Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 11th January 2024, commencing at 15:00
Lecture Theatre 2, Institute in the Park
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Dr. Hilary Cass – New Gender Development Service (12:00pm-1:00pm)							
Lunch (1:00pm-1:20pm)							
Trust Strategy Board (1:20pm-3:00pm)							
1.	**23/24/231**	**15:00 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/232**	**15:01 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/233**	**15:02 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **7th December 2023.**	**D**	Read enclosure
4.	**23/24/234**	**15:04 (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.	**23/24/235**	**15:05 (5 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**23/24/236**	**15:10 (30 mins)**	• **Integrated Performance Report for M8, 2023/24.** • **Finance Update for M8, 2023/24.** • **M9 Flash Report/ Operational Overview.**	Executives/ Divisions R. Lea A. Bateman	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M8 position. To receive an update.	**A** **A** **A**	Enclosure Presentation Enclosure
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
7.	**23/24/237**	**15:40 (10 mins)**	**Gender Development Service (North Programme) Update.**	L. Cooper	To provide an update on the current position.	**A**	Read report

8.	**23/24/238**	**15:50 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
9.	**23/24/239**	**15:55 (5 mins)**	**Mortality Report, Q2.**	A. Bass	To receive the mortality report for Q3.	**A**	Read report
10.	**23/24/240**	**16:00 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 18.12.23.** - **Approved minutes from the meeting held on the 15.11.23.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 15.11.23.	**A**	Read enclosure
The Best People Doing Their Best Work							
11.	**23/24/241**	**16:05 (5 mins)**	**People Plan Highlight Report.**	M. Swindell	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
12.	**23/24/242**	**16:10 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 20.12.23.** - **Approved minute from the meeting held on the 27.11.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 27.11.23.	**A**	Read enclosure
13.	**23/24/243**	**16:15 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Items for Information							
14.	**23/24/244**	**16:20 (2 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal

15.	**23/24/245**	**16:22 (3 min)**	• **Review of Meeting.** • **How can young people help the Board take forward the actions that have emerged from January's meeting?**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 8th February 2023, 9:00am, Lecture Theatre 2, Institute in the Park							

REGISTER OF TRUST SEAL
The Trust seal was used in December 2023: • 407: Deed of Variation - Neonatal Unit (18.12.23). • 408: Contractors Warranty - Neonatal Unit (18.12.23). • 408: Independent Certifiers Appointment - Neonatal Unit (18.12.23)

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M8, 2023/24	R. Lea
Alder Hey in the Park Campus Development Update.	D. Powell

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 7th December 2023 at 11:00am**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	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/Chief Financial Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Dr. F. Marston	Non-Executive Director	(FM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Communications	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
`	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Patient Story	Ms. L. Johnston	Acute Liaison Learning Disability Nurse	(LJ)
	Ms. B. Richards	Quality Improvement Project Manager	(BR)
Item 23/24/217	Ms. N. Palin	Director of Transformation and Change	(NP)
Observing	Mr. R. Johnson	Member of the public	(RJ)
Apologies	Mr. M. Flannagan	Director of Marketing and Communications	(MF)

Patient Story

The Chair welcomed the Trust's Acute Liaison Learning Disability Nurse, Lauren Johnston and Quality Improvement Project Manager, Bethany Richards who were invited to December's Trust Board to share a video about a patient called Eva and her journey with the Trust. Eva's mum, Gill recorded the video ahead of December's meeting to enable the Board to listen to Eva's story. Lauren also presented a number of slides to share her team's experience of applying a Brilliant Basics approach to Eva's situation and the impact that it had.

The Chair referred to Gill's suggestion about having a Parent Support Group at Alder Hey and advised that the Board is in full support of this idea. Lauren agreed to liaise with the Director of Community and Mental Health Services, Lisa Cooper to discuss a way forward to enable this to be progressed.
Action: LJ

Louise Shepherd thanked the team for the work that has taken place which is clearly making a difference for Eva and her family.

Lisa Cooper drew attention to the huge shift that is taking place across the system in terms of the large numbers of children being diagnosed and needing to access health care in relation to neurodiversity. It was pointed out that the Learning Disability/Autism team is a small, dedicated team and it was felt that it is imperative for the Trust to look at how it grows its workforce whilst thinking differently about training and education.

The Chair informed Lauren and Beth that the Board is very proud of the work that is being conducted and the impact that it is having on patients. The Chair asked that her thanks be relayed to Gill for telling Eva's story and pointed out that her voice represents that of so many parents in the same situation.

23/24/197 Welcome and Apologies

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

23/24/198 Declarations of Interest

There were none to declare.

23/24/199 Minutes of the previous meeting held on Thursday 9th November 2023
Resolved:
The minutes from the meeting held on the 9th of November were agreed as an accurate record of the meeting.

23/24/200 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

23/24/201 Chair's and CEO's Update

The Chair advised of the Charity Trustees' Board meeting that took place on the 6.12.23. The Trust shared a short synopsis of the 2030 Vision Strategy during the meeting which was well received by the Charity. It was also reported that the Charity has established a close working relationship with the Board of Ronald McDonald House and have agreed to launch a joint campaign to raise funds to improve the facilities of Mac House.

Louise Shepherd confirmed that the Integrated Care Board approved the Terms of Reference for the Children and Young People's (CYP) Board on the 30.11.23. It was pointed out that this is a critical move in terms of bringing together CYP services across Cheshire and Merseyside (C&M).

The Board was informed of the visit to the Trust by the National Director of Primary Care, Dr Claire Fuller that took place on the 6.12.23. Dr Fulham visited the Trust to understand the work that is being conducted with CYP and was overwhelmed by the passion of the organisation's employees and the thoughtfulness shown by Alder Hey in

terms of how the organisation is looking at the integration of CYP services and the governance that that entails.

It was reported that the Trust and the University of Liverpool hosted a joint workshop on child health and wellbeing, on the site of Alder Hey on the 6.12.23. Discussions took place during the session about the development of a shared strategy to drive forward the health of CYP. Attention was drawn to the success of the event which was attended by approximately eighty people from both organisations plus a number of children and young people.

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

23/24/202 Operational Issues

Operational Plan Progress

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

M8 Flash Report
Resolved:
The Board received and noted the Flash Report for month 8.

Integrated Performance Report (IPR), M7

The Board received the Integrated Performance Report (IPR) for Month 7. An update was provided on the following areas of the IPR:

It was reported that 42% of the Trust's frontline staff have received a Flu vaccination and 21% of have received a Covid vaccination. The organisation is continuing to raise awareness via weekly staff broadcasts, etc. and it was confirmed that clinics will continue until the end of January for Flu/Covid vaccinations. The Trust will continue to do all that it can to raise awareness of the importance of receiving a vaccination. It was pointed out that a large number of staff members have been unwell recently with viruses which has prevented them from taking up the Flu vaccination.

- *Accessible Services – Safety*
  - Antibiotics administered within one hour on ED (95%) and inpatient wards (94%). It was reported that there has been a continued improvement over the last four months in ED.
  - There has been a reduction in unplanned admissions to critical care from inpatient wards.
  - It was reported that there has been a reduction in the number of incidents with harm.

- *Unrivalled Experience – Caring*
  - *Complaints responded to within 25 working days:* Performance in October 2023 was 64%. It was pointed out that the complaints that the Trust is receiving are challenging.
  - *Friends and Family Test (FFT):* Performance increased to 89% in November.

- *Accessible Services - Effective*
  - The Board was advised of the impact that the new Electronic Patient Record (EPR) system and industrial action had on performance in September and October. There has been an improvement in November's performance figures with the Trust achieving the national standard of 76% for seeing patients in ED within four hours.
  - *Was Not Brought (WNB):* A new wave of tests have been launched to try and address the issues relating to WNB; which include appointments outside of school hours and asking families to choose an appointment time on a day that is convenient for them. Further work is required on follow-up appointments as two out of three WNB relate to follow-up care.

- *Accessible Services - Responsive*
  - *Forward Look (with actions):* There has been an increase of CYP waiting longer than 65 weeks for treatment. It was confirmed that the Local Negotiating Committee (LNC) has agreed for weekend work to take place therefore action is being taken to finalise extra contractual rates of pay to increase weekend elective activity.
  - *Diagnostics - % Completed Within 6 Weeks of referral:* It was confirmed that diagnostics achieved 90% and 85% as highlighted in the report.

Community and Mental Health Division

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

Division of Medicine

- There has been a 7% increase in ED performance against the 4 hour target to date.
- Evening and weekend work is being undertaken to increase activity.
- There are two workstreams in place to address sickness absence figures and support staff who have been absent for two weeks and four weeks plus.
- The Trust is looking to mitigate the demand pressures in the Division of Medicine, ED and the flow around the organisation.

Division of Surgery

- Recruitment is continuing and the Division is on the second phase of staff training and skill mix which will support the reinstatement of a new schedule by February. An update will be provided on this in due course.
- There are plans in place to transfer a number of elective procedures to the short-term capacity elective hub being piloted at Warrington and Halton in ENT, Paediatric surgery and plastics.
- The Division is looking to reinstate some pathways.
- The Division of Surgery hosted a health and wellbeing event for its staff members which was well received.

It was reported that a meeting is taking place on the 8.12.23 to discuss the forthcoming industrial action being taken by consultants and junior doctors. Concerns have been raised as there will be a large number of people on leave during the next round of industrial action. It was confirmed that the Trust will do all that it can to ensure the hospital is safe.

Research

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

Fiona Marston asked for an update on the Division's initiatives. It was reported that engagement is taking place with the wider research community and the Head of

Nursing for Research, Laura Rad is focussing on improving patient experience. The Trust is building the CRD and bringing in new expertise which will make a difference in 2024/25. The CRD have compiled a Research Strategy of which the final version will be available in January 2024.

Finance

- The Trust reported a £25k surplus at the end of October in line with the plan. The revised plan for the year is to achieve a £13m surplus by the end of March 2024 subject to no further industrial action and delivery of activity and financial plans, including CIP.
- CIP was posted behind plan by £1.8m, with £11m posted against the £17.7m target. It was confirmed that Divisions are looking to see what can be removed recurrently.
- Industrial action impact is c£4.7m YTD with loss of income and additional costs. It was confirmed that the Trust received funding of c£2m as detailed in the latest guidance.
- Regional and national discussions are to take place regarding financial plans.
- 2023/24 key risks for M7 include; income, inflation, system position, CIP and capital.

Detail was requested on the high risks that are incorporated on the risk register. It was agreed to include this information in January's IPR.

23/24/202.1 Action: RL

Resolved:
The Board received and noted the content of the IPR for Month 7.

23/24/203 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:

- *Reinstatement of the Park* – The Board was advised of the public meeting that took place on the 6.12.23 which was chaired by Liverpool City Council (LCC). The team provided an update on the park and Detect shared an overview of what the park will look in the next few years. The last remaining issue for the community is the swale in terms of its size and necessity. It was confirmed that the lighting in the park will be in situ by February. It was agreed to share the Detect presentation with the Board in the New Year.

23/24/203.1 Action: DP/JH

- *Neonatal and Urgent Care Development* – It was confirmed that the signing of the main contract is imminent. In terms of the ground floor of the building, work is taking place to look at the opportunities.
- *Catkin/Sunflower House:*
  - *Sprinkler System - Under-Croft Car Park* – The Trust has been advised that it is able to use the car park situated under Sunflower House. Discussions are taking place about the use of the car park during the morning periods.
- *Former Police Station Refurbishment* – The Trust is awaiting planning permission to enable the refurbishment of the former Police Station to commence.

Resolved
The Board received and noted the Campus Development update provided on the 7.12.23.

23/24/204 Emergency Preparedness, Resilience and Response (EPRR) Annual Report, 2023; including EPRR Position Report.

The Board received two reports; **1.** The Emergency Preparedness, Resilience and Response, Annual Report for 2023. **2.** The Emergency Preparedness, Resilience and Response (EPRR) 2023 Position Report.

In 2022 the Trust reported a substantially compliant return in alignment with the NHS England EPRR core standards. This year the Trust will see a significant reduction in the level of assurance relating to all domains across the EPRR portfolio, this is due to a much more stringent check and challenge processes into each individual standard alongside a number of changes to national guidance relating to EPRR.

This check and challenge process is to support the Trust in identifying and highlighting areas that require further progression to ensure a level of full compliance is met for each individual standard. Following the check and challenge process the Trust submitted an assurance rating of non-compliant in line with the requirements set out in the EPRR core standards in the annual assurance process for 2023/24. The new approach to check and challenge nationally has seen an overall reduction in assurance ratings for all organisations.

It was confirmed that there is a plan in place to address the Trust's reduced compliance rating and enhance the general governance of EPRR within Alder Hey. The Board was advised that individual organisations are providing assurance to the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) regarding this matter, as will the Trust.

The Trust's EPRR NED Lead, Kerry Byrne pointed out that it is essential to enhance the current capacity structure within the EPRR team to ensure the effective implementation of EPRR compliance to the enhanced standard required going forward. Kerry Byrne advised that the EPRR Manager is very competent and knowledgeable but emphasised the importance of ensuring he has the right support in the form of an experienced team. It was confirmed that regular bi-monthly meetings will take place to ensure the action plan is on track.

Resolved:
The Board:

- Noted the annual EPRR assurance report and approved the self-assessment assurance rating of non-compliance in line with the NHS England EPRR core standards for 2023.
- Noted and approved the approach outlined in the report to address the reduced compliance rating and enhance general governance of EPRR within the Trust.

23/24/205 Patient Safety Incident Response Policy

Resolved:
The Board received and approved the Patient Safety Incident Policy.

23/24/206 Brilliant Basics Update

The Board was provided with an oversight of the Brilliant Basics (BB) Delivery Plan for 2023/24 and received an update on the progress that has been made towards the development of a culture of continuous improvement. The following points were highlighted:

- Within the current BB Plan all of milestones are on track.
- The programme governance assurance is rated green in all areas.
- Progress is in line with the approved BB Delivery Plan.

- Progress on BB puts Alder Hey in a strong position as leaders in the improvement community both locally and nationally. It was reported that the Trust has moved into the top quartile in terms of staff feeling empowered.
- *NHS Impact* - A self-assessment has been published by NHS IMPACT that allows providers to assess their own position against the national standards. This assessment will inform Alder Hey's BB plan for 2024/25. The Trust is also working with NHS Impact to provide some BB case studies.

Louise Shepherd praised all those involved in the fantastic work that is taking place and advised that the Chair of Lancashire and South Cumbria NHS FT, David Fillingham is going to visit the BB team at Alder Hey as he is interested in the overall BB approach, especially the case studies.

Resolved:
The Board:

- Noted the progress that is being made in line with the approved BB Delivery Plan.
- Agreed to receive an assessment of the BB Delivery Plan in Q4 alongside a detailed NHS Impact self-assessment and BB plan for 2024/25.

23/24/207 Serious Incident 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 1.10.23 to the 31.10.23. The following points were highlighted:

- The Trust declared zero Never Events during the reporting period.
- One SI investigation was completed in the reporting period *(SI 2023/10739 – Delayed diagnosis of bone malignancy).*
- One SI action plan remained open and is within its expected date of completion.
- One initial duty of candour response was breached by one day *(InPhase ID 4773*).
- The Board was advised that there may be one additional SIRI in November.

Resolved:
The Board received the Serious Incident report for the period from the 1.10.23 to the 31.10.23.

23/24/208 DIPC Report, Q2

The Board was provided with oversight of Infection Prevention Control (IPC) activity and reporting for the Q2 period (1.7.23 to 30.9.23). The following points were highlighted:

- The IPC Committee is fully implemented and has a number of working groups/steering groups reporting into it.
- *Gram-negative Bacteraemias;*
  - The Trust is above the 2023/24 NHS threshold for all healthcare associated cases.
  - It was reported that the Trust is leading on a piece of work to see what the thresholds should be.
  - Attention was drawn to table one in the report and it was advised that the data relates to eight episodes in one patient.
  - A steering group has been established to address this area of work.

- The Board was advised that the Trust is looking at an overall restructure of the IPC service, taking into account some of the recommendations from the external report, including a digital solution.

A question was raised about the actions that are taking place to reduce line infections. It was reported that the Trust is in the process of establishing a steering group to address this area of work, has engaged with Boston Children's Hospital on this matter and is counting data in a scientific way that will help reduce figures. It is expected that the steering group will focus in great detail on central line associated blood stream infections (CLABSIs) and the Safety and Quality Assurance Committee (SQAC) will monitor the progress that is being made.

Resolved:
The Board noted the content of the DIPC report for Q2.

23/24/209 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 18.10.23 were submitted to the Board for information and assurance purposes. During November's meeting there was a focus on sepsis mandatory training and the quarterly Safeguarding report. An in-depth discussion took place about the level of compliance across the Trust in respect to safeguarding training. It was confirmed that the Committee will receive an update on this matter during December's meeting and will continue to monitor compliance until the level is satisfactory.

Resolved:
The Board noted the approved minutes from the meeting held on the 18.10.23.

23/24/210 Neonatal Governance Review

Regular monthly meetings have been taking place between Alder Hey's Chief Medical Officer (CMO) and the CMO at Liverpool Women's Hospital (LWH) to discuss the Liverpool Neonatal Partnership (LNP) and the requirement for a governance review due to the evolution of the partnership. As the LNP develops it is important for the Board to have clear oversight of the broad Neonatal service across both trusts, therefore it is being proposed that a joint away day take place with teams from Alder Hey and LWH to reset the partnership and the underpinning governance arrangements.

Board members shared their views following the update and the general consensus was that the away day is a positive way forward, but it was felt that it is important to gain agreement at senior level about what is to be done to progress the partnership further. It was pointed out that direction from a unified partnership board of the two trusts would be welcome.

Following discussion, it was agreed that Dame Jo Williams and Louise Shepherd will meet with the Chair and CEO of LWH before the workshop goes ahead, to look at developing a framework for the partnership. A suggestion was made about inviting a member of the ICB to the meeting as well. It was confirmed that a briefing will be provided by Alfie Bass ahead of the meeting, detailing the Trust's thoughts for progressing the partnership, for discussion purposes.

23/24/210.1 Action: DJW/LS/AB

23/24/211 Update on the Workshop with the University of Liverpool (UoL) held on the 6.12.23

It was reported that 82 people attended the workshop from two organisations which included a mixture of faculties, young people, and a headteacher from a local primary school. It was a really positive session that exceeded expectations and produced a real sense of togetherness. During the workshop the group looked at a joint strategy to determine the impact that joint working could have on CYP, and a longer-term goal that relates to the Child of the North programme.

A wash up session is to be scheduled between the Trust and UoL where the Child of the North business case will be discussed. A launch meeting is planned for March but it is dependent on having sufficient resources.

Fiona Beveridge advised that there is a genuine commitment from UoL. In terms of financial resources, a modest commitment will be required from both parties in order to unlock what could be a considerable reward. Bids for innovation funding will need to be responded to very quickly therefore it is imperative to have an infrastructure that will enable a pipeline of proposals. It was pointed out that this is also about long term leverage.

Louise Shepherd advised that the commitment of both organisations will make a difference and informed the Board of the Vice Chancellors commitment.

John Chester thanked Fiona Beveridge for supporting the workshop behind the scenes.

Resolved:
The Board noted the update on the joint workshop that took place on the 6.12.23.

23/24/212 3rd MRI Scanner Business Case

The Board received a business case for the purchase of a new 3T research/clinical MRI scanner (funded via a NIHR grant) and subsequent running costs, for approval purposes. Initially the scanner was to be used solely by the Research Division but work was undertaken with the Division of Medicine that has enabled both Divisions to use the scanner thus making the business case more viable.

An overview was provided of the running costs that contribute to a slight risk element in that it is impossible to forecast how many service scans/research scans will take place, and an explanation was provided with regard to the mitigations for the stretch targets. A discussion took place about the importance of building in all mitigations and naming accountable officers when producing a business case so that it can be accepted on the basis of the mitigations.

John Chester commended the business case for approval advising that the new scanner will provide a first-class facility for research and service needs. John Chester also praised the team who took the concept of a 3rd MRI scanner and made it a reality.

Resolved:
The Board approved the 3rd MRI Scanner business case.

23/24/213 Research and Innovation Committee

The approved minutes from the meeting held on the 10.7.23 were submitted to the Board for information and assurance purposes. During November's meeting a discussion took place on the Research Strategy and the work that is taking place to align it with the Futures Strategy. A framework is being developed for the strategy and progress is being made on a cost benefit analysis which will be built into the strategy. It

was reported that the funding opportunity with the Investment Zone is on-going, and the agreement between the Trust and Strasys is due to be signed within the next few days. It was confirmed that the Partnership Board has been established.

Resolved:
The Board noted the approved minutes from the meeting held on the 10.7.23.

23/24/214 People Plan Highlight Report

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

EDI Update

The Board received a high-level overview of the critical strategic and operational activity regarding Equality, Diversity and Inclusion (ED&I) during October and November 2023, including an update on the progress of implementing the North West BAME Assembly Anti-Racist Framework. The following points were highlighted:

- It was reported that the Trust's developing staff networks are going from strength to strength and have been welcomed by the workforce.
- The Board was advised that some of the data in the most recent WRES report and WDES report indicates the need for further work on a number of areas in terms of linking the People Plan.
- All of the networks have had engagement sessions or awareness days over the last few weeks with attendance from Board members to show their support.
- The statement that was provided by the Chair and CEO of the Trust was well received at 'Black History Month' and helped emphasize the Board's commitment to EDI at Alder Hey.

Resolved:
The Board noted the EDI update.

23/24/215 Equality Act:

The Board received the 2022/23 Workforce Race Equality Standard (WRES) report and the 2022/23 Work Force Disability Equality Standard (WDES) report. Both reports were submitted to the People and Wellbeing Committee (PAWC) on the 22.11.23 and it was acknowledged that time needs to be set aside to reflect on the data so that an action plan can be developed to demonstrate progress against the metrics. Additional work will also need to take place in terms of culture across the organisation. The Chair of PAWC, Fiona Marston advised that she would like the Trust to support a zero tolerance goal in terms of how staff are treated by other staff members at the Trust.

Resolved:
The Board:

- Approved the 2022/23 WRES report.
- Approved the 2022/23 WDES report.

23/24/216 People and Wellbeing Committee

The approved minutes from the meeting held on the 13.9.23 were submitted to the Board for information and assurance purposes. During November's meeting there was a focus on the People Plan element of the 2030 Strategy, which it was confirmed is progressing. The Committee received an update on Freedom To Speak

Up, and it was reported that Divisional metrics are showing positive trends particularly in relation to staff turnover. The Board was informed of the Trust's 60% response rate to the 2023 Staff Survey. The Chair of PAWC thanked Melissa Swindell and her team for progressing this area of work.

Resolved:
The Board noted the approved minutes from the meeting held on the 13.9.23.

23/24/217 Transformation Programme Update

The Board received an update on the progress of the delivery of Alder Hey's 2030 Strategic Plan (*April 2023 - October 2023*). It was reported that significant progress has been sustained across the year and the Trust has moved forward in the mobilisation of the Vision 2030 Strategy despite a challenging operational environment. During this period, the organisation has sought to strike the balance between driving forward a long-term multi-year programme, whilst advancing with the development of new capabilities with a specific focus on experience in year one. The active leadership of all Senior Responsible Officers (SROs) in recent months is allowing the translation of the programmes of work into deliverable plans.

Attention was drawn to the following points:

- Progress has been made across the organisation's strategic initiatives.
- Milestones are being delivered.
- A key shift has been the development of a Benefit Case framework, which not only identifies the baseline position and anticipated benefits; it also creates a robust framework for identification and tracking benefits achieved as result of the organisation's planned activities including those generating a cash releasing saving, efficiency, income generation and social value return. At the present time there are five benefit cases in various degrees of development which require further work. It is expected that there will be eleven benefit cases by January 2024 which will be reported on via RABD.
- There are plans to develop a single Integrated Plan for 2024/25 which will include both strategic and operational important change areas. The submitted report highlighted opportunities for further enhancement to ensure appropriate resource management aligned to a single Integrated Plan for 2024/25.

On behalf of the Board, the Chair thanked Natalie Palin for the update and recognised the work that has been conducted by the team to progress the delivery of an ambitious strategic plan. It was felt that huge steps have been made especially around benefits realisation.

The Board confirmed its support in terms of reviewing the organisation's change resources to ensure that they are suitably aligned to the Trust's strategic priorities, but acknowledged the challenges of doing this.

Resolved:
The Board approved the;

- Development of a Single Integrated Plan for 2024/25, including both strategic and operational important change areas.
- Enhancement of assurance ratings to include assessments on whether the Trust is making and embedding change in the 'right way' as per change management methodologies.
- Introduction of bi-monthly reporting into Trust Board.
- Reviewing the Trust's Change Resources, to ensure that they are suitably aligned to the organisation's strategic priorities.

23/24/218 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 23.10.23 were submitted to the Board for information and assurance purposes. During November's meeting there was a focus on benefits tracking, the Trust's financial position and understanding what next year's position will look like, and the issues relating to Project Co and the PFI.

Resolved:
The Board noted the approved minutes from the meeting held on the 23.10.23.

23/24/219 Board Assurance Framework Report (BAF)

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

- It was confirmed that the InPhase version of the BAF will be submitted to the Board in January. It was reported that there has been a lot progress with the InPhase system in the intervening months.
- There has been an extensive reframing of the risks relating to the Vision 2030 Strategy which will be modified in the course of time.
- There has been a reduction to the digital risk score following the implementation of Aldercare.

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

23/24/220 Any Other Business

There was none to discuss.

23/24/221 Review of the Meeting

The Chair advised of a question that was raised by a number of the Trust's young governors during an informal governors meeting, about whether Board members really think about CYP during Board meetings. The Chair asked for comments regarding this query.

Fiona Marston referred to the 3rd MRI scanner agenda item and pointed out that the Board had focussed on the cost aspect of the business case but not the impact that having state of the art equipment will have on the health of CYP, which is a really important factor.

Fiona Beveridge mentioned the workshop that took place on the 6.12.23 between Alder Hey and UoL and pointed out that the voices of the young people who attended the session sent a very powerful message to those who were in attendance.

Nathan Askew acknowledged that the Trust is on a journey to strengthen children's voices via a number of routes and capture the outcomes.

Date and Time of Next Meeting: Thursday the 11th January at 1:30pm in Lecture Theatre 2.

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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for January 2024							
9.11.23		Staff Story	Discussion to take place about CYP/music therapy at Alder Hey to support a conversation with the Arts Council in January.	L. Shepherd/ M. Thomas/ V. Greenwood	7.12.23	Dec-23	**5.1.23** - An update will be provided during January's Trust Board. **ACTION TO REMAIN OPEN**
9.11.23	23/24/175.1	Learning from the Letby Case	*Systems and Processes* - Discussion to take place around confidentiality versus openness .	Exec Team	7.12.23	Dec-23	**5.1.23** - A revised approach is to be submitted to the Trust Board on people practices and teams have been challenged to attend February's Trust Board meeting.
7.12.23	23/24/202.1	Integrated Performance Report	Include details in January's IPR on the high financial risks that are included on the risk register.	R. Lea	11.1.24	On track Jan-24	**5.1.23** - An update will be provided in January. **ACTION TO REMAIN OPEN**
Actions for February 2024							
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	Feb-24	**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.
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	Feb-24	**7.11.23** - A meeting is in the process of being scheduled. An update will be provided in February. **ACTION TO REMAIN OPEN**
9.11.23	23/24/173.2	Digital, Data and Information Technology Update	*External Reporting* - Discuss the possibility of compiling a report that focusses on the Trust's robust reporting processes and the lessons that have been learnt nationally, for submission to the Board.	J. Grinnell/ K. Warriner	11.1.24	Feb-24	**3.1.24** - This item will be included on February's agenda. **ACTION TO REMAIN OPEN**
9.11.23	23/24/175.2	Learning from the Letby Case	Board to return to this item in February 2024 to take a balanced review of what is working, how improvements can be made and to receive an update on the work that is taking place around the organisation's culture.	N. Askew/ A. Bass/ E. Saunders	8.2.24	Feb-24	
7.12.23	23/24/203.1	Alder Hey in the Park Campus Development Update	Share the Detect presentation with the Board that provides an overview of what the park will look in the next few years.	D. Powell/ J. Halloran	8.2.24	Feb-24	
7.12.23	23/24/210.1	Neonatal Governance Review.	Meeting to take place between Dame Jo Williams, Louise Shepherd, the Chair and CEO of LWH before the Away Day session goes ahead, to look at developing a framework for the partnership. Alfie Bass to provide a briefing ahead of the meeting, detailing the Trust's thoughts for progressing the partnership, for discussion purposes.	Dame Jo Williams/ L. Shepherd/ A. Bass	11.1.24	Feb-24	**5.1.23** - Contact has been made with the CEO of LWH. An update will be provided in February. **ACTION TO REMAIN OPEN**
Actions for March 2024							
7.9.23	23/24/106.2	Operational Issues	*Finance* - Submit a half yearly report on the cash share model that is emerging and provide detail in terms of how it is being managed from a risk perspective in the system.	R. Lea	7.3.23	On track March-24	

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

Alder Hey Children's NHS
NHS Foundation Trust

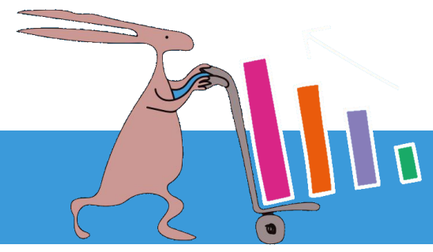
Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Status							
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
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	Closed	**19.1.23** - This item has been deferred to February's Trust Board. 29.3.23 - This item has been deferred to May's Board. **27.4.23 -** This item has been deferred to June's Board. **3.6.23 -** The ToR will be submitted to the Board in September once they have been reviewed by RABD. **1.9.23** - The ToR will be submitted to the Board in October once they have been reviewed by RABD. **4.10.23** - The ToR will be submitted to the Board in November once they have been reviewed by RABD. **23.10.23** - The ToR will be submitted to the Board in December once they have been reviewed by RABD. **1.12.23** - The ToR will be submitted to the Board in December once they have been reviewed by RABD. **3.1.24** - This action will be addressed as Futures evolves. **ACTION CLOSED**
9.11.23	23/24/171.1	Strategy Brochure	Action the feedback that was received from Board members in relation to the strategy brochure, during November's meeting.	C. Beaver	7.12.23	Closed	**3.1.23** - This action has been addressed. **ACTION CLOSED**
9.11.23	23/24/173.1	Integrated Performance Report	Look at options to address the lack of improvement in WNB figures.	A. Bateman	7.12.23	Closed	3.1.24 - An update was provided during December's Trust Board. **ACTION CLOSED**
9.11.23	23/24/173.3	Digital, Data and Information Technology Update	Send a letter of thanks to Meditech for their support with the AlderC@re Programme.	K. Warriner	7.12.23	Closed	**5.1.23** - This action has been addressed. **ACTION CLOSED**
9.11.23	23/24/174.1	Alder Hey in the Park Campus Development Update	*Park Reinstatement* - Comms to be compiled to advise the local community that the Trust is aiming for a completion date of March 2024 as a result of the challenges installing drainage under the football pitches.	J. Halloran	7.12.23	Closed	**5.1.23** - A Park Newsletter was issued to the local community inc via the Trust's website. Information was also relayed during the public meeting on 6.12.23. **ACTION CLOSED**
9.11.23	23/24/174.2	Alder Hey in the Park Campus Development Update	Discuss comms for families who have children with sensory needs so that parents/carers can be made aware of the noise from the construction work that is taking place on site, ahead of their child's appointment.	L. Cooper/ J. Halloran	7.12.23	Closed	**5.1.23** - A communications plan has been developed to respond to matters like this. The plan was presented to the Neo-Natal/UCC Programme Board in December. **ACTION CLOSED**
7.12.23		Patient Story	Liaise with Lisa Cooper to discuss a way forward in terms of the suggestion that was made by Gill (Eva's mum) about having a Parent Support Group at Alder Hey.	L. Johnston	11.1.24	Closed	**5.1.23** - Lauren has made contact with Lisa Cooper to progress Gill's suggestion about having a Parent Support Group at Alder Hey. **ACTION CLOSED**

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: December 2023



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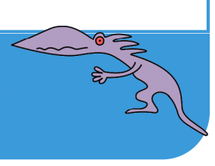


Icon Definitions

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

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

XmR chart

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

Process limits

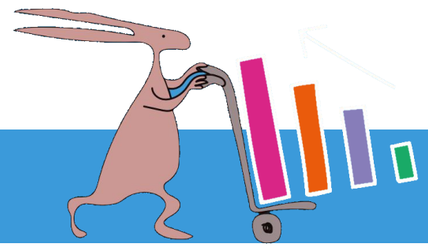
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

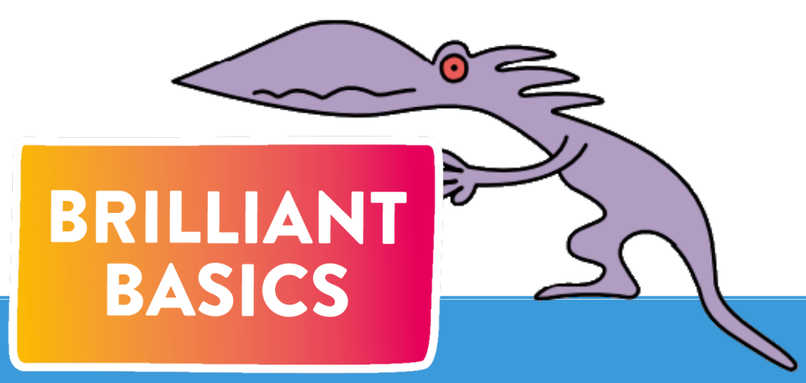
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

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

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

- 17.4% of our metrics are consistently achieving target
- 56.5% of our metrics are inconsistently achieving target
- We are not achieving the target for 26.1% of our metrics but experiencing improvement in 3 of these metrics.

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



Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety

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

Highlights:

No serious incidents and no Never Events reported. Sustained reduction in the number of patients admitted to Critical Care following deterioration on a ward. 95% of inpatients received antibiotics within 1 hour for sepsis

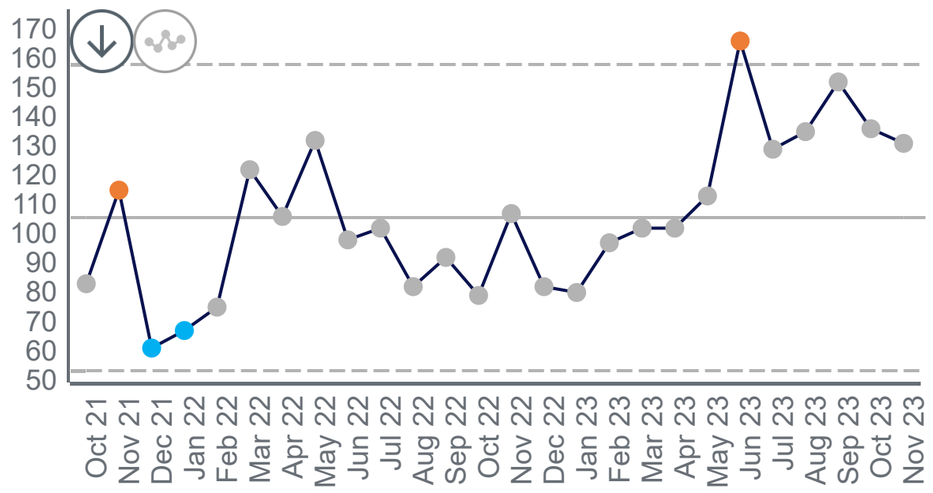
Areas of Concern:

Reduced performance in ED in relation to administration of antibiotics in 1 hour for sepsis; compliance 84% in month

Forward Look (with actions)

Further work is being undertaken with the aim of improving the accuracy of documentation of clinical concerns around sepsis in the medical record – through education and training of staff but also exploring improvements of electronic recording systems. This work has resumed following recruitment of the ED sepsis nurse

Number of Incidents rated Minor Harm and above



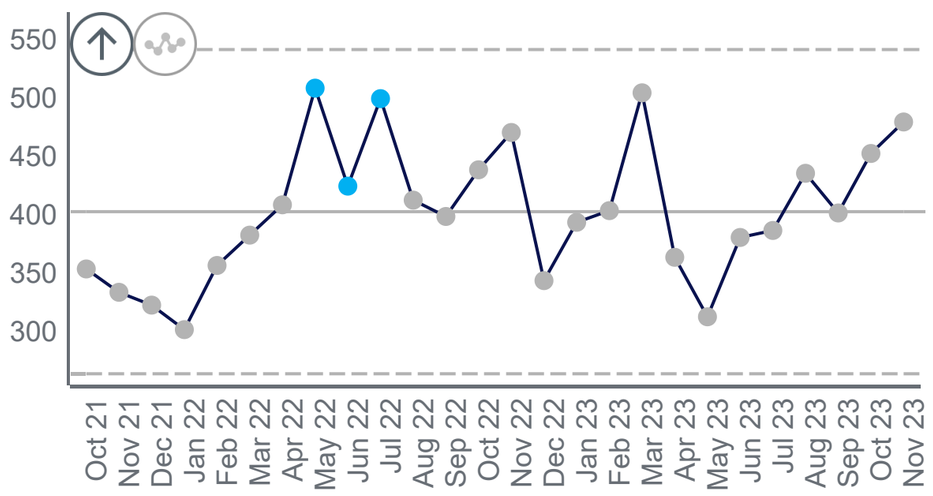
Technical Analysis:

This is interim measure of number of incidents instead of per 1,000 bed days due to data accessible at month end. November 2023 shows 131 patient safety incidents rated as harm which is 3rd consecutive reduction from September performance of 152 incidents. No common cause variation however recent months are higher than average of 105 across the period although new system was

Actions:

Continued evidence of high reporting culture overall in the Trust. All teams, services and staff are encouraged to report all incidents, including near misses, to enable learning

Number of Incidents rated No Harm and Near Miss



Technical Analysis:

This is interim measure of number of incidents instead of per 1,000 bed days due to data accessible at month end. November 2023 shows 480 patient safety incidents rated as no harm which is 3rd consecutive month increasing. No common cause variation, increase in no harm's mirrors reduction in harms above so steady number of incidents overall still being reported.

