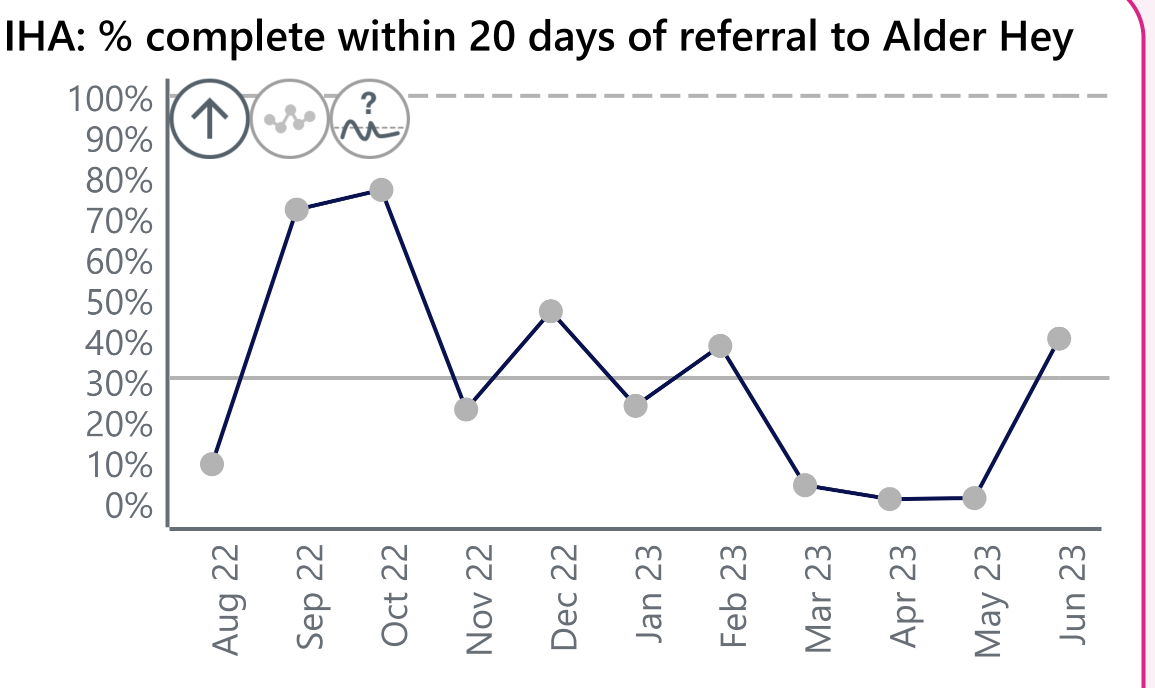
Integrated Performance Report | August 2023

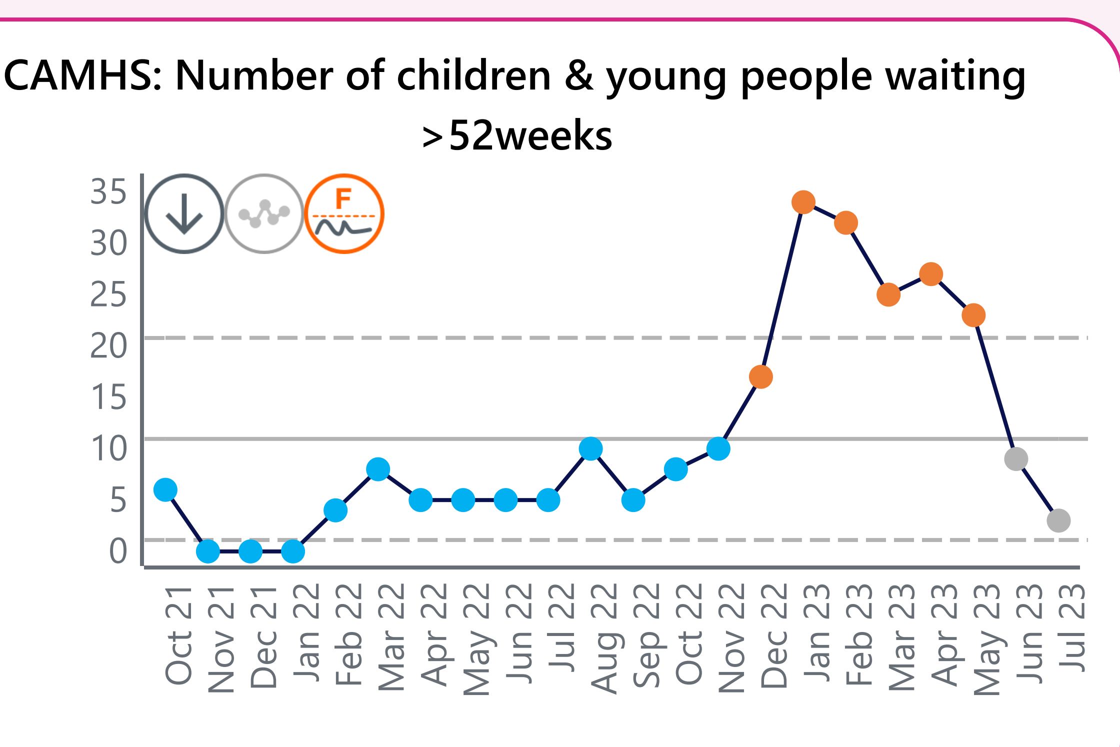


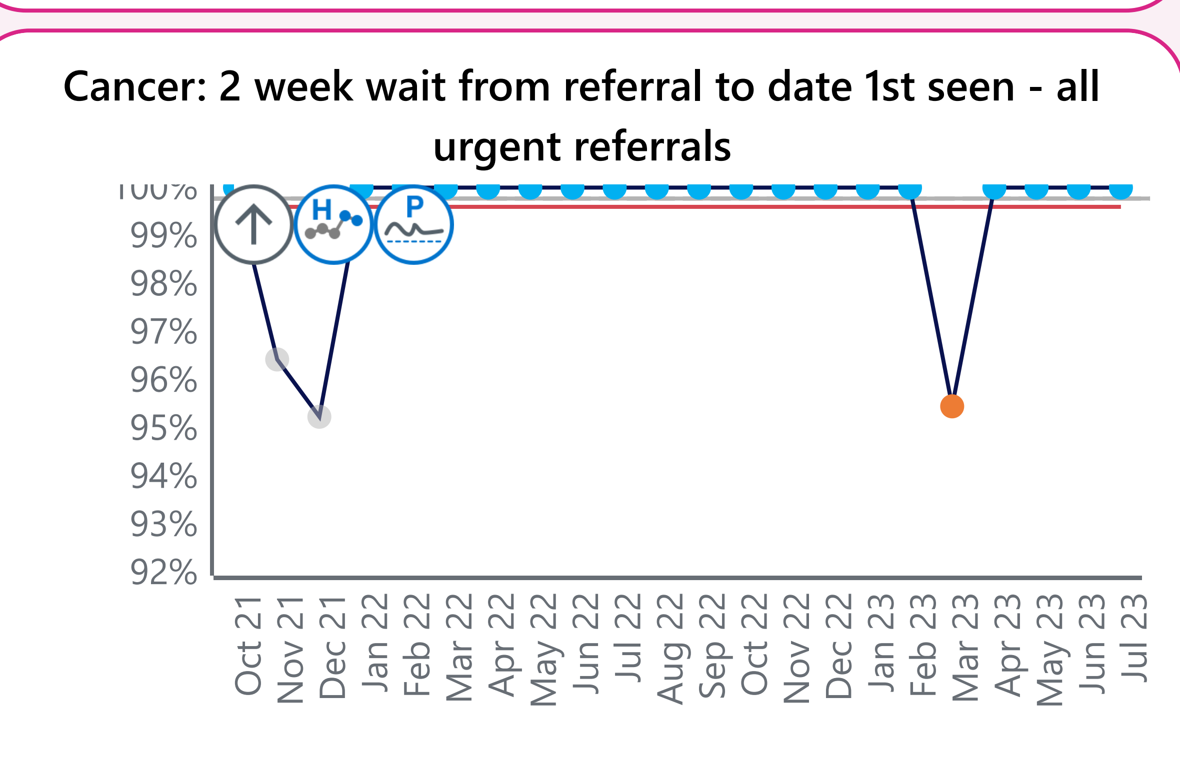
Smartest Ways of Working - Accessible Services: Responsive - Watch Metrics

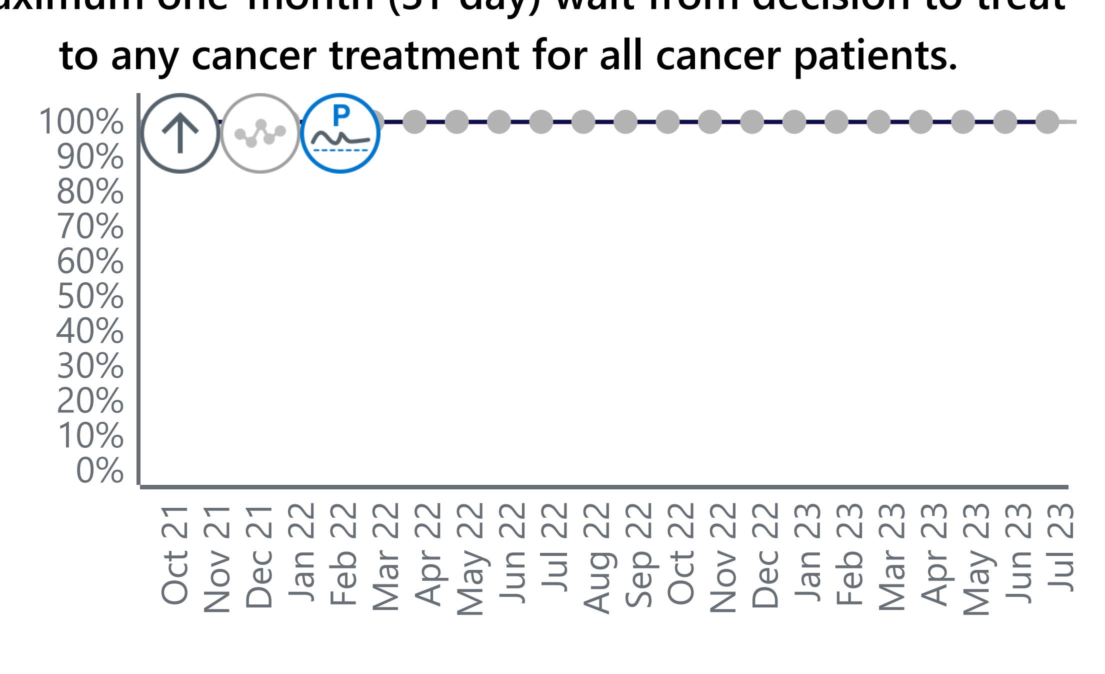


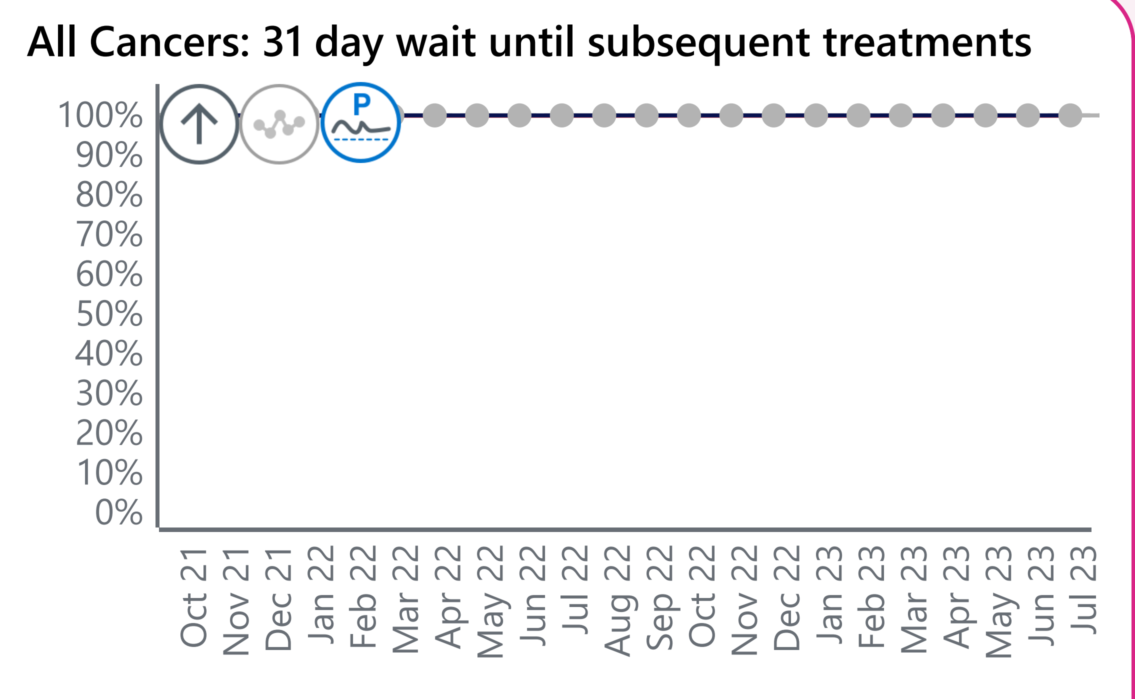


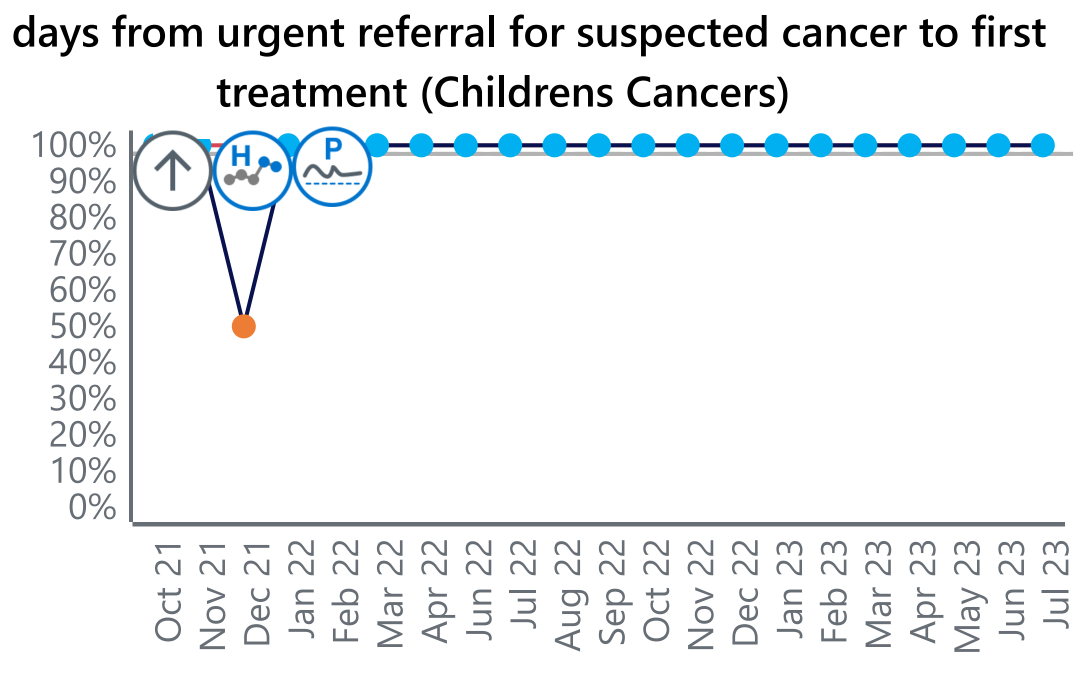


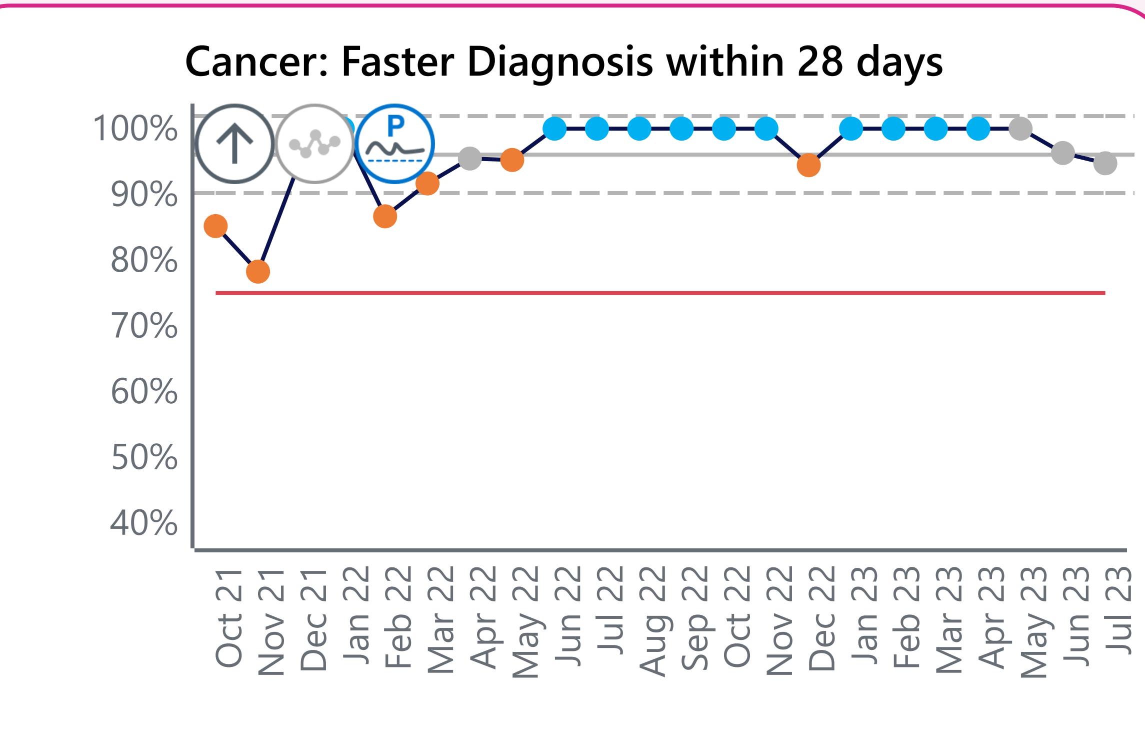


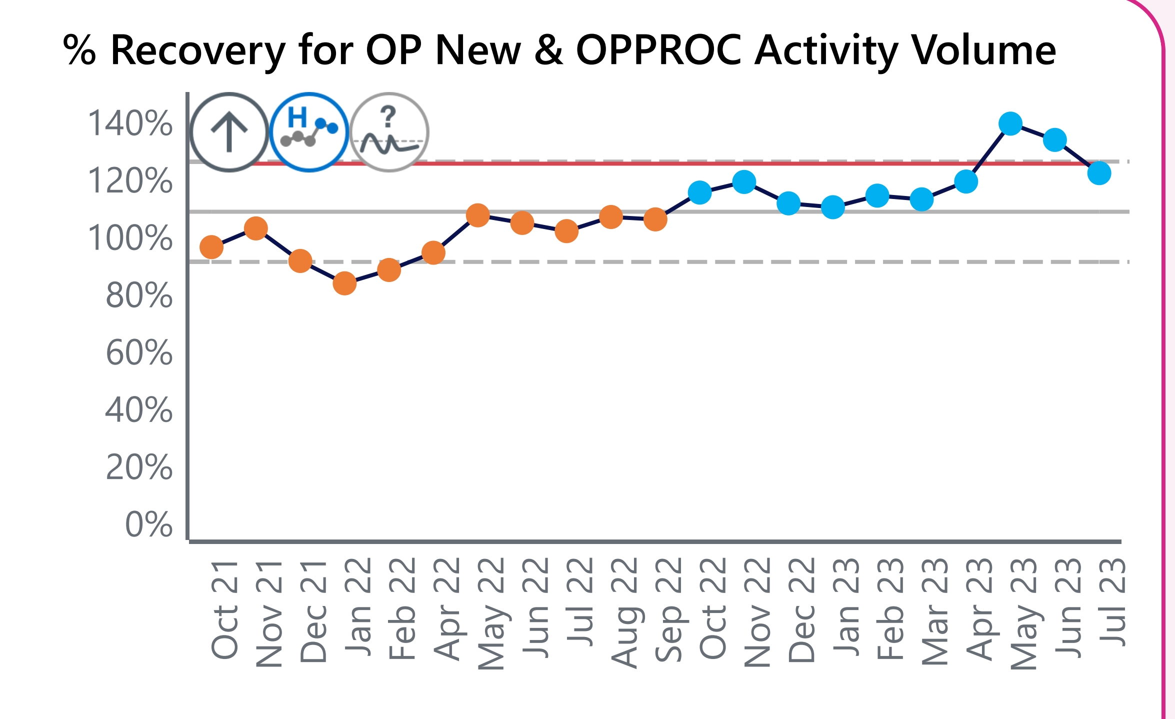


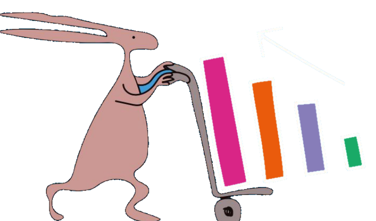












Collaborating for CYP - Reducing Health Inequalities: Responsive

SRO: Dani Jones, Director of Strategy and Partnerships

Highlights:

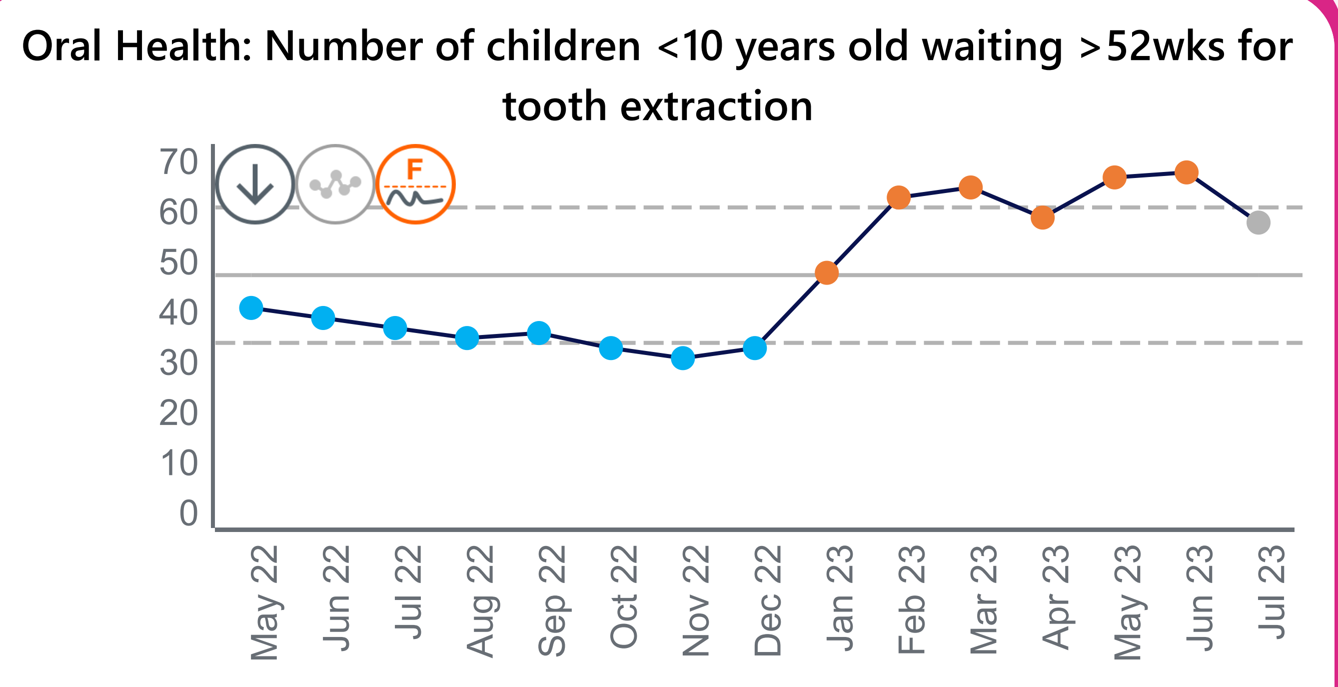
• These measures will be updated on a quarterly basis given the nature • This is a new direction of reporting for the integrated performance report, recognising both the Trust's ambitions in terms of reducing the impact of health inequalities and new strategic drivers such as Core20+5CYP. • A 'learn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

Areas of Concern:

Forward Look (with actions)

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

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



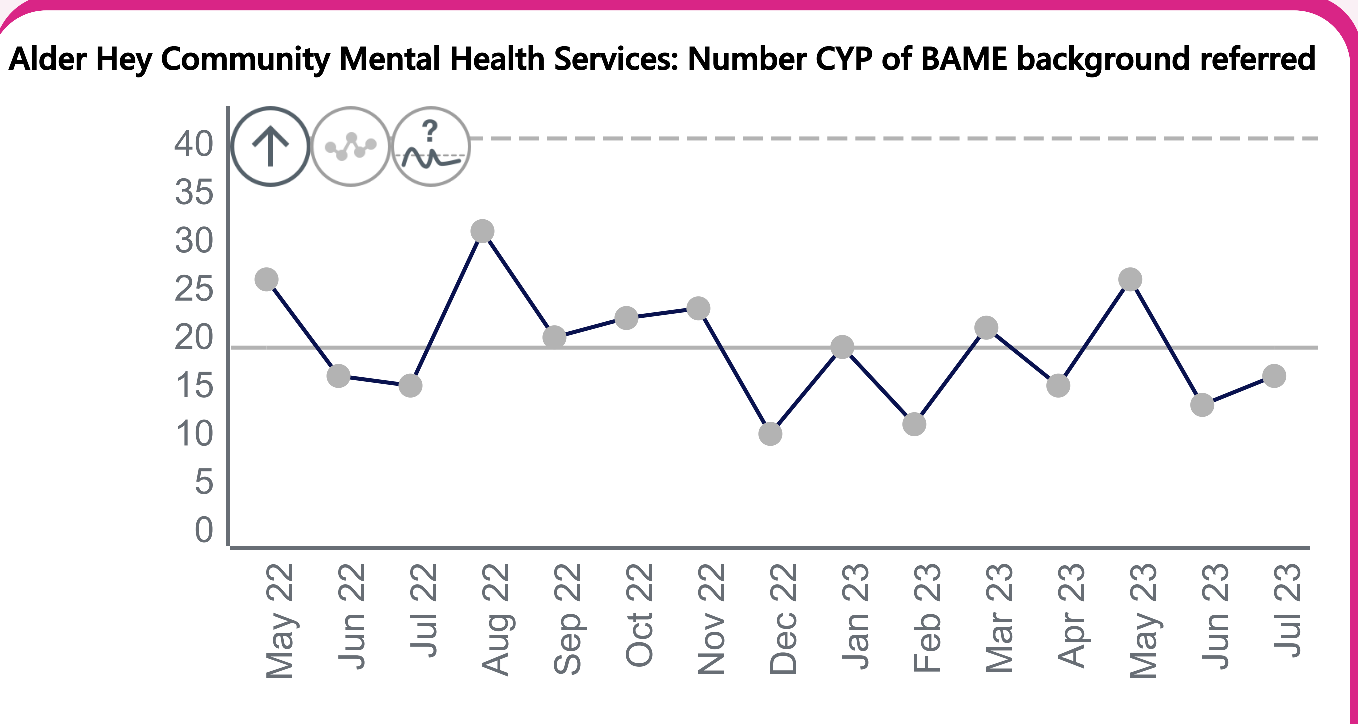
Technical Analysis:

Steady decline in children waiting >52 weeks up until Jan 23 where we have since seen a sudden increase, showing special cause varation of concern. Currently 58 children waiting >52 weeks, which decreased by 10 from June 2023. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Reduction in month in number of children <10 years old waiting >52 weeks by 10 based on increased capacity with the service, inclusive of insourcing investment.

Alder Hey Community Mental Health Services: Number CYP of BAME background referred



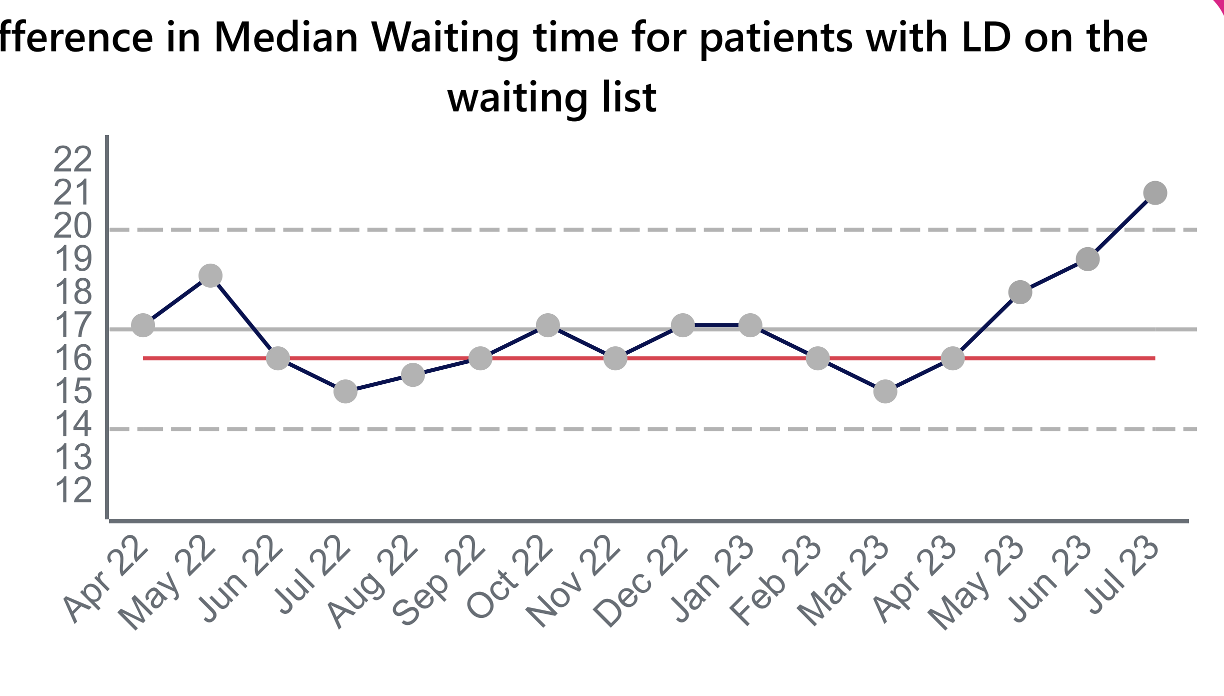
Technical Analysis:

New Metric which shows on average 19 referrals of BAME background are accepted per month, July shows 16 patients. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Defining metric and accurate capture of data as in progress, including national reporting of data

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

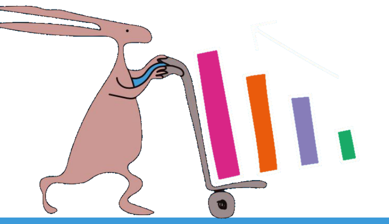


Technical Analysis:

Median wait of Learning and Disability (LD) patients (RTT open pathways) was 21 weeks as end of July, above the previous 12 month baseline target of 16 week median wait for non-LD patients and a further monthly increase. Waits for non LD patients have remained steady at 17 weeks. This will require a deep dive to identify cause behind this gap.

Actions:

Metric and associated improvement plan are work in progress.



Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

Staff availability as a result of both sickness absence and turnover show ongoing improvements, with a reduction in both over recent months. Sickness absence has been at target (5.5%) or below for the last 4 months, coupled with a reduction in staff turnover for the 3rd consecutive month, reaching Trust Target of 13% this month.

Areas of Concern:

Although the above is demonstrating a positive trend and therefore one to highlight, it is still very early on, so will continue to be monitored. The actions from both the task and finish group and the work from people plan workstreams will support and address these areas of concern.

Forward Look (with actions)

The people plan and associated work streams under the Thriving at Alderhey initative have PID's and actions in place to address improvement in a number of people metrics.

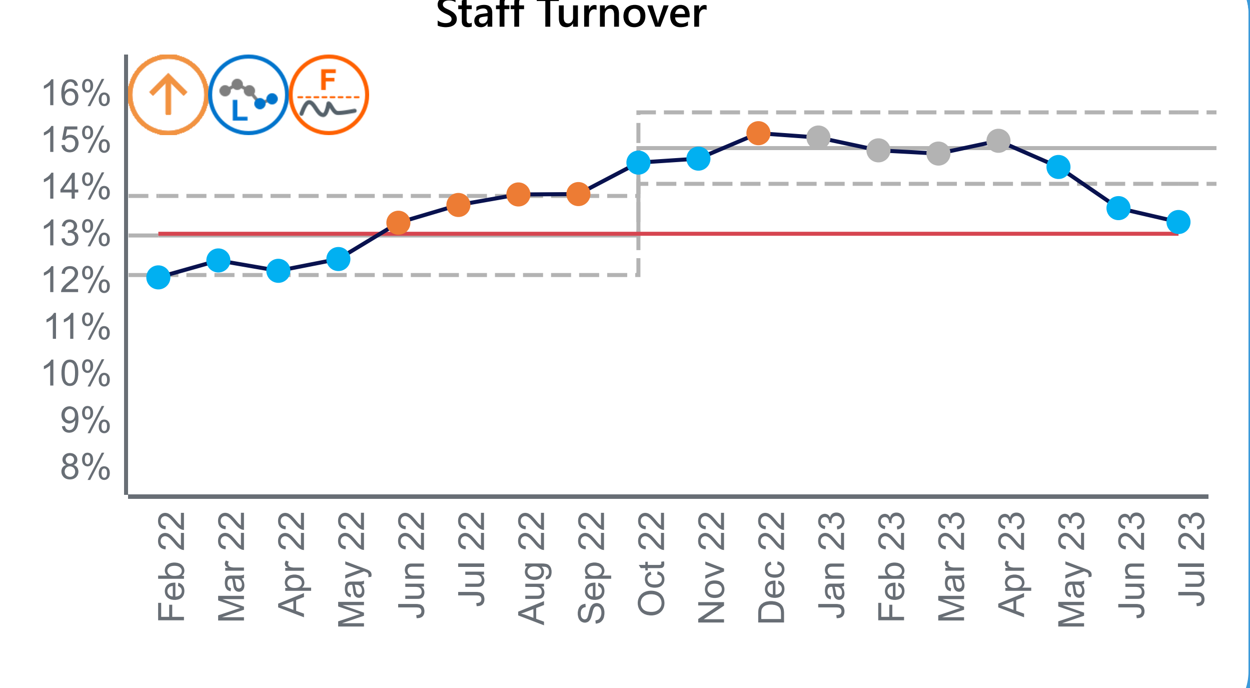
Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

NA

Staff Turnover



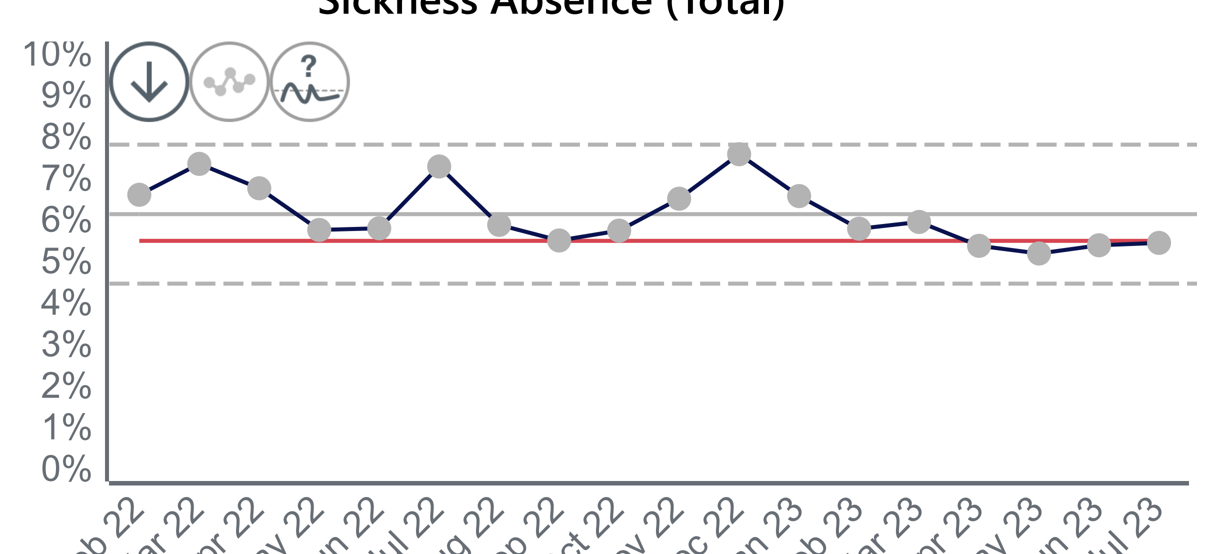
Technical Analysis:

Staff Turnover has demonstrated special cause varation, reducing to 13% which is the 3rd consecutive month with a reduction. This still remains a significant concern and this level of staff turnover is creating substantial risk for the Trust but July represents continued reduction and may signal the very early start of improvement.

Actions:

Turnover continues to be closely monitored as an area of concern, albeit the position has been stable since December 2023 and in this month has hit target of 13%. The task and finish group continue to address some immediate interventions in respect of data analysis and improved processes. More comprehensive and longer-term improvement plans are being

Sickness Absence (Total)

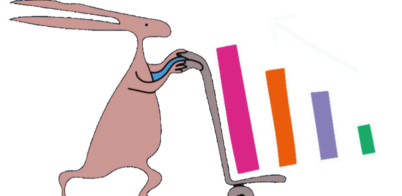


Technical Analysis:

Total sickness absence in July is 5.5% which is in line with the 5.5% target. An increase from June at 5.37%. July performance comprises STS at 1.74% and LTS at 3.77%. Still demonstrating common cause variation, consecutive months below the target.

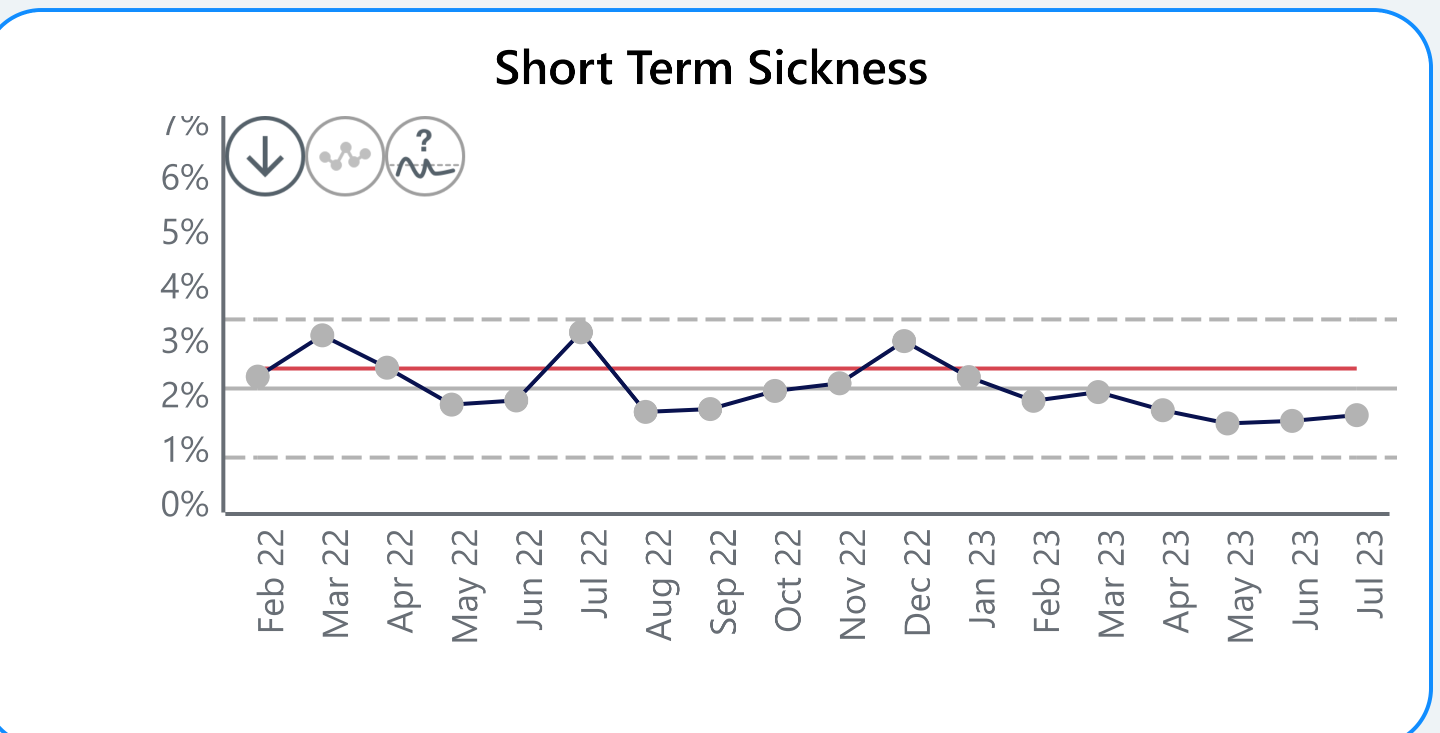
Actions:

Continued support is available to all managers managing sickness absence, including update training provision and designated HR support. Wellbeing will be further enhanced through the wellbeing workstream of the people plan. Improvements in absence levels have been apparent month on month over the last 4 months.

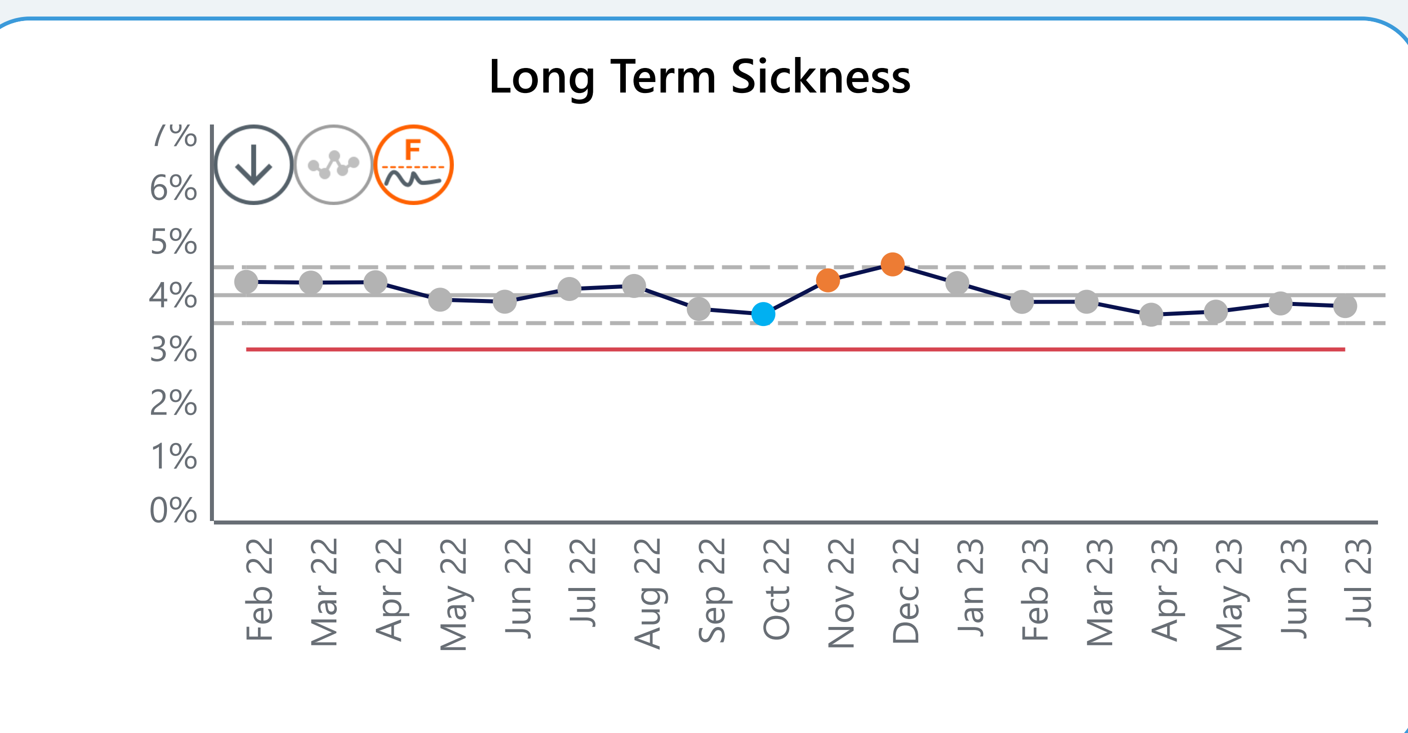


Well Led - Supporting Our People - Watch Metrics

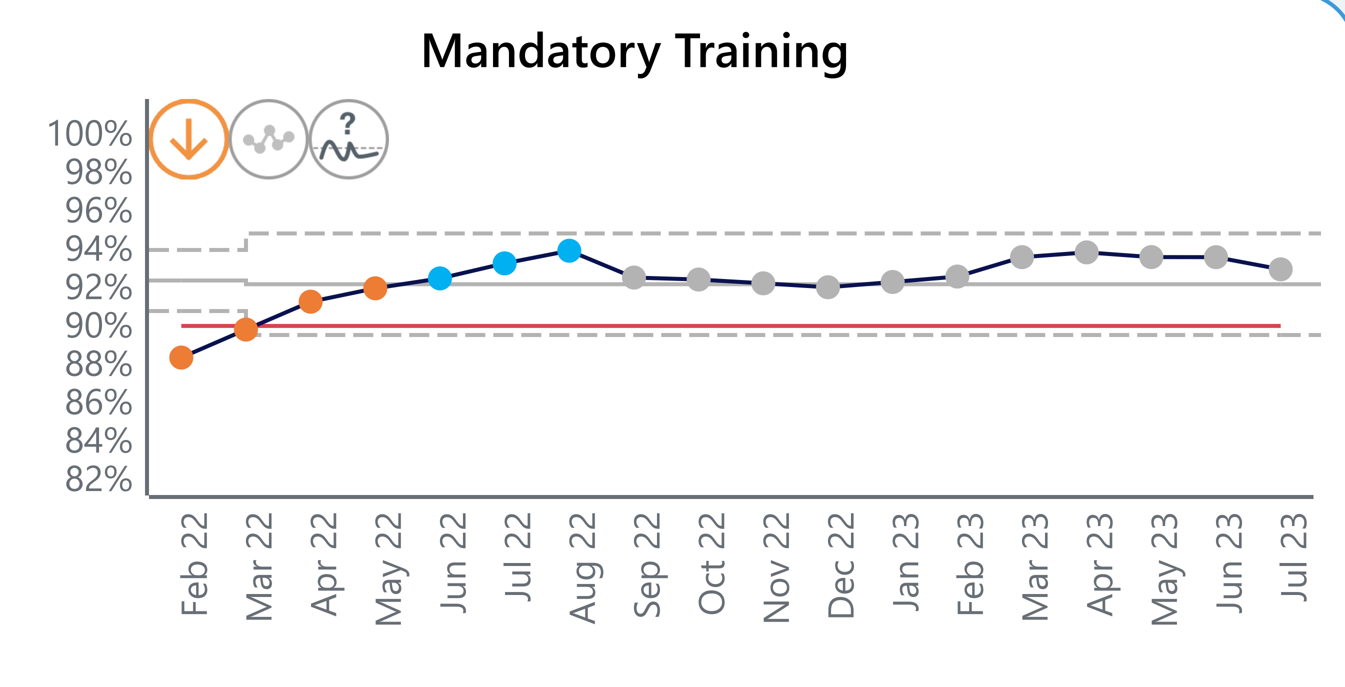
Short Term Sickness



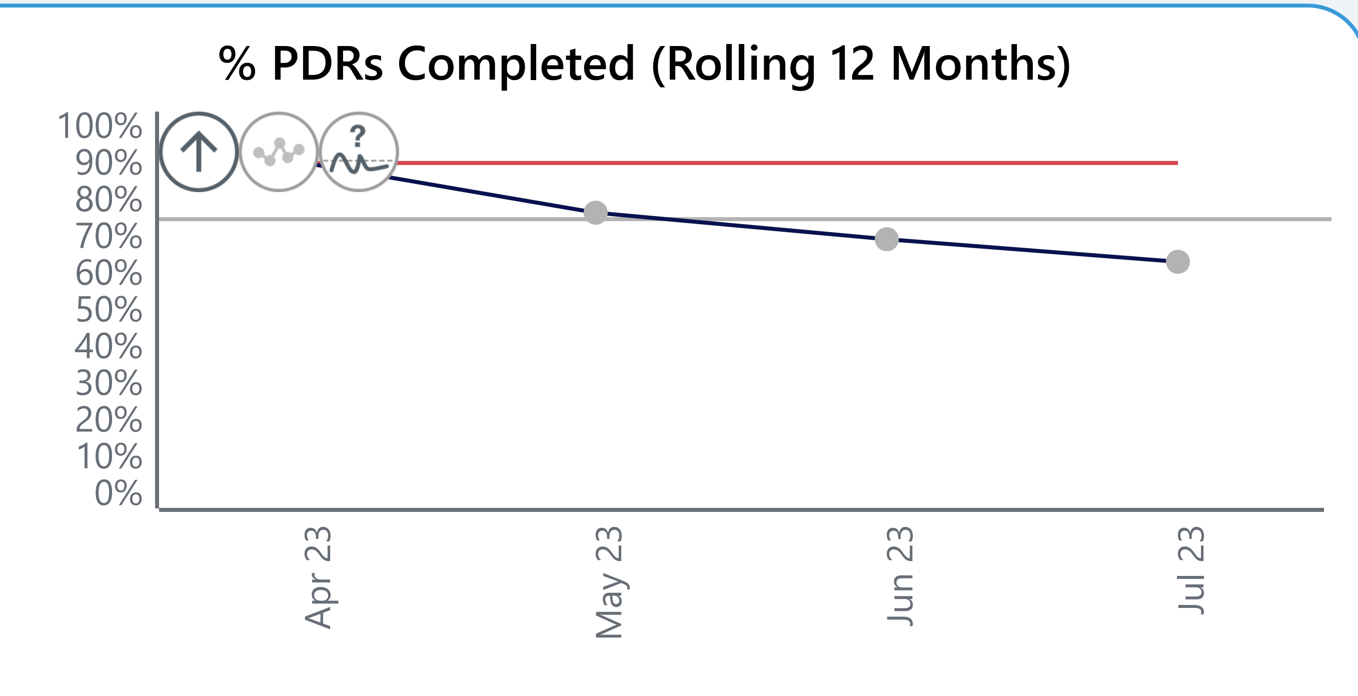
Long Term Sickness



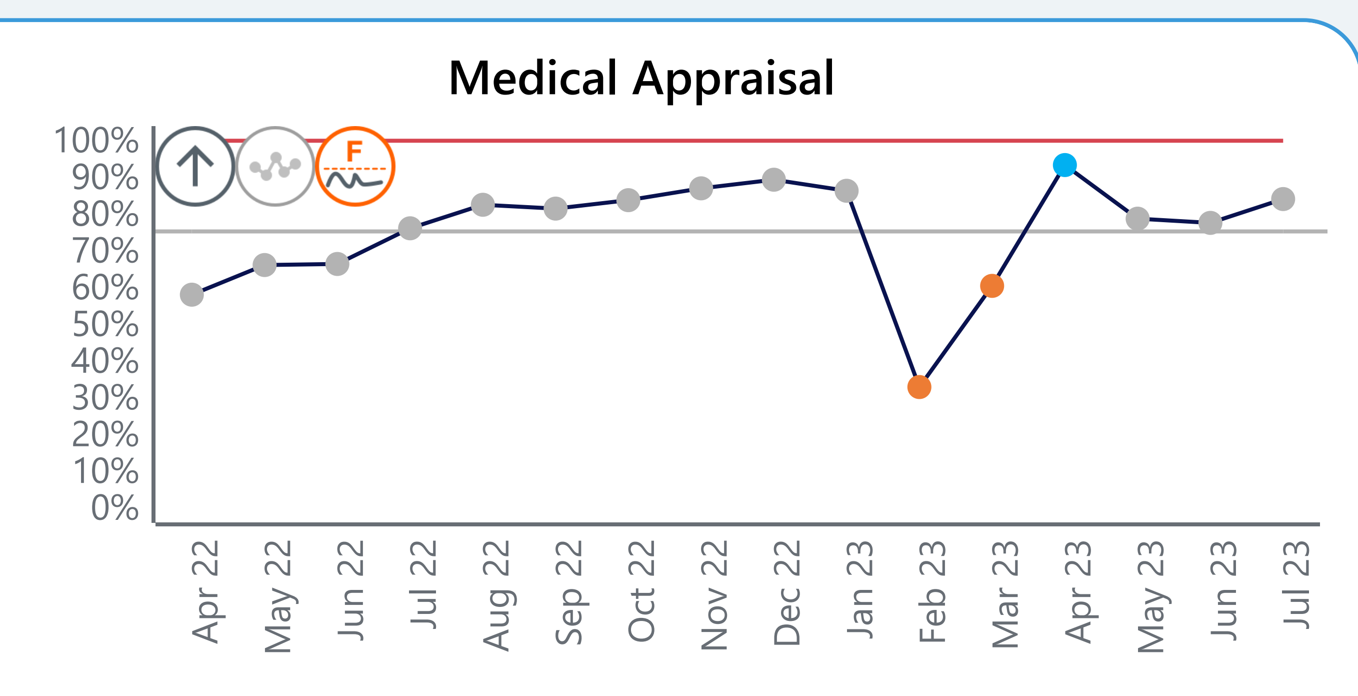
Mandatory Training



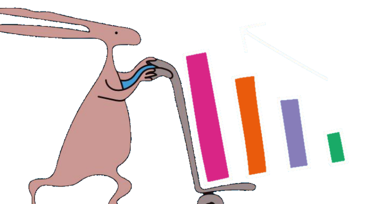
% PDRs Completed (Rolling 12 Months)



Medical Appraisal



Staff movement / Churn rate - In Development



Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

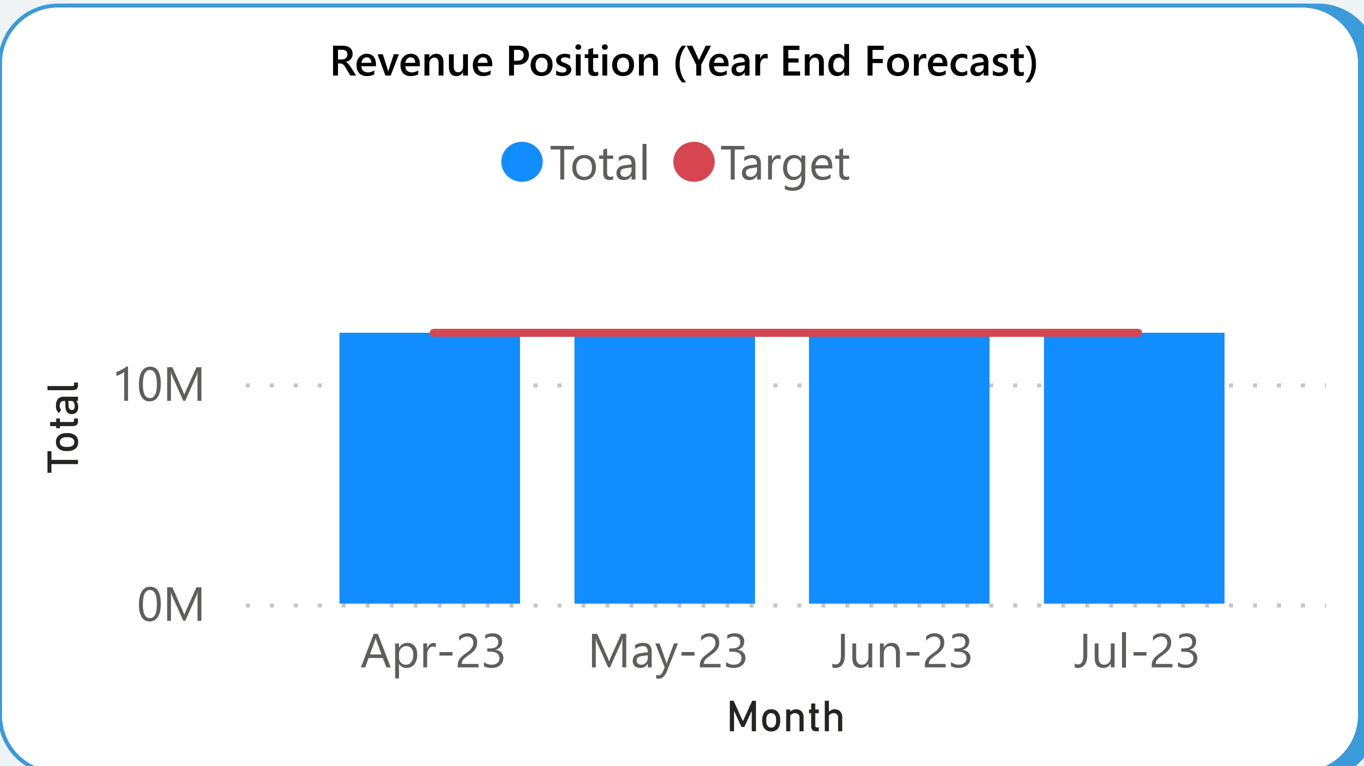
For July (M4), the Trust is reporting a small surplus of £9k in month (£1.5m deficit ytd) which is in line with plan. Forecasting to achieve £12.3m surplus subject to CIP risk & activity levels. CIP £1.2m behind plan ytd. Overall £6.3m CIP has been transacted with £6.2m in progress. Gap of £5.2m but includes £3.5m transformation schemes. Cash has remained high in line with plan & capital largely in line with expectations.

Areas of Concern:

CIP gap closing in year but transformational schemes still being worked up and represents a high proportion of the unidentified target. Challenging £12.3m control total surplus plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets.

Forward Look (with actions)

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

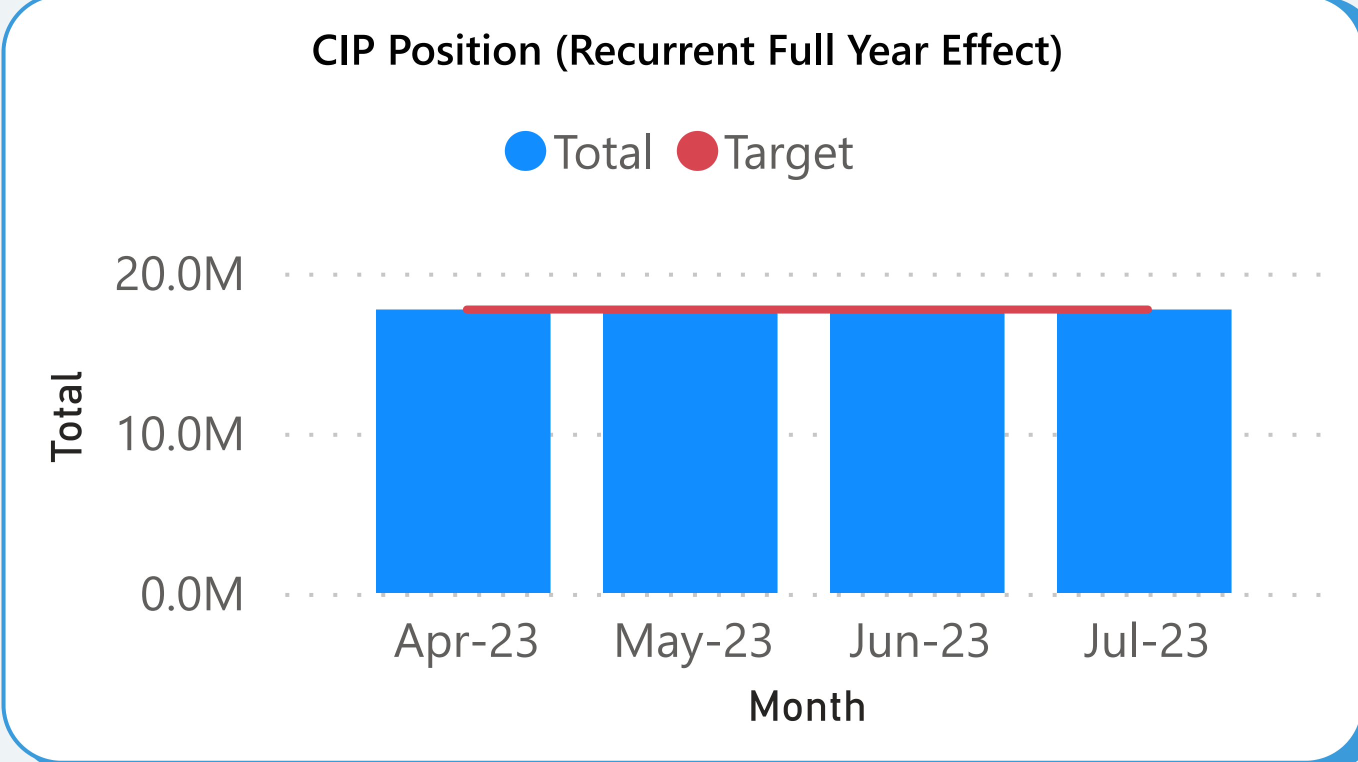


Technical Analysis:

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

Actions:

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

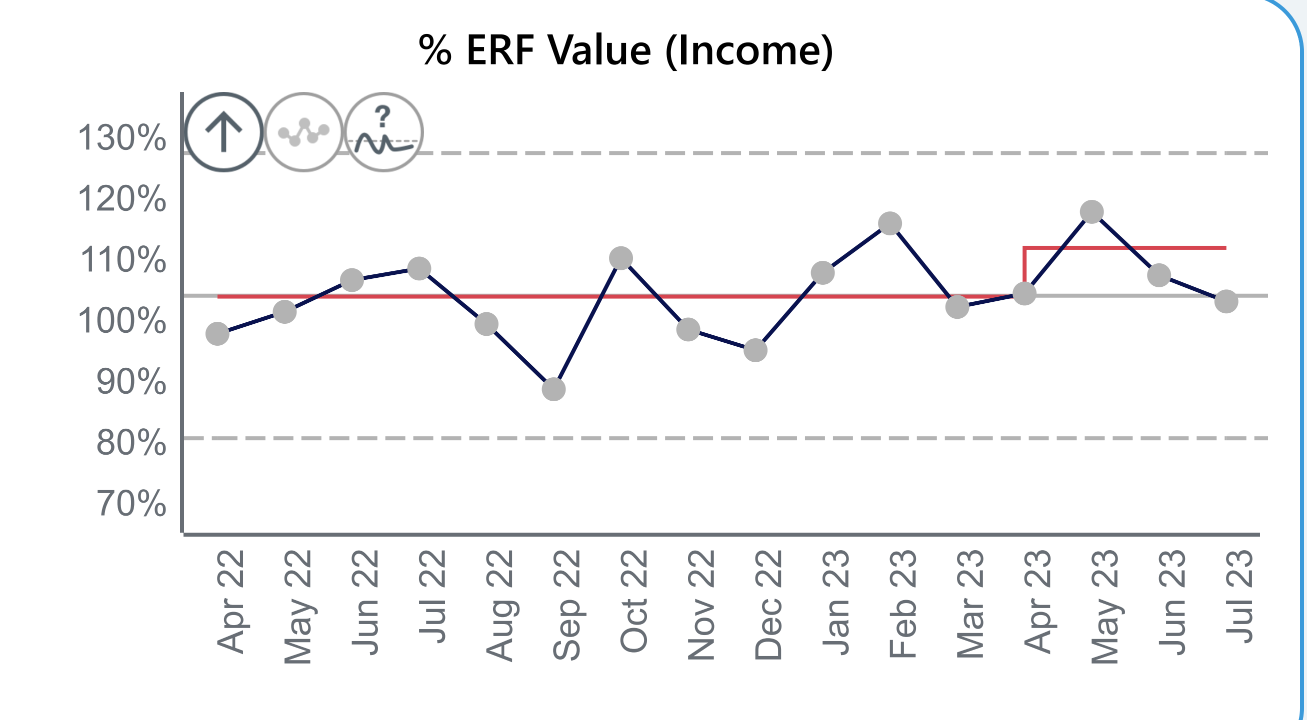


Technical Analysis:

Jul performance estimated at 103.2%. YTD performance estimated at 108.3%.

Actions:

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

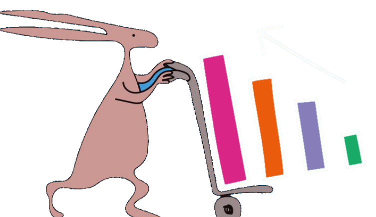


Technical Analysis:

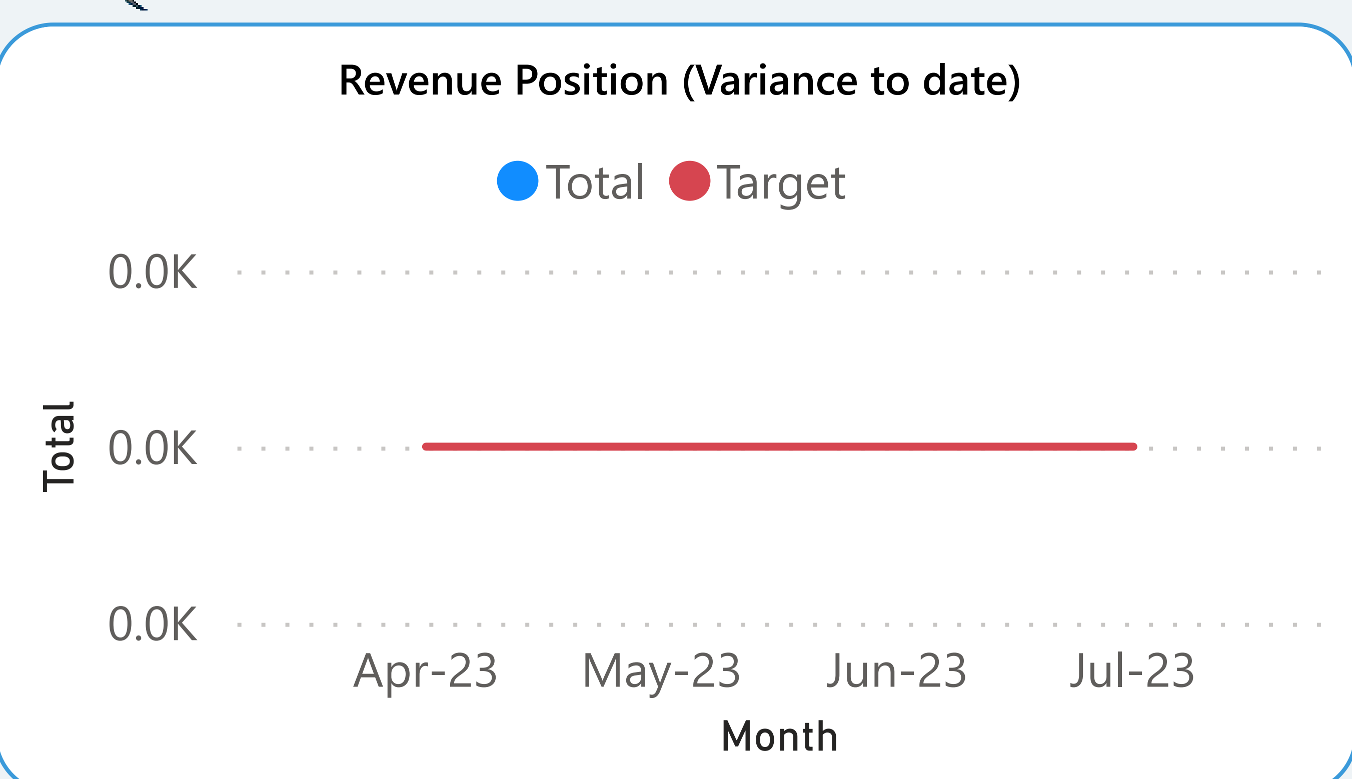
In year CIP identified and in progress is £12.5m. Of this, £5.7m is recurrent.

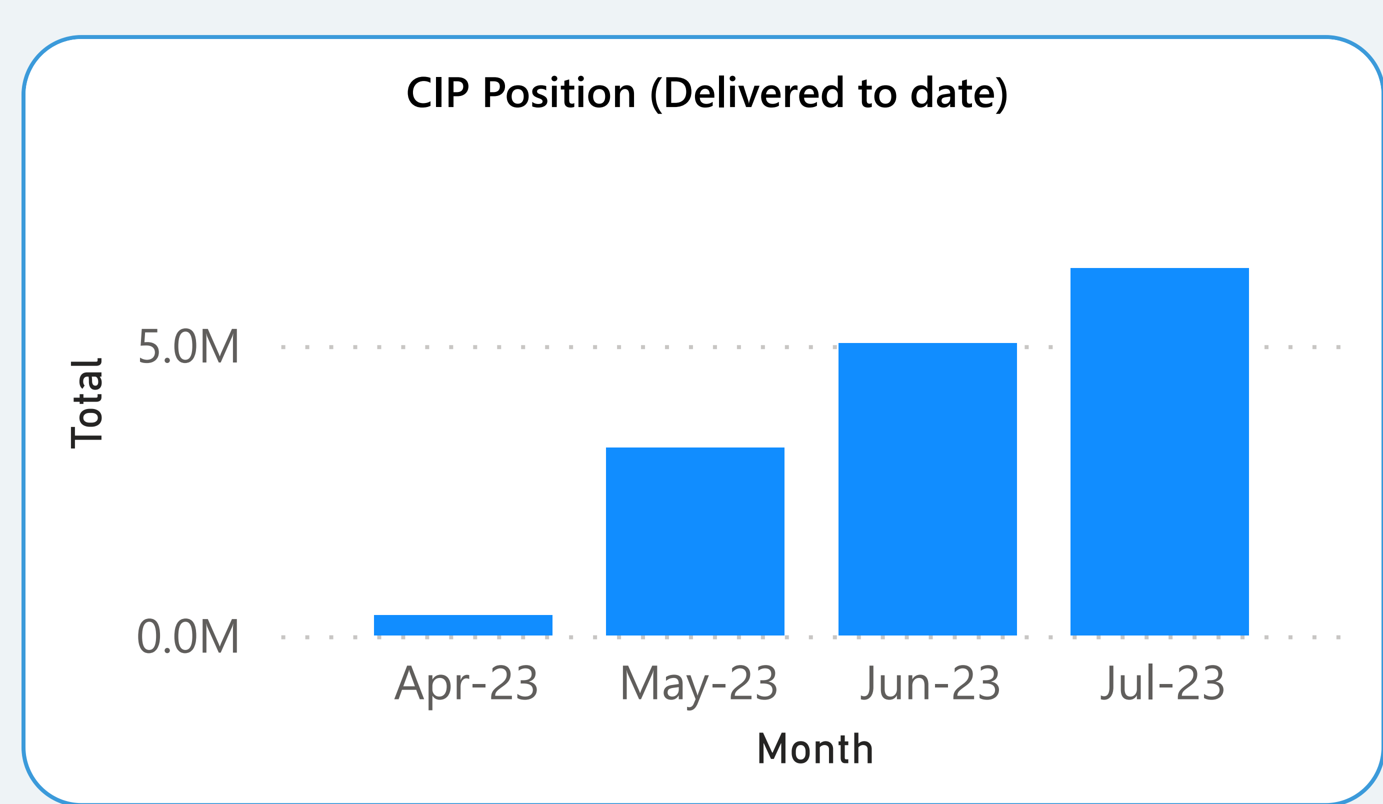
Actions:

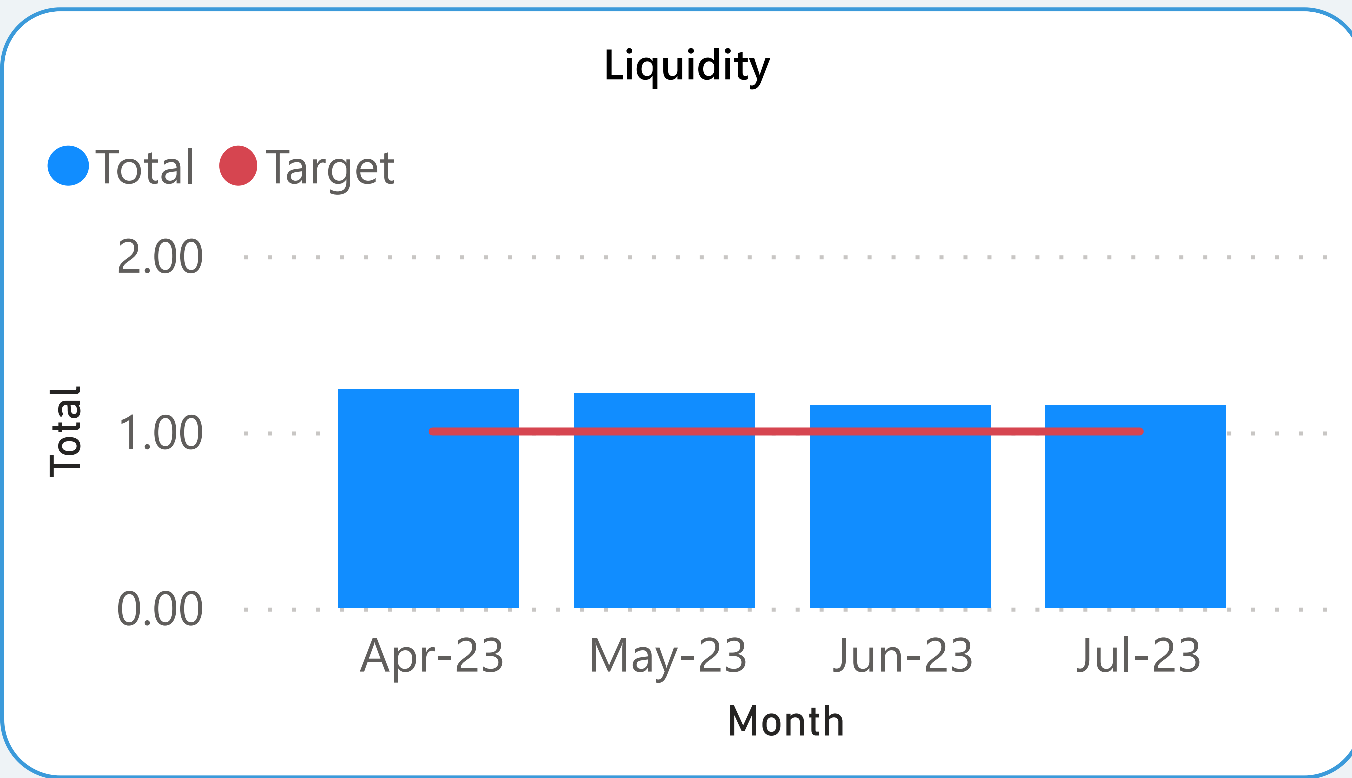
Support required with exec leads and transformation to identify the large scale opportunities through the Trust Strategic Initiatives session. Divisions have since M4 reporting now identified plans to meet their gap in full.

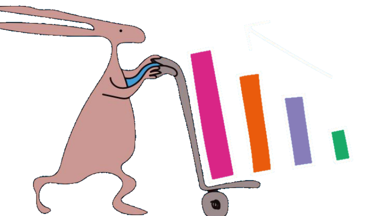


Smartest Ways of Working - Financial Sustainability: Well Led - Watch Metrics









Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

• Risk reporting continues to be fully embedded with In Phase.14 new risk reported in July 23: a similar picture of new reported risk when using Ullyses. • Ongoing support provision in place via divisional governance and corporate governance teams

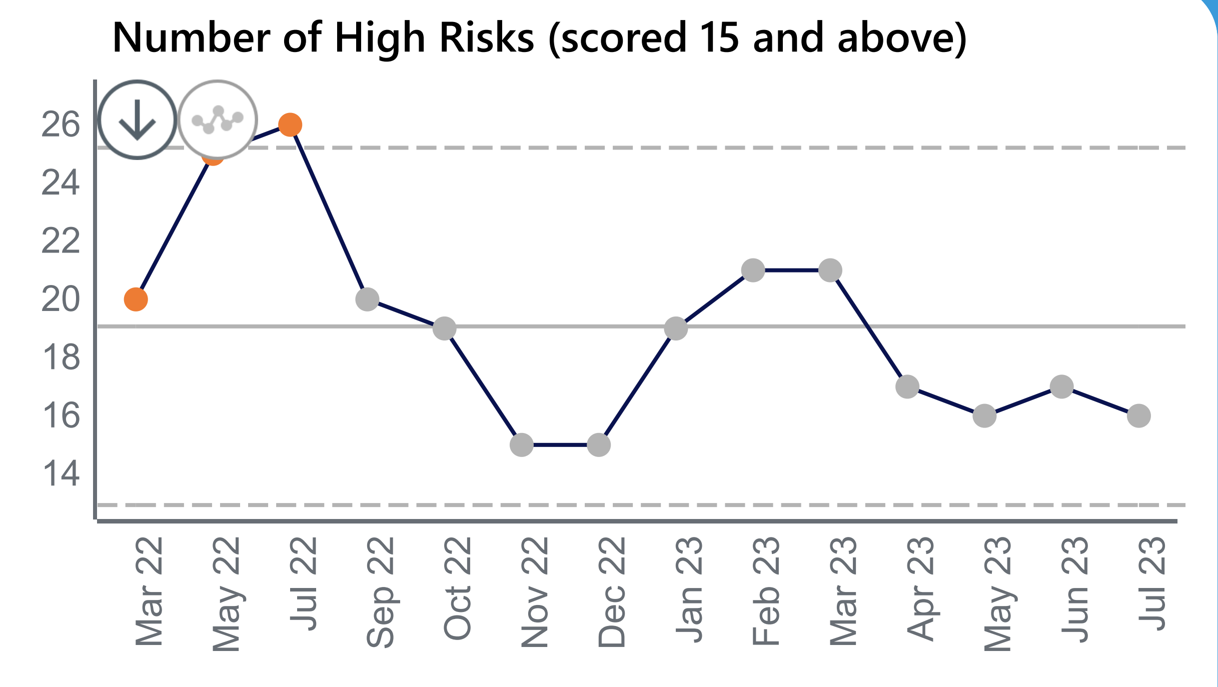
Areas of Concern:

• There remains no automatic notification for upcoming/overdue risk reviews via InPhase system-Escalted to InPhase project Board and Trust Execs. • Reporting continues to be a challenge.IT analyist supporting AHCT/LHCH Teams with reporting requirements to ensure reports meet the expected standards but continues to be problematic. • Risk access- Issues raised regarding the ability to add/edit controls and actions.Escalted to InPhase and system fix implemented • All above added to risk register No 22 score 3x3 =9.Escalated to Trust execs

Forward Look (with actions)

• Continue with support provision via risk oversight meetings/1;1 as required. • Risk 22 remains open with appropriate mitigations in place • Continue to work closely with BI/Analytics on report functionality.

Number of High Risks (scored 15 and above)



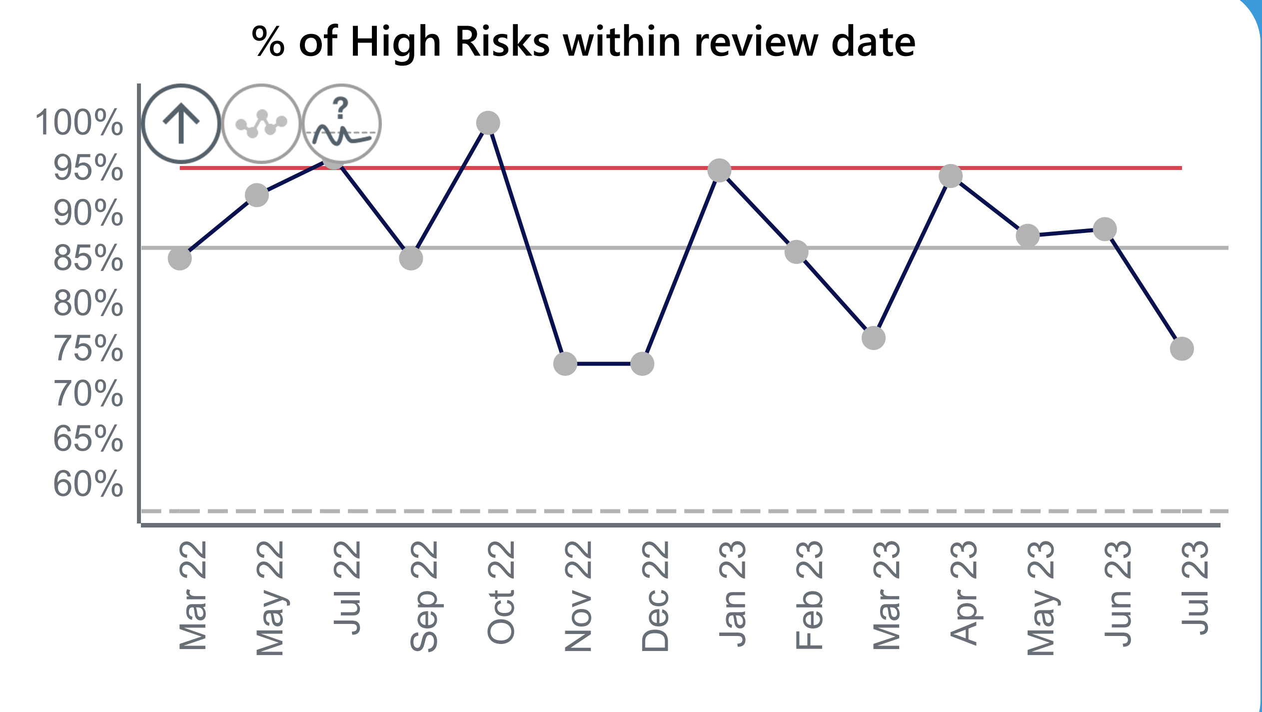
Technical Analysis:

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

Actions:

16 High Risks on register at the end of July 23. Figure remains stable with all risks now being managed via InPhase.

% of High Risks within review date

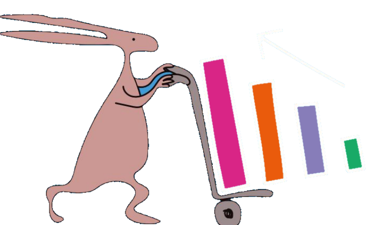


Technical Analysis:

Compliance of reviewing High risks within date is variable, with 4/16 risks overdue at the end of July. Action is required to ensure consistent compliance with the 95% target.

Actions:

75% of high risks within expected review date (4 overdue which have since been updated)



Smartest Ways of Working - AlderC@re - Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

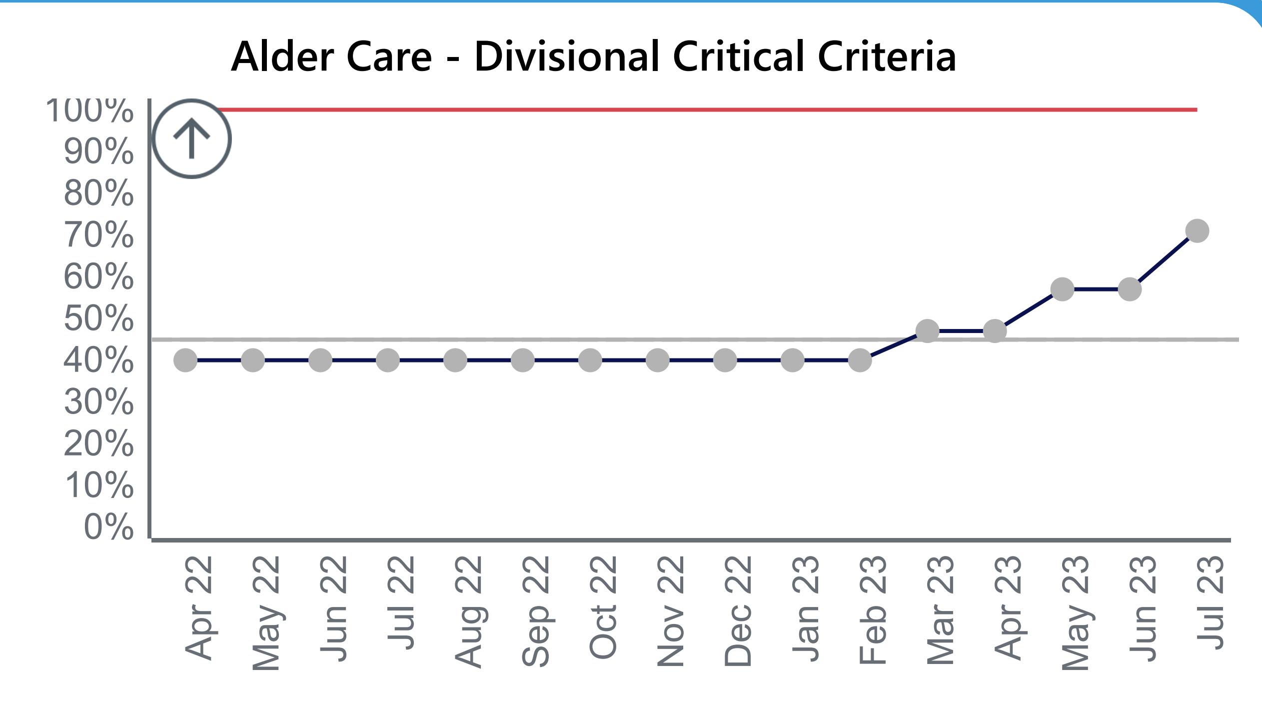
• Gateway 4 reported to AlderCare Programme Board 1st August 2023 • Training underway with over 900 attendees. • Detailed go live planning in place with weekly meeting of Operations / Clinical / Programme and Exec SROs

Areas of Concern:

• Completion of AlderCare build to time and quality still contains risks and is being monitored closely • Reporting workstream recovery plan in place and working with Meditech to resolve technical issues

Forward Look (with actions)

• Go / no go process to start in August 2023 • NHSE external readiness review to complete in August 2023 • Dress rehearsal activities in readiness for go live during August 2023

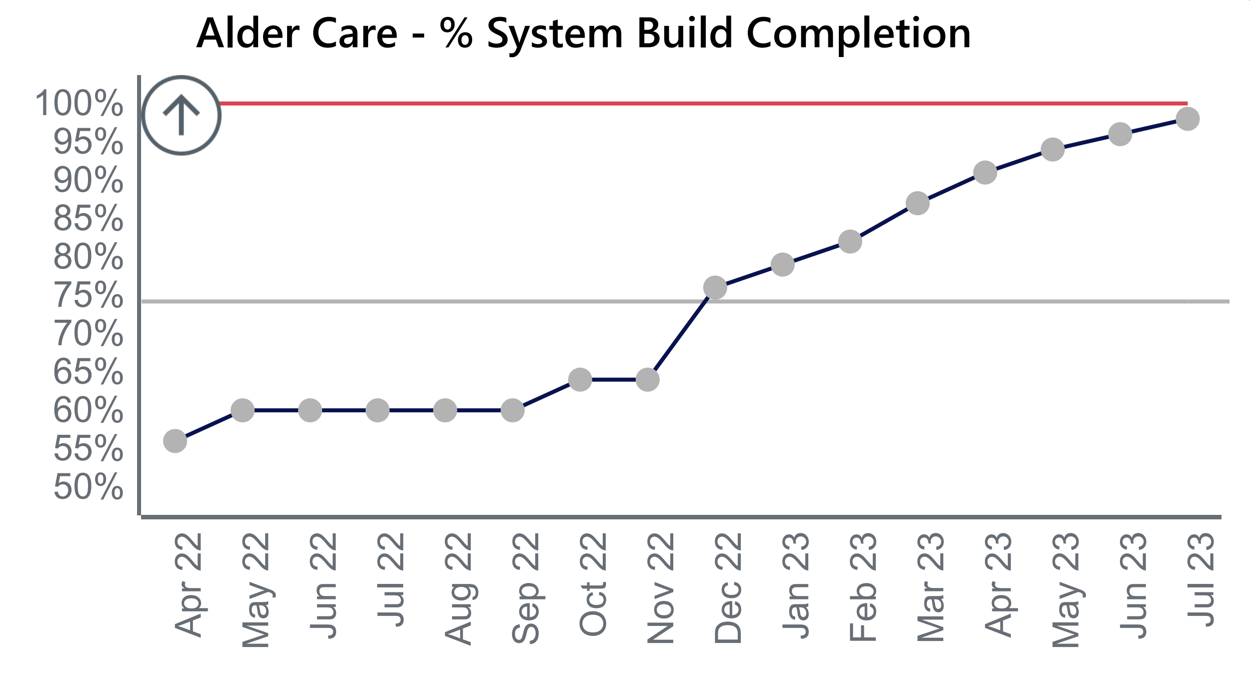


Technical Analysis:

10/14 critical criteria complete. Remainder awaiting system build, or resolution of P1 issues. "WHO checklist" removed as criteria for AlderCare go live.

Actions:

1) Complete process documentation and sign off mechanisms for remaining items.
2) Sign off final P1 issues following delivery from Meditech.

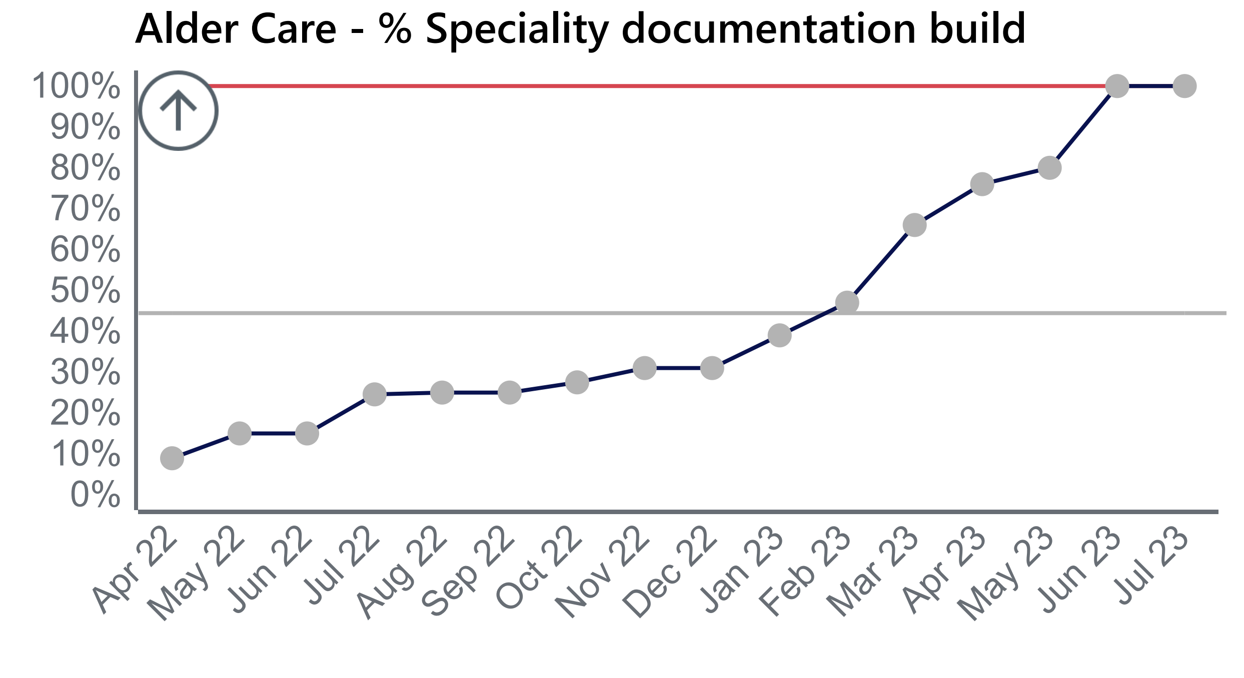


Technical Analysis:

This metric monitors build across all workstreams. Build completion continues to increase in line with individual trajectories. Majority of core build now complete and workstreams in wash up phase.

Actions:

1) Finalise wash up actions from build.
2) Complete final stage of EPMA (96%).
3) Action plan for completing Gateway items ahead of go / no go decisions.

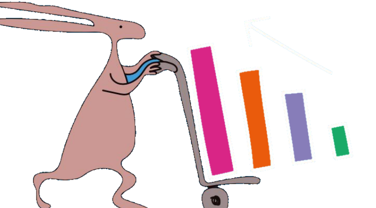


Technical Analysis:

100% of core specialty documents have now been completed. Programme Team working with Divisions to continue sign off process which is leading to some changes during a "wash up" phase.

Actions:

1) Continue build (80%) and sign off process (53%).
2) Work with divisions to sign off Specialty Packages build.



Collaborating for CYP - Green Plan: Well Led

SRO: Mark Flanagan, Director of Marketing and Communications

Highlights:

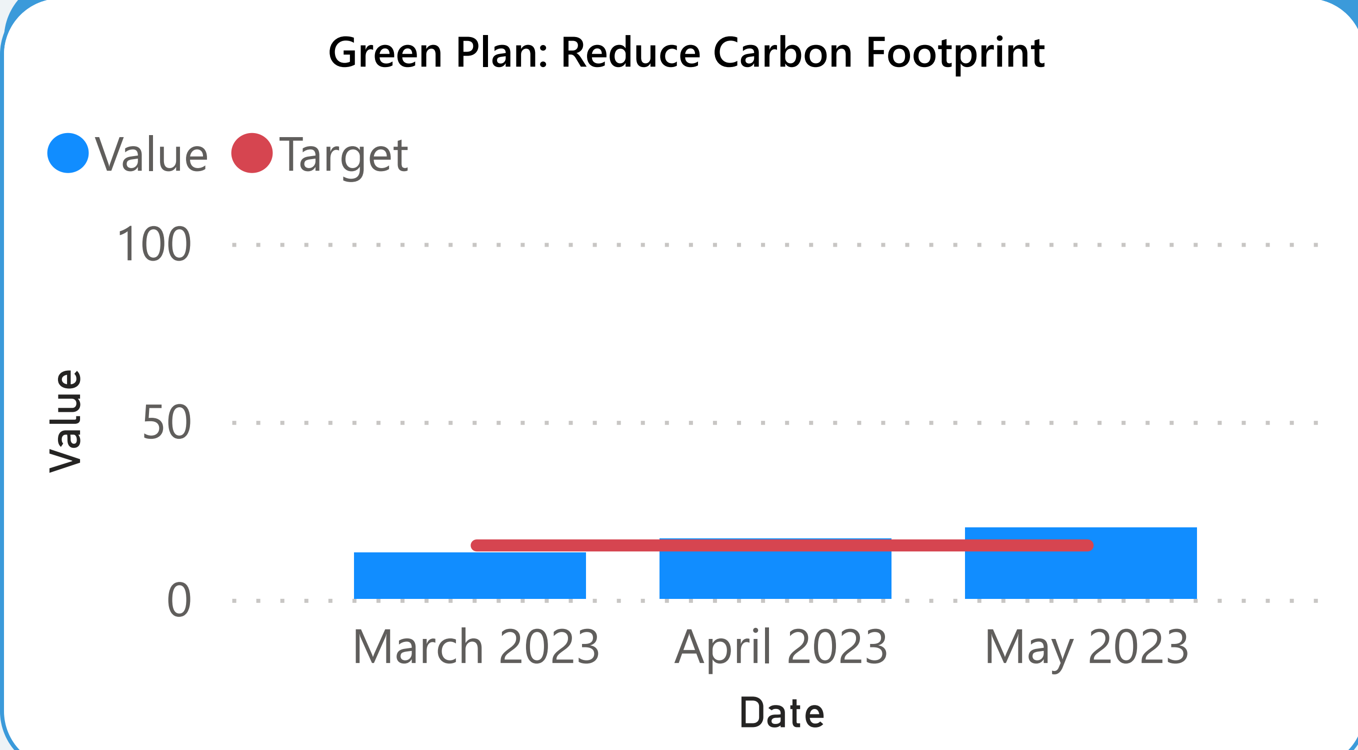
Shortlisted for HSJ award. Won small grant from "Clean air fund" with the charity.

Areas of Concern:

Energy performance has deteriorated and basic cause not yet defined.

Forward Look (with actions)

Complete analysis of energy changes. Complete Clean Air plan. Complete CHP improvements.

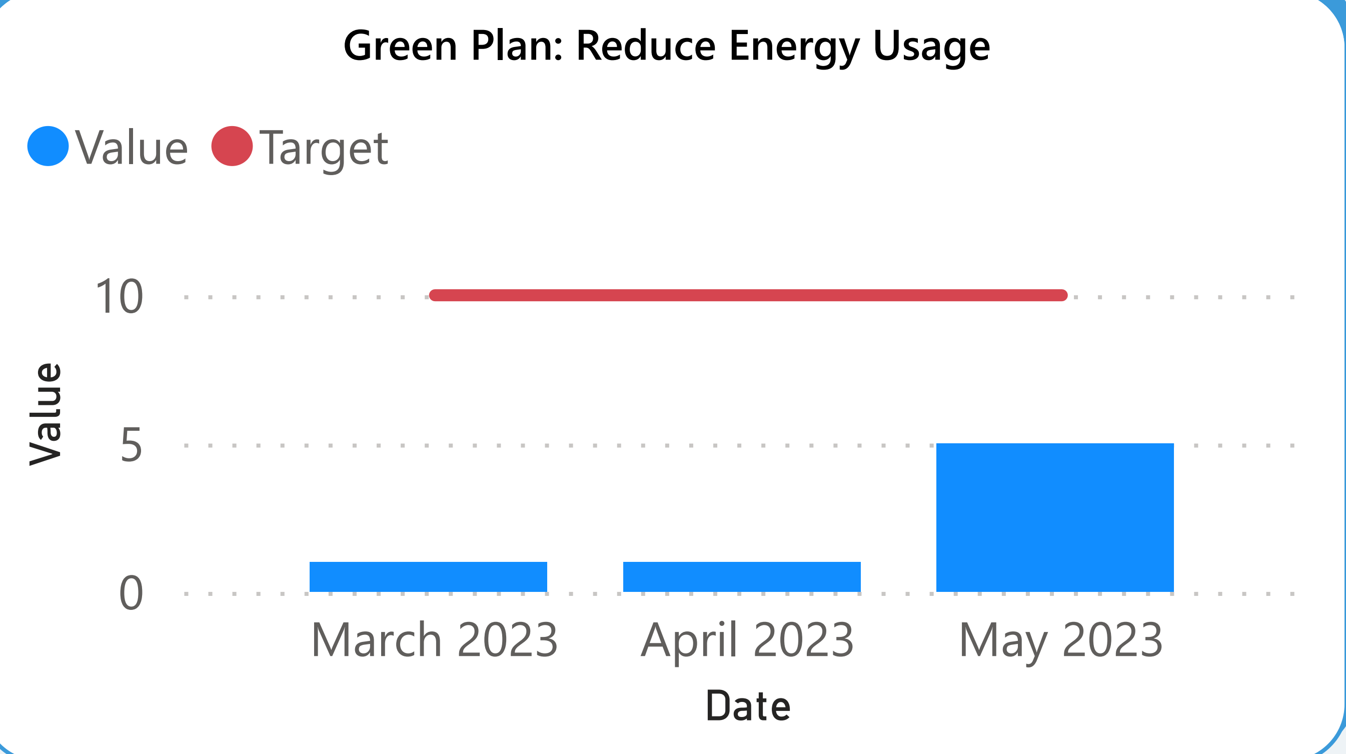


Technical Analysis:

Carbon increase driven by higher energy usage.

Actions:

LED and PV projects.



Technical Analysis:

Energy use nearly 10% higher vs 2022 driven by heating use.

CHP reliability at 60% vs target of 90%

Actions:

Complete analysis of energy use with MITIE. Join up with SPV works on water systems.

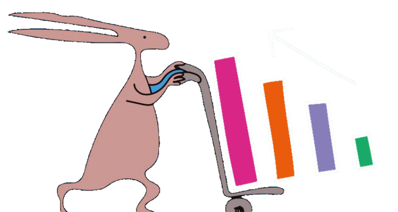
Complete CHP plan.

Technical Analysis:

Target to reduce waste with a cost saving of 50k

Actions:

Construction work for new compactor underway.



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Continued reduction in the longest waiting times in CAMHS (3 over 52 weeks at end July 2023) and forecast for zero over 52 week waits by end of August 2023. • Improvement in timeliness of Initial Health Assessments for children who are new into care, in line with agreed improvement plan (47% within 20 days once received by Alder Hey). • Non-recurrent investment in ASD and ADHD pathways agreed for 2023/24 • Strong financial performance at the end of Month 4. Division is forecast to deliver a £1m favorable variance with improvements in CIP delivery for M5 in line with agreed Divisional plan • Staff turnover continues to decrease and is now at same rate as same period last year (14%) • Sickness absence rates remain below 5% (4.7%) • 6% improvement in Was Not Brought Rate since April for specific clinical cohort (HCA clinics) • Improvement in FFT scores for percentage of people who would recommend outpatients to family and friends to 95% in July 2023. • Expanse readiness: 84% staff booked on training and 54% have attended.

Areas of Concern

• Number of clinic letters within 10 days of appointment remains a challenge but focus on those over 30 days has resulted in significant improvements in compliance with 9 over 30 days at the end of July. Focussed work with teams to address remaining areas of challenge. • Number of children and young people waiting over 65 weeks to completion of assessment for ASD and ADHD. Slight improvement since June but significantly above plan. • Continued challenges in WNB rates in CAMHS, specifically for Urgent choice appointments where young people are often offered multiple appointments in line with their triaged need. Specific project group established to address this need and a pilot transport scheme due to go live end of Q2. • There have been 3 breaches of routine Eating Disorder waiting time standard (referral to treatment within 28 days) in July. This was due to patient choice. • Increased number of formal complaints in July

Forward Look (with actions)

• Development of recruitment plan for ASD and ADHD in line with agreed investment and reprofiling of waiting time improvement plan (September 2023) • Mental Health recruitment plan in place and monitored monthly by Divisional Board • Strengthened controls established within Divisional recruitment panel including greater oversight of all additional activity requests (WLIs) to be in place 30 September 2023 • Plan for delivery of all PDRS will be developed and monitored through Divisional Board

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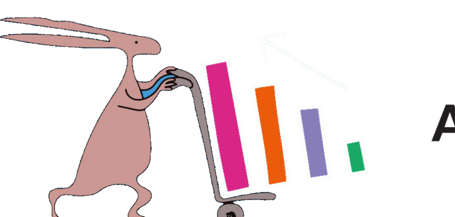
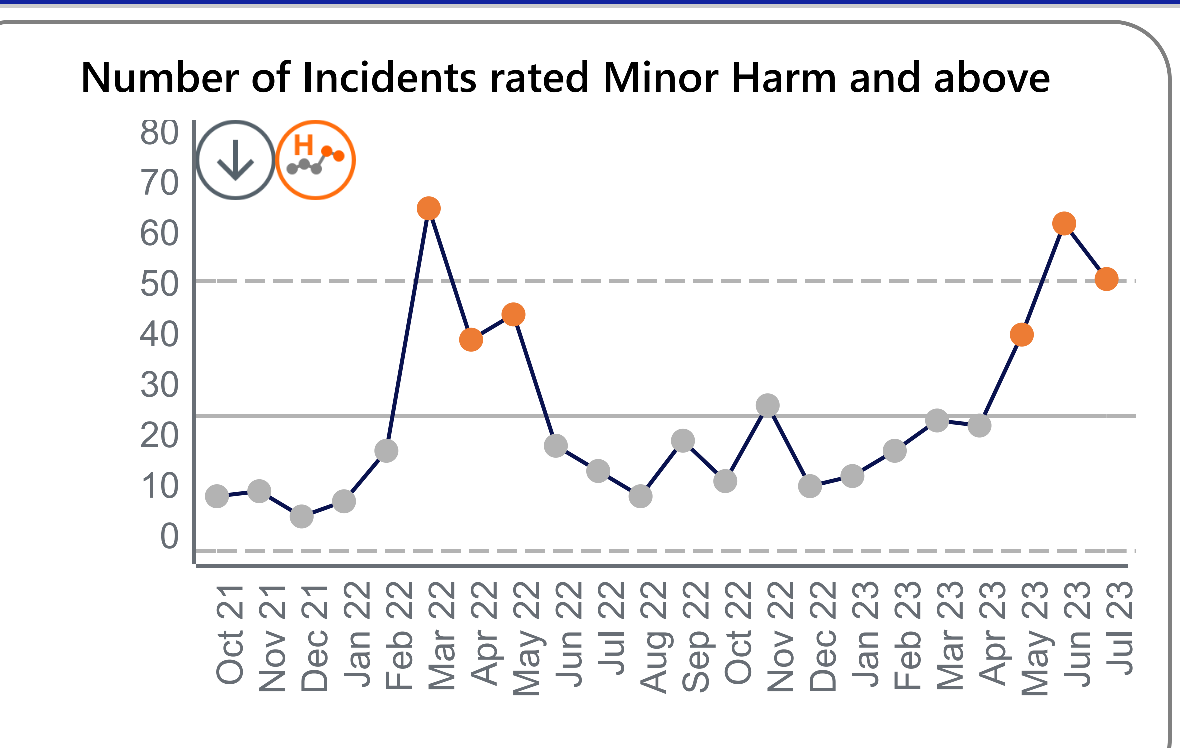
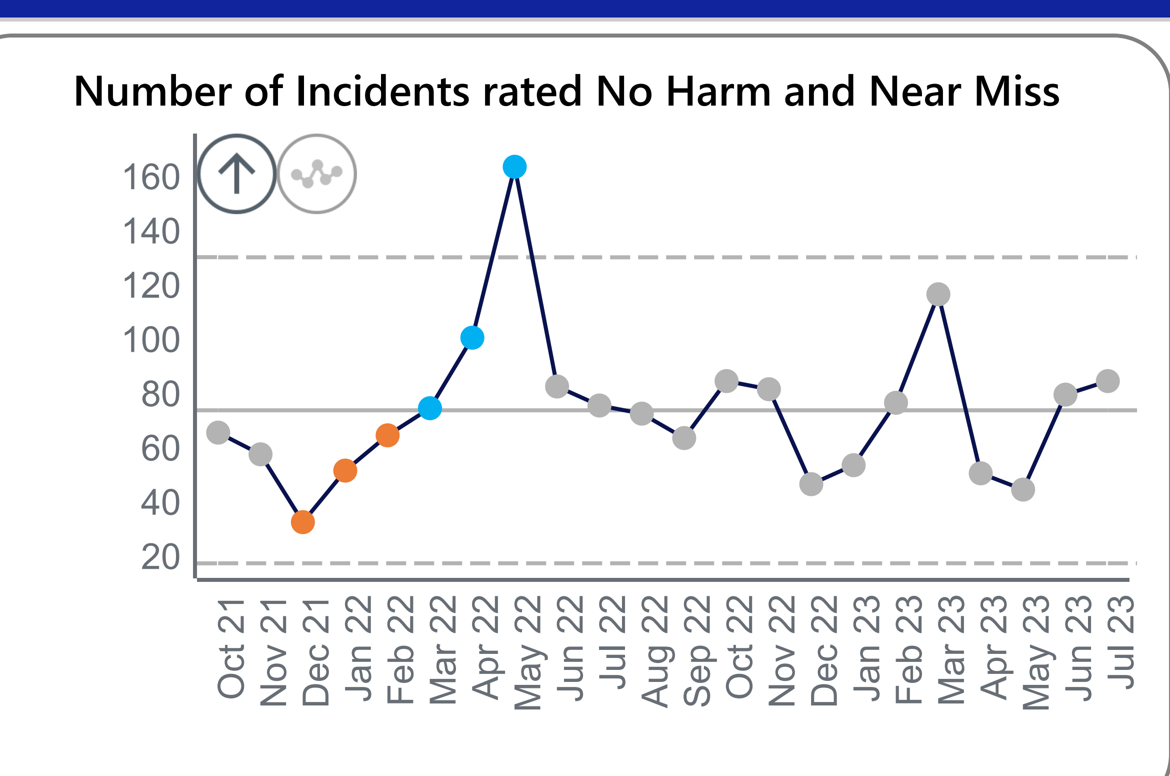
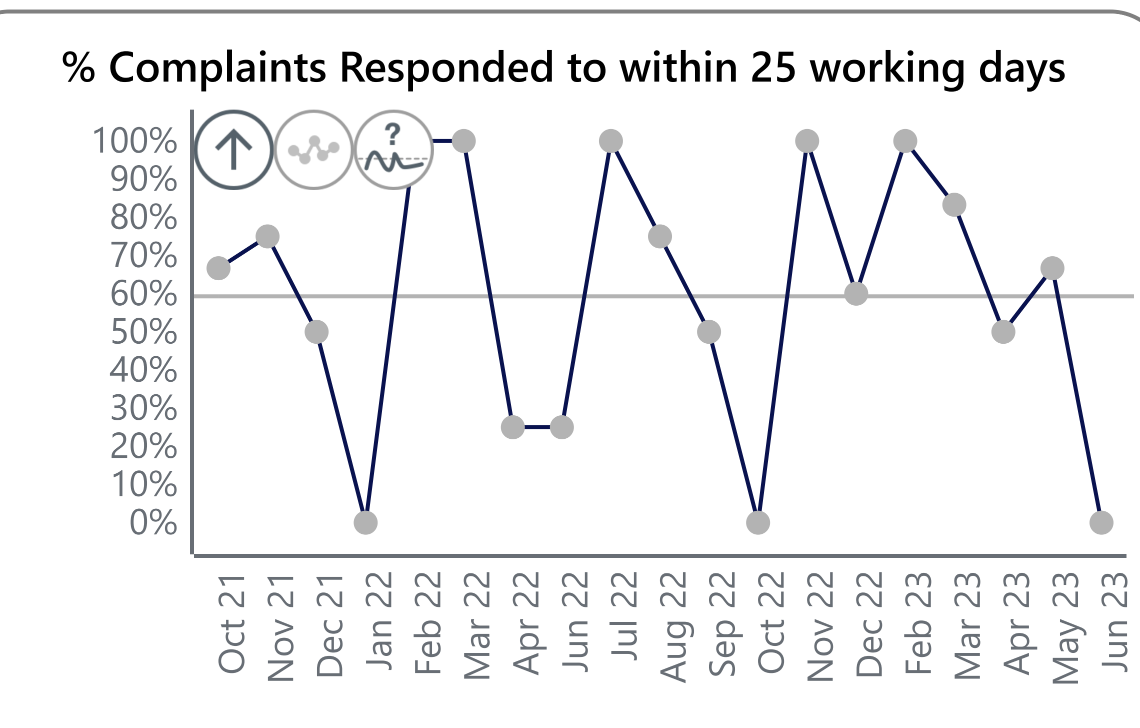
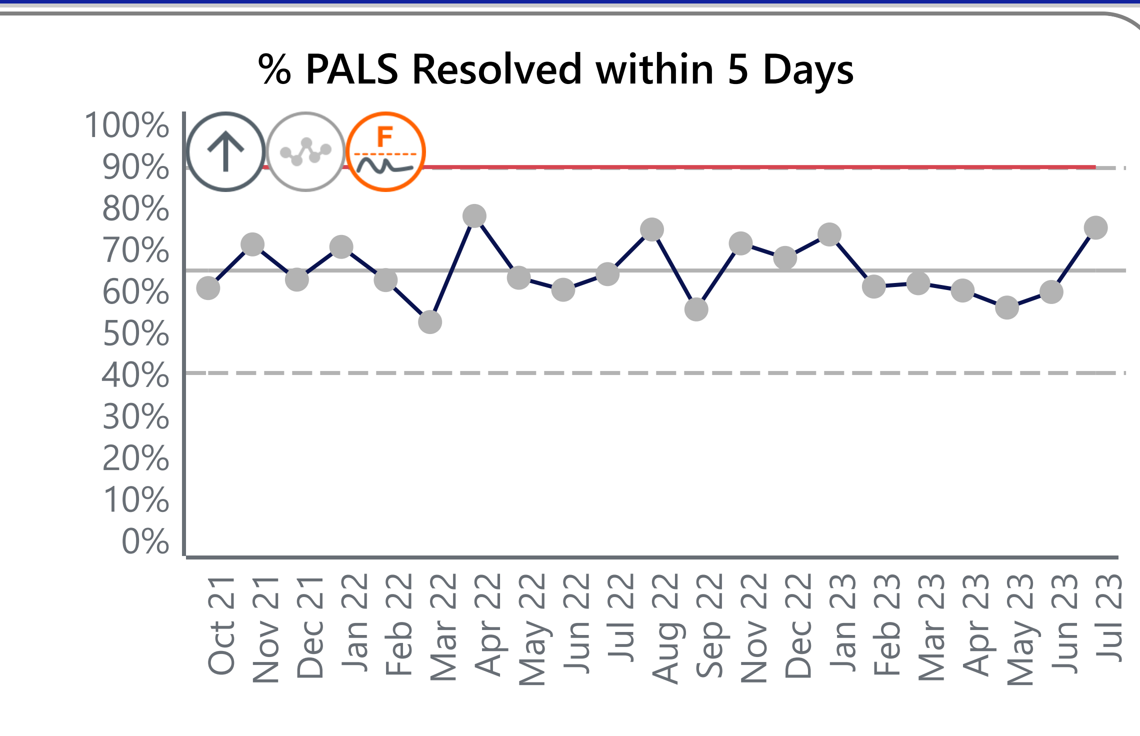


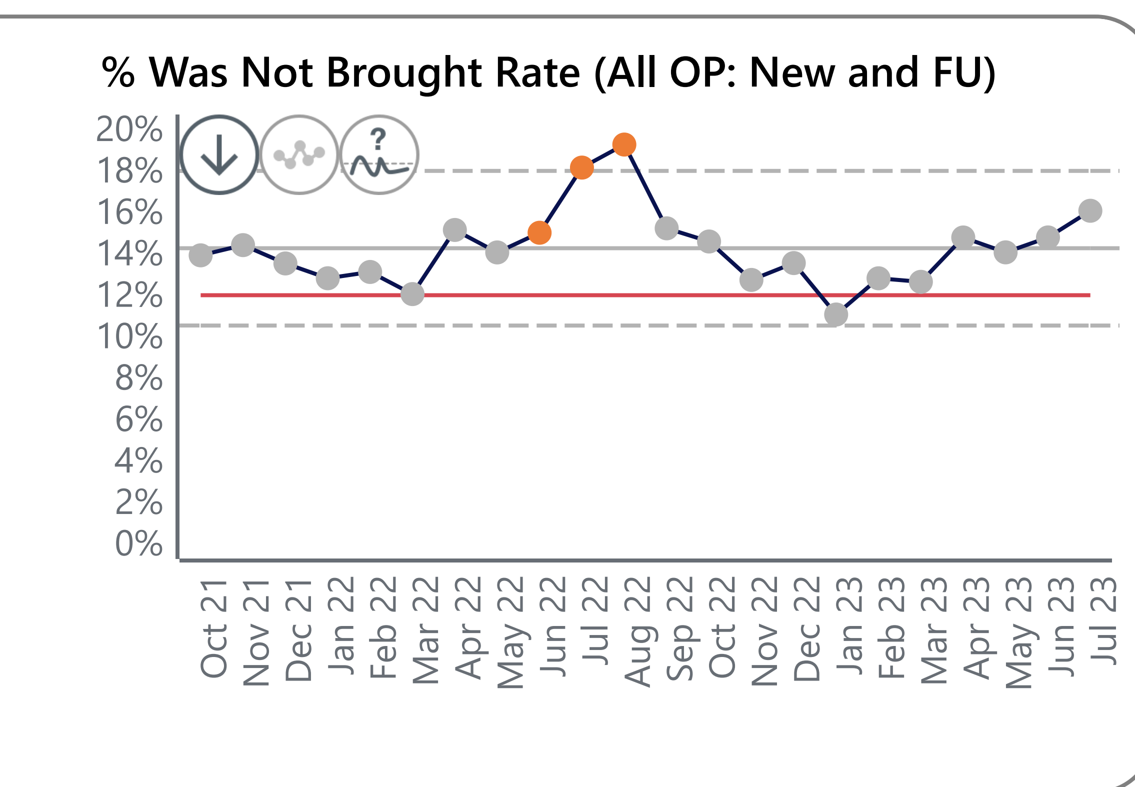
Divisional Performance Summary - Community & Mental Health

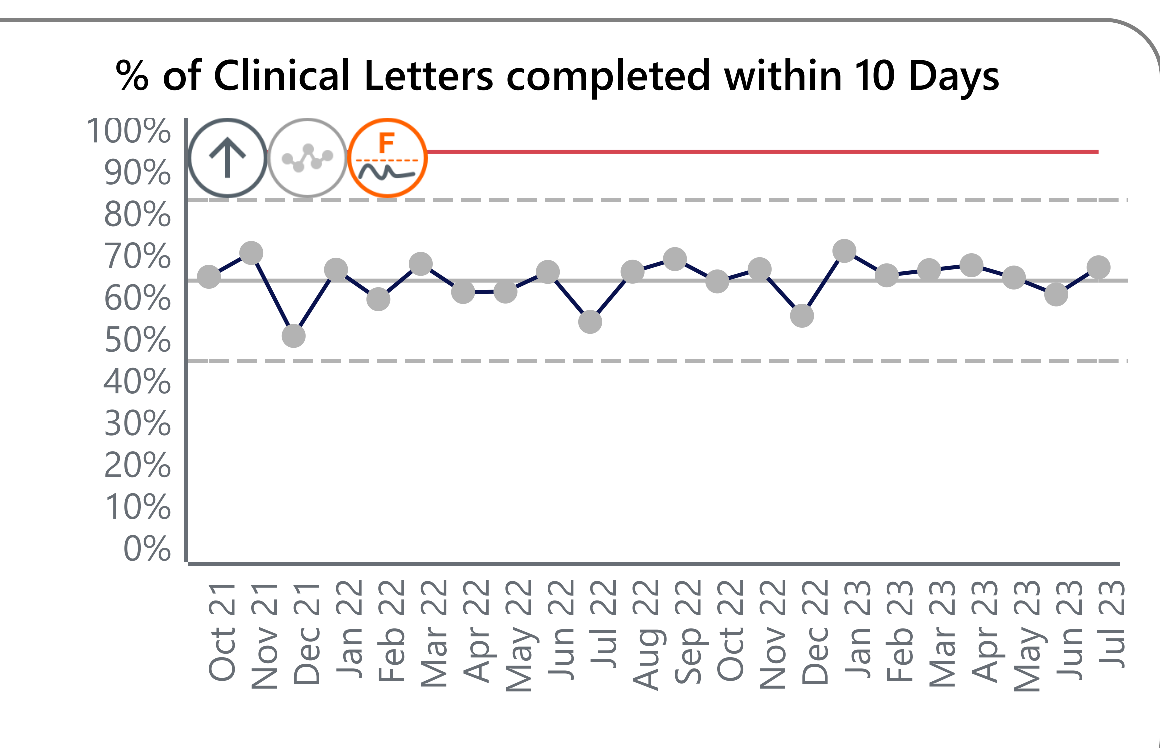


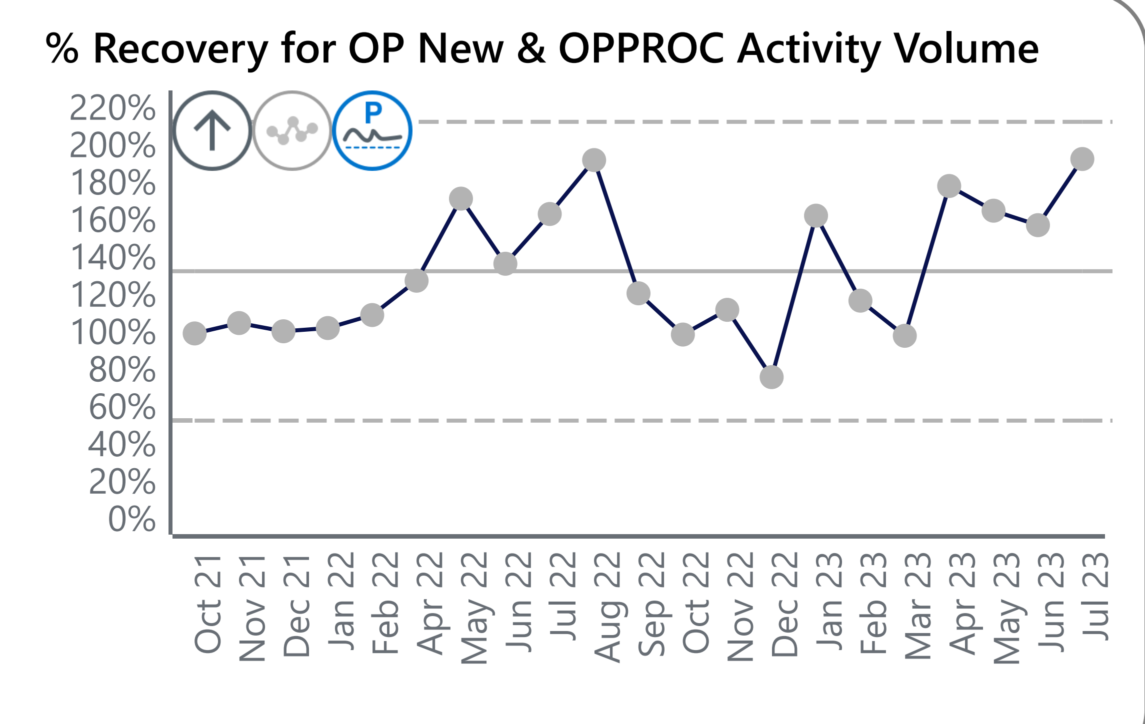


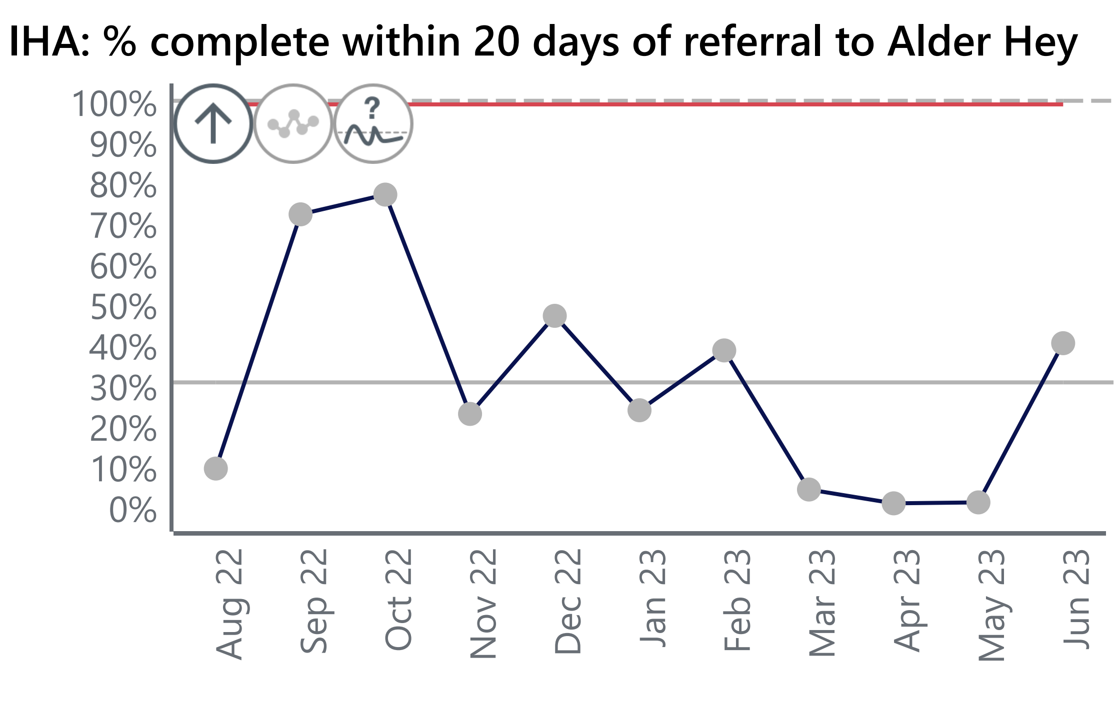


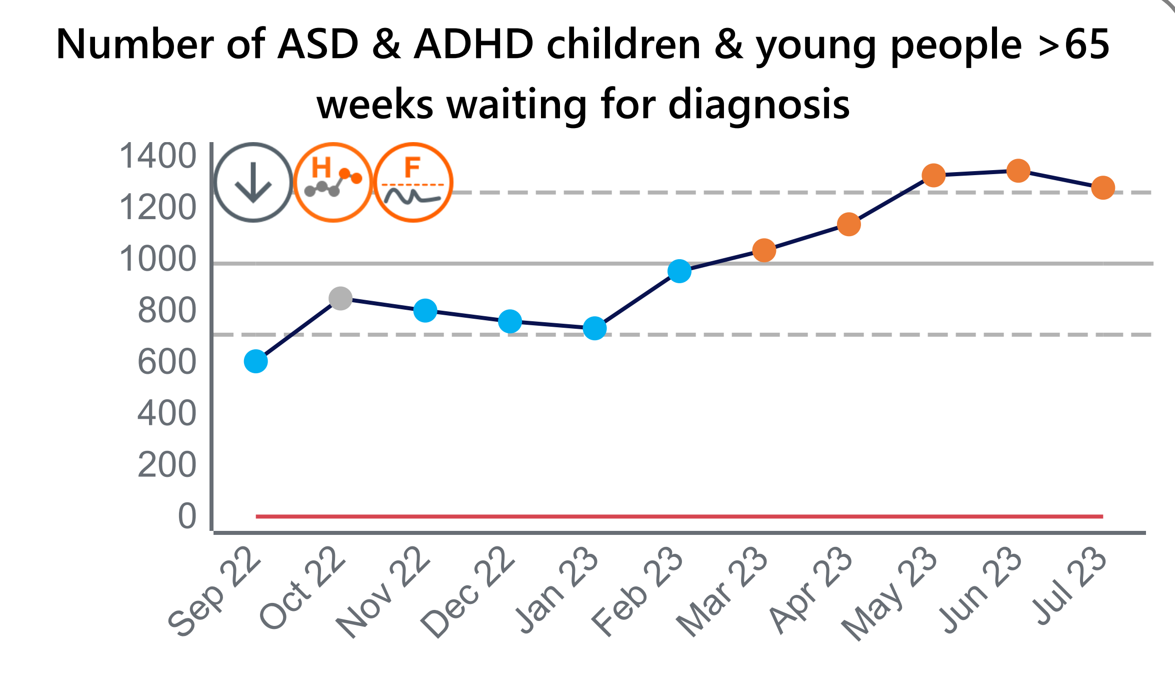


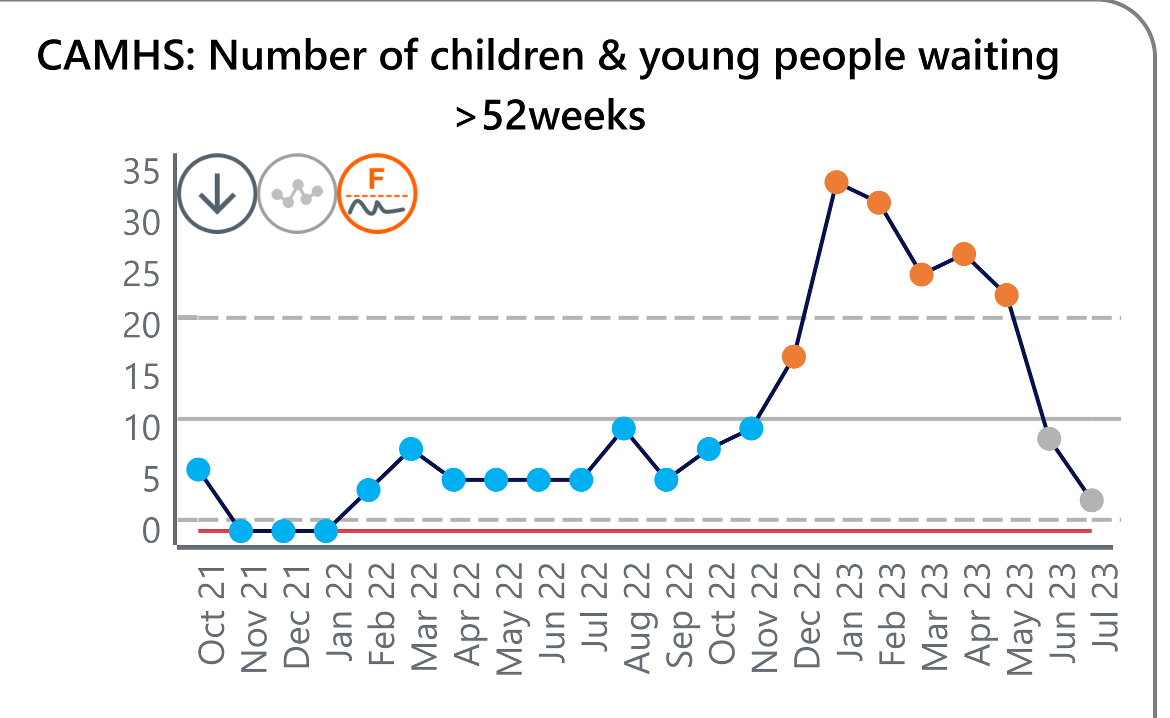


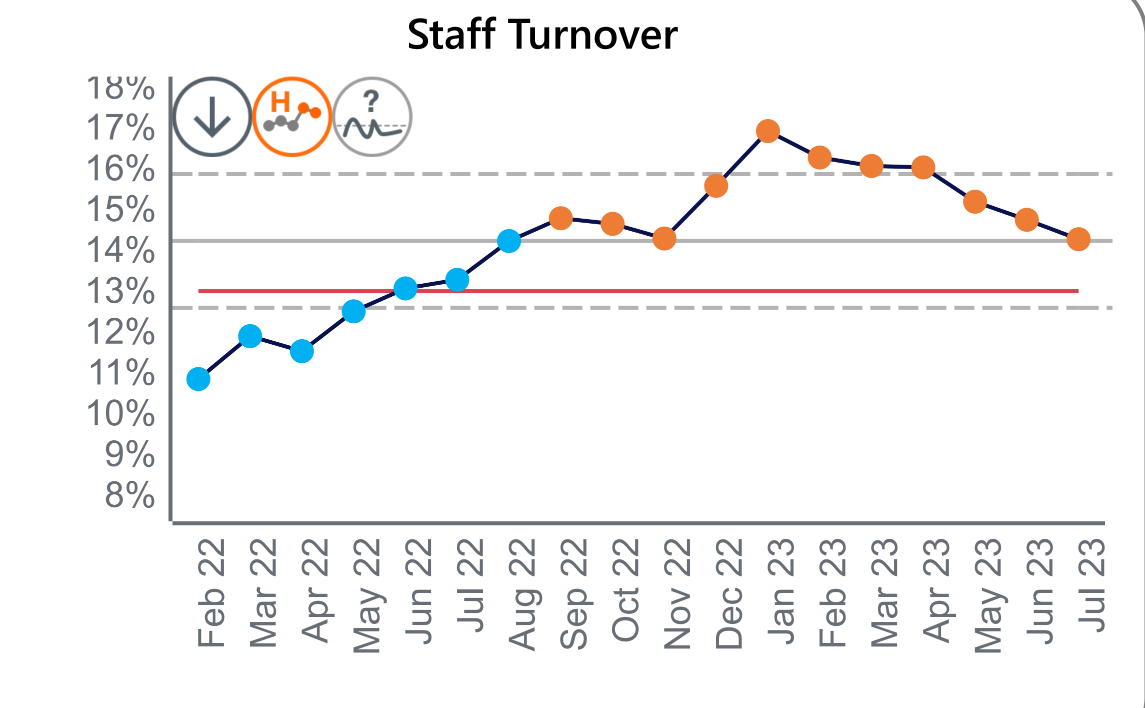


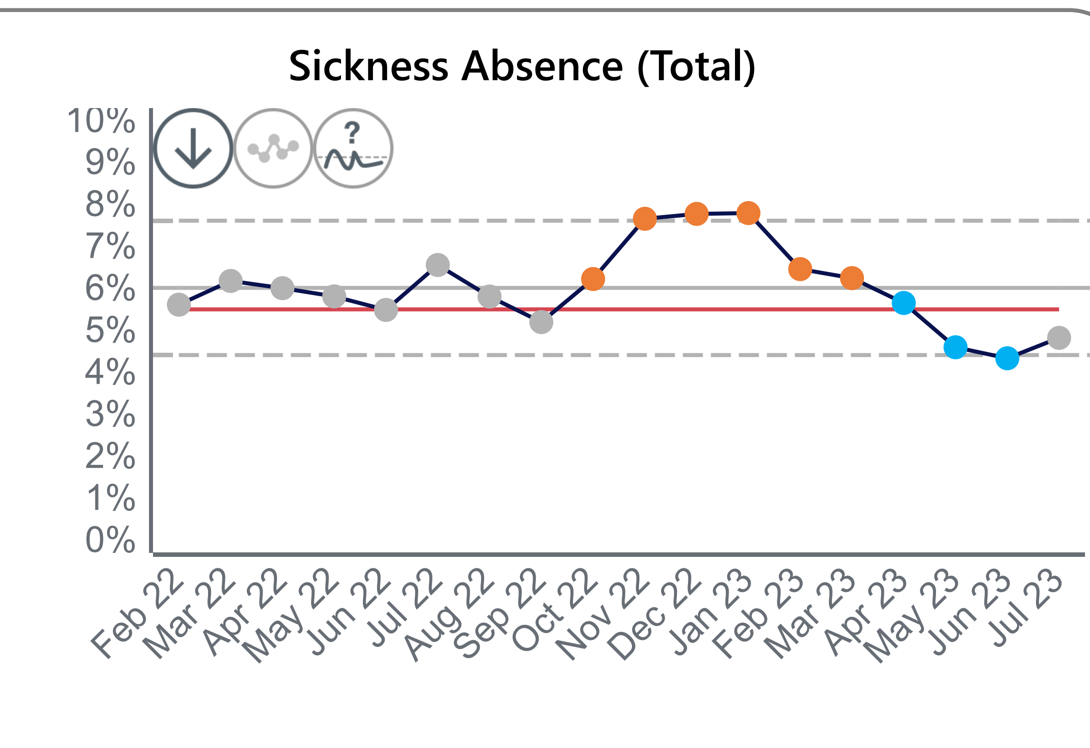












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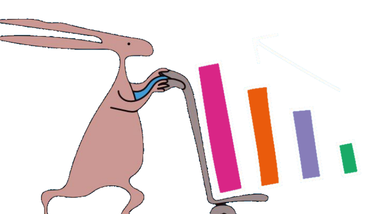
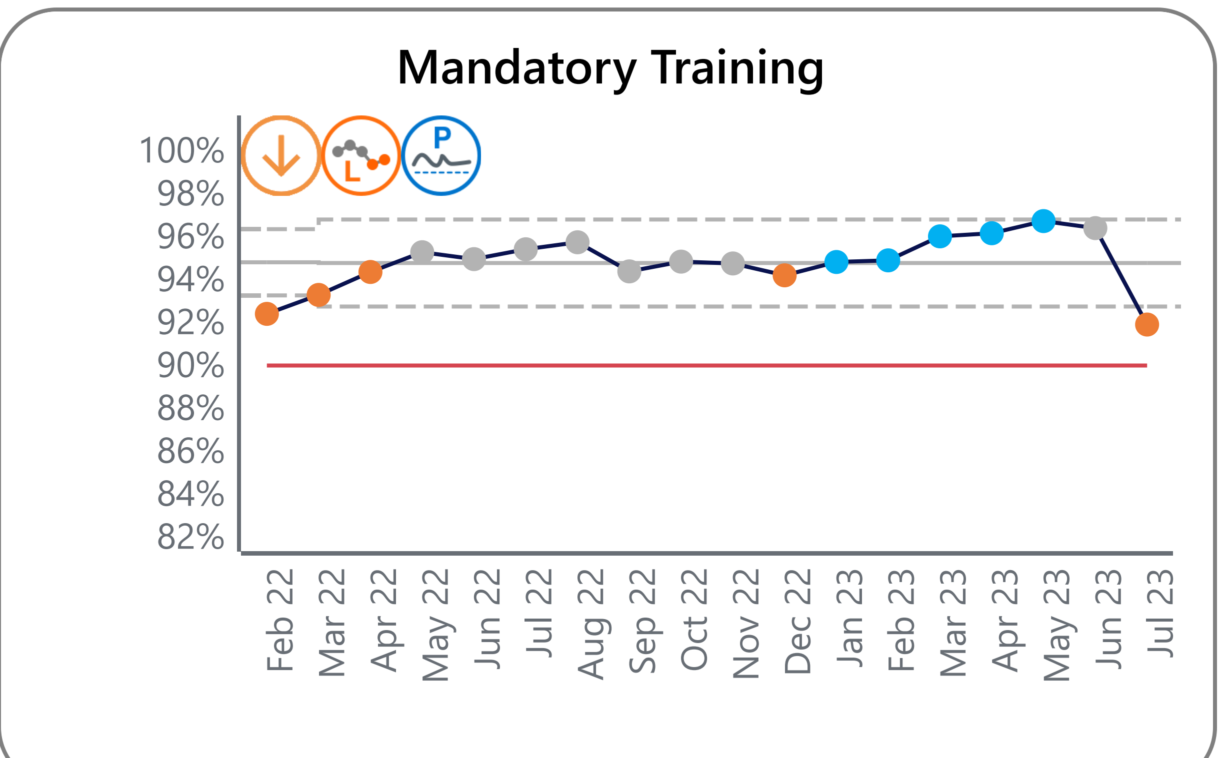
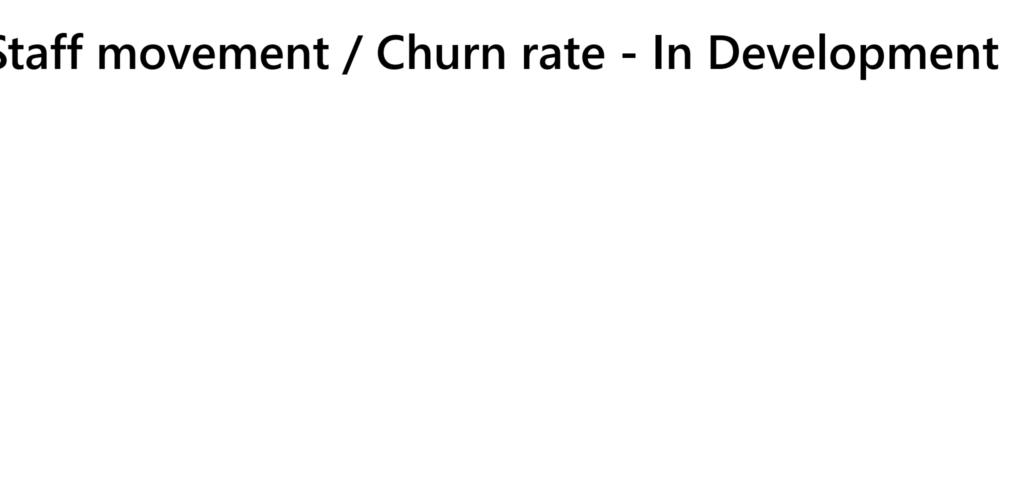