Actions:

Opportunities to undertake thematic learning in line with the PSIRF strategy are identified through the Patient Safety Meeting

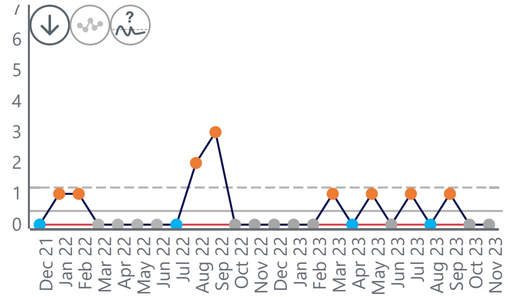
0024

Integrated Performance Report | December 2023

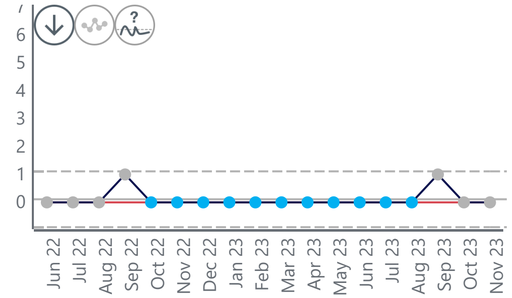
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

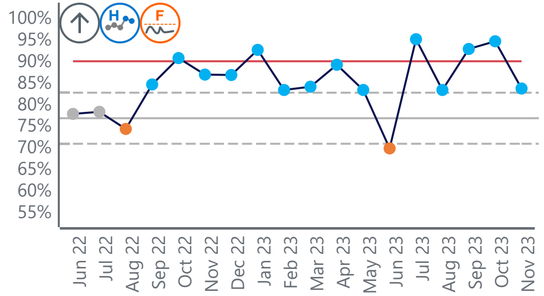
Number of Serious Incidents (Steis reported)



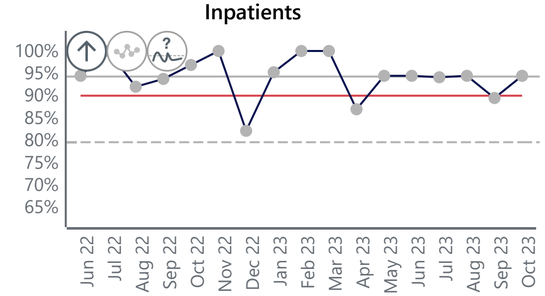
Number of Never Events



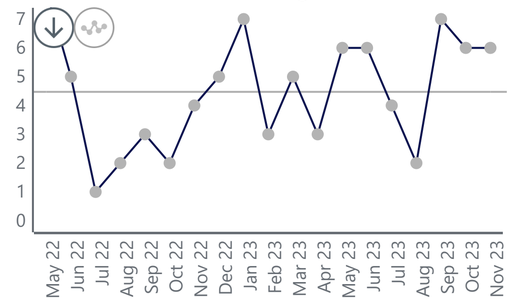
Sepsis % Patients receiving antibiotic within 60 mins for ED



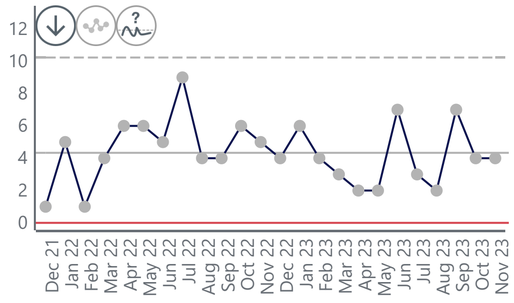
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



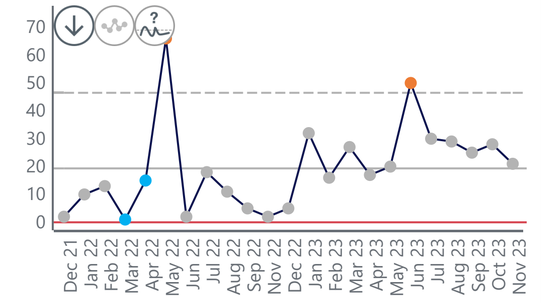
Medication Errors resulting in Harm



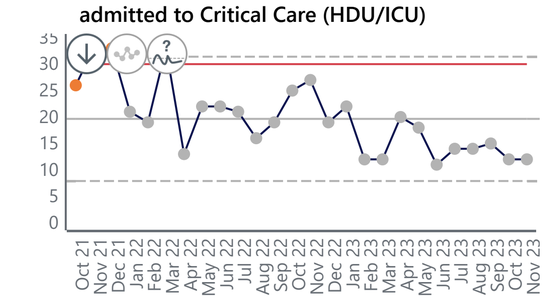
Pressure Ulcers G2-4



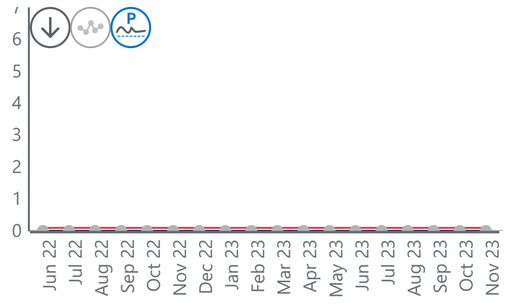
Use of physical restrictive intervention



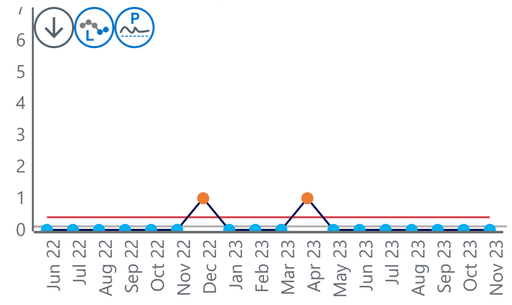
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



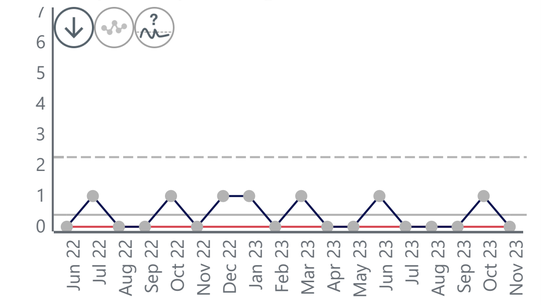
Hospital Acquired Organisms - MRSA (BSI)



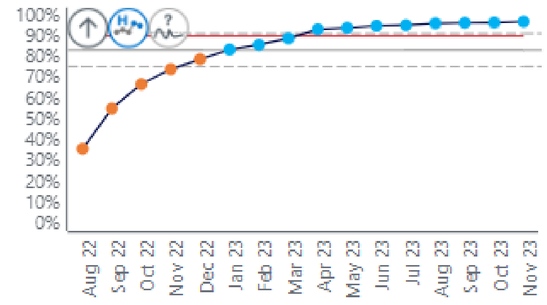
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring

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

Highlights:

Low number of formal complaints in comparison to the number of children, young people and families we treat and care for

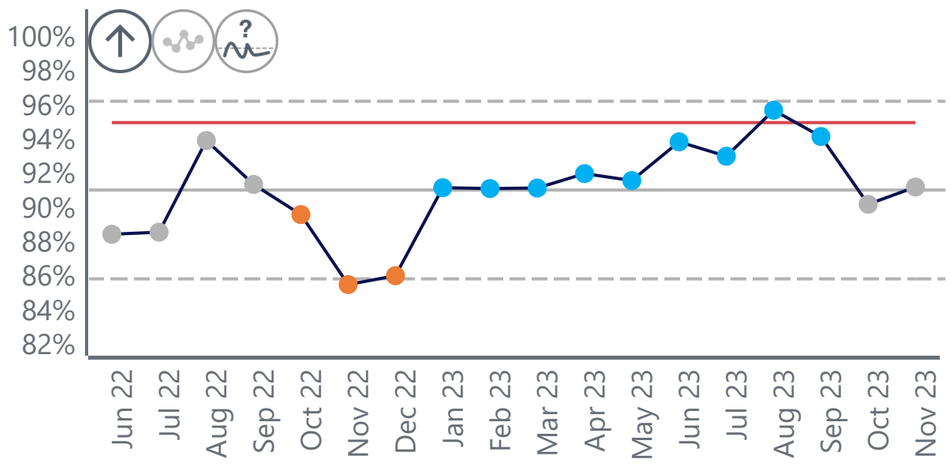
Areas of Concern:

Continued high number of PALS concerns; targeted work by Divisions in relation to the continued themes of concerns

Forward Look (with actions)

Review of FFT process

F&F Test - % Recommend the Trust



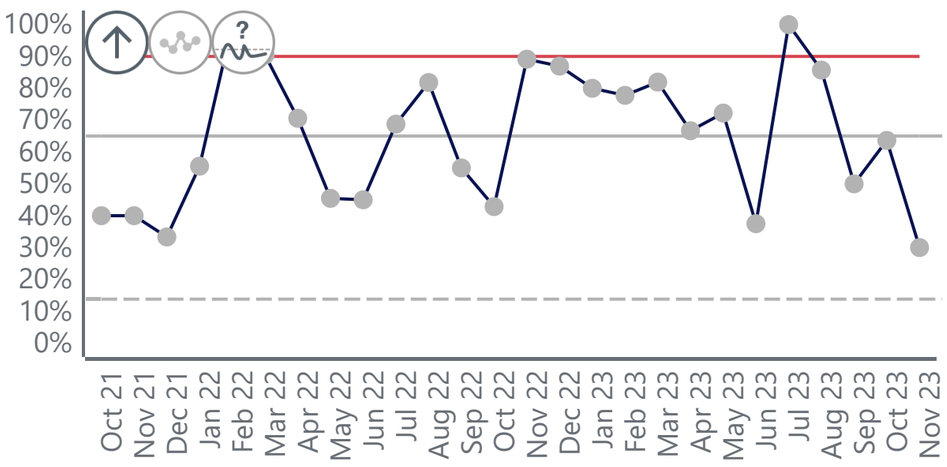
Technical Analysis:

Consistently not achieving the 95% target. November performance of 91% represents increase from October of 90%. However November 2023 is 4% higher than November 2022 lowest point since December 2022.

Actions:

Review of FFT underway with a plan to introduce new process in April 2024. This forms part of the Vision 2030 Patient Experience workstream

% Complaints Responded to within 25 working days



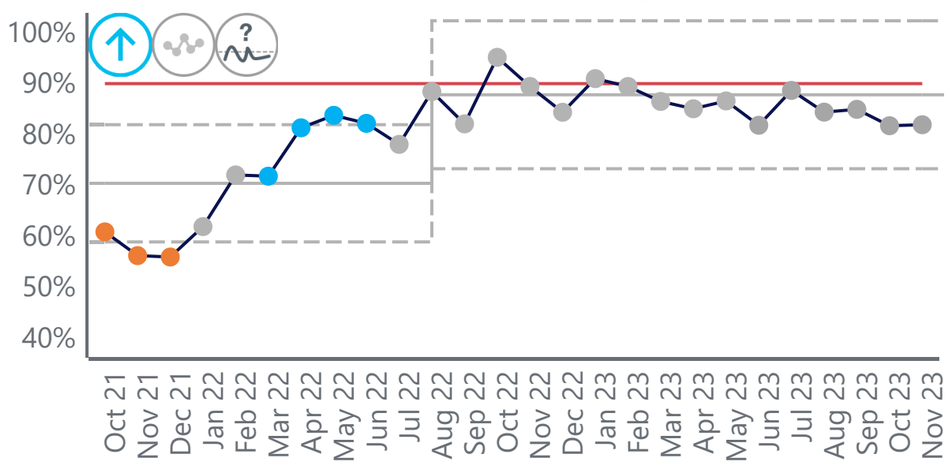
Technical Analysis:

Data refresh will occur 12/12/2023 AM

Actions:

Divisions to respond to families within 25 working days and follow the process for extension approval where it is deemed to be required

% PALS Resolved within 5 Days



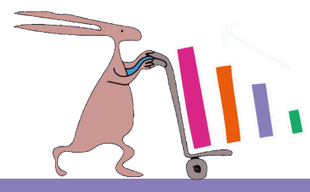
Technical Analysis:

Data refresh will occur 12/12/2023 AM

Actions:

Continued high performance. Process for local resolution reviewed with Patient Experience team

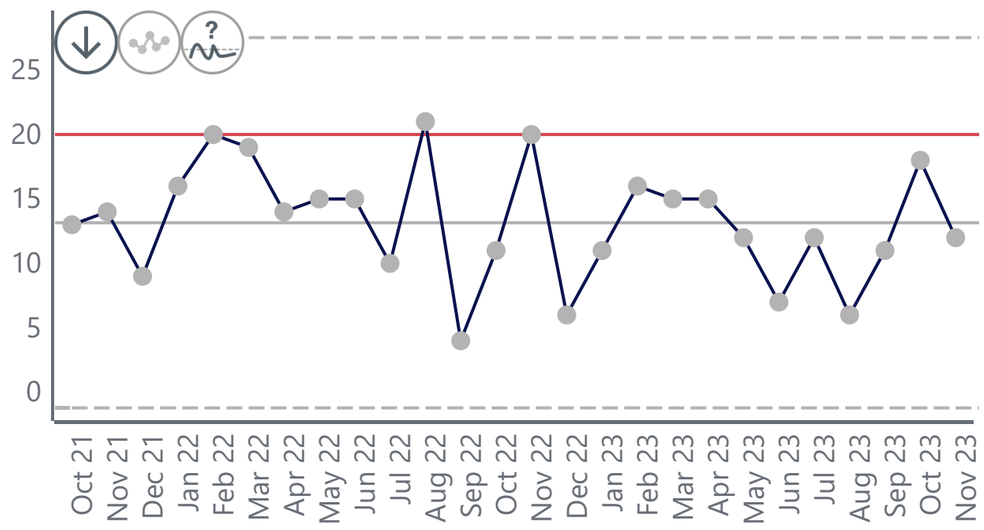
Integrated Performance Report | December 2023



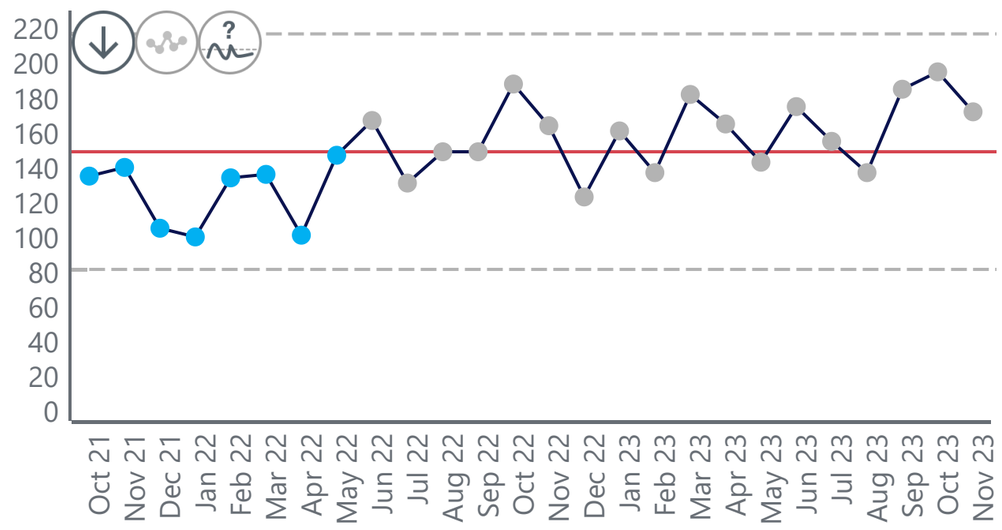
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

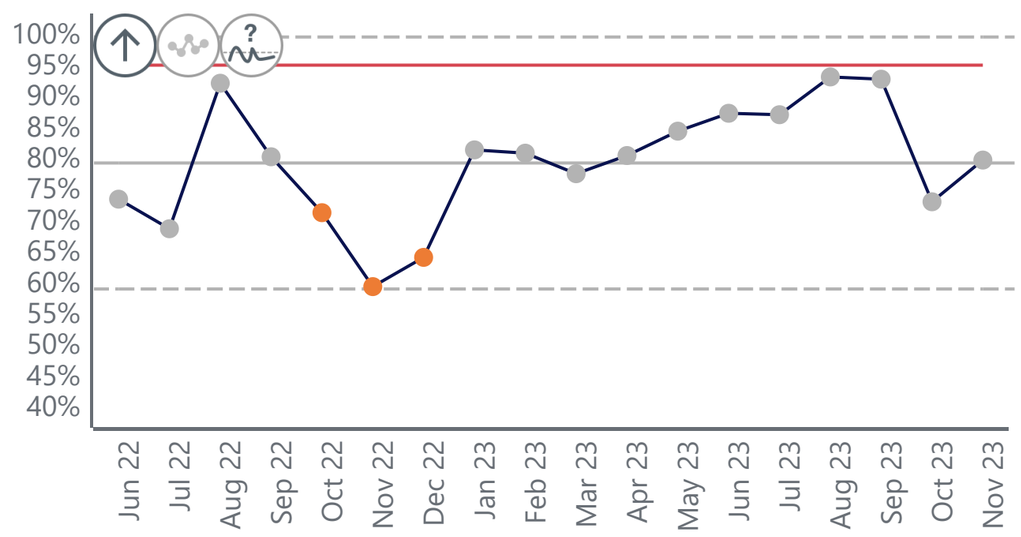
Number of formal complaints received



Number of PALS contacts



F&F ED - % Recommend the Trust



Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• ED performed restored to 79%, ie exceeding national standard of 76% • WNB reducing 3 consecutive months, and now achieving target (<10%) • Virtual Ward Bed Days showing evidence of sustained improvement and above target in the last 2 consecutive months

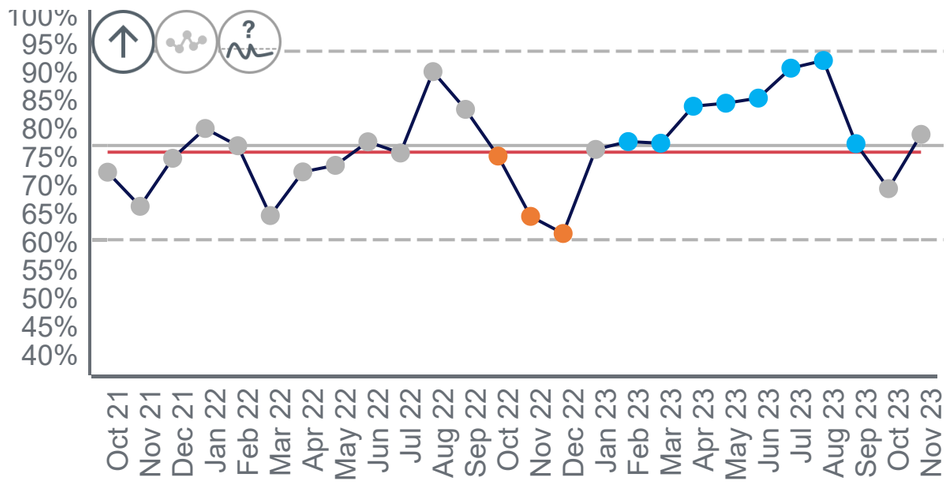
Areas of Concern:

• Some watch metrics showing static performance, including Cancelled Operations (on the day), Clinic letters completed with 10 days, Number of Stranded Patients (LOS>21 days)

Forward Look (with actions)

• Seeking further improvements in ED, to deliver >80% in Q4 and achieve criteria for Incentive Funding • Continued focus on WNB rate, with aspiration to bring reach <8%

ED: % Treated within 4 Hours



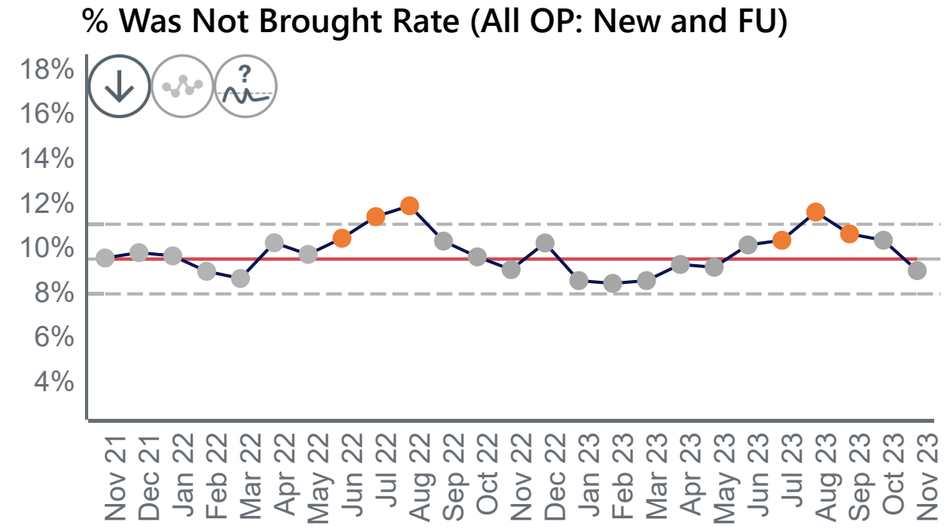
Technical Analysis:

Common cause variation has been observed with performance of 79.5% which is an increase following two consecutive months of reduction in performance following recent improvement. Trust achieving the national target (>76%) in November 2023, with November 2022 at 65%.

Actions:

• Maintain additional urgent care centre capacity through GP partnerships and Advanced Care Practitioner shifts • Additional ED Consultant cover at evenings and weekends over winter • Continuous improvement of PAU pathways

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



Technical Analysis:

WNB rates demonstrates common cause variation. Performance in November 2023 of 9% is inline with when compared to November 2022 (9.1%) and now the first month below the target of 10% since May 2023. Although a number of bookings are still be actioned for the month which could alter November 2023 position.

Actions:

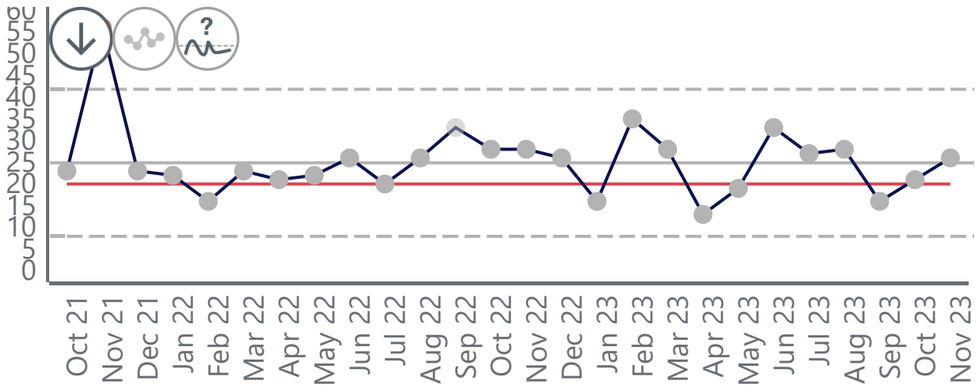
• Priority remains on those specialties where WNB is greater than 10% • WNB reminder calls include ADHD and mental health services • Alder Care Optimisation opportunities include relaunch of PDS demographic software, review of automated letter systems and improvements to the bidirectional text process

Integrated Performance Report | December 2023

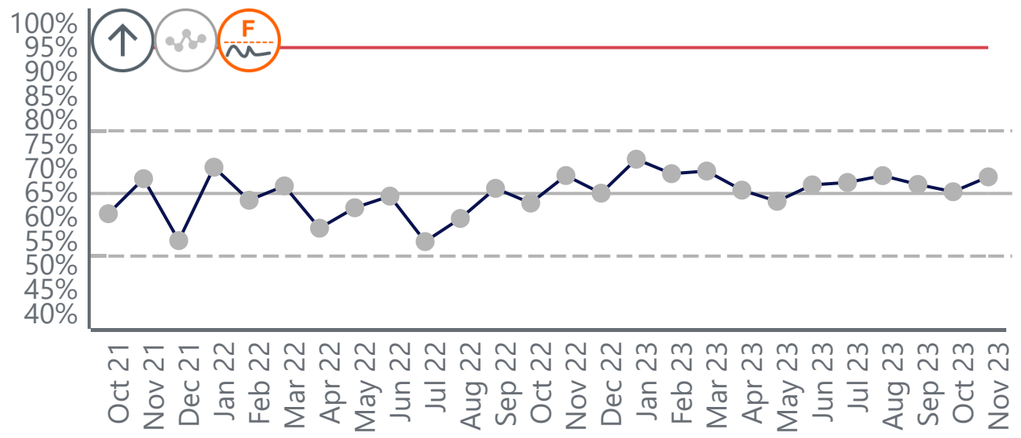
Alder Hey Children's NHS Foundation Trust

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

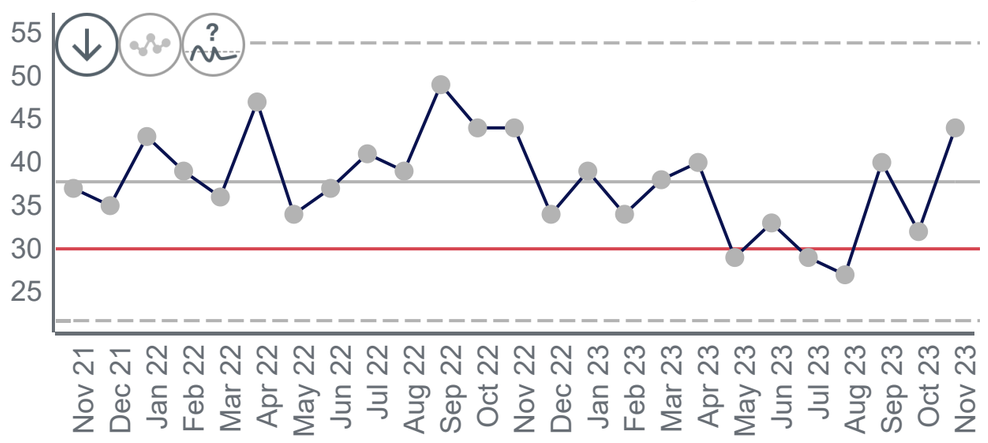
Number of Cancelled Operations (on day of admission for a non-clinical reason)



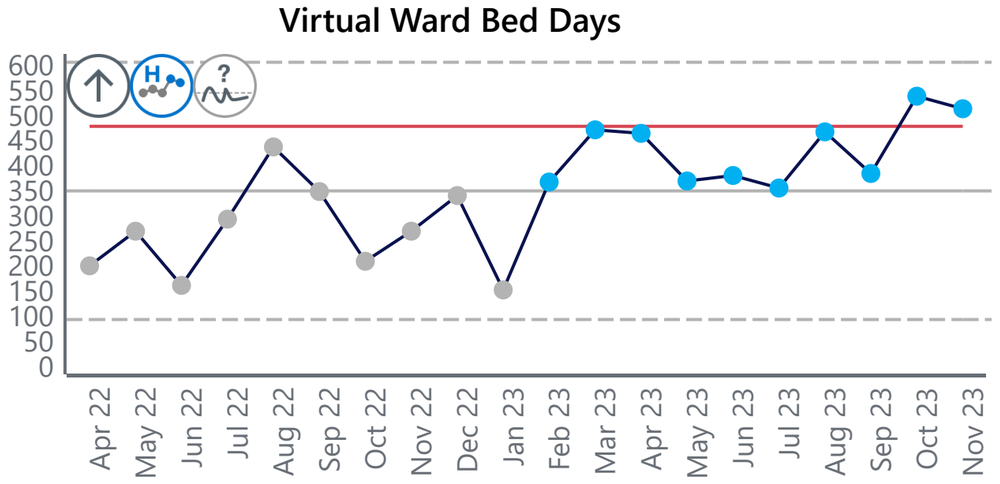
% of Clinical Letters completed within 10 Days



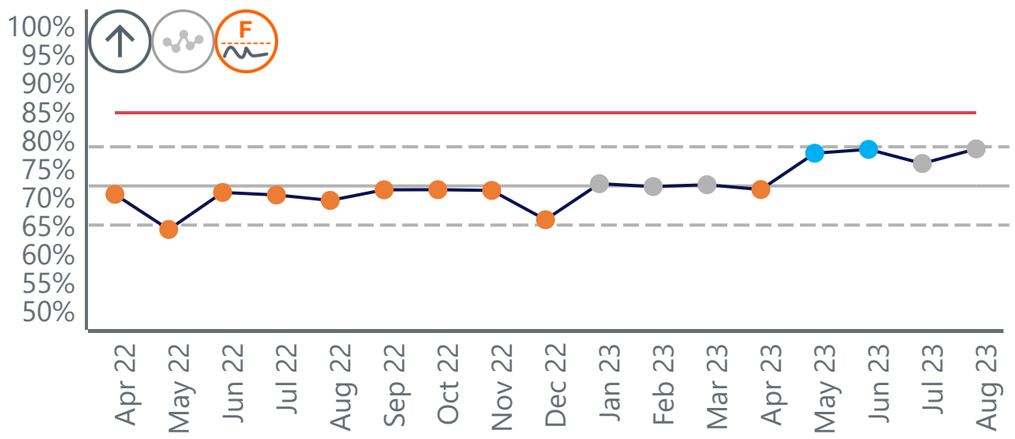
Number of Stranded Patients (21 Days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• Strong Activity Recovery (volume) in November with 103% for DC&IP and 137% for OP • Diagnostic 6 week waits (DM01) up to 88% in Novmber, with expectation of returning above 90% target in Q4 • 100% compliance for access to cancer services, exceeding national standards

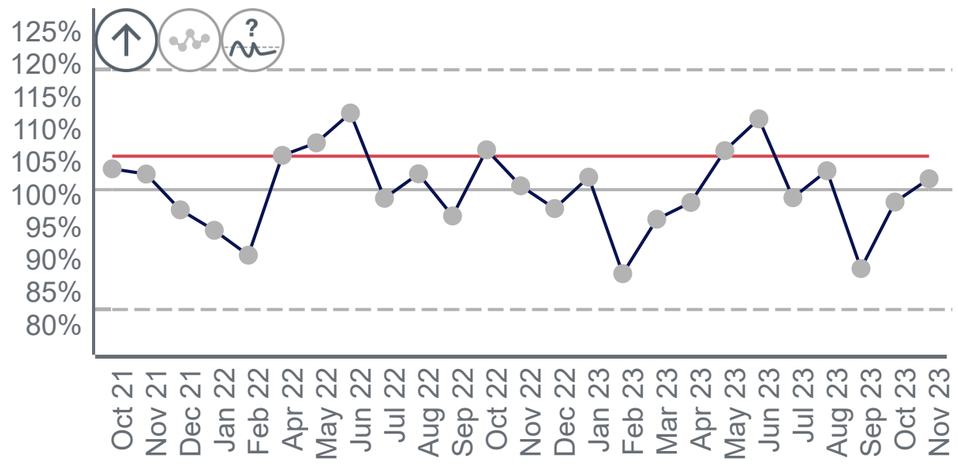
Areas of Concern:

• Long RTT waits with 192 children and young people waiting >65 weeks • ASD and ADHD long waits with almost 1,600 children and young people >65 weeks waiting for diagnosis • IHA within 20 days fallen to 5% in September and pending data for Oct/Nov (was 64% in July)

Forward Look (with actions)

• Review theatre schedule with plan to increase capacity from 1 Feb 2023 (currently 130 sessions per week to ensure sustainability and staff wellbeing through) • Protect ENT, Dental, Spinal theatre capacity • Focus on productivity and increased patients per list in Day Case to drive Recovery • Implement improvement plans with ASD/ADHD and IHA services

% Recovery for DC & Elec Activity Volume



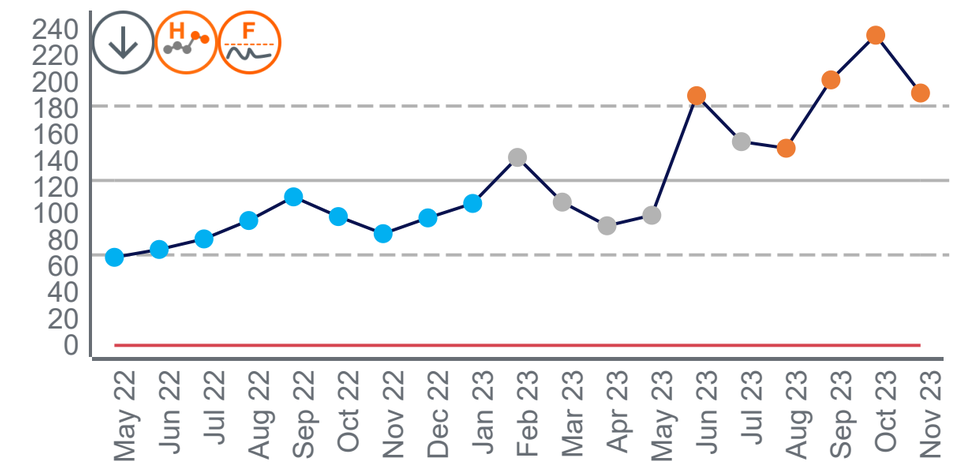
Technical Analysis:

November performance of 103% is 3rd consecutive month of improvement and is +2% higher than November 2022. The data series continues to demonstrate common cause variation.

Actions:

Review of theatre schedule to ensure appropriate reallocation of sessions to the areas with high patient demand in preparation for increased in capacity from 1st February 2024

Number of RTT Patients waiting >65 weeks



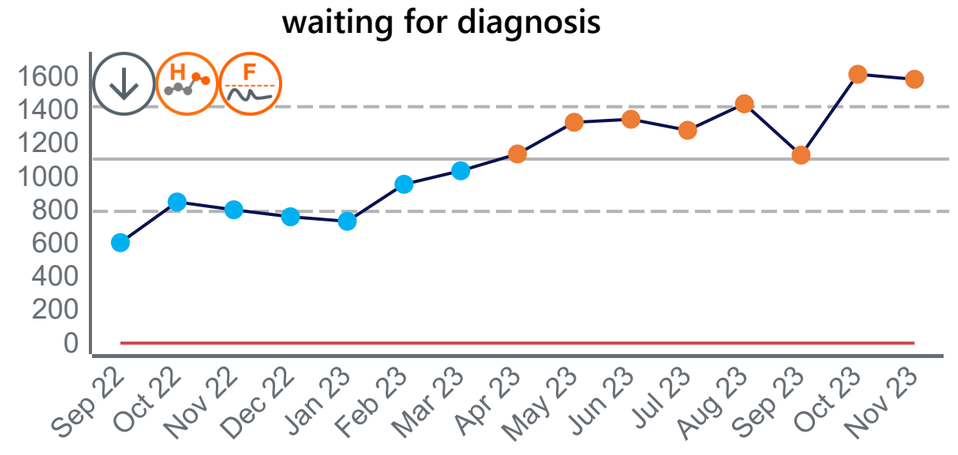
Technical Analysis:

Number of patients waiting > 65 weeks has decreased to 192 in November (236 in October). The current trend is showing special cause variation with an increase in breaches over the last 6 months. Dentistry (n=81) and ENT (n=93) make up 91% of the Trust total.