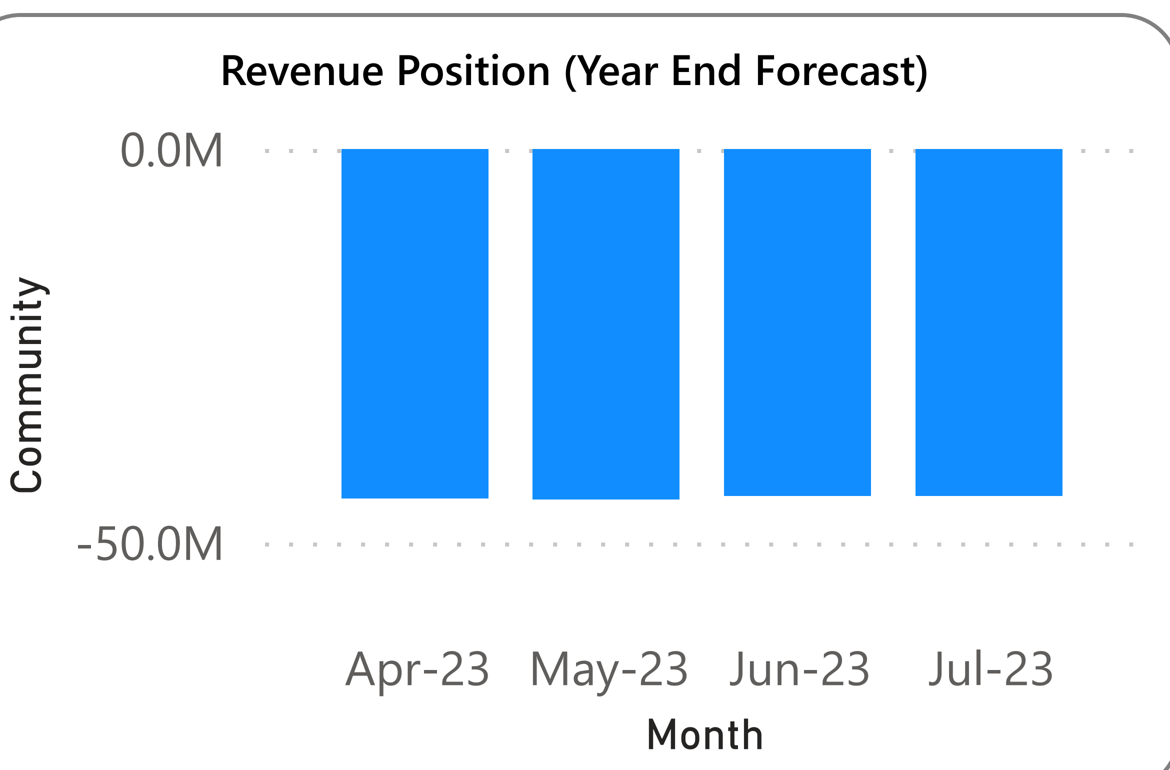
Divisional Performance Summary - Community & Mental Health

Mandatory Training

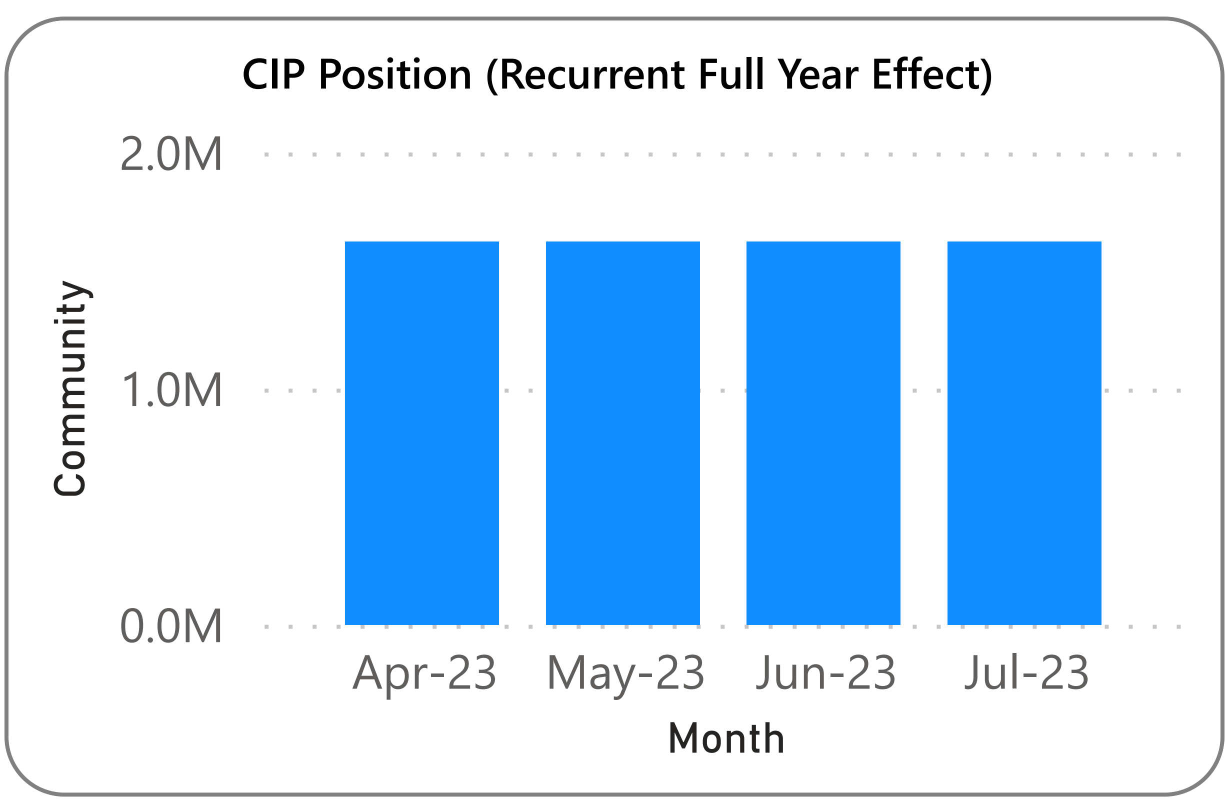




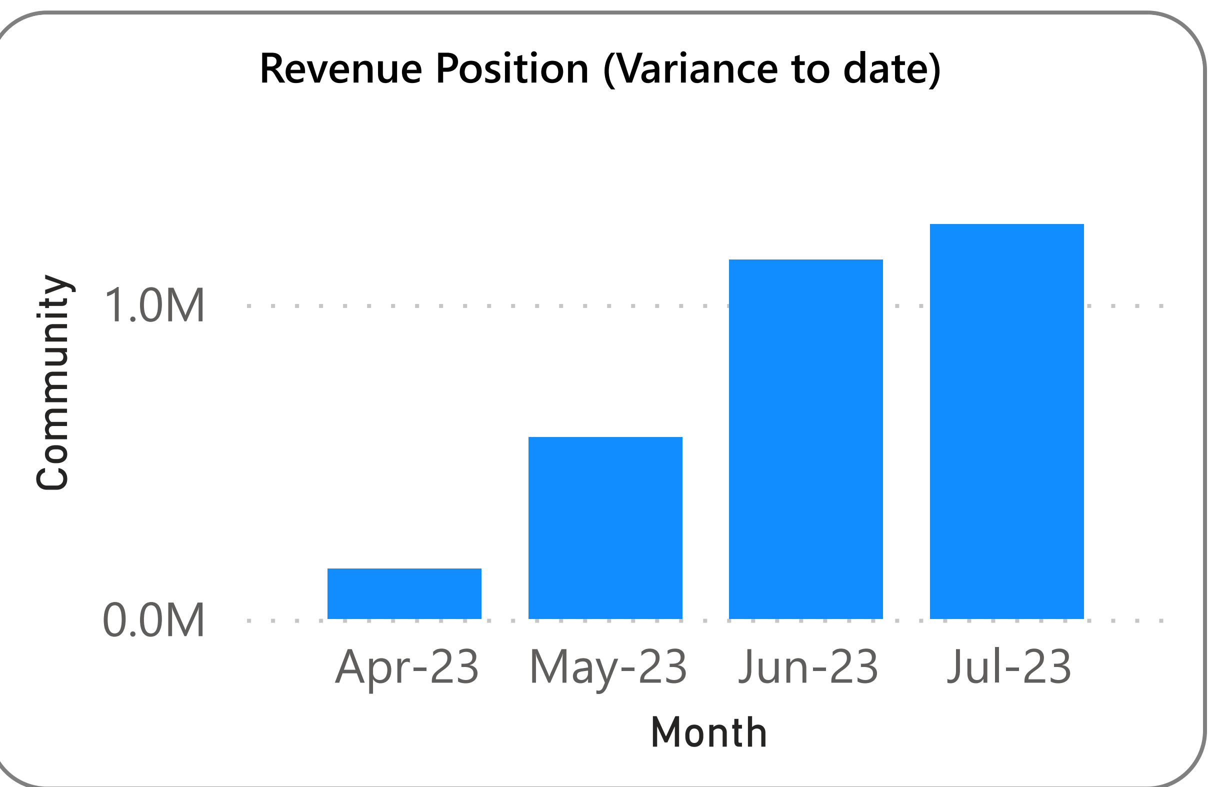
Revenue Position (Year End Forecast)



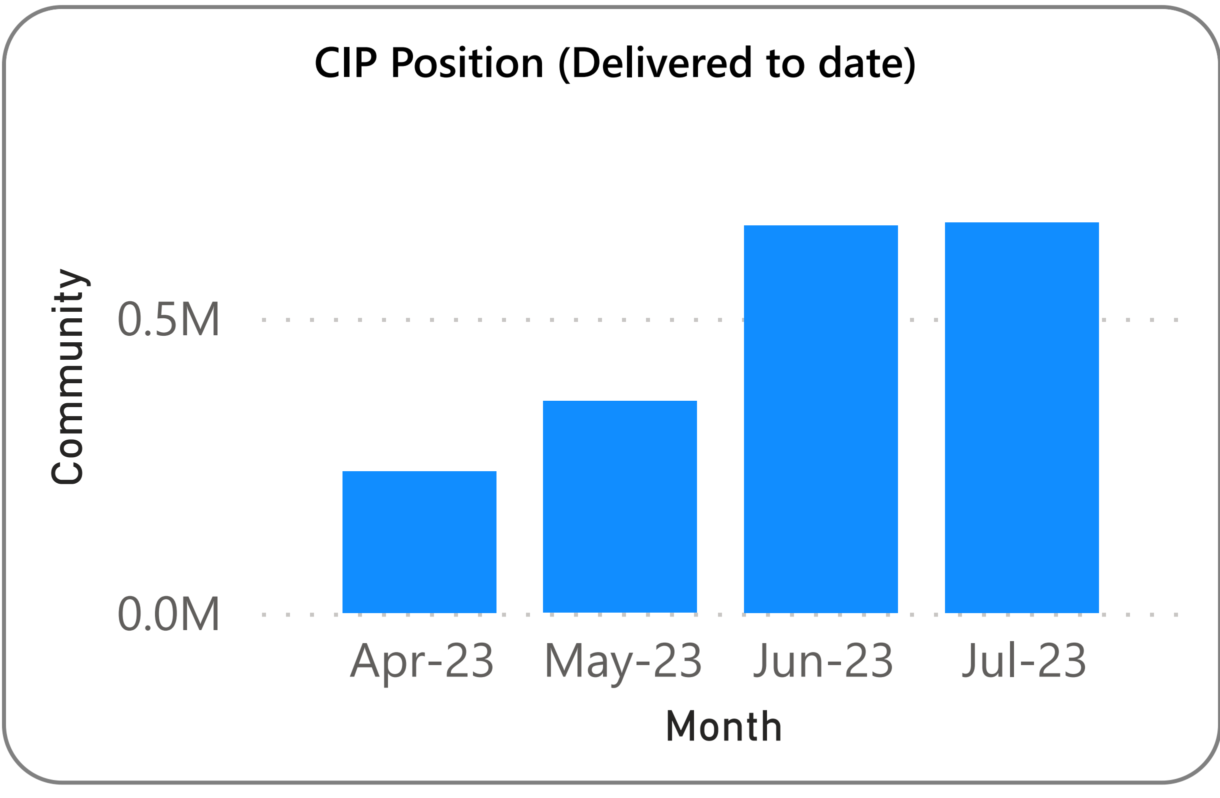
CIP Position (Recurrent Full Year Effect)

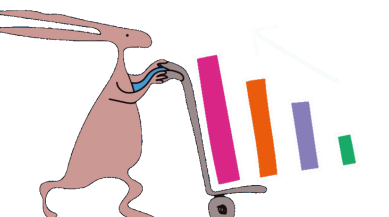


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Inpatient Sepsis (delivering antibiotics within 60 minutes) remains compliant for five of the last six calendar months. • ED performance continues an improving trend, achieving 91% in 4 hours in month; improved utilisation of the UTC and GP stream is supporting this position; PAU pilot commenced 8th August primarily focused on improving this indicator by offering direct assessment for GP and other health professionals to a Paediatric assessment. • Diagnostics compliance achieved 92% in medicine in month, achieving the target set in the national annual plan for 23/24; industrial action impacting gastroscopy in month and an increase of inpatient sleep referrals meaning demand exceeded capacity. • Sustained compliance with all standards for childrens cancer care. • Division remains compliant with mandatory training YTD • PDR compliance improved in month with the majority of Band 7+ staff now in date. • Divisional recovery remains strong, however some specialities considerably behind plan @M4 due to workforce restrictions and the impact of continued industrial action. Business case for 0.6 WTE Gastro Consultant approved at IRG and Dermatology business case (nursing and middle grade) to be considered at IRG 22nd August 23.

Areas of Concern

• Emergency Department Sepsis (delivering antibiotics within 60 minutes) compliance remains variable, although achieved in month; Head of Nursing has reviewed all breaches over the last 6 months and submitted the themes to SQAC. • IPR shows a 65 Week Breaches in month; no longer waiting for treatment. Performance against the 18-week RTT standard is stagnant at 57%, however, waiting list size has reduced by 800 in the last 4 months, signalling a positive recovery despite the impact of industrial action. Concerns remain regarding Dermatology, Gastroenterology and Neurology recovery. • The Division has a deteriorating financial position, driven by pay costs relating to Bank HCA spend across the medical wards and Consultant pay costs as a result of locum/agency expenditure providing cross cover for absent and restricted colleagues. • Virtual Outpatient rates remain below 25%; priority for OPFA both from a recovery and industrial action perspective means reduced OPFU clinics. • The number of Clinical letters signed off within 10 days remains non-compliant; however, considerable reduction in the total backlog of letters over 30 days from 688 on 30th May to 180 on 31st July; the Division has implemented a failsafe process monitoring all aspects of elective care performance. • Despite a positive CIP position at M4 (£1.8m) the Division is challenged in delivering recurrent savings and achieving the full £3.6m in year; A3 plans underway • Theatre utilisation continues to deteriorate based on the Capped utilisation indicator; further review required to balance the reporting e.g. removal of the IOMR from the data, assessment of case per clinician at speciality level as current presentation of data is misrepresenting.

Forward Look (with actions)

• The Divisional PDR plan aims for 90%+ compliance by 31st October, all PDRs are being scheduled by grade/ month • Enhanced financial controls made some impact in month and will continue. • Continue to develop recurrent CIP plans in line with the trust strategy
• Root/branch review of controls for the management of Sepsis in ED • Associate Chief Nurse has introduced additional controls to reduce the escalating HCA spend across the medical wards.

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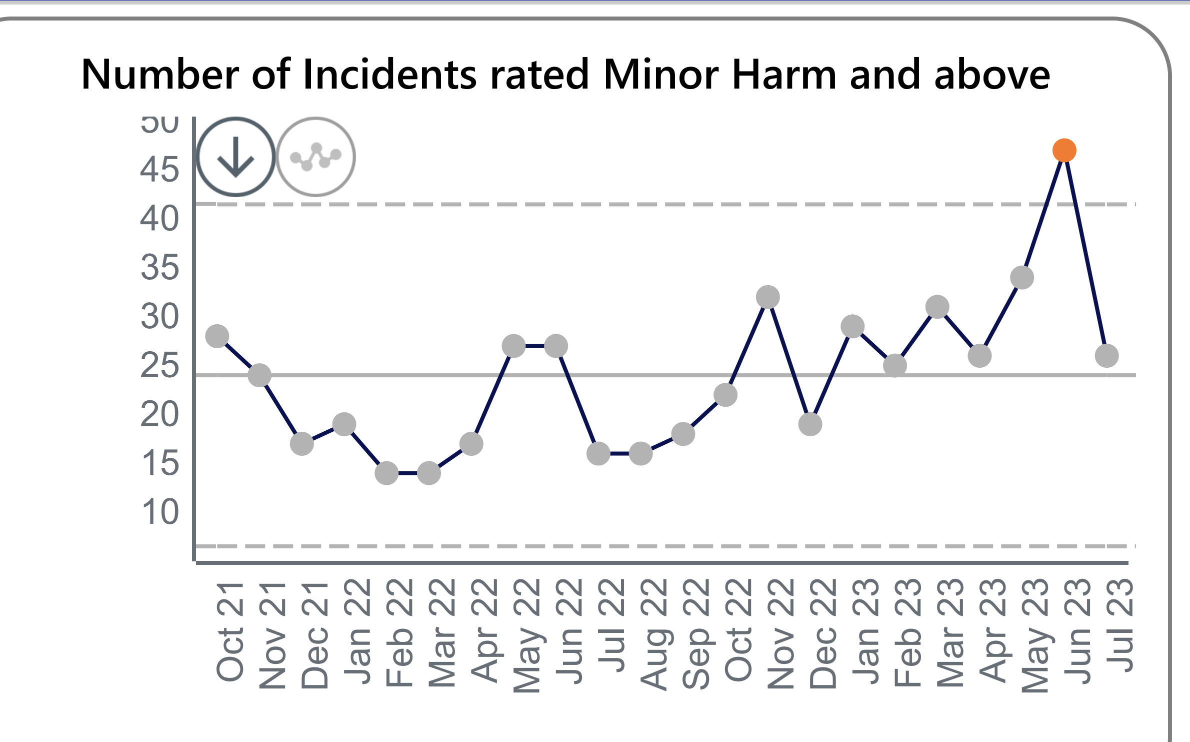
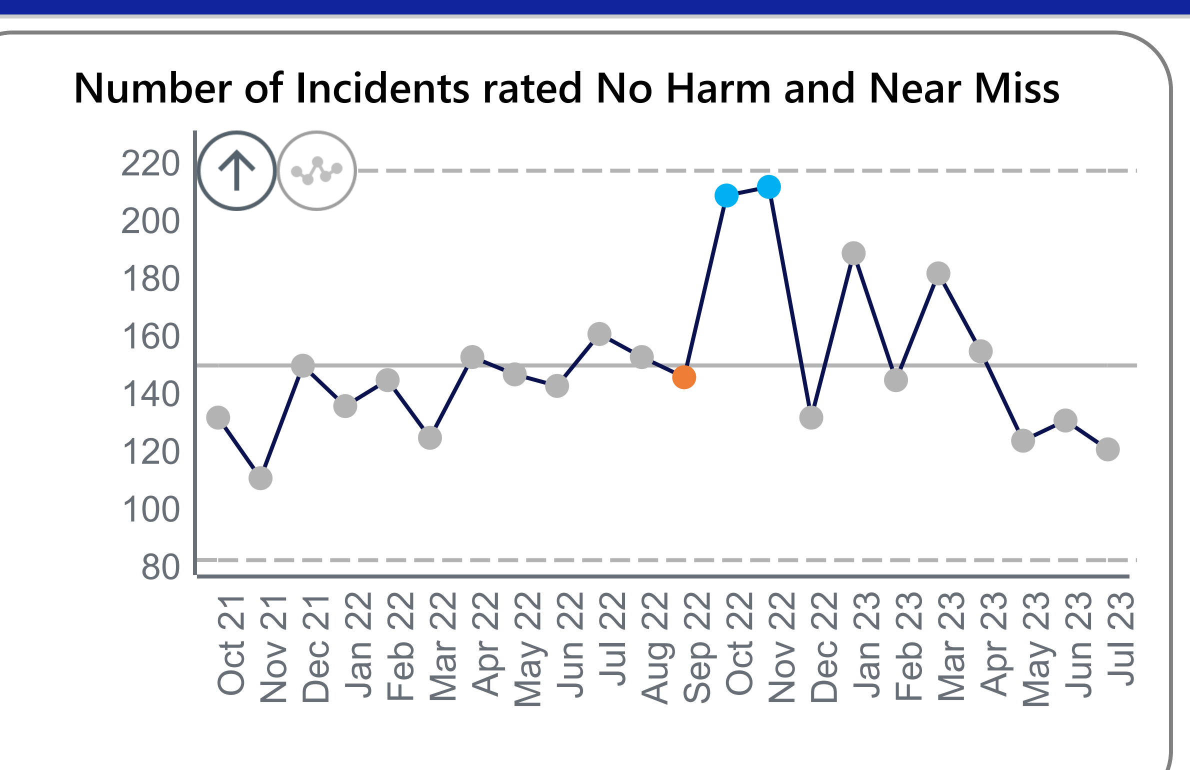
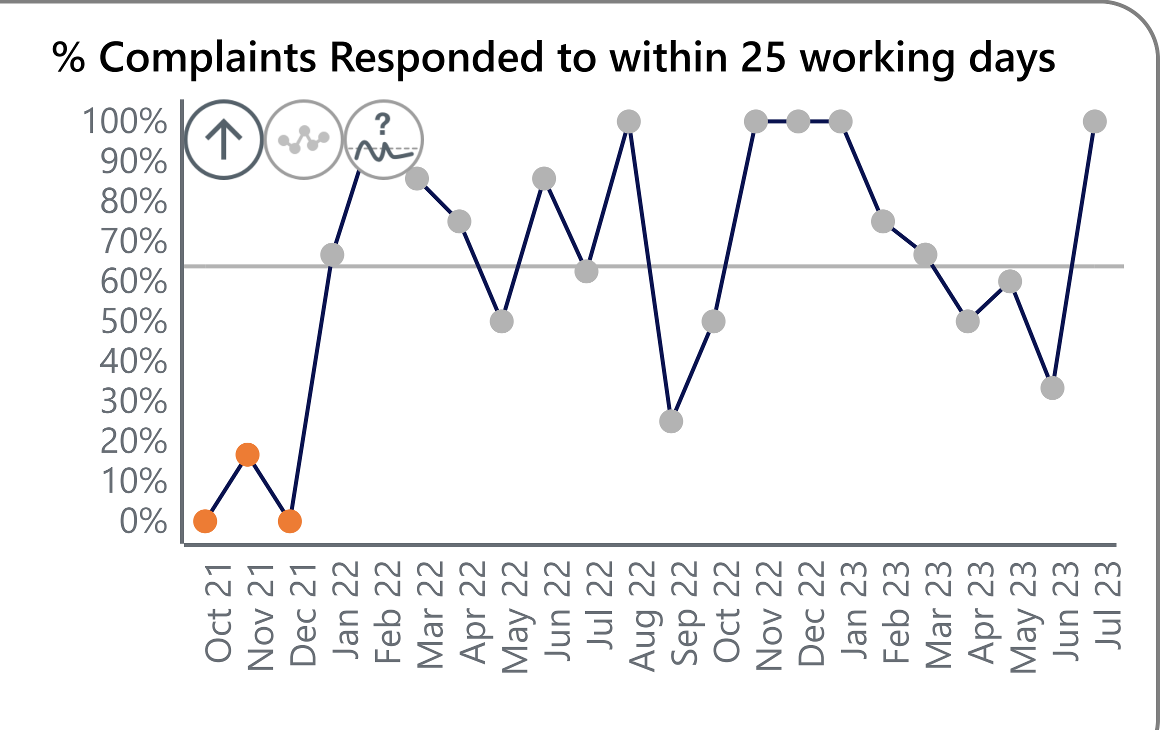
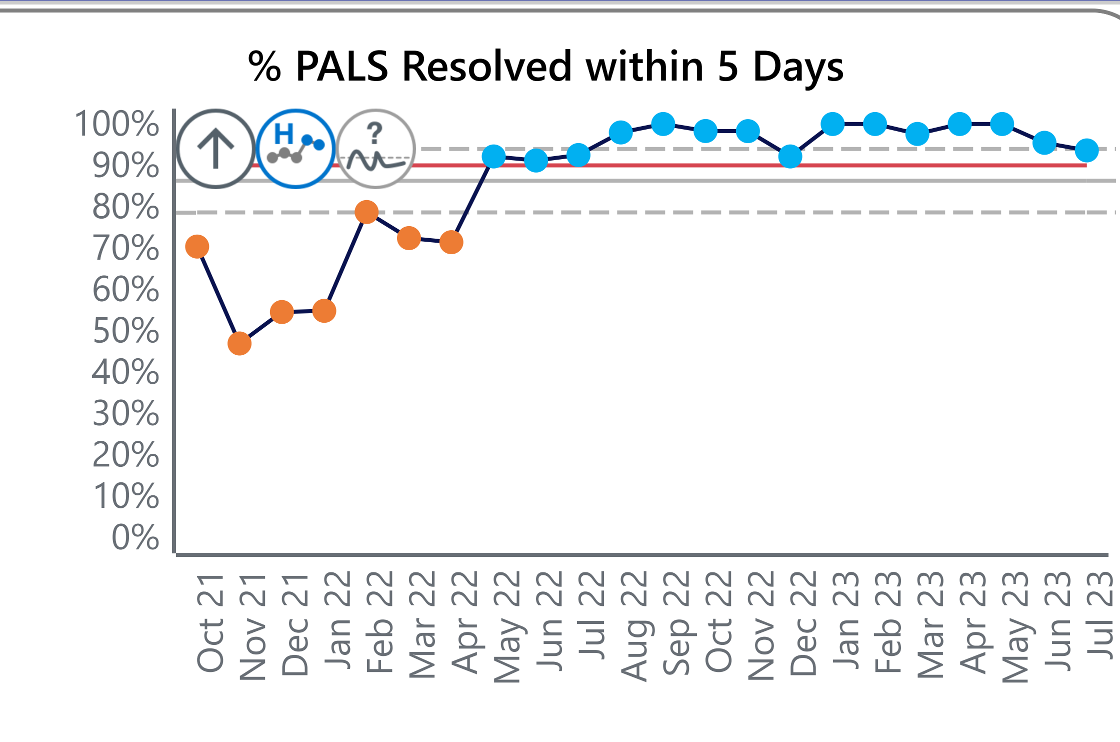
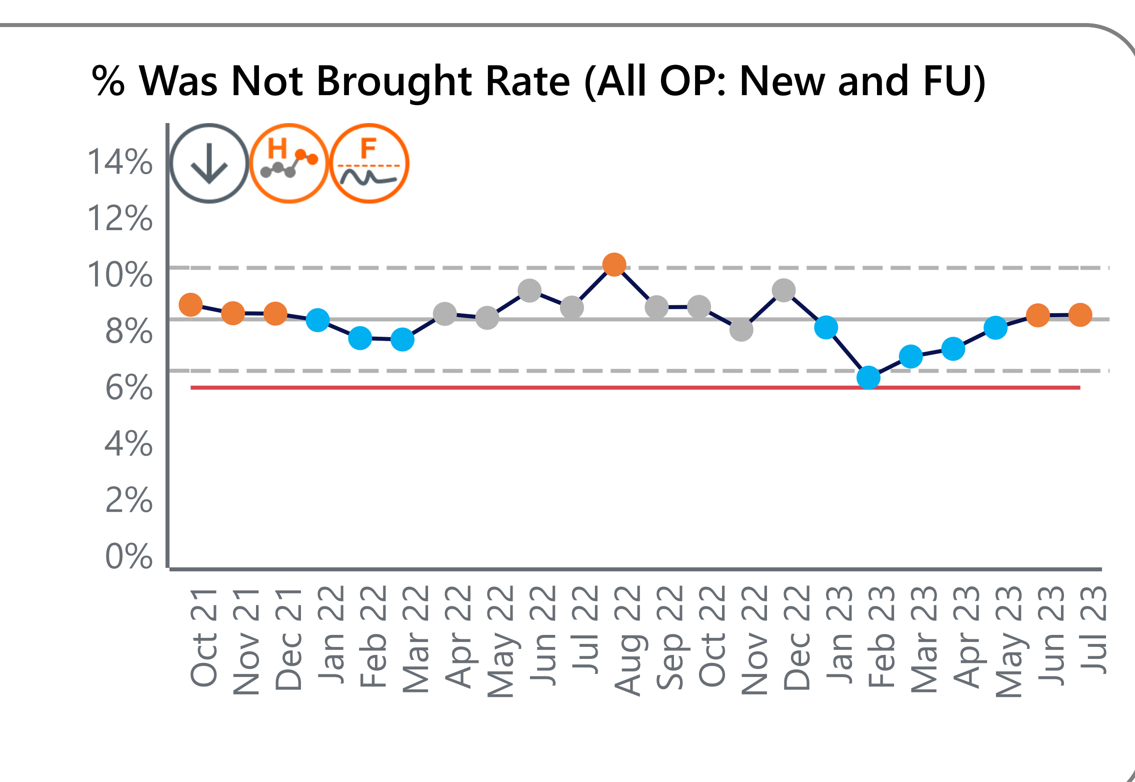
Divisional Performance Summary - Medicine

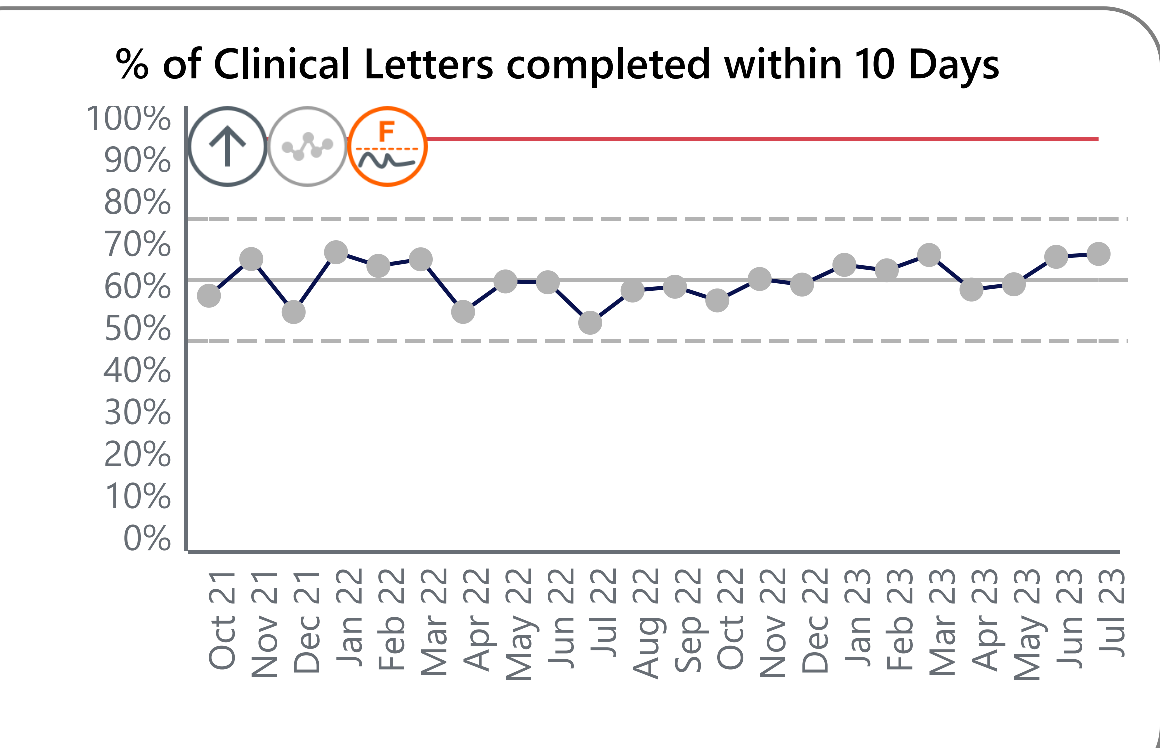


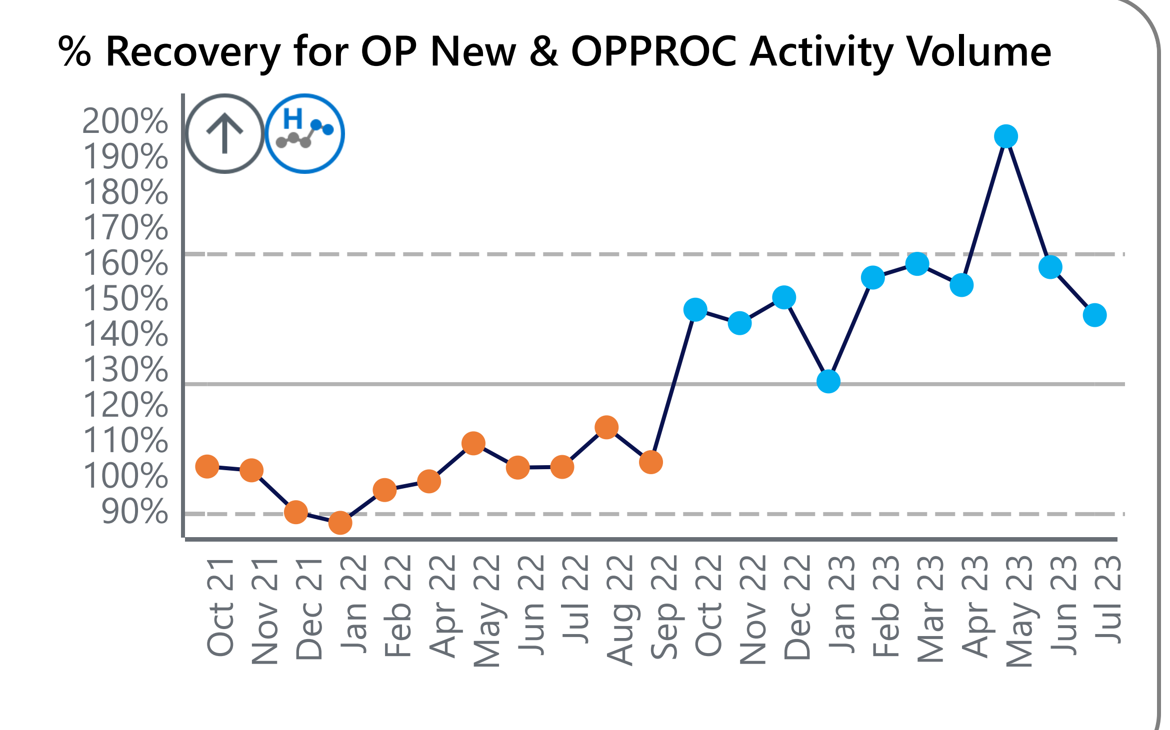


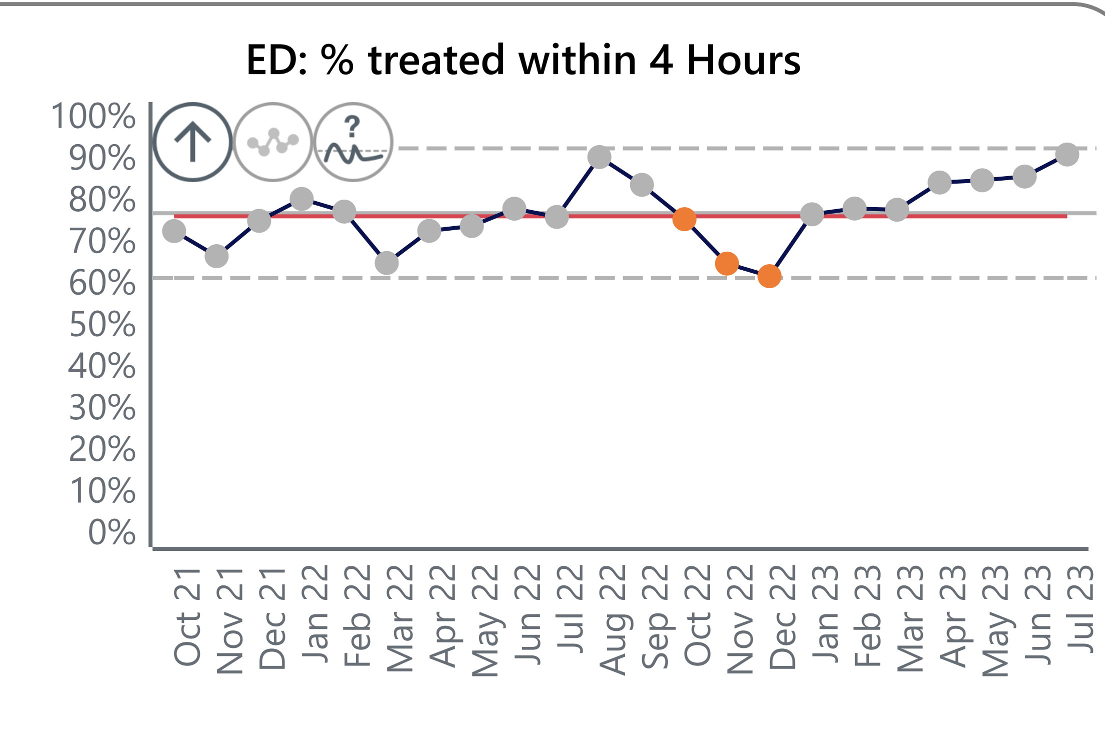


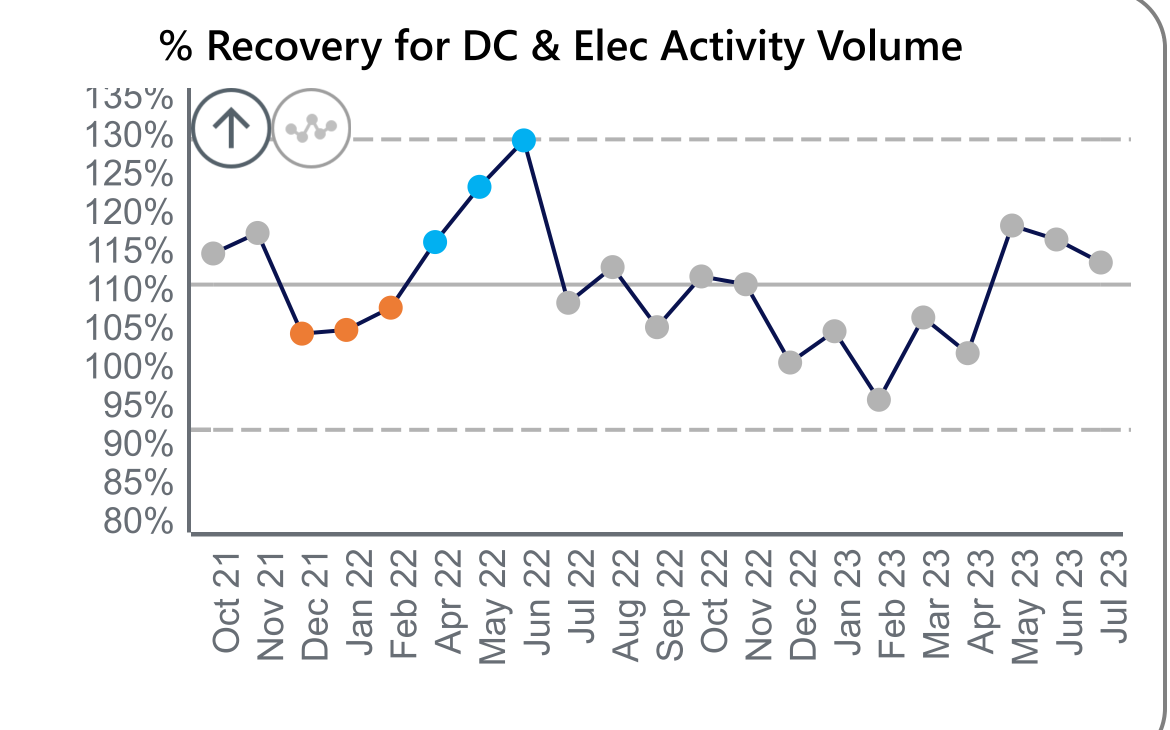


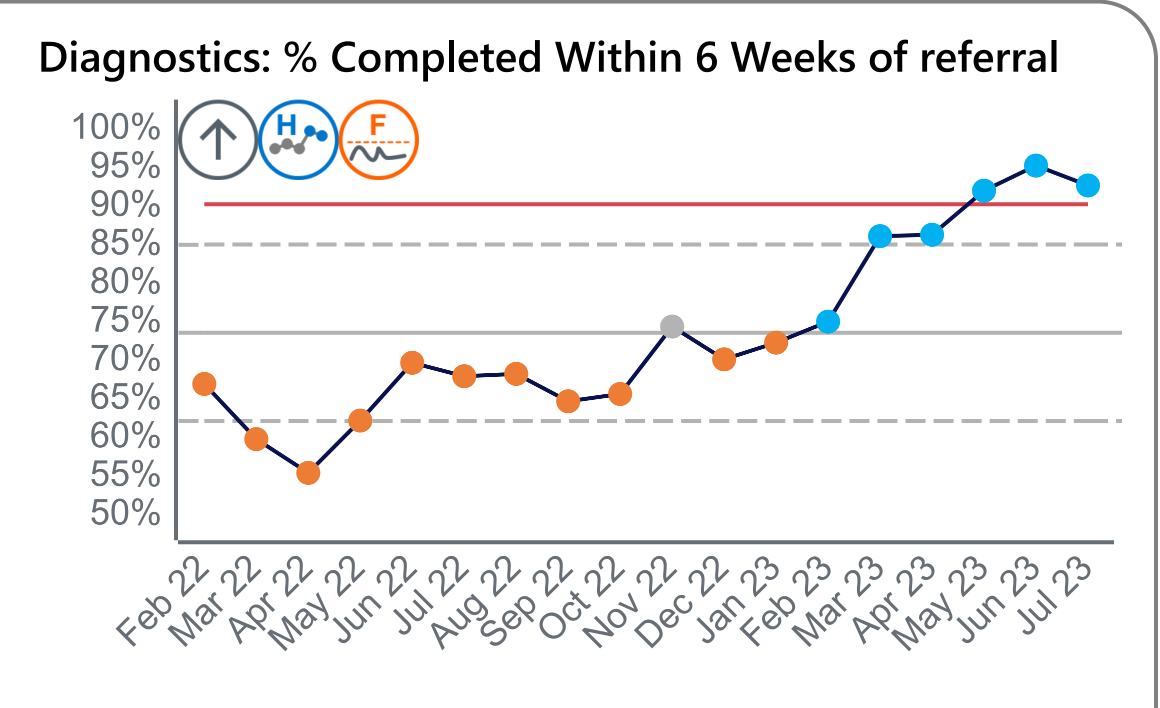


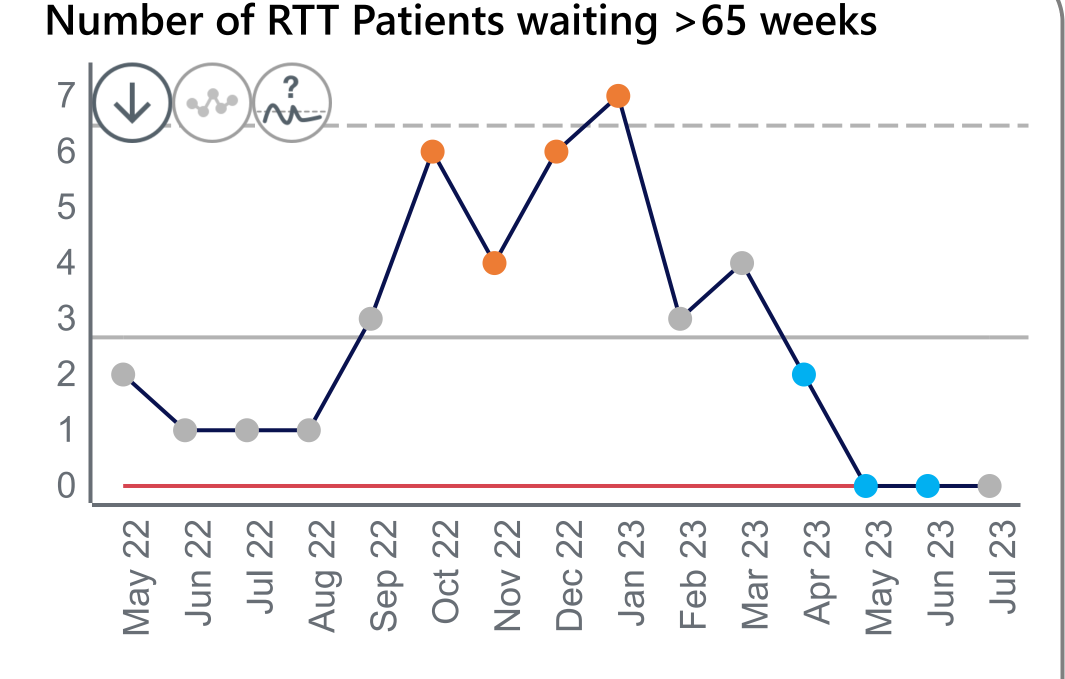


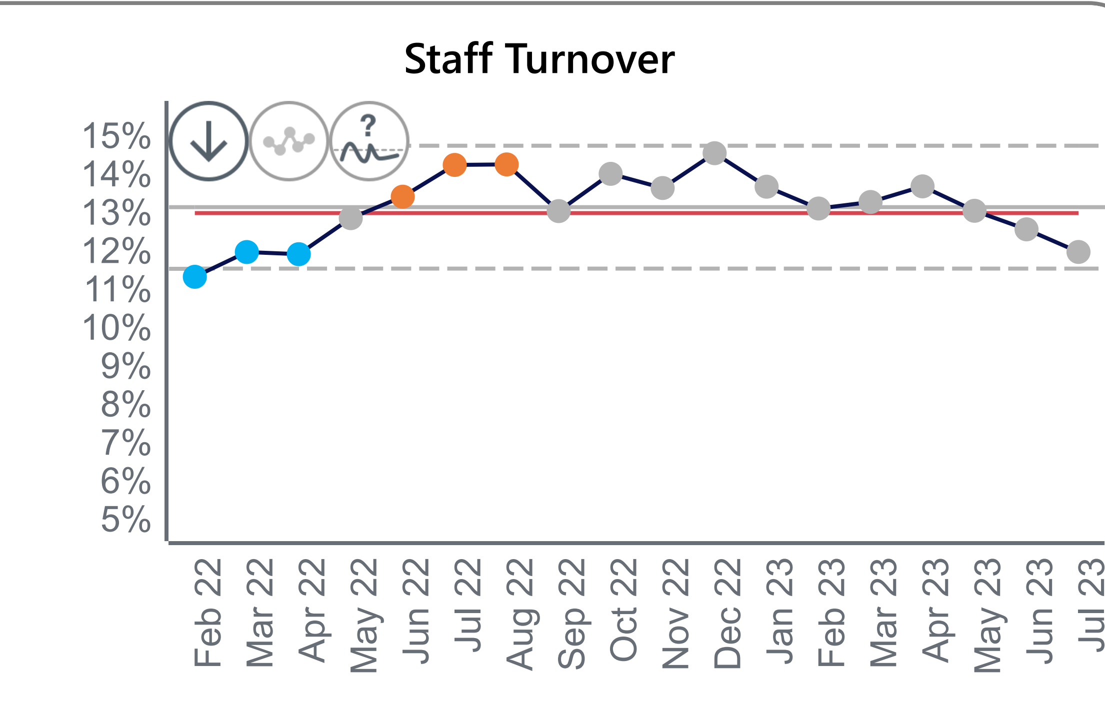












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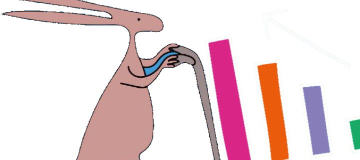
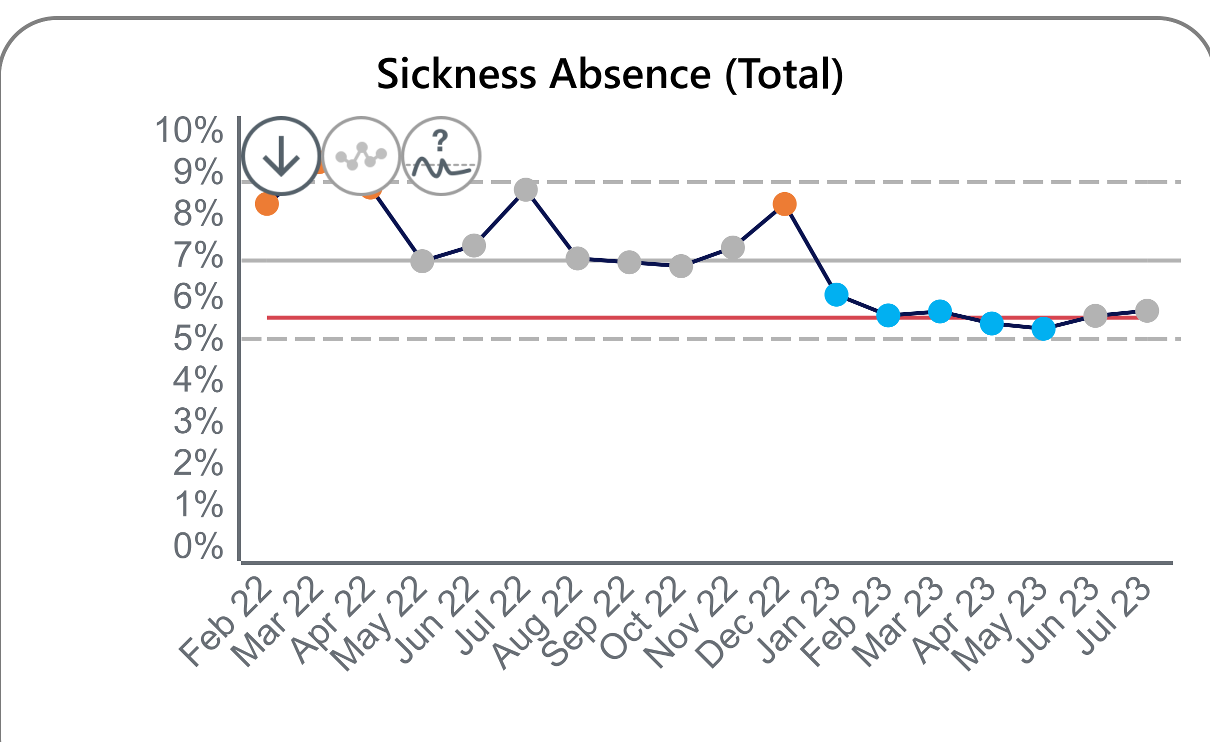
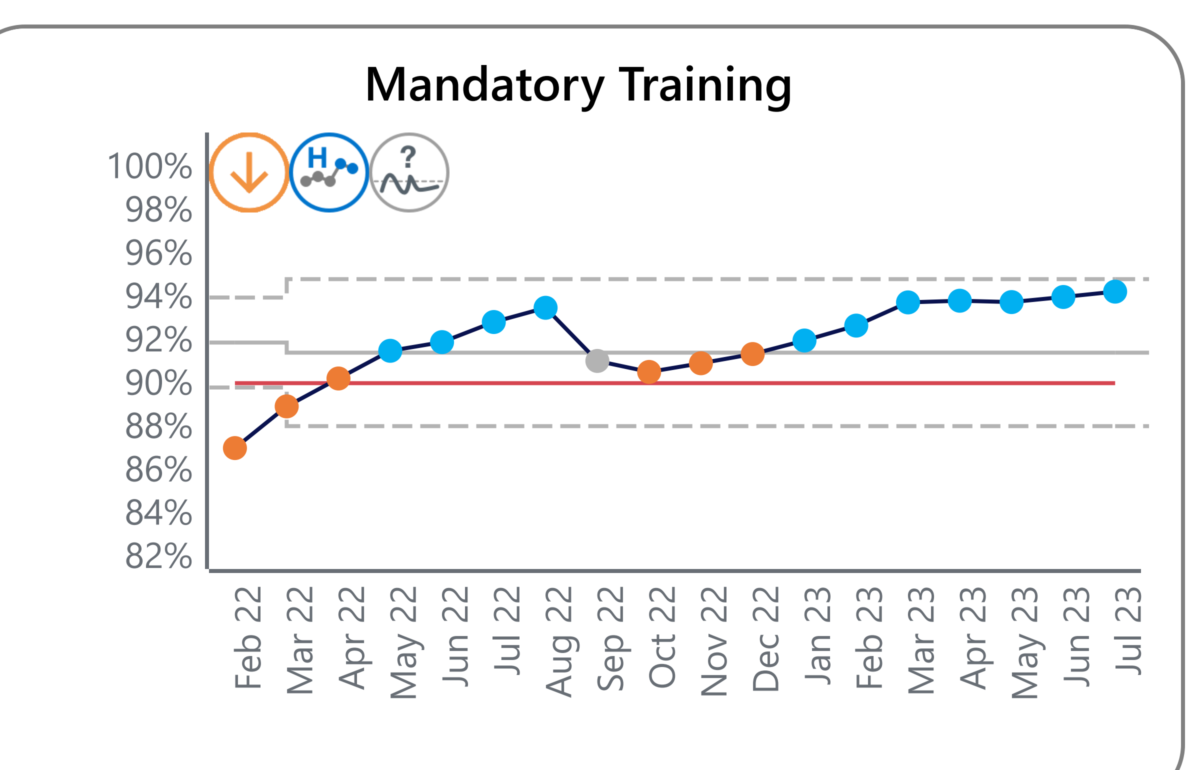


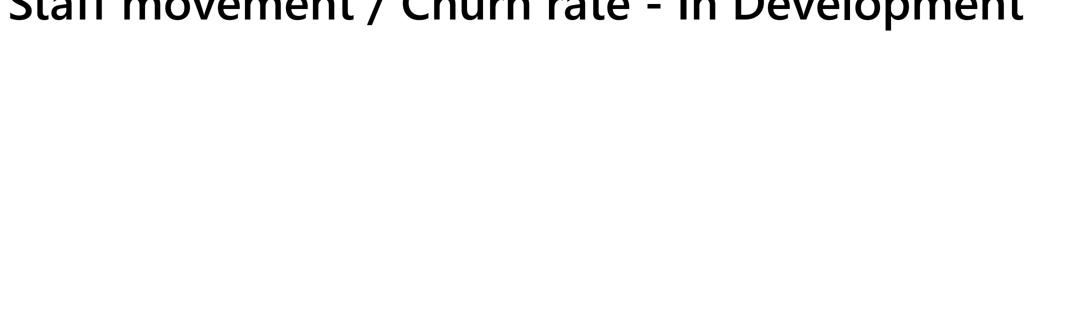
Divisional Performance Summary - Medicine

Sickness Absence (Total)

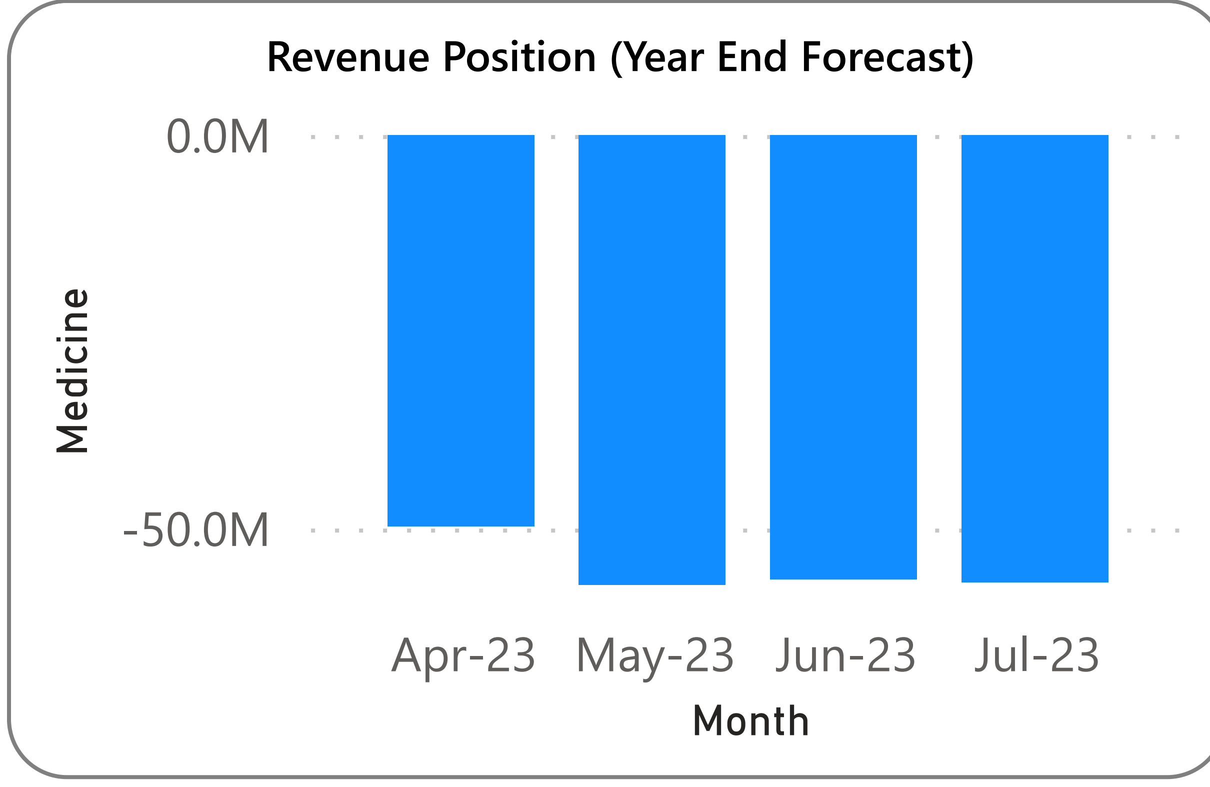


Mandatory Training

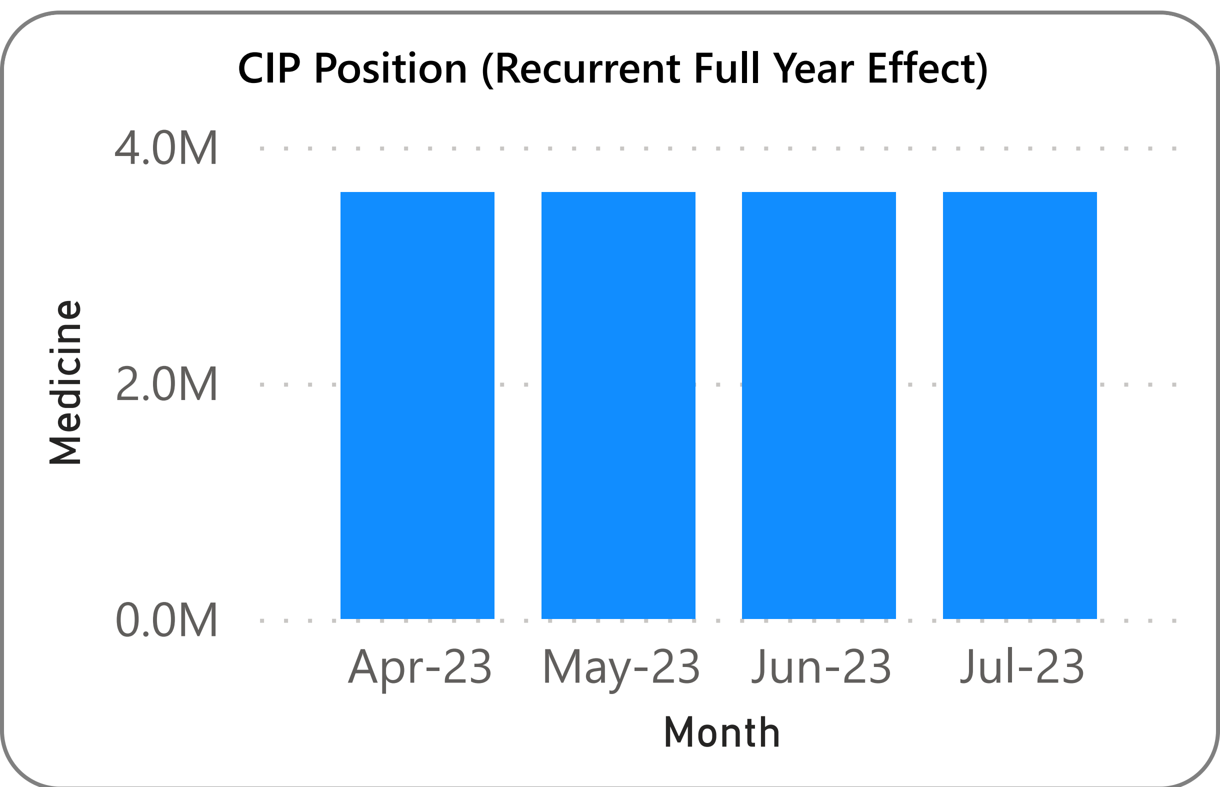




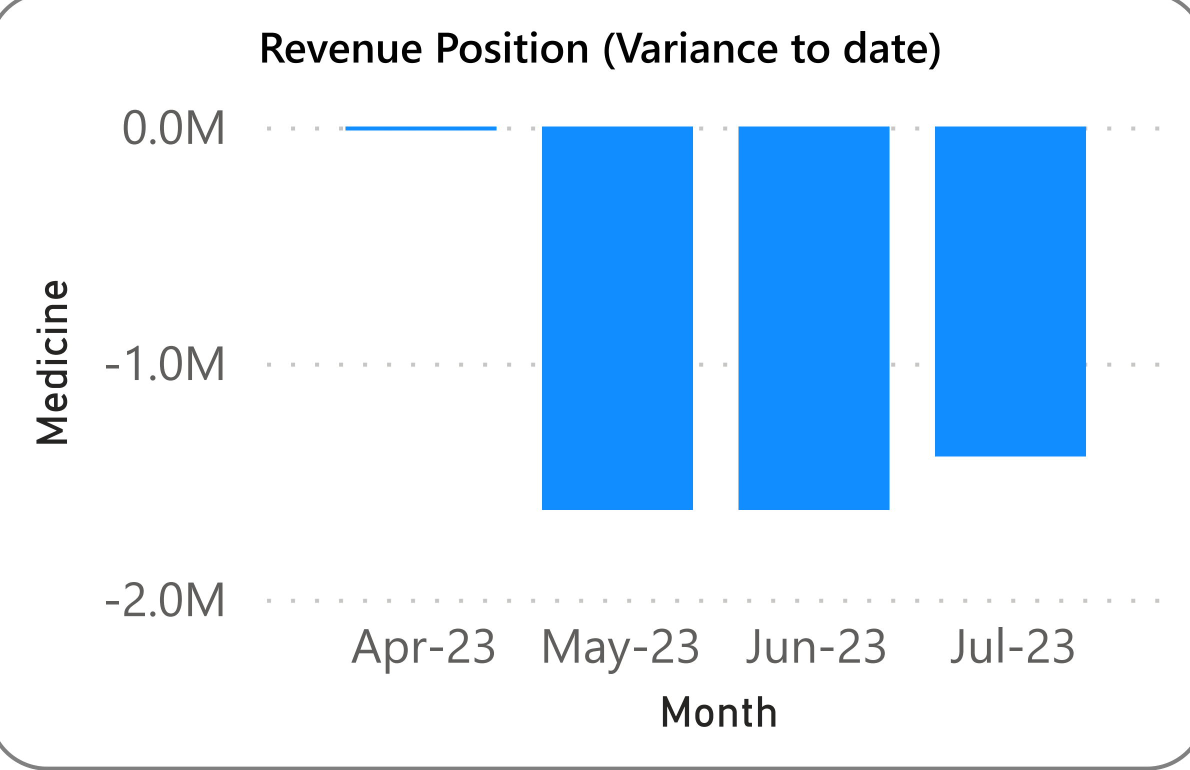
Revenue Position (Year End Forecast)



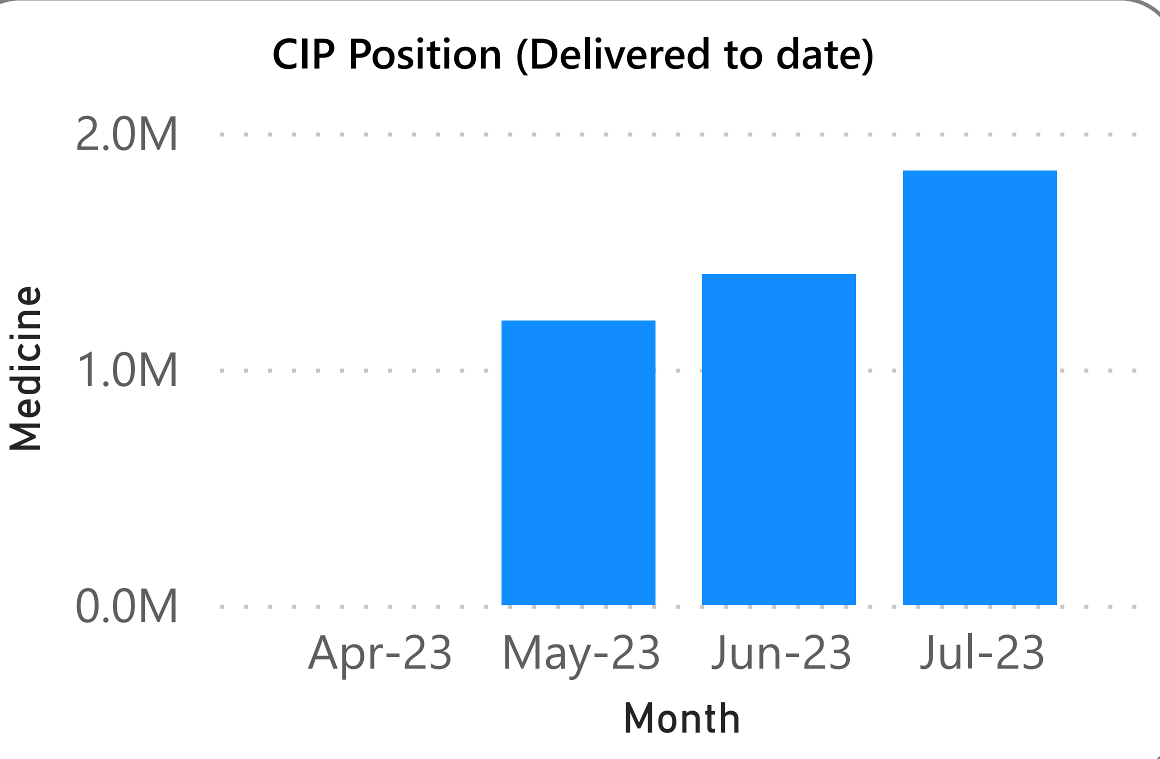
CIP Position (Recurrent Full Year Effect)

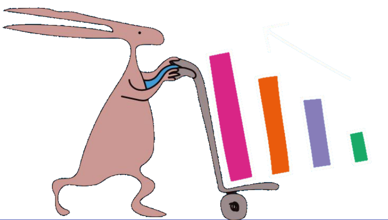


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• 100% Formal complaints & PALS responded to within target • Number of incidents rated no harm/near miss increased showing a positive reporting culture • Significant reduction in number of patients waiting over 65 weeks (reduction in both ENT & Dental) which is a significant achievement based on ongoing Industrial Action • Although OP NEW/OPROC decreased in month, still achieved 104% on 19/20 levels of activity • Staff turnover reduced for 3rd consecutive month • Mandatory training remains above trust target at 92%

Areas of Concern

• Sickness absence increased slightly and remains above trust target • Diagnostic performance remains below target at 63% in month. Patient numbers are extremely small & so any non-compliance has a significant impact. There is an improvement required within Cystoscopy which is currently undergoing an improvement plan. Industrial Action also continues to impact compliance • Although % of clinical letters completed within 10 days improved in month, remains below target and requires improvement.

Forward Look (with actions)

• Action plan in place to improve DM01 compliance (Cystoscopy) with expected improvement to be seen in September • T & F group commencing to review trust wide action plan to improve signing of clinical letters. This has been delayed due to capacity relating to IA and expanse preparation. Ongoing divisional oversight and escalation of individuals via governance leads. • Enhanced approach to activity forecasting & recovery plans in place for challenged specialities although this remains a significant risk due to ongoing IA

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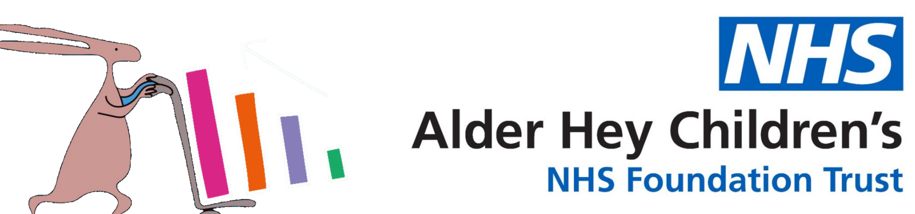
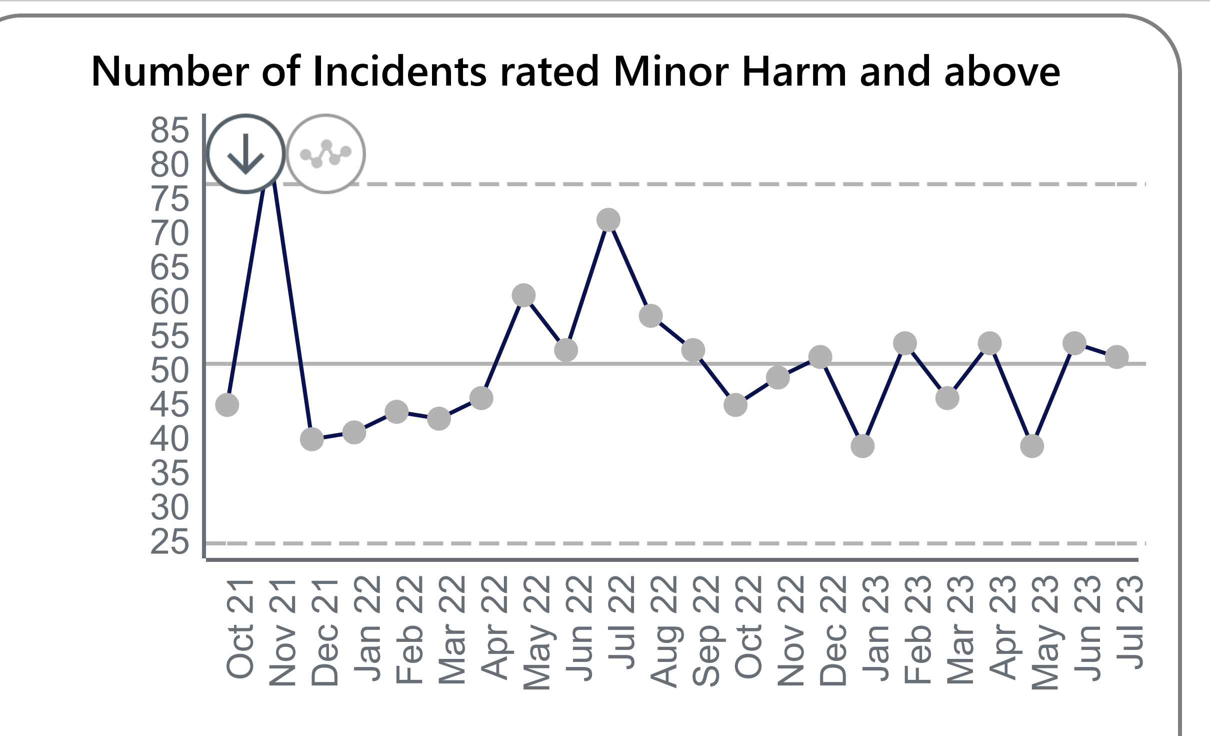
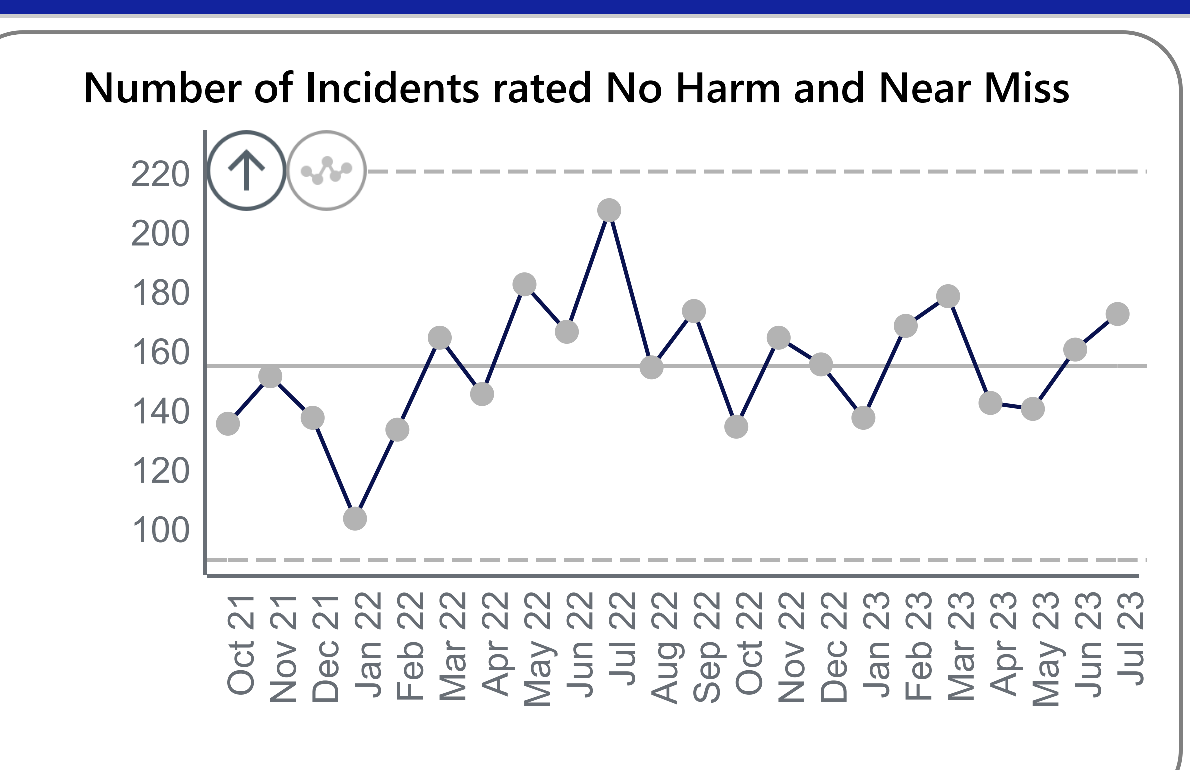
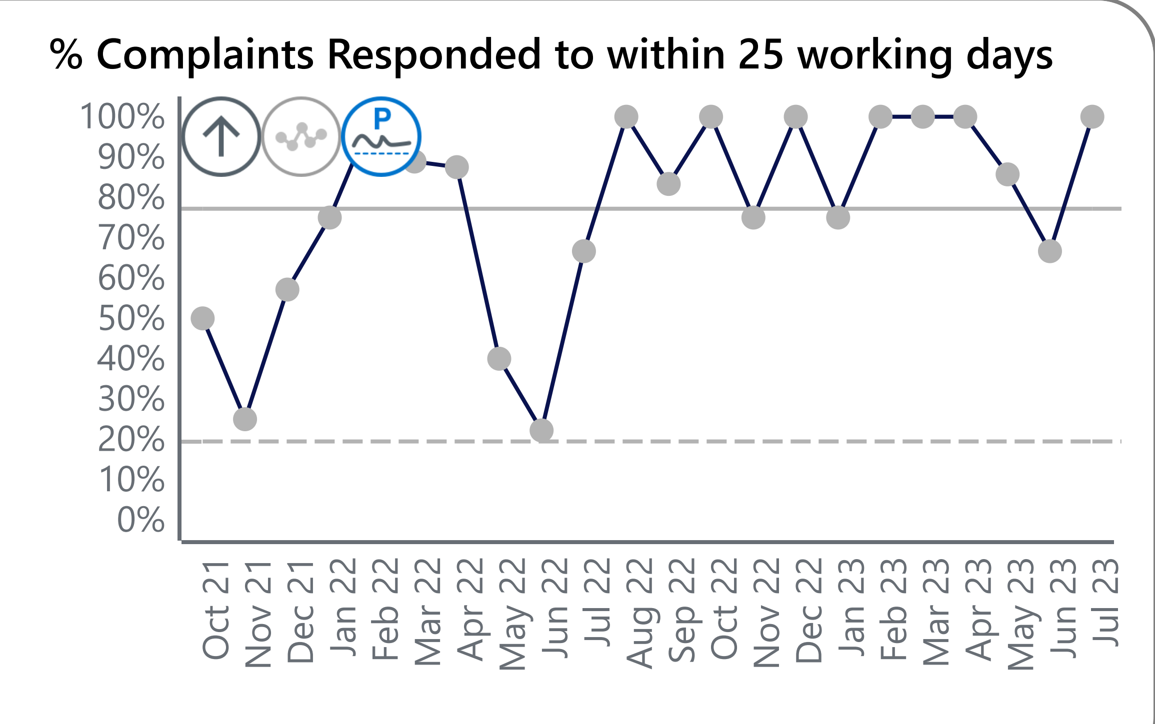
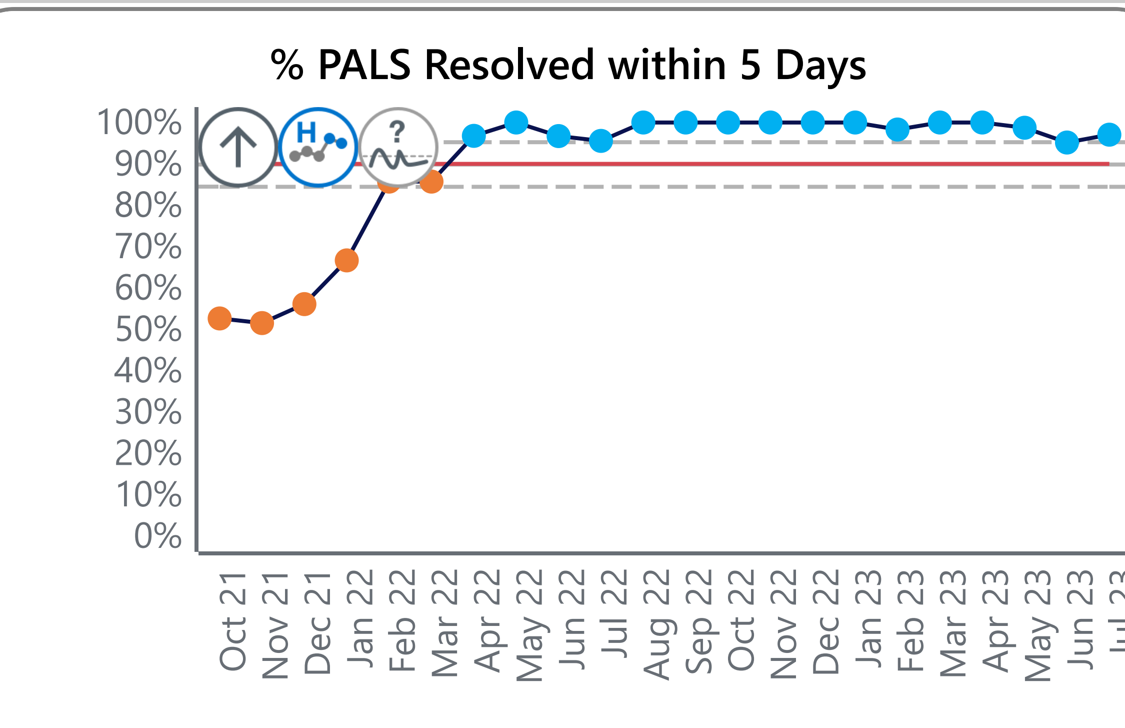


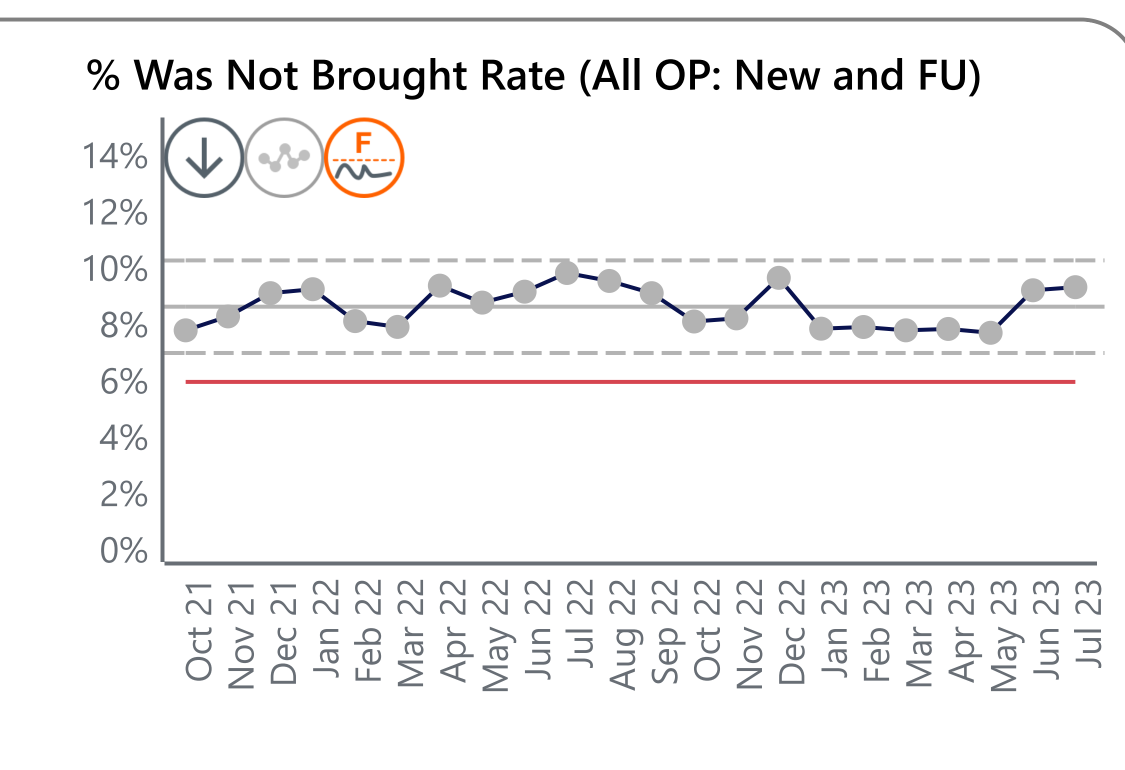
Divisional Performance Summary - Surgery

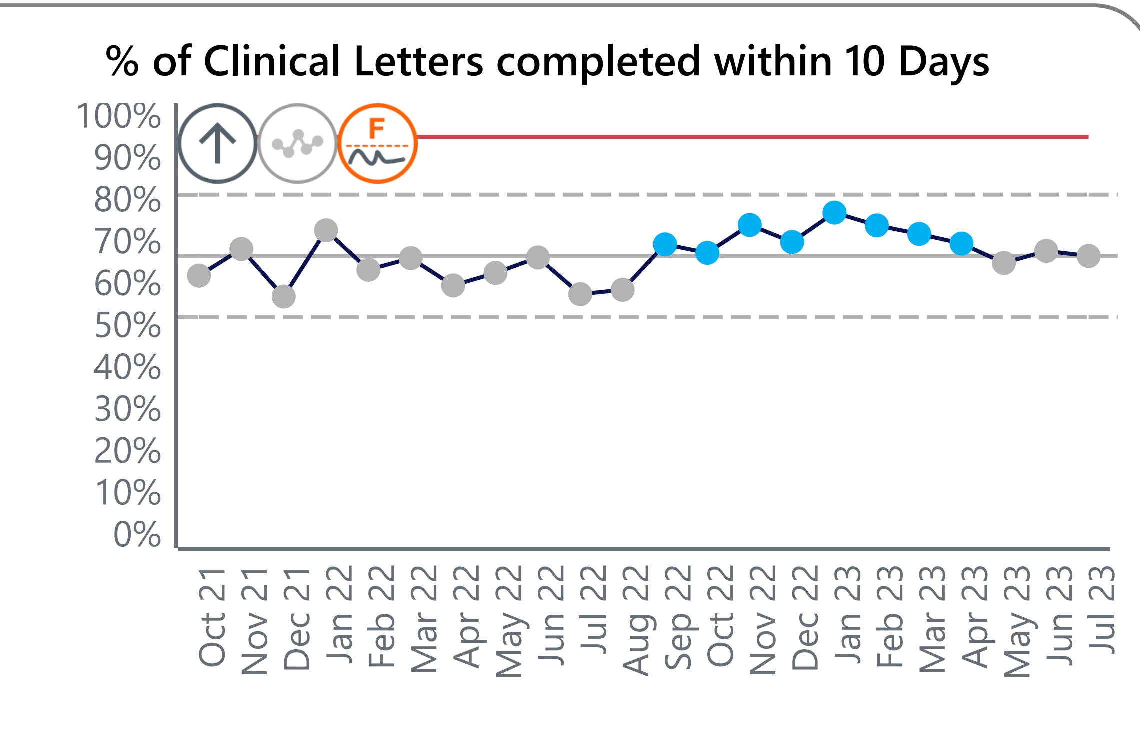


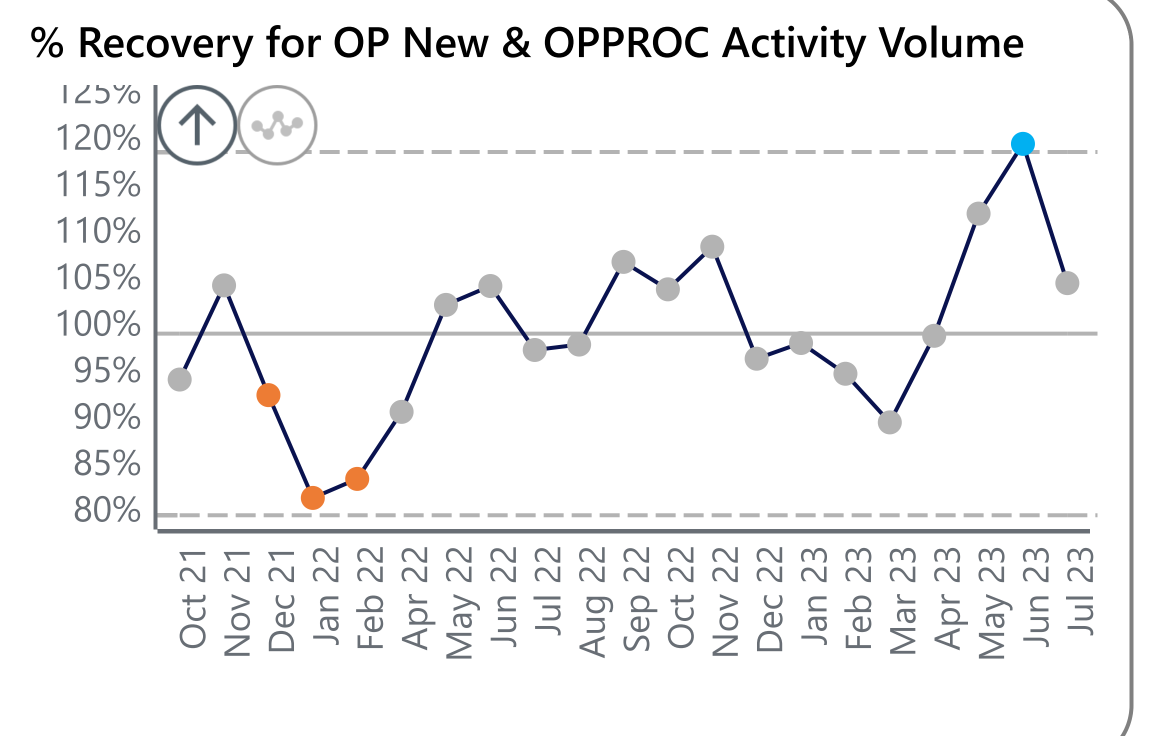


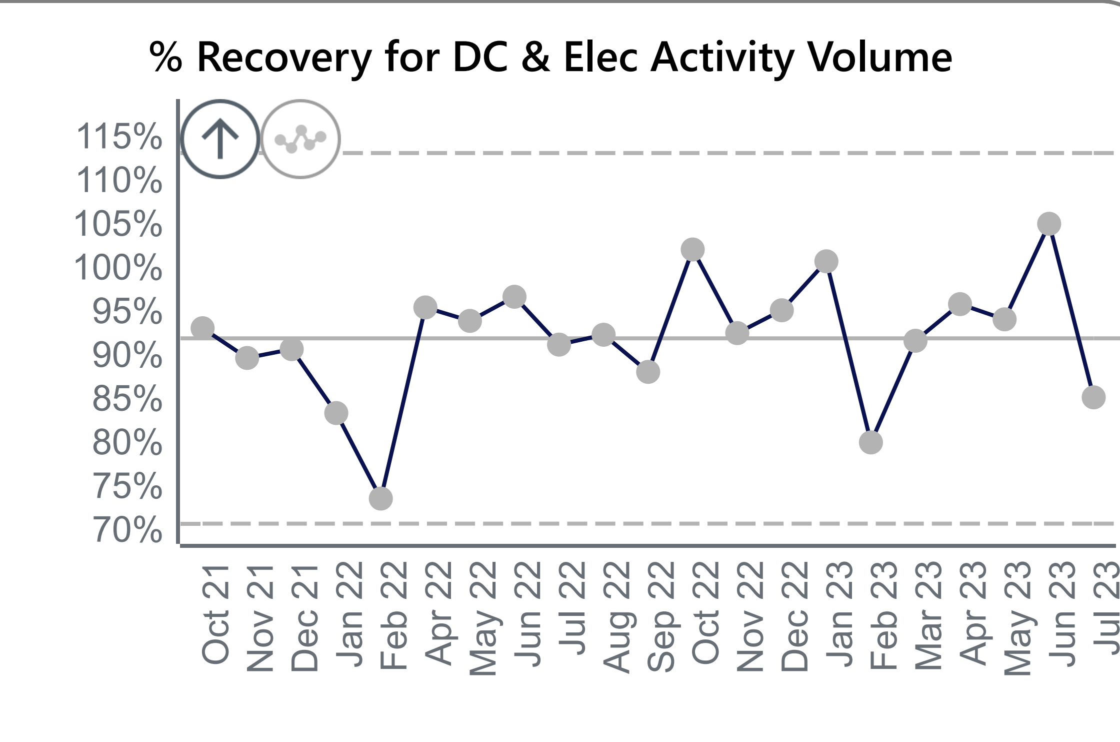


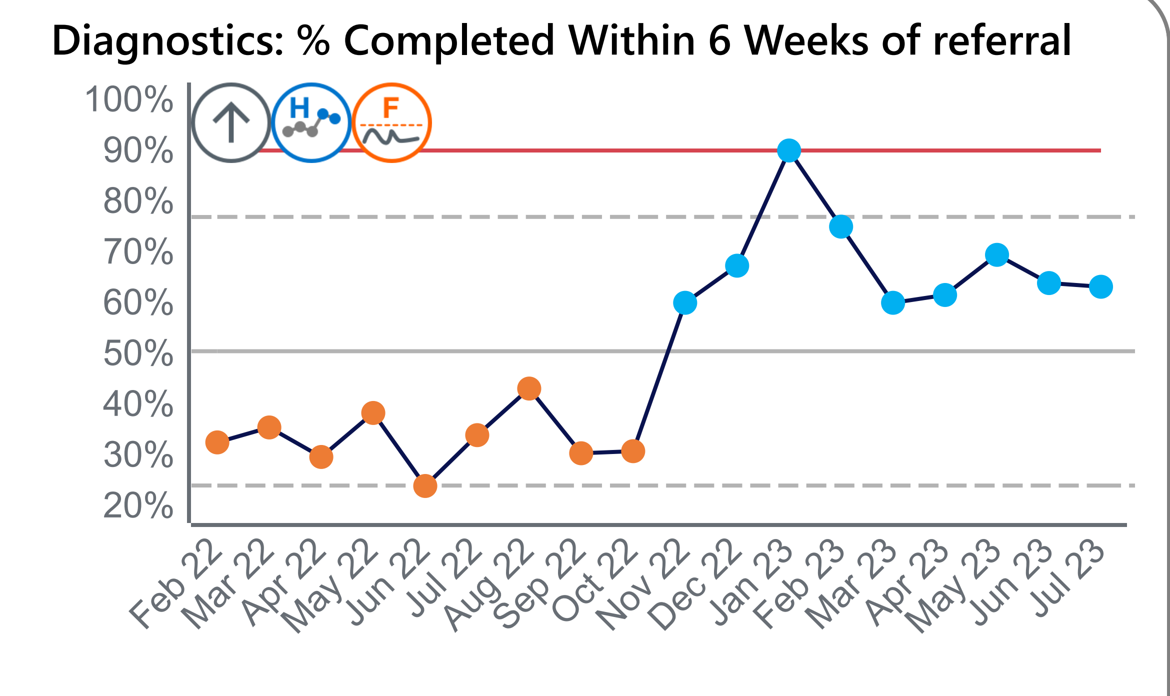


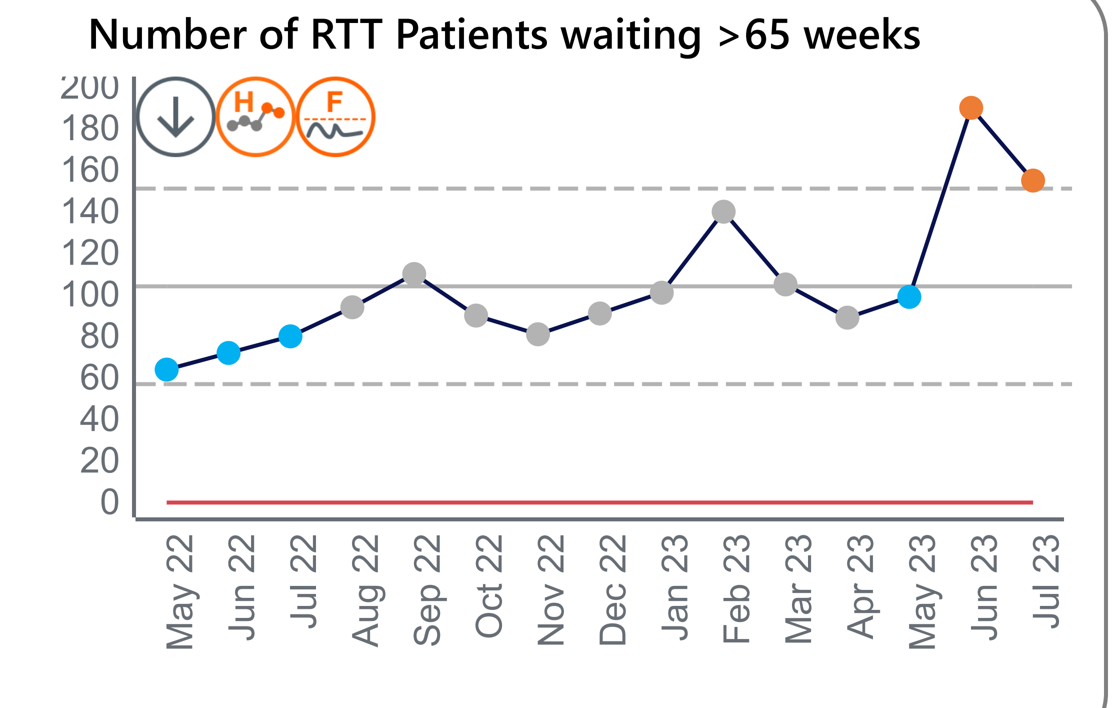


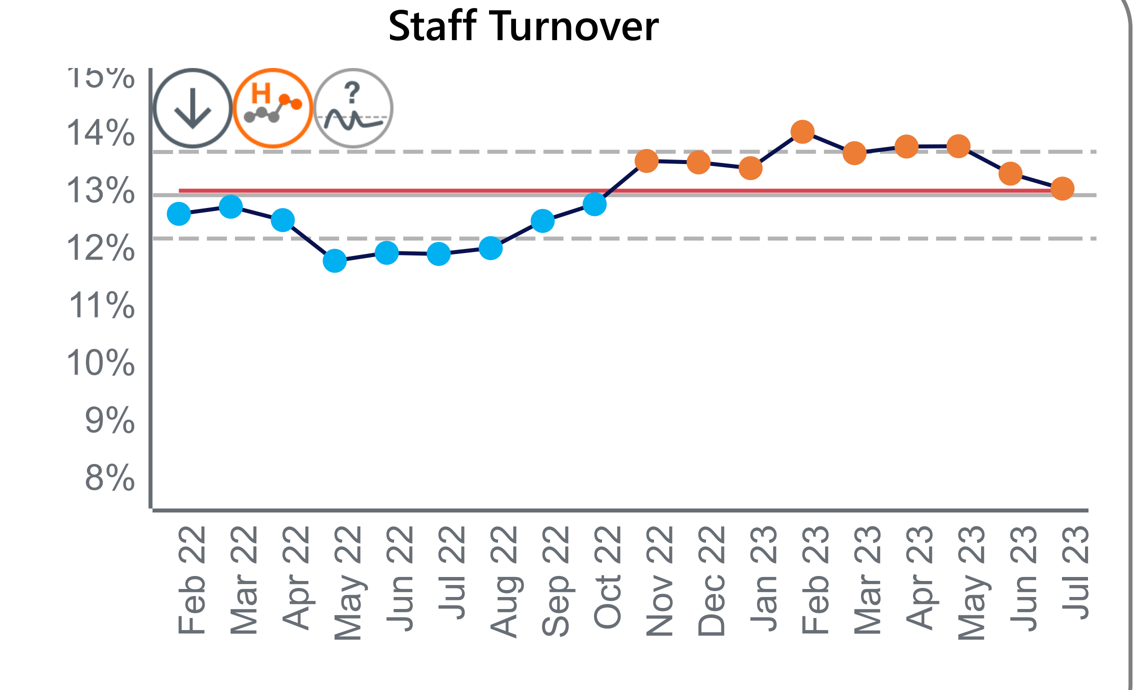


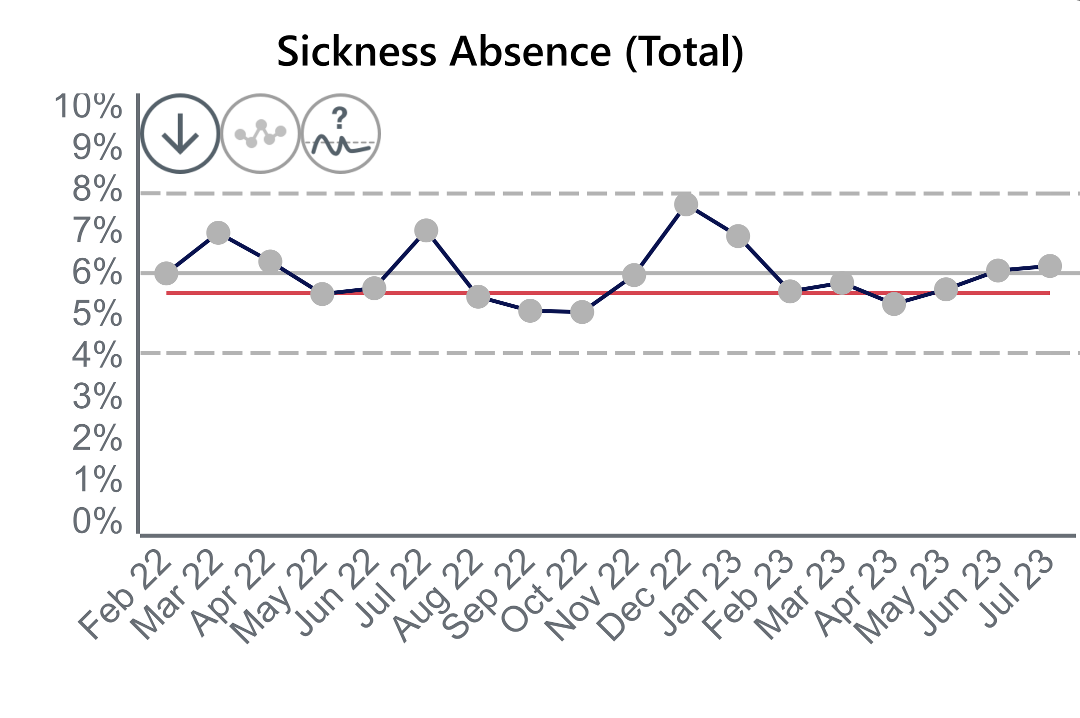












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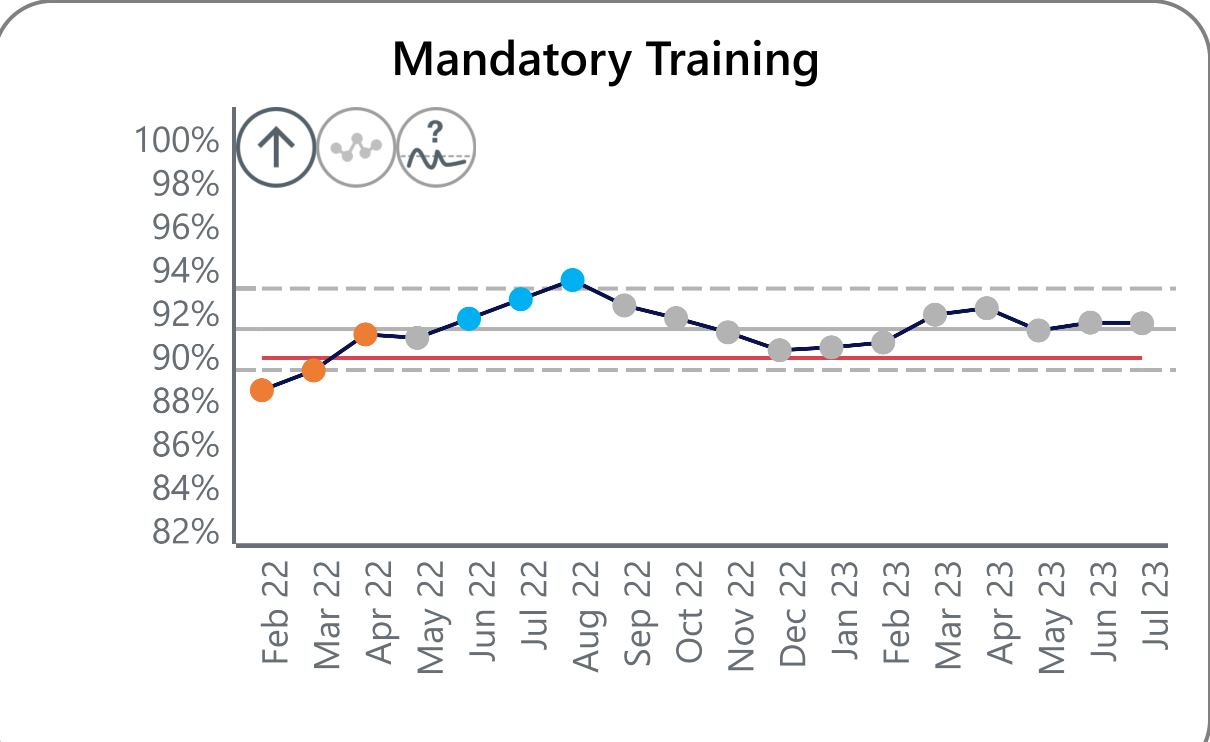
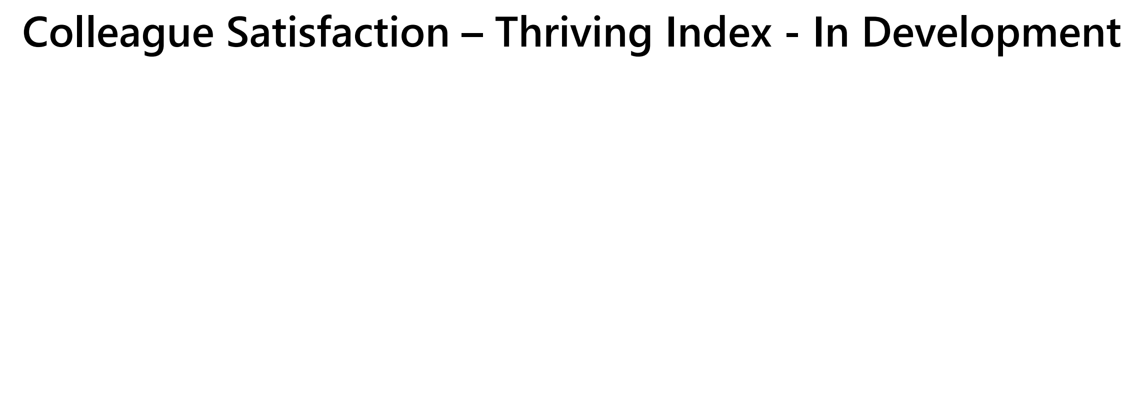
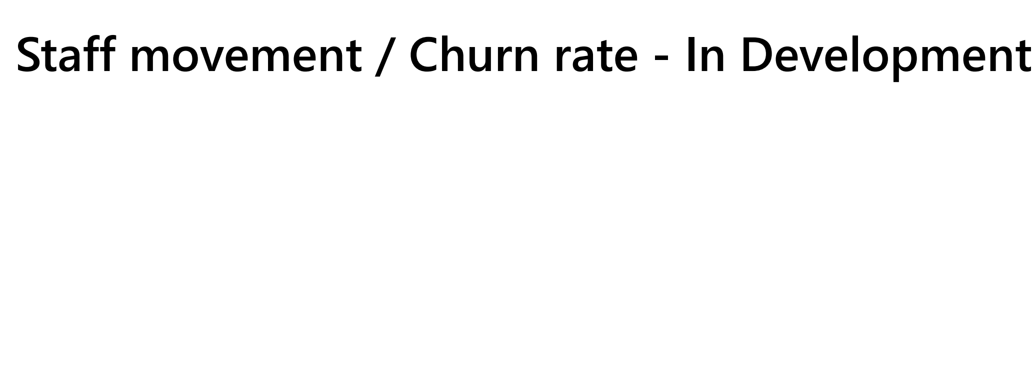
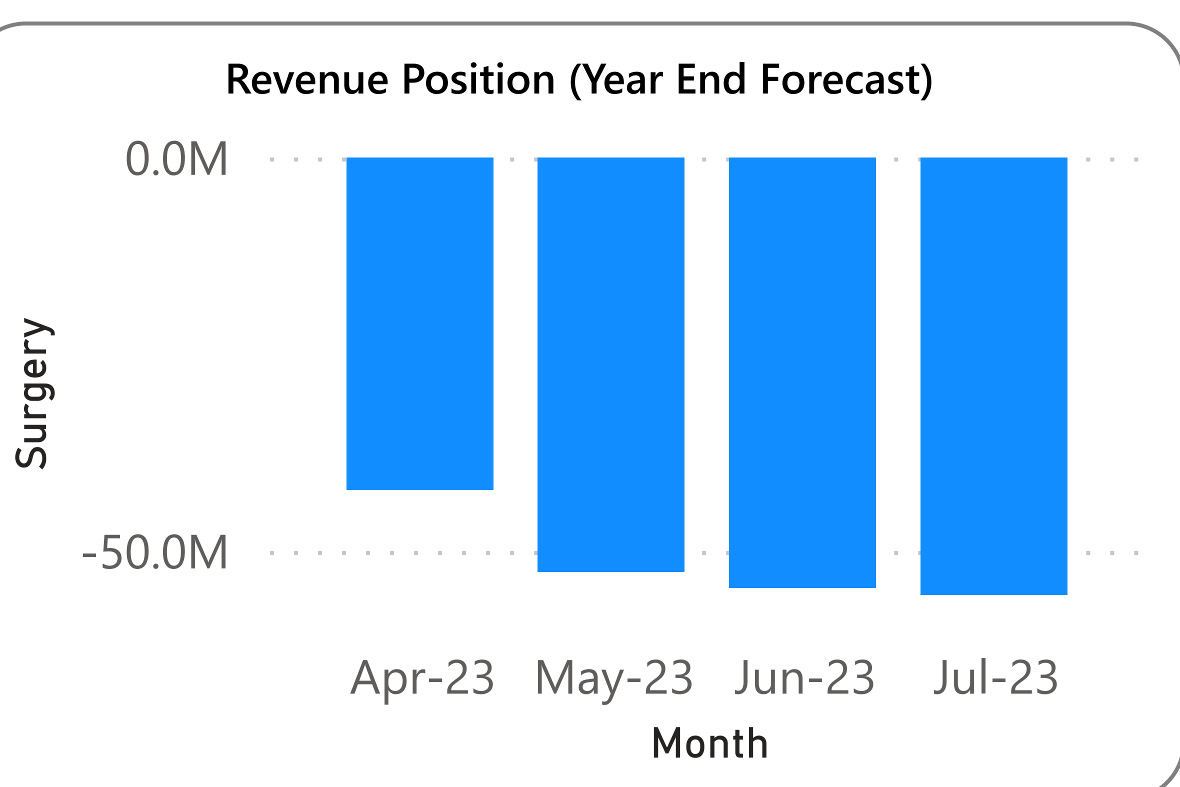
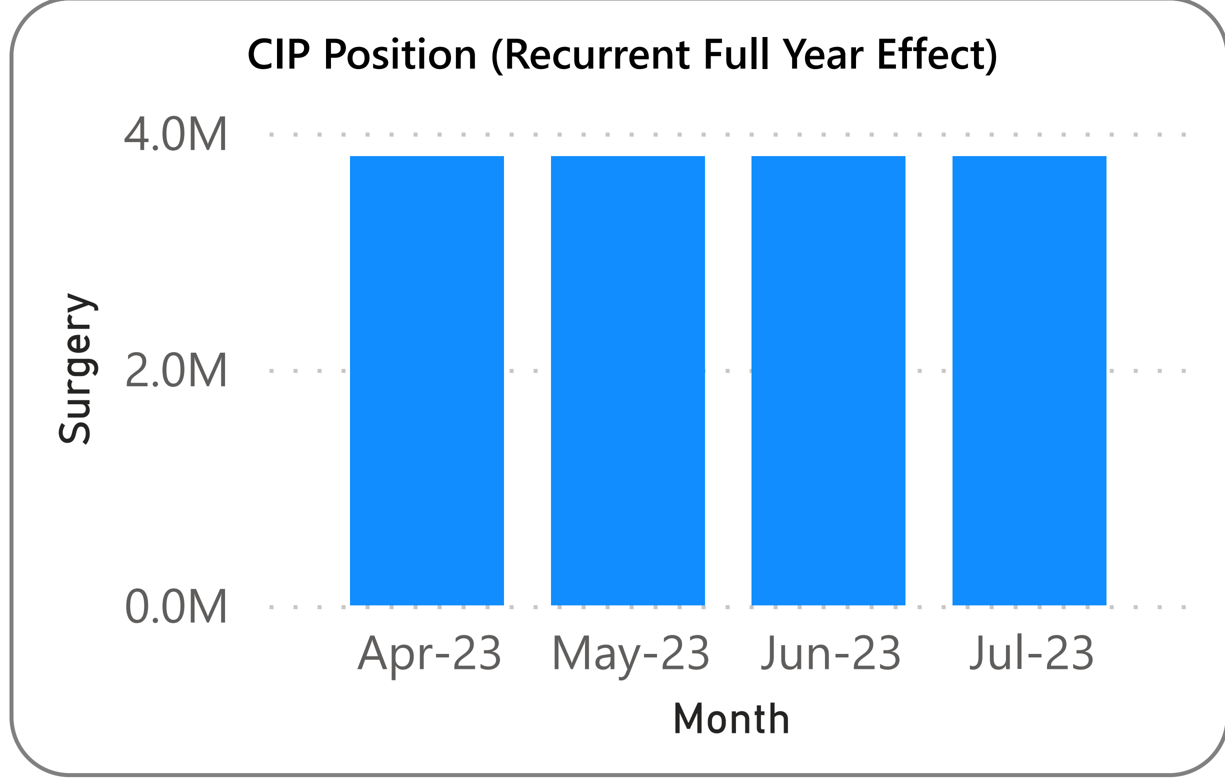
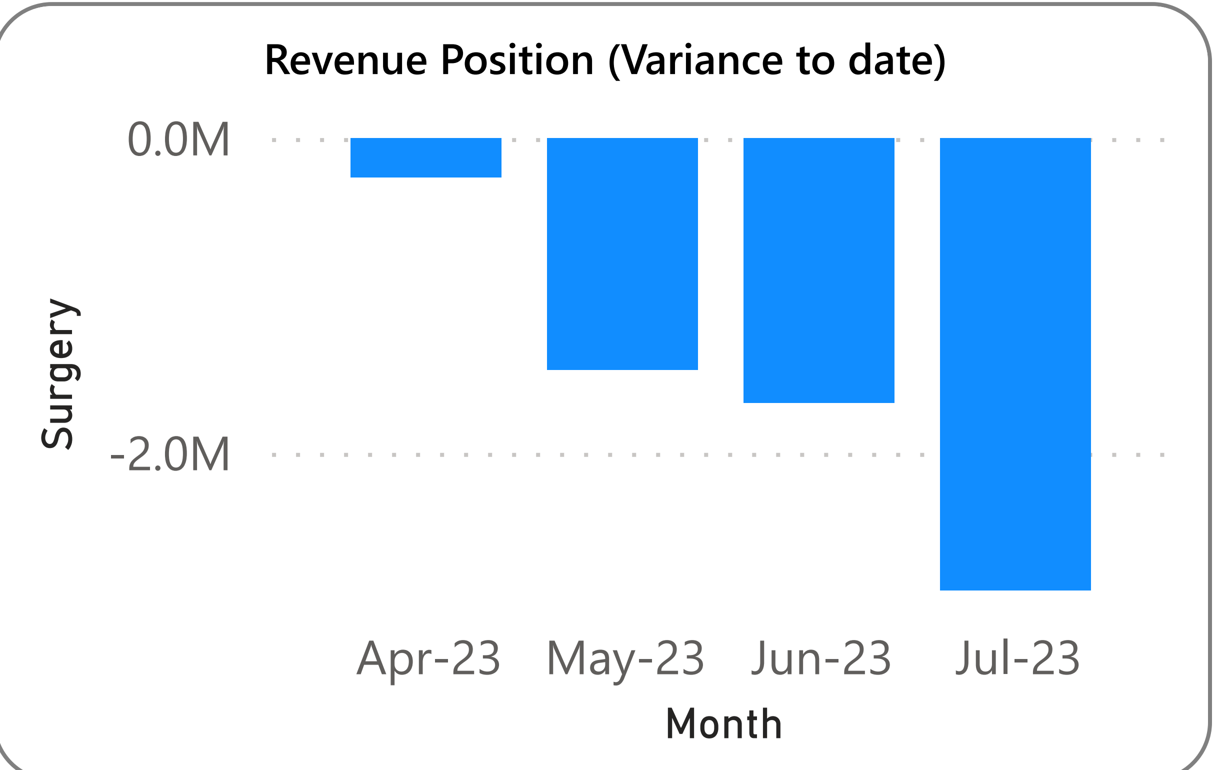


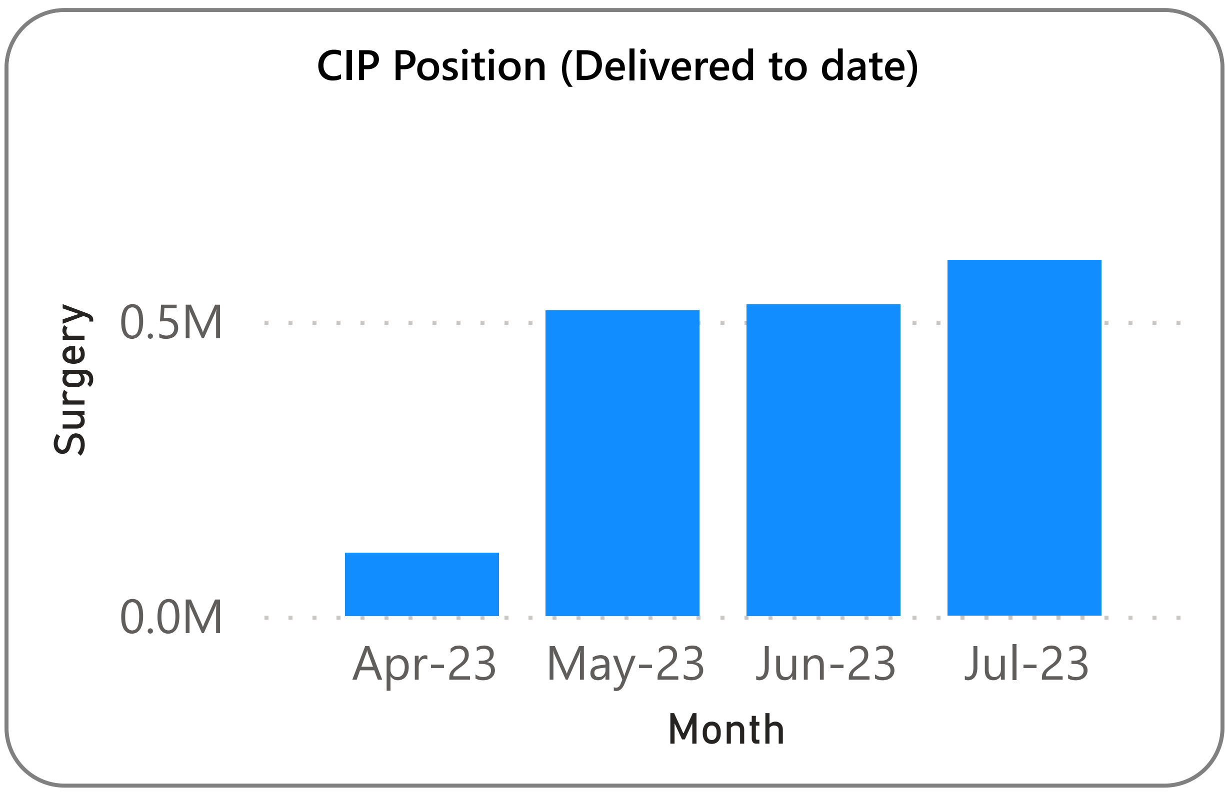


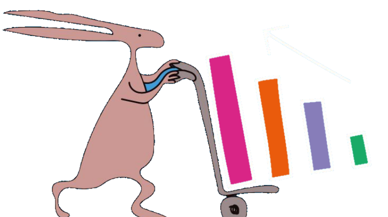












Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

Quarterly Update:

Investment : Alder Hey has been awarded £3.2M to fund 1) 3T MRI scanner, predominantly for clinical research 2) Additional building work required for MRI scanner 3) Laboratory equipment for research sample processing/analysis/storage.

Staff Turnover : Staff turnover has dropped to 18% (has been greater than 20% since Aug 2022).

Patient Experience : New research patient experience feedback platform introduced.

Areas of Concern

Study Recruitment : Overall recruitment of participants to studies has declined each month of 23/24.

Staffing Levels : Long-term sickness within the study governance team is impacting the pace and volume of study setup and associated financial processes.

Reduced support from pathology due to a temporary staffing gap likely to impact study setup and opening.

Forward Look (with actions)

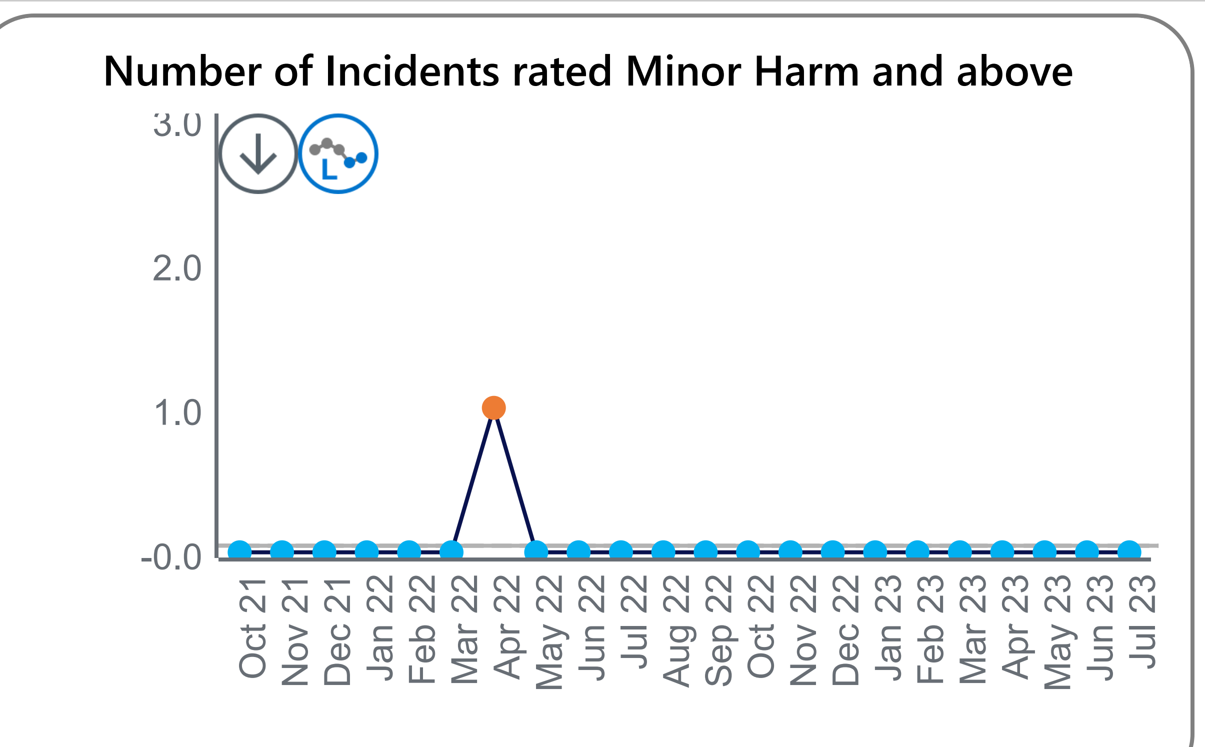
Research Strategy : Engagement with stakeholders underway.

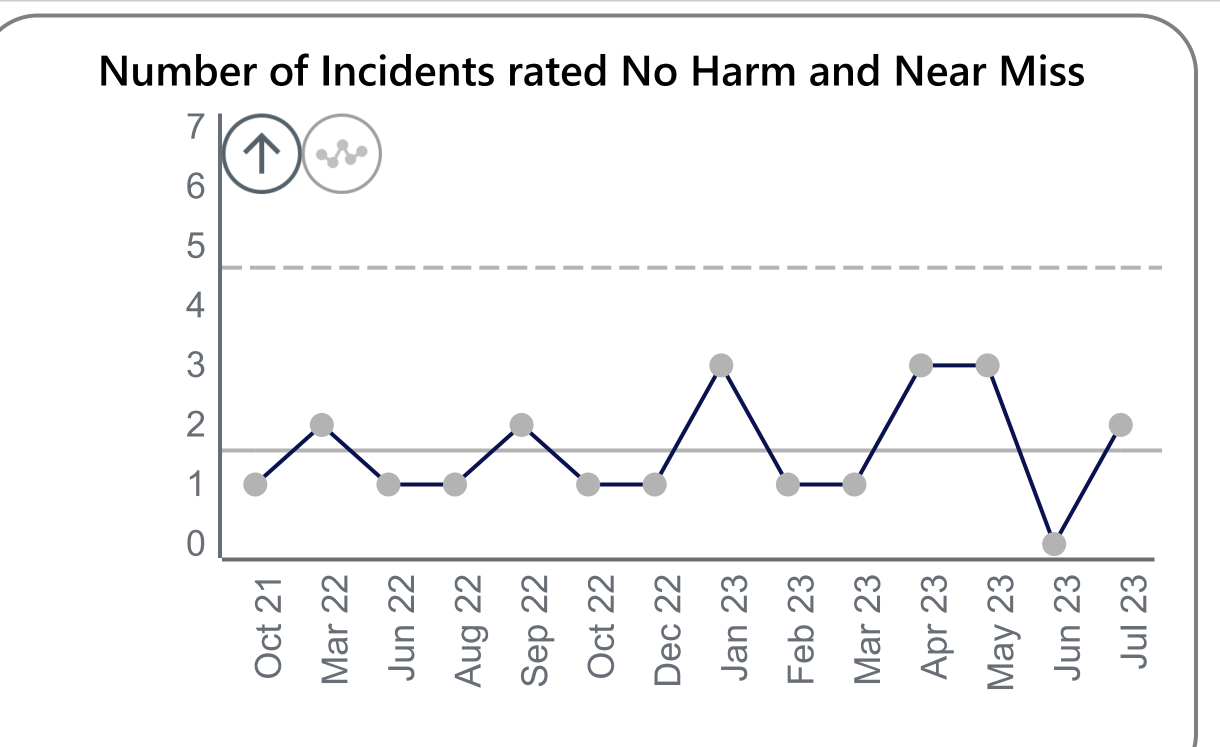
Study Recruitment : Contact with relevant study teams re study recruitment performance and request for plans to address.