Actions:

Focus remains on prioritising theatre capacity for Spinal, ENT and Dental surgery, and optimising productivity. All specialties remain on track to eliminate 65ww by March 2024, but there are significant risks in Q4

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



Technical Analysis:

On average 1104 patients are waiting for an ASD or ADHD diagnosis per month. November shows 1583 patients which is above the outer control limits, now showing special cause variation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

Actions:

Improvement actions for ASD and ADHD remain in place including additional staff based on funding from commissioners. Waits for ADHD diagnosis continue to be affected as clinical staff rightly prioritise daily huddles to mitigate impact of global shortage of ADHD medication

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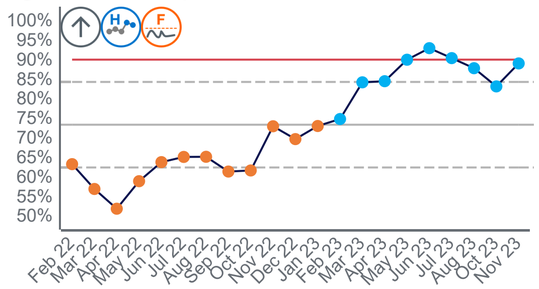
Integrated Performance Report | December 2023

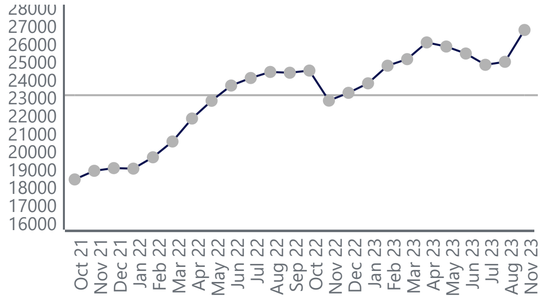
Alder Hey Children's NHS Foundation Trust

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

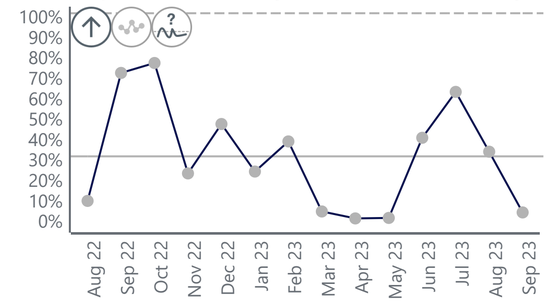
Diagnostics: % Completed Within 6 Weeks of referral



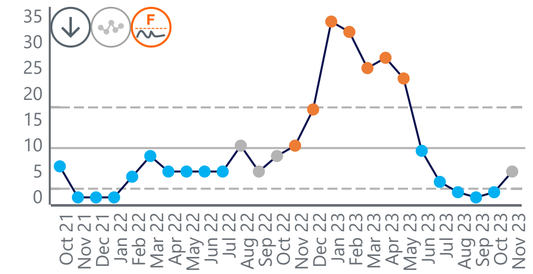
Waiting List Size



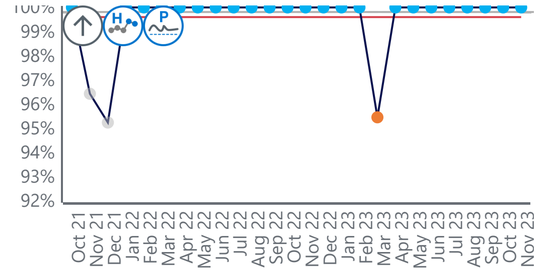
IHA: % complete within 20 days of referral to Alder Hey



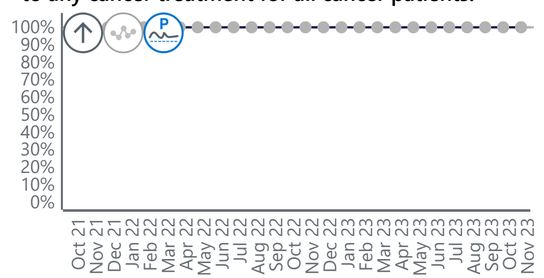
CAMHS: Number of children & young people waiting >52weeks



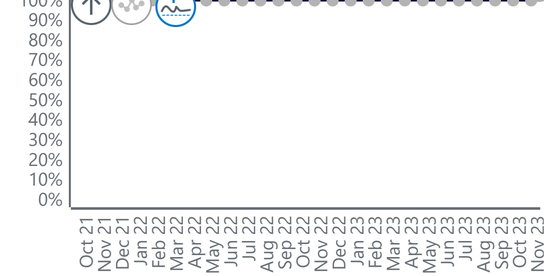
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



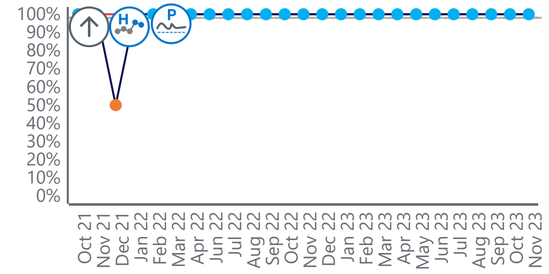
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



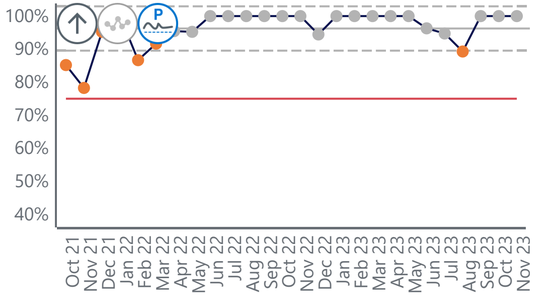
All Cancers: 31 day wait until subsequent treatments



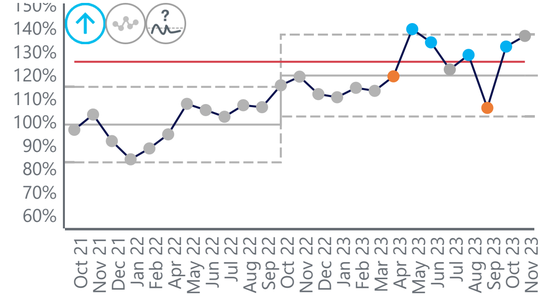
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Collaborating for CYP - Reducing Health Inequalities: Responsive

SRO: For collaborating in communities – Dani Jones & Exec Lead for Health Inequalities – Alfie Bass

Highlights:

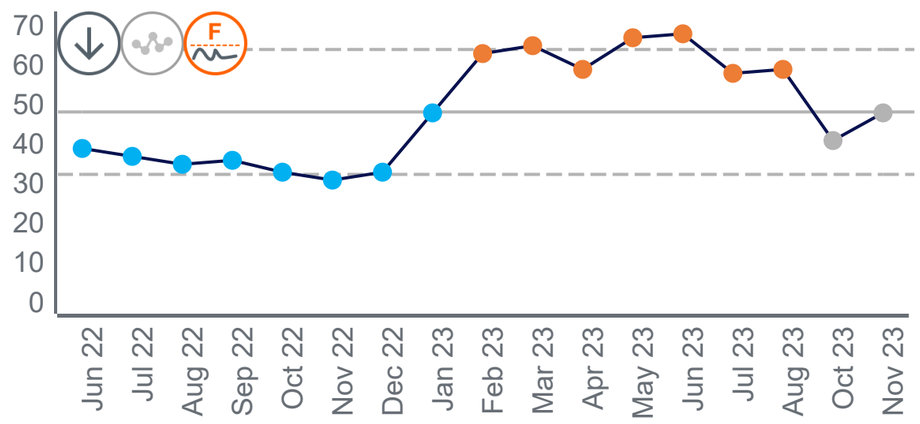
• These measures will be updated on a quarterly basis given the nature • This is a new direction of reporting for the integrated performance report, recognising both the Trust's ambitions in terms of reducing the impact of health inequalities and new strategic drivers such as Core20+5CYP. • A 'learn 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)

• City wide Lung Health programme in development with a focus on reducing health inequalities and prevention for CYP with respiratory conditions • Wellbeing Hub in development to provide a universal / targeted and specialist poverty proofing and wellbeing offer to all CYPF (April 2024) • Prevention in pathways work active across the organisation – Healthy Weight Mini Grant Scheme, Mini Mouth Care Matters, Health Inequalities Toolkit and Advice on Prescription for long waiters • Liverpool City wide Oral Health Strategy in development supported by Beyond • Deep dive into waiting times for CYP with LD (where this is captured on EPR) undertaken by PH Consultant; Exec agreement as a priority cohort for 'Personalise my Care' with practical action to address waiting times for these CYP.

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

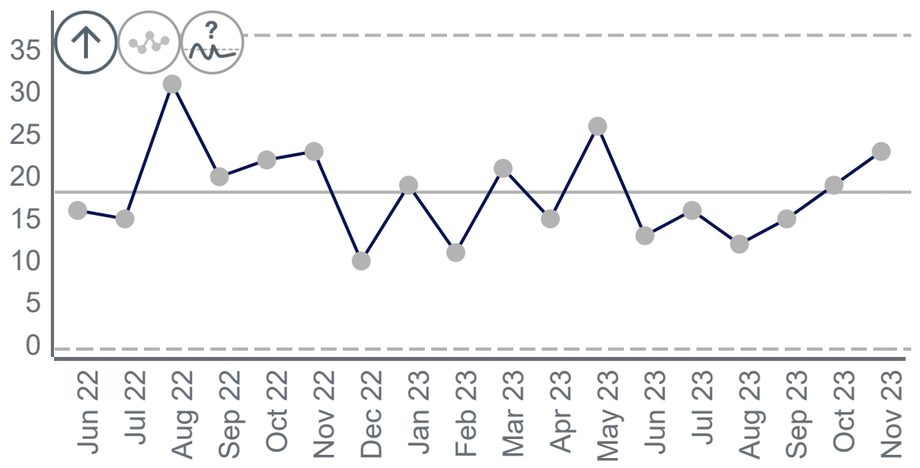


Technical Analysis:

Steady decline in children waiting >52 weeks up until Jan 23 where we have seen a sudden increase. Currently 48 children waiting >52 weeks, which increased by 7 from October 2023. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

CAMHS: Number of CYP of BAME background referred



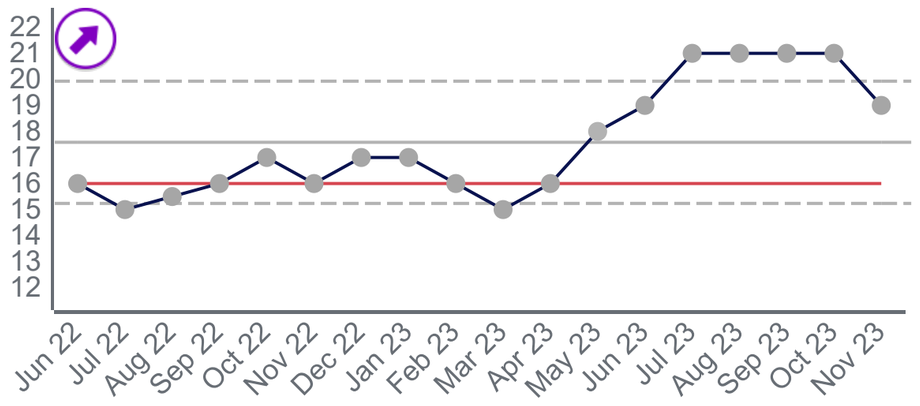
Technical Analysis:

New Metric which shows on average 18 referrals of BAME background are accepted per month, November shows 23 patients. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Defining metric and accurate capture of data as in progress, including national reporting of data supported by Analytics team and Public Health

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 19 weeks as end of November above the previous 12 month baseline target of 16 week median wait for non-LD patients, although a decrease from 21 weeks in October. Waits for non LD patients have remained steady at 17 weeks.

Actions:

Metric and associated improvement plan are work in progress supported by Analytics team and Public Health. CYP with LD aligned as priority cohort into 'Personalise my Care' - as outlined in summary above.

Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

Sustained reduction over 7 months for staff turnover. Analysis of this detail to evaluate impact of this continuing downward trend. Improved activities within Divisions to tackle Long Term Sickness (LTS) resulting in a 4% level, with Short Term Sickness (STS) at 2%- overall 5.8%. RTW (return to work reviews) recording improved to 79%, a 5% increase since October 23. PDR recording has improved 3% to 70% since October 23

Areas of Concern:

Overall sickness absence is marginally lower than October at 5.8%, but with an expectation that a downward trend will arise due to winter pressure. Ongoing monitoring required to maintain and improve staff and service availability.

Forward Look (with actions)

Anticipating evidence of increase in sickness absence over the winter period as per trend of previous years. Actions:
- Ongoing presence around absence support/advice continues in each division, at Boards, and for Division managers.
- New resignation & exit interview process is now online to capture qualitative data and analysis of turnover
- Review data on PDR completions per division is currently being gathered for ongoing action

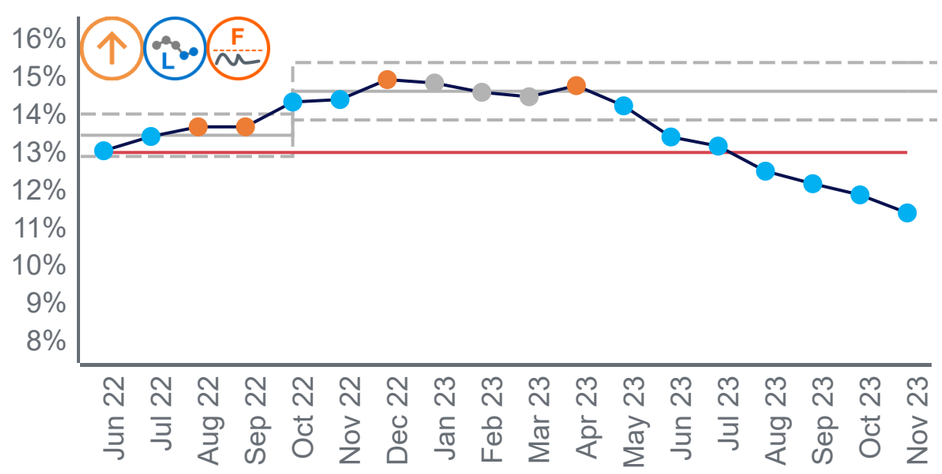
Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

Not applicable – this metric is in development

Staff Turnover



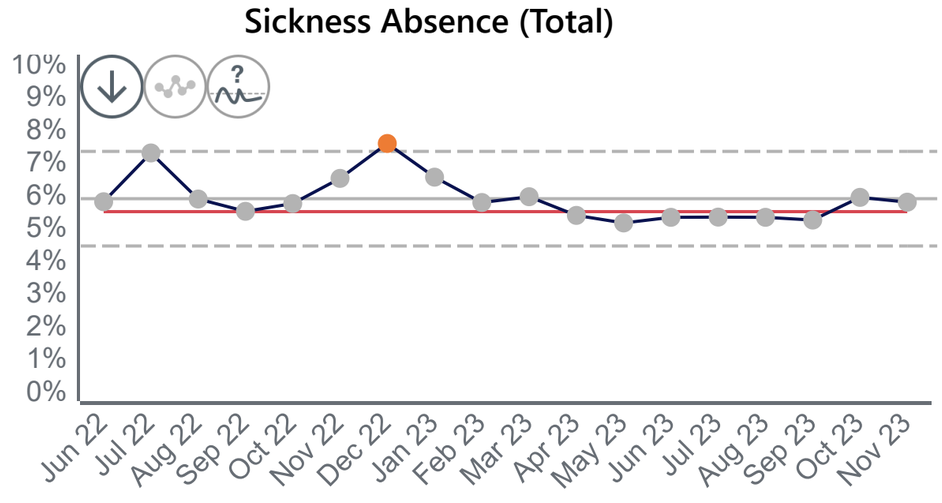
Technical Analysis:

Staff Turnover has demonstrated special cause variation , 11.4% is the 7th consecutive month with a reduction and 4th consecutive month within target.

Actions:

Turnover marginally reduced since Oct at 11%. Relative target for measuring overall turnover was previously adjusted from 15% to 13%. Analysis of divisional use of other resource routes (e.g fixed term) is being explored.

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in November is 5.82% which is over the 5.5% target. A decrease from October at 5.92% and November 2022 was 6.5%. November 2023 performance comprises STS at 2.22% and LTS at 3.60%. Still demonstrating common cause variation, 2nd consecutive month above target since March 2023.

Actions:

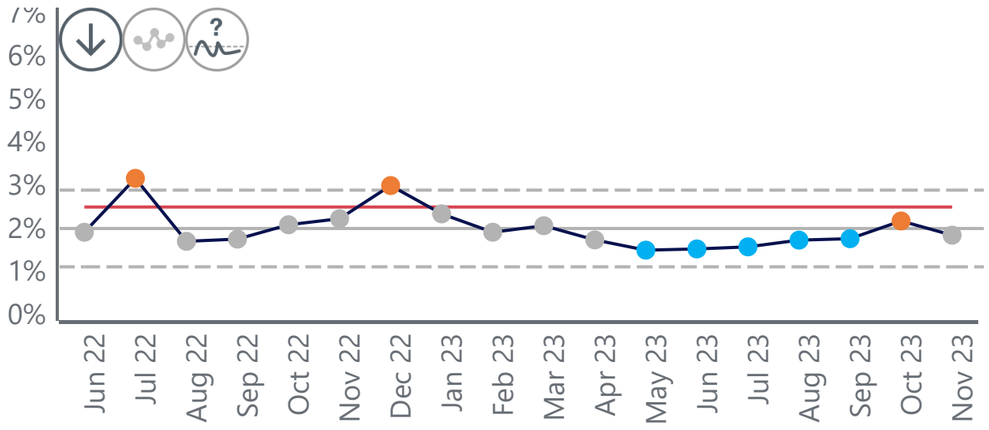
Continuing onsite discussions at Divisional Boards, management meetings and awareness raised with staff via wellbeing activities in Divisions; focus on Stage 3 LTS, resulting in returns or resignations. Return to Work discussions are being reinforced and new online form now in place. Proactive winter vaccine programme (flu/covid) continues onsite

Integrated Performance Report | December 2023

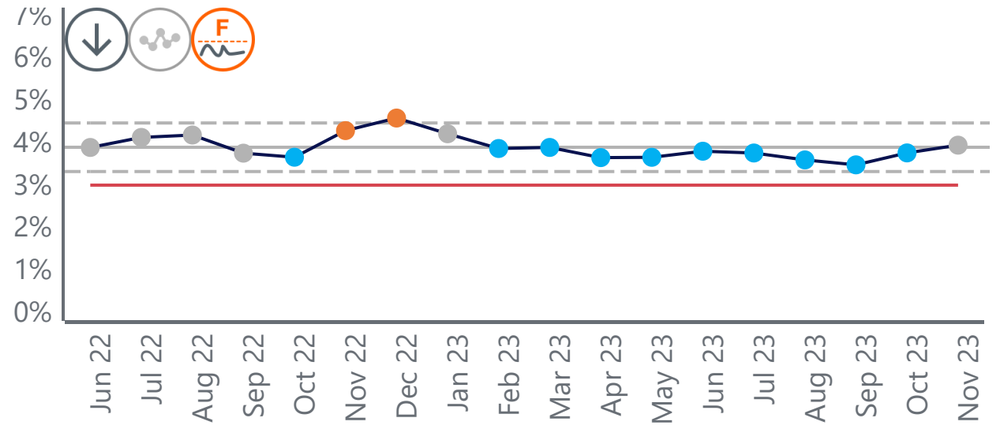
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

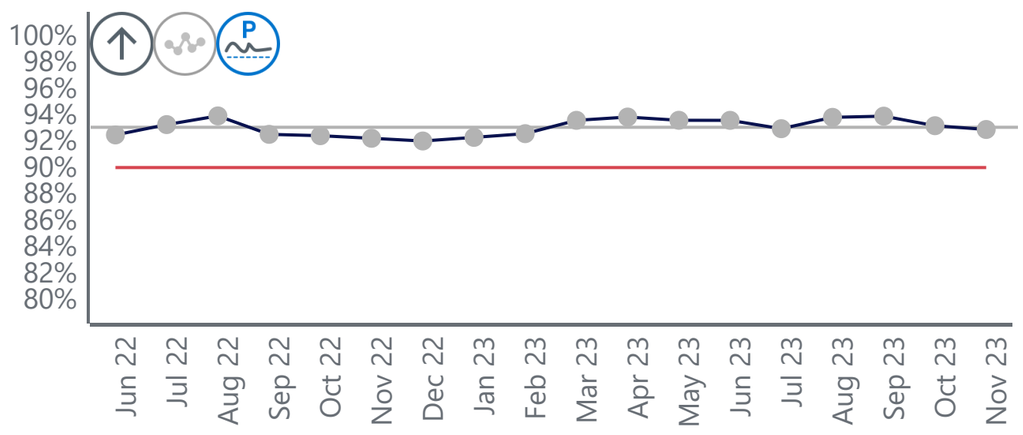
Short Term Sickness



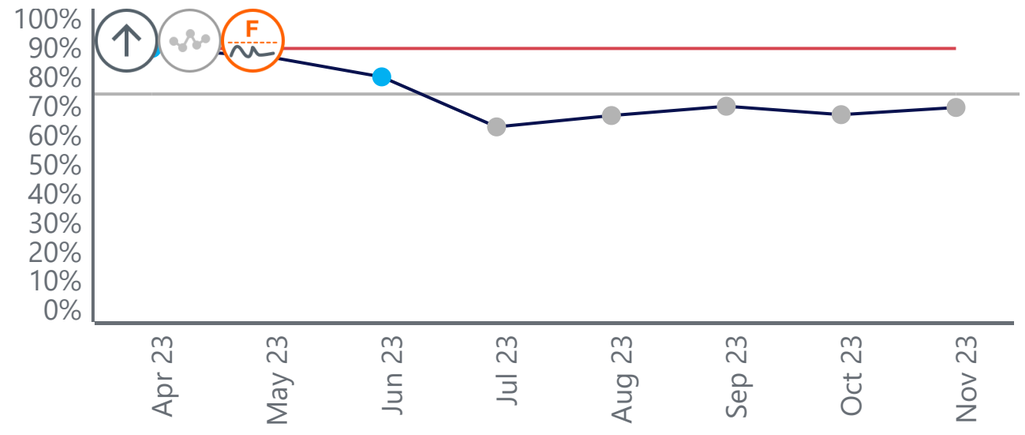
Long Term Sickness



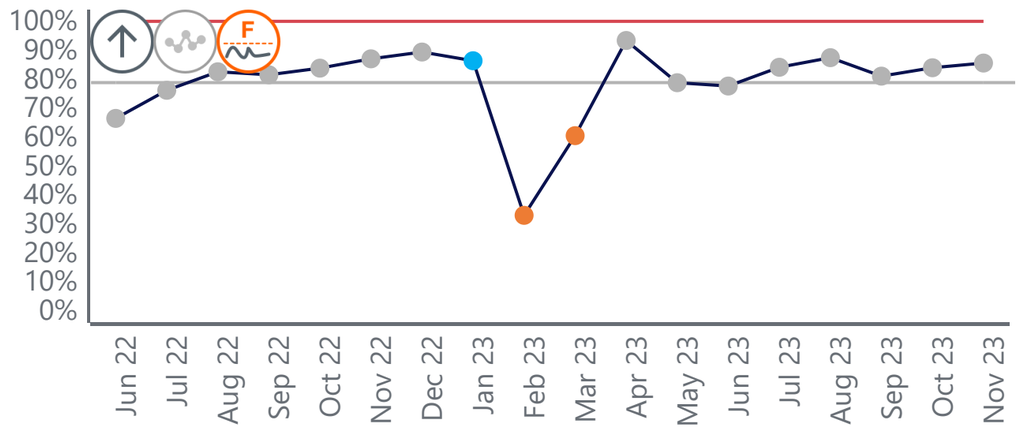
Mandatory Training



% PDRs completed since April



Medical Appraisal



Staff movement / Churn rate - In Development

Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

In November(M8), the Trust is reporting a £1.5m surplus (£1.5m ytd) which is in line with plan. Forecasting to achieve £13m surplus following revised H2 plans subject to CIP risk. CIP £1.3m behind plan ytd. Overall £13.8m CIP has been transacted with £3.9m in progress. On track to deliver subject to red & amber schemes. Cash has remained high in line with plan & capital in line with expectations.

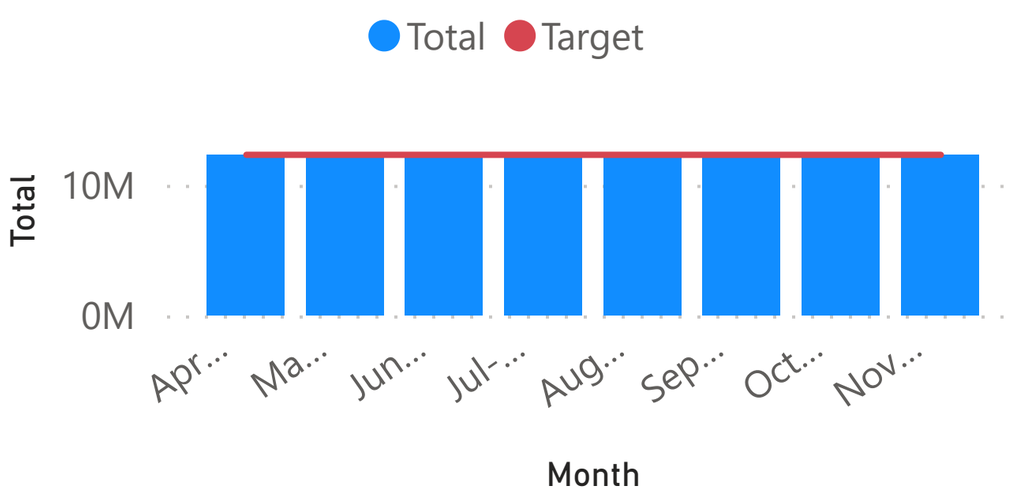
Areas of Concern:

CIP gap closed in year subject to delivery of red & amber schemes £3.9m. Challenging £13m control total surplus plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets. Recurrent CIP also area of concern given the gap recurrently is £11.9m which will be carried into 24-25 if not identified.

Forward Look (with actions)

Continued cost control to reach the £13m surplus requirement by end of the financial year. Urgent focus required on recurrent efficiency. Further H2 meetings taking place in December. Work also continues with divisions on transformation schemes to identify recurrent changes and benefits to be reported to January RABD.

Revenue Position (Year End Forecast)



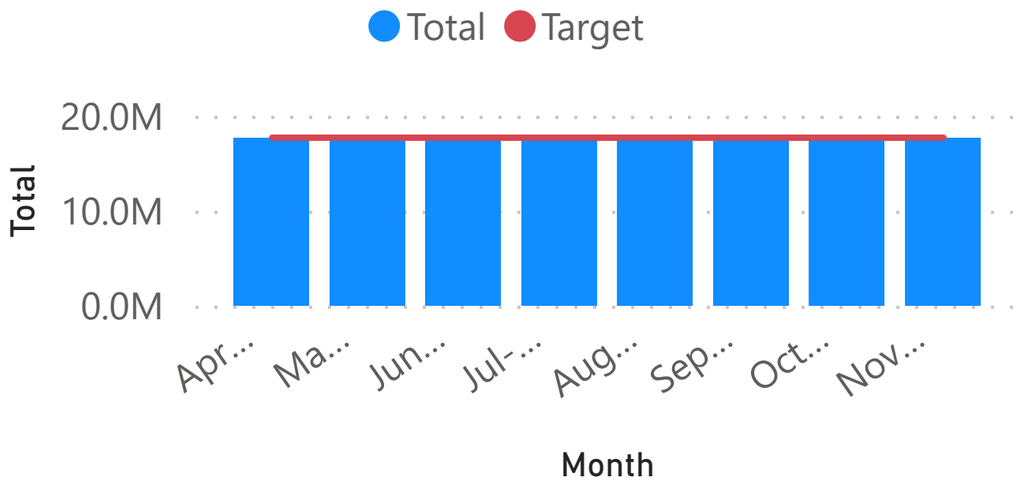
Technical Analysis:

Current forecast remains to achieve plan however risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures including industrial action.

Actions:

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

CIP Position (Recurrent Full Year Effect)



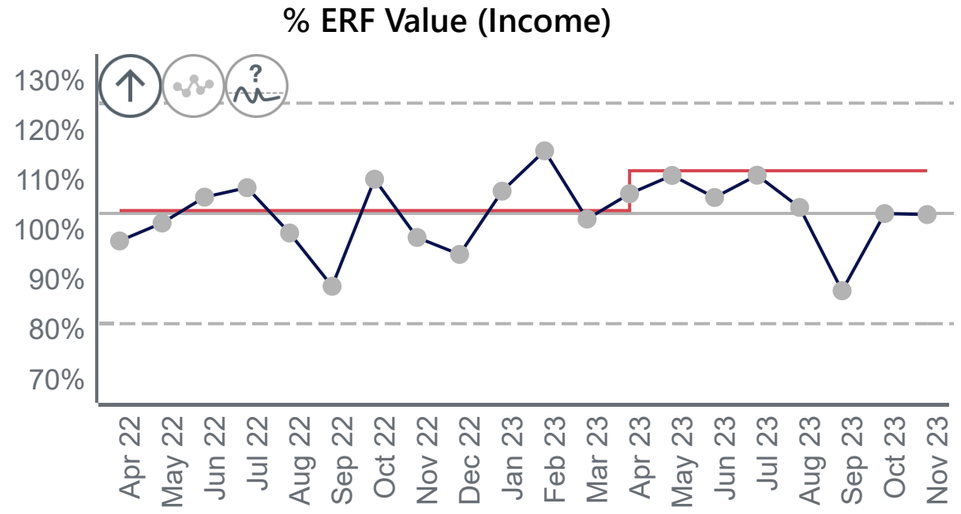
Technical Analysis:

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

Actions:

Support required with exec leads and transformation to identify the large scale opportunities. Work continues on wider change programmes to be reported to RABD in Jan. Still large gap recurrently of £11.9m.

% ERF Value (Income)



Technical Analysis:

November performance estimated at 103.2%. YTD performance estimated at 103.8%.

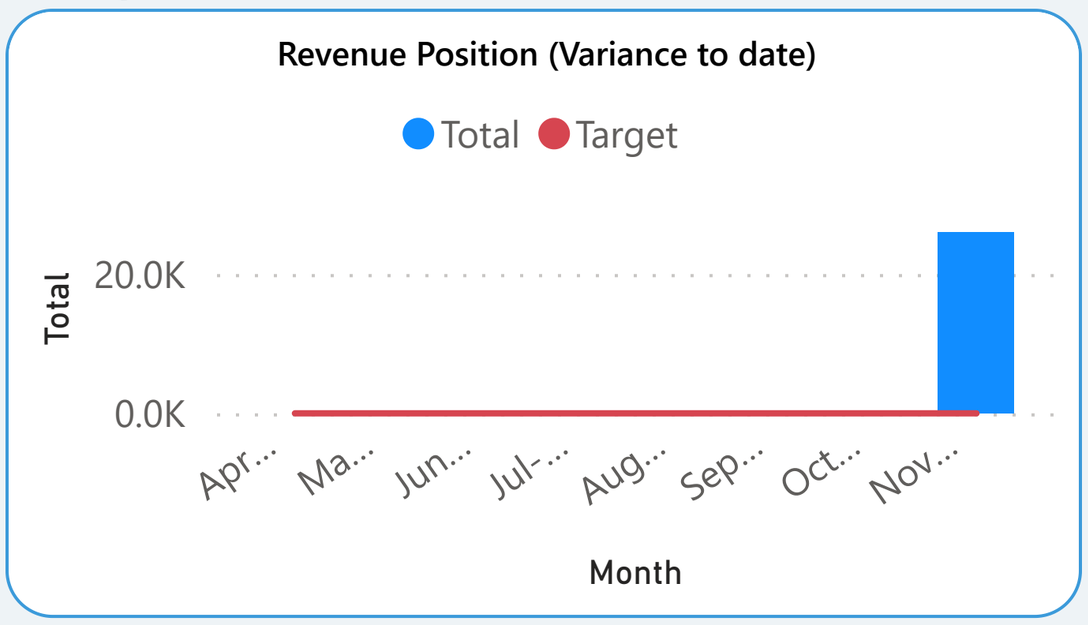
Actions:

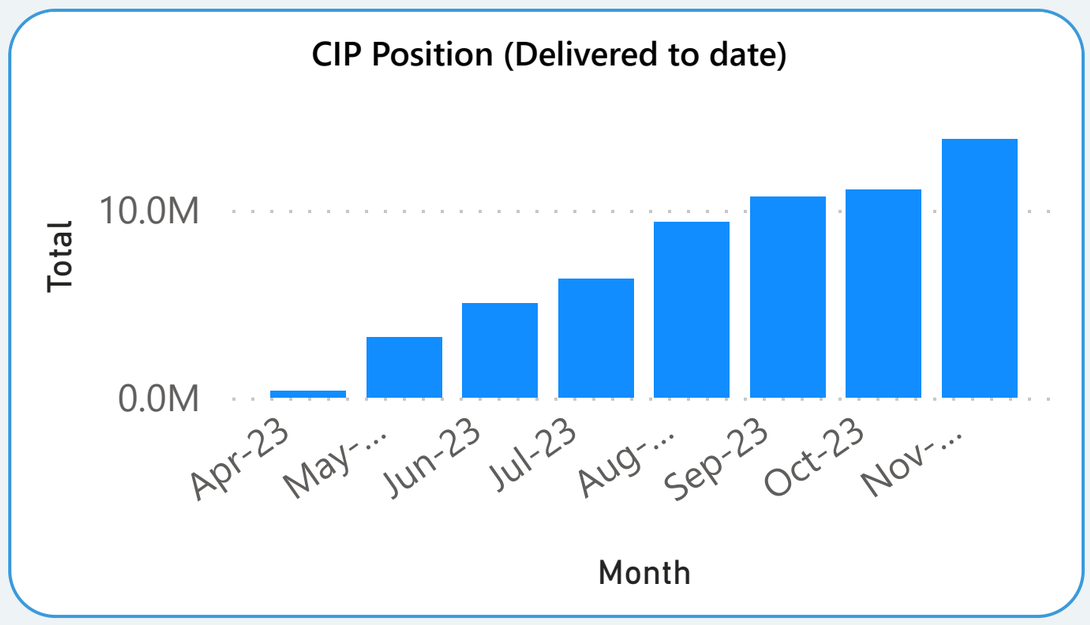
Continue to monitor those areas (at POD and speciality level) that are under performing versus plan.

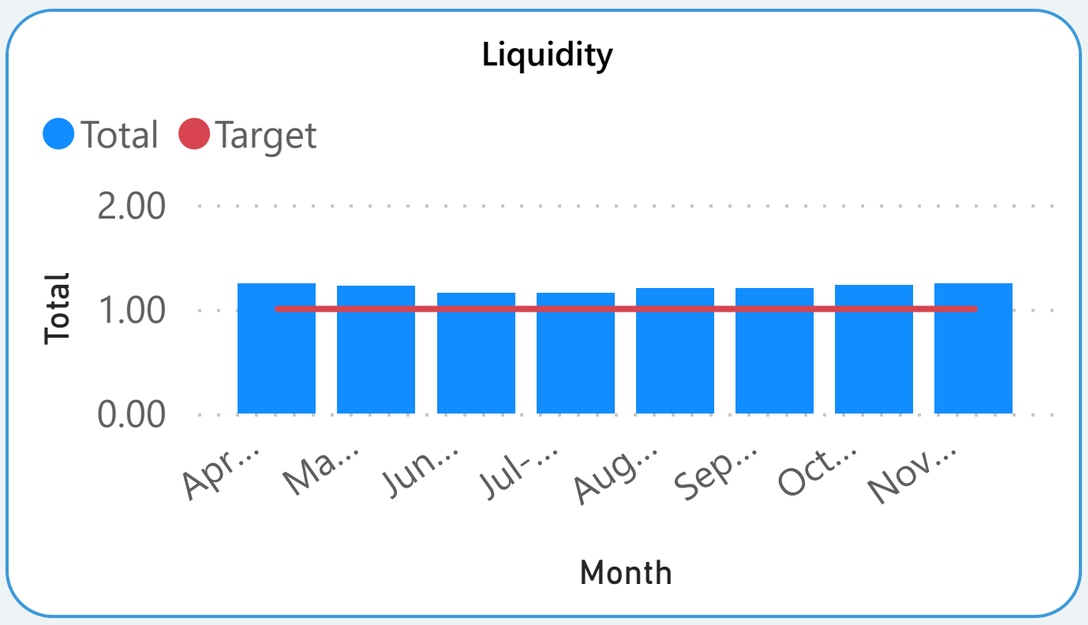
Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

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







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Risk reporting continues to be embedded with In Phase. Ongoing support provision in place via divisional governance and corporate governance teams. Weekly shared learning group established with LCHC regarding ongoing development of risk reports. Onsite meeting with InPhase to improve the reporting functionality. Continued shared learning sessions with LHCH on report visualization development.