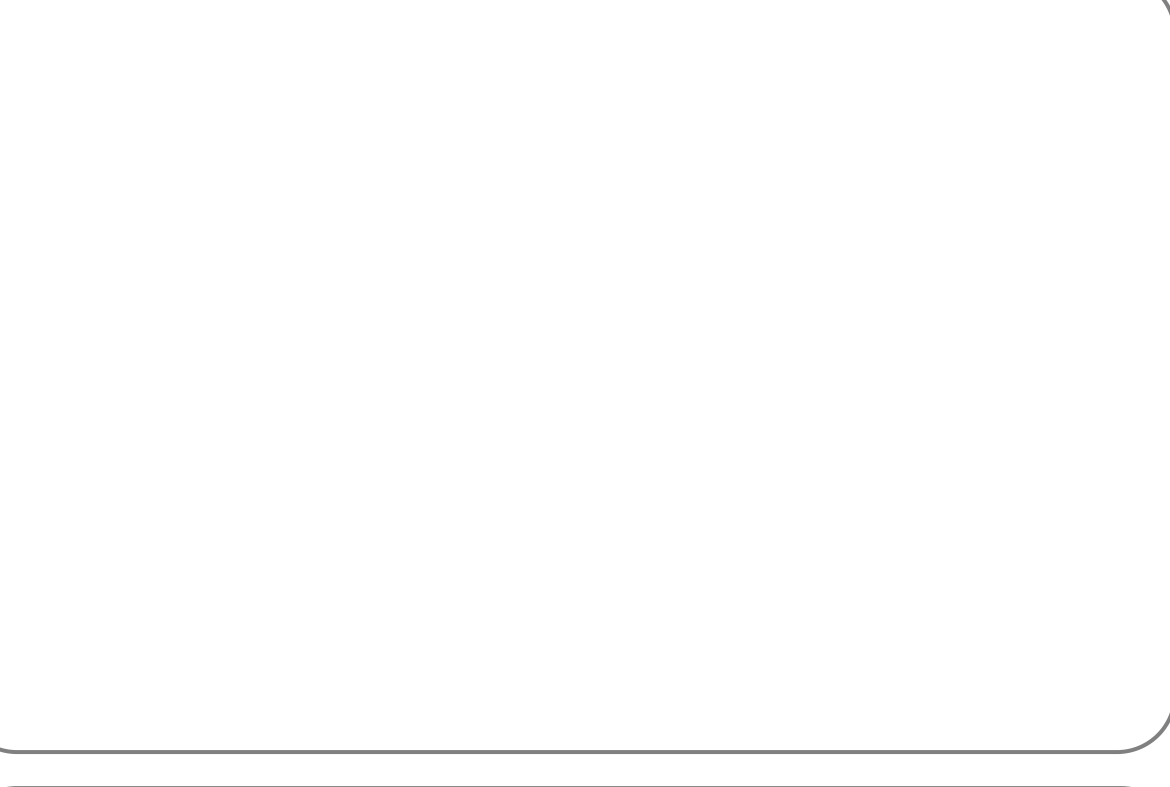
Staffing Levels : Plan to address staffing gaps underway include recruitment to several secondments, external guidance on efficiencies with digital systems and additional training for staff.

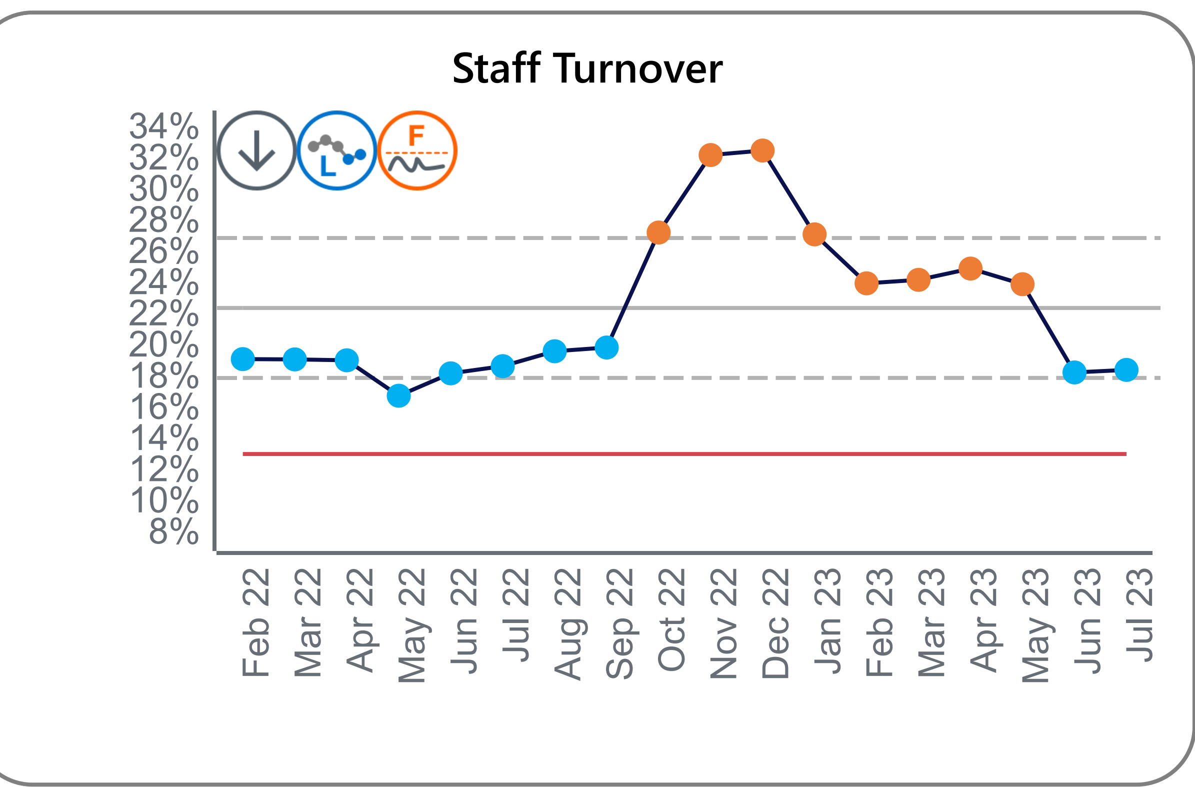
Integrated Performance Report | August 2023

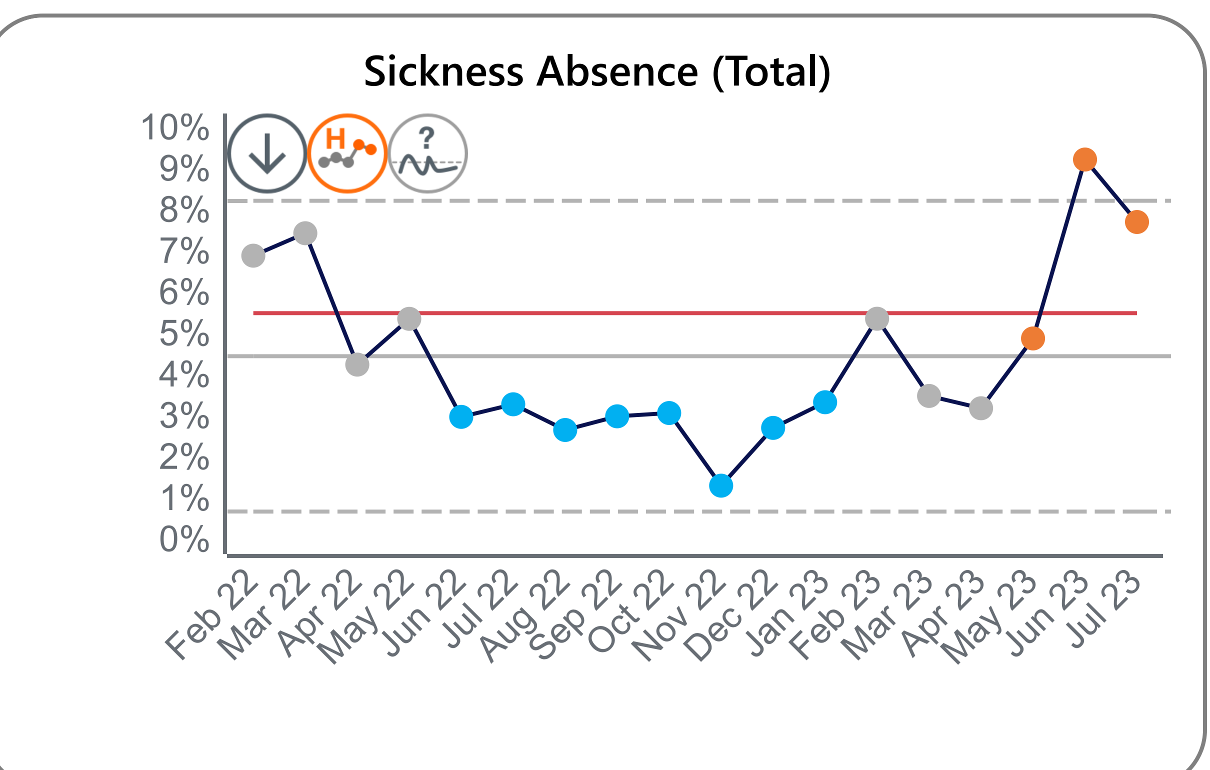
Divisional Performance Summary - Clinical Research

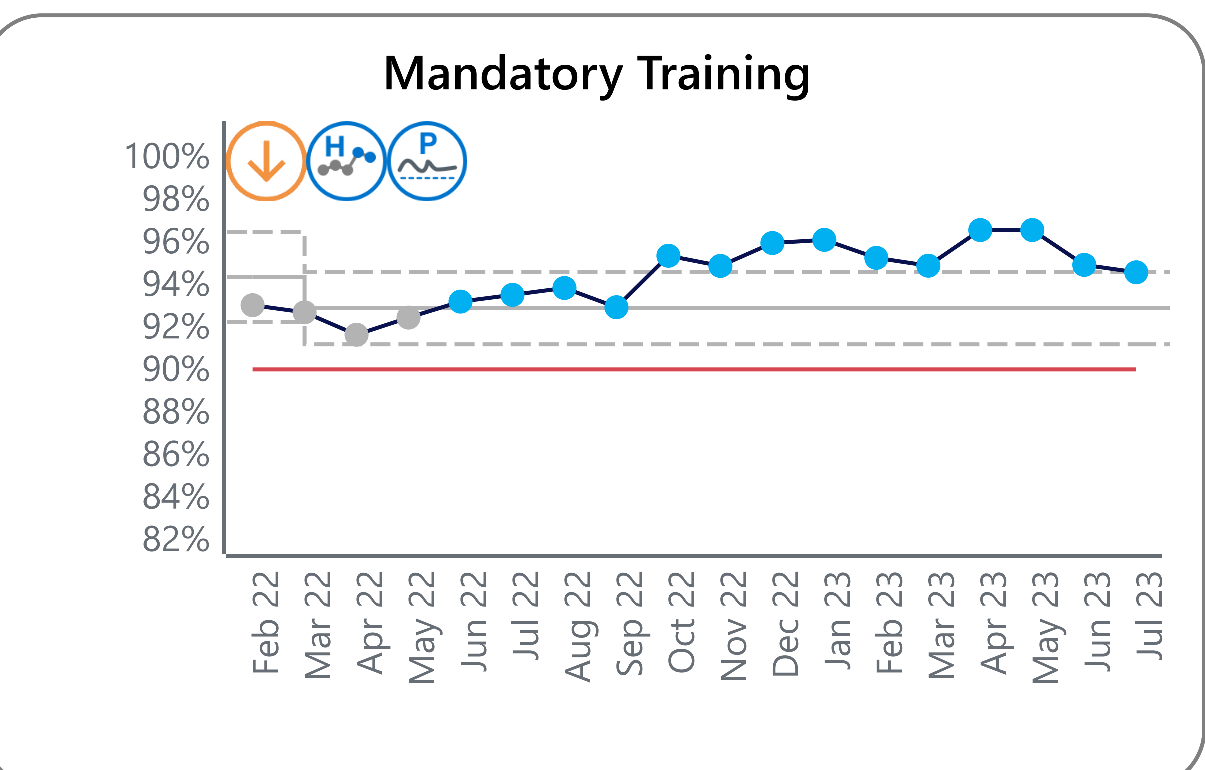


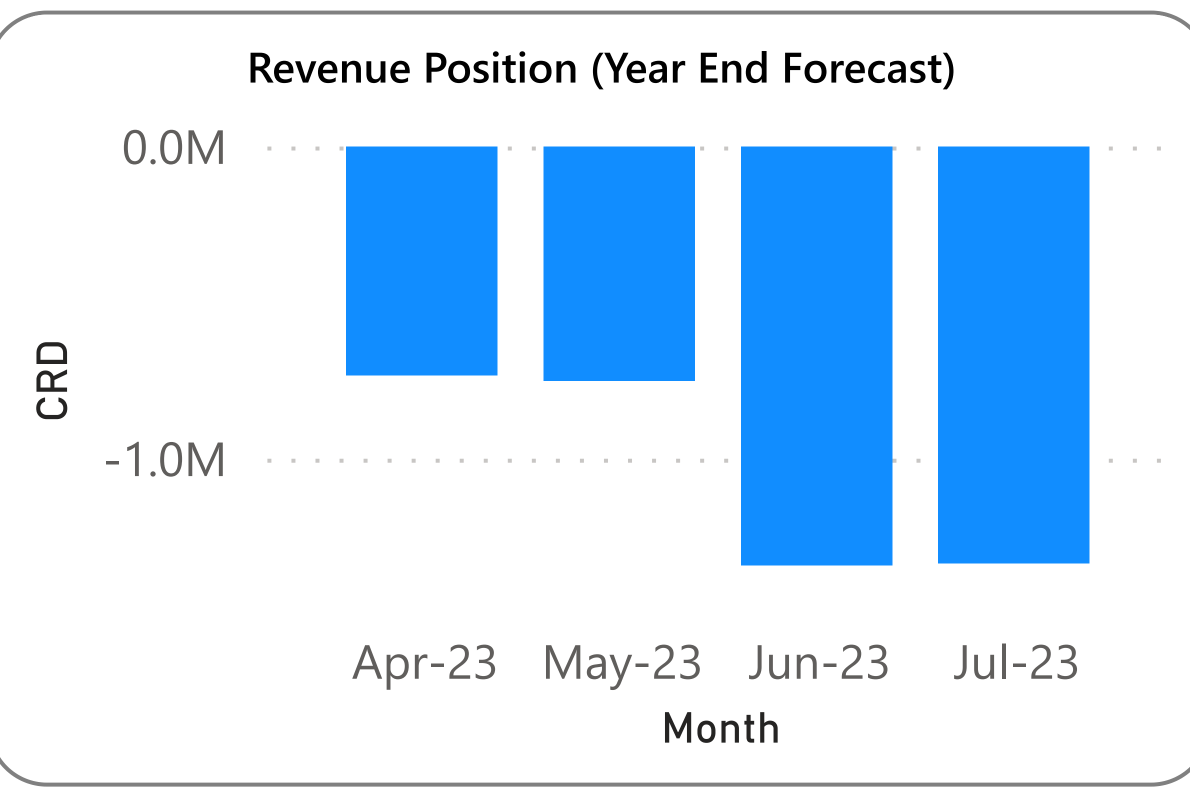


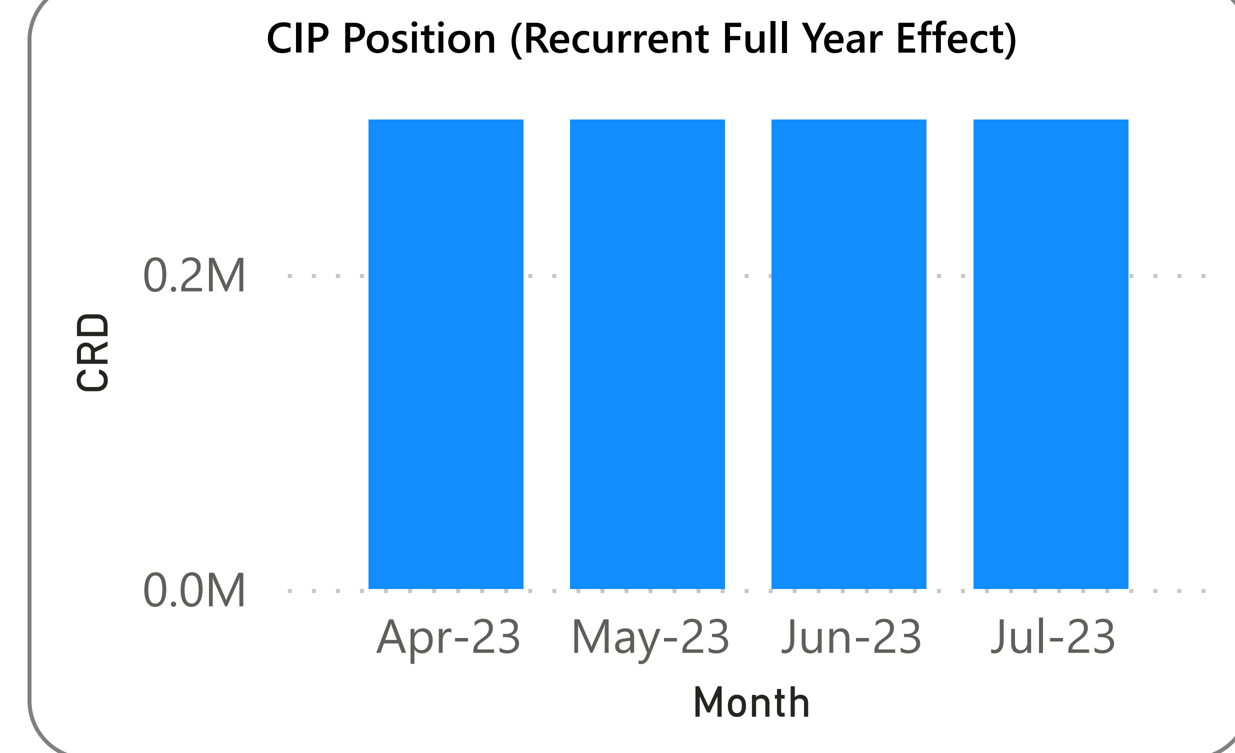


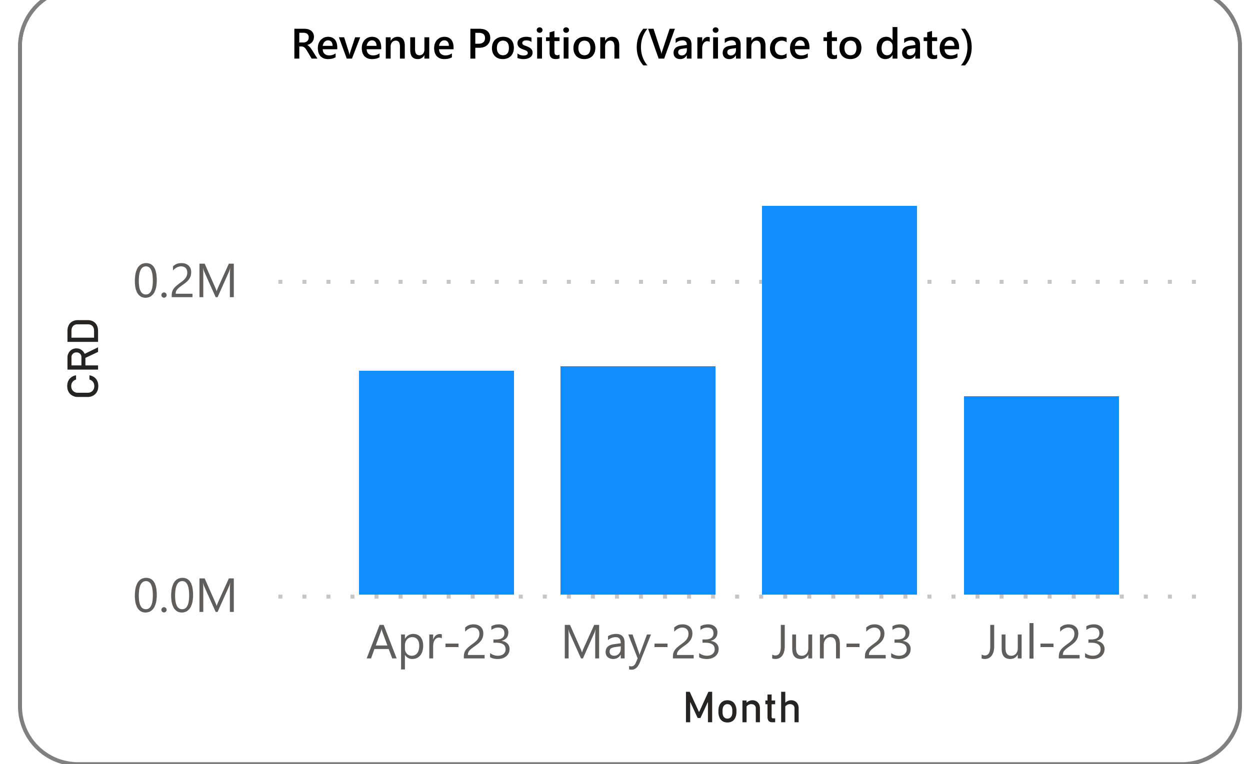


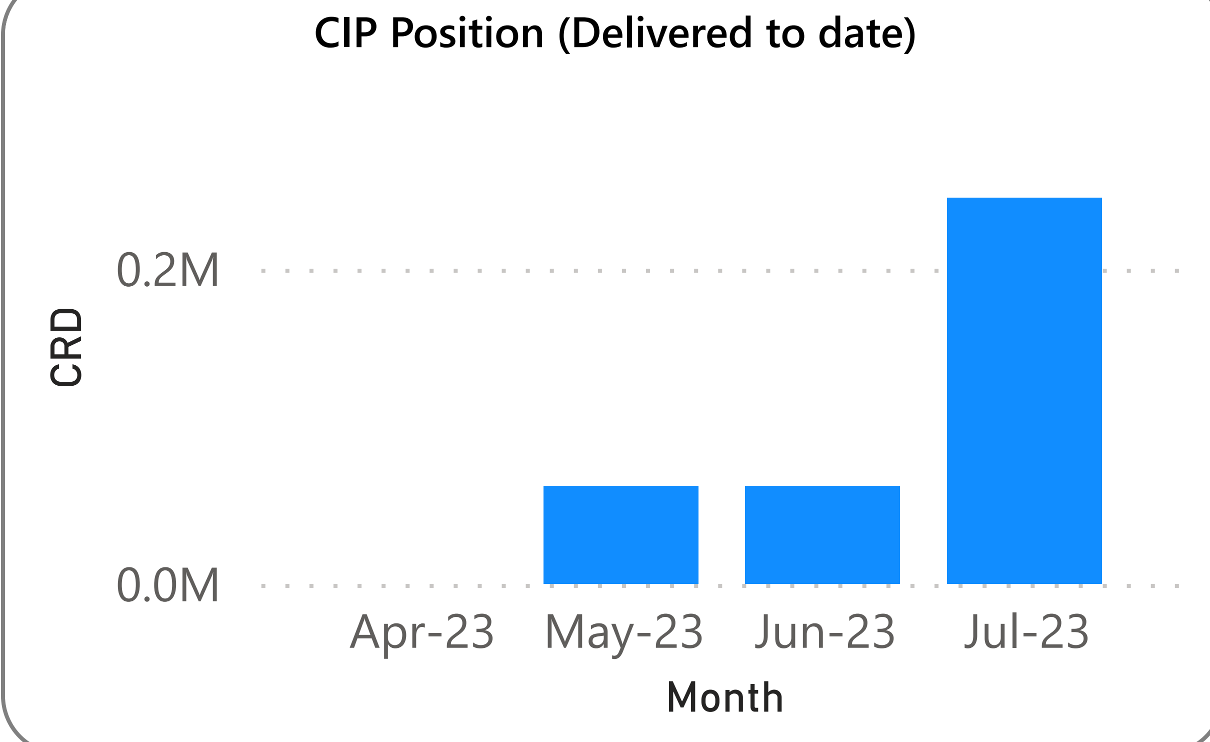


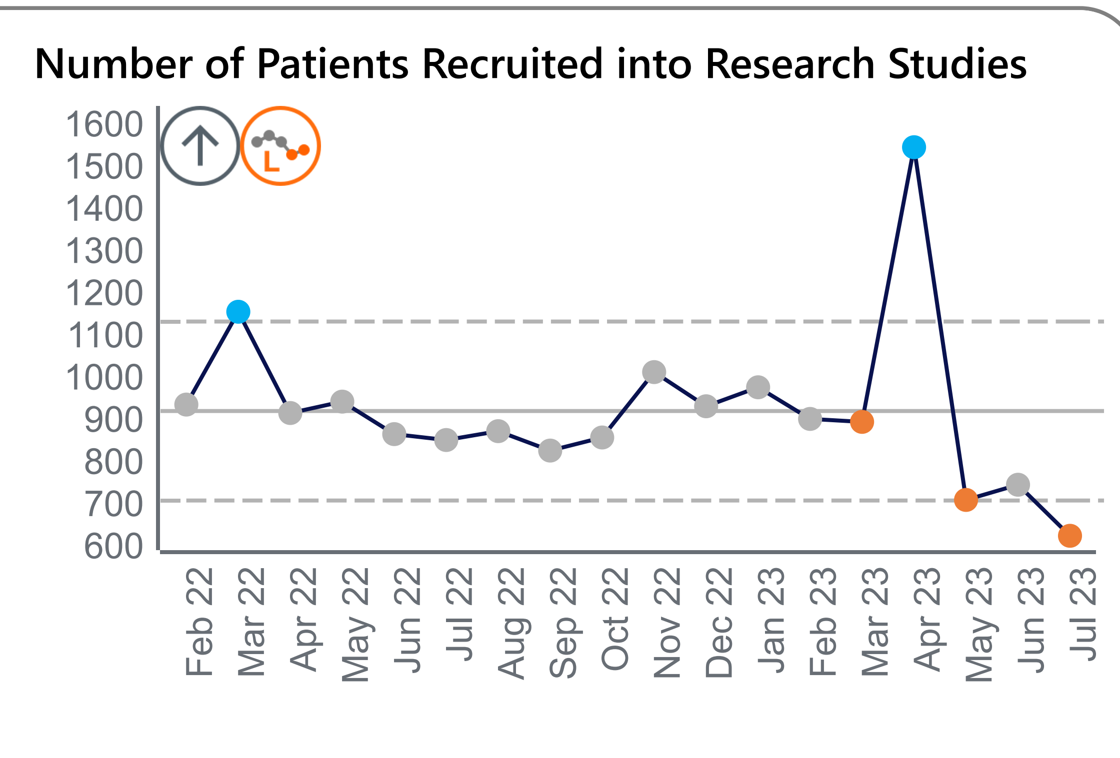


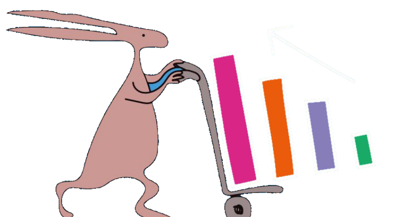








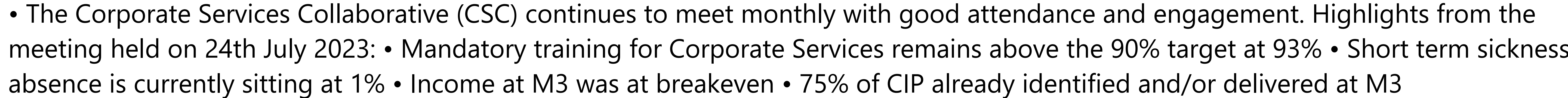




Divisional Performance Summary - Corporate

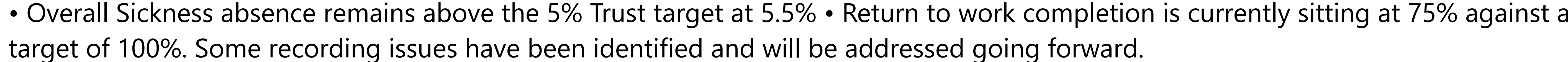
SRO: Erica Saunders, Director of Corporate Affairs

Highlights



• The Corporate Services Collaborative (CSC) continues to meet monthly with good attendance and engagement. Highlights from the meeting held on 24th July 2023: • Mandatory training for Corporate Services remains above the 90% target at 93% • Short term sickness absence is currently sitting at 1% • Income at M3 was at breakeven • 75% of CIP already identified and/or delivered at M3

Areas of Concern

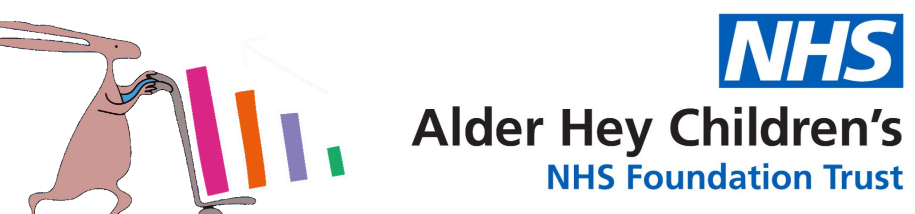


• Overall Sickness absence remains above the 5% Trust target at 5.5% • Return to work completion is currently sitting at 75% against a target of 100%. Some recording issues have been identified and will be addressed going forward.

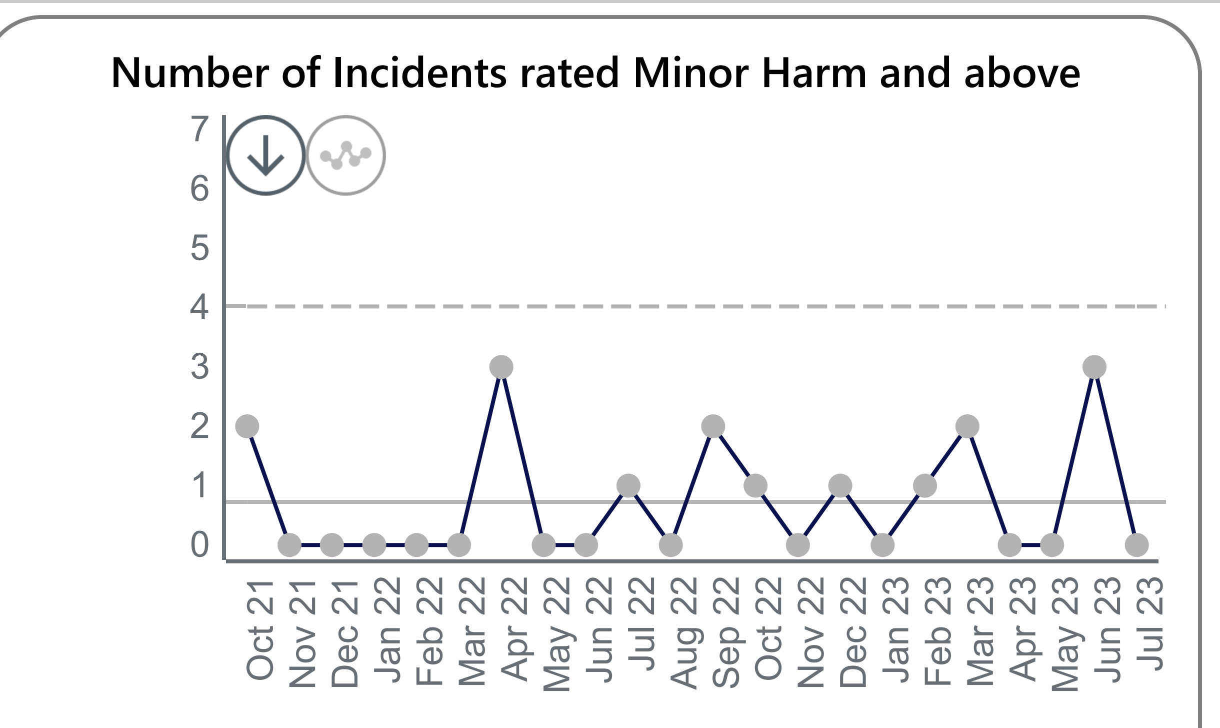
Forward Look (with actions)

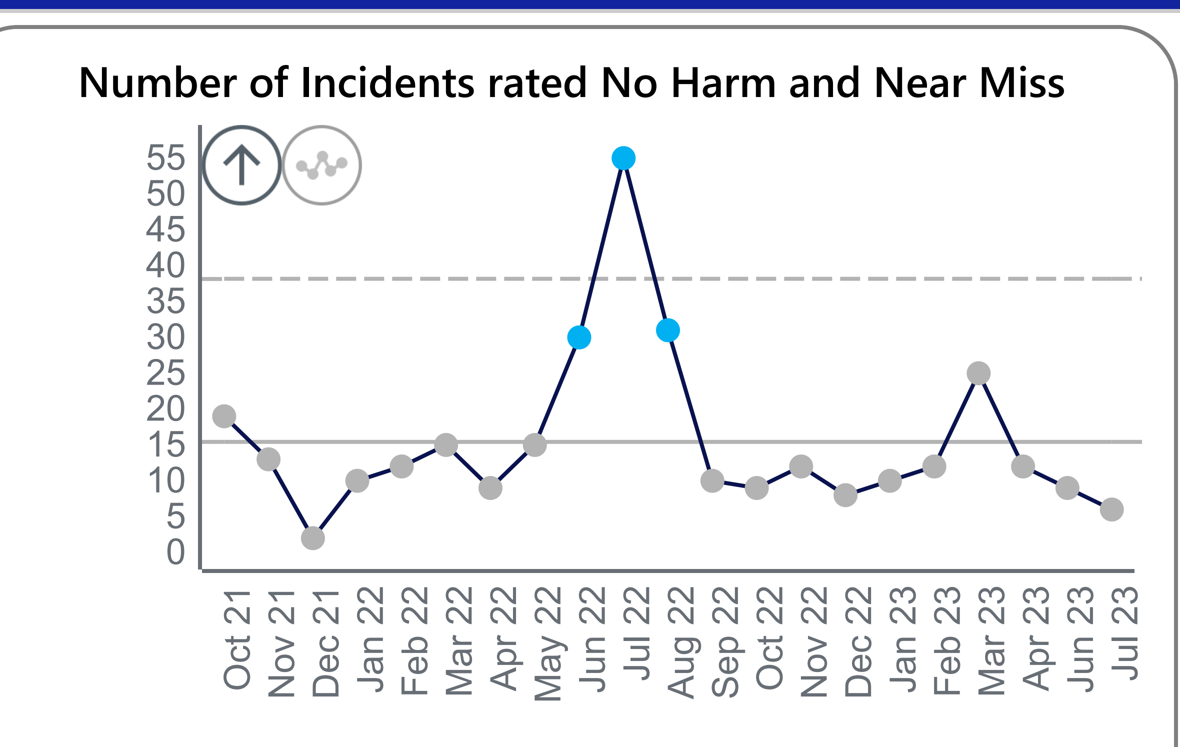
• Proportion of BAME Staff in workforce is currently sitting at 5%; this will be an area of focus going forward • Despite staff turnover rates dropping to its lowest since May 2022 this remains an area of focus, currently sitting at 13% • Zero Tolerance training programme for corporate services with a particular focus on hotspot areas such as security • Further analysis of bank and agency spend.

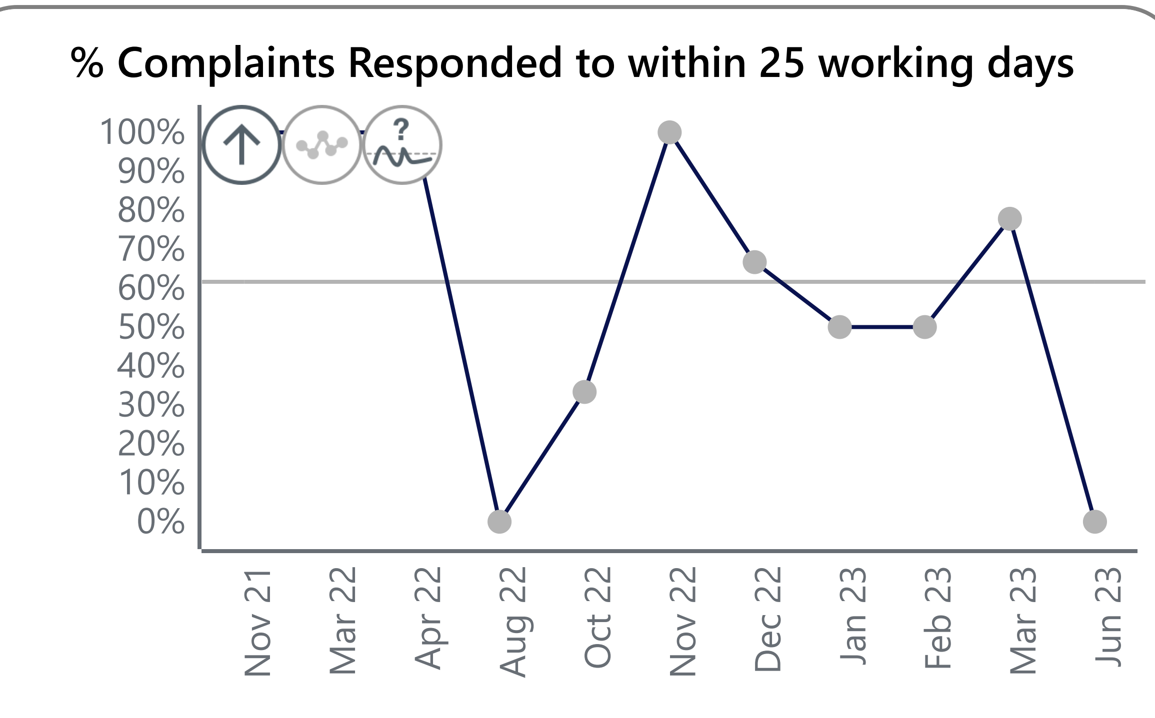
Integrated Performance Report | August 2023

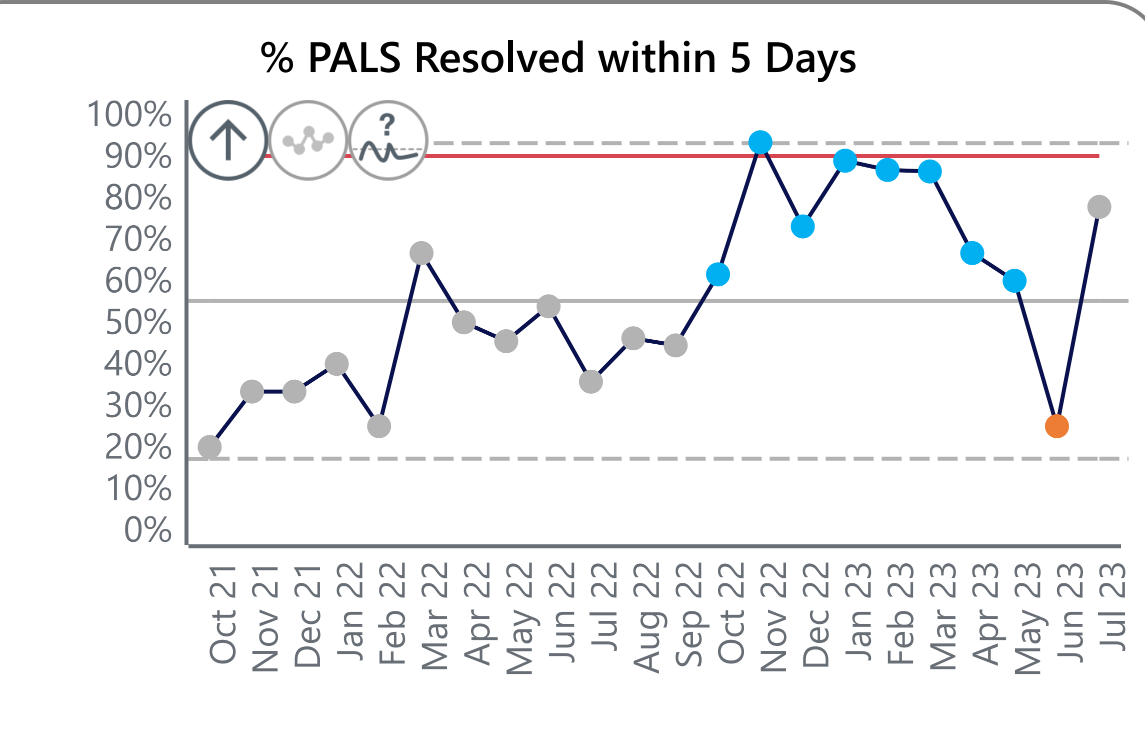


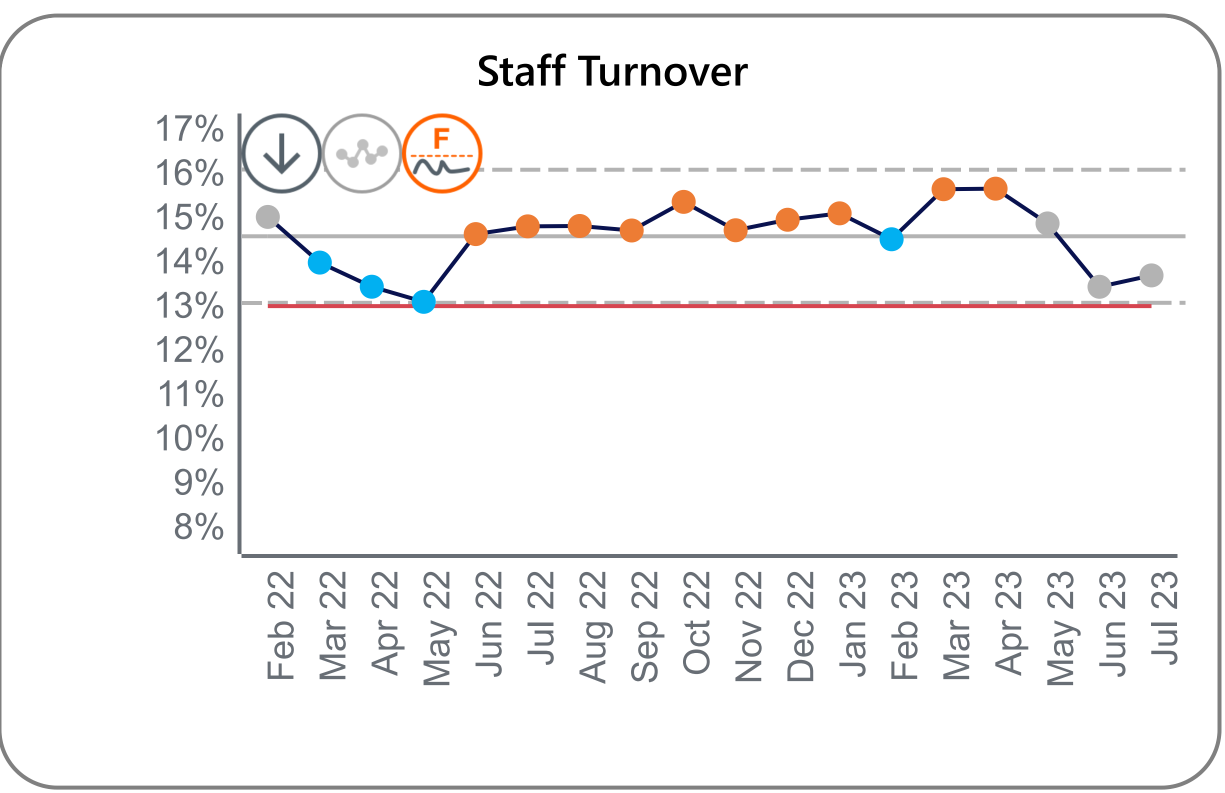
Divisional Performance Summary - Corporate

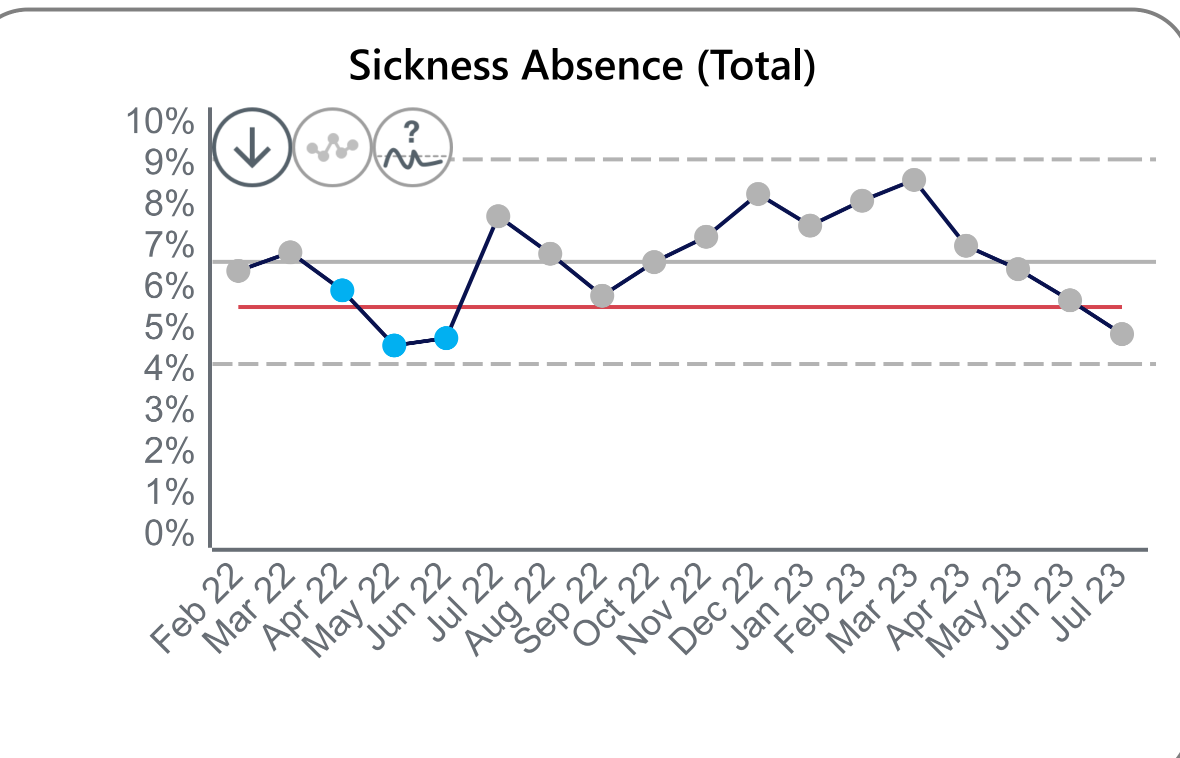


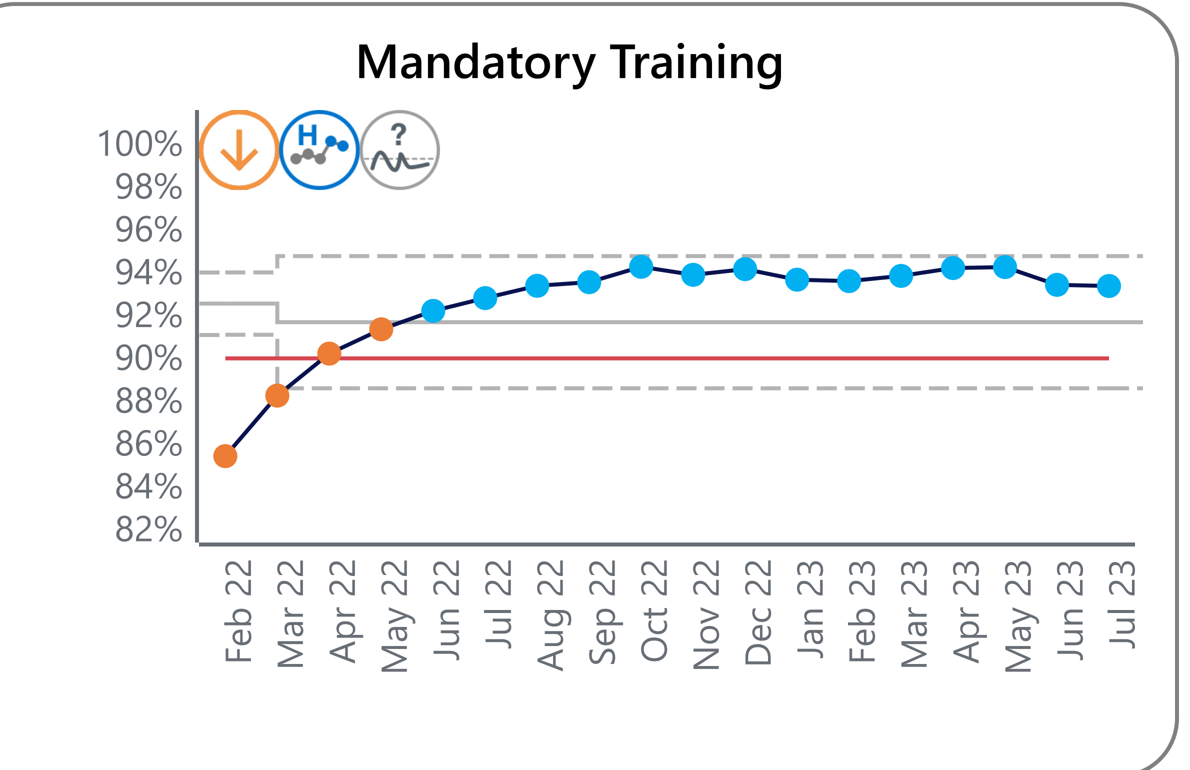


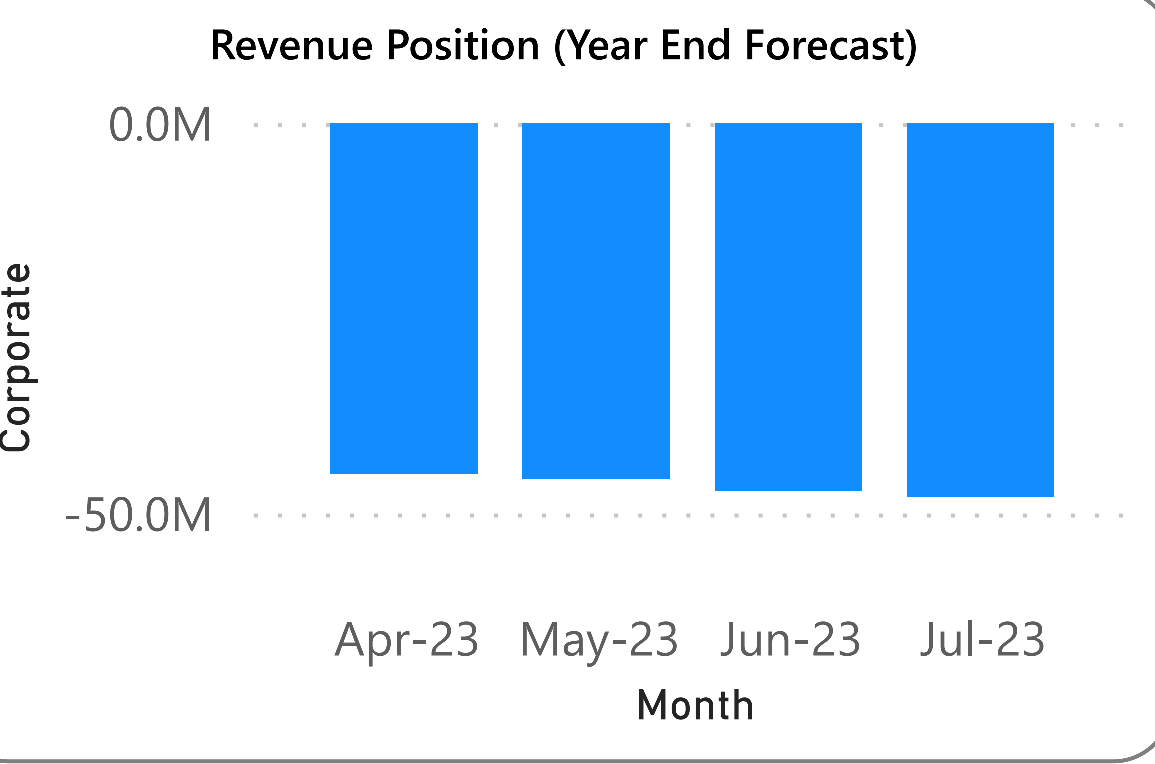


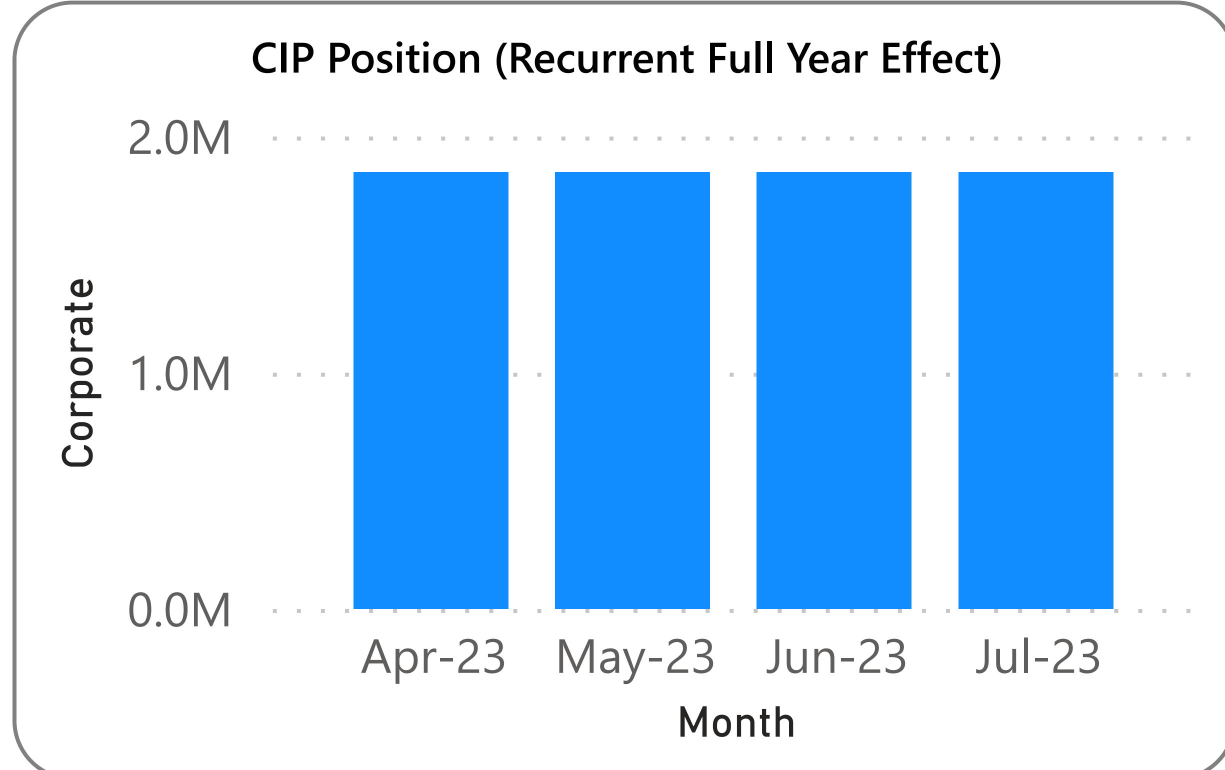


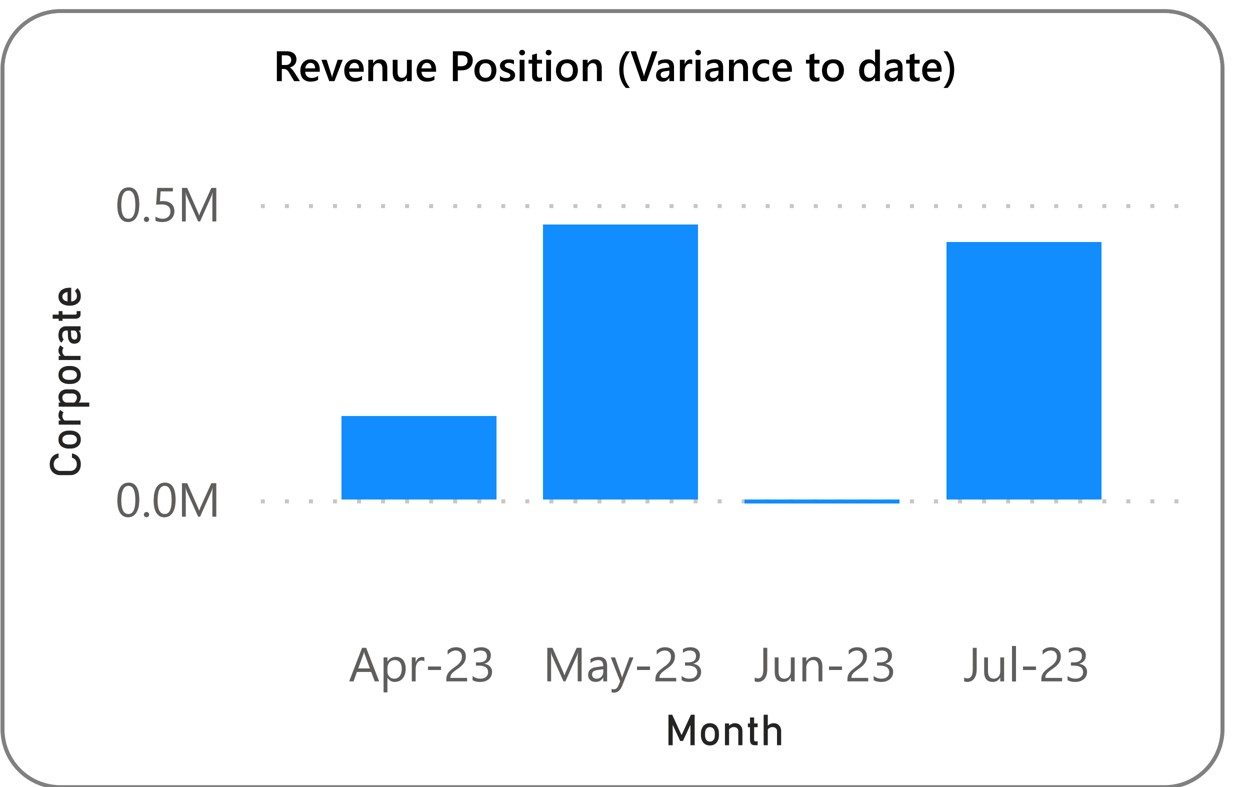


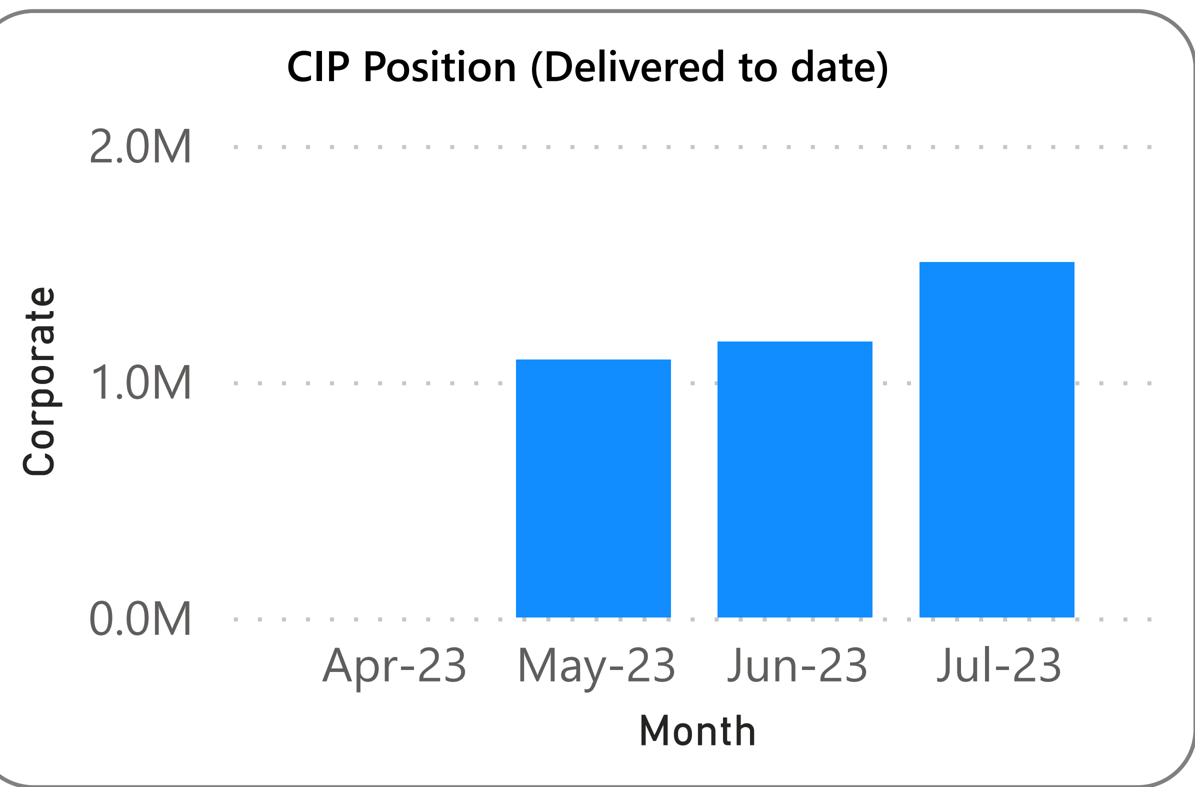












Safe Staffing & Patient Quality Indicator Report
April 2023 Staffing, CHPPD and benchmark
August 2023 Board Paper

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Vacancy		Turnover (Leavers)		Sickness		Medication incidents		Staffing Incidents		FFT			
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total	Total count of Patients at Midnight	CHPPD Rate		RN - %	HCA - %	RN - %	HCA - %	RN - %	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good	Pals	Complaints
Burns Unit	91%	-	100%	-	1836	**5**	367.20	9.12	-1.29%	0.00%	0.00%	0.00%	2.56%	0.00%	1	12	1	1	7	100%	0	0
HDU	67%	107%	59%	78%	6926	**234**	29.60	34.29	6.95%	-11.89%	2.99%	0.00%	7.56%	6.26%	2	17	0	2	2	100%	2	0
ICU	74%	107%	73%	53%	15292	**385**	39.72	34.29	7.13%	-130.26%	0.81%	0.00%	4.64%	6.67%	8	42	1	1	3	100%	1	0
Ward 1cC	87%	80%	85%	125%	6800	**476**	14.28	12.61	1.56%	-21.01%	1.75%	0.00%	2.65%	17.48%	5	19	1	6	6	83.33%	0	1
Ward 1cN	70%	0%	72%	-	3176	**225**	14.11	14.11	6.93%	17.70%	1.68%	0.00%	4.01%	0.00%	0	10	3	7	0	-	0	0
Ward 3A	94%	79%	91%	94%	7280	**645**	11.29	10.92	-9.39%	0.81%	0.00%	5.75%	8.22%	9.32%	4	16	0	4	39	97.44%	2	0
Ward 3B	82%	66%	77%	100%	4558	**336**	13.57	13.57	2.06%	-90.07%	0.00%	0.00%	5.82%	5.95%	0	0	0	5	2	100%	0	1
Ward 3C	90%	77%	74%	104%	7750	**665**	11.65	10.47	5.06%	5.69%	0.00%	0.00%	4.36%	17.35%	7	26	0	0	8	87.5%	1	0
Ward 4A	73%	57%	75%	33%	6848	**673**	10.17	10.73	3.71%	-14.45%	2.52%	0.00%	10.29%	3.51%	4	19	1	1	19	94.74%	2	0
Ward 4B	70%	91%	47%	98%	8184	**533**	15.35	13.94	7.86%	8.90%	6.52%	0.00%	20.76%	8.47%	5	36	1	1	7	57.14%	2	0
Ward 4C	88%	102%	82%	115%	7072	**758**	9.33	12.90	15.40%	4.50%	5.75%	0.00%	9.45%	19.48%	22	67	0	2	27	100%	0	0

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

Medicine

The over establishment on 3B for unqualified vacancies are the additional supernumerary staff who are awaiting a pin or occupational health clearance which has impacted the fill rate for registered as they are not yet counted in the numbers. During this month the ward has had to cover a high number of maternity leave posts and request additional bank shifts to cover the number of 1:1s on the ward.

Ward 3C continue to require additional bank shifts to cover 1:1s, there is inconsistency across the month in bank shifts being filled. The vacancy gaps improve from July onwards. HCA sickness on 3C is high as a percentage but is only 2 members of staff. In addition, 1-1 RN 24/7 has been required for a complex patient increasing CHPPD rate which is higher than the national benchmark.

Ward 4B sickness remains high for April, with an increase in short term sickness due to bereavement leave and pregnancy related sickness. HR drop-in sessions commenced w/c 13th February and a task and finish group has started to focus on staff wellbeing and retention. The over establishment on 4B for unqualified vacancies, includes the international nurses awaiting a pin or occupational health clearance which has also impacted the fill rate for registered as they are not yet counted in the numbers. The ward has also had to cover a high number of maternity leave posts.
Leavers RN increased this month 6.52%.

Ward 4C had 2 x HCA on long term sick and we saw an increase in short term RN sickness which reduces again from May.
Vacancy rate RN has increased to 15%. High turnover this month. Staff leavers at 5.75%. This starts to decline in July.
Medication incidents on 4C are notably higher than other areas but deep dive into incidents shows mainly near misses and good reporting culture.

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

During April, Burns unit was closed and patients moved to HDU due to maintenance work. Unfortunately, this is not reflected in the patients count or CHPPD figures. The ward also had to cover several maternity leave posts and staff seconded to other areas still sat on the burns line, this has been sent to finance to resolve.

Ward 1cCardiac are over recruited on the HCA line but have housekeeper vacancies. The HCAs job share and do 1 day a week as a housekeeper; therefore, this mitigates the over recruitment. This has been highlighted to finance to separate on the budget line.

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

Ward 3A RN fill rate continues over 90%, however they are over recruited on the RN line due to covering a high number of maternity leave posts. 3A had a number of long term sickness and had a young person with significant complex and behavioural challenges on the ward resulting in an increase in work related sickness for both RN and HCAs. The turnover for HCAs is reporting as 6%, however this equates to only 0.61 WTE. 3A have also had good uptake on bank shifts to cover sickness gaps and vacancy.

Ward 4A had 6WTE RNs off with complex long-term sickness, who are being managed in line with sickness polices and with HR support. The ward also had to cover 8WTE RN maternity leave posts. An action plan is now in place on the ward to pause any internal secondments and to only take as many newly qualified or less experienced nurses as they can safely manage and support. HCA shifts were requested to support with HCA vacancy and RN gaps; howeverthey have not been consistently picked up.

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 and ICU have had newly appointed supernumerary staff not reflected in the numbers whilst in training. Fill rate for care staff was 107% due to international nurses that had started and were working as band 4 prior to gaining NMC registration. In addition, HDU had some patients that required HCA 1:1’s on the unit, as well as usual HCA workload.

Fill rate is based on planned hours required for 100% occupancy however occupancy was lower due to industrial action, therefore quality and delivery of care not impacted.

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Summary

There are some differences in CHPPD benchmarks for the month of April. ICU, 1cC, 3A, 3C, 4B and 4C are notable.
Burns and HDU are reported incorrectly due to Burns patients being moved to HDU.

ICU during the month of April had reduced activity and patients resulting in higher than average CHPPD.
Ward 3A had less admissions during the month of April. Some activity was reduced due to industrial action.
1C cardiac activity reduced in April again due to industrial action resulting in higher than average CHPPD.

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

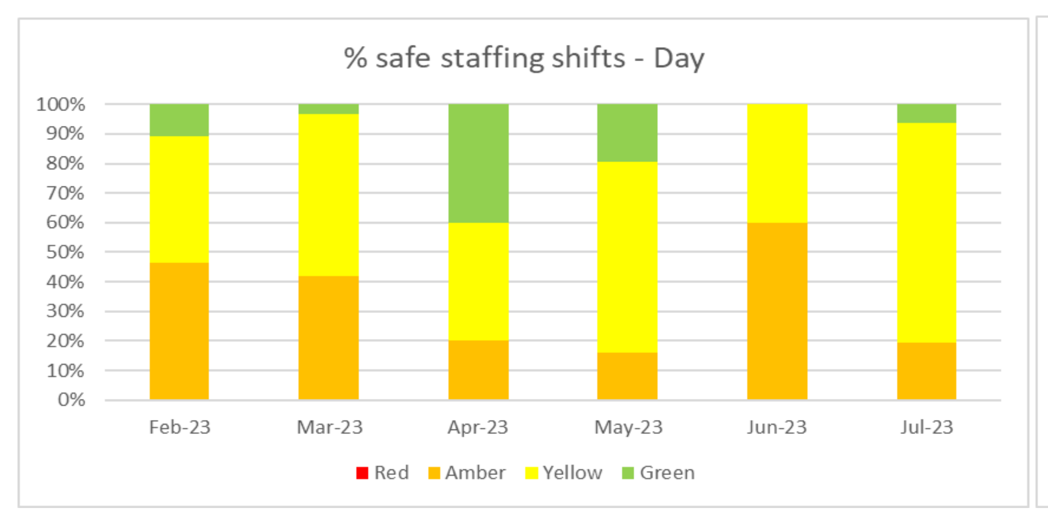
Wards 4C CHPPD is slightly lower as was particularly busy during this period and were at full capacity with high acuity patients.

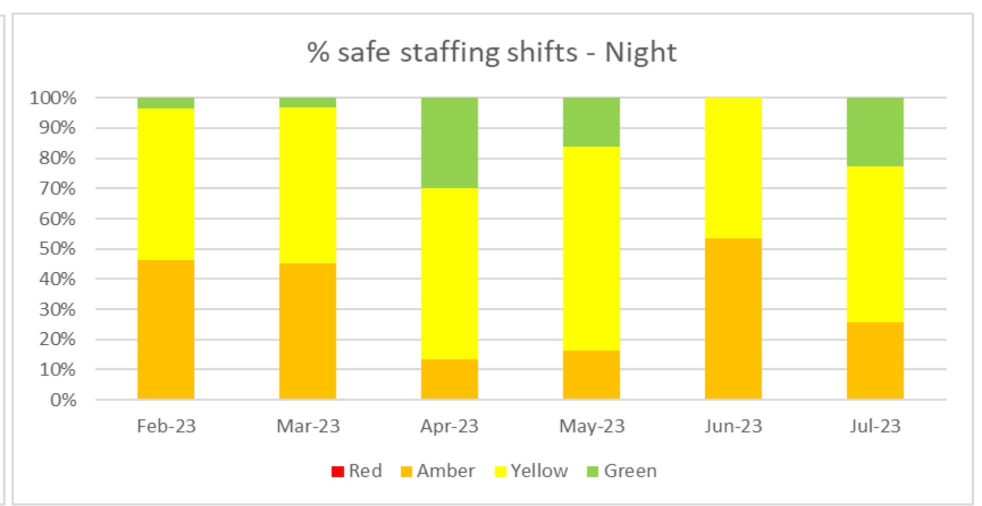
Industrial Nurses Action during April may have impacted the CHPPD.

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

Summary of July 2023 staffing

Staff rag has improved from June with an increase in green day and nights. 0 red days have been recordered since November 2022.





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OUR PLAN
INSPIRED BY CHILDREN
Alder Hey Children's NHS
NHS Foundation Trust
Financial Performance Report
Month 4 23/24
Trust Board
BRILLIANT BASICS

Contents

1. Financial Performance Report Month 4 – Executive Summary (full report included in information pack)

2. Key Risks – Month 4 status

1. Financial Performance Report Month 4 – Executive Summary

Executive Summary

Executive Summary for July 23-24

The Trust has reported a £9k surplus in July (M4), whilst year to date is a deficit of £1.49m which overall remains in line with the plan.

Although the Trust is reporting in line with plan and a £1.49m deficit, the financial plan is becoming increasingly challenging to maintain, with Industrial Action impacting on overall performance at c.£1.9m including lost income and costs which is being mitiagted to date by opportunistic beenfits such as high interest rates, unutilised provisions being reviewed and an assumption of addiditonal income above the mandated ERF targets. The Q2 financial profile moves to a break even position so delivery against plan will become more challenging given the uncertainty of future strike action and will represent a risk for the remainder of the financial year which we have reported to C&M ICB as part of the key monthly returns.

Key factors impacting on the year to date position include :

- Income £4.6m ahead of plan due to assumed additional income for increased PBR activity above planned levels (ICB activity), income from long stay patients as well as private patient income. The budget for interest receivable has been increased to reflect the higher interest the Trust will receive on its cash for the year.

- Pay £2.5m adverse to plan due to continued HCA 1-2-1 & sickness levels, waiting list initiative spend for recovery activity, Industrial Action costs and non-delivered CIP.

- Industrial Action impact YTD of £1.9m, including additional costs and income loss of cancelled activity.

- In month Divisional performance is varied with Surgery (£1.19m) and R&I (£0.58m) reporting adverse positions whilst the remaining divisions show a surplus (£1.09m). Year to date Surgery (£2.87m) & Medicine (£1.39m) are off plan.

In terms of forecast for the year, there is a heightened risk given the pressures arising in month 4 including Industrial Action and the requirement to deliver CIP in full, however as reported last month, the divisional forecast produced is showing a most likely achievement of the £12.3m plan surplus. This is being managed through increased oversight, through a programme approach including escalation finance meetings, launch of finance awareness programme, tighter expenditure controls and approvals and CIP oversight at Sustainability Delivery Group meetings.

The level of CIP posted to date, is behind plan by £1.2m. The plan for the year is £17.7m of which £6.4m has been posted so far, £1m increase in M4. A further £6.2m plans are in progress which means there is a £5.1m shortfall overall (including £3.47m transformation). The CIP programme is red status until delivered in full in year with a continued focus on recurrent delivery and needs radical remedial action if we are to get near annual targets. A leadership workshop took place in July with areas put forward that are being worked on through SDG. All schemes posted as NR are being reviewed by DOF to understand scope for delivering recurrently.

C&M ICB Position

C&M remains under considerable financial pressure, with 7 providers and the ICB all falling behind their planned position at M4. The impact of Industrial Action is an area of focus across the ICS, recognising the impact this is likely to have on the ability to achieve activity plans and recovery. Recurrent CIP across ICB is not currently forecasted to achieve plan which will impact on the exit run rate for 24/25. Work within the ICB is underway on the 3 year financial model with workshops due to take place in the coming months.

RAG ratings are based on assessment of the risks around delivery of the forecast out turn for each measure

Measure	G	A	R
Divisional Income & Expenditure		A	
Cost Improvement Programme (CIP)			R
Agency Cap	G		
Liquidity	G		
Activity Recovery		A	
Capital Programme	G		

Divisional Income & Expenditure

The collective position of the divisions at the end of M4 is a £2.4m adverse to plan, with the 2 most challenging areas being Surgery (£2.87m) & Medicine (£1.39m) off plan

The Medicine division has seen significant pressures within non pay (£0.4m YTD), this is largely due to a change in clinical practice relating to Respiratory Panel testing. Medicine is also experiencing pressures in pay associated with HCA sickness and 1-2-1 cover. There are also new pressures associated with consultant spend with cover to provide non-clinical duties and costs associated with Industrial Action. Plans are being implemented to monitor and reduce HCA 1-2-1 expenditure.

The Surgery division is reporting continued pressures associated with waiting list initiative spend and cover for gaps in the medical workforce. The impact of Industrial Action on the division has been (£0.5m YTD) cost and under performance on activity related income (£0.6m YTD). Reviews have begun with specialities to review the factors driving overspends.

Cost Improvement Programme (CIP)

The CIP target for 2023/24 is £17.7m.

CIP unachieved year to date is £1.2m. £1.04m was posted in M4 against a plan of £1.2m. A total of £6.32m has been posted for the year as at M4, with a further £6.2m in progress. There remains a gap of £5.17m to be identified and transacted, including £3.45m transformation and Trust-wide transactional schemes.

Further work has taken place since the month 4 reporting which now means the divisional CIP gap has now been closed in year only and will be reported as part of the month 5 position. Further work remains on the Trust wide transactional and transformational schemes in year delivery. Recurrent CIP remains a signficnat risk with a gap of £11m.

Executive Summary for July 23-24

Metric	Definition	YTD Plan £000	YTD Actual £000	Annual Plan £000
Income & Expenditure YTD	Distance from Financial Plan Year to Date	(1,500)	(1,491)	(1,500)
Income & Expenditure Forecast	Distance from Financial Plan Full Year	12,300	12,300	12,300
CIP	Distance from Cost Improvement Target required to meet overall Financial Plan	4,712	3,534	17,700
Liquidity	Days of Operating Costs held in cash or Cash-equivalent forms, including wholly committed lines of credit available for drawdown.	>1	1.15	>1
Activity Recovery	Internally set plan to deliver 112% of 19/20 activity. Reflects the aggregate financial value of our variable PODs.	26,240	25,623	80,062
Capital	Distance from CDEL (Capital Departmental Expenditure Limits)	(3,505)	(2,956)	(14,573)

Agency Cap

The agency cap for the Trust is £3m for the year. The Trust is below this cap at £0.5m year to date and a forecast of £1m for the year. The Trust continues with the agency Cost Control Policy for Staffing Agencies or Consultancy (Non – Medical Staffing). Bank spend, however, remains high and is being looked into further to understand the drivers.

Liquidity

The cash balance at the end of July was £79.77m and remains in line with the cash flow forecast to the end of the financial year.

Activity Recovery

Internally set plan to deliver 112% of 19/20 activity to reflect RTT requirements. However YTD achieved 108.3% and under the internal target set.

Capital Programme

Total capital spend to July was £2.956m against a total plan of £3.505m. This results in a difference to plan of £0.55m which is due to profiling differences. The overall capital programme remains in line with the plan for the year.

2. Key Risks – Month 4 status

23/24 Key Risks – M4 Poisition

Alder Hey Children's NHS

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	Initial Risk	Initial RAG	M4 Position	RAG M3	RAG M4	Change
Income	Internal target set above mandated target. Unknown impact of IA and Alder Care Go Live	Medium	M4 continued underachievement of higher internal target ICB performing well but specialist activity is under overall Estimated loss income £1m to M4 due to IA. National allowance 2% reduction for April but no guidance future months – high risk as enter into winter period	High	High	⟷
Inflation	Unknown future levels inflation, variable energy contract	Medium	No issues raised – continue to see benefit on energy Potential risk on medic pay award – awaiting final detail	Low	Low	⟷
System Position	Deficit plan with challenging assumptions. Restrictions may be imposed. Retract resources/time to support system position	High	Increase to 7 providers off plan at M4 including ICB position On national radar with some of biggest variances to plan Recurrent CIP concern both nationally and regionally – impact on exit run rate and 24/25 ICB Expenditure controls group to start imminently – AH not included at this stage 14 workstreams commenced supporting 3 yr recovery plan	Medium	High	↑
CIP	Plan assumes delivery of £17.7m recurrent. Highest level saving and lack of schemes in place.	High	80% CIP identified in year – increase 22% Only 36% recurrent identified – small improvement but not enough CIP workshop held – action in train but needs shift and focus.	High	High	⟷
Capital	Limited CDEL allocation 23/24 and 24/25 Significant capital investment and number high risk projects	Medium	Cost pressures continue to emerge in campus (neonatal/Park) and Digital (Aldercare) – managing through slippage other areas but impact future years, bid made for Aldercare ICB supportive £4m additional CDEL from incentive model – awaiting confirmation Incentive model launched national £150m fund if meet UEC targets	Medium	Medium	⟷

BOARD OF DIRECTORS

Thursday, 7th September 2023

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

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

Alder Hey Digital, Data and Information Technology Update

1. Executive Summary

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

Key headlines include:

- Update on Liverpool EPR review
- AlderC@re Update
- Good progress with Digital and Data Futures including 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 Update on National Digital Maturity Assessment

2.1 Digital Maturity Assessment

Alder Hey have now successfully completed the final submission for the National Digital Maturity Assessment prior to the formal deadline. The results have been published and can be viewed ata local, regional and national level. This will give Trusts the opportunity to complete more accurate benchmarking, identify areas for improvement and leverage national investment opportunities.

2.2 Liverpool EPR Review

The Liverpool Clinical Services review and the Cheshire and Merseyside's (C&M) ICB Digital and Data Strategy have highlighted the need for a review of connectivity of digital systems in order reduce fragmentation across the region. It is important that all key stakeholders in the system agree a common definition and vision for a solution which meets the future requirements of all.

To facilitate this an independent 3rd party have been commissioned to conduct a Strategic EPR Review across just the 6 Liverpool Trusts in C&M to address the strategic push towards integration and collaboration.

Alder Hey have actively participated in the review through two focus groups, which were attended by Executive and Senior Clinical colleagues.

3. Trust 2030 Strategy

Initial work has commenced on the Digital, Data and Insights components of the Trust 2030 Strategy, all of which are key parts of the Strategic Initiative – Smartest ways of working. The Digital Programme Initiation Document (PID) has been completed and approved by the Executive Committee. This includes a 4–7-year plan of how Digital will contribute and enable a number of key objectives within the overall strategy.

The Digtial and Data workstream has supported the delivery of the new Trust Website and a pilot of the patient portal solution – AlderHeyAnywhere, both are key enablers for the New Models of Care Programme. The deployment of AlderCare will be the next significant deliverable in September, helping enable more personalised care and better experience for patients and staff.

Insights and New Models of Care PIDs will follow and are currently at an earlier stage of development, in line with the wider plan.

4. Digital and Data Futures Progress

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

The pilot phase for AlderHeyAnywhere has commenced with up to 20 patients registered onto the patient portal. Initial feedback from children and families has been positive. The pilot will highlight areas of improvement which will be addressed prior to a trust wide roll out. This will be scheduled in following the deployment of AlderC@re.

The new 'External Trust Website' is now live and has received positive feedback both internally and externally. One of the main themes of feedback is that the new platform has enabled patients, families, staff and the wider NHS to find important information much easier using the new website.

4.2 Outstanding Records and Safe Systems

The Trust is now live with our new Risk and Incident Management System, InPhase, which has replaced Ulysses at Alder Hey. Overall, there has been positive feedback from users with initial teething issues largely in relation to reporting being progressed.

Electronic Medical Consent forms are now live across 7 specialties. iDigital are working with blood transfusion leads to embed blood transfusion consent process into current medical practices.

4.2.1 AlderC@re

The Programme remains on track to go live across the weekend of 8th – 11th September. The Digital team are working collaboratively with Divisional colleagues to ensure the organisation is prepared and ready for the transition. This was supported by a downtime dress rehearsal held on 18th / 19th August. This was successful with lessons learned on ensuring downtime documentation is up to date, and liaising with users to ensure they wait to use the system until data catch up has completed.

There is one remaining high scoring risk for the programme which is for Priority 1 (P1) issues requiring either a technical solution from Meditech or a confirmed mitigation plan. The issues are being reviewed daily with Meditech and good progress is being made on delivery. A weekly "flash report" is provided to AlderCare Programme Board and Executive Team for additional assurance on progress.

The programme has conducted Gateway 4 and the first two Go / No Go reviews in August. The Go / No Go recommendations are to proceed based on the resolution dates for the outstanding actions.

NHS England continue with external readiness review and have provided interim feedback, which has been positive. The programme has been commended for its documentation, governance, delivery and management of risk. A number of challenges and recommendations were highlighted which have been progressed.

Following extensive work, the progress with Clinical Safety and Critical Clinical Criteria were supported by the CNO and CMO on 30th August.

The next steps for the programme are:

- Go / no go Decisions 3 and 4
- Programme Cut Over and Go Live
- Aldercare Post Go Live Optimisation

4.3 Healthier Populations through Digital, Data and Analytics

The Data and Analytics service have completed the work around annual planning including finalising the elective recovery reporting and refreshing the Integrated Performance Report (IPR) for the new financial year. The IPR refresh includes 3 new pages for drive metrics which oversees, health inequalities, green and research and innovation.

The service have also delivered a new "Flash Report" which helps the board understand what happened in the organisation in the most recent month.

Finally, the service are currently scoping out the development of a Scorecard to monitor and track progress and impact of the 2030 Trust Strategy.

4.4 Technical roadmap and Operational Service Excellence

A number of projects and programmes are being worked on by the technical and operational teams. During this reporting period the team have supported the hardware and infrastructure requirements of aldercare, performed a significant storage upgrade and have refreshed devices in PICU. The Tech Bar has been refreshed with decoration and branding to ensure a modern and professional environment – see picture below.

4.4.1 Operational Performance

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

- 95% of tickets resolved within SLA.
- iMerseyside Service Desk resolved 45% of tickets.
- The Tech Bar team resolved 219 tickets in July.

5. Summary and Recommendations

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

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

BOARD OF DIRECTORS

Thursday, 7th September 2023

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

Campus Development Report on the Programme for Delivery

August 2023

1. Introduction

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

2. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Service diversion impact to programme and risk of inflation	Multiphase contract to allow continuation works with phase 1 complete and service diversion to commence. Ongoing discussions regarding programme and inflation impact of any delay with output and possible mitigations to be reported at RABD.
Catkin/Sunflower House Building	Car Park Sprinkler System Contract Claim	Performance specification agreed. Tender process due to commence with returns expected mid-September 2023. Indicative programmes to be returned as part of tender submissions. Contractor submission of Compensation Events (CEs) which are under review by the Trust and cost consultants with responses due w/c 11th September.
Elective Surgical Day Case	Confirmation of available space to accommodate Schedule of Accommodation (SOA). Full scope of works exceeds available budget.	Budget and scope review, led by Divisional senior leadership team supported by Development Team and Day PM. Revised scope of priority works to be determined.
Eating Disorder Day Case Unit	Full SoA cannot be accommodated within footprint of the building. Full scope of works exceeds available budget.	RIBA stage 1 completed. A revised set of floor plan drawings has been developed to accommodate the completion of the first phase (EDYS) by summer 2024. The Division has developed a business case for the second phase to include development of the master site plan to be reviewed by Executives.
Main Park Reinstatement	Work Package Risks Affecting Phase 3 Reinstate Park.	Revised completion dates assessed with Trust advisors and Beech. Mitigation plans developed.

3. Programme Delivery Timetable

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

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

4. Project Updates

Neonatal and Urgent Care Development

Current Status	Risks/Issues	Actions/Next Steps
Delay and Cost Implications to Service Diversion Works: Detailed paper discussed at RABD meeting with approval to proceed obtained on the basis of: 1) undertaking a deep dive on phasing opportunities within the construction programme, and 2) cost savings to be identified to help mitigate the cost pressure.	Increased costs, delay to unit opening.	Detailed programme meetings to develop the phasing plan. Agree EDU design and decant plan. Complete EDU charitable bid.
Blue light route diversion in place from 24.07.23. Site hoarding erected from 23.08.23.	Provision of on-going security patrol.	Agree content and location of vinyl information/display boards to be installed on the hoarding to illustrate the design of the new units, key facts and information.
Dependent infrastructure works will be managed in line with the construction programme. This will include: the water booster set, power connection alterations and the relocation of the 'green goddess' sub-station, all required to satisfy the site service master plan, to maintain services and to manage temporary installations currently in place.	Maintaining works in line with the construction programme. Ensuring robust engagement to support on-going business continuity.	
Phase 1 of the neo-look patient monitoring system is due for completion 30.08.23.	Coordination of technologies and flow of patient data between neo-look at the vital signs monitoring systems.	Define the scope and progress integration with vital signs monitoring.

Catkin & Sunflower House Building

Current Status	Risks/Issues	Actions/Next Steps
Finalising contract position.	Contractor Compensation Events	Trust to provide a response to the current compensation events. The responses to these CEs will then contribute to an indicated final claim which has been indicated to be issued in late summer 23.
Sprinkler system to be installed within the under-croft car park - tender to be issued imminently for return late-September 2023. Final completion estimated 8-12 months.	Fire compliance.	Proposals to be reviewed upon receipt, and costs available for RABD approvals September 2023.
Water safety issues are on-going and remain under review of the Water Safety Group via regular monitoring / testing.	Continued contamination.	Remediation of water safety issues (Catkin only). Remediation of water mains and back fill.

Modular/Office Buildings

Current Status	Risks/Issues	Actions/Next Steps
A Space Utilisation paper was presented at 03.08.23 Executive Director's meeting. The purpose was to agree a proposed framework with clearly defined principles for managing mid-long term space utilisation. This will form part of the wider master site planning and ultimately support the estates strategy for the Trust. The paper was approved.	Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for minor works/kit.	Develop action plan for each project and establish reporting / approvals mechanism.
The refurbishment works to the former police station cannot start due to the continued delay in signing the lease for the new police station (Catkin/Sunflower). Site set up works anticipated to commence mid-September. Completion date expected April 2024 completion date. It will be necessary to extend the lease of	Operational date currently assessed as April 2024. Increased cost c£150k initial extension lease.	Confirmed initial 3 month lease extension with Laing O'Rourke.

the 3-storey modular building (3SM) from October '23 as reported in the Space Utilisation paper presented to Executive Directors.		

Park Reinstatement

Current Status	Risks/Issues	Actions/Next Steps
Following the confirmed presence of non-licenced asbestos on the site of the former Catkin building and approval by Trust Board on 06.07.23 for its removal, the site was handed over to the contractor, Horticon, on 31.07.23. Work is underway to progress the construction of the playground and football pitches. The lighting was installed and the MUGA opened 07.08.23.	Budget review to assess impact of increased costs.	Close management of site works and programme involving all required Trust advisors.
A progress meeting was held 02.08.23 with FOSP and LCC. Preferred location of trees and planting agreed, and an updated drawing is being prepared for submission to Planning. A follow up meeting was planned for 24.08.23 involving the Trust, LCC and FOSP. LCC sent their apologies, so the meeting is to be rescheduled for early September. The Trust offered a walk and talk of proposals that have been updated following the last meeting to keep FoSP fully updated. A draft Community Charter and Terms of Reference for future meetings are currently being reviewed for acceptance.	Concerns raised by FOSP in relation to the size and depth of the swales, and the size of the football pitches agreed within the planning approval.	Future meeting dates to be agreed. Continued and maintained input & communications from all key stakeholders.
Proposal in discussion with LCC regarding the lighting for the Park.	Cost impact	Budget pressure to be managed.
Existing Infrastructure works are still present in the park area.	Delays in completion of preparation, soil and seeding of complete football pitches.	Development Team are to hold twice weekly catch ups to ensure Park & Infrastructure are fully coordinated in their works.

Fracture and Dermatology Outpatients

Current Status	Risks/Issues	Actions/Next Steps
The completion date currently remains as assessed, March 2024. Costs currently remain within budget. Planning has commenced on the development of the tender package submission for appointment of a construction contractor.	Timely appointment of a construction contractor. SPV/Mitie have not achieved dates set out in the programme.	Regular meetings. Close monitoring of critical risks. Regular SPV meetings continuing and Provisional Programme to be submitted. Mitie have appointed experienced Project Manager who is starting in September who will manage the formal response to TVE 390.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

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

Elective Surgical Day Case

Current Status	Risks/Issues	Actions/Next Steps
Budget and scope review, led by Divisional senior leadership team supported by Development Team and Day PM.	Programme, available budget.	Task and finish group to be established. Revised scope of priority works to be determined.

Eating Disorder Day Case Unit (EDYS)

Current Status	Risks/Issues	Actions/Next Steps
Draft proposal developed between the Division and the Development Team to consider a phased development: First phase to include re-provision of EDYS, and essential enabling works. RIBA stage 1 completed. A revised set of floor plan drawings has been developed to accommodate the completion of the first phase (EDYS) by summer 2024. Second phase to include the completion of building works, final service re-provisions and development of the master site plan.	Programme, available budget.	The Division has developed a business case for the second phase to include development of the master site plan which will be presented to Trust Executive.

Nursery

Current Status	Risks/Issues	Actions/Next Steps
Proposed outline delivery programme for the development of the former Knotty Ash Care Home site has been drafted. Step Places have completed survey works and site investigations for the site. planning has now been submitted. Anticipated commencement mid to late November 2023.	Outputs from survey works. Confirmed programme.	Regular meetings scheduled. Step Places Planning Advisor has stated that, based on information shared to date, there are no issues indicated with the site.

5. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 7 September 2023.

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 17th July 2023 at 13:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	Adam Bateman	Chief Operating Officer	
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nurse	
	Daryl Cassidy	Head of Financial Management	
	Esme Evans	Business Accountant, CAMHS	
	Rachel Greer	ACCO, CAMHS	
	Hannah Grierson	Divisional Accountant for the Division of Medicine	
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Catherine Kilcoyne	Deputy Director Business Development	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Chloe Lee	ACCO, Surgery	
	Graeme Montgomery	Business Accountant for Surgery	
	Mark Carmichael	ACCO, Medicine	
	Clare Shelley	Associate Director Operational Finance	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
	Gary Wadeson	Associate Director – Income, Costing & Commissioning	
Agenda Item:	Jim O'Brien	Associate Development Director	
	Jane Halloran	Acting Deputy Development Director	

23/24/55 Apologies:

John Grinnell	Deputy CEO/CFO	
Emma Hughes	Acting Manging Director for Innovation	
Mark Flannagan	Director of Communications	(MF)
David Powell	Development Director	

23/24/56 Minutes from the meeting held 26th June 2023

The above minutes were approved as a true and accurate record.

23/24/57 Matters Arising and Action log

Energy Investment - Solar Panels: Continuing to go through internal process. Industrial Action: Total loss for income and expenditure April – June 23, £1m. DC gave a breakdown of divisional loss.

AB noted operationally 600 outpatient appointments loss and 60 operations. Radiographers were also due to hold industrial action dates which would cause further impact.

X2 Surgery Business Cases: Final adjustments were being made to BC before being sent to Chair and SA, NED for approval tomorrow.

23/24/58 Declarations of Interest

There were no declarations of interest.

23/24/59 **Finance Report**
Month 3 Financial Position
£0.5m deficit was reported for June 23 as in line with plan. Risks going forward included further Industrial Action dates that may add further unplanned deficit.

Cheshire and Merseyside are working through off plans.

SA queried £5m CIP transacted. CS said the payment is going through however the payment may not be received until later in the year.

JK noted caution with recovery plans isn't impacting other areas.

Resolved:
RABD received and noted the M3 Finance report.

23/24/44 **Month 3 Integrated Performance Report**
AB highlighted:

- ED consistently achieving national waiting time standard, with performance at 85% and sustained for three consecutive months
- Was Not Brought rate remains above target and demonstrating normal cause variation with no statistical evidence of consistent improvement arising from the interventions implemented to date. New interventions are being worked through and implemented.
- Completion of Clinic Letters within 10 days remains static and significantly below the 95% target. Divisions continue to focus on reducing letters over 30 days.

Resolved:
M3 IPR report was received.

An introduction was given to the first quarterly divisional review.

23/24/61 **Surgery Division**
CL went through the activity performance noting Spinal and Cardiac Surgery elective for Q1 is behind plan. Urology remains a pressure area due to nursing gaps, intervention plans are in place.

The Chair asked why a month with industrial action dates did better than a month without. CK noted that Spinal surgery activity was low in May with further SS activity in June, some issues related to Theatre staffing.

Queries were raised in relation to the triangulation of overall divisional income with elective ERF income. The finance team will clarify this in future reports.
Action: GW

CIP target for Surgery Division is £1.6m, £0.5 is achieved with £1m identified and working through.

A discussion was held in relation to chasing recovery and whether this was causing deficits or premium. It was noted that development of SLR data had taken place and once the data is analysed in the next few months there would be a clearer answer.

CL provided assurance around a job planning review that is taking place.

Resolved:

RABD received and noted progress as well as challenges to date within Surgery Division.

23/24/62 **Medicine Division**

MC gave an overview of activity performance. MC highlighted the impact of industrial action dates noting the services that have been highly impacted include: Oncology, Haematology and Respiratory.

A discussion was held on the number of changes that had been implemented including increasing appointments and digital solutions to minimise attendance.

RL queried the reduction in non-elective income for Q1. MC to report back on the reasons for reduction.
Action: MC

CIP target for Medicine is £3.6m, £1.6m is currently not identified and is being worked through.

RL noted the cost control measures within the division were good to see.

Resolved:
RABD received and noted progress as well as challenges to date within Medicine Division.

23/24/63 **Community and Mental Health Division**

RG gave an overview of the CAMHS activity performance. EE discussed the SLA contracts with: Schools and Councils across the city is ahead of plan. Challenges include drug pressures and increase of dietetic services.

CIP target for CAMHS is £1,624m, there is a current gap of £386k. The Division discussed this at our recent planning session and will be looking to see if we can reduce the gap by reviewing skill mixes across teams and utilising Innovation, particularly RPA, to improve processes.

Resolved:
RABD received and noted progress as well as challenges to date within CAMHS Division.

23/24/64 **Corporative Collaborative**

ES gave an overview of income ahead of plan YTD.

CIP target for Corporate Collaborative is £1,849, there is a current gap of £420K. ES went through plans in place to mitigate the gap.

RL noted £2m workforce saving, it was currently being worked through were the savings would sit.

Resolved:
RABD received and noted progress as well as challenges to date within Corporate Collaborative Division.

23/24/65 **Neonatal Project**

In an exceptional RABD on the 14th October 2022 approval was given to allow enabling works and early orders to be placed on the project. This was to reduce the risk of inflation on the project and a limit put on the financial commitment.

A paper had been circulated to members with details of issues the project is facing along with the cost and delay to bring the programme back on track.
Resolved:
Following a lengthy discussion RABD APPROVED the three asks within the paper.

23/24/66 Aldercare

KW highlighted:
- Programme progress continues with overall build at 96% and core specialty packages build now complete.
- There are ongoing challenges with the reporting workstream which is reporting as red. Recovery actions are being progressed at pace.

Expanse Reporting
KW gave an overview of the reporting issues noting no intervention would see no full reporting until January 2024.

The favoured options from the four that have been worked through is option four: includes working with a third party partner can deliver this in time for the AlderCare go-live and is therefore the preferred option. MEDITECH have been approached to seek their support in covering part of the costs, and a funding request has been submitted to the NHS England Frontline Digitisation programme. A further meeting is taking place on Thursday with Meditech to review the ask.

Resolved:
RABD APPROVED the request to support option 4 as outlined within the paper.

23/24/68 Board Assurance Framework

ES introduced the BAF Report for the month of June 2023 and informed colleagues that following launch of the Trust's 2030 Vision, risks that threaten the achievement of the trust's strategic plans and long-term objectives would be updated during the Summer. This piece of work would likely result in a number of BAF risks that sit under the remint of RABD will transition over to Strategic Partnership Board.

JK referred to risk 3.4 'Financial Environment' which was rated 16 and had remained static for a number of months despite the increasing challenges across the NHS. It was suggested that this be more clearly referenced in the monthly updates and actions along with explicit reference to delivery of the new 2030 Vision.

Resolved:
RABD received and noted the Strategic Risks.

23/24/69 Cost Improvement Plan
Resolved:
RABD received the monthly CIP paper, CIP had been discussed under the Divisional quarterly updates

23/24/69 Any Other Business
No further business was reported.

23/24/70 Review of Meeting
RABD discussed the first quarterly face to face meeting.

AB asked if the Divisional Financial overview can be done together going forward. The Chair added that if possible it would be good to have on the right hand side of the front page of the Financial report. CS agreed to look into.
Action: CS

Date and Time of Next Meeting: Wednesday 30th August 2023, 1400, via Teams.

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 26th June 2023 at 13:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Urmi Das	Clinical Director, Medicine	
	Jane Halloran	Acting Deputy Development Director	
	Emma Hughes	Acting Manging Director for Innovation	
	Catherine Kilcoyne	Deputy Director Business Development	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Graeme Montgomery	Business Accountant,	
	Andy McColl	Associate Chief Operational Officer, Performance	
	Clare Shelley	Associate Director Operational Finance	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda Item:	Graeme Dixon	PFI Manager	
53	Chloe Lee	ACCO, Surgery	
53	Rachel Greer	ACCO, CAMHS	

23/24/39 Apologies:

Mark Flannagan	Director of Communications	(MF)
Jim O'Brien	Associate Development Director	
David Powell	Development Director	
Dani Jones	Director of Strategy and Partnerships	(DJ)

23/24/40 Minutes from the meeting held 22nd May 2023

The above minutes were approved as a true and accurate record.

23/24/41 Matters Arising and Action log

All actions had either been included on the agenda or were noted for a future date.

23/24/42 Declarations of Interest

There were no declarations of interest.

23/24/43 Finance Report

Month 2 Financial Position

CS presented a revised Finance report, RABD thanked the team for easier to read layout.

DJ asked for an update on Cheshire and Merseyside. RL noted a meeting was taking place on Friday to review Trust's that had a surplus or had gone off plan.

JK queried if financial loss incurred with Industrial Action dates had been under reported. CS agreed to look into.

Action: CS

Resolved:
RABD received and noted the M2 Finance report.

23/24/44 Month 2 Integrated Performance Report

AB highlighted:

- 5 out of 6 patients are being seen in ED under 4 hours.
- An update was received on the target to have no patient waiting over 65 weeks. Target services include: Dental, Spinal and Ears, Nose and Throat.

Resolved:
M2 IPR report was received.

23/24/45 Cost Improvement Plan

A letter with details of the CIP for 23/24 is to be sent to all staff with a follow up workshop.

Resolved:
RABD received and noted progress to date in meeting the Cost Improvement Plan 2023/24.

23/24/46 Campus update

JH highlighted:
Neonatal:
Mitigation proposal to be discussed in separate meetings with RABD and Trust Board.
Park: Revised completion dates to be assessed with Trust advisors and Beech.

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

23/24/47 Aldercare

KW highlighted:

- The formal Gateway 3 assessment was completed in May 2023 with a number of workstreams rated amber. A work off plan is in development and a further review of the criteria will take place at the end of June 2023.
- Change freeze in place from 1st June for Meditech and 1st July for wider digital projects
- Detailed cutover planning continues for the planned go live over the weekend of the 8th to 11th of September. Emergency and urgent care services will go live over the weekend with elective service such as outpatients and elective surgery to go live on the Monday. The programme team are working with operational teams to define the exact timings.

Resolved:
RABD received the monthly update on Aldercare.

23/24/48 Digital Futures Strategy – progress update

KW highlighted:

- MIAA two-phase Data Security and Protection Toolkit (DSPT) audit is now complete with the final report and assurance rating to be provided prior to final submission on 30 June 2023. It is anticipated a fully compliant 'standards met' assessment will be submitted

Resolved:
RABD received the bi-monthly update on Digital Futures Strategy.

23/24/49 **Communications update**

Resolved:
RABD received the communications report.

23/24/50 **PFI – Building report**

GD presented the PFI report. The Chair asked going forward for a one page executive summary sheet to be included.
Action: GD

Resolved:
RABD received the monthly update on PFI.

23/24/51 **Board Assurance Framework**

RABD noted that the Risk Profiling Tolerance action would be deferred until after the workshop.

Resolved:
RABD received and noted the Strategic Risks.

23/24/52 **Social Media Policy**

Phil McNamara presented the new social media policy noting it was in line with the current guidelines with further detail.

Resolved:
RABD ratified the Social Media Policy.

23/24/53 **Any Other Business**

RL introduced the 3 business cases that had been approved by Executive Committee. The ask to RABD today was to approve prior to presenting to Trust Board on Thursday 6th July 2023.

Surgery Business Case X 2
Recovery of Surgical Services
ENT and Dental
RABD queried if the request on the executive summary matched the ask to RABD in the report, further clarification was requested.

Resolved:
It was agreed the two business cases would be represented at the Extraordinary RABD in July.
Action: Chloe Lee

Community Business Case
RG presented the Clinical Health Psychology to support complex discharges. The executive team supported 50% of the funding to allow for investment to sustain priority services.

Resolved:
RABD APPROVED the request to support 50% funding for Clinical Health Psychology complex discharges.

23/24/54 **Review of Meeting**

The Chair noted good discussions on benefit realisation.

Date and Time of Next Meeting: Monday 17th July 2023, 1300, via Teams.

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	Alder Hey Community Mental Health Services (Liverpool & Sefton) proposed changes to waiting times standards & reporting
Report of:	Lisa Cooper Director Community & Mental Health Services
Paper Prepared by:	Rachel Greer, Associate Chief Operating Officer Kate Walker, General Manager

Purpose of Paper:	Decision ■ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Links to BAF risk 1.4 – Access to mental health services
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	National mental health financial allocation

Alder Hey Community Mental Health Services (Liverpool & Sefton)
Proposed changes to waiting times standards & reporting.

1. Purpose of report

The purpose of this report is to:

- Outline the current position of Alder Hey Community Mental Health Services (Liverpool & Sefton).
- Propose a change to the Trust reporting measures for Community Mental Health Services.
- Present an overview of planned improvements to meet the Trust's revised internal waiting time standards.

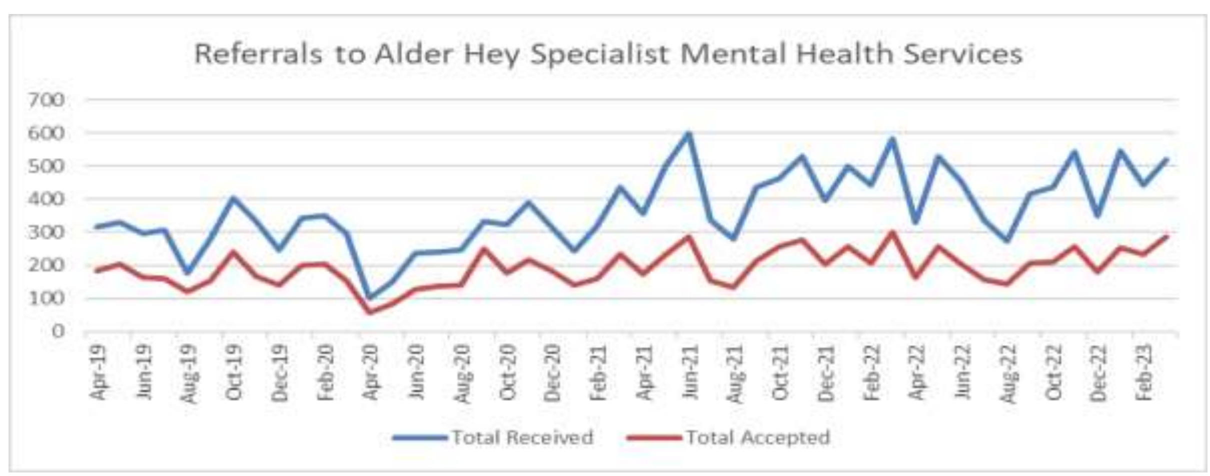
2. Current Position: Community Mental Health Services

Alder Hey Community Mental Health Services across Liverpool and Sefton experienced a significant increase in demand following the COVID-19 pandemic, which has resulted in deteriorating waiting times for children and young people.

In addition, there has been an increase in complex presentations of high-risk young people requiring urgent assessment and more intensive clinical intervention, which has subsequently increased demand for both urgent assessments (Choice appointments) and urgent treatment (First Partnership appointments).

The service has experienced a **41%** increase in received referrals in 2022/23 compared to 2019/20. Whilst referrals in 2022/23 were similar to the previous year, this shows a sustained increase in demand for Specialist Community Based Mental Health Services, both for received and accepted referrals **(Chart 1)**.

Chart 1: Number of Referrals to Community Mental Health Services



The demographic of children and young people seen by Liverpool and Sefton locality based mental health services includes those with complex needs and protected characteristics, for example children and young people with a learning disability; children in care; those involved with youth justice services and young people at risk of exploitation.

There has been an increase in the number of children and young people requiring urgent or emergency intervention with more complex presentations, with **41%** of accepted referrals being triaged as urgent in 2022/23. This does not include children and young people that are escalated to urgent whilst on the waiting list.

In addition, approximately **49%** of referrals to Liverpool and Sefton locality based mental health services received input from the Alder Hey Crisis Care Service in 2022/23, compared to approximately **36%** in 2019/2020. The length of stay in the service and the average number of outpatient appointments required for each child or young person before discharge has also increased.

3. Proposed Changes to Waiting Times Reporting

In the absence of national waiting times standards for access to children's mental health services, the current Trust internal waiting time standards are based on 'The Choice and Partnership Approach' (CAPA) model, which is a clinical model used in some child and adolescent mental health services across the UK and other countries, including Belgium, Canada and Australia.

Liverpool and Sefton locality based mental health services have been required to respond to an increasing waiting list alongside challenges in recruitment and develop clinical pathways to deliver treatment to as many children and young people as possible.

Services have responded to the access and workforce challenges by reviewing clinical pathways which includes new ways of delivering treatment outside of the traditional case management approach. Therefore, children and young people may receive one or multiple intervention(s) prior to allocation and appointment with a case manager (arranged via a First Partnership appointment). Interventions can include, but are not limited to, treatment provided by a psychiatrist, attendance at a group intervention or receiving a specific therapy.

In line with current reporting measures, Alder Hey has reported 52-week breaches in mental health services for children and young people as they are waiting for a First Partnership appointment, but they have had several other contacts that can be considered as intervention or treatment. Therefore, a proposed change to the consideration of what counts as 'treatment' is being requested.

In April 2021, Alder Hey were asked to be part of a pilot to build consensus on a definition and measurement approach for a potential access and waiting time standard for children and young people's mental health services. The pilot and subsequent draft waiting time guidance published in October 2022 focused on a standard from 'Referral to Help' where 'Help' would be measured as a first attended direct or indirect contact.

As part of this pilot, feedback from children and young people was sought and contributed to this project. Children and young people agreed with the proposed changes in terminology.

Whilst NHS England have not yet introduced a referral to treatment target and referral to help target as a national waiting time standard for children and young

people, as part of the national pilot it is considered positive practice for Alder Hey to consider this as future reporting standard.

The proposed changes to reporting measures are likely to positively impact on the referral to treatment performance, as this will identify where therapy or other interventions have taken place whilst a child or young person is on the waiting list for a First Partnership appointment.

7.1 Proposed Changes to Reporting

It is proposed that the agreed internal waiting times standards are adapted to reflect the interim national guidance for measuring waiting times and the various clinical interventions that are provided to children and young people as treatment:

- Referral to Help - % of children and young people waiting within 6 weeks (92%)

- Referral to treatment - % of children and young people waiting within 18 weeks (92%)

Metric	Definition/Measure	Reporting Submission/Board
Referral to Help - % of children and young people waiting within 6 weeks (92%)	First direct or indirect contact with Alder Hey Specialist Mental Health Services	• Integrated Performance Report • Trust Board
Treatment being provided within 18 weeks of referral (92%)	Attended appointment at agreed appointment types where treatment, intervention or therapy commences.	• Integrated Performance Report • Trust Board • Monthly Performance Contract Statements to Place

The referral to Choice assessment metric will continue to be monitored internally to manage waiting times with the expectation that many choice assessments will be the first attended appointment for a child or young person and will also satisfy the criteria of the referral to help metric.

Due to challenges with the current electronic patient record (EPR) in the first instance, only direct contacts (i.e. appointments, telephone contacts) will be reported as part of the Referral to Help metric. This will be developed to include indirect contacts (e.g. consultations) as part of ongoing EPR development.

It is proposed that the definition of 'treatment' in Liverpool and Sefton locality based mental health services is expanded. Types of appointment/therapy/interventions which **will** count as treatment include:

- Attendance at a First Partnership appointment
- Specific therapeutic interventions such as CBT, DBT and Family Therapy

- Attended appointment with a Psychiatrist
- Attendance at a group-based intervention, such as DBT Skills Group, NVR (Non-Violent Resistance), Riding the Rapids, Timid to Tiger, Helping your Child's fear and worries etc.
- Attendance at other intervention-based activities, such as Forest School, and engagement focused sessions with a Mental Health Engagement Practitioner.
- Attendance at low intensity treatments including Calm and Connected, Managing Worry, Brief Behavioural Activation.
- Peer Support Worker Sessions and social prescribing.

Types of appointments which **will not** count as treatment:

- Risk and treatment reviews – designed to control the risk of waiting by assessing and managing risk whilst waiting but do not specifically provide treatment.
- Contacts with non-clinical staff
- Young Person / Parent attending participation group

A specific pathway tool for mental health and other non-RTT services has been created in Alderc@re to support accurate pathway management which will be utilised following the Go Live period in September 2023.

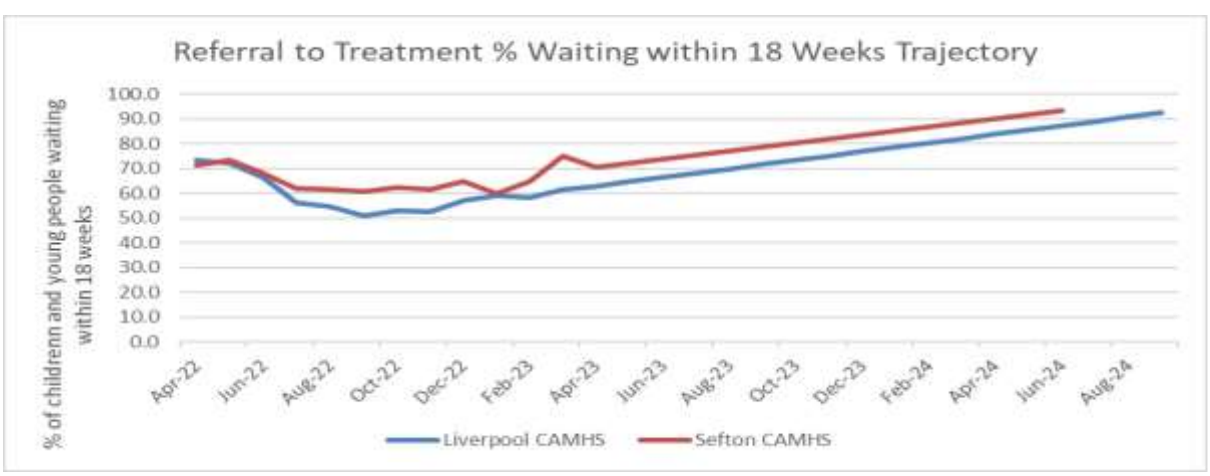
This will bring Liverpool and Sefton locality based mental health services in line with other Trust services, moving from an appointment type-based clock stop process to a process of confirming treatment has started through clinical decision via the electronic patient pathway form.

A set of interim arrangements will be required to ensure the changes to reporting measures are reflected accurately in internal and external performance reports.

4. Predicted Improvement Trajectory

Based on current performance and improvement to date a predicted achievement of the Trust's internal waiting time standards by 30 June 2024 (Sefton) and 30 September 2024 (Liverpool). This is subject to confirmation of additional investment in Q1 2023/24 and is detailed in **Chart 2.**

Chart 2: Community Based Mental Health Services Improvement Trajectory



This trajectory assumes no reduction in referral rates to pre-COVID-19 levels, as there is no indication locally or nationally that requirements for specialist mental health services will reduce. There are risks associated with the delivery of this recovery plan which include the following:

- Confirmation of additional investment for 2023/24. This plan assumes confirmation of funding in Q1 2023/24. Due to recruitment and induction timescales, it is expected that staff would commence in post on a phased basis, with all staff in post in December 2023.
- Ability to recruit to the required specialist clinical posts in the service.
- No changes in capacity due to increased staff absence.
- Demand levels have been based on current referral rates and this position will be challenged if referrals continue to increase.

To support an increase in access to community mental health services multiple actions are being implemented to increase capacity within existing resource through robust waiting list management, capacity and demand modelling and additional recruitment, along with the provision of a clinical strategy which is focussed on a delivery of a needs-based service model. Additional improvement actions are detailed in **Appendix 1**.

5. Next Steps

Alder Hey Trust Board are asked to note the contents of this paper and:

- Approve the change to reporting metrics for community based mental health services.
- Note the predicated improvement plan in relation to waiting times for Liverpool and Sefton locality based mental health services.

Lisa Cooper
Director Community & Mental Health Services

Appendix 1: Additional Improvement Actions

Additional improvement actions include following:

- Sefton Specialist Mental Health Services has introduced low intensity therapy for children and young people waiting for first partnership appointments. The purpose of this is to provide families with access to specialist advice and intervention whilst waiting to be allocated to a case manager to enable them to commence their partnership journey, also reducing the length of time they wait for intervention. This is monitored through a specific work waiting list and the offer is communicated to children, young people and their families following their Choice appointment. This was launched in January 2023.
- Review of standard operating processes including booking processes and discharge procedures to optimise clinical capacity and support children and young people to attend appointments as much as possible (by 30 September 2023)
- Action plan to reduce the Was Not Brought (WNB) rate. This includes a WNB predictor tool to identify those children and young people at higher risk of not attending their appointment. Utilising the Trust's quality improvement methodology, an A3 exercise has been created to monitor improvements in WNB rates (by 30 September 2023)
- The use of Patient Initiated Follow Up (PIFU) will be considered to aid safe discharge from Specialist Mental Health Services. Plans are already in place to meet with PIFU leads in June 2023 to develop an action plan (by 31 October 2023).
- Staff wellbeing and development continues to be an area of focus including service away days to undertake service improvement work with the aim to address challenges in the service such as the root causes of WNB and addressing staff satisfaction and wellbeing to reduce levels of staff turnover and absence (schedule for 2023/23 completed).
- Review of clinical job plans to ensure funded capacity is delivered alongside implementation of new enhanced supervision measures to support clinicians in their roles, which will include expected number of contacts. Case load size reporting and management will be improved – while there is no national standard, the average caseload for a typical mental health services practitioner is 25-30 per WTE (by 30 September 2023)
- A workforce plan has been completed which includes actions to support and retain the existing workforce and provide incentives and opportunities to increase staff headcount. This complements individual activity within locality based mental health services (completed).
- Referral triage processes to be reviewed, with options to be explored for an enhanced triage pathway which includes direct communication to children, young people and families at this stage of their pathway (by 30 September 2023).
- Approach to the management of urgent clinical appointments to be discussed with all Alder Hey Mental Health Services, ensuring seamless pathways between locality-based services and the Crisis Care Team (by 30 September 2023).
- Continue roll out of Routine Outcome Measures (ROMS) to show impact of service on children and young people's mental health (by 30 September 2023).
- Proceed with proposed reporting changes to Alder Hey internal waiting time standards (by 30 September 2023).

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	**Brilliant Basics Update**
Report of:	**Nathan Askew, Chief Nurse, Brilliant Basics SRO**
Paper Prepared by:	Jennie Williams, Head of Quality Hub

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This report provides assurance on the progress of the Brilliant Basics Delivery Plan 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:	None

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
2466	There is a risk that staff are unable to fully attend and be fully present for the Brilliant Basics evidence-based approach required to embed continuous improvement across the trust.					6
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 aim of this paper is to provide Trust Board assurance and oversight of the Brilliant Basics (BB) Delivery Plan 2023/2024. The plan details the key milestones that will support the development of a culture of continuous improvement.
The paper also provides:

- Evidence of ongoing work, **in addition** to the agreed plan, that demonstrates **scale and spread** of the use of BB within the organisation.
- An assessment of the trusts position against NHS Impact; Delivery and Continuous Improvement Review

Within the current BB Plan, 25% (n=4) of original milestones are completed.
Of the remaining milestones:

- ✓ 10 (**84%**) are **on track** (one of which will move to align into the Outstanding Care and Experience initiative of Strategy 2030)
- ✓ 1 (8%) will be refreshed to align with NHS Impact (the new, single, shared NHS improvement approach) and
- ✓ 1 (8%) is partially achieved and will be required to move to 24/25 plan.

There are **no risks or issues** to escalate to Board. Programme governance assurance is **rated green** in all areas. The oversight is managed through the Brilliant Basics Friday Forum that meets monthly and reports into Strategic Executives bimonthly. This allows for discussion, alignment and shared accountability.

The key messages highlighted in this report are: -

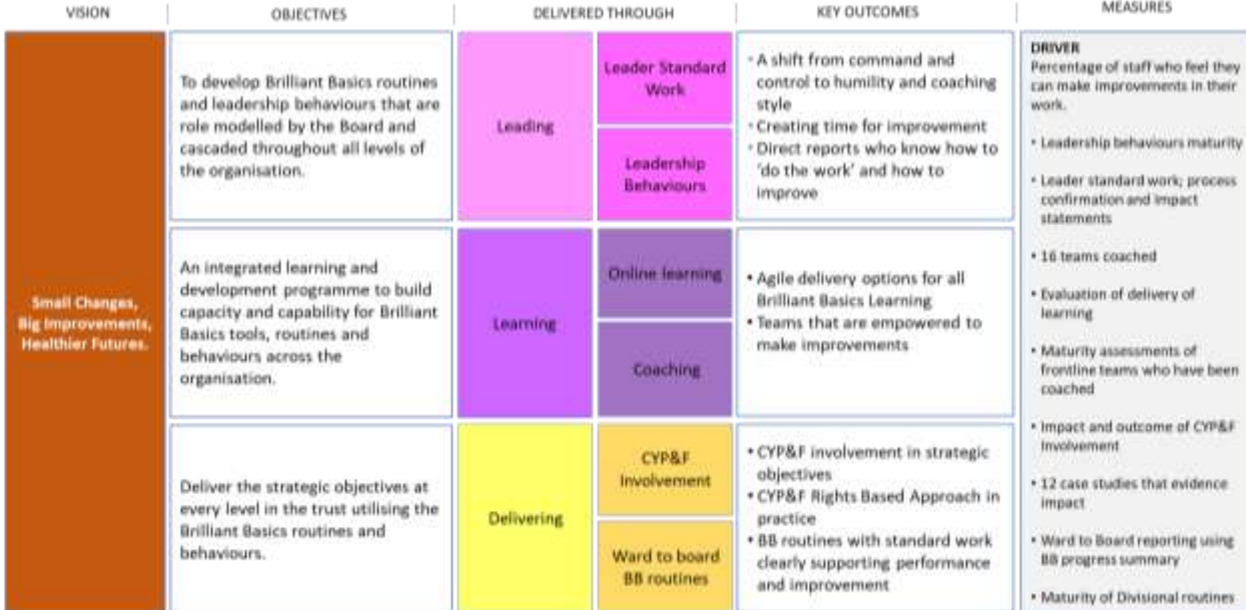
- Progress is in line with approved BB Delivery Plan.
- Scale and spread of BB is delivering broader organisation benefits.
- Progress on BB puts Alder Hey in a strong position as leaders in the improvement community locally and nationally.

2. Background and current state

Brilliant Basics Programme

Trust Board approved the BB Delivery Plan (March 23). Table 1 outlines the objectives, key outcomes, and measures for each of the workstreams.

Table 1: Plan on a page



VISION	OBJECTIVES	DELIVERED THROUGH		KEY OUTCOMES	MEASURES
Small Changes, Big Improvements, Healthier Futures.	To develop Brilliant Basics routines and leadership behaviours that are role modelled by the Board and cascaded throughout all levels of the organisation.	Leading	Leader Standard Work Leadership Behaviours	• A shift from command and control to humility and coaching style • Creating time for improvement • Direct reports who know how to 'do the work' and how to improve	DRIVER Percentage of staff who feel they can make improvements in their work. • Leadership behaviours maturity • Leader standard work; process confirmation and impact statements • 16 teams coached • Evaluation of delivery of learning • Maturity assessments of frontline teams who have been coached • Impact and outcome of CYP&F involvement • 12 case studies that evidence impact • Ward to Board reporting using BB progress summary • Maturity of Divisional routines
	An integrated learning and development programme to build capacity and capability for Brilliant Basics tools, routines and behaviours across the organisation.	Learning	Online learning Coaching	• Agile delivery options for all Brilliant Basics Learning • Teams that are empowered to make improvements	
	Deliver the strategic objectives at every level in the trust utilising the Brilliant Basics routines and behaviours.	Delivering	CYP&F Involvement Ward to board BB routines	• CYP&F involvement in strategic objectives • CYP&F Rights Based Approach in practice • BB routines with standard work clearly supporting performance and improvement	

Table 2 below provides high-level current state on progress of program milestones. Milestones that are rated amber have effective mitigations and controls in place which can be found in the text below the table. The most recent Programme Management Assurance has rated the delivery as green.

Table 2: Current Milestone progress

Workstream	Milestone	Progress Rating*
Leading	Executive Leader Standard Work (LSW) Review	
	Board Development Plan	
	Leadership Maturity	1
	Divisional LSW	
Learning	Online learning resource	
	BB approach to support strategy deployment	
	Leadership for Improvement offer	
	Teams coached through BB (16)	
	SharePoint site development	
	Health Inequalities embedded in learning	
Delivering	BB in the DNA of the organisation	
	CYP&F Involvement in Strategy and BB waves	
	Rights of the Child Approach	
	Alignment of priorities through BB cascade	2
	Divisional Routines; performance and improvement	
	BB approach utilised in Patient Safety Board	

*Key: Blue = completed and closed. Green = on track. Amber = changes identified.

Mitigating actions for the two milestones rated amber are:

1. NHS Impact 'Developing Leadership Behaviours'; BB will align to this workstream once further detail provided from the centre.
2. Alignment of priorities has been achieved to Divisional level but not yet cascaded explicitly to the frontline. This will be in plan for 24/25 alongside alignment of Strategic and Operational Boards and their prioritised plans.

Further detail on an assessment of each milestone with considerations for sustainability can be found in Appendix 1.

NHS Impact; Delivery and Continuous Improvement Review (DCIR)

A comprehensive review of the trusts position against NHS Impact DCIR was undertaken in May 2023. The link to the full document is contained in Appendix 2. The outcomes of this assessment are:

- The 23/24 BB plan will develop the organisation further to ensure compliance against national recommendations.
- The BB plan requires alignment on the 'Development of Improvement Leadership Behaviours' at all levels across the organisation once further detail received from the centre.

Scale and Spread of the use of Brilliant Basics

Table 3 below details examples of scale and spread of the use of BB in addition to the Delivery Plan.

Table 3: Scale and spread of the use of BB.

	Area of focus	**Delivered benefits**
Delivering	*Quality Connectors*. A community of practice across the organisation who have developed greater depth of QI knowledge, skills and competence.	Enhanced and visible support for QI. Sustainability of BB tools, routines and behaviours. Cross team learning.
	Quality Assurance Rounds. Embedding BB into QAR, closing the gap between assurance and improvement.	Supporting teams to utilise BB principles, problem solving and concise summary reporting. Closing the gap on assurance and improvement when BB support beneficial.
	Ward / Department Accreditation. BB questions being tested to assure tools, routines and behaviours are being utilised in practice.	Assures standard of implementation of BB in teams who have completed BB learning. Identifies teams where BB learning / coaching would be beneficial.
	Thriving Teams MDT. Working together with colleagues to support teams to thrive.	Aligned support for teams and prevents silo working across BB/OD/L&D/HR. Helps identify team readiness for BB.
	Support Requests. A route for support requests from individuals and teams.	44 requests for bespoke improvement support, e.g., away day facilitation, targeted process / pathway work.

3. Conclusion

This paper provides assurance on:

- Consistent progress to date against BB Delivery Plan milestones and mitigating actions where milestones have been identified as requiring further management control.
- The trusts positive position against NHS Impact Recommendations.
- Scale and spread of BB.

4. Recommendations & proposed next steps.

Recommendations are:

- Trust Board to note progress in line with the approved BB Delivery Plan.
- Trust Board to celebrate wider scale and spread of BB within the organisation.
- BB team to continually improve delivery and sustainability.
- Trust Board to continue to receive quarterly updates for information and assurance.

ENDS

Appendix One – Milestone Review and Sustainability Considerations

Workstream		Milestone	Plan: current state	Sustainability considerations
Leading	1	Executive standard work review and refresh utilising A3 thinking.	In place, on track.	Embed into Exec role to continue review and progres as required.
	2	Further board development plan scoped and implemented.	In place, on track.	Ongoing plan for new board members ro be established as SOP for onboarding.
	3	Leadership behaviours maturity assessment of Board colleagues and their direct reports.	Align with NHS Impact	For consideraton once NHS Impact Developing Leaders Plan is understood.
	4	Develop and coach leadership behaviours and leader standard work with Divisional leaders.	Plan to be established following Exec LSW (1)	Embed into COO role to conitnue review and progress as required.
Learning	1	Online learning and coaching tested, evaluated and embedded.	In place, on track.	How do we continue to recruit teams into the programme? Ownership to sit with leaders e.g. who needs to learn A3 thinking in your area? All execs to ask direct reports and their teams?
	2	Agile learning and coaching using BB tools, routines and behaviours to support strategy deployment.	In place, on track.	To build the offer of BB training / coaching into the strategy as an offer to teams that we are working with - builds recruitment.
	3	Leadership behaviours integrated into all learning and coaching opportunities that support the delivery of an integrated improvement model.	In place, on track.	To build improvement leaders tools, routines and behaviours into Thriving Leaders strategic initiative.
	4	Learning and coaching for 16 teams through face to face or online route.	In place, on track.	How do we continue to recruit teams into the programme? Ownership to sit with senior leaders e.g. who needs to complete BB in your area?
	5	Further development of SharePoint site to support cross team and organisational learning.	Complete.	Built into BAU of BB team.
	6	Health Inequalities knowledge integral to all methods of delivery of learning.	Complete.	Built into BAU of BB team.
Delivering	1	BB to become part of the DNA of Alder Heys mechanisms and processes to support the cultural change required.	In place, on track.	Brining these elements into BAU will allow BB to become more embedded in the organisaiton and will therefore become more of 'the way we do things around here'
	2a	CYP&F involvement in all strategically important and BB frontline improvement work.	In place, on track.	Support continues to be gained from CYP&F engagement leads. Skill set within BB team to take this further so not reliant on availability of engagement leads.
	2b	Rights of the child approach implemented in clinical areas.	Plan in place, align to strategy	N/A
	3	Alignment of strategic priorities and breakthrough objectives through the operational mangement system of BB to ensure board to ward cascade and return of reporting.	Partial achievement to Divisional level but not to frontline level.	Align into BB / Operational Plan 24/25
	4	Develop the maturity of Divisional Routines to manage performance and improvement.	In place, on track.	To be built into the performance accountability framework (to be drafted in September 23)
	5	Facilitate patient safety strategy board to ensure BB tools, routines and behaviours are utilised.	Complete.	Conintue to align improvement capability through the use of BB methodology aligned to PSIRP / PSIRF

Appendix 2

NHS Impact DCIR Review assessment paper

BOARD OF DIRECTORS

Thursday, 7th September 2023

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

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

1. Purpose

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

2. Background

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

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

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

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

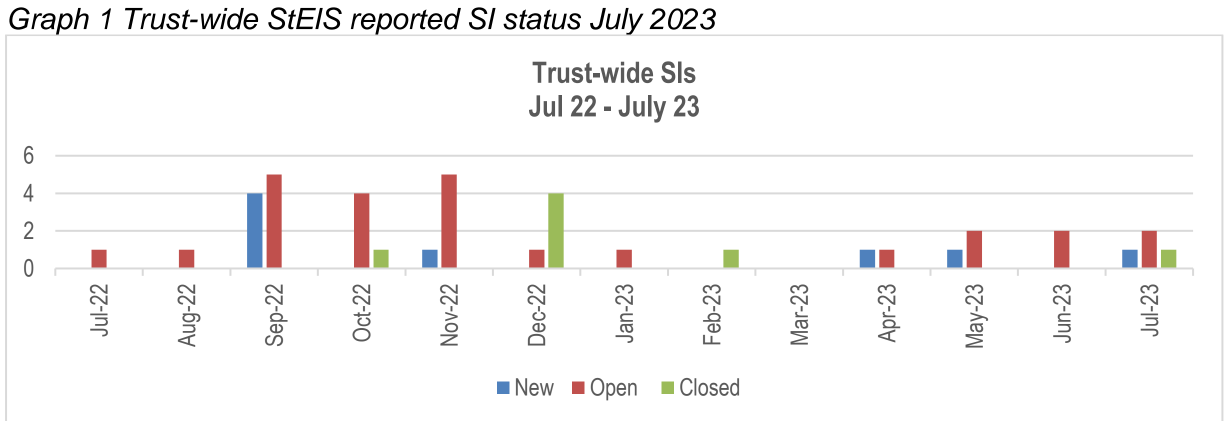
3. Local context

3.1 Never Events

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

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status July 2023



3.2.1 Declared Serious Incidents

The Trust declared **1** StEIS incident (SI 2023/12980) during the reporting period (1st June – 31st July 2023).

3.2.2 Open Serious Incidents

2 SIs were open during the reporting period as outlined in table 1.
1 SI investigation was completed in this reporting period (SI 2023 / 7350- Appendix 1).

Table 1 Open SIs July 2023

<table>
<tr><th>StEIS reference</th><th>Date reported</th><th>Division</th><th>Incident</th><th>Summary</th></tr>
<tr><td>2023/10739</td><td>23/05/2023 (reported to StEIS 31/05/2023)</td><td>Medicine</td><td>Delayed diagnosis of bone malignancy.</td><td rowspan="2">Refer to appendix 1.</td></tr>
<tr><td>2023/12980</td><td>02/07/2023 (reported to StEIS 05/07/2023)</td><td>Surgery</td><td>Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.</td></tr>
</table>

3.2.3 Serious incident reports

3.2.4 SI action plans

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

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

3.3 Internal level 2 RCA Investigations

The Trust declared **one** internal level 2 RCA investigation during the reporting period (1st June – 31st July 2023).

3.4 Duty of Candour

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

1 initial and 5 final Duty of Candour responses were required and completed within expected deadlines during the reporting period (1st June – 31st July 2023).