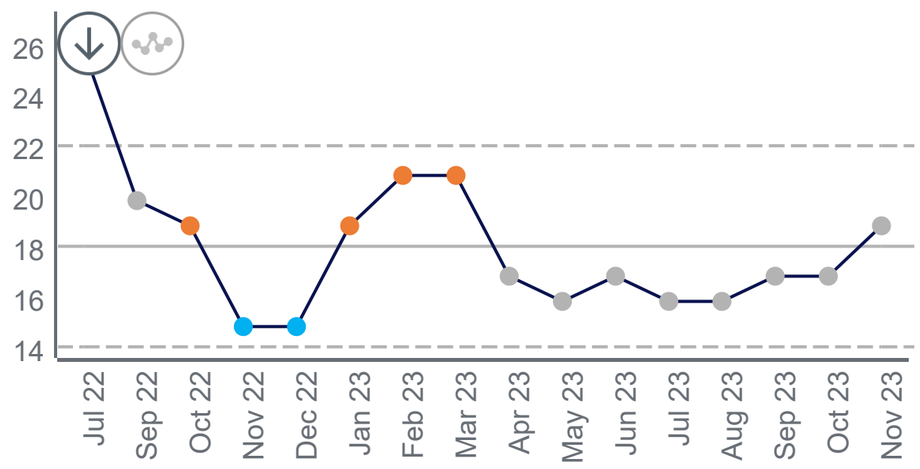
Areas of Concern:

End users reporting that not all risks are saved on InPhase following review. Issue escalated to InPhase. Reviewed by InPhase technical team and rectified with soft wear updated. Report functionality continues to be developed by digital/BI team. Remains on risk register but risk score reduced from 12 to 9 (No 22 score 3x3=9) until fully mitigated. Number of long standing high moderate risks (>12 months) on register remains static despite several mitigations in place. Deep dive of long standing high moderate risk to be undertaken on Januarys 24 Risk management Forum

Forward Look (with actions)

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

Number of High Risks (scored 15 and above)



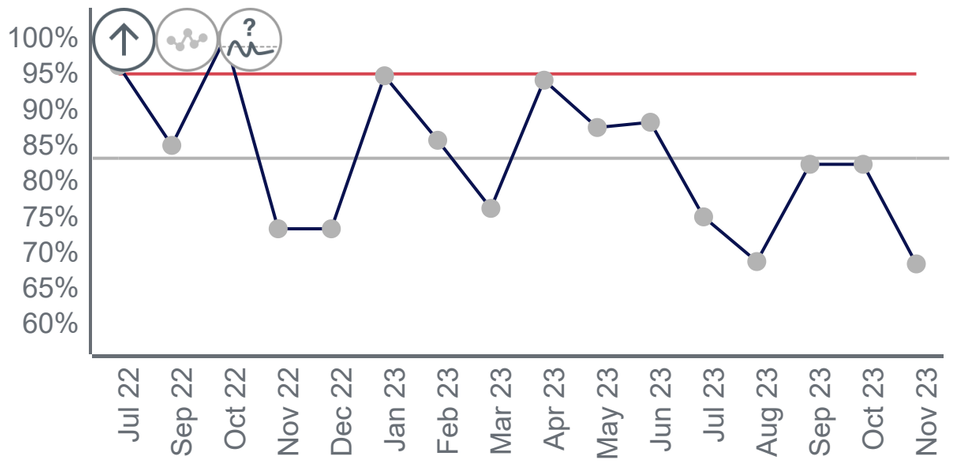
Technical Analysis:

There are 19 High Risks on the risk register at the end of November. Overall, this remains stable and is within the normal range.

Actions:

19 high risks on risk register as of 30th November 23

% of High Risks within review date

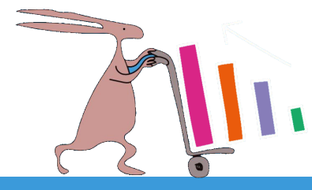


Technical Analysis:

Compliance of reviewing High risks within date is variable, with 6/19 risks overdue at the end of November. Action is required to ensure consistent compliance with the 95% target.

Actions:

68.4% high risks within review date (13/19). 6 high risks overdue review at time of reporting all of which have been escalated directly to the divisional leads/directors for urgent review



Smartest Ways of Working - Safe Digital Systems- Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

Feedback on national funding to support the development of AlderHeyAnywhere has been positive and formal announcement expected in December. AlderCare Phase 2 (Optimisation) has commenced and a set of development priorities have been agreed with the Divisions. The first cohort of developments are expected to be completed in December. Good progress has been made with AlderCare Reporting including the successful validation of the Waiting Lists alongside other key reports.

Areas of Concern:

Validation of remaining reports ongoing but expected to complete in December.

Forward Look (with actions)

Insight-Led Decisions workshop to take place in December with key stakeholders around the hospital. This will be an opportunity to shape the priorities, focus and benefits for the 2030 Strategic Initiative. Plan to be developed to deploy AlderHeyAnywhere Phase 1 taking direction from Revolutionising Care Board

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

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

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

Collaborating for CYP - Green Plan: Well Led

SRO: Mark Flanagan, Director of Marketing and Communications

Highlights:

Recent increase in energy consumption resolved. Workshop with technical teams from trust, SPV and MITIE identified 3 key problems driving energy use. New compactor and baler in place.

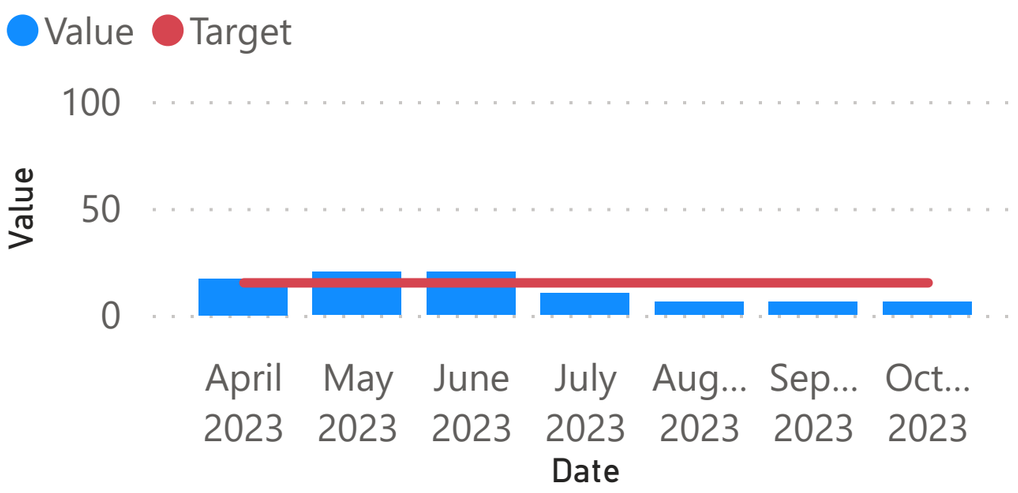
Areas of Concern:

CHP reliability still low. MITIE working on a maintenance contract to support this.

Forward Look (with actions)

Plan to resolve 3 key problems being developed. Gloves off project ready to go once funding agreed. ATE/NHSE project kicking off in December.

Green Plan: Reduce Carbon Footprint



Technical Analysis:

Recent energy rises driven by ROCK works removing sludge in pipes. Energy increase concentrated in GSHeat Pump circuits.

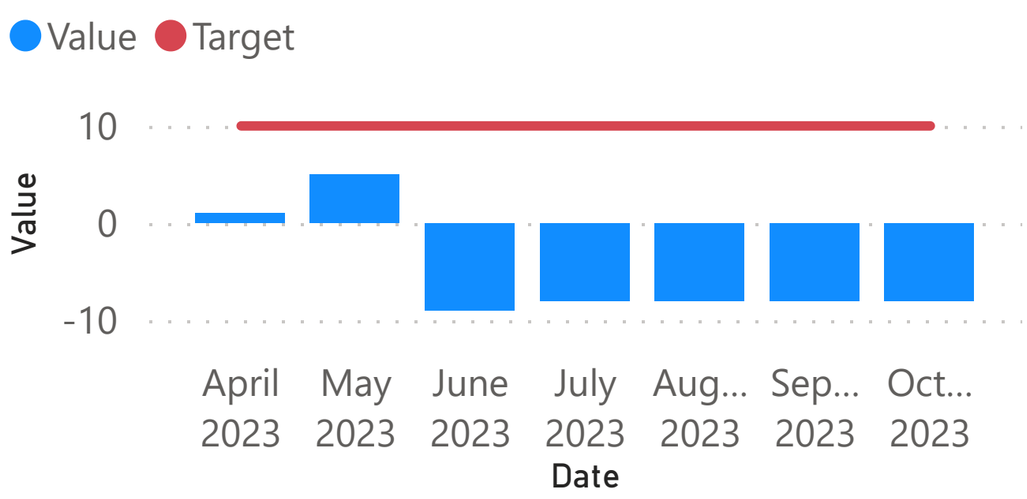
Solar Panel Project

Actions:

Project finished.

Taking business case to IRG

Green Plan: Reduce Energy Usage



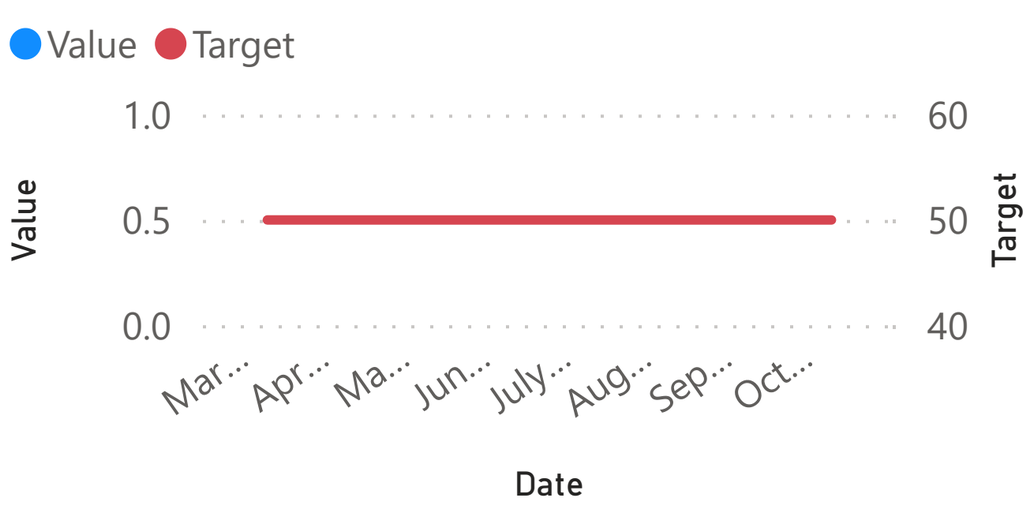
Technical Analysis:

Car park LED

Actions:

SPV completing tender

Green Plan: Reduce Waste



Technical Analysis:

Compactor and baler now arrived

Actions:

Measure savings

Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

•Reduction in WNB rates for third consecutive month (12%) and divisional improvement project in place supporting new pathways including early and late HCA appointments and transport pilot project commenced in CAMHS

•ASD/ADHD number waiting over 65 weeks reduced from previous month

•Number of minor harm incidents reduced from previous month

•Compliance with mandatory training remains high

•Staff Survey overall response rate for Division 66% and more staff completed than last year

•Reduction in sickness absence back to 6%

•Continued reduction in staff turnover to 13%

•Favourable financial position due to additional income received from Service Level Agreements and continued vacancies across teams. CIP plans have progressed and Division has achieved target of £1.6m for this year, of which £1.1m is recurrent.

Areas of Concern

• Continued high level of demand for ASD and ADHD assessment and impact of ADHD medication shortage on assessment waiting times

• Increase in number of children and young people waiting over 52 weeks in CAMHS (5)

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

• Compliance with IHA statutory timescales remain a challenge for the division and improvement plan in place to support

Forward Look (with actions)

• Continued weekly meeting to review impact of ADHD medication shortages on service including capacity and waiting times.

• Improvement programme established in division which reports monthly to divisional board

• Increased capacity for IHA to go live in January 2024

• Contribution to development of Cheshire and Merseyside Neurodiversity pathway following launch event in December

• Improvement in PDR compliance and focus for remaining quarter to ensure all staff have had an appraisal completed within the last 12 months.

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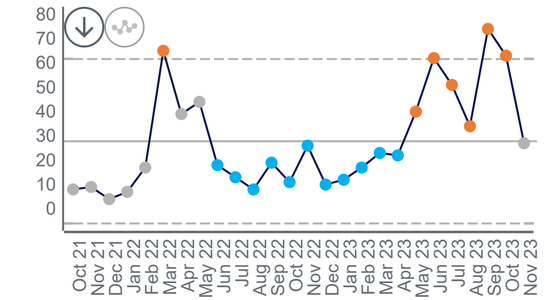
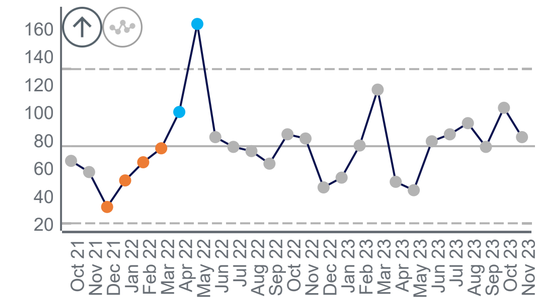
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

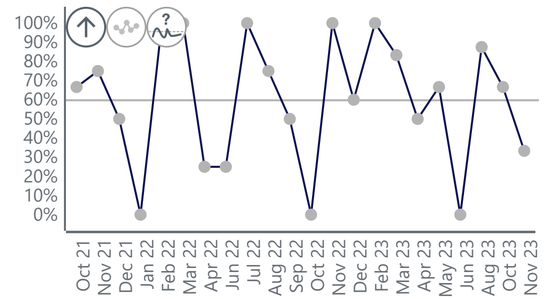
Number of Incidents rated Minor Harm and above



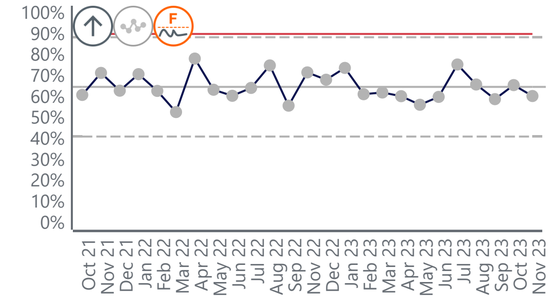
Number of Incidents rated No Harm and Near Miss



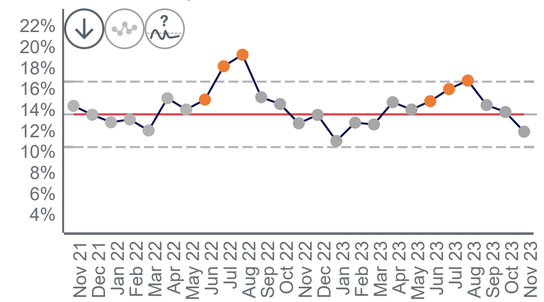
% Complaints Responded to within 25 working days



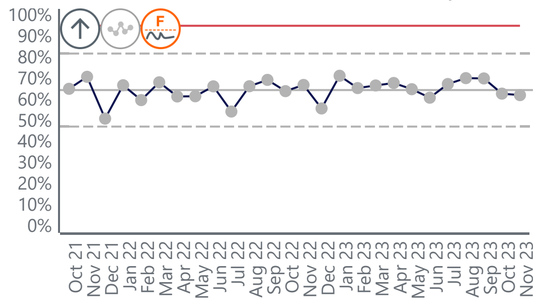
% PALS Resolved within 5 Days



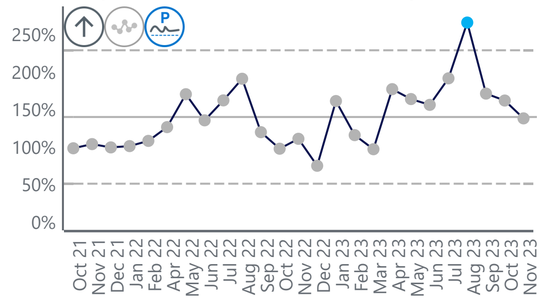
% Was Not Brought Rate (All OP: New and FU)



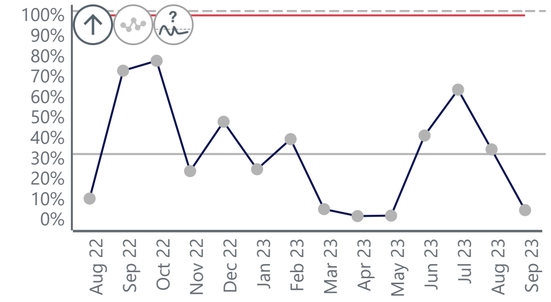
% of Clinical Letters completed within 10 Days



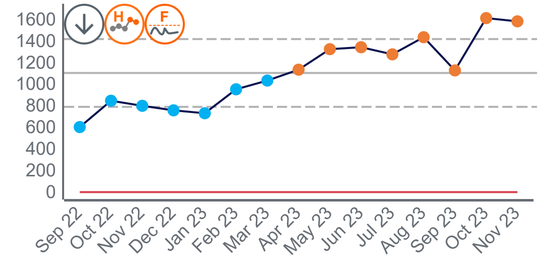
% Recovery for OP New & OPPROC Activity Volume



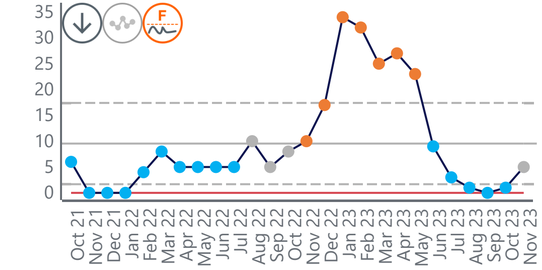
IHA: % complete within 20 days of referral to Alder Hey



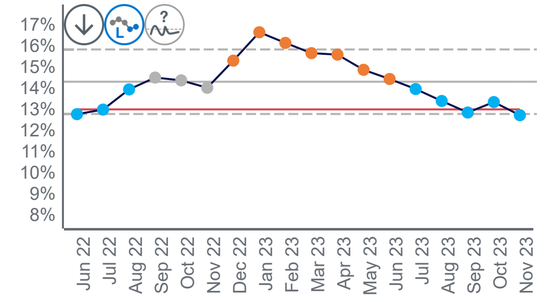
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



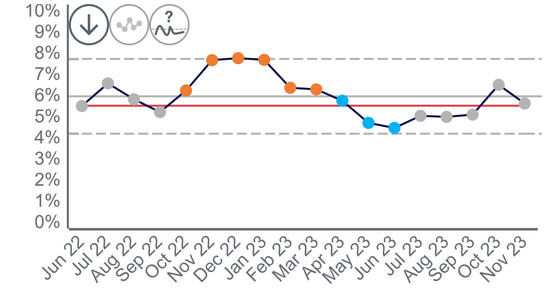
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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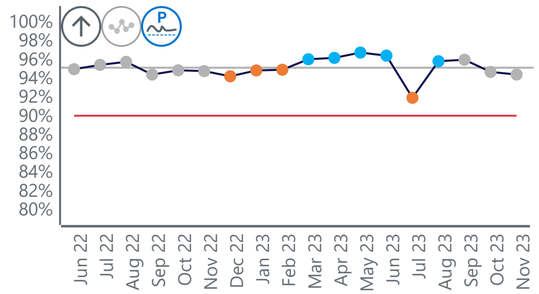
Divisional Performance Summary - Community & Mental Health

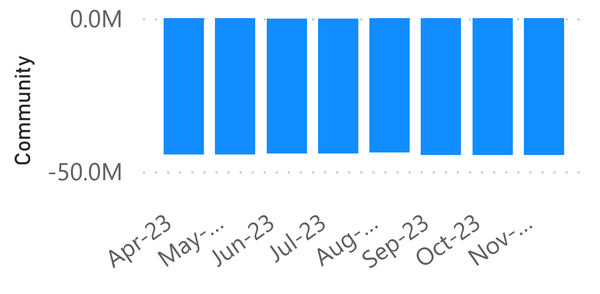
Mandatory Training



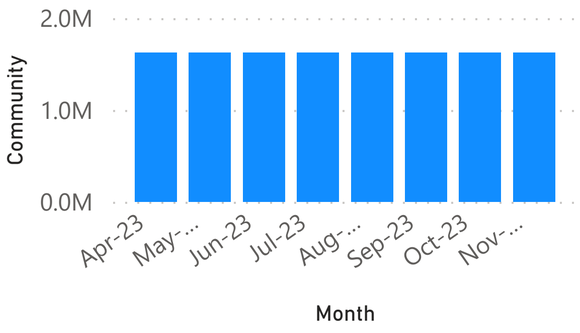
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

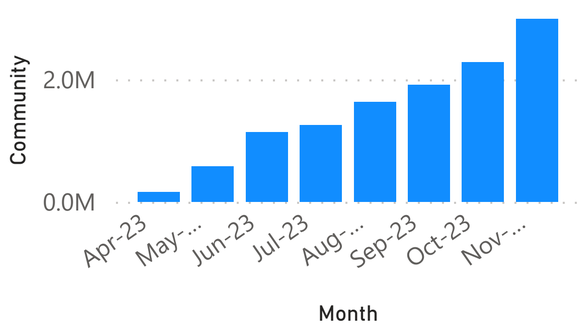
Revenue Position (Year End Forecast)



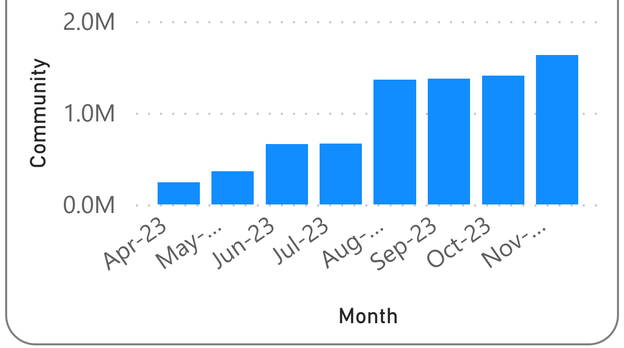
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

•Improvement in ED 4 hours performance by 7% and therefore achieving national standards

• Reduction in WNB rate following implementation of high impact actions to address

• Improved diagnostic compliance to 89%, slightly below target; however, key actions in place to ensure continued improvement

• Health and wellbeing week held in the division noting over 800 staff members participated in an array of events held across the week

• Continued reduction in staff turnover

• Improvement in ED F&F associated with reduction in waiting times

• Sustained compliance with all standards for cancer care

• Delivery of over 2.5mil CIP YTD

• Reduction in sickness absence of 6.2%

Areas of Concern

•Increase in patients waiting over 65 weeks, owing to reduction in capacity with Alder Care roll out and reduced theatre capacity. Increased review of scheduling to avoid further decrease

• Reduction in Emergency Department Sepsis (delivering antibiotics within 60 minutes) 84% in month, all delays were reviewed by the clinical team

• Increase in incidents rated minor harm and above for 3rd consecutive month

• Neurology service review underway way to ensure safe clinical model is provided while recruiting to immediate consultant vacancies

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

Forward Look (with actions)

• Revised focus on forecasting and activity levels to improve waiting times and income generation

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

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

• Focus on coding review to support income and CIP opportunity

• Continued DMO1 working group to improve compliance

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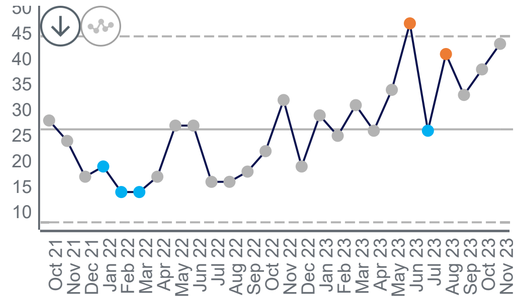
Divisional Performance Summary - Medicine

Number of Incidents rated Minor Harm and above



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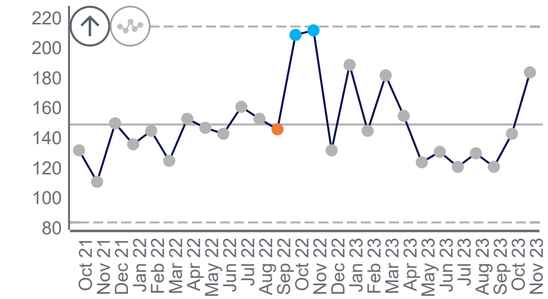
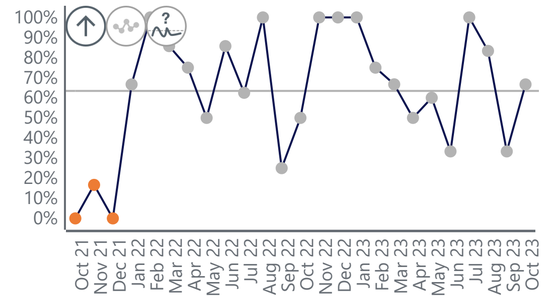
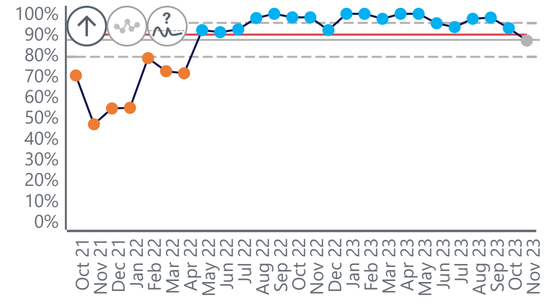


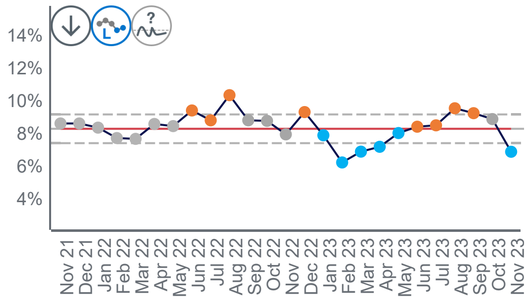
% Complaints Responded to within 25 working days



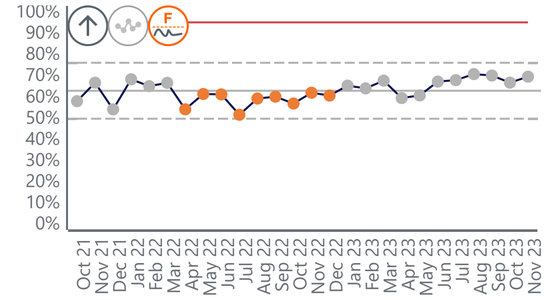
% PALS Resolved within 5 Days



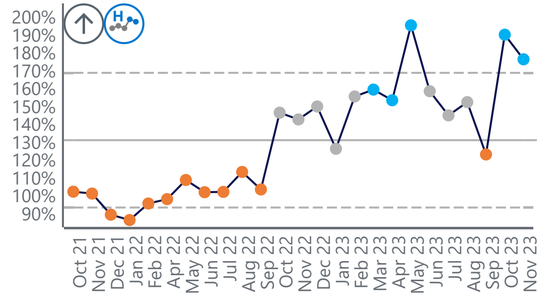
% Was Not Brought Rate (All OP: New and FU)



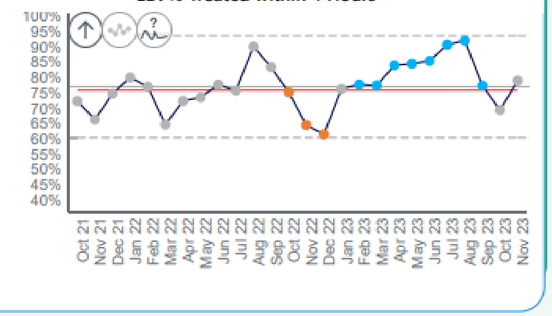
% of Clinical Letters completed within 10 Days



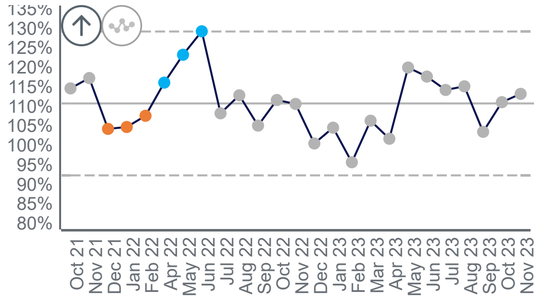
% Recovery for OP New & OPPROC Activity Volume



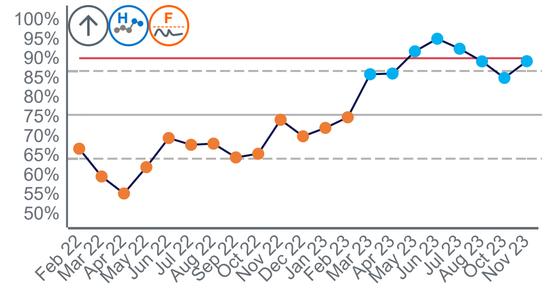
ED: % Treated within 4 Hours



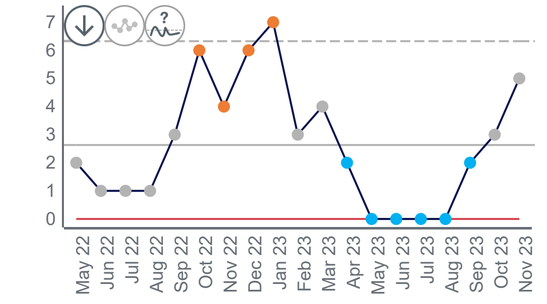
% Recovery for DC & Elec Activity Volume



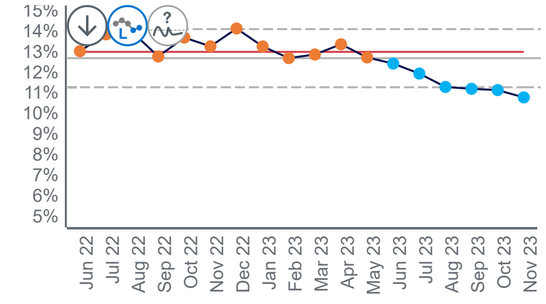
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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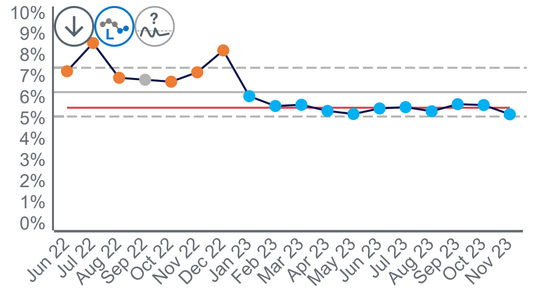
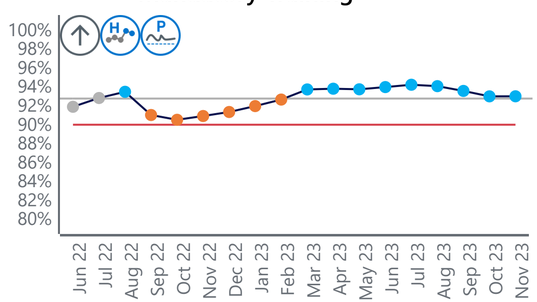
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

Sickness Absence (Total)



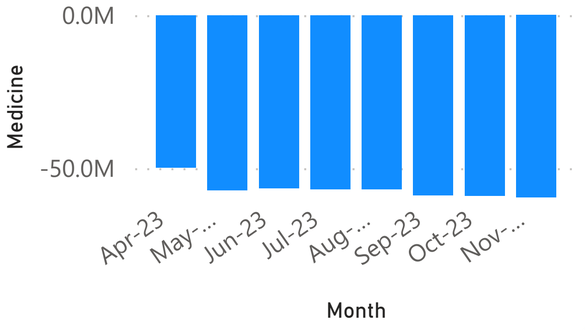
Mandatory Training



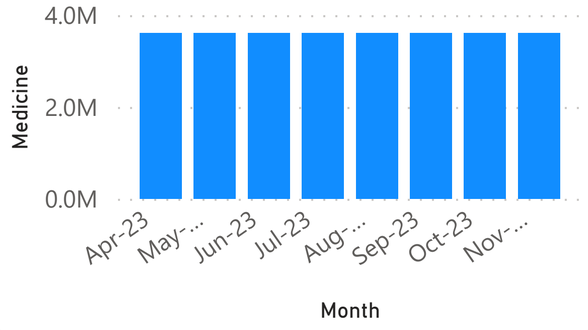
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

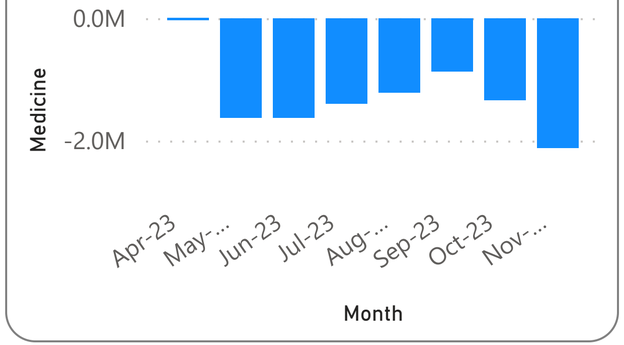
Revenue Position (Year End Forecast)



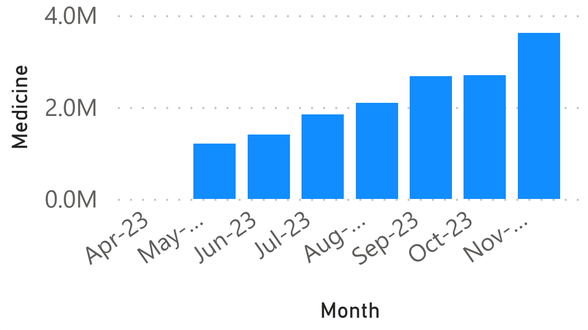
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Significant increase in DC & Elective recovery in November

• Significant overperformance in OPNEW and PROCs at 116% of 2019/20 activity volume. Key increases in activity in Audiology, ENT, Orthodontics, Spine & Orthopaedics

• Number of patients waiting over 65 weeks was significantly reduced in month and slightly ahead of trajectory with a reduction of 47 C & YP in month.

• Reporting of incidents relating to No Harm or Near Miss increased in month which is reflective of a positive reporting culture

• Staff turnover decreased in month

• Delivery of £2.1m savings YTD

• PALS remain at 100% compliance

Areas of Concern

• ERF income is behind in month, however, there remain some significant data quality issues with activity & income within SLAM post expanse. The biggest variable being the inpatient spell and establishing the HRG which is significantly impacting income. There is also a backlog of uncoded episodes and the division has an issue with OPROCS and sedation activity whereby they are coded under the incorrect pod or not accounted for. There is ongoing work underway to resolve this.

• Challenge remains within Dental, ENT and Spine for achieving no patients over 65 weeks by end of March 2024, however specialities are on track with trajectories.