4. Learning from serious incidents

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

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

1 SI action plan was completed during the reporting period (1st June – 31st July 2023). Immediate lessons learnt from all SIs are outlined where applicable in this report.

The main themes identified from the completed SI action plan were:

- Inaccurate documentation regarding the patient's diagnosis.
- Antibiotic administration was over the expected timeframe. However, whilst the panel felt this might have been beneficial to administer antibiotics earlier due to the patient's rapid deterioration, there were no concerns regarding the patient having sepsis.

Recommendations

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

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2023/10739 **InPhase ID - 783**	Delayed diagnosis of bone malignancy.	Limping child guidelines should be followed. Number of attendances should be reviewed and taken into consideration. Multiple attendances resulted in no clear diagnosis even though there were ongoing symptoms.	Referred to Orthopaedics. Child has now been referred to the oncologist for a biopsy, staging and subsequent treatment. Potential amputation required as the tumour is extensive. **July 2023:** Records and statement requested from the GPs involved. Invite for a representative from the GP surgery to attend the panel meeting on 08/09/23.
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. **July 2023:** Initial duty of candour completed. Investigation underway.

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Number of extensions
2022/23391	10/08/2022	02/11/2022	Clinical Research	Never Event – wrong side biopsy.	30 1 action outstanding.	30/09/2023	NA	0
2023/7350	23/05/2023	31/05/2023	Medicine	Patient triaged to UTC GP stream with watering left eye. Seen by Go to Doc, discussed with ED Senior doctor, and discharged home with oral antibiotics. Returned 6 hours later with swollen eye and signs of orbital cellulitis. Required emergency theatre overnight for drainage of collection.	4 All actions completed 31/07/2023.	10/08/2023	NA	0

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 21st June 2023
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	John Chester	Director of Research & Innovation	(JC)
	John Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Jo Revill	Non-Executive Director	(JRe)
	Paul Sanderson	Acting Chief Pharmacist	(PS)
	Erica Saunders	Director of Corporate Affairs	(ES)
In Attendance:			
	Kelly Black	Surgical Matron – Surgery Division	(KB)
23/24/51	Will Weston	Medical Services Director	(WW)
23/24/52	Mark Carmichael	Chief Operating Officer – Medicine Division	(MC)
	Jayne Guy	Head of Nursing & AHP's for Diagnostics & Clinical Services	(JG)
	Natalie Palin	Associate Director of Transformation	(NP)
23/24/53	Kim Hewitson	Sepsis Nurse	(KH)
23/24/53	David Porter	Sepsis Lead, Consultant - Infection & Immunology	(DP)
	Julie Grice	Mortality Lead	(JG)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Jill Preece	Governance Manager	(JPr)
	Laura Rad	Head of Nursing-Research	(LR)
	David Reilly	Associate Director of Digital Systems	(DR)
	Jackie Rooney	Associate Director of Nursing Governance	(JRo)
	Linda Wain	Corporate Governance and Risk Manager	(LW)
(Observing)	Natalie Murphy	Infection Prevent control Programme Co-ordinator	(NM)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)
Apologies:	Alfie Bass	Chief Medical Officer	(ABa)
	Pauline Brown	Director of Nursing	(PB)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Melissa Swindell	Chief People Officer	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)

23/24/47 Welcome and Apologies
The Chair welcomed everyone to the meeting and noted the apologies received.

23/24/48 Declarations of Interest
None

23/24/49 Minutes of the Previous Meeting
Committee members were content to APPROVE the notes of the meeting held on 17th May 2023

23/24/50 Matters Arising and Action Log
The action log was received and updated.

Assurance on Key Risks

23/24/51 Patient Safety Strategy Board update
WW provided an update on the work of the Patient Safety Strategy Board:-

- Significant success regarding the updated format of the Patient Safety Strategy Board meeting following agreement of the new Patient Safety Strategy Board Terms of Reference, and workplans for the Patient Experience, Patient Safety and Clinical Effectiveness Groups. This has resulted in the

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Patient Safety Strategy Board having a larger agenda, with a slightly different approach to the meeting with enhanced focus and efficiency.
- Careful scrutiny had been applied to workstreams, 13, 15, 16,17 & 21.
- Patient Safety Strategy Board had approved a decision document relating to the Neonatal and new-born screening programme, which highlighted that Alder Hey Children's NHS Foundation Trust is the first paediatric Trust to implement a programme of this type working in partnership with NHSE.
- A comprehensive update regarding Parity of Esteem, which over time had expanded from 2 to 4 lines of work.
- Patient Safety Strategy Board received an update from the Learning Disabilities workstream which highlighted that Alder Hey Children's NHS Foundation Trust had hosted a NLD Champions network event in May 2023 where Makaton training was provided.
- Antimicrobial resistance workstream announced that their work had been selected for a research grant into inequalities and Antimicrobial resistance, the team also updated on a partnership which had been formed with John Hopkins to become a pilot site for AMS and Paediatric intensive care.
- The Hospital Optimising programme is progressing well and is advancing at varying speeds.
- Patient Safety Strategy Board welcomed a report regarding TPN administration errors which described an increase in errors relating to TPN administration. The Patient Safety team have since engaged with the team involved and would soon be using seeps methodology to progress with their work.
- There had been improvements across 5 workstreams, including Parity of Esteem and Neonatal.
- SQAC welcomed another good month of progress, and continuous improvement across an array of Patient Safety workstreams. Patient Safety Strategy Board had embraced the challenge of incorporating assurance elements from the former Clinical Quality Steering Group meeting into the Patient Safety Strategy Board.

FB requested clarity regarding the terminology - 'spread' noted in the overview slide, WW advised that this terminology would be amended for the next Patient Safety Strategy update as the word 'spread' is confusing for colleagues and advised that this referred to uptake/cascading or participation.

Jo R referred to neonatal new-born screening programme. Jo R sought clarity whether Alder Hey Children's NHS Foundation Trust have an agreement with Liverpool Women's NHS Foundation Trust, WW advised that there is more detail with regards to the New-born Hearing Screening which WW would share offline with Jo R.

Resolved WW to share New-born Hearing Screening Programme details with Jo R.

WW advised that Neonatal work and genomics programme is important to ensure both are aligned.
FB referred to other relevant providers in addition to Liverpool Women's NHS Foundation Trust, and that it may be a slightly wider report than just the relationship with Liverpool Women's NHS Foundation Trust, i.e., where C-GULL (Children growing up in Liverpool) intercepts for the new birth cohort programme.

Resolved: WW would consult with L Greenhaugh, Chief Medical Officer at Liverpool Women's Foundation Trust offline and would provide SQAC with an update.

KB referred to some challenges experienced through the deployment of Inphase. JR advised that a range of issues had been escalated to Inphase through the project board and solutions are actively being sought.

Resolved: SQAC welcomed an update on Inphase issues for the July SQAC meeting.

AB stated that the quantum and the quality of the work is outstanding and queried whether any additional thought is required regarding the impact that these issues are having, and potentially measuring this. AB queried whether colleagues are sufficiently tracking in an ongoing way and queried whether colleagues feel safer to speak out and raise concerns, and whether colleagues think the new framework is more effective and aids learning. AB highlighted the importance of outcome measures or indicators of culture and the appropriate tracking over time which may be able to show the impact/outcomes.

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WW advised that two of the main metrics that are going to be used on a regular basis at Patient Safety Strategy Board relate to harms per 1,000 bed days, with the second key metric relating to measuring culture.

JR stated that she regularly meets with WW and CT on a weekly basis, and colleagues could already see the benefits of no longer undertaking repeated RCA's. JR advised that capturing the impact of the new system is really beneficial and would be addressed through the PSIRF implementation group.

FB expressed thanks to WW & JR for comprehensive update and ongoing work.

Resolved: SQAC received and **NOTED** the Patient Safety Strategy Board update and welcomed an update in Inphase issues at the July 2023 SQAC meeting.

Delivery of Outstanding Care
Safe

23/24/52 ED MH attendance & ED @ its best update report

MC presented the ED MH attendance & ED @ its best report and welcomed feedback from SQAC regarding the format as this is the revised reporting using the IPR.

SQAC **NOTED** the incremental change month on month across the majority of indicators. MC advised that there are still some variables, particularly with regards to Sepsis compliance which is not a consistent improvement, with ongoing work to address.

- During May 2023, the ED department received the highest number of mental health presentations at ED with 73 patients (90%) referred to the Crisis Care. With regards to 9 children who were not referred, these patients had been reviewed, and a number of these children were known, had been referred to alternative services, or deemed not appropriate for a mental health referral. With 3 children whereby further work is required with the medical team to understand why a crisis care referral had not been made.
- MC advised that the ED department had experienced challenges over 19th & 20th June 2023, with high acuity and a high number of ED presentations during late afternoon and into the evenings. MC advised that within the North that Alder Hey Children's NHS Foundation Trust are the third best ED with regards to four hour ED compliance, with continued focus having a significant impact.
- ED @ its best programme had ended and was now business as usual, with some elements transferred into the hospital optimisation workstream.
- Overall absence rate 1 ½% improvement over the last 12-15 months, however the proportion of staff that remain absent due to stress related issues had increased.

FB stated that the format is much improved with regards to the clarity for those children who had not been referred to crisis care, this was echoed by KB.

NA referred to section 4 and requested continuous run charts, rather than tables for future reports.
SQAC received and **NOTED** the ED MH attendance & ED @ its best update report and welcomed run charts to be incorporated into future reports.

23/24/53 Sepsis Quarterly Report

DP presented the Sepsis Quarterly Report, key issues as follows:-

- Ongoing data accuracy work in ED
- Sepsis team acknowledged that the new reporting timeframe meant some of the data in this report was not different to the last report.
- ED Antibiotics <60 minutes is fairly consistently at 80-90%
- Inpatient Antibiotics <90 minute target is above 90% for the last 12 months
- Training - Current figures showed slight improvement, noting overall broadly no real change since March 2023 figures, Medical staff are still approximately 80%, with ongoing work taking place to improve compliance

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Next 6 months
An update was given with regards to areas of focus over the next 6 months, with improving data accuracy in the sepsis dashboard and training compliance identified as high priority areas.

- DP referred to whether over the longer term Sepsis updates could return to previous reporting timeline.

FB alluded to where the responsibility for reviewing staff mandatory training compliance is currenting aligning. FB stated that the Divisional leadership teams needed to be proactive in providing support to enable improved sepsis training compliance and improved traction.

Resolved: Divisional Directors to respond to and indicate how they are going to pursue this issue to enable an improvement in Sepsis training compliance.

JG alluded to the data and work in progress over the next 6 months and queried whether DP is content that this is on trajectory. JG stated the importance of having clear data access for teams. DP referred to the dashboard and indicated that there are various issues in this regard. DP stated that DR in IM&T had been keen to support colleagues, and due to lack of time and availability of DP this had not been able to rapidly progress. KH had been attempting to increase traction with the data team; however, the team had been extremely busy with other priorities. KH advised that DP and KH are due to meet with C Quirk in early July 2023 to review as the data is not updating as appropriate.

DR, advised that colleagues in IM&T are fully committed to supporting the Sepsis team and would provide support once the team are able to engage, with continued focus from IM&T to improve/resolve this ongoing issue.

JG requested a progress update at July 2023 meeting, with the aim of resolving rapidly, - SQAC agreed it would be beneficial to receive update on progress at July 2023 SQAC meeting.

KB referred to the potential impact on the ED Sepsis nurse leaving and sought clarity whether there had been any cross cover training between the inpatient and ED nurse. DP advised that there is some cover and during the period of vacancy, work would need to be prioritised, DP stated it would not be possible to deliver the full remit of the role until the new post holder is in place.

FB welcomed a rapid and successful recruitment round and welcomed an update on recruitment at the next Sepsis update.

Resolved: SQAC to receive a briefing/position statement/update at the July 2023 meeting regarding Sepsis mandatory training compliance/Sepsis data issues/ Dashboard.

FB thanked DP & KH for Sepsis update.

Caring
Effective

23/24/54 Board Assurance Framework

ES advised that there are structural changes taking place with regards to the Board Assurance Framework.

ES stated that ‘Long waiters’ remain a significant issue with continued focus, with continued focus also on Safety.

FB acknowledged the Board Assurance Framework transition.

FB alluded to the incorporated risk of industrial action and sought further detail from AB or ES regarding the potential impact from a safety, quality and access viewpoint. AB referred to the recent Junior Doctor Industrial Acton which had affected the Trust for three working days. AB advised that from a safety perspective, that the Trust had a strong level of cover with sufficient flexibility in place, resulting in a collective endeavour to ensure that the Trust had safe cover. AB confirmed that there had been no

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serious incidents relating to Industrial Action, with minor logistical issues which had arisen, as opposed to any significant harm.

AB advised that as colleagues had been more familiar with the different working patterns, that colleagues had the ability to increase the number of elective patients treated, and as a result the Trust managed to maintain two-thirds of the elective programme, which is different to previous rounds of Industrial Action.

AB alluded to the provisional dates of Industrial Action in July 2023 and advised that this is likely to be significant, given the level of impact and disruption should Industrial Action proceed, that it is envisaged that the Trust would need to adopt the Christmas Day service model from a medical staff perspective.

Jo R alluded to the financial environment and risk and sought clarity regarding whether the Trust assesses the impact with regards to suppliers having to pass on increased costs and queried the impact. NA referred to the previous report presented to SQAC regarding increased drug costs through Pharmacy and that colleagues are working to manage this and advised that SQAC are sighted on this issue. JG advised that these inflationary pressures are tracked through RABD with good oversight at RABD.

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

23/24/55 Aggregate Analysis of Incidents, Complaints, PALS, Claims and Inquests Quarter 4 2022/23 (January 2023 – March 2023)

JR presented the Aggregate Analysis Report, key issues as follows:-

- A summary of the report was presented which gave insight into the top level areas that are emerging as themes for the organisation.

FB expressed thanks to JR for comprehensive report, KB echoed FB comments regarding the content of the report. KB sought clarity regarding reporting schedule as KB assumed this report had moved to a 6 monthly presentation, as opposed to quarterly reporting. NA confirmed that this was 6 monthly on the work plan and in future the report would cover a 6 month period.

KB questioned if there was a data accuracy issue, as for example the number of self harm reported incidents fluctuates considerably by quarter. KB stated that it would be helpful for appropriate colleagues to review to ascertain whether there is a data anomaly. JR agreed to review.

FB referred to AATD and stated that there is a great deal of vastly different activity within this, and that there are some issues that are unavoidable i.e., delaying treatment and cancellations, however it may be helpful to review whether the organisation is doing everything possible to manage people's expectation when waiting a long time. JR advised that this is one of the top 5 themes that has been identified through the PSIRP which would be addressed from September 2023. JR advised that 4-5 years of previous data had been reviewed and colleagues are working with the Business Intelligence team to review sub themes to ensure appropriate focus on correct themes. Colleagues are also working with Innovation Team regarding utilising artificial intelligence, to enable targeted focus improvements in order to enhance further.

NA recognised the good practice by Community & Mental Health Division, which had affected medication issues and had moved from the top priority to the rear of top 5. NA queried whether it would be helpful for SQAC to have a granular review of medication issues as a deep dive at a future meeting.

Resolved: SQAC received and **NOTED** the Aggregate Analysis of Incidents, Complaints, PALS, Claims and Inquests Quarter 4 2022/23 (January 2023 – March 2023), SQAC **NOTED** the continued positive reporting culture and learning from incident throughout the Trust demonstrated within the report.

Resolved: SQAC accepted assurance that the Trust is compliant with the reporting requirements of the NHS Quality contract.

Resolved: SQAC to receive Deep Dive on Medicine Safety at July 2023 SQAC meeting.

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23/23/56 Mortality Report/Mortality Annual Report

JG presented the Mortality Report/Mortality Annual Report, key issues as follows:-

- JG alluded to the substantial change, with regards to the way SUDIC is reported. Following covid the there had been a change in presentations, resulting in a peak over the winter period, there are still variations, and there had also been a number of high profile trauma deaths which impacted on figures.
- HMRG Performance – there had been a slight decrease in HMRG performance which can be attributed to the recent industrial action.
- No potential avoidable deaths during 2022
- Rapid reviews process relating to CYP who attend in cardiac arrest is being revised and improved through a brilliant basics approach to ensure consistency across the organisation.
- VTE prophylaxis in medical patients – whilst there is a clear policy for surgical patients no consistent approach for medical patients, it is extremely rare in the child population and work is ongoing to create a pathway and proforma, which is ongoing.
- Number of coroners cases being held at short notice impacting on clinicians as staff are called at noticeably short notice as the coroners are trying to address backlog.
- ME introduction had been delayed nationally, Alder Hey Children's NHS Foundation Trust had appointed a Medical Examiner - 1PA – delay regarding documents which are required to be uploaded onto meditech to train the Medical Examiners, this is with EXPANSE team who are under significant pressures.
- Learning – SharePoint is almost ready with learning points included from main teams, with relevant information which is effective and easily accessible.
- Significant learning had been obtained from bereaved families which is invaluable with a much clearer process in place.

FB stated that it is a really clear report, which provided a high level of assurance with reflection and learning. FB acknowledged the issues relating to meditech and the time taken regarding changes to systems set up and established.

JG confirmed that one form is required for Medical Examiner to enable a summary of care, with the requirement for an appropriate form to be incorporated into Meditech.
DR requested JG to liaise with him directly should any escalation be required for additional support with regards to Meditech and incorporating the ME form, JG stated that it had been escalated to Digital Oversight Board and thanked DR.

Resolved: FB welcomed update on this at the next update.

JR referred to a discussion held regarding linking the learning from deaths criteria with the PSIRF investigations and that she would email JG offline to follow up in this regard to ensure a robust process.
Resolved J Rooney would liaise offline with JG to ensure robust process.

FB thanked JG for comprehensive Mortality Report which highlighted strong assurance

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

23/24/57 CQUIN Quarterly Report

NA advised that CQUINS were paused during Covid 19 pandemic, and that there was no requirement to report on or deliver against CQUINs. Over the last 18 month period the CQUIN process had been restarted.

On review over the last year there had been no financial penalties for non delivery of CQUINs. Majority of the CQUINs were delivered, significant an outlier regarding flu uptake for staff which was set at 80% and the Trust delivered at 50%. NA stated that there is a need to refresh and reinvigorate the flu vaccine programme for this year.
NA advised that PB had reviewed the process for oversight and governance, and it is embedded in clinical divisions, with leadership clearly aligned. NA stated that SQAC would see CQUIN reporting to SQAC on a quarterly basis. NA stated that it is unlikely that the Trust would face any financial penalties, however with the caveat within the current financial climate that this may potentially change.

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FB stated that on review of the report, it was extremely clear that flu was going to be challenging, however FB was less clear on the other challenges, and queried when in the year SQAC would be sighted on this. NA advised that the perinatal mental health CQUIN may present some challenges but that the others identified should be achievable with the design of correct reporting.

PS advised that the AOS team are aware of the medication CQUIN and are already working through this, PS envisaged that this would not be a problem.

PS referred to the DMS referrals and sending community pharmacy details of discharges directly to community, which is resulting in conversations regarding how to train community pharmacists better, with regards to how they deal with children and young people on discharge, and potentially leading to some changes in practice.

Jo R referred to shared decision making, and assumed this would apply across the Trust to produce evidence that it is happening. NA advised that this is across all Trusts, and that the adults CQUIN is focussed regarding cardiology and cardiac surgery, Alder Hey Children's NHS Foundation Trust had negotiated this within the asthma service. NA advised that there are usually only ever two-thirds of CQUINs that relate to C&YP, and that generally relates to mental health work. NA advised that the other CQUINs are negotiated. NA stated that there had been a significant delay with the negotiation process which commenced in February/March 2023, with negotiations on how they become applicable to children and young people.

Resolved: SQAC received and **NOTED** the CQUIN Quarterly Report and welcomed the next Quarterly update at the September 2023 SQAC meeting.

Clinical Governance Effectiveness
Well Led

23/24/58 Clinical Audit Annual Report 2022/23

JG presented the Clinical Audit Annual Report 2022/23 for the period 1st April 2022 – 31st March 2023. Clinical Audit Annual Report outlined delivery of clinical audit activity that had taken place for 2022/23, and evidenced themes, trends and recommendations from both national and local audit findings any reports and actions to those findings and provides assurance to the Trust Board regarding delivering on Trust audit activity and that it is progressing in line with accepted practice.

Clinical Audit – the organisation have a Trust Clinical Audit plan for 22/23 and it illustrates activity in relation to those mandated national clinical audits to NCEPOD, Confidential Enquiries to National service improvement programme and Trust wide clinical audits that were undertaken to fulfil the requirements of the quality contract and the NHS England and NHSE requirement.

- The Trust participated in 13 national audits and 5 national confidential enquiries
- The Trust participated in 2 national audits and 1 national confidential enquiry where the Trust could not submit the required number of case notes, due to lack of capacity within the team to complete the forms.
- The findings from published national clinical audit reports and confidential enquiry reports were also reviewed during 2023, and the recommendations from those reports were actioned and the outputs undertaken.
- 2 national enquiry reports are pending publication, once published those recommendations would be reviewed and actioned as appropriate.
- 13 priority audits, of which 8 were included due to NHS Quality contract requirements. All of those audits were continuous data collection and colleagues will continue into 23/24 and findings from four of those audits are provided within the Annual Report.
- For 2023/24 there were 249 local audits registered last year, of those 81 were completed, the emerging themes and trends related to review of clinical pathways, staff education and training. Further audit work is required and improved documentation.
- 24 re audits registered in the last 12 month period, of which 12 had been completed, emerging themes are remarkably similar to those local audit findings - clinical pathway review, staff training and education.
- Process of approval and monitoring of audits would continue to be a focus for 23/24.

- Proposal for formation of Trust Wide Clinical Effectiveness and Outcomes Group which would come into effect in July 2023 to provide oversight of all audit activity and provide assurance to SQAC.
- Significant shared learning across specialties, regionally, internationally, noted that there is no Trust wide forum for sharing outputs and findings from audits, this is an areas for further development.
- Clinical Audit training had been paused during pandemic and would be a focus of development for 2023/24 across all staff groups.
- A series of audit development sessions had taken place in Quarter 3 with the corporate clinical audit team and divisional governance leads, to improve process collectively and collaboratively regarding clinical audit, with a comprehensive action plan developed to facilitate that work.
- Further work is required to develop processes and internal systems to provide oversight of the implementation of the actions and recommendations though assurance on how the organisation had embedded that learning, the Clinical Effectiveness Group would be conduit in this regard.

FB expressed her thanks to JR for outstanding and comprehensive report detailing 22/23 Clinical Audit activity, this was echoed by KB. KB alluded to the significant work undertaken with regards to the report and also acknowledged further developments to embed actions.

KB referred to 3 areas whereby the Trust did not submit 100% national mandated audit and sought clarity whether there would be any financial penalty. JR expressed thanks to KB for feedback. JR advised that she was not aware of any financial penalty with regards to not submitting data and that she could follow this up offline. JR advised that from feedback from clinicians related to the format in which the reports are provided from the National Enquiry team, is that they had not got the data, or it is not relevant, however JR did recognise that there are capacity issues within the team. JR highlighted the importance of systematically undertesting who is responsible, and timeframes when submitting information.

Jo R stated that this was a superb report and advised that Trust wide learning is extremely important and highlighted the importance of clinical audit being prominent across the organisation, Jo R sought clarity regarding whether this is sufficient priority for staff requested to participate in clinical audits and whether this is included in development plans. JR alluded to audits that are meaningful, and that there had been a significant data cleanse across the divisions, this is part of development work.

Resolved: SQAC received and **NOTED** the Clinical Audit Annual Report

23/24/59 Divisional update/Quality metrics, Deep Dive – FFT

NA referred to one theme regarding the number of overdue risks/actions and advised that this would be rectified as this related to the change over from Inphase. Divisions confirmed that this was the case.

A deep dive presentation was given relating to FFT.

FB thanked JP for update and stated that there are a number of actions identified. FB alluded to the deep dive and stated that SQAC expectation would be to have received an enhanced update on reflective learning and examples of good practice and that following the update useful learning had been extremely limited.

LC noted that the action plan required specific and measurable actions to be included.

Resolved: LC requested specific and full dates/timescales to be included within the action plan.

LC alluded to appropriate measures for children and young people, with regards to engagement and whether further consideration is required to increase obtaining different feedback from children and young people.

NA echoed LC comments and alluded to how colleagues move the strategy forward and also demonstrating engagement of children, young people and families and living and learning form what children and young people are providing feedback on.

NA stated that the action plan had scope for being extremely focussed on gathering increased feedback, whilst reviewing additional methods of gathering data. NA advised that it is time to refocus on generating a high number of responses in order to obtain a realistic indication. NA advised that this is the responsibility of every member of staff job to collect feedback either through text messaging or at the point of discharge.

KBI advised that there are plans within the Division to undertake targeted work to empower families to raise any concern in a care episodes and not following discharge to address and share issues in real time.

LR advised that the Research Division are moving towards their own platform that would serve the national NIHR with Friends and Families test questions incorporated, with a plan over the coming months to export the main platform back into the Friends and Family test, with significant engagement work taken place to date. LR stated she envisaged improvements with response rates going forward.

Resolved: SQAC requested that within the Divisional reports within the Risk sections, that each of the Divisions record what the actions are and whether the actions are progressing as planned, together with a description of the risk. JR would follow up with A.C.N's as appropriate and would be reviewed through the A.C.N monthly meetings.

Resolved: SQAC received and **NOTED** the Divisional Update and FFT Deep Dive and **NOTED** that further refinement is required with regards to future reports. SQAC were supportive of continuing with focussed Deep Dives.

23/24/60 Clinical Audit Policy

Resolved: SQAC received, **NOTED** and RATIFIED the Clinical Audit Policy.

23/24/61 Any other Business

NA referred to the Deep dives for future SQAC meetings and advised that the Deep Dive for Medication would be provided to July 2023 SQAC meeting.

Resolved: SQAC agreed to receive a detailed update/deep dive slides on compliance and progress with outstanding NICE Guidance from service/NICE leads at July 2023 SQAC meeting, with further progress updates thereafter.

Resolved: Action log to be updated to include update on unactioned notifications and any high risk notifications and an update on Clinical Coding errors – with updates to be received at July SQAC meeting.

23/24/62 Review the key assurances and highlights to report to the Board

Good level of engagement

- Patient Safety Strategy Board update, which highlighted that the new Patient Safety Strategy Board is operating as intended, bringing a clearer focus on patient safety. The report outlined satisfactory in each of the work strands which had been reviewed in month, and a satisfactory level of assurance regarding Patient Safety Strategy Programme.
- Update on ED MH Attendance & ED @ its Best update report
- A higher % of ED MH attendances had been referred to Crisis Care (90%) and reporting had improved on patients not referred.
- Sepsis Quarterly update. SQAC agreed that the Sepsis reporting plan would be reviewed to address whether Sepsis Team is reporting to SQAC in the correct sequence. SQAC agreed that Divisional Directors/Leads would lead the review of Sepsis training exemptions. Progress with data issues would be reviewed in month. Overall a good presentation and discussion of key issues was held at SQAC.
- Board Assurance Framework. Discussion took place regarding the impact of the Junior Doctor Industrial Action, with assurance being given that a safe level of cover was being maintained during Industrial action, whilst recognising the impact on access. The impact of budgetary pressures linked to cost of living matters was raised: this would be discussed at the forthcoming Non-Executive Away Day.
- Aggregate Analysis report, with strong assurance provided.

- Mortality Report/Mortality Annual Report which provided high levels of assurance, with associated learning and reflections within the report.
- CQUIN Quarterly Report.
- Clinical Audit Annual Report, which demonstrated good assurance, and considerable progress in this area, with further improvements identified for 23/24. SQAC noted the considerable level of improvement through 22/23 to ensure that effort expended on audit was directed into priority areas, and that audits were well-conceived, well-governed, and actioned appropriately; moreover, that lessons learned are shared appropriately and thematic learnings also drawn out. SQAC expressed their thanks to J Rooney and others for their efforts. The new Clinical Effectiveness and Audit Group would oversee this work from July and there has been good engagement from across the Divisions and Corporate Services.
- Divisional reports in the new format, with further refinement agreed regarding risk. SQAC were supportive of continued focus on deep dive process.
  Discussion was held regarding Friends and Family Tests deep dive, with further work required. SQAC were supportive of receiving a Deep Dive on Medication at the July 2023 SQAC meeting.
- SQAC received and approved the Clinical Audit Policy

Date and Time of Next Meeting: 19th July 2023 at 9.30 am

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Research and Innovation Committee

Confirmed Minutes of the meeting held on **Tuesday the 18th April 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. J. Kelly	Non-Executive Director	(JK)
	Dr. F Marston	Non-Executive Director	(FM)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance	Ms. A. Bibi	Assoc. Chief Operating Officer - Research	(ABi)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Kirkpatrick	Assoc. Director of Commercial, Control and Assurance	(EK)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. L. Rad	Lead Research Nurse	(LR)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mr. J. Taylor	General Manager, CRD	(JT)
Observing:	Ms. F. Ashcroft	CEO of the Charity	(FA)
Item 23/24/12	Mr. D. Cole	Senior Project Advisor	(DC)
Apologies:	Mr. A. Bass	Chief Medical Officer	(AB)
	Ms. K. Birch	Academy Director	(KB)

23/24/01 Apologies

The Chair noted the apologies that were received.

23/24/02 Declarations of Interest

There were none to declare.

23/24/03 Minutes of the previous Meeting

The minutes from the meeting held on the 6.2.23 were agreed as an accurate record of the meeting pending the following amendment:

- Amend Emily Kirkpatrick's job title from Finance Manager to Associate Director of Commercial, Control and Assurance.

23/24/04 Matter Arising and Action Log

Matters Arising

There were none to discuss.

000126 *Action Log*

Action 22/23/36.1: *Market Communications Plan Update (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)* – The Trust is still in discussion with Agent.
ACTION TO REMAIN OPEN

23/24/05 How Research and Innovation fit into the Vision 2030 Strategy

The Committee received a presentation that depicted how research and innovation fit into the Vison 2030 Strategy. A number of slides were shared that provided information on the following areas.

- Our Vision;
  - A healthier, happier and fairer future where every child and young person can achieve their full potential.
- CYPF areas of need;
  - Get me well.
  - Make my care more personal.
  - Improve my life chances.
  - Bring me the future today.
- Our strategic goals;
  - Unrivalled experience.
  - Supporting our colleagues.
  - Pioneering breakthroughs.
  - Collaborating for children and young people.
  - Smartest ways of working.
- Vision 2030: The dialogue.
- Futures - Why? What? How?

A question was raised which John Chester responded to about how the Trust will balance the Futures focus with the current focus in terms of prioritising resources. A discussion ensued and feedback was provided around the importance of being able to measure impact which it is felt is critical to achieving success.

Louise Shepherd pointed out that the Trust is in the process of designing the Futures element of the strategy. During the first quarter of the year there will be a focus on key elements and how they will be prioritised. This will incorporate future facing components and the deployment of opportunities that Alder Hey has already created, into practice. A report on Futures is to be submitted to the inaugural meeting of the Strategy Board on the 6.7.23 and will provide further detail on the points raised.

The Chair highlighted the importance of having a spring clean of the pipeline to halt progress on projects that won't fit into the Futures Strategy thus freeing resources to enable the Trust to deliver the strategy from Q1 onwards. It was queried as to whether there is a plan in place for this process. The Committee was advised that time has been set aside to prioritise this work, and the same principles the Clinical Research Division (CRD) used to conduct a winter clean will be adopted.

23/24/05.1 Action: EH

The Chair asked as to whether a conversation should take place on the new vehicle structure. It was reported that discussions are ongoing regarding this matter and therefore it would be slightly premature to comment at the present time, but there is a general opinion that a joint vehicle approach should be taken.

Resolved:

The Committee received the presentation on 'How Research and Innovation fit into the Vision 2030 Strategy' and noted the content.

23/24/06 Research Performance 2022/23 and Annual Planning Report 2023/24

The Committee received an update on the 2022/23 performance for the CRD and an overview of the Annual Planning Report for 2023/24. Information on the following areas was provided:

- Celebrations.
- Key highlights of 2022/23.
- Divisional alignment to the Trust's 2030 Strategy in terms of research priorities and themes.
- Top 5 improvements.
- Divisional performance;
  - Improvement and impact.
  - Impact of approved studies.
  - Plans to improve productivity.
- Workforce.
- Governance.

Following discussion a number of points were made:

- The Committee was advised that the Business Intelligence Unit (BIU) have some great learning following the DETECT project and it was suggested that a discussion take place with Kate Warriner to see if lessons learned can be built into the Research Work Programme. It was agreed to discuss this matter outside of the meeting.

23/24/06.1 **Action: ABi**

- The Committee was advised of the compilation of a Research Strategy which is scheduled to be finalised in October 2023, and it was felt that conversations on future developments, etc. should take place following the completion of this document.

23/24/06.2 **Action: JC**

The Chair concluded the agenda item by offering thanks to the team for the work that has taken place which has enabled progress and changes to be made. The Chair also thanked the teams involved in the collaborative work that is being undertaken from a research and innovation perspective.

Resolved:
The Committee received and noted the content of the Research Performance 2022/23 and Annual Planning Report 2023/24.

23/24/07 2022/23 YTD Financial Update and 2023/24 Financial Plan

Refer to agenda item 23/24/09.

23/24/08 Innovation Performance 2022/23 and Annual Planning Report 2023/24; including:

The Committee was provided with an update on innovation performance for 2022/23, the impact of the Innovation Strategy which was launched in May 2022 and the activity plan/KPIs for 2023/24. Information on the following areas was provided:

- Successes and lessons learnt to date from year one of the Innovation Strategy.
- Operational highlights.
- Impact and performance.
- 2022/23 performance against quarterly deliverables.
- Update on priority projects.
- Workforce.
- Governance.
- Principles and rationale for budgeting and activity planning for 2023/24.
- 2023/24 Annual Plan;
  - Q1 priorities – Benefits and Costs Workshop across teams to develop scope of ROI action plan for capture and reporting financial impact to the Trust.
  - Budget 2023/24 recommendations.

The Committee was provided with background information regarding a proposal to create a Data Access Panel. It was reported that the proposal will be submitted to the Committee in July for approval. It was recommended that the Trust's SIRO; Kate Warriner and Caldicott Guardian; Nathan Askew be included on the panel.

23/24/08.1 **Action: EH**

The Chair asked as to whether the Committee was in agreement for a Benefits and Costs workshop to be arranged. Committee members confirmed their approval of this request.

Resolved:
The Committee received and noted the content of the Innovation Performance 2022/23 and Annual Planning Report 2023/24.

23/24/09 **2022/23 YTD Financial Update and 2023/24 Financial Plan**

The Committee received the 2022/23 year to date update and the 2023/24 Financial Plan. A number of slides were shared that provided information on the following areas:

- CRD: Finance overview for M12 2022/23 and draft outturn.
- Innovation: Finance overview for M12 2022/23 and draft outturn.
- Business Planning for 2023/24 – Overview and next steps.

A lengthy discussion took place on the Research and Innovation (R&I) budget position in terms of the underlying position, funding, income and cost pressures. Attention was drawn to the importance of having an alternative financial model going forward for R&I and Futures to make sure that the right structure is in place and sustainability can be achieved.

It was agreed to prepare a report on the R&I Financial Strategy that supports the direction of travel and submit it to the Committee on the 10.7.23. Louise Shepherd felt that it is imperative to produce the strategy forthwith and share it with the Board to gain support and ensure Board members are sighted on this area of work.

23/24/09.1 **Action: JC/EH**

The Chair pointed out that the development of a new joint vehicle is fundamental to the Financial Strategy and queried as to whether a paper could be submitted to provide further detail at the next meeting. It was reported that this development will need to be addressed via a staged process and will be part of the longer-term financial structure. It was agreed to discuss this matter outside of the meeting.

23/24/09.2 **Action: JC/SA**

The Chair queried as to whether the 'Benefits and Costs Workshop' could take place before the next R&I Committee in order to receive an update on the outcome

of the session. It was confirmed that this is a priority and recommendations and discussion points from the workshop will be shared at the next Committee meeting.

23/24/09.3 **Action: EH**

Resolved:
The Committee received and noted the 2022/23 YTD Financial Update and 2023/24 Financial Plan

23/24/10 **Grants and Proposals Tracker, Q4**

The Committee was provided with an update on the grants that are currently being worked up or have been submitted during Q4 and are awaiting an outcome. It was reported that for large grants there is a considerable timeline between submission and anticipated start date.

Fiona Ashcroft raised a query relating to an item in the tracker. Following a conversation it was agreed to look into this matter further outside of the meeting.

23/24/10.1 **Action: EK**

Resolved:
The Committee noted the content of the Grants and Proposals Tracker for Q4.

23/24/11 **Strategic Outline Case**

The Committee was advised that the Trust is planning to submit a Strategic Outline Case (SOC) to the Treasury for investment purposes.

It was reported that a socialisation workshop took place on the 14.3.23 to share Alder Hey Innovation (AHI) updates on the vision for the project, review objectives, model options and shortlist options. The Committee was provided with an overview of the outcomes of the workshop, the next steps that have a completion date of May, and the actions that will need to be progressed from May onwards.

A number of slides were shared that provided information on the updated objectives following feedback from the workshop, and impact measures. It was confirmed that the next version of the draft SOC will be submitted to the R&I Committee in July.

Feedback on the outline case was provided by Committee members and attention was drawn to the importance of engaging and influencing stakeholders, having clarity in terms of the pitch, creating an economic case that is compelling, having resources with additional skills to help support the growth of funding, and delivering an alternative financial model.

A number of actions were agreed following discussion:

23/24/12.1 **Action:** Meeting to take place to discuss the pitch of the project to ensure clarity. **EH/LS/JG**

23/24/12.2 **Action:** Meeting to take place to discuss the work that is required to create a compelling economic case. **EH/LS/JG**

23/24/12.3 **Action:** Submit a specific outline case proposal detailing objectives, impact and outcomes. **EH**

Resolved:
The R&I Committee noted the update provided on the Strategic Outline Case.

23/24/12 **Commercial Partnerships Agreements and Business Development Prospects**

The Committee was provided with an update on the tracking and transparency of commercial activities, and assurance was received as a result of the monitoring of specific agreements, deal progression status and potential commercial revenue opportunities. Information on the following areas was provided:

- Highlights for the Q4 2022/23 period.
- Looking ahead to 2023/24.
- Commercial product opportunities.
- Product solution updates.
- AHI process for impact and sustainability.
- Checks towards commercialisation.
- Proposed pipeline model: Stage vs Status.

A discussion took place around commercial opportunities in terms of framing business offers for products that have been proven to work, sale prospects, providing solutions in an alternative way to make a product more commercially viable, having a Market and Communications Plan for each product and forming commercial partnerships.

Concerns were raised about the cost involved if the Trust makes a decision to undertake the piloting, marketing and sale of products.

It was acknowledged that commercial activity is fundamentally interlinked with the Financial Strategy and to make it more meaningful it was felt that a discussion should take place at Exec level to discuss an approach for a marketing and commercial offer for the sale of products.

The Chair brought the agenda item to a close and asked that the following action be progressed:

23/24/12.1 **Action:** Meeting to take place to discuss an approach for a marketing and commercial offer for the sale of products. **EH/DC/Execs**

23/24/13 **Board Assurance Framework Report**

The Committee received the Board Assurance Framework Report (BAF) for February 2023. It was reported that work is to be undertaken to reprofile the strategic risk for R&I during the coming period. A reframing of the risk description will take place along with a refresh of the gaps in assurance based on discussions during the meeting. There are some shared areas of control and assurance on the current risk, but further work will need to be conducted in order to link R&I. From an operational perspective a summary of the risks that are ranked as 12 and above will be required to identify where they sit.

Resolved:
The Innovation Committee noted the contents of the BAF report for February 2023.

23/24/14 **Research and Innovation Committee Terms of Reference**

The Committee received the draft Terms of Reference (ToR) for approval purposes. It was acknowledged that the membership will need to be amended once the Futures work commences therefore it was agreed to review the ToR in October 2023.

Attention was drawn to the name change to the research role in the ToR. Laura Rad agreed to link in with John Chester to provide the finer detail.

23/24/14.1 **Action: LR**

Resolved:

The R&I Committee approved the R&I Terms of Reference pending the name change to the research role.

23/24/15 Innovation Committee Annual Report, 2022/23

Resolved:

The R&I Committee received and approved the Innovation Committee Annual Report for 2022/23.

23/24/16 Any Other Business

There was none to discuss.

23/24/17 Review of the meeting

The Chair felt that the quality of the reports submitted to the Committee were good in terms of clarity and how they were presented, and some in depth discussions took place during the meeting which produced a number of actions.

Date and Time of the Next Meeting: Monday 10th July, 9:00am-12:30pm, via Teams

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	**2022-2023 Annual Submission to NHS England North West**
Report of:	**GMC Appraisal and Revalidation Compliance and Assurance**
Paper Prepared by:	Helen Blackburn, Appraisal and Revalidation Manager

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

Remember to:

- *Keep your report risk focussed remembering the Board/Committee's strategic assurance role & core purpose*
- *Keep reports* ***as short as possible*** *highlighting key issues*
- *Make yourself aware of cut off points for submission of papers - late papers will not be accepted by Committee Chairs*
- *Ensure reports give a clear direction as to the required outcome e.g., approve X or decide between options A and B*

1. Introduction – summary of key risks and issues

The Annual Organisational Audit has been stood down for 2023. The GMC has asked the Trust to provide assurance that the Trust is managing appraisals for clinicians, ensuring that they have access to appropriate resources and support. The attached report details the activity for 2022-23 and highlights future plans.

2. Background and current state

Following the appointment of the new Chief Medical Officer, who is also the Responsible Officer, a new Responsible Officer's Advisory Group (ROAG) has been implemented. The ROAG meets on a bi-monthly basis, the group reviews revalidation recommendations, ensures that the evidence provided by clinicians meets GMC requirements. Clinical staff are required to undertake an annual appraisal, the revalidation cycle is five years long. They also collect colleague and patient feedback within each cycle, to provide assurance for continued practice. The Trust purchased L2P to manage appraisals and mutli-source feedback.

The majority of appraisals took place within the required timescale, the move to birth months has presented challenges for some appraisees.
There has been an in increase in the number of exceptions relating to appraisal completion, most cite either workload or wellbeing issues as the barrier to completion.

3. Conclusion

The Trust is compliant with GMC requirements. The information contained within the attached report reflects how we manage appraisals and how we intend to support clinicians throughout the next phase of appraisals.

4. Recommendations & proposed next steps

A peer review will be organised with local Trusts, this will enable benchmarking and sharing of best practice.

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

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Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**Alder Hey Children's NHS FT**
What type of services does your organisation provide?	Acute paediatric care

	Name	**Contact Information**
Responsible Officer	Mr Alfie Bass	alfie.bass@alderhey.nhs.uk
Medical Director	As above	
Medical Appraisal Lead	Dr Zahabiyah Bassi	Zahabiyah.Bassi@alderhey.nhs.uk
Appraisal and Revalidation Manager	Mrs Helen Blackburn	helen.blackburn@alderhey.nhs.uk
Additional Useful Contacts	Ms Carol Pickup, Administrator	appraisallead@alderhey.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: **Please describe arrangements for Responsible Officer to report to the Board:** **Date of last RO report to the Board:** **Action for next year:**

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	382
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	25
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	1
Total number of appraisers as at 31 March 2023?	72

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	69
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	19
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	1

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	
How many doctors have been referred/ discussed by the GMC between 1 April 2022 and 31 March 2023?	**8**
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	**13**
How many doctors have been restricted/excluded from practice between 1 April 2022 and 31 March 2023?	**6 restricted from clinical practice**

	0 fully excluded from all activities

Organisational Policies

List your policies to support medical appraisal and revalidation	**Implementation date**	**Review date**
Medical Revalidation & Appraisal Guidelines	July 2021	July 2024

List your policies to support MHPS and managing concerns	**Implementation date**	**Review date**
HANDLING CONCERNS ABOUT CONDUCT, PERFORMANCE & HEALTH OF MEDICAL & DENTAL STAFF POLICY	September 2022	December 2023

Other relevant policies	**Implementation date**	**Review date**

How do you socialise your policies?
We have a Document Management System on the Intranet; all policies are available via this platform. The appraisal policy is also available on L2P.

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes – Mr Alfie Bass
Action for next year (1 April 2023 – 31 March 2024).

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

We have a dedicated appraisal team. Consultant Appraisal Lead, Appraisal and Revalidation Manager and Administrator.
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? **We use L2P database for all substantive postholders. Drs who have short term contracts use either a paper appraisal or exit form. We intend to use L2P for all short-term contracts of 12 months or more. The contracts of 6 months or less will continue to use the Exit Reports**.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024).

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review? **No, we intend to contact Liverpool Women's Hospital, Liverpool Heart & Chest Hospital and Walton Neuro centre to initiate a local peer review group.**

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes, we contact all Drs who work in the Trust to ascertain the most effective way to support their needs.

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

All locum or short-term Drs can apply for study leave or attend internal training events. We allocate an appraiser to support the individual. The revalidation manager meets them to discuss requirements for appraisal and revalidation. Individual plans are developed to provide support, using either paper appraisal, access to L2P or an Exit form to record their CPD depending upon the type of contract.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes – it was implemented in March 2023
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

No
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

We organised a coaching event for our appraisers. The event was well attended and the feedback received will be used to extend the programme to all appraisers, particularly new appraisers. **We had two appraiser update events.** **We have drop-in clinics for appraisers, appraisees to discuss problems.**

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Continue with coaching sessions. **Organise welcome events or 1-1 meetings for new Drs.** **To introduce a newsletter.**

5.5 How do you train your appraisers?

They all attend an accredited external course followed by attendance of at least one update training session per year.

5.6 How do you Quality Assure your appraisers?

We review the content of the appraisals and cross reference this with the appraisal feedback.

5.7 How are your Quality Assurance findings reported to the board?

We audit the appraisals and report this via the People and Wellbeing Committee (PAWC)

5.8 What was the most common reason for deferral of revalidation?

Lack of required number of appraisals or MSF. Covid did affect the collection of feedback during 22/23. We are in a better position now and Drs seem able to collect feedback more easily.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

We contact them directly via email or in person initially. If required we will also send formal letters, we use GMC templates, stages 1-4 informing them of their responsibilities. The information is shared in bi-weekly Appraisal Lead meetings and monthly 1- 1 meetings with RO.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

Maintaining High Professional Standards (MHPS) – monthly meeting.

Membership includes Chief Medical Officer, Divisional Directors, Chief People Officer, Dir. Corp Affairs and HR Business Partners. All formal cases and any concerns discussed and monitored. Escalated to GMC if required.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

MHPS minutes are provided to Board. Analysis is via the HR function.

6.3 How do you ensure that any concerns are managed with compassion?

All cases have Executive and HR oversight. Formal cases have a nominated Non-Executive Director to ensure that processes are adhered to. Employees are all treated with respect and compassion in line with our Trust values.

6.4 How do you Quality Assure your system for responding to concerns?

The MHPS policy processes are used to ensure that quality is maintained. MHPS monthly meeting, Board review, delegated Board member has oversight to each individual investigation.

6.5 How is this Quality Assurance information reported to the board?

Updates/ outcomes are reported by the Chief Medical Officer/ Delegated Case Manager to the Board.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

The TOI requests are completed by the Revalidation Manager, shared with requesting Trust within 3 days of receipt. We communicate via email or telephone as required.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

There are processes in place to ensure that clinical governance concerns are managed within the Trust's policies. The ROAG group meets to review cases, the group members are the Responsible Officer, Appraisal Lead, Revalidation Manager and Medical Staffing Manager.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

Case Investigator training – to underpin the knowledge of consultants required to undertake investigations and promote good practice.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

We will continue to review current practice to aid further improvements.

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

The recruitment process is managed by the wider HR team and Clinical Directors. The processes follow national guidelines to ensure that all pre-employment checks are undertaken before employment contracts are issued.

Do you collate EDI data around recruitment and /or concerns information?

Yes
If yes, how do you use this information?' **We use the information to ensure that we are meeting legal requirements and to improve the workplace by identifying gaps, biases or other work-related issues.**

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

Section 9: Statement of Compliance:
The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chair (or executive if no board exists)]

Official name of designated body: ……………………………………………………………..………

Name: ………………………………………………………………………………………………

Role: ……………………………………………………………………………………………..

Date: ………………………………………………………………………………………………..

BOARD OF DIRECTORS

Thursday 7th September 2023

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

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

1. Introduction

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

2. People Metrics

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

- Total sickness absence for the month of July was 5.5% in line with the Trust Target of 5.5%, which comprises, Short-Term Sickness (STS) of 1.74% and Long-Term Sickness (LTS) of 3.77%
- Turnover has been stable since December 2023 but has now seen a reduction to 13% in July.
- A focused effort from the whole Trust is required in respect of PDRs with a July position of 63% against the target of 90%.

3. Industrial Action

The Trust continues to respond to industrial action through the tactical command structure and weekly meetings are in place. In addition, frequent Trust wide communications and updated FAQ's are issued and available on the Trust intranet for all staff, as well as ongoing staff support through the Trust SALS Service.

List of next dates for Consultant strike action for BMA members are listed below:

The BMA are also currently re-balloting junior Drs to extend their mandate for strike action, which closes on 31st August 2023. Once the outcome of that ballot is known dates and further information will be shared.

4. Annual Staff Survey 2023

The annual NHS Staff Survey will open from 11th September – 24th November 2023 (national window). Due to the launch of Alder Care that weekend we have requested a go live date of Wednesday the 20th of September, to allow the Trust to focus on the Alder Care roll out prior to commencing with the staff survey.

There are a number of changes to this year's survey the majority of which are related to internal bank staff and therefore don't apply to us as a Trust. The other notable changes are the removal of 3 COVID-19 questions and the addition of 2 Health and Wellbeing questions, we have also included 3 local questions around Health and Wellbeing to allow benchmarking with other local organisations around wellbeing.

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

Sharon Owen
Deputy Chief People Officer
August 2023

BOARD OF DIRECTORS

Thursday, 7th September 2023

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

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

1. Introduction

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

2. Equality, Delivery System 2022 update

In July, NHS England and the Integrated Care Board held an EDS2022 workshop to provide regional NHS providers with information and support in successfully delivering the EDS2022. The workshop provided valuable information regarding the implementation and collection of evidence to support this. We will work closely with other regional trusts to gain insight into the process, providing peer support. Engagement has started to ensure that we successfully implement EDS22 at Alder Hey.

3. Staff Networks

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

- **LGBTQIA+** our staff network attended the Liverpool Pride celebration on 29th June. It was a fantastic celebration that brought the community together to support Pride. The Navajo assessment will be taking place over two days in August/September. This will involve the Navajo assessment panel engaging with several of the board members, senior leadership team, and staff at Alder Hey. They will also work with us to review our policies, procedure, and training. Supporting us to ensure we are an inclusive organisation which understands and supports our LGBTQIA+ staff
- **REACH** staff network held the first engagement event on the 18th of July. They are supporting the head of EDI to review the Workforce Race Equality Standard data, supporting the development of a meaningful action plan which will address our weaknesses and look to improve the experiences of our ethnic minority staff.
- **Armed Forces** staff network is working hard to put plans into place to celebrate remembrance Sunday in November. The network is being supported by our Chaplaincy Team who will be holding a Remembrance Day service open to all staff, families, and patients.
- **Disabilities and Long-Term Conditions** staff network held its second meeting in August. The network has started to work with the learning and development team to develop a bespoke training programme for managers. They have also renamed the network and are waiting for final member responses before launching the new name. The network will also work with the Head of EDI to analysis the data from the Workforce Disability Equality Standard, developing an achievable action plan.

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

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	**NHS North West Black, Asian and Minority Ethnic Anti-racist Framework**
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:	To share the recently developed Anti-Racist Framework, developed by the North West Black Asian and Minority Ethnic Assembly and seek approval to formally adopt the Framework.
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

The purpose of this paper is to share with the Board the North West Black, Asian and Minority Ethnic Anti-Racist Framework issued by the North West Black, Asian, and Minority Ethnic Assembly in June 2023 and seek formal approval from the Board to adopt the framework within the trust as well as a commitment to support the ambition and necessary work to achieve and maintain the gold level of the framework.

2. Northwest Black, Asian, and Minority Ethnic Assembly Anti-Racist Framework

In June 2023 the North West Black, Asian, and Minority Ethnic Assembly contacted all NHS Trusts and Integrated Care Boards to support organisations on their journey towards becoming intentionally anti-racist. It has been developed by the North West Black, Asian and Minority Ethnic Assembly in conjunction with the Northern Care Alliance's Inclusion Centre of Excellence and NHSE North West. It is not a standalone document and very much supports other ongoing work including the Workforce Race Equality Standard (WRES), Equality Delivery System (2022), as well as the National NHS Equality, Diversity, and Inclusion Improvement Plan which was also recently launched by NHS England.

The framework is constructed around five anti-racist principles:

- Prioritising anti-racism
- Understanding lived experience
- Growing inclusive leaders
- Act to tackle inequalities
- Review progress regularly

It provides a mechanism for NHS organisations to work towards the ambition of becoming anti-racist organisations and is structured around three levels of achievement: Bronze, Silver, and Gold with each level building on the next encouraging organisations to make incremental changes and take positive actions towards eradicating racial discrimination in their organisations. By making a commitment to implement the framework we will be encouraged to challenge racism and discrimination through collaboration, reflective practice, accountability, and action. Working together to embed these objectives into our organisation will help transform our processes, policies, and culture, embedding meaningful change.

3. Organisational planning and next steps

Organisations are asked to undertake an initial self-assessment using the tool provided. This will form the basis for the necessary action plan to achieve the first stage within the Framework and inform the further action required. Once completed the assessment and associated action plan will be shared with and monitored by the People and Wellbeing Committee with regular reports to the Board.

People and Wellbeing Committee
Minutes of the last meeting held on 24th May 2023
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director **(Chair)**	(FM)
	Alfie Bass	Chief Medical Officer	(AB)
	Fiona Beveridge	Non-Executive Director	(FB)
	Asia Bibi	ACOO – Service Improvement	(AB)
	Garth Dallas	Non-Executive Director	(GD)
	Nathan Askew	Chief Nursing Officer	(NA)
	Mark Carmichael	ACOO – Medicine	(MC)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	Rachel Greer	ACOO – Community & Mental Health	(RG)
	John Grinnell	Deputy Chief Executive	(JG)
	John Kelly	Non-Executive Director	(JK)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MSW)
	Audrey Chindiya (Guest)	Finance	(AC)
In attendance:			
	Angela Ditchfield	EDI Lead	(AD)
	Jo Potier	Associate Director of Organisational Development	(JP)
	Sharon Owen	Deputy Chief People Officer	(SO)
	Katherine Birch	Director, Alder Hey Academy	(KB)
	Jill Preece	Governance Manager	(JP)
	Kelly Black	Matron – Surgery	(KB)
	Emma Palmer	Compliance Lead	(EP)
	Katie Jones	HRBP – Surgery	(KJ)
	Emma Hughes	Managing Director – Innovation	(EH)
	Clare Shelly	Associate Director of Operational Finance	(CS)
	Julie Worthington	Staff Side Rep	(JW)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Apologies:	Chloe Lee	Associate COO – Surgery	(CL)
	Kerry Turner	Freedom to Speak Up Guardian	(KT)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
	Natalie Palin	Associate Director of Transformation	(NP)
	Adam Bateman	Chief Operating Officer	(AB)
	Kathryn Allsopp	Head of Operational HR	(KA)
	Pauline Brown	Director of Nursing	(PB)
	Urmi Das	Director, Division of Medicine	(UD
	Ian Quinlan	Non-Executive Director	(IQ)
	Jacqui Pointon	Associate Chief Nurse	(JP)
	Maisie StJohn	Service Manager	(MSt)
	Jeanette Chamberlain	Staff Advice & Liaison Service Manager	(JC)
	Adrian Hughes	Deputy Medical Director	(AH
	Gill Foden	HR Manager	(GF)
	John Chester	Director of Research & Innovation	(JC)
	Lisa Cooper	Director of Community & Mental Health Services	(LC)
	Rachel Hanger	Associate Chief Nurse – Surgery	(RH)
	Neil Davies	HR Business Partner	(ND)

Jacqui Lyons-Killey	Associate Chief Nurse – Research	(JLK)
Sarah Marshall	HR Business Partner, Community & Mental Health	(SM)
Phil O'Connor	Deputy Director of Nursing	(POC)

22/23/152 **Declarations of Interest**

No declarations were declared.

22/23/153 **Minutes of the previous meeting held on 22nd March 2023.**

The minutes of the last meeting were approved as an accurate record.

22/23/154 **Matters Arising and Action Log**

Action log was updated accordingly.

22/23/155 **People Plan 2030**

Following launch of the Trust's Vision 2030, MSW delivered a presentation on the next steps of the People Plan.

MSW provided an update on the current position highlighting that a business case seeking final decision on investment funding has now been completed and was submitted to Executives on 22nd May 2023. This remains under review by Head of Finance with a focus to recruit to posts from June 2023 if successful.

FB questioned the fallback position should the investment funding not be awarded for delivery of the Plan and was advised that further internal conversations would be required to determine what resource would be required from the HR Team specifically in connection to resource. FB commented noting the Committees support to help move this forward.

JK stressed the importance of articulating the achievement of CIP targets and measurable benefits in business cases to maximise their impact.

Next Steps:

People Plan has progressed with creating workshops in line with progression of the module:

- Thriving at Alder Hey: Workshop one - 7th June 2023
- Thriving at Alder Hey: Workshop two - 14th June 2023
- PID will be presented to Execs ahead of the Strategy Board – 6th July 2023

Resolved: Committee noted progress made with the people plan and awaits feedback on the outcome following financial review.

22/23/156 **Monitor Progress against the People Plan – Divisional Metrics (April 2023 data)**

Community & Mental Health Division:

The Committee received the divisional metrics report. RG reported that divisional overall compliance continued to increase and drew specific attention to the following:

- HR metrics continues to conduct deep dives relating to turnover by reviewing high level areas including staff movement and access improvements.
- Sickness has seen a reduction. Hot spot areas continue under review and HR colleagues progress forward with supporting Managers across the division.
- Return to work continues to be managed with support and guidance from HR.
- Big conversations / Staff Survey is making good progress and continues to be communicated across the patch. All areas are reminded and encouraged to complete by end of May 2023.

Next steps: Team continues to monitor data and drive improvements across the division.

Research Division:

AB presented the divisional metrics report from research highlighting the following.

- Sickness figures continue to reduce relating to both short term and long term sickness rates. Team continues to provide support across the department with assistance from all Managers and HRBPs in order to stabilise.
- Mandatory training remains complaint. All areas are encouraged to complete all essential training when required to meet trust target.
- Big conversations received good engagement following latest session held by the division and continues to make good progress.
- No leavers recorded for the month of May 2023.
- Turnover remains consistent with continued plans of support.

Good progress has been made in connection to wellbeing with conducted staff engagement forums, staff surveys and onsite face to face meetings. Two Celebration days was held and proved successful and continues making good progress across departments.

Research Division - Recruitment has now appointed:
- ➢ Dr Dan Hawcutt, Director of research
- ➢ Sarah Leo, Head of Research, Operations
- ➢ Laura Rad, Head of Nursing

Next Steps: Team continues to monitor data progression and drive improvements across the division.

Medicine Division:

The Committee received the medical division metrics report.

- Sickness remains stabilised in line with other divisions
- Staff Survey position is at 54% which is making good progress.
- Big Conversations packs have been distributed across all areas and all conversations to take place by 31 May 2023.
- Return to work has reduced for the month of April 2023.

- Turnover position is at 14% and remains a cause for concern and continues to be regularly monitored with support from HRBPs.
- PDR Compliance is above trust target at 92%
- Mandatory training remains stable at 94% which continues to make steady progress.

Next steps: Team continues to monitor data and drive improvements across the division.

Surgical Division:

The Committee received and accepted the divisional metrics report noting progress to date. KB drew the Committee's attention to the following:

- Metrics overall continues to display a month on month trend.
- Staff turnover position is at 14% relating to numerous amounts of fix term contracts
- Reasons for leaving displays a variety of work life balance, staff age group and promotions. Division continues exploring improving ways of communications with support and guidance form HR colleagues.
- Sickness has shown a reduced with long term cases being managed supported by line managers and HRBPs. Divisions remains focused on improving return to work documentation
- Mandatory training position is over 90% trust target.
- PDRs are preparing to cascade new paperwork protocol shortly for 8A and above for completion within 4-6 weeks to allow cascade to the workforce.
- Time to hire shows KPI stood at 32 days to date.
- Staff survey remains a focus - team away days, big conversations, leadership days has commenced across the division with positive feedback.

HR fed back in relation to nursing profession, some staff who leave want to return back to alder hey and the team are viewing on how to fast track those members who have left within 6 months by reviewing and looking at bespoke packages.

Corporate:

Committee received and accepted the corporate metrics report and noted progress to date. ES highlighted the following:

- Corporate services collaborative has now commenced and is doing well with initial focus on workforce metrics and conducting deep dives into hot spot areas across the organisation and continues to review monthly.
- Mandatory Training figures remain stable and making good progress.
- PDRs remain stabilised and on course of deadlines.
- Turnover position is at 16% with a focus to monitor vacancies and recruitment with a plan to introduce a process to review upstream and how to assist.

- Sickness is below target relating to long term and remains under management process again trust policy. Teams continue to review all hot spot areas.

MS thanked all divisions for their data reports for the month of May 2023 noting areas are showing good progress and provides assurance.

Action: Divisions to provide more detail into the big conversations, what teams are agreeing to do / what they would like to see and do differently.

MS noted, herself and Darren Shaw, Head of L&D will be attending all Divisional Board Meetings to discuss PDRs and open up conversations to help steer and support.

22/23/157 **Quarter 3, 2022/23 Turnover Analysis Report**

The Committee received the Turnover Report for quarter 3 and noted progress made to date.

The report detailed turnover rates dating back to 2021 and current trends happening within the NHS demonstrating that recruitment and retention is a national issue across the NHS. KJ drew attention to the following:

- Turnover position is above trust target (16.41% at December 2022).
- Leavers including reasons showed the majority related to work life balance which is an ongoing concern across the organisation.
- Exit Interviews remains consistent with 13 completed for quarter 3. Teams continue to push for initial feedback by exploring ways to improve the process to retain staff in a timely manner.

Next Steps:
Turnover position aims to be presented at Divisional Board Meetings to maintain and monitor exit interviews that are being completed including exit interview questionnaires to identify themes in order to improve data. Task & Finish Group continue to meet monthly to review interventions to reduce turnover figures which includes the support from all divisions, staffside and freedom to speak up colleagues.

NA commented advising there was an estimate of 200 international nurses employed by Alder Hey with a total of two leavers. It was highlighted that Alder Hey has been successful in gaining a one year funding investment for a fixed term post for Retention within nursing in connection with Brilliant Basics and Methodology which will add some specific interventions for all nursing colleagues. Promotion structure for band 6 and above remains a challenge but continues to be investigated and explored where possible.

NA confirmed there is a workforce plan relating to AHPs currently in development with the aim to start working alongside the nursing workforce plan which looks into each service line individually relating to different challenges and continues on track.

NA provided assurance in support of the turnover data report noting, there is a huge number relating to demographic data in each of the protected characteristics which is

not always recorded and or / accurate and would be helpful as an organisation to encourage colleagues to complete those wider demographics across all categories.

MF talked about radicalising how we work and particularly our offer in terms of working patterns and referred to some shared learning from 'blue chip' companies. The conversation led to what, if any freedoms we have to respond to the challenges of losing staff as a result of the new AfC payscales i.e., staff leaving due to lack of opportunity for a pay rise for a number of years within their band. It was agreed that this was an area for further exploration.

Resolved: the Committee noted the Q3 Turnover Report and local actions in place to improve the position and increase staff availability.

22/23/158 **Freedom to Speak Up Update**

Committee received the quarterly Freedom to Speak Up Update. ES drew the committees attention to the summary of activities in the last quarter highlighting that the report now provided detail of themes and that work was continuing to make the data more meaningful and ensure better triangulation. The number of contacts with FTSU have also been added to mirror what SALs is collating in terms of data for better understanding of the services that colleagues are using and to ensure all colleagues are signposted to the correct department for support and guidance.

.

There is continued development to include the wellbeing guardian for assurance to present how we as an organisation are maximising our speaking up opportunities for colleagues which remains a focus including appointing a formal FTSU Deputy role.

Following a request from Trust Board, compliance for FTSU training was now included in the report. ES informed the Committee of the one year plan around communications and policy statement around FTSU and delivery which had been presented to Board earlier that month.

Further dill down into the themes would be provided for the next quarterly report.

Action: Team to feedback on how things are progressing with the Wellbeing Guardian before the next quarter. ES to liaise with Jo Revill in relation to updated plan around this.

TJ to circulate Communications Plan and Policy Statement to PAWC.

Resolved: Committee noted the progress made and agreed further exploring into the key challenges highlighted.

22/23/159 **EDS2 Report**

Committee received EDS2 report submitted for ratification by Committee membership.

AD introduced the EDS22 and provided a detailed overview for assurance on the progress made since embedding equality, diversity and inclusion into our business practices and supporting that culture of transparency, accountability and inclusivity.

The EDS2 has been developed due to architectural change in the ICS and ICBs and with covid and it's more a comprehensive way of collecting that evidence to show that we are making sure that were not discriminating and providing services that are accessible and equitable for everyone. There have been 18 outcomes achieving 8 of these and currently developing 7 and exceling in 3 with EDS2 replacing EDS22 which including a briefing of what's coming in the next year.

FB queried around the improvement process in other areas such as patient safety and access and how that link is being made to the teams that are leading projects in other parts of the system. AD commented advising when we undertook this, we ensured we were working collaboratively with those stakeholders and working closely with Patient Experience to identify those areas of need.

AD added, we are working closely with ICS to ensure that we identify the services that we evaluate that so they want us to look at a service that were excelling in a service that maybe were not doing as well in which displays 3 in total we will be looking at and remains a key engagement piece.

Next Steps:
AD referred to the EDS2 noting future plans of development will involve making clear action plans to excel in all areas as possible and to start to determine a key group of stakeholders to identify key holders and identify the services we want to appraise.

GD added there are numerous discussions taking place in the EDI Steering Group and advised the key initial focus is to identify those stakeholders and provide an ownership culture.

Resolved: Committee noted progress made and approved the EDS22.

22/23/160 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

ES introduced the Board Assurance Framework reflecting the April 2023 position.

A deep dive combined with all assurance Committees continues to be conducted across all areas with plans in place to mitigate those risks going forward with assurance that the appropriate leads are assigned.

A new risk management reporting system "Inphase" will commence in due course following the transitioning process.

ES assured the Committee continued work will be undertaken over the coming months ahead to review all strategic risks associated against 2030 vision.

The Committee noted the Board Assurance Framework update for the month of April 2023.

22/23/161 **Committee Self-Assessment Annual Report**

The Committee received the Committee Self-Assessment Annual Report

Resolved: The Committee approved its Annual Report 2022/23

Ratify HR / Health & Safety Policies

22/23/162 **Apprenticeship Policy**

KB introduced the Apprenticeship Policy to the Committee. This was a new Trust Policy which aims to improve access to and promote the uptake of a wide range of Apprenticeship training Programmes, supporting the Trust to achieve its vision as part of the People Plan and Brilliant Basics, meeting both current and future workforce needs. The Policy intends to capture existing process whilst reflecting the suite of regulation in respect of apprenticeships.

Particular attention was drawn to section 8 of the Policy pay for discussion:

- Statement that every vacancy (bands 2–4) should be considered as an apprenticeship if possible.
  The Committee agreed that we should be considering every vacancy as an apprenticeship opportunity and for this to remain in the Policy.
- In terms of pay, KB explained that existing members of staff who choose to undertake an apprenticeship would remain on their full-time salary in line with the NHS Terms and Conditions but that new apprentices would be placed on a living wage as per the funding rules.
  The Committee agreed for this to remain as is in order to maintain flexibility in our approach to recruiting apprenticeships.

FM welcomed the use of short videos of successful apprentices & better use of social media channels to promote this area. MF confirmed the use of all social media channels but stated that internal targeted comms was needed in this area regarding the benefits of apprenticeships. Comms team to present to a future meeting.

Resolved:
Approved by the Committee.

22/23/163 **Food Safety Policy & Procedures**

The Food Policy & Safety Management was introduced to the Committee. An overview had been submitted to the Committee indicating no major changes. Assurance was provided that the Policy had been subject to review by the Health and Safety Committee ahead of submission to PAWC. FM undertook to highlight the responsibilities of the Board in relation to this Policy.

Resolved:
Approved by the Committee.

22/23/164 **Arson Policy**

Arson policy was introduced to the Committee. An overview had been submitted to the Committee.

Minor change noted to correct a job title. Assurance was provided that the Policy had previously been reviewed by the Health and Safety Committee. –

FM undertook to highlight the responsibilities of the Board in relation to this Policy..

Resolved:
Approved by the Committee.

22/23/165 **Pay Progression Policy**

The Pay Progression Policy was introduced to the Committee. An overview had been submitted to the Committee noting no major changes. Assurance was provided that the Policy had previously been reviewed by the Employment Policy Review Group

Resolved:
Approved by the Committee subject to confirmation around relevance of pay steps in section 6.1.13.

Sub-Committee and Working Groups

22/23/166 **Health & Safety Committee (HSC)**

The Committee received the approved minutes of the HSC meeting held on (February 2023).

22/23/167 **Joint Consultative and Negotiation Committee (JCNC)**

The Committee received the approved minutes of the JCNC meeting held on (March 2023).

22/23/168 **Local Negation Committee (LNC)**

The Committee received the approved minutes of the LNC meeting held on (February 2023).

22/23/169 **Education Governance Committee (EGC)**
The Committee received the approved minutes of the EGC meeting (February 2023).

22/23/170 **Any Other Business**

No other items of business were raised.

22/23/171 **Review of Meeting – Chair's Report to Board**

People Plan: People Plan was introduced to the Committee with good goals of achievement across the organisation – further plan to being back in few months' time to review progress.

Divisional Metrics Update: Divisional metrics remains stable and on track, challenges remain a focus and divisions have plans in place to address and stabilise.

PDRs / Turnover & sickness absence remains a key area of focus with plans in place to monitor.

EDI: EDI making good progress, EDS22 was introduced to the Committee for final ratification and was approved by the Committee. Good progress being made.

New Apprenticeship Policy welcomed.

The Chair thanked the Committee for today's insightful discussion and challenging questions and comments and welcomed any feedback on content and discussion of the meeting.

Date and Time of Next meeting
Tuesday 11th July 2023 at 2pm via MS Teams.

BOARD OF DIRECTORS

Thursday 7th September 2023

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

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP QUARTERLY REPORT

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 activity in the quarter and continue to support the overall direction of travel.

3. Quarter 1 data

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

Themes *	Open	Closed	Total cases	Number of total contacts**
Patent Safety and Quality	0	1	1	4
Worker Safety and Wellbeing	0	0	0	0
Inappropriate Attitudes and Behaviours	10	6	16	64
Policies, Processes, Procedures, Systems	4	7	11	44
Infrastructure/Environment	0	0	0	0
Cultural	0	0	0	0
Leadership	0	0	0	0
Senior Management Issue	0	0	0	0
Middle Management Issue	0	0	0	0
Total	**14**	**14**	**28**	**112**

***Speak Up cases often contain multiple themes; therefore, data sets do not always equate together. Reports are recorded under the worker's own description.**
**** this is the total average number of hours spent on each case**

Open cases

Of the 14 cases that remain open in Q1:

- 1 is due to the individual currently being on sick leave and therefore unable to progress
- 2 have recently been escalated to the next line of management and. due to annual leave, a meeting has yet to take place
- 11 cases are progressing, and these should conclude in the next 4-6 weeks.

The length of time to resolve each case does vary slightly. This is due to a multitude of different reasons such as:

- Several meetings with the individual worker to fact find.
- Several meetings with other staff, managers etc. to gather more information to ensure there is clarity regarding the concern.
- Once a decision has been made regarding escalation, a further meeting is scheduled to describe the concern and discuss plan of action.
- Following escalation, delay in progression may occur due to individuals' capacity which is out of the Guardian's control. However, the FTSUG does monitor this to ensure the concern is progressing as far as possible.
- Conclusion meeting is then scheduled to ensure the individual (s) is satisfied with the resolution.

There are currently 10 cases remaining open from Q1-Q4 2022-23., Of these cases 2 are unable to progress due to long term sickness of the individuals raising the concerns, 1 is currently going through a formal route and the remaining 7 are in relation to a concern raised within a department that is also currently going through a formal route.

Closed cases

For the 14 cases closed in the quarter, the following actions were taken / lessons learned:

- A requirement for managers to ensure that they understand the application of policy regarding special leave, this has been raised with our HR team.
- A review of the management of cases, involving the breakdown of relationships, to ensure the informal resolution route has been robustly explored before progression to formal, HR involvement.
- Discussion with manager regarding good communication and ensuring that staff have clarity regarding an ongoing situation.

- Discussion with member of staff regarding AFC review.
- Part of the wider Trust programme regarding reasonable adjustments for staff if they potentially sit within the Equality Act 2010 and how managers support these staff and the adjustments.
- Lesson learnt, lack of understanding regarding NHSP and investigations.
- Additional section proposed regarding the Recruitment Policy, covering exceptions.
- Discussion with Lead for ANP/ACP regarding the framework for this group of staff within the organisation and how it is evolving to ensure there is clarity in terms of line management.

In terms of detriment, there has been one case reviewed where the individual believed they had suffered as a result of raising a concern; however no evidence could be found to support this. There were however, lessons learnt within the FTSU process in respect of concerns being raised that then may go down a formal route and identifying who is responsible for progressing this.

Feedback from closed cases

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. Towards the latter end of Q1, we have introduced a questionnaire for staff to complete at the closure of the case, there have been 6 responses to this to date. The below questions form part of the questionnaire with % responses shown:

	Disagree	Neutral	Agree	Strongly Agree
I have had a positive experience of speaking up	-	-	16.7	83.3
I have felt psychologically safe through this process	-	-	33.3	67.7
I feel there have been no negative consequences for me when speaking up	-	16.7	16.7	66.7
I feel listened to and heard	-	16.7	33.7	50.0
When people speak up in this organisation, things change	33.3	50.0	-	16.7
I feel confident that action will be taken after my concern has been raised	-	33.3	33.3	33.3
I would use this service again	-	-	16.7	83.3
I would speak up again	-	-	16.7	83.3

In regard to staff feeling confident that things will change and action will be taken as a consequence of their speaking up, clearly this is an area that requires a focus of attention, especially given recent events in the media, therefore a review of the process for raising concerns will be conducted to ensure that when action is required, it is taken and lessons learnt and these are then shared widely via FTSU Communications.

4. NGO Training for All Staff

Following due consideration by the Board in March 2023, it was agreed that the Speak Up, Listen Up, Follow Up E-Learning modules, should be mandated for all staff depending on their job role., This proposal has now been presented to the Education Governance Committee on the 10th August 2023 for their information. There are some challenges in delivering the Listen Up and Follow Up modules, as the ESR system does not break down information by job title but by band, therefore as these two modules are only required to be completed by managers and leaders, there is a requirement to identify how this can be achieved in practical terms. Communication regarding the Speak Up training was delivered to all staff on the 21st August 2023.

5. FTSU Guardian Activity/FTSU Champions

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

Following on from, and in addition to, the confidential support sessions organised and delivered by Dr Jo Potier and the FTSUG for our Nurses and Doctors, there has now been similar sessions organised for our Pathway Coordinator (PCO) workforce, because of the additional workload resulting from strike action and the impact this has had on this group of staff who are on the front line when communicating to parents, that their child's treatment has had to be postponed due to industrial action. This session was well attended, with a further one scheduled; learning from this has been identified, with identified actions that have been shared.

Freedom to speak Up Champion monthly meetings are well attended and there has been an increase in numbers to the group. The review indicated earlier in this paper, will form part of a scheduled away day, on the 10th October 2023, attended by Erica Saunders. This is a 3 hour session with the FTSUG and the champions, there will be analysis of the process for raising concerns via the FTSU route, providing clarity to staff, there will also be focus on any action required and lessons learnt from raised concerns. Due to an increase in new FTSU Champions, the FTSU champions training will be delivered.

The NGO tool "Learning from Case Reviews" supports a gap analysis approach. This has been completed with support from Gill Foden HR Business Partner. A follow-on meeting has now been scheduled with the Deputy Chief People Officer, to

identify what actions need to occur as a result of an identified gaps. This will aid improvement in our speaking up arrangements.

6. Reducing Barriers to Speaking Up

The NHSE letter of the 18th August 2023, released following the verdict in the Lucy Letby trial, urged Leaders and Boards to implement a number of urgent points, one of which was:

"Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place."

In light of this, the FTSUG and the REACH Chair Anne Marie Davis, are planning to meet to understand the challenges staff may experience and consider whether it may support staff to raise concerns, if we adopted a collaborative approach and rather than meet just the FTSUG, that they meet the FTSUG and the REACH Chair and indeed the other Network Chairs.

There are also currently underway FTSUG Walkabout sessions. These sessions are planned for all wards and departments, with the aim to promote the profile of FTSU, identify what barriers staff face and potentially recruit into the FTSU Champions network, with the aim to ensure the FTSU Champions are reflective of our diverse organisation and are therefore a point of contact for all staff at local level. Leaders for these areas have been contacted and positive response has been received with regard to attending the areas and team meetings.

7. FTSUG involvement nationally and regionally

Attendance at the NW Regional FTSUG meetings continues, and this remains a space where shared learning can take place amongst the regions FTSUGs.

8. FTSU Awareness Raising

Recent communication, regarding the implementation of In-Phase as a means of reporting concerns, has been delivered to all staff. This is to ensure that staff who wish to raise a concern anonymously, are aware that they can do this via the In-Phase system, thus potentially removing a barrier for staff who are fearful of speaking up. There is also a plan to deliver posters and pull up banners across the organisation whilst on the FTSU walkabouts.

9. Next Steps

Further work will take place to agree the requirements for the review of the FTSU process with a particular focus on lessons learned, following discussion with the Board.

Kerry Turner
Freedom to Speak Up Guardian
September 2023

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

Publication reference: PRN00719

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

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communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard	**Sir David Sloman**	**Dame Ruth May**	**Professor Sir Stephen Powis**
NHS Chief Executive	Chief Operating Officer NHS England	Chief Nursing Officer, England	National Medical Director NHS England

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BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	**Board Assurance Framework Report 2023/24 (July)**
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.

<table>
<tr><td colspan="7">Does this relate to a risk? Yes ☑ No ☐</td></tr>
<tr><td>Risk Number/s</td><td colspan="5">Risk Description</td><td>Score</td></tr>
<tr><td>As detailed in the report</td><td colspan="5">This report provides an update against all Board Assurance Framework Risks for the month of July 2023.</td><td>As detailed in the report</td></tr>
<tr><td>Level of assurance
(as defined against the risk in InPhase)</td><td>☐</td><td>Fully Assured
Controls are suitably designed, with evidence of them being consistently applied and effective in practice</td><td>☐</td><td>Partially Assured
Controls are still maturing – evidence shows that further action is required to improve their effectiveness</td><td>☐</td><td>Not Assured
Evidence indicates poor effectiveness of controls</td></tr>
</table>

Board Assurance Framework 2023/24

1. Purpose

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

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

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

2. Review of the BAF

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

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Resources and Business Development Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Resources and Business Development Committee
1.4	Access to Children & Young People's Mental Health	Resources and Business Development Committee
		Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment	Trust Board
3.6	Risk of partnership failures due to robustness of partnership governance	Resources and Business Development Committee
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	Research & Innovation Committee

3. Summary of BAF - at 8th August 2023

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

4. Summary of July 2023 updates:

Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. (DJ).
Risk reviewed; no change to score. Vision 2030 progressing as per agreed timeframes. Draft Vision 2030 Strategy to Board in September and progression of the next Strategy Board in October.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed; no change to score. Agreement to proceed with CYP Committee from ICS.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed in month and no change to current score. In the process of refining the partnership quality assurance round pack.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed and no change to risk score.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  Discussed at recent liaison committee early June. Regular board to board meetings are in place to ensure progress and provide updates to exec leads. Weekly meetings with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. The second phase of improving water quality within the closed loop system is underway with the program due to complete in October 2023. It is hoped that this will prevent further pipework from corroding. In response to out-of-range temperatures we have local mitigations in place such as filters on water outlets, and later this year we will introduce a chemical dosing system across the site. Further details on the installation are awaited from the SPV having been chased wb 19th June. The chiller works continue and we are awaiting a date for the removal of the temporary ones. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. On site inspection took place wb 3rd July with a view to a new contractor maintaining plus remote monitoring. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  We are now consistently achieving the 85% national standard for access to ED. Development of winter plans are in progress to ensure enhanced resilience during this time.

  Access to diagnostic tests has now exceeded the 90% target for 6 week waits.

  We have seen a short-term increase in elective patients waiting greater than 65 weeks but investment in ENT and dental is now in place with expectation of eliminating 65 week waits by March 2024. Ongoing industrial action remains a significant threat which is being actively managed to

ensure safe delivery of services.

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

- ***Access to Children and Young People's Mental Health (LC)***
  Review undertaken and actions in place. I have uploaded approved paper shared with Place leads regarding investment, planned workforce and predicted improvement plans based on this.

- ***Financial Environment (JG).***
  Risk reviewed and score remains static. CIP gap closing in year but recurrent emphasis required ongoing monitoring of financial pressures through RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  Possession of full site at been awarded to the Park Contractor. Completion of the multi-use games area which is due to open to the public 7th August 2023. Works have commenced on site levels and the setting out of the new infant and junior playgrounds.

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed, actions progressed in reporting period. Aldercare progressing for September go live, risks being managed via programme and programme board. Go live preparedness group in place with senior and operational leads identified.

- ***Workforce Sustainability and Development (MS).***
  Risk reviewed and no change to risk score.

- ***Employee Wellbeing (MS).***
  Risk reviewed. Actions reviewed and updated and new action added.

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  No change to risk score this month. However, a provisional £4.5 mill from Investment zone is identified. A resource and financial plan is in development on how to spend £4.5 mill to support strategic growth

Erica Saunders

Director of Corporate Affairs

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	Corporate Risk Register Report (CRR)
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Jo Gwilliams, Trust Risk Manager

Purpose of Paper:	Decision Assurance Information Regulation	☐ ■ ☐ ■
Background Papers and/or supporting information:	Risk Strategy & Risk Management Policy & Procedure and supporting policy documents Board Assurance Framework CQC standards	
Action/Decision Required:	To note To approve	■ ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	■ ■ ■ ■
Resource Impact:	Supports resource identification	
Associated risk(s)	N/A	

1. Purpose

This paper provides the Risk Management Forum with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR).

2. Summary CRR:

Total number of open high risks = **16** (excluding BAF, Cheshire & Merseyside Children's & Young People's Partnership and network risks).

Risk Register High risks	**Current reporting period** 1st May – 15th August 2023	**Current reporting period** 1st – 30th April 2023	**Previous reporting period** 1st February – 31st March 2023	**Previous reporting period** 1st December 2022 – 31st January 2023
Number of new high risks reported	**2**	**0**	**3**	**6**
Number of high risks closed or removed	**0**	**2**	**1**	**2**
Number of high risks with increased risk score	**3**	**1**	**1**	**1**
Number of high risks with decreased risk score	**4**	**6**	**0**	**4**
Number of high risks overdue review	**2**	**1**	**5**	**0**
Number of high risks with no agreed action plan	**2** (Ref: 25, 39)	**3** (Ref: 2100, 2360, 2741)	**5** (Ref: 2100, 2741, 2754, 2755, 2779) *	**4** (Ref: 2741, 2753, 2754, 2755)
Number of high risks with actions past expected date of completion	**9** (Ref: 1524, 2100, 2463, 2767, 2779, 2360, 2627, 2579, 2073)	**5** (Ref: 1524, 2441, 2463, 2753, 2779)	**5** (Ref: 1524, 2463, 2684, 2740, 2787)	**1** (Ref: 2657)
Number of high risks with static risk scores	**11**	**12**	**17**	**9**

Table 1 – New high risks
Table 2 – Risks with increased scores
Table 3 – Risks with decreased risk scores
Table 4 – Long-standing high risks (greater than 12 months since identification)

3. Themes

Note: The list of risk categories in InPhase is currently under review. The high-risk details presented below are currently reported under the risk categories identified in InPhase.

There are currently seven themes identified on the CRR: clinical (7 risks), staffing & HR (3 risks), financial (2 risks), operational (1 risk), public relations (1 risk), people (1 risk) and quality – safety (1 risk).

Clinical

Risk 1524 (4x4 = 16) *"Delayed initiation and review of ADHD medication"* due to a lack of capacity in ADHD Nurse Led Service, specifically medical supervision of ADHD medication initiation and completing prescribing. Mitigations include nurse prescribers in place for ADHD service, SOPs to support safe prescribing. Business case to be developed. Risk reviewed and actions added.

Risk 2441 (5x3 = 15) *"Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval"* caused by Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work, this includes on call and out of hours. Revised SOP implemented for neonates requiring non urgent transport. SOP to be created for paediatrics.

Risk 2463 (4x4 = 16) *"Risk that children and young people will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard)"* caused by significant increase in referrals to ASD continuing from 2020 (start of covid) and capacity within current pathway is funded to set level by Commissioners. Controls include regular meetings with commissioners and divisional senior management team. Strategic planning meetings are underway and digital platform for referrals to ASD pathway to be developed. Risk reviewed and risk remains the same.

Risk 2073 (4x4 = 16) "*Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service due to insufficient workforce (wte) within Clinical Health Psychology to respond to the demand of the service"*. Mitigations in place include weekly waiting list management, offering brief interventions, group interventions and self-help resources and a daily duty team is in place Monday – Friday to triage referrals and offer urgent intervention if required. Ongoing actions include data on the waiting times to be presented at August's Access Meeting and recruitment into the service. Controls reviewed, actions updated, and no change in risk score.

Risk 2627 (3x5 = 15) *"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 therefore previous medical records including safeguarding history are attached to the new NHS number. Ongoing actions include review, update, and formalise an interim process for closing the previous medical record when a new NHS number is assigned to a newly adopted child or young person. Risk reviewed and action plan in place. Actions ongoing and work underway.

Risk 2657 (5x3 = 15) *"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”* caused by no consistent method for recording and communicating resuscitation decisions across the Trust.** Mitigation includes the Trust’s Resuscitation Policy. Ongoing actions include implementation of ReSPECT across the Trust. Meeting chaired by Dr Gates, discussion regarding the implementation of ReSPECT and improving the Resus workflow on Meditech. Unable to facilitate development prior to Expanse go-live in September. Dr Grime and Dr Neame to liaise with Dr Holt. ReSPECT widget demonstrated; resus order needs reviewing.

Risk 2746 (5x3 = 15) ***“The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust” due to chest drain management processes are substandard and do not encompass all relevant national guidelines.*** Mitigations an overarching trust risk assessment is in place. Ongoing actions comprise the chest drain policy to be rewritten and to reduce the risk of the filter being wet. Business case written. Awaiting decision from ICB in relation to funding. Actions have been completed as far as is possible with the current system. Risk score remains high due to the inability to safely apply a second suction liner to the drain.

Staffing Levels & HR

Risk 2767 (4x4 = 16) ***“There is a risk that the Safeguarding Team will be unable to provide a service for children/young people and/or staff in the hospital”*** **due to gaps in the 1st on and 2nd on medical rotas for Safeguarding.** Draft SOP developed. Further actions include rotas to be published 6 months in advance – weekly meetings in place. Risk reviewed and actions in place.

Risk 2360 (3x5 = 15) ***“Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgent and 18-week referral to treatment target for routine)”*** **due to demand on the service outweighing commissioned capacity in the team**. Mitigations include Crisis Care Team are available 24/7 to ensure urgent clinical need is met for patients waiting for specialist CAMHS and agency staff are in post to provide clinical cover where there are staffing gaps. Risk reviewed and actions in place.

Risk 2719 (4x4 = 16) ***“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” due to insufficient Consultant Neurologists.*** Mitigations include a locum consultant in post (0.6WTE) and a weekly improvement meeting to develop an alternative Neurology model to support retention. Ongoing actions include consultant vacancy HR resolution to allow recruitment and resolving job plans for the current team. Approval to advertise for posts ahead of RCPCH approval. 3 posts to be advertised. Meeting with DGH leads planned for 22/9 to agree outreach model. Weekly meeting to discuss plans for interim cover as not all elements of the service will be able to be covered during the interim period; estimated October 2023 to January 2024 will need to be a reduced service model.

Financial

Risk 2579 (3x5 = 15) ***“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” due to CIP delivery risks, junior doctors and HCA and Bank spend.*** Controls include vacancy approval and divisional scrutiny via Divisional Group. Further actions consist of a service review to mitigate financial risk. Key drivers for overspend identified, consultants, nursing/HCA, M&S and income - plans / forecasts in development.

Risk 25 (3x5 = 15) ***“Defective Ventilators - The Trust has procured 14 V60 ventilators from Philips Respironics, and 5 HFOV's from Fabien. All these ventilators have underlying defects which make them unsafe for use and they have now not been in circulation/use for over 2 years which is a financial***

cost to the trust of circa £500,000 and both sets now require replacing at an additional cost of circa £800,000 to the Trust." due to a manufacturing fault which cannot be resolved to a sufficient safety standard in line with MHRA regulations". A business case was approved, and the order was placed 31/07/2023. £100k was provided by charitable funds and the remaining cost will come from capital reprofiling and remuneration from Philips for the V60 devices. We expect to have the new ventilators sometime in September 23.

Operational

Risk 2753 (4x4 = 16) *"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"* due to children and young people are waiting beyond the national standard to access planned care post Covid 19 pandemic due to a prolonged loss of capacity. Mitigations in place include a clinical review has been undertaken of patients who have waited 52 weeks with no clinical intervention e.g., outpatient appointment and weekly reviews of referral to treatment waiting times for each specialty to monitor progress towards reducing waiting times in line with national / internal targets. Further actions being taken consist of trajectory plans for ENT, dental and spine. Reviewed and position remains the same.

Public Relations

Risk 2779 (4x4 = 16) "*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" caused by the current provider of a service that supports children and young people with gender incongruence or gender dysphoria receiving significant scrutiny from media outlets.* Controls include a supporting governance structure, a national communications group and Gateway review process in place. Risk reviewed and no reduction is score at this review, actions are in place.

People

Risk 2100 (4x4=16) "*Risk of inability to provide safe staffing levels",* caused by high level of sickness and absence. The Trust target is no more than 5%. Controls include, sickness and absence policy, corporate report monitoring, Occupational Health Service, early intervention service. Risk reviewed. Actions in place, but risk remains. Signs that sickness absence levels are improving, however still high in the region. Industrial action continuing. 5 days of junior doctor strike action plus 2 days of consultant industrial action in July and a date for society of radiographer strikes pending.

Quality – Safety

Risk 39 (5x3 = 15) *"Tracheostomy Store - Location of storage of tracheostomy tubes. Inability to manage stock levels of tracheostomy tubes due to the location and inability to manage stock levels"*. New risk approved for adding to the risk register 07/07/2023.

Table 1: NEW HIGH RISKS

Division/Service	Ref / Score CxL	Risk	Reason/ comment	Risk Owner	Date Opened
Surgery (Division Wide)	25 5x5=15	Defective Ventilators - The Trust has procured 14 V60 ventilators from Philips Respironics, and 5 HFOV's from Fabien. All these ventilators have underlying defects which make them unsafe for use and they have now not been in circulation/use for over 2 years which is a financial cost to the trust of circa £500,000 and both sets now require replacing at an additional cost of circa £800,000 to the Trust.	Manufacturing fault which cannot be resolved to a sufficient safety standard in line with MHRA regulations.	Rachael Hanger, Divisional Associate Chief Nurse	19/06/2023
Surgery (ENT)	39 5x3=15	Tracheostomy Store - Location of storage of tracheostomy tubes. Inability to manage stock levels of tracheostomy tubes.	Location and inability to manage stock levels.	Grace Khong, ENT Consultant	07/07/2023

Table 2: RISKS WITH INCREASED SCORES

DIVISION	Ref	Risk	Prior Score /New Score	Reason for increase
Surgery (Paediatric surgery)	2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust" caused by chest drain management processes are substandard and do not encompass all relevant national guidelines	4X3=12 5x3=15	Awaiting decision from ICB in relation to funding. Actions have been completed as far as is possible with the current system. Risk score remains high due to the inability to safely apply a second suction liner to the drain.
Medicine (Paediatric Neurology)	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" due to insufficient Consultant Neurologists	4x3=12 4x4=16	Risk rating upgraded due to potential impact of 1 WTE leaving service and overall potential for further resignations within consultant team. Improvement plans are ongoing, but service is fragile and could experience a further period of crisis in staffing.
Medicine (Division Wide)	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	3x3 = 9 3x5 = 15	No rationale recorded.

000182		NHS services, reduced effectiveness of services, inability to invest and innovate and potential of increased workforce pressures.		

Table 3: RISKS WITH DECREASED SCORES

DIVISION	Ref	Risk	Prior Score /New Score	Reason for decrease
Community & Mental Health (CAMHS – All)	2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal).	3x5 = 15 3x3 = 9	Risk reviewed and score reduced as 2 x highly capable specialist LD staff have now started - one has picked up a caseload and one is being inducted - expecting to achieve target risk rating by September 2023.
Medicine (Haematology)	2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4 = 16 4x2 = 8	Score reduced due to a locum consultant in place until the end of October at this stage. We also have a locum consultant post out to advert.
Corporate Services (Innovation)	2694	Delayed growth plan (strategy KPISs).	4x4 = 16 4x3 = 12	Developed a strategic outline case for development and investment and identified investment from LCR investment zone.
Corporate Services (Nursery)	2741	The ability to maintain OFSTED ratios as a result of staff availability/turnover. Health and Safety concerns operating the nursery in its current position in the centre of a building development.	4X4=16 4X3=12	Increase in staffing levels and decrease in absence rates as staff return from sick leave.

Table 4: LONG-STANDING HIGH RISKS (greater than 12 months since identification)

Division/ Service	Ref	Risk Owner	Risk Score (CxL)	Risk	Date identified
DIVISION OF COMMUNITY & MENTAL HEALTH:					
ASD / ADHD	1524	Lisa Cooper, Divisional Director	4x4 = 16	Delayed initiation and review of ADHD medication. **Summary** Risk score remains static.	**December 2017**

000183

ASD / ADHD	2463	Lisa Cooper, Divisional Director	4x4 = 16	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard). **Summary:** Risk remains static.	**July 2021**
Rainbow – Children In Care	2627	Lisa Cooper, Divisional Director	3x5 = 15	Not compliant with national guidance with transferring and transcribing patient records following adoption. **Summary:** Risk remains static.	**May 2022**
CAMHS - Sefton	2360	Lisa Cooper, Divisional Director	3x5 = 15	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgent and 18-week referral to treatment target for routine). **Summary:** Risk remains static.	**February 2021**
DIVISION OF SURGERY:					
Neurosurgery	2441	Adam Bateman, Chief Operating Officer	5x3 = 15	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval. **Summary:** Risk remains static.	**June 2021**
DIVISION OF MEDICINE:					
Palliative Care Team	2657	Susannah Holt, Consultant Palliative Care	5x3 = 15	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. **Summary:** Risk remains static.	**July 2022**
CORPORATE SERVICES:					
HR	2100	Melissa Swindell Director of People	4x4 = 16	Inability to provide safe staffing levels. **Summary:** Risk remains static.	**January 2020**

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	**New Fit and Proper Persons Test Framework**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper outlines the new requirements of the Fit and Proper Persons Test (FPPT) Framework published in response to the Kark Review recommendations (2019).
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
BAF 1.1	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.					3x3=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

1. Executive Summary

The Fit and Proper Persons Test (FPPT) was originally introduced in 2014 via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of this regulation is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

In July 2018, the then Minister of State for Health, Stephen Barclay MP, commissioned Tom Kark KC to undertake a review and make recommendations in relation to the existing FPPT process. The Kark Review highlighted areas that needed improvement to strengthen the operation and effectiveness of the current regime. In response to the seven recommendations made, NHS England published a new Fit and Proper Persons Test Framework on 2nd August 2023.

2. Applicability

The new Framework applies to the board members of NHS organisations. Within the guidance, the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments
- those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, i.e., performing the functions of or functions equivalent or similar to the functions of a director.

3. Background and current state

To date, the Care Quality Commission has been solely responsible for holding trusts to account in relation to the fit and proper person regulation. Historically, the Trust has undertaken an annual exercise with Board members to seek assurance that all Executive and Non-Executive Directors are suitable and fit to undertake the responsibilities of their role. These have been kept locally on file and made available for inspection when required.

The legislation has not changed but the new Framework aims to support NHS organisations' compliance with the regulations and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements.

It will also introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The new Framework is effective from 30th September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

Key elements of the new Framework include:

- The **Electronic Staff Record** (ESR) will now be used to store information related to FPPT checks and references.
- Review of **FPPT dashboard and evidence** and conclusion for each individual board member whether they are fit and proper is required (Chair for CEO and NEDs and Chief Executive for EDs).
- A **sign off** process for each completed FPPT is required by:
  - Chair (for CEO and NEDs)
  - CEO (for EDs)
  - SID (for Chair)
- **Annual submission to NHSE** Regional Director of the ESR FPPT Dashboard is now required following review and sign off.
- The framework introduces a new standardised **board member reference** to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no 'recycling' of unfit individuals within the NHS. These are to be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role and should be sought by employing NHS organisations when making a job offer. The reference is based on the NHS standard reference template but includes additional questions relevant to the FPPT. From 30th September 2023, the board member reference template should be used for all new board appointments, and new references completed and retained locally for any board member leaving after this date.
- **The full framework should be fully implemented by 31 March 2024.**

It is acknowledged that there could be circumstances where, for instance, board members are deemed competent but do not hold relevant qualifications. In such circumstances there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director.

Furthermore, there may be a limited number of exceptional cases where a board member is deemed unfit (that is, they failed the FPPT) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to continue their current employment as a board member. In such circumstances there should be a documented explanation as to why the board member is unfit and the mitigations taken, which is approved by the chair. This should be submitted to the relevant NHS England regional director for review, either as part

of the annual FPPT submission for the NHS organisation, or on an ad hoc basis as a case arises.

The new framework can be found HERE.

4. Next steps

Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year.

It is good practice for the Chair to present a report on completion of the annual FPPT to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

The framework announces an evaluation of its effectiveness 18 months following this launch and advises that future consideration will be given to implementing a public facing register and including other 'significant roles' within scope.

Jill Preece
Governance Manager
August 2023

BOARD OF DIRECTORS

Thursday, 7th September 2023

Paper Title:	**Summer 2023 Governor Election Results**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	**Governance Manager**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide the Board with the outcome of the summer governor election round.
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:	The cost of running the summer election round is estimated at £11,880.

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

1. Executive Summary

The purpose of this report is to provide the Board with the outcome of the summer governor election round.

2. Background and current state

In July 2023 the Trust issued election notifications for the following governor seats:

Constituency:

- Public: Merseyside (1 to elect)
- Patient: Parent & Carer (4 to elect)
- Public: Cheshire (1 to elect)
- Public: Wider North West (2 to elect)
- Patient: Merseyside (1 to elect)
- Staff: Other Clinical Staff (1 to elect)

Following a successful election process which concluded on Wednesday 30th August 2023 we would like to welcome the following Governors to the Council:

Elected unopposed:

Staff: Other Clinical Staff – Michael Mander *(re-elected)*
Patient: Merseyside – Josh Martin
Patient: Parent & Carer – Carly Brown, Lewis Clements, Ana Samuel *(re-elected)* and Nicola Thorbinson *(re-elected).*
Public: Merseyside – Brian Lawless
Public: Wider North West – Simon Jacobs *(re-elected)* and Suzanne Thoms *(re-elected).*

Elected via a public vote

Public: Cheshire – John O'Hanlon

Appointed Governor Update

We have recently welcomed the following appointed governors to the Council to represent voluntary / local interest / community groups and look forward to working with them in the future:
Monique Collier, Chief Executive - Young Person's Advisory Services
Howard Lewis, General Manager – Paddington Village Novotel.

Erica Saunders
Director of Corporate Affairs

BOARD OF DIRECTORS

Thursday, 7th July 2023

Paper Title:	ARC – Chair's Highlight Report from the meeting held on the 13.7.23.
Report of:	Kerry Byrne - Audit & Risk Committee Chair
Paper Prepared by:	Kerry Byrne - Audit & Risk Committee Chair

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that took place on the 13th July 2023, along with the approved minutes from the meeting held on the 22nd June 2023.
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Implications:	None

1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

2. Agenda items received, discussed / approved at the meeting

The July meeting is a much reduced agenda, predominantly focusing on risk items only.

- Update on the implementation of InPhase in relation to risk management
- Presentation from Community & Mental Health Services on risk management processes within the division
- Board Assurance Framework*
- Update from the Risk Management Forum including the Corporate Risk Register**
- Approval of the Terms of Reference for a revised approach to auditing key financial controls
- Update on the outstanding recommendations from the Consultant Job Planning internal audit
- Non Clinical Claims Report for 22/23
- Approval of increase to £20,000 for requiring quotations for purchases and the approach for waiver exemptions in specific circumstances
- Approval of policy for engagement of external auditors for non-external audit work
- Update on a retrospective check on documents for a sample of recruitment processes 2017 to 2020

* The BAF report was much reduced in detail than previously due to lack of functionality in the InPhase system following implementation in May 2023.

** The Corporate Risk Register was only available up to 30 April 2023 for the same reason.

In addition, the Trust Risk Management Report was unable to be produced. The Trust is working with InPhase to address post go-live issues.

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

As mentioned above the key risk management reports usually presented to the meeting were either much reduced in detail, or not available due to problems with InPhase post implementation. There are also other issues, such as lack

of notifications to risk owners of risks that are due for review which need to be addressed. The Trust is working with InPhase to resolve the issues.

4. Positive highlights of note

Nothing specific to highlight.

5. Issues for other committees

None

6. Recommendations

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

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 22nd June 2023**
Via Microsoft Teams

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. E. Kirkpatrick	Assoc. Director of Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JR)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
	Ms. L. Wain	Corporate Governance and Risk Manager	(LW)
Item 23/24/	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Apologies:	Mr. G. Dallas	Non-Executive Director	(GD)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mr. D. Spiller	E&Y Accounts Manager	(DS)
	Mr. J. Wilcox	Divisional Accountant	(JW)

23/24/28 Introductions and Apologies

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

23/24/29 Declarations of Interest

There were none to declare.

23/24/30 Minutes from the Meeting held on the 20th of April 2023

Resolved:

The minutes from the meeting that took place on the 20th of April were agreed as an accurate record of the meeting.

23/24/31 Matters Arising and Action Log

Matters Arising

In-Phase

The Committee received an update on the implementation of the Trust's new Incident and Risk Management System; InPhase that went live during May 2023. It was reported that

there have been a number of issues with the risk module functionality and obtaining data from the system which has created a problem in terms of providing risk assurance reports to the Trust Board and Assurance Committees that feed into the Board. This issue has been escalated to the Chief Nurse; Nathan Askew from a BAF perspective and has been incorporated on the risk register with a risk rating of 12. Repeated discussions have taken place with InPhase about the Trust's dissatisfaction and the potential for reputational damage to both organisations if this matter is not rectified in the near future.

Kate Warriner advised that this issue has been formally escalated to InPhase and a list of urgent reports has been shared that need to be built. The Trust has asked for a response by 23.6.23 in order to conduct a gap analysis to determine what is missing and what is acceptable in terms of providing assurance at Board level. The Committee was advised that the likelihood of the risk may increase to 16 depending on the response from InPhase.

Action Log

Action 22/23/19.1: *Clinical Audit Annual Report, 2021/22 (Divisional Clinical Audit Action Plans - Once completed, submit the Divisional Audit Plans to the Committee)* – It was confirmed that the Divisional Clinical Audit Plans will be submitted to the Committee during October's meeting following their presentation to SQAC. **ACTION TO REMAIN OPEN**

Action 22/23/60.2: *Update on the Risk Management Process within the Division of Medicine (Discuss using the Brilliant Basics methodology to trial the use of huddle boards in potential areas in the Division of Medicine based on three top risks and a weekly check in* – It was agreed to address this action from a management perspective.
ACTION CLOSED

Action 22/23/81.1: *Internal Audit Follow-up Report (Consultant Job Planning Review - Invite Urmi Das to provide an update on progress on the recommendations.* It was confirmed that a process is being agreed for the standardisation of job plans in terms of how they are to be compiled and transferred onto L2P. Service Managers are to take responsibility for uploading job plans onto the system for their respective cluster of consultants and ensuring that the overall process is standardised. Compliance is being monitored by the HR Medical Staffing Manager which has resulted in a 78% compliance rate for job plans being uploaded onto L2P.

Work is ongoing with the University of Liverpool to finalise a process for a cluster of clinical academics who have dual appraisals, and Divisional General Managers are to liaise with their respective consultants who haven't got a registered job plan. The Committee was advised that associated policies are in the process of being submitted to the LNC for approval; with the Pay Progression Policy due to be presented in August. It was felt that the recommendation will be addressed by the time the next ARC takes place and the Trust will be in the monitoring phase for this area of work. An update will be provided in October. **ACTION TO REMAIN OPEN**

Action 22/23/81.2: *Internal Audit Follow-up Report (Post Project Assessments/Benefits Realisation Exercises on Projects - Conduct a post project assessment/benefits realisation exercise on the new Sunflower and Catkin buildings during Q4 2022/23 or Q1 2023/24 using the developed process. MIAA to review implementation of the assessment and report to ARC as to whether the recommendation can be closed)* – It was confirmed

that MIAA are going to address post project assessments, benefits and realisation as part of the Project Management Audit which will be reported via MIAA's Follow-up Report in October. **ACTION TO REMAIN OPEN**

Action 22/23/92.1: *BAF Report (BAF Risk 3.2 (Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships) - Compile a list of derogations and refresh it once contracts have been agreed in the new services that the Trust needs to derogate from as part of the new commissioning. This list, and associated action plans to be monitored by RABD)* – It was agreed to compile a list of derogations once the 2023/24 contracts have been signed and include this item on the RABD workplan going forward; whether it be as part of the contract element or a standalone report. Confirmation will be provided once this matter has been addressed. **ACTION TO REMAIN OPEN**

Action 22/23/96.1: *Internal Audit Progress Report (NHS Financial Sustainability Review - Liaise with Ian Quinlan about the possibility of RABD monitoring the action plan that is in place following the financial sustainability review self-assessment)* – It was confirmed that work has taken place on the action plan following the financial sustainability review self-assessment but the plan is yet to be submitted to RABD for monitoring purpose. Rachel Lea agreed to arrange for this item to be included on July's agenda.
ACTION TO REMAIN OPEN

Action 22/23/98.2: Anti-Fraud Progress Report *(Purchase Order (PO) versus Non-PO Report - Provide an update on the outcome of the deep dive/analysis which is being undertaken to understand the cause of the issues highlighted in the POr v the Non PO report)* – A piece of work has taken place with the Procurement department on PO versus non PO. In terms of value, the percentage is stark due to a small number of line items that are of very high value and currently don't have a PO, for example, PFI spend. It has been agreed to conduct a further piece of work on high spend items without a PO to see why this route has been taken and look at the mitigating controls to determine an appropriate way forward. An update will be provided in October. **ACTION TO REMAIN OPEN**

Action 23/24/13.1: *Internal Audit Follow-up Report (Consultant Job Planning - Collective discussion to take place between MIAA, Alfie Bass and Urmi Das about the actions required to achieve the target date for the completion of recommendations)* – This action has been addressed (Action 23/24/81.1 now relates to the Consultant Job Planning actions). **ACTION CLOSED**

Action 23/24/13.2: *Internal Audit Follow-up Report (Consultant Job Planning - Submit a position paper to the Committee to highlight the achievements and the work that needs to be conducted)* – It was agreed to consolidate this action with action 23/24/81.1.
ACTION CLOSED

The Chair queried as to whether an update will be ready for October's meeting in relation to action 23/24/71.1 *(External Audit Review - Confirm as to whether a date has been agreed in terms of commencing a review of External Audit)*. It was confirmed that an update will be provided in October.

23/24/32 Bank Mandate Fraud

The Committee was advised of a bank mandate fraud that occurred in May 2023. It is believed the perpetrator of the fraud intercepted emails sent from the Trust to a supplier.

The perpetrator then sent new supplier bank details that were updated by the Trust and an invoice for £30,000 was consequently paid using these details. It was confirmed that £9,273.00 has successfully been recovered.

It was reported that the Trust has taken several actions to ensure the event is appropriately investigated and escalated to the relevant people; the police, the bank and MIAA. Investigations are being undertaken by MIAA and the Trust is conducting an internal review in order to identify any lessons learnt and immediate actions that could be taken to mitigate against this risk occurring in the future.

Upon reflection following the review, it was felt that whilst the process for ringing and emailing the new supplier was in place, the process documentation wasn't as clear as it could have been. As a result of this a number of steps have been implemented, including clearer documentation of the process, audit log of checks being carried out as well as training and stakeholder engagement around new supplier checks and the requisition process. The Trust has circulated guidance provided by MIAA on what bank mandate fraud is and MIAA are going to meet with a number of teams to give a talk on this area of fraud.

The Trust doesn't believe that it will recover the outstanding £20,727.00 and is awaiting feedback from the Police as to whether they will be taking this matter further. It was confirmed that an update will be submitted to the Committee once the MIAA investigation has concluded.

23/24/32.1 **Action: EK**

The Chair queried as to whether it would be possible to introduce an automated system control to ensure that bank details can only be changed once authorisation has been granted by an approved person. It was reported that process documentation has been updated and now includes a checklist that has to be signed off by a junior and senior member of the team. In terms of having the checklist inbuilt into the NEP system, enquiries would have to take place. It was agreed to provide an update in October.

23/24/32.2 **Action: EK**

The Committee was informed that this type of crime is becoming very sophisticated. The Trust has wrapped around this event and implemented new processes to mitigate against this risk occurring in the future. A question was raised as to whether the Annual Governance Statement (AGS) should be updated to reflect this fraud. It was pointed out that the Trust doesn't believe that there are any fundamental gaps in controls, but that the documentation of controls, and whole team adherence to controls could have been stronger, hence the actions taken. It was felt that this event was a one-off and, as highlighted in the report, the issue originated from the supplier's end therefore the organisation does not intend to update its AGS.

MIAA drew attention to the importance of having a verbal check in place with supporting documentation at all times. It was also felt that further thought should be given about having a robust process to follow when there isn't an established/historical relationship with a supplier.

Resolved:

The Audit and Risk Committee received and noted the report on the bank mandate fraud.

23/24/33 **Final Head of Audit Opinion 2022/23**

Resolved:

The Audit and Risk Committee noted the Internal Audit Annual Report and the final Head of Opinion for 2022/23.

23/24/34 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the Internal Audit Plan during the period from April 2023 to June 2023. The following points were highlighted:

- Three reviews were finalised in this reporting period;
  - Access to Health Records review which resulted in a substantial opinion.
  - Emergency Preparedness, Resilience and Response (EPRR) review which resulted in a moderate opinion.
  - Health Procurement Liverpool (HPL) audit which was part of the 2022/23 Internal Audit Plan, which resulted in a substantial opinion.
- There are two reviews currently in progress;
  - Data Quality (fieldwork).
  - On Call/Overtime (fieldwork).
- Audit Plan Changes;
  - The Trust has requested that a review of on call payments is added to the Internal Audit Plan. It was confirmed that discussions have taken place off line in relation to using the days released from the revised key financial controls review.
  - It was reported that the Chair of the Audit and Risk Committee has asked that a review of Expanse Readiness is undertaken due to the lack of independent assurance and the criticality to the Trust's service provision. This review would replace one of three reviews already in the Internal Audit Plan; Freedom to Speak Up (FTSU), Project Management or Cyber. The Committee was asked to consider this change.

Kate Warriner referred to the Expanse Readiness review and advised that NHSE Expert Digital are due to commence an independent Readiness Assurance audit for the Trust as part of the Expanse Readiness pre go live. It was agreed to share the outcome of the audit with the Committee once complete.

23/24/34.1 Action: KW

A discussion took place about whether it would be beneficial to conduct an Internal Audit Expanse Readiness review taking into account the audit that NHSE are due to commence. Kath Stott agreed to liaise with Kate Warriner to deduce as to whether the Committee should take an alternative approach to the review/look at different areas and relay the outcome of the findings to the Chair.

23/24/34.2 Action: KW/KS

[Post meeting update: KW & KS met and concluded that the scope of the NHSE review is comprehensive and therefore an internal audit of this area is not required].

The Chair confirmed that the FTSU and Safeguarding audits will take place early in 2024/25. [Post meeting update: as the suggested Internal Audit review of Expanse Readiness is not now to take place, FTSU audit will be undertaken this year as per the original plan].

Attention was drawn to the EPRR review and a query was raised about the process for ensuring senior managers engage with on call training as it was felt that it wasn't explicit

in the management response in the report. It was confirmed that the formal escalation process is via the Chief Nurse, Nathan Askew who is the Executive Lead.

The Chair referred to the HPL review and queried the process for receiving confirmation/ assurance that all actions have been implemented. The Committee was advised that the actions were followed up by the Walton Centre, who are the host organisation for the HPL audit and it was confirmed that all actions have been implemented. An update will be reported via the Internal Audit Progress Report during October's Committee meeting.

23/24/34.3 Action: KS

It was also pointed out that it wasn't easy to deduce the recommendations, findings and management response in the HPL audit in terms of the way they have been summarised in the Progress Report. Kath Stott agreed to consider this in future Progress Reports when summarising the outcomes of audits.

The Chair asked MIAA to include their Client Satisfaction Questionnaire in the body of the 2023/24 Internal Audit Annual Report. It was agreed to action this request.

23/24/34.4 Action: KS

A question was raised about whether NHSE has commissioned a procurement review. It was reported that there are a number of discussions taking place at the present time around procurement collaborations and NHSE has set up a commercial function that incorporates procurement. It was agreed to look into this matter and provide an update via e-mail.

23/24/34.5 Action: RL

Resolved:
The Audit and Risk Committee noted the content of the Internal Audit Progress Report.

23/24/35 External Audit Year End Report on the Trust's Accounts for 2022/23

Trust's Annual Report 2022/23

The Committee received the Trust's Annual Report for 2022/23 which was prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. The Committee was provided with an overview of the report which it was felt captures the culture and essence of Alder Hey. It was pointed out that it is reflective of the factual status in terms of what has happened in the organisation throughout the year and covers the breadth of requirements and activities to provide a level of accountability to the Trust's members and the wider public.

Once approved by the Trust Board the 2022/23 Annual Report and Accounts will be submitted to NHSE on the 30.6.23 and laid before Parliament ahead of the summer recess, mid July. Erica Saunders paid tribute to Jill Preece for leading on the Annual Report.

Jo Revill felt that the report was outstanding and summarises the major points. It details the pressures that the Trust has experienced and met as well as the substantial improvements that have been made.

The Chair advised that she had a number of minor comments to make about the report and agreed to forward this information on to Jill Preece.

23/24/35.1 Action: KB

Trust's Annual Accounts 2022/23

The Committee was provided with an overview of the 2022/23 Annual Accounts and the supplementary finance report. It was reported that the Trust's year end position for 2022/23 was £5.5m surplus, £800k favourable to plan. It was confirmed that there aren't any material changes to the organisation's control total that would change the Trust's financial performance for the year.

Attention was drawn to a small number of high level points, as detailed in the supplementary finance report; **1.** £49k adverse impact on the performance against the control total. **2.** The full revaluation of the Trust's estate and the reversal of impairments. **3.** Adjustments to accruals.

The Chair referred to the matter relating to the reversal of impairments following a full revaluation, taking note of the point that was made about this being not something that is dealt with on a regular basis, and queried as to whether there is a process that can be implemented ahead of future audits in terms of reviewing anything unusual that has happened throughout the year. It was agreed to look at the possibility of building this into the timetable for next year. It was also reported that training has been arranged with other trusts on fixed assets.

Rachel Lea advised the Committee that the Trust is working collaboratively across the system to look at the skills gap in terms of people not having the necessary experience to deal with particular areas of work due to the framework the NHS has been operating in.

The Chair thanked the Finance team for the hard work that has taken place to achieve the positive year-end position.

'*ISA 260'*

The Committee received the external Audit Results Report for year ended the 31st of March 2023. The following points were highlighted:

- *Changes in Materiality* - It was reported that there has been a change in materiality levels following receipt of the Trust's draft financial statements. Based on E&Y's materiality measure of operating expenditure, the overall materiality assessment has been updated to £7.58m.
- *Status of the Audit* – It was confirmed that the audit is substantially complete but there are certain areas outstanding, as detailed in the report.
- *Audit Differences* – There were a number of amendments identified which have been addressed and amended appropriately.
- *Areas of Audit Focus* – Two recommendations have been identified in relation to impairment and the Remuneration Report.
  - In terms of the valuation of non-current assets and the error that has occurred, it has been recommended that further training be provided in this area to support the understanding of the required accounting treatment.
  - In respect to the Remuneration Report it has been recommended that management ensure that the individuals responsible for providing information have an understanding of the requirements.

- *Responsibilities for VFM* – The value for money (VFM) risk assessment has been completed and there were no significant weakness identified against the three reporting criteria required to consider under the code.
- *Annual Governance Statement* – It was confirmed that there were no issues to report.
- *Audit Report (section 4)* – An audit opinion will be provided on the 23.6.23 once the internal consistency review has been completed. The Committee was advised that E&Y are proposing an unqualified opinion unmodified which it is felt is a positive position for the Trust.
- *Assessment of Control Environment (section 6)* - It was noted that the matching of PO's against invoices produced two very large transaction lines. It was reported that this event does not appear to have created the opportunity for financial loss to the Trust therefore this recommendation is to be closed. Management have been encouraged to monitor and remind individuals to assist in reducing the prevalence of this issue.
- *Independence (section 7)* – It was confirmed that additional time was required on the audit therefore a discussion will take place with Management on the fee implication.
- *Outstanding Matters (Appendix B)* – It was reported that there are a number of outstanding areas that need to be addressed before all audit procedures are complete but it was felt that the audit will be finished within the reporting deadline. It was confirmed that there are no issues to date that would cause E&Y to modify their opinion.

Queries were raised about the delay in the issuing of the opinion and whether there are any substantial items that will still be outstanding when the Board of Directors meet to approve the Trust's accounts on the 27.6.23. In terms of the opinion, it was reported that additional information was provided by the Trust on legislative requirements which is in the final stage of being checked. With regard to outstanding documentation as detailed in Appendix B, it was reported that **1.** The information requested on the effectiveness of IT controls on the testing of property, plant and equipment has been received. **2.** The team is awaiting an update on the financial statements which will link into the final testing of the Remuneration Report. Hassan Rohimun confirmed that the audit is coming to a close and there are no significant points to raise.

John Kelly asked for it to be noted that E&Y's proposal of an unqualified opinion is conditional until the Trust is in receipt of confirmation. The Committee was advised that the issuing of the opinion will take place following Trust Board approval of the accounts. Attention was drawn to the deadline for submission of the accounts which is noon on the 30.6.23.

On behalf of the Committee, the Chair offered thanks to John Kelly for attending the meeting, the teams who have produced the Trust's Annual Report and Accounts and E&Y for the work that has been conducted on the audit.

Letter of Representations

The Chair requested confirmation from the respective members of the Committee in terms of there being no reason as to why the Letter of Representations shouldn't be signed by herself on behalf of the Trust. It was confirmed that there is no reason as to why the document shouldn't be signed by the Chair of the Audit and Risk Committee.

The Chair referred to the response letter that was sent to E&Y to advise on "understanding how the Audit and Risk Committee gain assurance from management". It was pointed out that the Chair wasn't aware of the breaches relating to Access to Health Records when producing the report but it was confirmed that this omission didn't affect the accounts or the ongoing operations of the Trust.

Resolved:
The Audit and Risk Committee approved the Annual Report and Accounts for 2022/23.

23/24/36 Understanding How the Audit Committee Gains Assurance From Management

The Committee received a copy of the response letter that was sent to E&Y in this regard. It was reported that information is compiled as part of the audit process to provide E&Y with an overview of the risk assessment of fraud/error on the accounts and how the Trust manages risk generally.

Resolved:
The Audit and Risk Committee noted the Chair's letter to E&Y that provided an understanding of how the Committee gain assurance from management.

23/24/37 Clinical Audit Annual Report, 2022/23; including: 2023/24 Clinical Audit Plan for Mandatory and Trust-wide Audits

The Clinical Audit Annual Report for 2022/23 was submitted to the Committee to provide assurance that the delivery of the Trust's clinical audit activity (including national, regional, and local clinical audits) is progressing in line with accepted practice. The report outlines the clinical audit activity that's taken place throughout the twelve month reporting period and evidences the audit themes, trends and recommendations from both national and local audit findings as well as the Trust's response to those findings. The Committee was asked to note the challenges and the plan of action that has been compiled to improve this area of work in 2023/24. The following points were highlighted:

- During the reporting period from the 1.4.22 to the 31.3.23, the Trust participated in 13 National Clinical Audits and 5 National Confidential Enquiries which covered services provided by Alder Hey.
- It was reported that there were 2 National audits and 1 National Confidential Enquiry where the Trust failed to submit the required number of case notes requested which is being addressed with the relevant Divisions. It was pointed out that this occurred due to the lack of capacity in the teams and will be addressed as part of the organisation's development going forward. It was queried as to whether the Trust will incur a penalty due to the breaches. It was confirmed that the commissioners could impose a financial penalty but the Trust hasn't been advised of this to date.
- There were 13 Trust priority audits on the audit plan of which 8 audits were included due to NHS Quality Contract requirements. All audits were continuous data collection and will continue into 2023/24. Of the remaining 5 Trust priority audits, 4 are continuous data collection audits, with reports provided to SQAC and the bi-monthly commissioners contract and review meeting in line with the Quality Schedule reporting requirements. The remaining 1 Trust priority audit remain under development.

- The Committee was advised that 249 local audits were registered throughout the reporting period, of which 81 were completed. Included was a review of clinical pathways, staff education training, further audit/improvement work and documentation. It was pointed out that 24 re-audits were registered in the time period of which 12 have been completed.
- A review of the Divisional audit approval processes and oversight meetings took place in December 2022 and it was found that whilst there is a commonality in what each of the Divisions do there isn't a generic approval process across the Divisions/Corporate Services therefore work will take place to address this as part of the development plan going forward.
- A proposal was submitted to SQAC in March 2023 for the establishment of a Trust wide Clinical Effectiveness and Outcomes Group. The proposal was agreed and the inaugural meeting is scheduled for July. This group will oversee all clinical audit activity.
- It was reported that the Clinical Audit Policy has been re-written and was approved on the 21.6.23 by SQAC.
- The Committee was advised of the work that is to be undertaken to establish a wider Trust wide learning forum for sharing of audit findings, and clinical audit training for all staff groups in the next twelve months.
- Clinical audit development sessions have taken place with the Divisions to look at the current pathway and how improvements can be made. It was confirmed that a full action plan is in place to take this forward.
- The Associate Director of Nursing and Governance, Jackie Rooney reported that further work needs to take place to improve internal processes but felt that the Trust has a robust plan that can be taken forward in terms of development in 2023/24.

The Chair advised that this is the first time that the Committee has received an assurance report for clinical audit and felt that it was very clear and informative. It was noted that there are further improvements to be made in order to provide additional assurance, but with the exception of two/three audits the Trust has largely delivered its mandatory requirements which it was felt was a positive outcome.

Resolved:
The Audit and Risk Committee noted the improvements made during 2022/23 and approved the content of 2022/23 Clinical Audit Annual Report.

2023/24 Clinical Audit Plan for Mandatory and Trust-wide Audits

The Committee was presented with the Trust's Clinical Audit programme for Nationally mandated and Trust wide priority clinical audits for 2023/24. The following points were highlighted:

- A total of 20 national and 14 local Trust priority audits are currently included on the Trusts Annual Audit Plan for 2023-2024.
- It was reported that the Trust's Annual Audit Plan will develop as part of an iterative process, being updated as new national audits and confidential enquires are published throughout 2023/24. Likewise, if the Trust's priorities change due to the Patient Safety Strategy the audit plan will also be updated.
- The Clinical Audit Plan was approved by SQAC on the 21.6.23.

The Chair advised that the 2023/24 Clinical Audit Annual Work Programme for the Divisions is to be submitted to SQAC ahead of the Audit and Risk Committee in October 2023.

It was pointed out that the Trust wide audits look to be a mixture of internal and external requirements therefore the Chair felt that it would be useful to split the audits into categories to determine what has been delivered and whether lessons have been learnt.

23/24/37.1 Action: JR

Resolved:
The Audit and Risk Committee approved the Trust wide Clinical Audit Plan for 2023/24

23/24/38 Annual Assurance Report for 2022/23 and Forward Plan for 2023/24 – Data Quality

The Committee was provided with an overview of the Data Quality Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24. The following points were highlighted:

- The Trust has demonstrated good performance throughout the year and is in line with external benchmarking. It was confirmed that there are no significant areas of concern to raise.
- There is a large programme of improvement activities in place including a new Data Quality Strategy and the reformation of the Data Quality Steering Group.
- The Committee was advised that MIAA have completed a Data Quality audit within the last financial year on a section of the Trust's Integrated Performance Report and concluded that there was 'High Assurance' on these processes.
- Attention was drawn to the activities/developments taking place in 2023/24, as detailed in the report. It was pointed out that the Expanse migration is a significant project for the team.

The Chair queried as to whether there is an action plan in place to address the registered GP practice data. It was confirmed that this area of work is being tracked by the Data Quality Steering Group.

Resolved:
The Audit and Risk Committee noted the content of the Data Quality Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24.

23/24/39 Annual Assurance Report for 2022/23 and Forward Plan for 2023/24 – Cyber Security

The Committee was provided with an overview of the Cyber Security Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24. The following points were highlighted:

- The Trust is reporting a green status against national priorities.
- It was reported that additional resources have been invested both from a senior leadership/Cyber Security Apprenticeship perspective. The apprenticeship scheme will enable the Trust to upskill junior colleagues and grow its own cyber security expertise.
- The Committee was advised that the Trust is an active partner in the system work that is taking place across Cheshire and Merseyside around cyber security.
- It was confirmed that there is a very comprehensive plan in place for priorities in 2023/24, which includes cyber security training for Board Directors.

Resolved:
The Audit and Risk Committee noted the content of the Cyber Security Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24.

23/24/40 Annual Assurance Report for 2022/23 and Forward Plan for 2023/24 – Data Protection

The Committee was provided with an overview of the Data Protection Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24. The following points were highlighted:

- The Committee was advised of the data protection issues that were experienced in 2022/23 as a result of the backlog of Access to Health Records subject requests. A new leadership team has been established and a rapid review/ improvement plan has been implemented supporting the Trust to demonstrate compliance from January 2023. This legacy issue led to a large volume of complaints, PALS contacts and a single point of contact being assigned by the Information Commissioners Office (ICO). The Trust has worked closely with the ICO and the risk that was initially scored at 16 has been reduced to 6 with robust processes and monitoring now in place. It was confirmed that the single point of contact has been formerly stood down. A key piece of learning took place along with a deep dive and the Trust is now in a sustained compliance position. MIAA have also conducted an Access to Health Records audit which resulted in a 'Substantial' opinion.
- The Trust is scheduled to submit its Data Security and Protection Toolkit (DSPT) at the end of June 2023. There is an additional measure that has been included as part of the DSPT process around cyber security. The submission is being supported by an independent two-phase audit by MIAA. It is anticipated the Trust will submit a compliant return for 2022/23.

Jo Revill queried as to whether there is a balance between mandatory training and other required areas of training. It was reported that a concerted effort took place in respect to Information Governance training during the previous DSPT reporting period to ensure that the organisation was compliant on this area of training. Cyber communications are also circulated Trust wide and education sessions take place with a number of teams therefore it was felt that there is a real balance between both areas of training.

The Chair queried as to whether a quarterly update could be submitted to the Committee throughout the year on the areas highlighted in the assurance reports where there are turnaround times, themes, etc. in order to keep track of progress and highlight areas of concern. It was agreed to action this request.

23/24/40.1 Action: KW (quarterly update) / KMC (to update ARC Workplan)

Resolved:
The Audit and Risk Committee noted the content of the Data Protection Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24.

23/24/41 Annual Assurance Report for 2022/23 and Forward Plan for 2023/24 – Freedom of Information

The Committee was provided with an overview of the Freedom of Information (FOI) Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24. The following points

were highlighted:

- The Committee was advised of the challenges that the Trust has experienced in terms of achieving the national target of 95% for FOI compliance, which has been reflective of increasing pressures across the organisation to respond to a 23.2% increase in requests in 2022/23.
- Under the leadership of the Data Protection Officer, Wyn Taylor; processes have been refreshed/improved and the organisation has far better oversight. Performance has improved and is at 92% to date. It was pointed out that the Trust hasn't achieved the 95% national target but is doing much better than previously.
- There is a significant reliance on wider organisational leadership and turnaround times required by departmental and Divisional teams to support FOIA compliance, therefore management of breaches and escalation of potential breaches will continue to be supported by the iDigital senior management team.
- It was reported that FOI workshops have taken place for staff, and a large piece of work has been conducted with the Exec Team in terms of increasing oversight; a report is submitted on a regular basis during Exec Team meetings and a request has been made for Executive sponsorship to provide support to Divisions/ departments that receive a high number of FOI requests. It was confirmed that the Information Governance Team will continue to provide regular oversight to the Exec Team to ensure compliance and breach management is minimised within their respective portfolios.

The Chair queried the reason behind the increase in FOI requests and asked whether a highlight report could be submitted during October's meeting to identify the type of FOI's that the Trust receives. A further request was made for the submission of a one page briefing to provide an overview of the type of data protection incidents that have occurred and the lessons that have been learnt as a result of these incidents. It was agreed to present this information to the Committee in October.

Action: KW/ES (to be incorporated in action 23/24/40.1 to reduce duplication)

Resolved:
The Audit and Risk Committee noted the content of the Freedom of Information Annual Assurance Report for 2022/23 and the Forward Plan for 2023/24.

23/24/42 Audit and Risk Committee Annual Report for 2022/23

Resolved:
The Committee received and approved the Audit and Risk Committee Annual Report for 2022/23.

23/24/43 Committee Annual Reports for 2022/23:

Resolved:

The Audit and Risk Committee received and approved the 2022/23 Annual Reports for the;

- Resources and Business Development Committee.
- Safety and Quality Assurance Committee.
- People and Wellbeing Committee.
- Innovation Committee.

23/24/44 Update on progress against actions from the Audit and Risk Committee Self-Assessment

The Committee received an update on the progress against actions arising from the 2022 Audit and Risk Committee self-assessment exercise. It was reported that there are two actions that are still outstanding but progress is being made and they are well underway;

- *Risk Appetite and Tolerances* - This area of work has recently been discussed by the Assurance Committees to look at refining tolerances and a conversation on risk is scheduled for the Trust Board during July's meeting.
- *Clinical Audit* – This area of work has been further developed and there is to be a focus on risk awareness and training.

Whilst the last assessment was reported to the Committee in April 2022, it is recommended to not undertake a further assessment until the actions relating to Clinical Audit and Risk Tolerances have been completed. Updates on the two outstanding actions will be provided as required during the year.

Resolved:
The Audit and Risk Committee received and noted the update on progress against actions from the Audit and Risk Committee Self-Assessment.

23/24/45 Gifts and Hospitality Register, 2023/24

The Committee received the Gifts and Hospitality register for 2022/23 which provided a summary of the gifts that have been offered and declined throughout the year.

The Chair raised a number of questions, as follows;

- Does the Trust have a policy that determines the maximum amount of hospitality that Alder Hey can receive from one company, Trust wide?
- Does the Trust have a policy that sets out guidelines for payment to individuals when participating during the Trust's time? It was reported that the Trust policy states that anything over £50 should be donated or used within a ward or departmental fund. In terms of personal payment, Jill Preece agreed to look into this further.
- Do the large entries that relate to research belong on the Gifts and Hospitality Register?

Jill Preece agreed to look into the questions raised by the Chair.

23/24/45.1 Action: JP

23/24/46 Any Other Business

There was none to discuss.

23/24/47 Meeting Review

The Chair thanked everyone for their contributions throughout the duration of the meeting.

Date and Time of the Next Meeting: Thursday 13th July 2023, 2:00pm-5:00pm, via Teams.