• WNB rate remains below target at 9%- key areas of focus is Community Ophthalmology who are a significant outlier

• Sickness absence remained static and slightly over target in month, hotspot areas include theatres and critical care

• Temporary spend increased significantly within critical care nursing due to high patient demand and current gaps in establishment, alongside winter incentive rates

Forward Look (with actions)

• Review of theatre schedule to ensure appropriate reallocation of sessions to the areas with high patient demand in preparation for increased in capacity from 1st February 2024

• Pilot to start in January 2024 within Community Ophthalmology to test a hybrid booking scheme to target WNB rate

• Close work with digital team to ensure coding improvements are actioned (those missing and new opportunities)

• Continued focus on big CIP schemes alongside review of recurrent schemes for next year

• Although mandatory training compliance is above target, divisional focus on Sepsis compliance with targeted discussions

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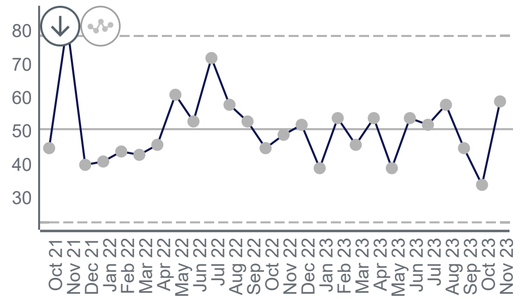
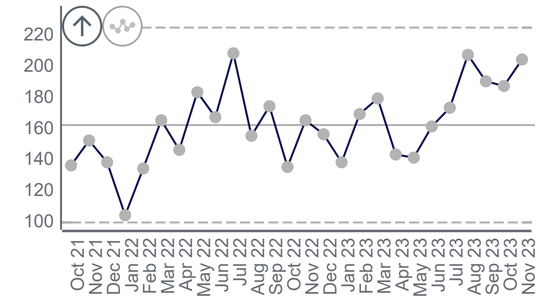
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

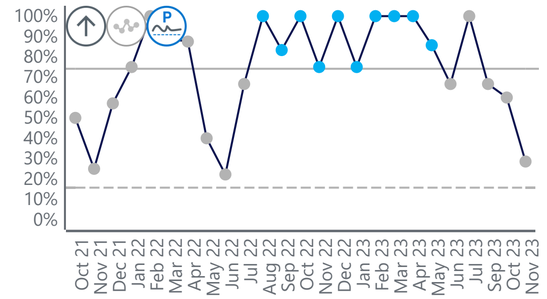
Number of Incidents rated Minor Harm and above



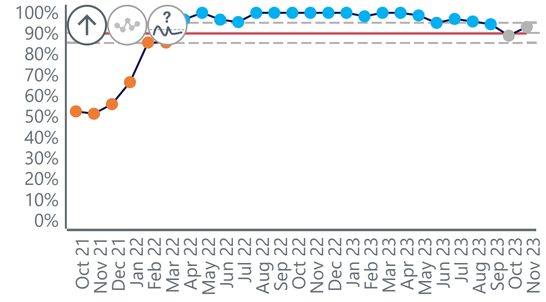
Number of Incidents rated No Harm and Near Miss



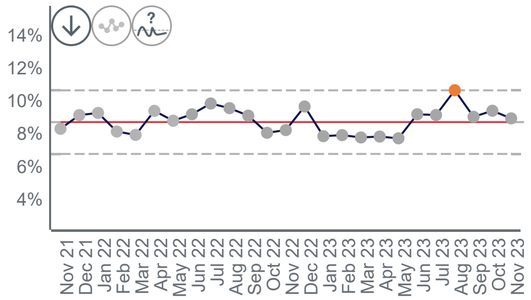
% Complaints Responded to within 25 working days



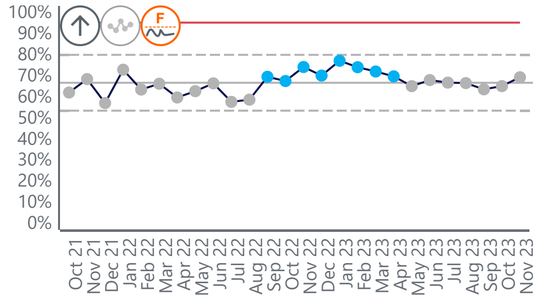
% PALS Resolved within 5 Days



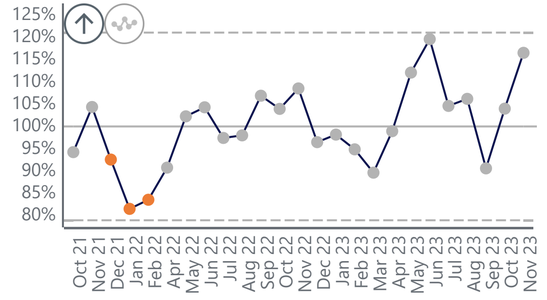
% Was Not Brought Rate (All OP: New and FU)



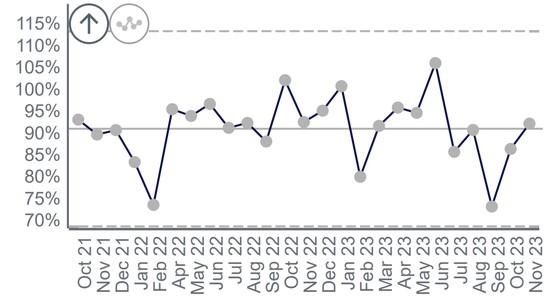
% of Clinical Letters completed within 10 Days



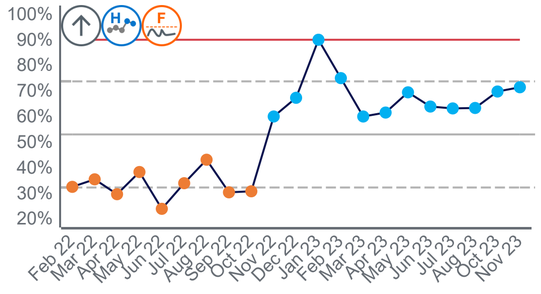
% Recovery for OP New & OPPROC Activity Volume



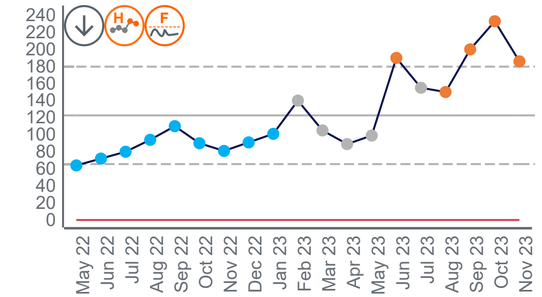
% Recovery for DC & Elec Activity Volume



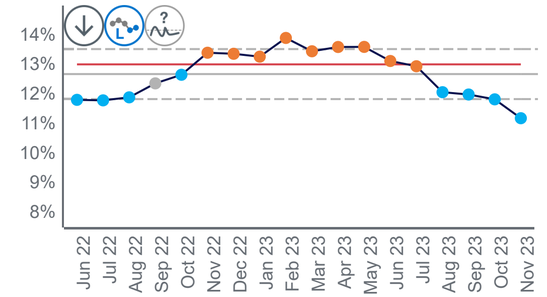
Diagnostics: % Completed Within 6 Weeks of referral



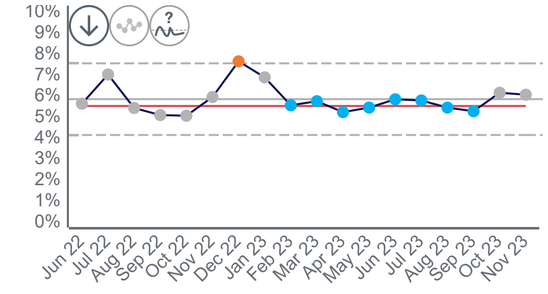
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)



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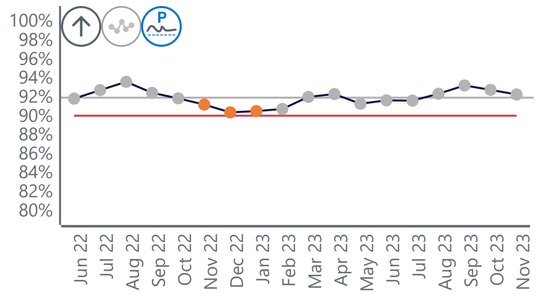
Divisional Performance Summary - Surgery

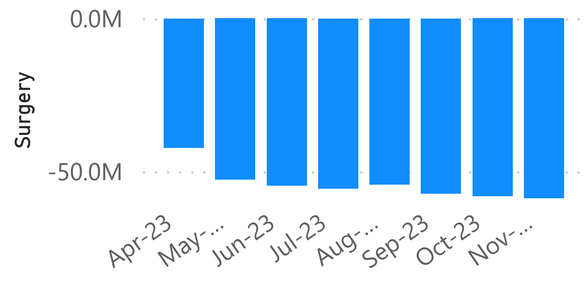
Mandatory Training



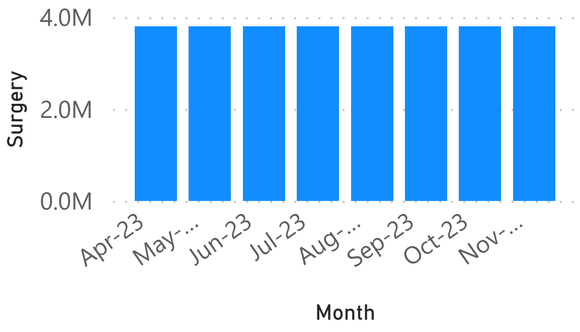
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

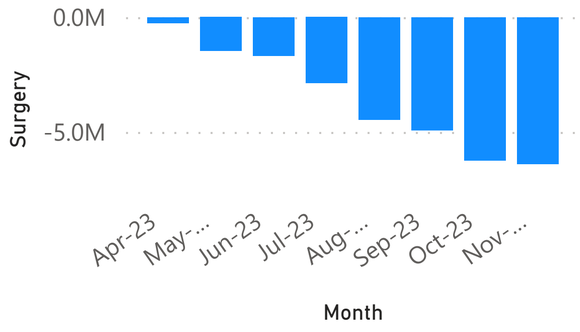
Revenue Position (Year End Forecast)



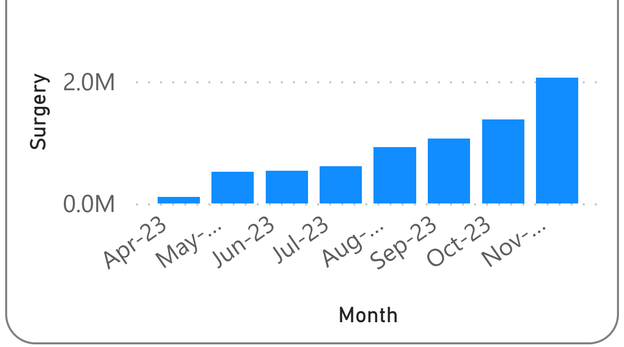
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• NIHR Research for Patient Benefit award confirmed for 'Parent co-Designed Drug Information for parents and Guardians Taking Neonates home (PADDINGToN 2) - a Feasibility Study' led by Louse Bracken – the review panel Committee commended the patient and public involvement section as a whole, and the inclusion of a PPI member with lived experience

• Further grant activity – Alder Hey lead applicant NIHR HTA national call in improving medication safety submitted (Hawcutt; Bracken; Gill; Ashleigh;Ainsworth); Alder Hey co-applicants on NIHR HTA Asthma call (Messahel;Hawcutt)

• Top recruiter nationally (8 sites open across UK) for the CRESCENT trial (inhaled carbogen as adjunctive treatment of paediatric convulsive status epilepticus) recruiting 16/25 participants enrolled at end of November

• Participant experience surveys have continued to increase in November with continued positive feedback

• Staff turnover continues to decrease and remains below target

• Mandatory training remains on track and plans for safeguarding training are in place

Areas of Concern

• Ongoing challenge - under-achievement against commercial income target and commercial study set up target (relates to national position as well as local challenges)

• Sickness rates have increased in month and are slightly above Trust target due to a small number of long term sick cases.

• Increased subscription pressures in year relating to partnership working with Liverpool Health Partners which will continue to be a pressure in 24/25

• Incident relating to low physical harm and low psychological harm reported in November relating to courier not collecting safety bloods and requirement for participant to return for repeat bloods – fully investigated and actions being implemented to reduce likelihood of repeat occurence

Forward Look (with actions)

• Collaborative meeting with University of Liverpool to develop a Child Health Institute taking place on 6th December

• Investment case for 3rd MRI scanner will be considered by Board on 7th December

• Financial sustainability case for Alder Hey Research Strategy in preparation for R&I Committee in January

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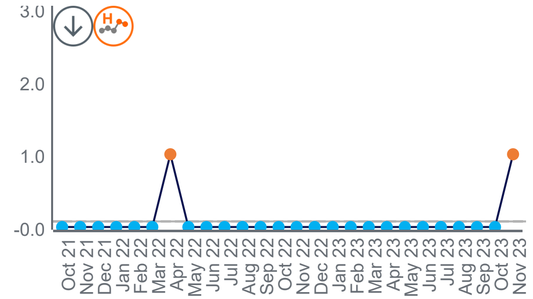
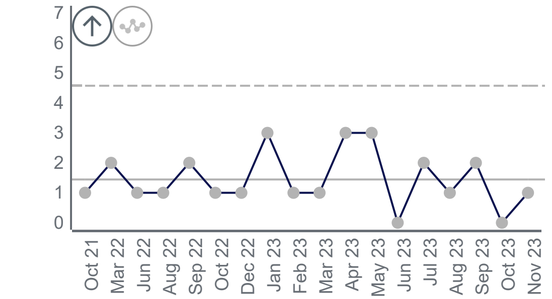
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

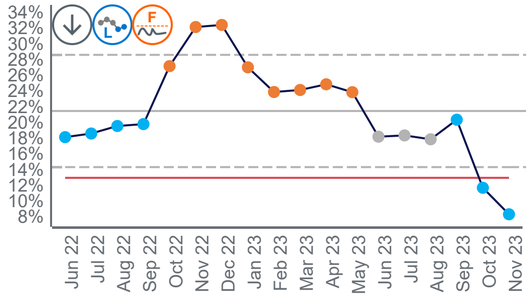
Number of Incidents rated Minor Harm and above



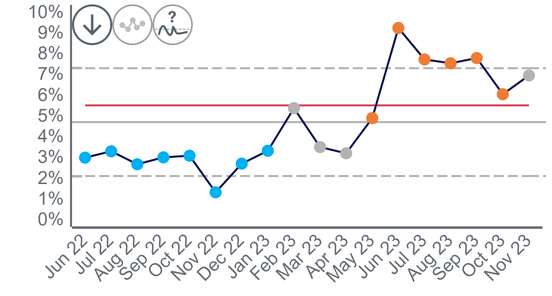
Number of Incidents rated No Harm and Near Miss



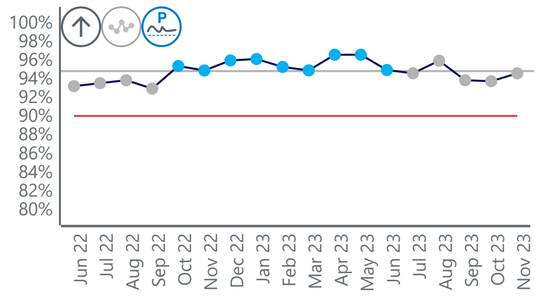
Staff Turnover



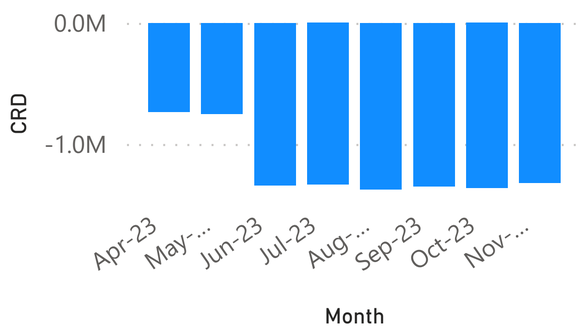
Sickness Absence (Total)



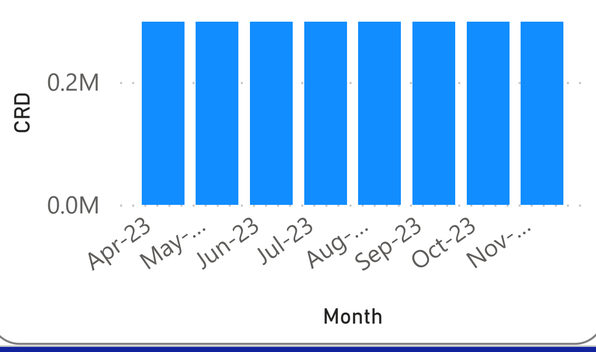
Mandatory Training



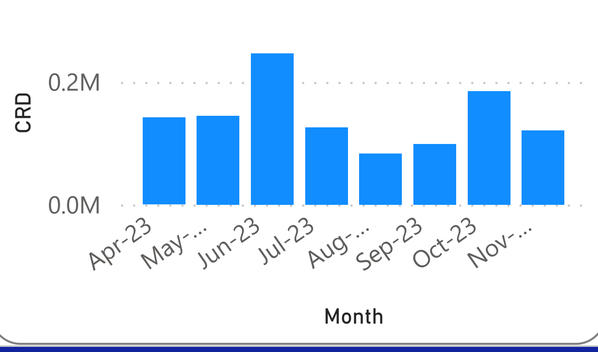
Revenue Position (Year End Forecast)



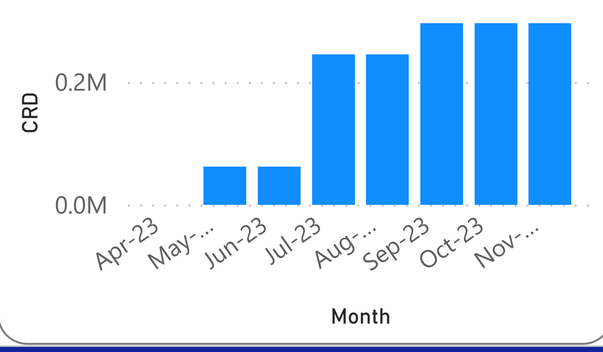
CIP Position (Recurrent Full Year Effect)



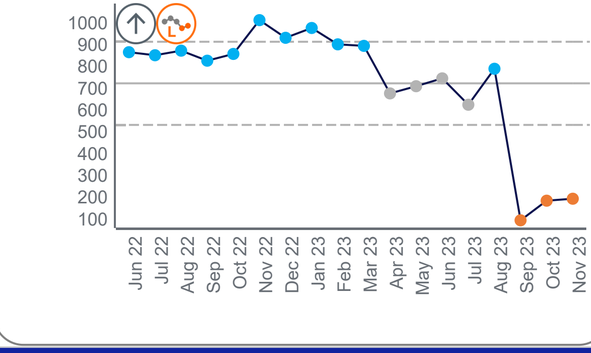
Revenue Position (Variance to date)



CIP Position (Delivered to date)



Number of Patients Recruited into Research Studies



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative continues to meet monthly with good attendance. Highlights from the meeting held on 22nd November are:

• Mandatory training for Corporate Services remains above the 90% target at 93%.

• £1.5m CIP posted by M7 against a target of £1.8m.

• Staff Turnover has reduced by 1% and is now at 12% which is below Trust target, however this remains an area of focus for HR with the formation of a T&F Group to review data and agree immediate actions.

• Long term sickness has remained stable in month and is currently sitting at 4%.

• Positive engagement in all service areas in monthly review of risks and actions required regarding any overdue risks. 91% of corporate risks in date on 20th November 2023.

Areas of Concern

• Short term sickness is 3% and is slightly above Trust target (2.5%).

• PDRs for B7+ is currently at 68% which is below target.

• PDRs for all staff is at 70% the target of 90% in rolling 12-month period.

• Safeguarding training remains a focus for the Corporate Collaborative.

Forward Look (with actions)

• Ensuring all risks are reviewed within timescale.

• Continued focus on bank and agency spend.

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

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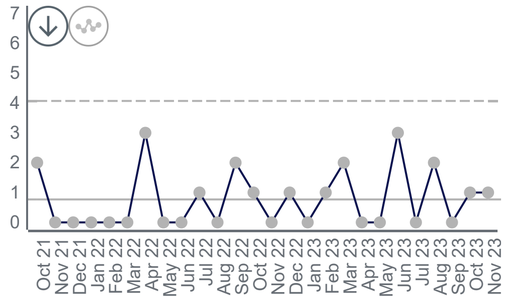
Integrated Performance Report | December 2023

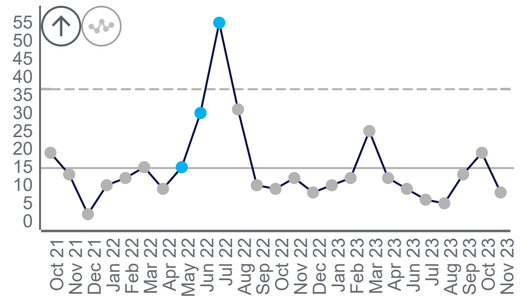
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

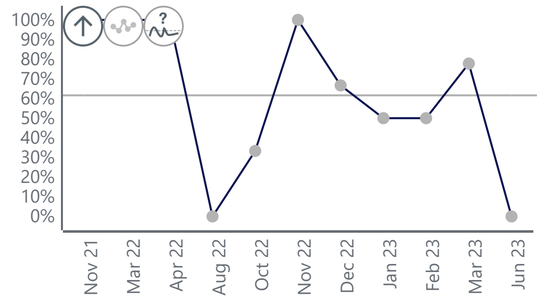
Number of Incidents rated Minor Harm and above



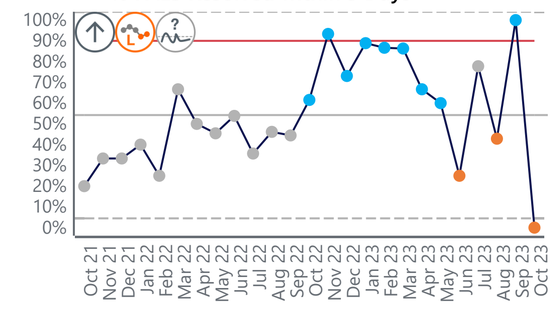
Number of Incidents rated No Harm and Near Miss



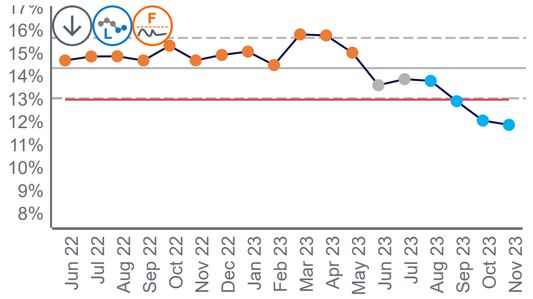
% Complaints Responded to within 25 working days



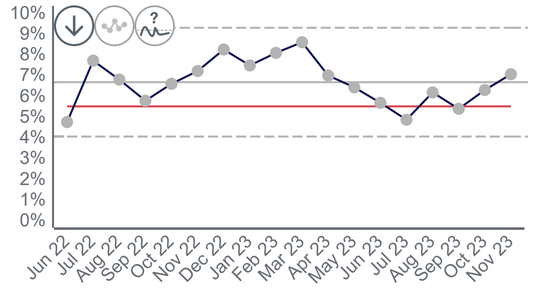
% PALS Resolved within 5 Days



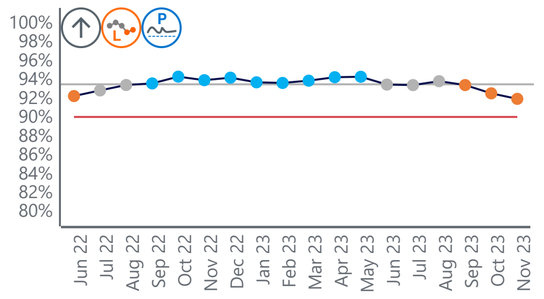
Staff Turnover



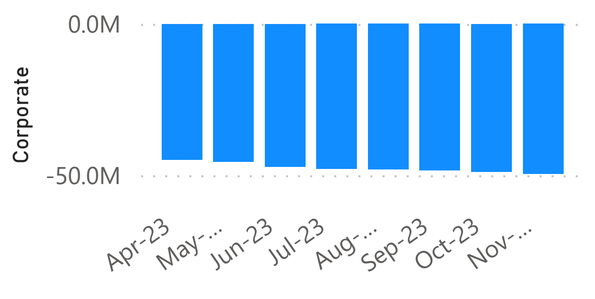
Sickness Absence (Total)



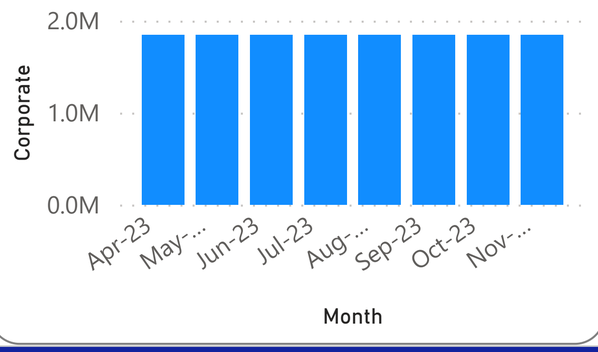
Mandatory Training



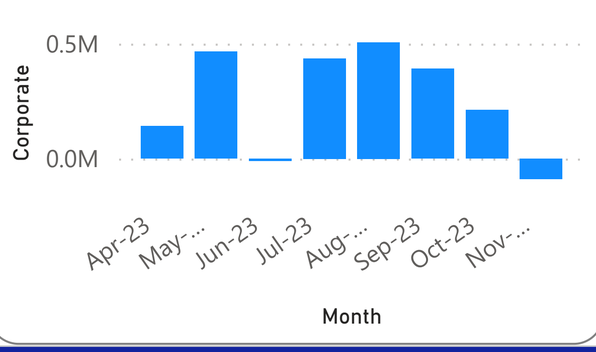
Revenue Position (Year End Forecast)



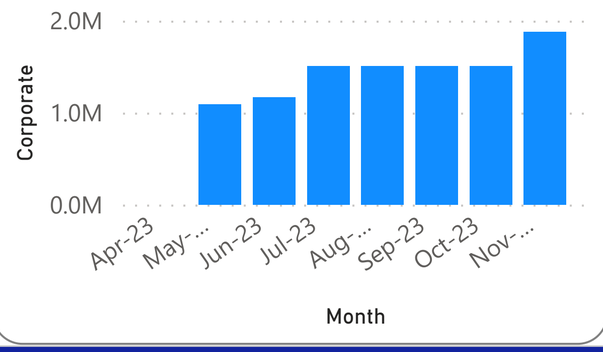
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



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

	Day		Night		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 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	97%	-	98%	-	98	21.4	14.87	5%	0%	0.00%	0.00%	2.04%	0.00%	1	22	0	1			0	0
HDU	69%	103%	66%	110%	227	33.1	32.22	4%	2%	0.88%	0.00%	6.01%	0.00%	2	47	0	3			0	0
ICU	74%	73%	70%	61%	255	58.5	32.22	3%	0%	0.00%	0.00%	5.93%	0.00%	2	81	0	1			1	0
Ward 1cC	81%	92%	78%	73%	409	15.8	12.31	6%	-6%	0.00%	0.00%	6.37%	14.50%	4	38	0	6			1	0
Ward 1cN	69%	23%	75%	-	228	14.8	13.14	15%	-2%	0.00%	0.00%	2.80%	0.00%	5	28	0	7			0	0
Ward 3A	90%	60%	93%	133%	714	10.5	10.27	-7%	5%	0.00%	0.00%	6.90%	8.80%	4	35	0	5			1	0
Ward 3B	74%	97%	75%	-	375	13.3	7.28	24%	-10%	0.00%	0.00%	8.10%	34.17%	7	33	0	5	6	100%	0	0
Ward 3C	88%	83%	76%	118%	5680	14.6	10.31	18%	-6%	0.00%	0.00%	6.23%	5.27%	6	71	0	0	29	92%	0	0
Ward 4A	75%	80%	75%	71%	701	10.7	10.19	8%	-2%	0.00%	0.00%	7.42%	1.09%	2	38	1	3			0	0
Ward 4B	56%	76%	48%	74%	485	14.6	10.28	0%	4%	3.78%	2.99%	6.03%	11.62%	3	54	0	1	4	80%	0	0
Ward 4C	86%	85%	84%	92%	598	11.7	10.36	15%	5%	0.00%	0.00%	5.29%	15.84%	14	142	0	2	21	100.00%	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.

Please Note, FFT for the division of surgery for August is not available for individual areas. Overall compliance: Total numbers of surveys completed for August 702 responses, with 96.3% good or very good

<u>Medicine</u>

The over establishment on 3B for unqualified vacancies are the additional supernumerary registered nurses who are awaiting a pin or occupational health clearance, this has impacted the fill rate for registered as they are not yet counted in the numbers. HCA sickness equates to 2.0 WTE who are currently on LTS.

Ward 3C LTS improved in August equating to 1.6 WTE absent. The HCA sickness equates to 1.0 WTE but due to low numbers of HCA's within the overall ward establishment the percentage is high. The ward are also supporting an RN 1:1 and HCA 1:1 on a long-term basis due to safeguarding reasons. There was an increase in overall 1:1 for HCA's overnight.

Ward 4B RN sickness levels continued to be monitored in August. Short term sickness (STS) was highest amongst the qualified staff with 6.45 WTE being absent, in total with Long term sickness (LTS) and maternity leave this increases to 19.45 WTE unavailable to work. HCA sickness has improved to 10.88 WTE (combined STS and LTS) Due to the staffing model being reviewed on 4B this has been managed with minimal bank usage. 2.61 WTE qualified staff commenced in post therefore supernumerary in August.

Ward 4C continue to have a high RN vacancy rate equating to 11.89 WTE staff due to a high turnover over the last few months. 9.0WTE new staff have been recruited starting from October so this will slowly start to improve over the next few months. This was mitigated by low patient numbers in August

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

Burns RN vacancy percentage is showing high but due to low numbers, equates to 1 WTE.

Ward 1cCardiac fill rate continues over 80% in the day, however dips under on nights. There are a number of vacancies. New staff have been recruited (8 WTE in August) but won't be reflected in the numbers until the end of October. The over establishment on the HCA line is due to the band 2 to 3 uplift and funding not yet being received in the budget line. There was a mix of long and short term sickness for RNs.

Ward 1cNeo staffing is overseen by safer staffing and supported by the Liverpool Neonatal Partnership, with nurses being deployed from LWH if required. Recruitment and training for the new neonatal unit is ongoing for the number of cots. Supernumerary staff are allocated on to most shifts during the initial training period. Issues relating to staffing are discussed with the Surgical Matrons and support is offered where needed. All patients are nursed in line with BAPM standards, acuity information shared at all safer staffing meetings to ensure that staffing levels are supportive of patient acuity. Staff sickness in August was 4.49%, turnover 9%. There were some staff moves to other areas. Non- registered staff do not provide care hours on 1C Neo. Overall occupancy in August was 91%

Ward 3A RN fill rate continues over 90%, within the Registered nursing cohort. The HCA shifts were mainly filled by CSWD healthcare trainee posts supporting via NHSP and recruitment and some have now been successful in permanent posts. The ward has also had to cover a high number of 1:1 patients, with additional shifts not always being picked up, and one long term 1:1 who will remain until the New Year.. There was an increase of STS towards the end of August.

Ward 4A continues to have a high number of vacancies due to a combination of LTS/ maternity leave and leavers. This is expected to be a consistent theme until November. To mitigate, new starters commenced in post in August and October, following a period of induction and supervision they will commence in the numbers from November.

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 have an average fill rate due to several international nurses that are working as band 4 prior to gaining NMC registration. 3 international nurses that started in April were still supernumerary in July, 2 of them have gone into the numbers in September and one of them is still training. An additional 3 international nurses started in July and will be supernumerary for some time. 10.1 WTE STS, 3.7 WTE LTS and 5.1 WTE on maternity leave. There was also low acuity in August with staff moves to support other areas.

ICU vacancies improve in August. 4.5 WTE have been on LTS since June and the ward have 8.0 WTE on maternity leave. New starters commenced in post in October, following a period of induction and supervision they will commence in the numbers from January.

Summary

Unfortunately, the National benchmark data on model hospital for August is unavailable, therefore we continue to benchmark against the data available which is from June There are some differences in CHPPD benchmark in August, this may be due to the National benchmark still reporting for June and many of the wards within the Trust had lower acuity or activity in this month.

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

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

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

Ward 1cNeo are normally comparable with the national data however we have saw an increase in our CHPPD due to the ongoing recruitment and training supported by the Liverpool Neonatal Partnership.

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

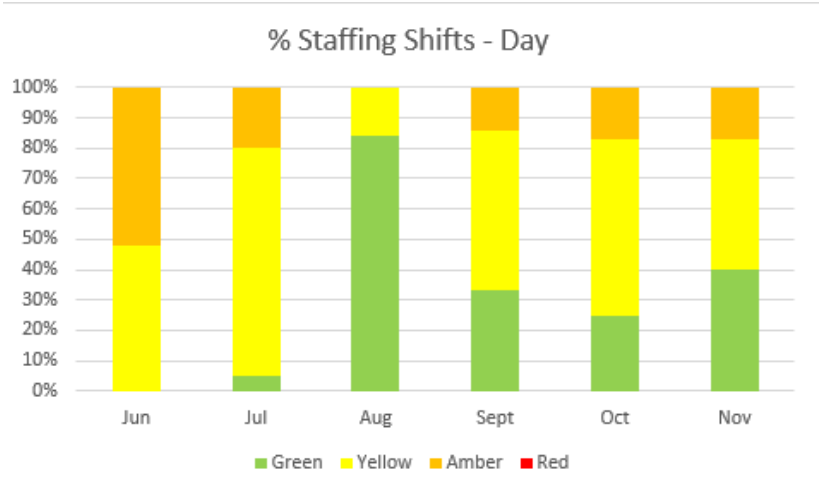
There is a consistent difference from the National benchmark for Ward 4B. Ward 4B has been consistently higher over the last few months. Deep dive into capacity and staffing has been undertaken and a full review of the nursing model is currently being undertaken with the aim to changing the nursing patient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

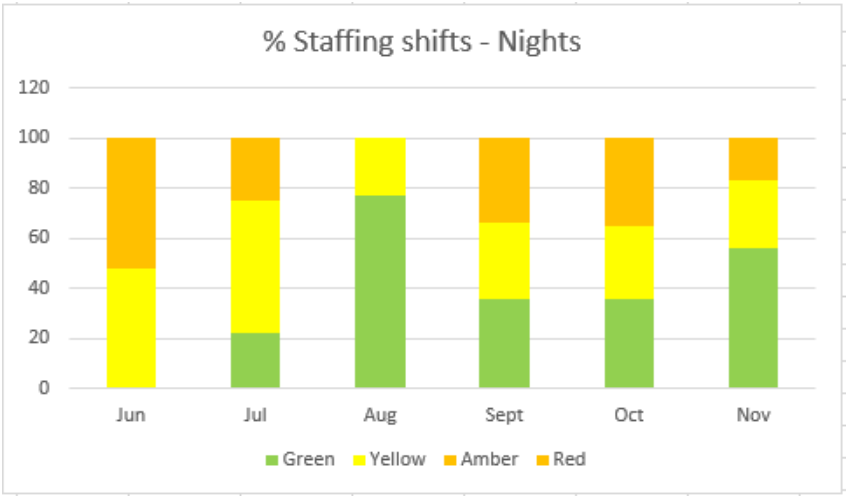
Ward 4C continues to significantly improve during August, reporting higher than the national benchmark, this could be attributable to lower patient numbers on the ward in August

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

Summary of November staffing

There was a higher percentage in green staffing status in November compared to the last 2 months and no red days reported.


% Staffing Shifts - Day
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun
Jul
Aug
Sept
Oct
Nov
Green
Yellow
Amber
Red


% Staffing shifts - Nights
120
100
80
60
40
20
0
Jun
Jul
Aug
Sept
Oct
Nov
Green
Yellow
Amber
Red

Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

Flash Report -December 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for December
Unrivalled Experience	**Deliver our Patient Safety Strategy**	Number of Incidents rated Moderate Harm and above	0	**2**
		Number of Serious Incidents (Steis reported)	0	**0**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**3 (MSSA)**
		FFT - % Recommending Trust	> 95%	**93.0%**
Supporting our Colleagues	**Increase people Availability and Wellbeing**	Sickness Absence Total	<5%	**5.81%**
		Staff Turnover	*<13%*	***11.2%***
Collaborating for CYP	**Handover Springfield Park to the community**	Return Springfield Park to Liverpool City Council	By Nov 2023	**Final works will be completed by March 2024. This includes: lighting, paths, signage, and drainage / final seeding of the football pitches.**
Smartest ways of Working	**Improve Access to Care and Reduce Waiting Times**	ED: % treated within 4 Hours	> 76%	**85.2%**
		Number of RTT Patients waiting >65weeks	0	**200**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,636**
		Elective Recovery (Vol)	> 106%	***111.1%***
		Diagnostic Performance	> 90%	**87%**
	Financial sustainability	Revenue position – Year End forecast	13m Surplus	**£13m surplus**
	Aldercare optimisation	Optimisation of Aldercare	Optimisation programme has been scoped and is being initiated	

Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary

Published 9 January 2024

Strategic Goals	2023-24 Operational Priorities	Progress in December 2023	Areas of challenge
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• Deployment of the new notification process with significant improvement and oversight of acknowledgement of results • Initial phase of Martha's rule scoped with planned pilot in February 2023 • Improved InPhase reporting and oversight	• Some continued challenges with data reporting following expanse – to be resolved in December
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Thriving Leaders Management Essentials programme – remains on track • Preceptorship – joint framework in progress and on track	• Capacity & resource remains a challenge - business case with executives for approval
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• Approval of investment case for 3rd MRI scanner supported by Medicine and Clinical Research Divisions • Publication of scientific paper co-developed with Research Ambassadors (CYP 13-18 years old) • Significant progress made in next stage of Investment Zone in preparation for final Gateway stage gate (January 2024); shortlist of individual projects selected. • Consultancy and engagement between Strasys and Alder Hey Innovation to identify ready now products.	• Under-achieving against commercial income target and commercial study set up target (relates to national position as well as local challenges) • Capacity and resource of Alder Hey Innovation team with additional workloads and competing priorities. • Early discussions with wider Alder Hey Innovation team to ensure engagement operationally to inform partnership agreement.
Collaborating for CYP	**4. Handover Springfield**	• Tree planting commenced.	• Areas of residual Trust infrastructure works

	Park to our community	• Path preparations (eg: ground levelling) to complete the path network ongoing. • Playground: Play equipment installation completed. Street furniture installation ongoing.	blocking full site possession for the park contractor. • Poor weather conditions.
Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Services coping well with winter pressures: 85% patients seen within 4 hrs in December. • Positive impact of PAU and high utilisation of the virtual ward • Number of patients waiting over 65 weeks reduced from 236 in October to 200. • Number of children and young people waiting to complete thier ASD or ADHD assement over 65 weeks remains significantly above planned levels due to increases in demand	• We project to achieve zero patients waiting over 65 weeks (excluding patient choice) subject to no further industrial action in Q4. • Focused on treating more than 80% of patients within 4 hrs in Q4. • Trust part of the launch event for the C&M Neurodiversity pathway which inlcuded ideas for improvements which will be developed further during 2024 • Discussions with place based commissioners underway to agreed ASD/ADHD activity plan for 24/25
Smartest ways of Working	**6. Financial sustainability**	• Elective and outpatient recovery was improved in November and in December we estimate that we treated 111% of the volume of patients in Dec 2022, driven by a theatre scheduled that continued to deliver a high volume of lists despite industrial action and a good winter plan.	•
Smartest ways of Working	**7. Optimisation of Aldercare**	• 14 developments requests approved through CDDA for December • 9 development requests completed in December	• Timescales for delivery for the 2nd part of Resource Mode fix, Working with Meditech to expedite.

		• Highlights include – Ward Discharge workflow, ED Pathway, Coroner Requests, Resource Mode - Part 1 • 4 Emergency development requests completed in month	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th January 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Trust Board paper 2023
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☑ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	N/A

1. Purpose of report

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

2. Background

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

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

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

3. Summary of progress

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

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

- Estates
- Workforce and Recruitment
- Finance and Contracting
- Governance

4. Estates

A suitable premises for the service has been identified in Warrington, which is based within the Northwest and benefits from access to national, regional and local transport links. The building is a standalone, two-story property which the service will have full and sole use of. The building lease for 5 years is due to be signed week commencing 08 January 2024 and then some building renovations and changes will commence to ensure the building meets all statutory requirements for the provision of health services. Warrington Local Authority and Cheshire & Merseyside ICB are supportive of the planned location.

Children and young people are involved in the design and approval of the internal features of the building including decoration, furniture and sensory space. Suggestions from previous estates projects e.g. Sunflower House, Catkin Centre and sensory environments will also be included.

5. Workforce and Recruitment

Alder Hey as the host of the new service is the lead for recruitment to all posts within the service. Recruitment commenced in December 2024 and to date several senior posts have been recruited to including the service's Clinical Director, Clinical Lead and General Manager. Recruitment is ongoing to the service and there is a minimum staffing level required to support the service to go live in Spring 2024.

6. Finance and Contracting

The North programme's business case was approved by NHS England on 28 November 2023 and relates to the mobilisation of the service in line with the interim service specification and commitment to take children and young people from the national waiting list. There remain ongoing discussions with NHS England regarding the potential transfer of an open caseload to the service from the current provider and the management of risks associated with this transfer.

The North programme will work with NHS Northwest Specialised Commissioning to develop the specifics of the contract for an initial 5-year commission in line with lease arrangements, including any sub contractual arrangements with Royal Manchester Children's Hospital.

7. Governance

The new service will sit within the Community & Mental Health Division at Alder Hey and follow the divisional and Trust governance processes embedded across the division. Clear lines of accountability to the Director of Community & Mental Health Services for the service including the Clinical Director and Clinical Lead roles will be in place for service at go live. In addition, all necessary arrangements with the CQC will be in place prior to service go live.

8. Recommendations

It is recommended that Trust Board note the programme continues to progress at pace and remains on track for implementation of the nationally commissioned specialist, tertiary Gender Service for children and young people. Implementation is in line with the national interim service specification, pending a resolution regarding the transfer of the open caseload from the current provider and management of associated risks.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th January 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. NHS Patient Safety Strategy. NHS Improvement. July 2019. Never Events List (revised February 2021).
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	

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

1. Purpose

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

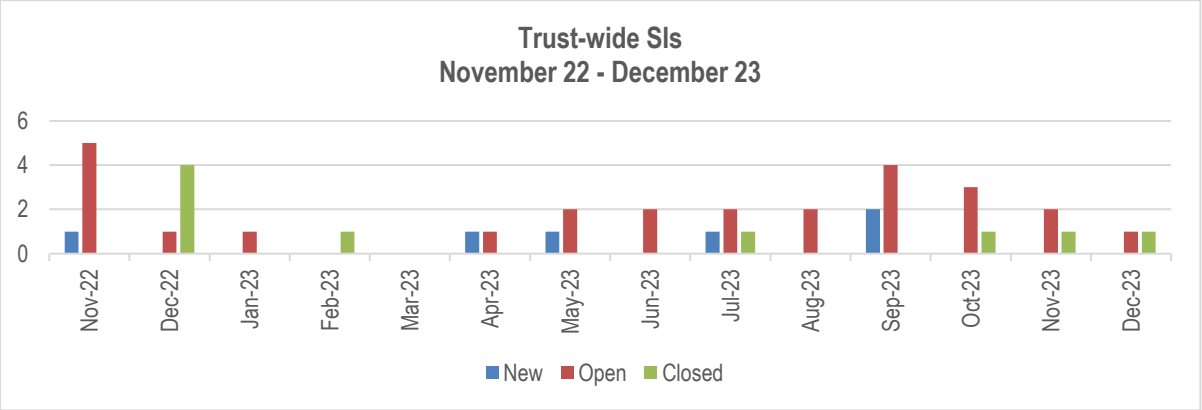
3. Local context

3.1 Never Events

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

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status December 2023



3.2.1 Declared Serious Incidents

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

3.2.2 Open Serious Incidents

1 SI was open during the reporting period as outlined in table 1.
2 SI investigations were completed in this reporting period (1st November – 31st December 2023) (SI 2023/12980 – Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection and SI 2023/17791 – Never Event – wrong implant / prosthesis used).

Table 1 Open SIs – December 2023

StEIS reference	Date reported	Division	Incident	Summary
2023/18692	30/09/2023 (reported to StEIS 06/10/2023)	Surgery	1 year 9 months female admitted for elective craniofacial surgery 29/09/2023. Cardiac arrest on ward post-operatively, transferred to PICU. Cardiac arrest secondary to tension pneumothorax. Patient sadly died 02/10/2023.	Refer to appendix 1

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st November – 31st December 2023):

3 SI action plans remained open and are within their expected date of completion.
0 SI action plans were completed.

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

3.3 Internal level 2 RCA Investigations

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

3.4 Duty of Candour

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

2 initial and 3 final Duty of Candour responses were required. All duty of candour responses were completed within expected deadlines during the reporting period (1st November – 31st December 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.

2 SI investigations were completed during the reporting period (1st November – 31st December 2023). Immediate lessons learnt from all SIs are outlined where applicable in this report.

In line with national Patient Safety Strategy, AlderHey will transition from the SI framework to Patient Safety Incident Response Framework (PSIRF) on 1 January 2024. As a result, the format and content of any future Baord report will change from providing lessons learnt to providing assurance and oversight in relation to trends, themes, and areas for improvement.

Recommendations

The Trust Board is asked to note the contents and level of assurance provided and note that this is the final SI report under the current SI framework as the Trust transitions to PSIRF on 1 January 2024.

Alder Hey Children's NHS Foundation Trust

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2023/ 12980 **InPhase ID - 1802**	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	Escalation could have happened sooner. Line could have been removed sooner. Antibiotic usage was appropriate. Unclear escalation plan in place.	Review of escalation of patients in and out of hours so it is clear for the Neonatal Unit. Review as to why the line was not removed earlier. **December 2023:** RCA investigation completed and sent to commissioners 03/11/2023. Scheduled to be presented at North Mersey SI Panel 03/01/2024.
2023/ 17791 **InPhase ID - 3854**	Wrong implant / prosthesis used.	Request form needs to be visible to all staff (needs to be uploaded to EPR and printed as part of the preop paperwork). The Lines List Calendar should be more widely visible. Code/description for listing post and CVL on Meditech v6 were the same. On Expanse the procedures have their own descriptions on the ambulatory order. This process changed the Monday preceding the operation. Need separate E-consent form for tunnelled CVL/port/haemodialysis line. Better system for Line Requests necessary – Should be on Expanse with Ambulatory Order to allow for end-to-end audit of process. IT Equipment should be available for the forms to be viewed correctly. The Line Request forms should be easier to read. The selection should be more clearly visible.	Separating out of consent forms for individual procedures. Making lines list calendar visible to all consultants and registrars completing the lines list. Include lines list request form as part of lines list huddle. **December 2023:** RCA investigation completed and sent to commissioners 18/12/2023. Awaiting confirmation of the date for presentation at the North Mersey SI Panel.

2023/ 18692 **InPhase ID - 4287**	1 year 9 months female admitted for elective craniofacial surgery 29/09/2023. Cardiac arrest on ward post-operatively, transferred to PICU. Cardiac arrest secondary to tension pneumothorax. Patient sadly died 02/10/2023.	SUDIC protocol not triggered, safeguarding team since aware, social work referral made and discussion took place with Merseyside Police 04.10.23, log number 406041023. Airvo implemented but plan of care not documented. Inconsistency in completion and documentation of observations.	Planned debrief with medical and nursing staff scheduled. Joint morbidity and mortality meeting to be coordinated between medical teams caring for the patient. **December 2023:** Draft report written. Extension agreed to 18/01/2024. On track for submission by the deadline.

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
2022/10739	23/05/2023	31/05/2023	Medicine	Delayed diagnosis of bone malignancy	17 16 actions completed.	31/12/2023	29/02/2024 – Extension agreed to work with the ICS on the outstanding action.	1
2023/12980	02/07/2023	05/07/2023	Surgery	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	10 4 actions completed.	31/01/2024		0
2023/17791	15/09/2023	21/09/2023	Surgery	Never Event – Wrong implant / prosthesis used.	9 0 actions completed.	01/05/2024		0

END

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th January 2024

Paper Title:	**Trust Mortality Report Quarter 2**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass/Julie Grice

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

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

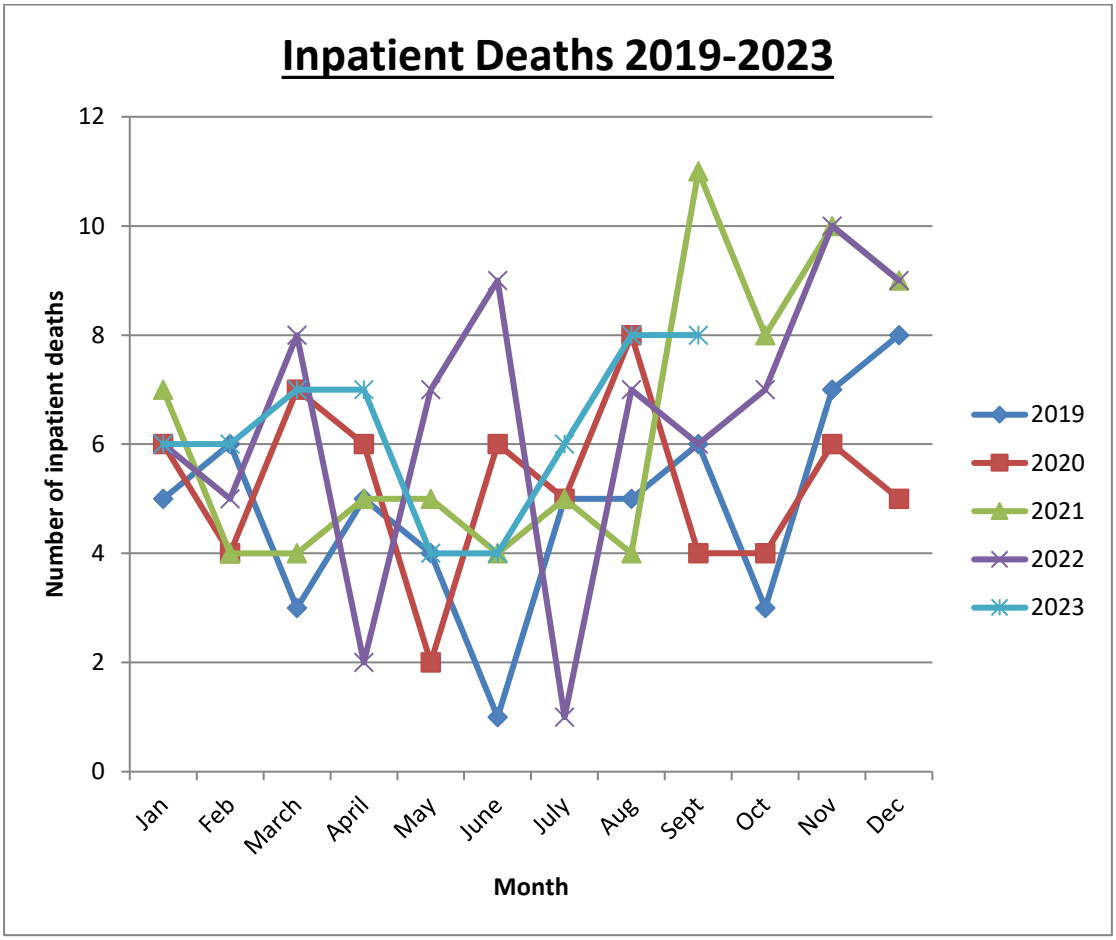
MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG), including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

Section two is the Quarter 1 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected versus observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG)



Looking at the 5-year figures, the number of deaths is slightly higher than usual at this time of year but only very minimally. This year, there have been several infectious diseases including strep A circulating at higher rates than normal, resulting in increased mortality. There are no concerning trends, as will be discussed later in the report.

The mortality process in the Trust continues to evolve because of issues identified by HMRG members and bereaved families, plus external changes:

1) One of the most significant changes is the introduction of the Medical Examiner (ME) process. This was due to be a legal requirement in April 2023 but has now been delayed until April 2024. Alder Hey has appointed two paediatric medical examiners to join the LHUFT Medical examiner team. The AHCH process has been planned but introduction has been delayed due to IT issues which are being addressed.

2) Following the Letby case, it is vital that we as a Trust can provide assurance that the review of our neonatal cases is thorough and highlights any concerns and learning. There is a high likelihood that national guidance will be instituted but we are pre- emptively improving our process. All neonatal deaths are reviewed using the PMRT(Perinatal mortality review tool) where the care from both the obstetric and neonatal aspects are reviewed. Since AHCH is a specialised Paediatric Trust we cannot undertake a PMRT but will continue to complete our Child Death review process. We need to ensure that the neonates receive the full scrutiny so we need to link in with the PMRT. This will be discussed further in the neonatal section which is a new addition to the report.

3) A mortality dashboard has been created by the BI team which offers considerable potential going forward to scrutinise our mortality data to identify any potential areas that need improvement.

4) Over the next few months there will be an update of the HMRG policy, terms of reference and HMRG forms following advice from Trust legal team because of Coroner's cases. In addition, there will be changes relating to PMRT and ME so that is as complete as possible

Current Performance of HMRG

Summary of 2023 Deaths

Number of deaths (Jan. 2023 – Oct. 2023)	56
Number of deaths reviewed	31
Departmental/Service Group mortality reviews within 2 months (standard)	45/48 (93%)
HMRG Primary Reviews within 4 months (standard)	29/30 (97%)
HMRG Primary Reviews within 6 months	30/30 (100%)

The percentage of cases being reviewed within the 4-month target is currently very high due to the hard work of the HMRG members. They are very flexible and committed to their role to ensure that the reviews are completed in a timely manner with comprehensive scrutiny. To achieve this the group consists of members with a wide range of expertise including NWTS (the regional paediatric transfer team), LWH (neonatology), psychology, Snowdrop (bereavement) team aiming for as robust process as possible.

Most cases are very complex for a variety of reasons and often require multiple discussions so entailing a considerable amount of time, but this is vital to ensure that the correct conclusions and learning is achieved. The meetings are held monthly on Teams, enabling more people to attend allowing the DGH clinicians to be involved if they wish.

Outcomes of the HMRG process 2023

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
							Internal	External		
Jan	6	6	6	6	6	2				4
Feb	6	6	6	6	6	2				2
Mar	7	7	6	6	7	1				
April	7	7	6	7	7	2				1
May	4	4	4	4	4				1	2
June	4	1	4							
July	6		5						1	
Aug	8		8							
Sept	8									
Oct										
Nov										
Dec										

Potentially Avoidable Deaths

There have been no potentially avoidable deaths in this reporting period which is very reassuring.

Neonates

The definition of a neonate is a baby less than 28 days old, so this section highlights this group. Over the reporting period, there have been 10 neonatal deaths which is 32% of the total deaths. Of the cases, 70 % had the diagnostic code of congenital, genetic, and chromosomal anomalies. The other cases were all 10 % each covering with diagnostic codes being cardiac causes, SUDI (Sudden unexpected death of infant) and sepsis. The sepsis was not hospital acquired and there was an underlying medical condition that made the baby very vulnerable.

The PMRT process states that the review should be undertaken in the Trust where the baby dies, however this is not possible in AHCH as no obstetric care is provided. Therefore, the proposed process is the initial part of the PMRT will be undertaken in either LWH or the DGH where the baby was born. This PMRT will then be shared with AHCH and the HMRG members will review this prior to

completing the HMRG review. The HMRG form will be altered to enable the PMRT learning and summary of review to be shared. This linking of the two mortality processes will enable all the neonatal cases to have similar scrutiny. Currently, this is a proposal to the neonatal network and needs to be agreed although been received very positively. In future, there will be closer working links with LWH, as part of the LNP, and meetings are organised to ensure clarity on both sides.

Learning disabilities

The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 31 cases, reviewed in 2023, 29 % were identified as having learning disabilities. The Learning Disabilities Mortality Review (LeDeR) Programme was set up to ensure all deaths of patients with Learning Disabilities are comprehensively reviewed. Since July 2023 the requirement to report the deaths of C/YP age 4 and over with a learning disability and/or Autism to LeDeR has been removed. Now, all deaths of young people will now be reported via usual child death processes. Then a national report will be produced via the LeDeR team with a focus on C/YP with a learning disability and/or Autism deaths.

As a trust, the plan is to continue to review all LD /autism deaths including less than 4 years old so they can be reviewed thematically and reported on to support internal learning and overview.

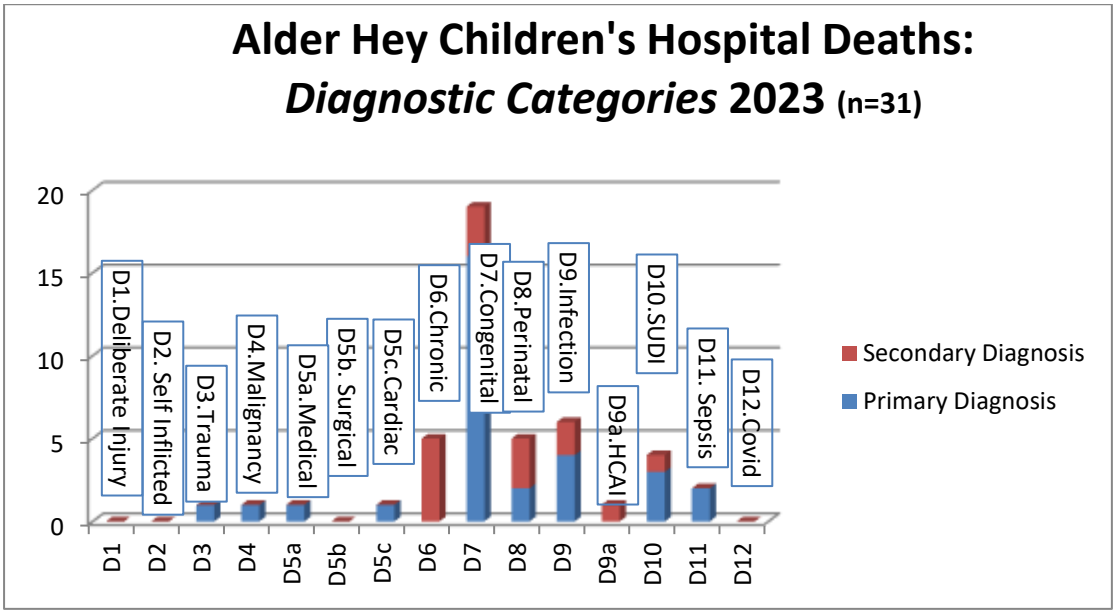
Family

The Snowdrop (bereavement team) at Alder Hey provide an exceptional service, supporting the family for a considerable time after a patient has passed away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide. The Snowdrop team will be involved in the discussion about the introduction of the ME process to minimise the impact on the families.

External Benchmarking

In the last year, AHCH has engaged with Birmingham Children's Hospital with the opinion that it was the Trust with the closest workload and demographics to us. It has enabled us to compare figures and trends and to work together to improve our processes and learn from each other and this will continue.

Primary Diagnostic Categories

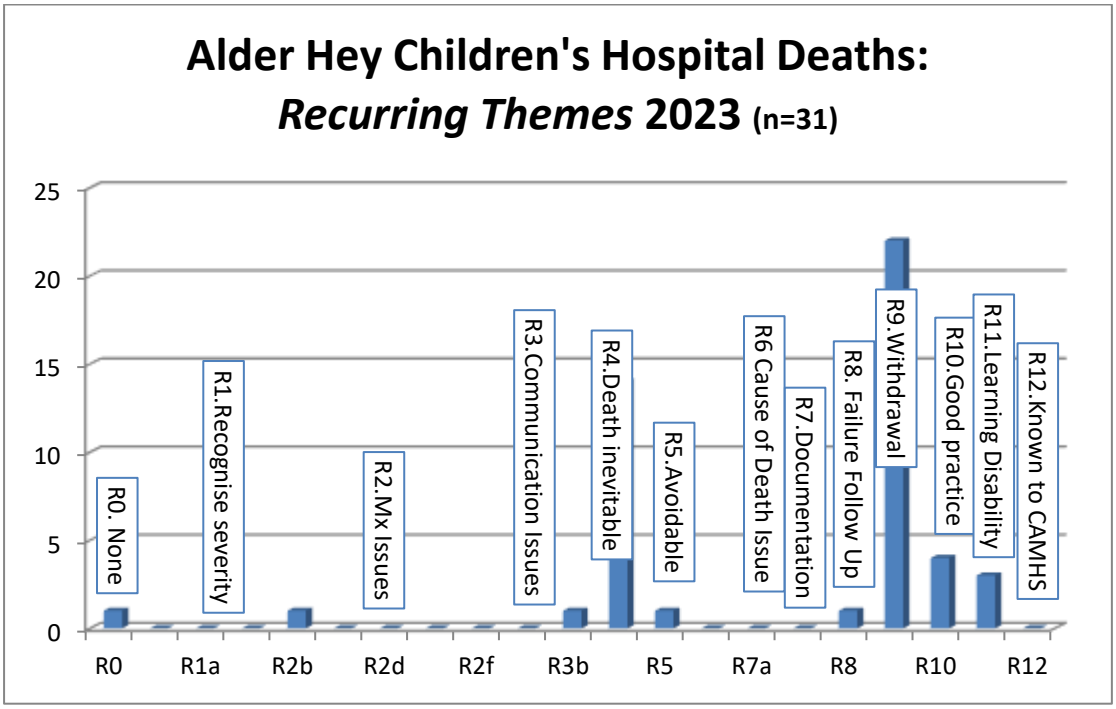


Diagnostic/Disease Categories

D1. Deliberately inflicted injury, abuse or neglect
D2. Suicide or deliberate self-inflicted harm
D3. Trauma & other external factors – *excludes deliberate self-inflicted harm (D2)*
D4. Malignancy
D5. Acute Medical or Surgical condition – subcategories:
D5a. Medical D5b. Surgical D5c. Cardiac
D6. Chronic medical condition
D7. Chromosomal, genetic and congenital anomalies
D8. Perinatal / Neonatal event
D9. Infection (proven or clinical) – subcategory:
D9a. Healthcare-associated infection (home or away)
D10. Sudden unexplained, unexpected death / SUDI / SUDC – *excludes SUDE (D5)*
D11. Sepsis (proven or clinical)

The cases reviewed in 2023 show that the highest diagnostic code is 'children with underlying congenital conditions' (52 %), these are often the most complex with several issues on going and are the most vulnerable patients. Next, with 13 % is the diagnostic code: 'infection 'which is different to sepsis. This would relate to the earlier statement about the high rate of infections that have been circulating in the population this year

Recurrent Themes



Recurring Themes

R0. No RT

R1. Failure to recognise severity of illness – subcategories: R1a. Failure to ask for Senior/Consultant review

R2. Possible management issues – subcategories:
- R2a. External
- R2b. Delay in Transfer
- R2c. in Alder Hey
- R2d. Delay in supporting services or accessing supporting service
- R2e. Difference of opinion re: Rx – Patients & families
- R2f. Difference of opinion re: Rx – Clinical teams

R3. Communication issues – subcategories:
- R3a. Patients & families
- R3b. Clinical teams

R4. Death inevitable before admission

R5. Potentially avoidable death – subcategories:
- R5a. Alder Hey
- R5b. Medical
- R5c. External

R6. Cause(s) of death issue – subcategories:
- R6a. Incomplete or inaccurate Death Certificate
- R6b. Should have had a post-mortem
- R6c. Not agreed
- R6d. Failure to discuss with the Coroner

R7. Documentation – subcategories:
- R7a. Recording
- R7b. Filing

R8. Failure of follow-up

R9. Withdrawal / Limitation of care

R10. Example of Good Practice

R11. Learning disability

R12. Known to CAMHS

The main recurrent code for 2022 was withdrawal of care (71 % of cases), which demonstrates that the intensive care team are working with families to ensure

that no child/young person suffers unnecessarily when all treatment options are explored but are not suitable.

Death was concluded to be inevitable in 45%, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.

The main codes for 2023 were identical despite the much lower number of cases reviewed. The figures were 58% for withdrawal and 33% for death inevitable category.

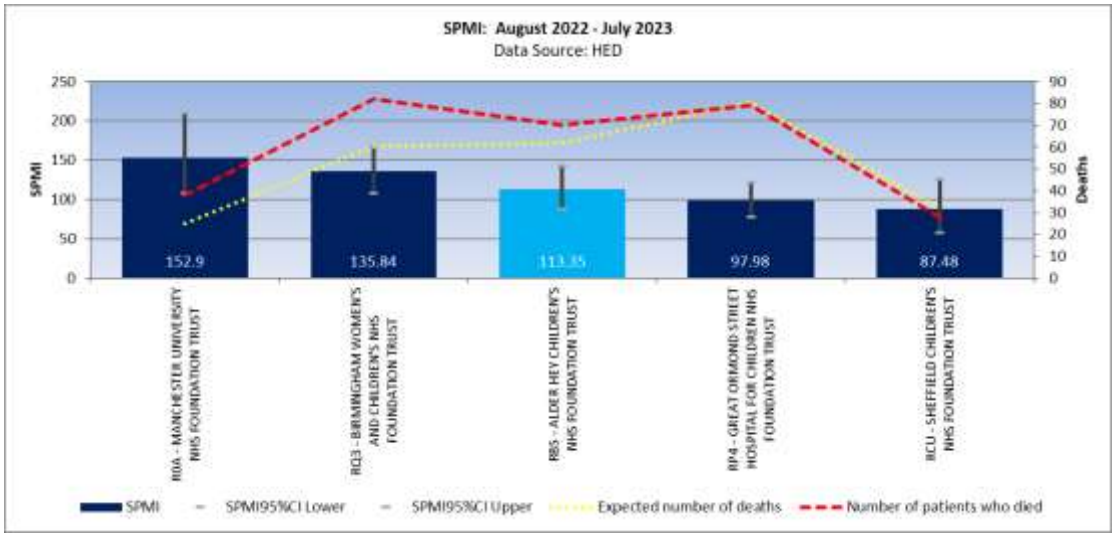
It is interesting to note that the group recorded 13 % of the cases so far in 2023 as good practice since the members tend to be very reserved at allocating this. They believe the standard of care, we as a Trust aim to achieve is extremely high. Therefore, to achieve 'good practice 'is when the team concerned has clearly gone way 'beyond the normal'.

Section 2: Quarter 2 Mortality Report: July 2023 – Sept 2023

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering August 2022 to July 2023.

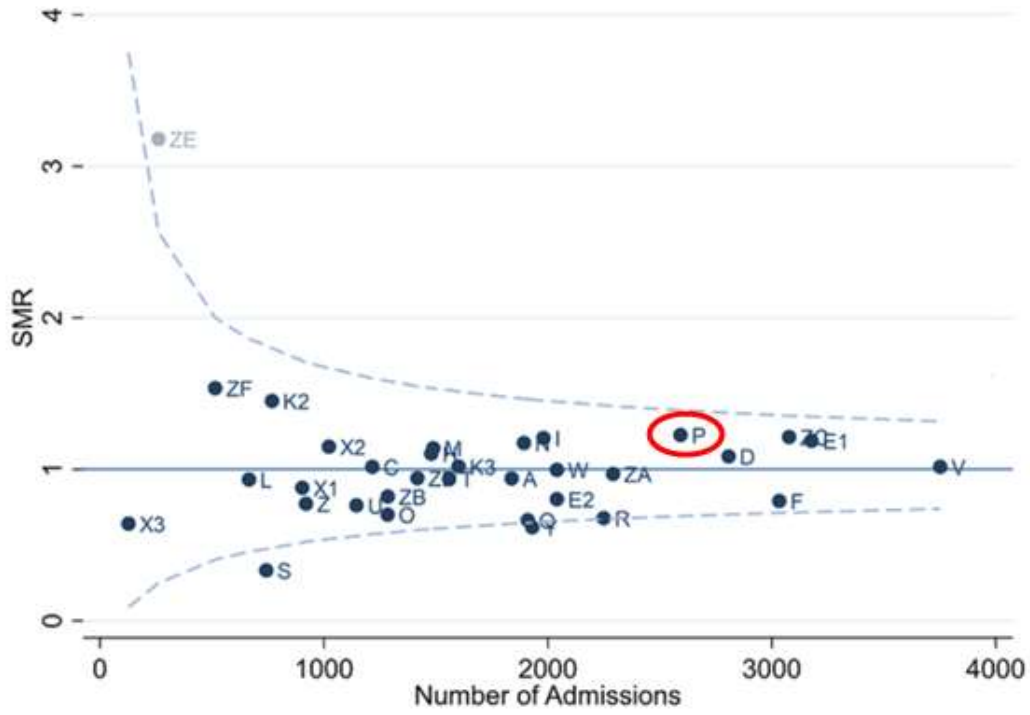


The chart shows that Alder Hey has performance of 70 deaths against 61.8 expected deaths. This is similar to Birmingham Childrens (indeed the difference there is more significant) who are the most comparable Trust to us with their workload and demographics. Looking at the recurrent themes with the death inevitable being such a high percentage more so than previous years. It does raise the point are we importing mortality so increasing our number of actual deaths above expected deaths.

PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other Children's Trusts. In the most recent PICANet report (2021 Annual Report of the Paediatric Intensive Care Audit Network 2019-2021), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
There was no evidence that any PICU had an excess mortality rate compared to what would be expected based on the level of sickness at the time of admission across the three-year reporting period. This is illustrated in Figure 5 based on inclusion of all SMR estimates being contained within the control chart limits.

Figure 5: Risk-adjusted Standardised Mortality Ratio (SMR) by health organisation for under 16 year olds, 2019–2021

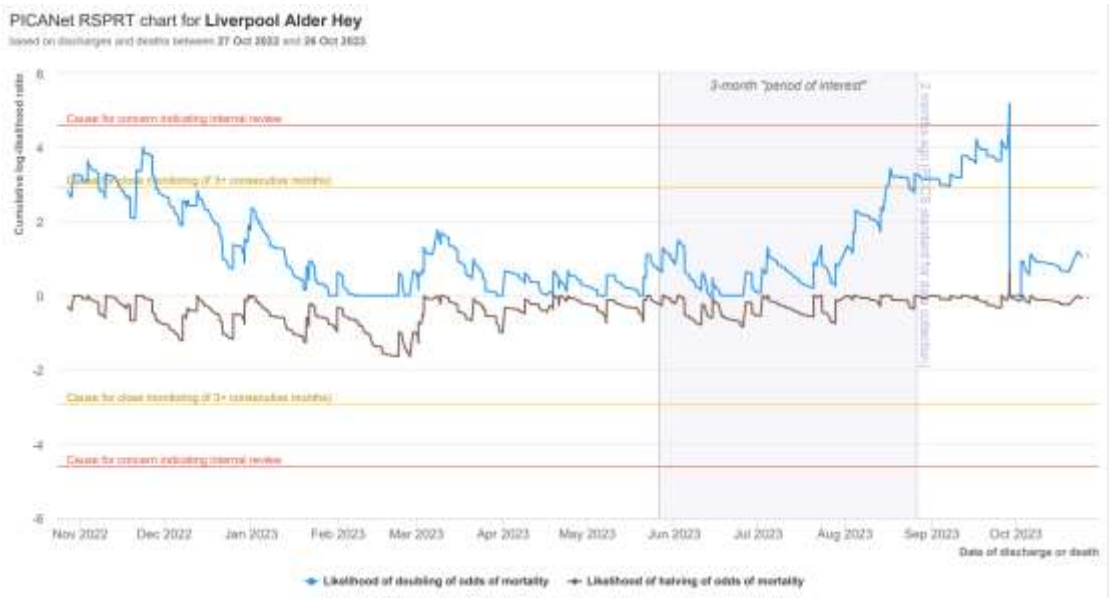


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'. Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.



During the 'period of interest' which is adjusted due to PIM3 we have largely remained in the 'safe zone'. Towards the end of August / early September the cumulative log-likelihood ratio has crept into the close monitoring section. During this period, we noted a series of cases that at service group review were considered to represent cases where death was inevitable in hindsight including acute trauma and patients with life-limiting conditions entering a terminal phase. PICU continue to review all cases within 4-6 weeks that feeds into further review at HMRG. The subsequent resetting of the graph displayed above needs to be reconsidered once it enters the period of interest (adjusted) zone.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, meeting the 4-month target. There is a considerable amount of work that needs to happen over the next few months in addition to maintaining the timeliness of the reviews.

The introduction of the ME process has proved to be more complicated than expected due to a number of factors some internal and others external. It is vital that these are resolved, and the ME system is functioning ready for the legal requirement in April 2024.

As discussed in the report, there is ongoing work relating to the PMRT process to ensure that the neonates in AHCH receive the same scrutiny of their care as they would in other Trusts.

There are no concerning trends that have been identified for patient deaths and the issues that have been raised by staff or families there is work underway to try and resolve them.

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 8**

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html). **Pg 10**

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 11**

Alfie Bass
Medical Director

Julie Grice
Trust Mortality Lead

8/11/23

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 15th November 2023
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Divisional Director Community & Mental Health Services	(LC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	John Grinnell	Managing Director/Chief Financial Officer	(JG)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RH)
	Jacqui Pointon	Associate Chief Nurse–Community & Mental Health Division	(JP)
	Jo Revill	Non-Executive Director	(JRe)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Paul Sanderson	Interim Chief Pharmacist	(PS)
	Melissa Swindell	Chief People Office	(MS)
In Attendance:			
	David Reilly	Assistant Chief Digital Information Officer	(DR)
	Jayne Guy	Head of Nursing & AHP's for Clinical and Diagnostic Services	(JG)
23/24/131	Kim Hewitson	Sepsis Nurse Specialist, Infectious Diseases & Immunology	(KH)
23/24/131	David Porter	Consultant Infection & Immunology, Infectious Diseases	(DP)
23/24/132	Will Weston	Medical Services Director	(WW)
23/24/135	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	(NO)
	Natalie Palin	Director of Transformation and Change	(NP)
	Jill Preece	Governance Manager	(JPr)
	Laura Rad	Head of Nursing-Research	(LR)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)
Apologies:	Pauline Brown	Director of Nursing	(PB)
	John Chester	Director of Research & Innovation	(JC)
	John Grinnell	Managing Director	(JG)
	Peter White	Chief Nursing Information Officer	(PW)
	Sarah Wood	Consultant Paediatric Surgeon, Surgery Division	(SW)
	Catherine Wardell	Associate Chief Nurse, Medicine Division	(CW)

23/24/128 Welcome and Apologies

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

23/24/129 Declarations of Interest

None

23/24/130 Minutes of the Previous Meeting

Committee members were content to APPROVE the notes of the meeting held on 18th October 2023.

23/24/131 Sepsis Data current position

DP advised that the Sepsis data is currently in the same position as notified previously. DP stated that the dashboard data is still down. DP advised that colleagues are receiving a level of interim manually generated reports from the I.T. team, this does not fulfil the same role as the previous data in the dashboard, resulting in the sepsis nurses having to spend more time generating the Sepsis data.

FB advised that SQAC needed to continue to keep this issue under close review and stated that it is envisaged that there would not be progress made in month.

DR stated that there is a regular reporting meeting held 3 times per week whereby colleagues discuss all issues that are reliant on the reporting process out of EXPANSE. DR confirmed that he would ensure that DP is linked into these discussions and that DR would provide an update to DP offline regarding timescales to address the issue.

Resolved: SQAC to receive an update from the Expanse Programme Board led by the I.T. digital team regarding reporting across the Trust in general, ensuring that the update also includes an update on Sepsis data at the December 2023 SQAC meeting.
Resolved SQAC received and **NOTED** the Sepsis Data current position update and welcomed an update from the Expanse Programme Board at December 2023 meeting.

Assurance on Key Risks
23/24/132 *Delivery of Outstanding Care*
Safe

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

- Workstream 1 special cause of variation in instances of harm per 1,000 bed days, and whilst this was at first concerning there is an acknowledgement at the Patient Safety Strategy meeting, that this could have been for a number of reasons, with agreement at Patient Safety Strategy to further drill down into the data if there is a continued upward trend at the next Patient Safety Strategy meeting which is scheduled to take place on 16.11.23.
- Neonatal new-born screening - currently a support programme in place for Advanced Nurse Practitioners to undertake National New-born and Infant Physical Examination Programme Screening (NIPE) within their respective specialties
- Learning Disabilities and Autism Spectrum condition continues to see an increase in appropriate referrals which demonstrate the continued success of the project, and colleagues welcome the relaunch of the Learning Disabilities Champions in January 2024.
- Patient Safety Strategy Board received an update from the Hospital Optimisation workstream which is broken down into three key projects, namely acutely unwell child, the paediatric assessment unit and the ATTD (attendances, admissions, transfers and discharges). These projects are all at different stages of development. Patient Safety Strategy Board were pleased to see progress reported in all three areas, and in particular welcomed a clear HDU escalation flow chart, which is now in place for out of hours care.
- Patient Safety Strategy Board welcomed the formal reporting of the paediatric assessment unit which opened in August 2023.
- Patient Safety Strategy Board received excellent work presented by the Quality Assurance Team who were able to triangulate data and reinforced the importance of the patient pathway work which is already underway in the Community and Mental Health Division.
- Implementation date for PSIRF has been set for 1st January 2024, Patient Safety Strategy colleagues plan to join a Community PSIRF event in December 2023.

JRe thanked WW for informative update and sought clarity regarding the hospital optimisation and the improvements required regarding escalation of deterioration patients and sought clarity whether this related to the careflow system and sharing of information.
WW advised that this related to specific issues discussed earlier at SQAC regarding reporting of information and the issue regarding real time data being available for all staff. JRe stated it would be helpful to be aware of the detail.
ABa provided an overview of current position and alluded to work which commenced 18 months ago, ABA stated that a Business Case had been established regarding providing resident paediatric cover across the Trust, a workshop is planned in the future. ABa advised that this also ties in to Martha's rule and aligns with work regarding the patient observations are directly transferred into EPR rather than manually transferred by a nurse. ABa advised that this is a significant piece of work detailing how the Trust responds to deteriorating patients overnight. ABa stated that he is trying to align and articulate all of the work which is taking place across the Trust to achieve the safest hospital 24/7.

KB sought clarity regarding the Learning Disabilities and autism programme, and alluded to the problem statement referring to health inequalities and incorrect adjustments, however when reviewing the driver metrics there is no information in relation to those areas and just addresses appropriate referrals. KB sought clarity whether there are any sub metrics or whether these are still requiring development. WW advised that there would be some sub metrics and that he would update colleagues to relay KB's suggestion.

FB advised that SQAC had gained assurance in relation to governance regarding patient safety work from this report and from the summary report from the Patient Safety Strategy Board, with good points raised for follow up.

Resolved: SQAC welcomed the good progress made in month and the continuous improvement across an array of patient safety workstreams.

Resolved: KB requested WW to review the 2nd metric regarding hospital optimisation, WW agreed to review this.

Resolved: SQAC received and **NOTED** the good progress in month and welcomed future Patient Safety Strategy updates.
FB expressed thanks to WW and Patient Safety colleagues for comprehensive update.

23/24/133 ED MH attendance & ED @ its best update report

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

- UD advised that she was unable to provide all of the metrics, given that colleagues are unable to retrieve data.
- The Division had seen an increase in attendance in October 2023 compared to the three previous months.
- 71% of patients were treated within 4 hours, which is lower than the national recommended time, this had been attributed to the increase in attendances.
- UD alluded to the position in August 2023 and advised that all of these parameters would show a negative trend if colleagues were able to produce the data. 30% of the attendances were streamed to the UTCs, however the UTCs were also experiencing similar staffing issues. Medicine Divisional team members had met and are reviewing key improvement areas.
- UD advised that the Mental Health data is the August data, however colleagues believe that there will be an increase in attendance in October 2023 and November 2023
- UD alluded to the work undertaken in ED at its best, which commenced in April 2022, colleagues reviewed the first quarter 22/23, together with the first quarter of 23/24, which highlighted improvements across many of the metrics.

FB stated that in comparing the first quarter of each year this highlighted a positive position, however given the issues regarding resilience there would be a need to maintain focus on this. UD stated that this is being addressed with the Senior Leadership Team.

NP advised that some of the improvement work which is ongoing relates to the get me well cohort, and that there is work progressing now from urgent care system perspective, particularly with a Liverpool PLACE focus. NP related to focus regarding respiratory and advised that the plan would be to move forward with some of those activities which hopefully would support resilience and also reduce admissions into AED.

FB revered to the external context regarding the system, which is really important, and the data used to demonstrate across the system.

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

23/24/1134 NatSSIPs Report

RP presented the NatSSIPs Report

RP advised that in January 2023 NatSSIPs 2 was launched which had some additional requirements and a review of the Trust approach. In line with this the Trust is going to use this as opportunity to review all of the NatSSIPs processes. RP highlighted the importance of having a localised and bespoke process in other areas and reviewing all of the quantitative and qualitative reporting to provide assurance. RP stated that there is currently oversight of the numbers of invasive procedures, however further improvements would be beneficial regarding qualitative data, compliance and standards to support those processes. RP stated that the plan is to undertake a review of all NatSSIPs and Locsips across all areas, this is envisaged to take 4 months, this would be a collaborate approach across all divisions with involvement from Matrons who would be involved in leading and supporting this review. RP referred to the need to redefining the processes, underpinning the framework for the organisation and the reporting of this in the future.

FB referred to the completion of the work undertaken by February 2024 and sought clarity whether there is a national deadline. RP stated that she could not locate a deadline within the framework and that she would re review the framework. RP stated that the last time this was launched Trusts were given 2 years to complete the work.

JRe referred to the current problems regarding reporting systems and delays and sought clarity whether such delays may have an impact on NatSSIPs given the ambitious timescale for completion. RP stated that this is a possibility as colleagues are currently experiencing difficulties extracting the data. RP stated that the Trust has never had a dashboard for reporting for NatSSIPs which would be really beneficial.

ABa referred to the difference between work imagined, and the work done, and queried how the organisation would know that colleagues are doing these and how assurance is provided.

FB sought clarity whether the organisation have a good fix on how much of this work is within the Surgery division and how much invasive procedure work is being carried out across the other divisions. RP stated that 85%-90% is within the Surgery Division, with the majority being within theatres, followed by critical care, followed by ED and work on 3A, with some in outpatients – dental and ENT department. RP advised that this is quite widespread, and alluded to how the organisation provide assurance that the processes are being followed is always the most challenging. RP stated that it is more straight forward in theatres, as observational audits could be undertaken more easily as it is a contained area and that is it slightly more challenging across other areas in having the availability of somebody to observe the compliance.

RP stated that she could provide an update in due course if helpful.

FB stated that challenges may also relate to digital challenges in terms of documentation.

FB thanked RP for informative update and SQAC welcomed future updates on progression through the periodic reports.

Resolved: SQAC received and **NOTED** the NatSSIPs report.

23/24/135 Safeguarding Quarterly Report

NO presented the Safeguarding Quarterly Report

- Continued increase in multi-agency safeguarding hub requests, with a month on month increase.
- Challenges relate to level 3 safeguarding training compliance, Safeguarding medical rota and the Named Doctor role.
- NO alluded to the roll out of the new level 3 Safeguarding training across the organisation and the additional investment which had been secured following the successful business case investment, both internally and within the ICB.

FB referred to the Safeguarding training both level 3 training and level 1 training and the levels of compliance and sought clarity whether this is receiving sufficient priority across each of the divisions. FB welcomed comments from each of the divisions on how to improve compliance.

LC advised that Community & MH compliance for Safeguarding mandatory training is slightly better than other divisions solely as the service aligns with the Community & MH division. LC acknowledged the ongoing work by NO and the safeguarding team for the revamped training offer which is now a face to face session. LC stated that this is a priority for the division as is all mandatory training to improve compliance across the division.

Medicine Division – UD echoed LC comments and stated that this is a priority within the Medicine Division. UD stated that a number of clinicians requiring mandatory training had been highlighted to UD, and UD is writing to these colleagues personally to ensure staff are undertaking safeguarding mandatory training.

FB stated that a lot of the 'yellow' within the table which related to corporate services. FB welcomed thoughts from MS on how to improve this. ES stated that MS is not responsible for Mandatory training, and this is within the Academy portfolio. ES stated that colleagues do try and drive this through the Corporate Services monthly collaborative discussions. ES stated that she could place more emphasis on this, with the aim of receiving granular information. ES agreed to review this offline and would update SQAC at the December meeting.
NA acknowledged the ongoing work of divisions to improve compliance with good work regarding the online mandatory training. NA stated that as a children's hospital focussing on the care of children and young people that the Safeguarding Mandatory training figures are unacceptable.. NA stated that with the exception of level 3 training all the Safeguarding training is online, and the training is not onerous, it is good quality and is really informative. NA highlighted the importance on the need to address those outstanding members of staff who are required to undertake the online training, with a very firm deadline set for when the training needed to be completed, as it is not acceptable to have any amber or red staff for Safeguarding mandatory training. NA stated that for the areas that are required to have level 3 training that there needed to be an individual review of each person who is not compliant, with assurance that the individual has been booked onto the training and has attended training, and that anything less than this level of scrutiny is not acceptable as a children's hospital.
Resolved: NA agreed to undertake this discussion offline with NO and colleagues. SQAC to receive an update at December 2023 meeting regarding what actions are being taken to directly address those staff and to secure completion of training.

KB referred to the Named Doctor for Safeguarding as the report states that the Trust does not have one and this is a statutory requirement. LC stated that the organisation does have a Named Doctor for Safeguarding however they are not currently able to undertake the role. LC stated that it is not appropriate to update SQAC at this meeting and that she would update NEDS offline. FB stated it would be helpful to know when this is likely to be resolved and what the interim arrangements are to ensure any cover. LC stated that discussions had taken place with the ICB as usually the designated doctors for safeguarding would provide cover, there are not many of these colleagues, and that they have agreed that on an interim basis that they would support wherever possible. This has been on the risk register since January 2023.

Resolved: SQAC noted that this is on the Risk Register and that colleagues are working towards a resolution in the interim and are working towards a resolution.
SQAC welcomed an update at the appropriate time.
FB referred to some funding within the team that wasn't funded by Cheshire & Merseyside and sought clarity whether colleagues had recruited to all the posts that funding had been received for.
LC advised that the Named Doctor for Children in Care is currently out to advert, this is a post that this Trust had never had, although this is a statutory requirement.
LC alluded to the Medical Advisor Fostering and Adoption post and confirmed that this post had been recruited to.
LC stated that these are difficult to recruit posts, as they mandate that individuals need to be a paediatrician predominantly either a general paediatrician or a community paediatrician and that there are not many of these and there are not many who want to undertake safeguarding.

Resolved: SQAC received and **NOTED** the Safeguarding Quarterly Report. SQAC welcomed an update at the December 2023 SQAC meeting on what actions are being taken to directly address those staff requiring mandatory training to ensure completion of training.
Caring
Effective

23/24/136 Quarter 2 Engagement Report

LC presented the Quarter 2 Engagement Report

- LC stated that it is important to recognise the outstanding work undertaken by Jess and Alex to support the engagement of children and young people.
- LC stated that colleagues feel strongly regarding offering the children & young people opportunities and that the Trust is providing a qualifications and life skills programme for them, with significant ongoing work to support. There had been a successful bid from the charity with regards to the

different qualifications that they can undertake. Some Children & Young People had completed level 2 youth work and are commencing with the level 3 youth work.

- Children & Young People had undertaken the first level of British Sign language course and are communicating really well.
- Children & Young People had compiled a video for the AGM which was presented to AGM on 13.11.23.
- LC alluded to one of the Children & Young People priorities regarding inclusion, equality and PRIDE and that they had a week of action within the atrium regarding PRIDE.
- LC alluded to a case study regarding a young person whose sibling is in hospital long term and the case study refers to the sibling bonding of the children and young people forum.

FB stated that the report is outstanding and that the qualifications and skills achieved for the children and young people is really important and that this is an outstanding model and approach. FB referred to the outputs and insights which is really important. FB referred to the youth bank and sought clarity what would be different and what would happen in the future. LC stated that when stating this has gone live that it refers to the applications are open for community groups to apply for funding and then the Youth bank committee then decide what they do or do fund.

KB referred to the 50 forum members which is a significant achievement, together with the diversity of the forum is outstanding. KB alluded to Section 3.3 of the report and acknowledged that a good half of the outputs are clinical input and experience input which is outstanding. LC stated that during the summer period both Jess and Alex reported that they had both seen a shift change for the young people who were all involved in activities at different stages, with a phenomenal experience for children and young people, and the uniqueness for this allows this to further develop and enhance.

JRe stated that it was great to see the breadth of work undertaken and sought clarity regarding how this relates to the wider ICB work and whether there is going to be a Childrens Committee within the ICB and whether the Trust has the opportunity to share this information into the Children's Committee. LC stated that the Children's Committee had just been established and that she would like to see an Engagement group, LC stated that the Trust does link in with the NHSE National Youth Forum and the Trust does share information across the ICB. Jess and Alex had attended a training session across the ICB, the Trust work with both Councils and youth groups. LC referred to C&M animation regarding mental health and that LC received this by an amination provided by another organisation, LC provided feedback regarding involvement of children and young people and questioned why the animation had not been narrated by children, LC shared the link with Committee members.

FB commended the ongoing work of the Children & Young Forum and expressed thanks to the team.
Resolved: SQAC received and **NOTED** the Drugs & Therapeutics quarterly report

23/24/137 In phase update

DR presented Inphase update.

- DR advised that a number of the outstanding reports had now been submitted for validation and these are currently with relevant teams for approval
- There is an increased focus regarding improving visuals and creating effective dashboards which is being led by IM&T team in collaboration with the respective report owners.
- There had been a face to face Inphase development day which was held on 31.10.23 which was really effective and enabled several issues to be resolved.
- The next focus would be on the nursing audits module, with the aim to replace tendable prior to the contract ending in March 2024.
- Colleagues are working with morbidity and mortality module with J Grice & C Talbot.
- Across all modules colleagues continue to share development and improvements with Liverpool Heart and Chest who are undertaking a similar process.

KB stated that she understands that a lot of reports are showing as complete and are signed off, so the data may be extracted, however this is not reflected how we would like to be displayed. KB queried how this would be reported going forward as there is currently a large gap. DR agreed that he would follow this up offline and would work with the team offline to ensure there is an indication that there is assurance that the data required, and that it is in an acceptable format.

NA advised that there is a daily report which has originated from the Inphase project group, that uses the same visuals and templates as those used for the EXPANSE deployment which clearly displays the daily progress together with information whether any development is needed for each report. NA

suggested that from December 2023 that the highlight report would be presented in that same style to provide the assurance required.
NA stated that with the exception of PALS and Complaints that the data glitches had all been resolved for each of the six reports, and most of the further developments are regarding visualisation rather than the content of the reports.

FB welcomed the highlight report for the December 2023 meeting, and welcomed the nuanced reporting detailing priorities and progress in responding to the different requests and needs regarding user acceptability.

FB expressed thanks to DR and the team for ongoing support.

Resolved: SQAC received and **NOTED** the progress within the Inphase update

23/24/138 Safe Waiting List update

AB presented the Safe Waiting List update

- AB advised that following the Root Cause Analysis in Urology two years ago, the final outstanding action regarding ensuring a more robust discharge process will be delivered this month following EXPANSE go live. This would ensure that all of the actions from the RCA are completed.
- AB referred the impact that Alder care has had on data quality resulting in a 5 fold increase in the number of patients who are flagged for having an issue with their pathway as a result of going live with EXPANSE, with significant validation to be undertaken to get back on trajectory. It has been agreed to have an independent assessment of waiting lists to reconcile everybody and account for everybody, as a common issue in electronic record patient upgrades is that data goes missing and patients go missing from waiting lists. KB and AB had agreed with the intervention required. Once the analysis is available AB would share this with SQAC, AB envisaged this would be in approximately 3 month time.
- AB referred to the size of the challenge regarding the follow up waiting list. A follow up waiting list programme had now been established, largely as a result that some children are coming to harm. All of the incidents related to follow up care had been reviewed, there had been 70 submitted, unfortunately there had been 15 low harms, either psychological or physical and 1 moderate psychological harm. AB stated that this is a motivator to address the follow up waiting lists programme. AB stated that the data has issues with it, and part of the solution is to validate the follow up waiting lists in the same way as the validation had taken place for the new patients. AB stated that colleagues are listing more patients for follow up that can be seen, and there is an underlying issue with the need to adopt new models of care, such as a patient initiative follow up.

FB sought clarity whether this work is also taking place nationally across other trusts and queried whether there is any shared learning. AB stated that there is no national structured programme for follow up care and that there are pockets of practice in different Trusts across the country that are reviewing this. AB referred to patient initiated follow up for children where there is no national guidance the Trust works with the Hospital Childrens Alliance, and our Trust has listed thousands more patients for PIFU than other Trusts.
AB stated that paradoxically nationally there had been a signal to see less follow up patients, and the Trust had been paid less for follow up patients, which makes this a more complex environment in which the Trust is operating in. AB stated the importance of understanding the value for follow up for the child and family as some patients opt out, and some patients who frequently do not attend. AB highlighted the importance of distinguishing those patients who truly need a follow up appointment and those patients who are high risk who need to be seen on time and finding new models of care for those low risk follow up patients and for those patients who do not regularly attend, given that they should not be on the review waiting list, given that there are so many patients at high risk and are overdue.
FB stated that in an age when colleagues are using texts to remind people regarding appointments that some of the patient initiated follow up is not necessarily leaving people with no contact and that colleagues could send a reminder stating that they could book a follow up appointment should they want an appointment regarding patient initiations. AB stated that this is correct and that there is also the My Alder Hey patient portal.

JRe stated that within R&I there is work taking place regarding artificial intelligence and how artificial intelligence can be used as a tool to help manage waiting lists, and in particular reviewing how this impacts on the wider health inequalities in the area, and how the health inequalities work relate to how waiting lists are managed, and whether there are ongoing discussions regarding artificial intelligence.
AB stated that this is established and due to the volume of 80,000 patients some of the lower risk patients there are expectations that pathway management review process would be manged by robotic processes automation. the Trust does need to clinically set the parameters for these patients, and this can then be automated.
KB alluded to when a new pathway is designed or when a pathway is redesigned and sought clarity whether there is a conscious step to think about exception reporting, and whether colleagues try and proactively address areas that could potentially arise. AB stated that this is good point and stated that he would need to give this further thought to enable discussion with the team, whilst acknowledging the longevity.

FB thanked AB for comprehensive update and ongoing support. FB acknowledged the ongoing challenges with regards to the follow up waiting list and welcomed future updates.

Resolved: SQAC received and **NOTED t**he Safe Waiting List update.

23/24/139 Board Assurance Framework

ES presented the Board Assurance Framework
ES advised that this is the first iteration of the Inphase Board Assurance Framework. ES stated that there are still minor glitches which are being addressed, e.g., where there is a dual assurance committee relating to a risk it appears that RABD is displayed.
ES suggested that the Trust is in a steady state regarding the updated risks for 2030 vision and advised that colleagues are still working through this with a view to heading towards the January 2024 Strategy Board.

ES stated that there has been continued focus on process over the recent months, which had not prevented the updates. ES stated that the Trust is in in a strong position in terms of mitigation.
FB expressed her thanks to ES for Board Assurance Framework update and stated that it was good to see this progressing.

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

23/24/140 Quarter 2 PALS & Complaints Quarterly Report

NA presented the Quarter 2 PALS & Complaints Quarterly Report

- NA advised that this is a much improved report compared to the previous month. NA expressed apologies for the late sharing of the report, as this enabled the most up to date information to be reported.
- Whilst there had been a similar number of complaints over the last quarter, compared to the previous quarter, whilst noting that back in April 2022 there had been a reduction in complaints each month. With relatively small numbers of complaints currently.
- Performance had been variable during the quarter, mostly due to the issues and challenges with recording. The 3 day acknowledged is 100% for September 2023.
- Responsive rate times was 100% for September 2023, following challenges moving to the new system.
- PALS- similar number of PALS seen compared to previous quarters.
- Challenges related to responsive and is still quite low, this is variable by divisions. Corporate services had made a significant improvement. NA is hopeful that the 3 divisions would now have improved visibility which would result in improvements in response compliance levels.
- Report included learning from PALS & Complaints.
- There had been 4 reopened complaints.
- There had been 0 PHSA referrals in month.

FB thanked NA for Quarter 2 PALS & Complaints update.

Resolved: SQAC received and **NOTED** the Quarter 2 PALS & Complaints Quarterly Report

23/24/141 Complaints Review – ASD – ADHD Report

LC presented the Complaints Review – ASD-ADHD Report, as a follow up to the request from SQAC at the October 2023 meeting.

LC advised that a deep dive had been undertaken from 136 formal complaints reported across the Trust, 15 complaints related to ASD and ADHD services.

- Main themes related to waiting times and communication. There is an extensive improvement plan for both ASD and ADHD services which had been shared at Operational Delivery Board, Trust Board and various other Committees. LC advised that colleagues utilised the Brilliant Basic improvement plan which had really helped both services to continue to improve, whilst reviewing offers regarding feedback appointments and concluding the assessment and diagnostic pathway for children and young people. LS stated that the significant increase in referrals has had a significant detrimental impact on both waiting times and access to the services.
- LC advised that there is ongoing work taking place regarding appointment letters.
- The implementation of Aldercare had resulted in some delay, this is now on trajectory.
- Colleagues are reviewing software and the RPA processes, this is a very administration based service, are whilst there is an online portal there is a significant amount of work that takes place as they are very detailed and comprehensive assessments.
- Further improvements had been made to the telephone service and colleagues now look to audit calls to families, some families are extremely challenging. At present there is a national shortage regarding ADHD medication and as a result staff are experiencing levels of abuse.

FB referred to the challenges and stated that the Trust could have the best robust complaint process in place; however, complaints are going to continue given the national access issues, and colleagues know that referrals are going to increase and unless there is a way to resolve these issues that there are still going to be ongoing complaints. LC stated that it is fair to say that people have the right to complain, and that the ASD/ADHD numbers are small.

- LC referred to Sefton parent carer forum which is a local offer event live with the Trust having a heavy presence at these sessions.
- Division continue to have ongoing discussions with ICB colleagues regarding funding, however it is due to the sheer number of increasing referrals.

FB expressed her thanks to LC for deep dive, which provide SQAC with assurance that the Trust are continuing to learn from complaints and improving processes, whilst recognising that complaints would continue whilst the waiting list remains so long, and that there is little that could be done without additional resources.

Resolved: SQAC received and **NOTED** the Complaints Review – ASD-ADHD Report.

23/24/142 NICE Compliance Update

JRo presented the NICE Compliance update for the period 1st – 31st October 2023

- A total of 29 NICE Guidance Publications were received in the Trust since the last reporting period of which 7 publications were relevant to the Trust, 3 are still pending feedback on relevance review by the identified leads.
- A total of 16 NICE Guidance Publications are currently open across the Trust, of which 6 are at baseline assessment and 10 are at action plan stage.
- 1 guidance had breached the three month baseline timeframe by two months and had been escalated to the relevant lead and to the division for relevant action.
- From the 10 publications at action plan stage, 3 action plans within the Medicine division are out of compliance, and JRo is planning a deep dive with the division to address this.
- 1 out of compliance guidance spans across both the Surgery and Community and Mental Health Divisions.
- There are an additional 3 NICE guidelines within the Community and Mental Health Division, however JRo expressed a note of caution within the report as no new NICE guidance had been issued for a number of the publications.

JRo had met with Community & Mental Health Division on 10.11.23 and had revisited a number of the publications and as such had re reviewed the baseline assessment to ensure that they are still fit for purposes and to assure that they are reflective of the service that they are providing. This has resulted in the development of new action plans which are on trajectory and are being monitored within the division and would be reflected in the next reiteration of this report.

- JRo alluded to the Transition guideline which spans across the Medicine and Surgery divisions which is out of compliance, however JRo is assured that this is being reviewed via the Transition Steering Group and had been shared with them as part of the action plan.

FB stated that SQAC had obtained assurance from this report and thanked JRo for the comprehensive report.

NA highlighted the importance of the focus required in order to ensure that the outstanding guidelines are on trajectory.

JRo stated that she is happy to have an offline discussion with the Medicine Division and would follow up offline, the discussion would include UD.

Resolved: SQAC to receive update at December 2023 meeting to advise whether a meeting had taken place to address the longstanding outstanding guidelines given that there had been no improvements despite being highlighted as a priority.
FB welcomed the update received and acknowledged those new guidance received which had been reviewed and the new baselines being addressed quickly, with actions plans in place and delivered.
SQAC received and **NOTED** the contents of the report, SQAC **NOTED** the escalation of the overdue assessment and action plans. SQAC **NOTED t**he assurance that this is robustly being monitored through the Clinical Effectiveness & Outcomes Group (CEOG)

23/24/143 Clinical Audit & Effectiveness Assurance

JRo presented the Clinical Audit & Effectiveness Assurance Report which provided SQAC with oversight of the clinical audit activity from 1st October 2023-31st October 2023

- At the time of reporting the Trust had 20 mandated national audits, and all are progressing as expected.
- No regional mandated audits.
- 14 Trust wide priority audits, all progressing as expected.
- 31 new audits were registered in October 2023.
- 13 audits had been completed in the same time period.
- Emerging themes from completed audits, include improvements to documentation and information, clinical pathway review, and no changes required.
- JRo advised that since the report had been produced 4 out of the 8 overdue audits had now been completed, and the clinical audit team are awaiting the information to be returned.
- The Clinical Audit team had established weekly audit meetings with divisions to support compliance and shared learning, with improved traction.

JRe stated that this is significant progress at a challenging time. JRe referred to the Consent audit and consent issues and sought clarity how the Trust record patient consent and how patients consent to treatment and whether this is a reporting issue, or whether this is a new system with regards to the local audit patient consent and disclosing information and consent to treat, and sought clarity whether this is the same consent process. JRe stated that she could not answer this query as this would need a response via the divisions who are undertaken the audit.
FB stated that this emerged from one particular adverse event, and the issue related that this was well documented in surgery, but not necessarily well documented for other parts of the Trust, and the electronic patient record system was amended to ensure this was captured and captured regularly over a course of treatment as well as an individual event, with updated consent as patients progressed.
FB stated that for the more recent specific audits FB is less clear on the origins.
JRo advised that she would liaise with appropriate team to obtain the results of the audits and would forward them to JRe. JRo advised that MIAA are also reviewing this and that JRo would review MIAA Terms of Reference.

RP referred to the e consent module which had made a significant difference to ensure oversight in one place which has significantly helped. RP advised on the plan to roll out with regarding to blood transfusion, RP queried whether the Trust could do more regarding e consent to make this more auditable.

Resolved: SQAC received and **NOTED** the Clinical Audit & Effectiveness Report and accepted that oversight of Clinical Audit is being undertaken through the monthly Clinical Effectiveness Group.

23/24/144 Quarter 2 Confidential Enquiries/national guidance assurance report/NCEPOD Report

JRo – presented the Quarter 2 Confidential Enquiries/national guidance assurance Report/NCEPOD Report which provides oversight and learning from the Trust participation in the National Confidential Enquiry NCEPOD and any national improvement programme for the reporting period Quarter 2.

- The Trust participated in 5 Confidential Enquiries and 1 national service improvement programme during the quarter 2 period July 2023– September 2023.
- NCEPOD Transition from child to adult health study published, recommendations had been shared with the transition leads in June 2023. This had been shared with steering group who are working on the relevant recommendations.
- The Confidential inquiry regarding Testicular Torsion closed in Quarter 2, the Trust submitted the relevant case notes as requested. The national report is pending publication and is due in February 2024, on receipt of this JRo would provide a brief for Trust colleagues.
- 3 submissions were made to MBRRACE within the 30 day timeframe.
- From quarter 2 nationally Trusts and providers are no longer required to submit any cases to the LeDeR platform which is the learning disability platform. JRo advised that any death from children with a Learning Disability is reviewed through the Trusts local internal review processes and through the Child death review panel, with all cases being shared with the Hospital Mortality Review Group.
- JRo stated that there is no data available for Quarter 2 report.
- Next steps – there is a new NCEPOD study entitled Juvenile Idiopathic Arthritis which had been developed nationally by a consultant at Alder Hey. Data collection had commenced at the end of October 2023 with a deadline of submission for 11.12.23.

Resolved: SQAC **NOTED** progress and accepted oversight and assurance that the Trust is participating in all of the National Confidential Enquiries and that the Trust is upto date with all of the Trust submissions.

23/24/145 DMO update

NP presented the DMO update which provided an Executive Summary, Background/current state, Assessment and recommendation and proposed next steps.

NP sought SQAC approval to the cessation of the Quarterly DMO report submission to SQAC. NP alluded to the new mechanisms that had been developed to ensure that the DMO team are providing assurance across the organisation. NP stated that the current reporting framework that is operating does provide for a level of duplication to SQAC and that the cessation of reporting to SQAC would ensure a more effective use of committee focus and would not be detrimental to SQAC as the DMO maintain the systems of control that ensure that SQAC receives governance and assurance relating to projects that directly relate to patient safety, whilst also maintaining the opportunity at any time for SQAC to request a specific report should they seek further assistance or advice or guidance in relation to any formal projects that are being delivered and initiated.

FB stated that this is the consequence of the new governance arrangements in place. FB requested whether SQAC were content with the proposal of the cessation of DMO Reports. SQAC were supportive of this approach.

Resolved: SQAC received and **NOTED** the DMO update.

Resolved: SQAC Approved the cessation of SQAC receiving quarterly DMO reports, SQAC workplan would be amended to reflect.

FB thanked NP for submitting reports to date.

23/24/146 Divisional Update and Deep Dive regarding Sepsis Mandatory training compliance:

Surgery Division – RP provided Divisional update:-

- Key successes related to Medical photography receiving charity funding to support the palliative care service which is being piloted for 1 year.
- A new Locum Consultant within Cardiology had joined the team, this would assist with the reduction of waiting lists.
- 2 challenges within the division relate to Dietician support for the cardiac team, this remains on the risk register, there is a review in place to try to support in the new year.
- Challenges remain regarding the lack of the clinical dashboard following EXPANSE transfer.
- Risk profile remains static, division are planning an in depth review of the risk register focussing on legacy risks. RP referred to a risk regarding chest drains and stated that there is a long term solution in January 2024, with an interim solution regarding training and guidance.

KB sought assurance regarding the risks generally and referred to table in 5.1 and stated that there had been very little movement since July 2023, and that on average there is 1 risk per month and that only 1 risk had been closed in this time period. RP stated that there is definitely not the movement that the division would expect and that the division are going to undertake a divisional review to understand why this is static. RP stated that some of the issues may relate to staff who may have moved or changed roles, and that the documentation had not been updated. RP stated that the move to Inphase had further impacted this, RP stated that some of this issues would be administrative, and some issues relate to the process not quite right, RP envisaged that the December report would have a marked improved position regarding risk.

Community & MH – JP provided Divisional update and update on Sepsis Mandatory training compliance:-

The Division had 3 successful recruitments - Mental Health & Learning Disability Practice Educator, Medical Advisor for Fostering and Adoption and Consultant Neurodevelopmental paediatrics.

- Challenges related to national ADHD medication shortage and the work required to manage approximately 600 children who are on the ADHC medicines that are short in supply and the larger population of who had been upset or worried regarding the process. Parents of children with ADHD are also struggling. The ADHD teams had worked extremely hard to manage this and had been supported by pharmacy staff.
- Learning from how the Surgery division manage their incidents, the Community and MH Division put in place a different way of receiving reports back to the division in a timelier way, this had been positive resulting in reports returned timelier. JP expressed thanks to Surgery division for the shared learning.
- Community & MH Division are currently undertaking a review of all investigations undertaken within the last year, to enable assurance that all actions that had been identified had been completed.
- Sepsis - 71 out of 806 staff are out of date with Sepsis training, 205 members had not been identified as requiring sepsis training, however they require training. Priority areas - community matrons, community nursing and home care services are all 100% compliant with Sepsis training. Outpatients' teams are just above 95%.
- 71 staff who require Sepsis training have received a personal message to address this issue.

Medicine – JG provided Divisional update and update on Sepsis Mandatory training compliance:-

- Successful PAU pilot had now moved to business as usual; the pilot had been completed and is being regularly reviewed.
- Response team had been fully recruited to and are providing 24 hour cover 7 days per week.
- The division had increased pharmacy ward cover during the winter period.
- Challenges regarding the reconfiguration of the Neurology Service with the loss of a neurology consultant, plans are being reviewed regarding the on call cover in conjunction with other areas across the country.
- Challenges regarding the on call medical rota, with increased sickness and trainees removed from the on call rota, resulting in increased gaps, and medical cover out of hours, this is being reviewed by colleagues within the Medicine Division.

- Sepsis Compliance – division are currently reviewing at the Sepsis Steering Group all roles within the division. JG stated that some individuals and departments had added themselves onto ESR, which had resulted in a slight decrease. 3 areas had increased compliance -3B, MDU had remained at 100% and ward 3C compliance had increased. 8 of the medical care specialities had remained at 100% compliance. JG stated that there is ongoing focus with the Sepsis Steering Group are reviewing over 830 job roles within medical division, it is envisaged that this is likely to take until December 2023 to review all of the job roles.
- There had been an increase in Pressure sores with 3 pressure sores in October 2023, all had been reviewed at the Rapid Review meetings in conjunction with tissue viability colleagues and all were deemed non preventable due to the complexities of the patients.

Research Division - LR presented the Research Divisional update and update on Sepsis Mandatory training compliance:-

- Division reported a decrease in recruitment over the last few months, a deep dive had been undertaken, the division had recognised that there were a number of patients who were missing from reports as the Research division recruitment data is not connected to the BI system. Division had retrospectively reviewed these reports again.
- Division had the first sub divisional patient and experience engagement group which was held in October 2023.
- Division had a visit from NIHR and the Department of Health and Social Care on 17th October 2023, which was a planned routine visit connected with the CRF, the visit went well with good feedback received.
- LD alluded to the new pathways being followed regarding muscle biopsy patients with joint working with Surgery who had taken ownership of two of the incidents related to admission on meditech. Working group continuing with support of the digital team to ensure patients do not have duplicate admissions and that all admission detail (including site intending of biopsy are added by PCO staff).
- Sepsis – LR expressed thanks to HR colleagues and to KH for reviewing the Research staff lists. LR stated that there were staff members within the division who had not been included on the list. The division held a Sepsis month in October 2023, resulting in staff being included on ESR and having access to the Sepsis training module. Division are currently at 89% - this relates to 4 members of staff who are currently on long terms sickness, 2 staff are expected to return this month and therefore it is envisaged compliance would increase.
- LR stated that the division had also agreed the same type of event/focus to address Safeguarding training, LR envisaged improved compliance in December 2023.
- The division are continuing to receive Patient feedback through the new Alder Hey research feedback platform, overall feedback is positive, the most common negative response related to patients knowing how they will receive the results of the study. This requires consideration as not all studies would disseminate published results to participants and would need addressing on a national level.

FB stated that it is a challenge regarding providing feedback on ultimate studies and sought clarity whether there could be an interim report which could provide feedback on progress of the study within Alder Hey Children's NHS Foundation Trust, or nationally within a 12 month follow up requirements. FB stated it may be helpful for patients to receive interim update of the study.
FB expressed her thanks to Divisions for Divisional updates and for the Sepsis Deep Dive updates which had been extremely constructive.

Resolved SQAC received and **NOTED** the Divisional updates and the Deep Dive regarding Sepsis Mandatory training compliance.

23/23/147 *Well Led*
Responsive
Winter Planning Report
AB presented the Winter Planning Report for Ratification.
Resolved: SQAC received, **NOTED** and Ratified the Winter Planning Report

23/24/148 **PSIRF Policy**
JRo presented the PSIRF Policy which supports the PSIRF plan. PSIRF policy had been approved at Patient Safety Strategy Board in October 2023, PSIRF policy would be presented to Trust Board for

sign off in December 2023 and would be presented at PLACE. PSIRF Policy would be presented to ICS on 14th December, pending this the Trust would go live with PSIRF on 1st January 2024
FB stated that this extremely thorough Policy, with external scrutiny.
FB expressed thanks to JRo and the team for ongoing support drafting the policy.
FB referred to the importance in the shift of emphasis to learning lessons and implementing them, as the Trust does not want to lose sight of the process, and the timeliness of responses, and the dual process going forward, rather than a shift of emphasis. FB stated that colleagues need to be careful regarding how this is presented internally.
LC stated that the reference to 'hospital' is removed as should read Alder Hey Children's NHS Foundation Trust or the organisation.
JRo welcomed any further feedback.

Resolved: SQAC received, **NOTED** and **Ratified** the PSIRF Policy.

23/24/149 Clinical Effectiveness and Outcomes Group Chairs highlight report

JRo presented the Clinical Effectiveness & Outcome Group Chairs highlight report and expressed apologies for lateness in submitting the report as the Clinical Effectiveness and Outcomes meeting only took place on 10.11.23. JRo advised that this was a positive meeting with in depth discussions and assurance relating to progress regarding clinical audits and NICE guidance.

- The CEOG Chair had contacted the audit leads who had not responded to previous prompts/reminders, resulting in 4 out of the 8 audits had now been completed.
- Feedback from all attendees noted the rapid progress that had been made with improving compliance and oversight of clinical audits and compliance and recognising the positive engagement.
- Thanks were expressed to Dr.J Ratcliffe who had chaired the Clinical Effectiveness meetings in the absence of the current recently appointed Chairs, as Dr. JR steps down from interim Chair of Clinical Effectiveness & Outcomes Group.
- Active discussion was held at CEOG regarding the call for topics nationally for the national inquiries, the Trust has to submit some suggested topics for review nationally in February 2024.
- Several Health and Safety and Infection Prevention Control Policies are out of date, with limited/no progress made. JRo stated that there is an Infection Control Committee meeting scheduled on the afternoon of 15.11.23 and all policies would be approved at that meeting, prior to submission to December SQAC for ratification. JRo stated that she would be sharing the same information to the Corporate Collaborative meeting regarding the Health & Safety Policies and this would be addressed at the next meeting.

Resolved: SQAC received and **NOTED** the Clinical Effectiveness and Outcome Groups Chair highlight report.

23/24/150 Any other business - None.

23/24/151 Review the key assurances and highlights to report to the Board.

- SQAC received a positive Patient Safety Strategy update, which provided assurance on progress and governance.
- SQAC received ED monthly report: MH attendances and ED @ its best update. SQAC noted the challenges and the need to address resilience as soon as attendance increases and as soon as staff sickness increases.
- SQAC received NatSSIPs report, with good insight with regards to the revised guidance and how this is being managed.
- SQAC received the Safeguarding Quarterly report, with robust discussion held regarding the need to focus on training across the Trust, with an update to be provided to SQAC at the December 2023 meeting detailing a plan for those areas requiring focus for further improvement.
  SQAC also noted the investment going into this area, whilst noting the difficulties regarding recruitment to these posts.
- SQAC received the Quarter 2 Engagement report, which detailed the activity across the organisation and the support provided to the Children & Young People by our teams.
- SQAC received an Inphase update which provided SQAC with some assurance regarding the attention that this is receiving on a regular basis.

- SQAC were supportive of a change in focus of the report, to enable SQAC to see any nuances and development of the report.
- SQAC received the Safe Waiting List update and noted the challenges and progress being made.
- SQAC received the new Board Assurance Framework.
- SQAC received the Quarter 2 PALS & Complaints report.
- SQAC received the deep dive of complaints relating to ASD/ADHD, with SQAC understanding the broader issues.
- SQAC received the NICE compliance update, with positive reports, providing assurance on progress made and compliance.
- SQAC received the Clinical Audit & Effectiveness Assurance Report, with positive reports, providing assurance on progress made and compliance.
- SQAC received the Quarter 2 Confidential Enquiries/national guidance assurance report/NCEPOD report with positive reports, providing assurance on progress made and compliance.
- SQAC received the DMO update and SQAC agreed that they did not require any further DMO updates in light of the new governance structures.
- SQAC received Divisional updates which also included a deep dive regarding Sepsis mandatory training compliance levels, with an update on compliance for high-risk areas. SQAC recognised a range of challenges within the Divisional updates and things to be proud off. SQAC noted that the Sepsis mandatory training deep dive demonstrated that attention is being provided and that progress is being made, however there is further work to do with regards to new colleagues who had been added to the group requiring mandatory training.
- SQAC received the Winter planning report for information, having been previously scrutinised.
- SQAC received and Ratified the PSIRF Policy
- SQAC received a good report from the Chair of Clinical Effectiveness and Outcome Group meeting.

FB expressed thanks to all

Date and Time of Next Meeting: 18th December at 9.30 -11.30 am via Microsoft teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th January 2023

Paper Title:	People Plan highlight Report.
Report of:	Chief People Officer
Paper Prepared by:	Amanda Harrison, Head of HR Business Partnering

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Summary / supporting information:	To provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce.
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 provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during December 2023.

2. People Metrics

The detailed people metrics can be found within the Integrated Performance Report (IPR). Complete sickness figures for December are not available at the date of this report writing, but will be available for discussion at Trust Board though the IPR:

- Turnover has had its 8th consecutive month of reduction and has dropped to 11%, within the annual target of 13%.
- A focused effort from the whole Trust is beginning to show improvement in respect of PDRs with a December position of 70% against the target of 90%, which represents a continued increase of 10% in the last 6 months.

3. Industrial Action

The Trust continues to respond to industrial action through the tactical command structure. Following unsuccessful talks with the government, the **junior doctors** took strike action from 20th - 23rd December 2023, and from 3rd - 9th January 2024. No further dates have been shared at this stage.

In addition, a ballot of **junior doctors in Wales** (by the BMA) was successful, and a strike will take place for 72 hours, starting on 15th January 2024. There are currently 4 Welsh trainees working at the Trust, with divisional teams planning accordingly.

There is a break in consultant strikes as the BMA put the offer from the government to their members; the vote closes on 23rd January 2024. Should the offer be accepted, this will bring the action to an end (with consultant colleagues). Of note, the BMA re-ballot of consultants for strike action, should it be required, was successful (ballot closed on 18th December 2023).

SAS doctors (Specialty Doctors, Associate Specialists & Specialist Doctors) are now also being balloted for strike action. This ballot closes on Monday 8th January 2024. The Trust employs 24 SAS doctors and dentists.

4. Staff Survey 2023

The annual NHS Staff Survey closed on the **24th of November 2023.** The results are currently being analysed and a detailed update will be provided on completion of the analysis.

5. Summary Highlights

- **Turnover** - Sustained reduction in staff turnover with further opportunities to analyse this detail to understand the continuing downward trend.
- **PDR progress Further work is required to ensure 90%** Attention to encourage quality conversations, including stay discussions, health & wellbeing included in process.

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6. Actions:

- Ongoing presence around absence support/advice continues in each division, for Divisional managers.
- New resignation & exit interview process is now online to capture qualitative data and enhance analysis of turnover.
- Review data on PDR completions per division continues to be gathered with ongoing action.

Amanda Harrison
Head of HR Business Partnering
3rd January 2024

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 27th November 2023 at 13:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	Fiona Marston	Non-Executive Director	(FM)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	(JG)
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nurse	
	Colin Beaver	Deputy Director of Communications	
	Audrey Chindiya	Accountant, Medicine	
	Dani Jones	Director of Strategy and Partnerships (DJ)	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Natalie Palin	Associate Director Transformation	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	
	Gary Wadeson	Associate Director Income, Costing & Commissioning	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda Item:	Jane Halloran	Acting Deputy Development Director	
	Sian Calderwood	ACCO, Medicine	
	Dan Hawcutt	Senior Lecturer	

23/24/126 Apologies:

Catherine Kilcoyne	Deputy Director Business Development
Emma Hughes	Acting Manging Director for Innovation
Claire Liddy	Managing Director of Innovation

23/24/127 Minutes from the meeting held 23rd October 2023
The above minutes were approved as a true and accurate record.

23/24/128 Matters Arising and Action log
All actions for this month have been included on the agenda.

23/24/129 Declarations of Interest
There were no declarations of interest.

23/24/130 Finance Report
Month 7 Financial Position
RABD noted £1.5m surplus, whilst year to date is a small surplus of £25k. This is slightly ahead of the breakeven target. An update on workforce and forecast was received. CIP is £1.8m off plan. Further detail on the underlying position will be presented at the December RABD.
Action: Finance team

Resolved:
RABD received and noted the M7 Finance report.

23/24/131 HFMA Sustainability review
CS provided a summary of the Healthcare Financial Management Association (HFMA) on the briefing to Improving NHS financial sustainability. The review was welcomed as a way of reviewing processes against best practice. This has led to a series of initiatives rolled out.

In summary, all areas are now green with ongoing learning.
Resolved:
RABD received and noted the outcome of the HFMA Sustainability Review.

23/24/132 Month 7 Integrated Performance Report
AB highlighted:
Patients seen within four hours was back at 77% in October after the drop in September. Effort continues for 80% upwards.

Update was received on improving staffing levels for Theatres.

Alder Hey occupancy was at 90%.

International nurses are due to start in post in January 2024.
Resolved:
M7 IPR report was received.

23/24/133 Debt Write Off
RABD was asked for approval to write off £348,366.40 of bad debt. The debt relates to two invoices related to recharge of specialist mental health restraint costs (Prometheus), incurred by Alder Hey back to Birmingham NHS Trust and Salford City Council for a patient who arrived in England from an African war zone, and moved around the system.

It can be confirmed that processes have since been updated to ensure that approval is gained with third parties before costs are incurred.

Resolved:
RABD APPROVED write off £348,366.40 of bad debt.

23/24/134 Third MRI Scanner Business Case
SC went through the above BC case requests RABD approval for the purchase of a new 3T research/clinical MRI scanner (funded via a NIHR grant) and subsequent running costs of the scanner. All capital costs will be met from the NIHR grant. Based on most likely scenario it is believed from year four onwards running costs will be covered by new income streams, with a small contribution to the Trust bottom line.

DH went through in detail the difference this would make to research across Alder Hey and wider.SC noted a operational plan was being worked through with Radiology. DH added that an MRI Scanner was coming to the end of it's use at Alder Hey, if it was felt three scanners were not needed this scanner would not be replaced.

Resolved:
RABD APPROVED the Third MRI Scanner subject to achieving stretch measures detailed in the paper.
Further ratification to be received at the December Trust Board.
Going forward progress of the Third MRI Scanner would be monitored through the Research, Development Committee.

23/24/135 Benefit Realisation
The primary purpose of this paper is to respond to feedback provided at the RABD committee (Oct 23) regarding the Trust's Benefit Realisation approach. The Benefit Realisation Framework was broadly endorsed; however, some improvements were suggested. The first was to 'bring to life' a benefits case through a worked example

and subsequently provide further details for the management and oversight for conversion into cash releasing and efficiency savings. It is anticipated that the rigor of the approach outlined will inevitably identify areas of risks and considerations on where resources are prioritised based on the wider ROI.

Resolved:
RABD discussed how this could be used further going forward and thanked NP for the development to date.

23/24/136 Campus Update

RABD received a paper with current position for each of the projects.

Park: Phase 3 to be completed by March 2024 with seeding of pitches to take longer.

A private RABD was held on 7th November 2023, approval was given to fund inflation costs of £1.4m subject to the team developing a mitigation plan in relation to increased SPV/other costs.

Gender development services are due to commence from April 2024, further updates to be received through Campus updates.

Resolved:
RABD received the current position of the Campus development.

23/24/137 Digital Futures Strategy

In the essence of time the above paper was noted as read.

Aldercare
Aldercare is now in it's second phase and the first Programme Board is due to be held this afternoon.

The Chair asked for details on issues raised around finance reporting. KW said good progress continues to be made whilst remaining under review.

Resolved:
RABD noted Aldercare is now live in all services and is now in the post go live phase.

23/24/138 PFI

Skylight replacement in ICU has been stood down for the winter. Three pods have been successfully completed. The programme will recommence in April 24 with the final three skylights completing the following October.

Resolved:
RABD received and noted the current position.

23/24/139 Communications

Details of plans for the Medicinema to be funded by Alder Hey Charity was shared with the public and was well received.

Alder Hey's breathlessness clinic was recently featured on CBBC's Operation Ouch with new presenter Dr Dan and included our very own Mr Ian Street, Dr Ian Sinha and Physiotherapist Claire Hepworth from the multidisciplinary team.

Resolved:
RABD received and noted the communications report.

23/24/140 Energy Procurement

Alder Hey moved to a flexible contract for FY23/24 based on expected savings vs the fixed price. We are on track to beat these forecasted savings with the market trending down over the last 6 months.

As Flexible prices are still lower than fixed, Alder Hey has tendered a flexible 24-month contract.

Resolved:
RABD APPRPOVED the Energy Procurement Strategy.

23/24/141 Board Assurance Framework

RABD noted:

- updated position with regards to management of the BAF risks;
- agree the reduction in score for risk 4.2, Digital Strategic Development and Delivery from 4x4 to 3x4 following Aldercare go live.

Resolved:
RABD received and noted the Strategic Risks.

23/24/142 Any Other Business

No further business was reported.

23/24/143 Review of Meeting

RABD noted good discussions and development of items discussed.

Date and Time of Next Meeting: Wednesday 20th December 2023, 1500, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th, January 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Monthly BAF Reports
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☑ Game-changing **research and innovation** ☑ **Strong Foundations** ☑
Resource Implications:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

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

Board Assurance Framework 2023/24

1. Purpose

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

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

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

2. Review of the BAF

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

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Resources and Business Development Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Resources and Business Development Committee
1.4	Access to Children & Young People's Mental Health	Resources and Business Development Committee
		Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Failure to deliver the best experience for Staff, Children and Young People and their Families	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	Resources and Business Development Committee
3.2	Strategy Deployment	Trust Strategy Board
3.4	Financial Environment	Resources and Business Development Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Research & Innovation Committee
4.2	Digital and Data Strategic Development & Delivery	Resources and Business Development Committee

3. Summary of BAF at 9th January 2024

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Delivery of Outstanding Care *(Outstanding care and experience)*				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	RABD / SQAC	**4x5**	3x3
1.3 AB	Building and infrastructure defects that could affect quality and provision of services	RABD	4x3	2x3
1.4 LC	Access to Children and Young People's Mental Health	RABD / SQAC	**3x5**	3x3
STRATIC OBJECTIVE: The best People going their best work *(Support our people)*				
2.1 MS	Workforce Sustainability and Development	PAWC	**3x5**	3x2
2.2 MS	Failure to deliver the best experience for Staff, Children and Young People and their Families	PAWC	3x3	3x2
2.3 MS	Workforce Equality, Diversity & Inclusion	PAWC	**3x5**	4x1
STRATEGIC OBJECTIVE: Sustainability through external partnerships *(Collaborate for children and young people)*				
3.1 RL	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	RABD	3x4	3x2
3.2 DJ	Strategy Deployment	Strategy Board	3x4	4x2
3.4 JG	Financial Environment	RABD	**4x4**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	**4x4**	3x3
STRATEGIC OBJECTIVE: Game-changing Research and Innovation *(Pioneering breakthroughs)*				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Research & Innovation	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Digital and Data Strategic Development & Delivery	RABD	3x4	2x4

4. Summary of December 2023 updates:

- ***Strategy Deployment (DJ).***
  Risk reviewed; no change to score. Vision 2030 progressing as per agreed timeframes.
  Strategy Leadership Group have hosted two sessions for Get Me Well and Personalise my Care in Oct 23 and Dec 23, lead by our Clinical Leaders, to progress this agenda.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; Current risk evidence, actions and controls assessed and no change to score in month. Specific updates include:
  1. ICS commitment to CYP is taking shape through progression of the CYP Committee, which met informally in Sept and Nov 23, and formally for the first time in Dec 23.
  2. Various stakeholder engagement sessions took place in Dec 23 or are scheduled for Jan 24 to begin formal engagement and socialization of Vision 2030 with partners. Feedback so far has been very positive, and there is much system alignment on the priorities for CYP.
  3. On 7th December NHSE confirmed that the North West region would proceed with delegation of the first phase of specialised services in April 24.
  4. Place level capability and capacity within the strategy team remains a risk.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed; work continues to update in line with the 2030 Vision. No change to risk rating.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  Weekly meetings with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved.

  The second phase of improving water quality within the closed loop system has been extended to December. The SPV have issued a corroded pipework report to the Trust and both parties met on the 27th November to discuss. The Trust and Project Co reps undertook a walk round to verify report and found actions outstanding LOR and Project Co to mop up and re-issue to Trust end of Jan 2024.

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

  Further details on the online dosing system have been requested. P Co / Mitie have been slow to respond. site visit has taken place December 23. First pack of carbon filter pricing has been provided to WSG. Mitie to provide remaining parts prior to 22nd Jan joint safety meeting.

  Temporary chillers have been removed from the MSCP in December 23 the permanent ones are undertaking commissioning works in Jan Project Co to update end of Jan.

Works on the skylights will recommence April 2024.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in December was exceptionally challenging, with a significant increase in attendances and acuity and the department has increased the number of GP streams in response. However, in month performance against the 4 hour target for December was 85.2%, exceeding the national standard of 76%. Other key elements of the winter plan include Virtual Ward, PAU and UTC to support ED performance and access over the coming months.

  Diagnostic waits have been sustained and we delivered 89.90% compliance during December.

  Capacity to reduce long waits (RTT) remains a challenge, with agreement to reduce the number of sessions per week in the Theatre schedule from end of October to mitigate pressures including staff absence. However, there has been a decrease in 65ww (from 236 to 200) in month. Division of Surgery continue to actively manage this with focus on ENT, Dental and Spinal (all of which have protected theatre sessions). There is an ongoing risk regarding the potential for further Industrial Action which is a threat to elimination of 65ww by March 2024.

- ***Inability to deliver safe and high-quality services (NA).***
  BAF 1.1 has been reviewed and remains static. Further review and alignment to continue this year as we move to alignment with 2030 Vision. The risk is reviewed and monitored through SQAC.

- ***Access to Children and Young People's Mental Health (LC)***
  Review of actions completed and updated.

- ***Financial Environment (JG).***
  Risk reviewed and score remains at 16 due to some uncertainty on the 23/24 forecast with the recent industrial action impact and also the exit run rate and underlying position going into 24/25. Work has progressed on identifying and closing the recurrent CIP gap and significant improvement has been made in the month. The 11 benefit cases are in development using the new benefits framework and will be reported to RABD in February. Annual planning is underway for 24/25 and will be reported through RABD with the draft plan to Board in March.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed in month. No change to score. No new gaps/ issues identified. Countdown to handover of the Park to the Council now in progress. Contract for the main works on the Neonatal scheme has been agreed.

- ***Digital and Data Strategic Development and Delivery (KW).***
  Risk reviewed, score remains static.

- ***Workforce Sustainability and Development (MS).***
  Risk reviewed and work continues to update in line with the 2030 Vision.

- ***Failure to deliver the best experience for Staff, Children and Young People and their Families (MS).***
  Risk reviewed and actions amended and updated. No change to risk rating. Agreed with CPO that risk will be reviewed and updated to reflect changed risk outline and description to broaden scope and include risks relating to organisational culture.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  Risk reviewed. No change to score in month. Actions remain on track.

5. Corporate risks (15+) linked to BAF Risks (as at 9th January 2024)

There are currently 18 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked
STRATEGIC OBJECTIVE: The best people doing their best work *(Outstanding care and experience)*				
1.1 Inability to deliver safe and high-quality services (3x3=9)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.4
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval	5x3	Surgery	
2672	Not compliant with national guidance with transferring and transcribing patient records following adoption	3x5	Community	
2657	As there is no consistent method for recording and communicating resuscitation decisions across the trust there is a child may be resuscitated inappropriately and receive inappropriate and potentially harmful treatment. A child may not receive resuscitation when it is in their best interests to do so.	5x3	Medicine	
67	NatPSA/2023/010/MHRA - Risk of death from entrapment or falls	5x3	Business Support	
91	Junior doctor staffing in general paediatrics	5x3	Medicine	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care (capacity).	4x4	Surgery	1.2 & 2.2
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	2.2
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	2.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	2.1 & 2.2
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	2.1 & 2.2

Risk	Risk Title	Score (IxL)	Division	Linked
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)				
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2
2019	Delay in treatment for Speech and Language Therapy	3x5	Community	1.2
2360	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18 week referral to treatment target for routine).	3x5	Community	1.2
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care (capacity).	4x4	Surgery	1.1 & 2.2
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)				
	None			
1.4 Access to Children and Young People's Mental Health (3x5=15)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.1
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.1
STRATEGIC OBJECTIVE: Delivery of Outstanding Care *(Support our people)*				
2.1 Workforce Sustainability and Development (3x5=15)				
91	Junior doctor staffing in general paediatrics	5x3	Medicine	1.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.2
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.2
57	Capacity/demand issues for the statutory Adoption Medical Advisor role	4x4	Community	2.2
2.2 Failure to deliver the best experience for Staff, Children and Young People and their Families (3x3=9)				
2741	The ability to maintain OFSTED ratios as a result of staff availability/turnover.	4x5	Business Support	

Risk	Risk Title	Score (IxL)	Division	Linked
	Health and Safety concerns operating the nursery in its current position in the centre of a building development			
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.1
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.1
57	Capacity/demand issues for the statutory Adoption Medical Advisor role	4x4	Community	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care (capacity).	4x4	Surgery	1.1 & 1.2
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1
2.3 Workforce Equality, Diversity and Inclusion (3x5=15)				
	None			
STRATEGIC OBJECTIVE: Sustainability through external partnerships *(Collaborate for children and young people)*				
3.1 Failure to fully realise the Trust's vision for the park and Alder Hey campus (3x4=12)				
	None			
3.2 Strategy Deployment (3x4=12)				
	None			
3.4 Financial Environment (4x4=16)				
2579	Risk of failure to achieve financial balance due to existing and emerging cost pressures, impact of Industrial Action on the delivery and recovery of NHS services, reduced effectiveness of services, inability to invest and innovate and potential of increased workforce pressures	3x5	Medicine	
3.5 System working to deliver 2030 Strategy (4x4=16)				
	None			

Risk	Risk Title	Score (IxL)	Division	Linked
STRATEGIC OBJECTIVE: Game-changing research and innovation *(Pioneering Breakthroughs)*				
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)				
	None			
STRATEGIC OBJECTIVE: Game-changing research and innovation *(Revolutionise Care)*				
4.2 Digital and Data Strategic Development and Delivery (3x4=12)				
	None			

6. Recommendation

The Board/Committee is asked to:

- note the updated position with regards to management of the BAF risks;
- note the ongoing issue with regards to target risk score colour not pulling off the system correctly. InPhase are continuing to investigate.

Erica Saunders
Director of Corporate Affairs

Inability to deliver safe and high quality services	
Risk Number	Strategic Objectives
1.1	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	Safety & Quality Assurance Committee

Description
Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

Jan 2024	
Control Description	Control Assurance Internal
The Trust has a quality improvement programme 'Brilliant Basics', where quality improvement is at the heart of everything we do and provides staff with the skills, knowledge and confidence to learn, lead and deliver in an improvement style.	Formal and informal training and coaching available to support departments to make positive changes. Outcomes shared through the SharePoint site and reported to board bi-annually against agreed plan.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through CQSG, learning bulletin produced and learning from RCA's shared at the meeting
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC

Gaps in Controls / Assurance
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis 2. Failure to comply with NICE guidance review and implementation in line with recommended timeframes 3. Robust reduction programme in the number of medication incidents and near misses 4. Impact of Industrial action in the safe delivery of care and progress against recovery 5. The CQC will move to a new oversight framework which may reduce our CQC ratings 6. The 2030 vision sees a shift to a consumer focussed experience with 5 workstreams with key deliverables for year 1, without any additional resource 7. The new models of care workstream will need to redefine the delivery of services whilst maintaining the principles of the strategy 8. Alder Care (Expanse) has been implemented across the organisation which poses risks until stabilisation.

Action	Description	January 2024	
		Due Date	Action Update
Alder Care (Expanse)	8. The risks to quality and safety need to be monitored during the period of stabilisation	30/11/2024	Command and control in place through the deployment which includes the monitoring of quality and safety data,.
Delivery of 2030 Vision	6. The programme will need to articulate resources required against impact of no additional resources being available. The experience focus underpins all other parts of the vision and key to the delivery of the overall strategy	31/01/2024	Resource requirement and impact assessment currently under development.
Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2024	There has been improvement in administrations times which continue to be monitored through SQAC to embed improved performance.
Industrial action	4. The ongoing industrial action by various unions has a potential impact on the safety and quality of our care. This is managed through the EPRR process to ensure the hospital is safe but does impact children and young people through cancelation and rearrangement of various services including OPD and elective surgery.	31/03/2024	IA planning group in place for the current Junior Doctors, consultant and recently reported radiographers IA. Managed through EPPR route and planning in place
Medication Errors and Near Misses	3. Proactive programme of work in place to reduce medication errors	31/03/2024	Dashboard in place with insight into the causes of medication errors and a proactive reduction plan monitored through Patient Safety board.
New CQC Assessment Framework	5. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2024	Key executive and corporate staff have undergone training in the new process and will continue to work with the CQC whilst change over date is pending
New Models of Care	7. Clinical leaders will need to be appointed to oversee the process and provide challenge on the principles of the strategy	31/03/2024	Clinical summits have been held which will prioritise the changes that will have the biggest impact.

Children and young people waiting beyond the national standard to access planned care and urgent care	
Risk Number	Strategic Objectives
1.2	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
■ Effective ■ Responsive		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
20	9	Resources and Business Development Committee

Description

Capacity and Demand modelling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care, and risk to achieve the national standard of eliminating waits >65 weeks by March 2024. Our challenged specialties include ENT, Dental, Spinal Surgery, ASD/ADHD and CAMHS. In addition, unprecedented demand for urgent care has increased the wait for clinical assessment and reduced the percentage of patients treated within 4 hours. These factors combine to create a risk that waiting times for elective and urgent care will exceed national standards, with potential detriment to experience and outcomes for Children, Young People and their families.

Jan 2024	
Control Description	Control Assurance Internal
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	Daily reports to NHS England -@ Daily Performance summary -@ monthly Performance report to Operational delivery group -@ Performance reports to RABD Board Sub-@Committee -@ bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	Corporate report and divisional Dashboards -@ Performance reports to RABD Board Sub-@Committee -@ Use of electronic patient pathway forms to signify follow-@up clinical urgency and time-@frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	Significant decrease in waiting times for Sefton SALT -@ Corporate report and divisional Dashboards -@ Performance reports to RABD Board Sub-@Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	monthly Performance report to Operational delivery group -@ Corporate report and divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	monthly oversight of project delivery at Programme Board -@ bi-@monthly transformation project update to SQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - SDG forum to address challenged areas and approve cases for investment where access to care is challenged.
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

Gaps in Controls / Assurance

1. Reduce to zero the number of C&YP waiting over 65 weeks for treatment to reduce the long-wait backlog for planned care
2. In urgent and emergency care, consistently exceed national standard of 76% of patients treated within 4 hours (aspire to 85%) and a time to clinical assessment of 60 minutes

Action	Description	January 2024	
		Due Date	Action Update
Reduce the long-wait backlog for planned care	Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	31/01/2024	Investments in capacity including insourcing have been deployed with reduction in number of long waiters in ENT and dental
Urgent and Emergency Care Standards	Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	31/01/2024	Actions implemented to date have led to improved access to A&E, which is now exceeding the 85% national standard

Building and infrastructure defects that could affect quality and provision of services	
Risk Number	Strategic Objectives
1.3	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Resource And Business Development Committee

Description
Building defects that remain unresolved by Project Co could impact on patient services, reputation and financial sustainability

Jan 2024	
Control Description	Control Assurance Internal
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations. Review of the action plan takes place monthly to ensure all remains on track.	
Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.	
Regular oversight of issues by Trust committee (RABD)	Monthly report to RABD on progress of remedial works
Trust Board aware of the ongoing status and issues.	Monthly report to Board on mitigation and remedial works

Gaps in Controls / Assurance
Remedial Works not yet completed; lack of confidence in timescales being met.

Action	Description	January 2024	
		Due Date	Action Update
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	30/11/2023	
Remedial Works to be completed	Undertake regular inspections on known issues/defects. Inspections continue on all areas via a weekly walk around.	31/12/2023	Inspections underway

Access to Children and Young People's Mental Health	
Risk Number	Strategic Objectives
1.4	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	9	Resource And Business Development Committee

Description

There has been a significant increase in demand for Specialist Mental Health Services at Alder Hey following the COVID-19 pandemic which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours. This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

Jan 2024	
Control Description	Control Assurance Internal
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)
Business case for investment submitted to Liverpool and Sefton CCG's. This is also included in the Cheshire & Merseyside ICB submission.	Business case (attached)
Weekly performance monitoring in place for operational teams which includes: • Weekly Tuesday/Wednesday meeting with PCOs • Divisional Waiting Times Meeting each Thursday • Trust Access to Care Delivery Group each Friday This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: • Monthly contract statements • Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software

Gaps in Controls / Assurance

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to legacy waiting times and recruitment issues as a result of national workforce shortages.

Action	Description	January 2024	
		Due Date	Action Update
Action plan to reduce was not brought rate	Action plan to reduce was not brought rates across Liverpool and Sefton CAMHS including: - using WNB predictor to identify CYP at higher risk of non attendance - A3 exercise to monitor improvements - Transport pilot - ongoing, due to commence 31.10.2023	31/03/2024	
Continued workforce planning	Continued workforce planning including: - introduction of new roles - continued representation at C&M workforce meetings - review of all job descriptions and person spec to ensure consistency and ability to progress - development of preceptorship/development pathway	31/03/2024	
Data / BI - case load monitoring	Case load size reporting and monitoring to be improved including: - BI dashboard to be created - validation of data	31/03/2024	Open caseload report has been validated and clinicians are reviewing this in MDTs and reporting any issues.
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/03/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/03/2024	- Decision has been made to take PIFU Discharge to parent/carer forums and participation groups before implementation. Implementation takes at least 28 days. The initial delay will be taking it to the groups for discussion and then the 28 days for implementation will create a further delay. - Jo M to discussed with Kate W 03.11.23 to agree a new due date
Proceed with changes to CAMHS internal waiting times measures	Proceed with changes to CAMHS internal waiting times measures including: SOP/Pathway to be created Training plan for clinical and admin staff to be created and rolled out Data and reporting	31/03/2024	
Recruitment - timely recruitment to vacancies using 2023/24 funding	Timely recruitment to vacancies to include - meet with finance to review skill mix for services	31/03/2024	
Referral triage process to be reviewed	To review referral triage process across CAMHS	31/03/2024	
Review of KPIs and Reporting Measures	Review of KPIs and reporting measures for Sefton & Liverpool place	31/03/2024	
Review of standard booking processes	Review of booking and discharge processes across Liverpool and Sefton CAMHS to ensure consistency in approach, and management in line with trust processes.	31/03/2024	Choice booking now 4 weeks in advance which is supporting reduction in DNA/Cancellations and wasted appointment slots. Date extended to end of March to ensure this is embedded and consistent before action is closed.

Workforce Sustainability and Development	
Risk Number	Strategic Objectives
2.1	The Best People Doing Their Best Work

CQC Domains	Linked Risks	Owner
▪ Safe ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	6	People & Wellbeing Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation.

Jan 2024	
Control Description	Control Assurance Internal
Monthly Ops Board monitoring	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
People Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Apprenticeship Strategy implemented	Annual update to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to Board and PAWC
Nursing Workforce Report	Reports to PAWC, SQC and Board
Nurse Retention Lead	Bi-monthly reports to PAWC
Recruitment Strategy currently in development	progress to be reported PAWC
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation

Action	Description	January 2024	
		Due Date	Action Update
1. Not meeting compliance target in relation to some mandatory training topics	Process in place to monitor take up of training by topic; subject matter experts engaged in the process	31/03/2024	Work continues to monitor sickness absence through the divisions and will all of the relevant support through OH and SALS
3. Workforce Planning	3. Workforce planning across the organisation.	30/04/2024	Establishment control project close to completion before commencing the wider workforce planning project
5. Lack of a robust Trust wide Recruitment Strategy	5. Recruitment Strategy currently being developed in line with the actions set out in the NHS people plan	30/06/2023	Action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased. A Business Case has been shared with Exec Team - outcome awaited.

Workforce Equality, Diversity & Inclusion	
Risk Number	Strategic Objectives
2.3	The Best People Doing Their Best Work

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	4	People & Wellbeing Committee

Description
- Failure to have a diverse and inclusive workforce which represents the local population. - Failure to take steps to become an inclusive work place where all staff feel their contribution as an individual is recognised and valued. - Failure to provide equal opportunities for career development and growth.

Jan 2024	
Control Description	Control Assurance Internal
PAWC Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PAWC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by EDI Manager	monitored through PAWC
People Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	Diversity and Inclusion Action Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked until Nov 2020
EDI Steering Group now established - Chaired by NED	Minutes reported into PAWC

Gaps in Controls / Assurance
EDI under resourced to deliver significant EDI agenda

Action	Description	January 2024	
		Due Date	Action Update
EDI resource	Business case requires further development	31/03/2023	

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	
Risk Number	Strategic Objectives
3.1	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
		Rachel Lea

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Resource And Business Development Committee

Description
The Alder Hey long term vision for the Alder Hey Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale and in partnership with the local community and other key stakeholders as a legacy for future generations

Jan 2024	
Control Description	Control Assurance Internal
CEO Campus Highlight Update Report	Fortnightly Report
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board and RABD Stakeholder events / reported to Trust Board and CoG
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
Development Team monthly meetings	Outputs reported to RABD via Project Update
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision.
Weekly Programme Check.	The Development Team run a weekly programme check.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
Exec Design Group	Quarterly Minutes of Exec Design Reviews
Programme and plan (agreed with LCC and LPA) to return the park back by March 2024 (phase 3).	Updates on progress through Campus report .
Meetings held with Liverpool City Council at key stages	public meetings held
Planning application for Neonatal and Urgent Care	Full planning permission gained
Neonatal Programme Board	monthly meeting
Strategic Estates and Space Allocation Group	Chaired by Exec, meets quarterly

Gaps in Controls / Assurance
PARK: 1. Adoption of the SWALE by United Utilities 2. Residual infrastructure works delaying possession of land 3. Weather conditions causing potential delays CAMPUS: 1. Planning approvals for modular buildings to allow continuation of park works. 2. Successful realisation of the moves plan. 3. Funding availability and potential market inflation.

Action	Description	January 2024	
		Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	31/03/2024	
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2024	Regular updates continue to be provided to RABD and Trust Board as appropriate
Infrastructure works	Weekly coordination meetings, site walkarounds, RAMS, mitigation measures identified	05/12/2023	
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	31/03/2024	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves	30/04/2024	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell

Financial Environment	
Risk Number	Strategic Objectives
3.4	Strong Foundations

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		John Grinnell

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	12	Resource And Business Development Committee

Description

Failure to meet NHSI/E target, impact of changing NHS finance regime and inability to meet the Trust ongoing Capital requirements.

Jan 2024	
Control Description	Control Assurance Internal
Organisation-wide financial plan.	Monitored through Corporate Report and the monthly financial report that is shared with RABD and Trust Board.
NHSi financial regime, regulatory and ICS system.	Specific Reports submitted monthly and anually as part of business plan process (i.e. NHSI Plan Review by RABD)
Financial systems, budgetary control and financial reporting processes.	Daily activity tracker to support divisional Performance management of activity delivery -@ Full electronic access to budgets &@ specialty Performance results -@ Finance reports shared with each division/@department monthly -@ Financial in-month and forecast position reported through SDG, Exec team, RABD, and trust Board -@ Financial recovery plans reported through SDG and RABD -@ Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend 5 Year capital plan ratified by Trust Board
Divisional performance discussed at RABD with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting with divisional leads ('3 at the Top')
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / RABD and SDG for the relevant transformation schemes
RABD deep dive into any areas or departments that are off track with regards to performance and high financial risk area	RABD Agendas, Reports & Minutes
Financial Review Panel Meetings	Any area/division that is off plan is expected to attend a financial review panel meeting with DDOF with action plan detailing mitigation to bring back into budget.

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations and overall financial position of Trust.
2. Long Term tariff arrangements for complex children shows underfunding of c£3m for Alder Hey
3. Devolved specialised commissioning and uncertainty impact to specialist trusts
4. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
5. Long Term Plan shows £3-5m shortfall against breakeven
6. Deliverability of high risk recurrent CIP programme
7. Increasing inflationary pressures outside of AH control

Action	Description	January 2024	
		Due Date	Action Update
Changing financial regime	1. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2024	
Delivery of 5 year programme	4. Five Year capital plan	31/03/2024	23/24 Capital plan submitted in final plan. Due to changes in CDEL limits for the future years, further work is ongoing on the next 3 years including a review with each capital lead. This work will be complete and presented to executive team early June and reported back through RABD and TB once full risk is known.
Devolved specialist commissioning	3. Regular reporting to strategic execs and assurance to RABD and Trust Board Financial Analysis required to understand risk	31/03/2024	
High risk recurrent CIP programme	6. Ensure procurement processes followed to obtain value for money	31/03/2024	
Inflationary Pressures	7. Monitor closely impact of inflation increases	31/03/2024	Target date extended as action will need to be re-monitored in 23-24 as risk continues.
Inflationary pressures	7. Monitor closely impact of inflation increases	31/03/2024	
Shortfall against LTP	5. Long Term Financial Plan	31/03/2024	Annual planning process complete and bridge completed by division. However further delays to the completion of the LTFM and the productivity work has resulted in this not being completed in the time-frame initially set. This will form part of the 2030 financial strategy to be completed in Q2.
Underfunding of Long Term tariff arrangements for complex children	2. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2024	

Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.					
Risk Number			Strategic Objectives		
4.1			Game-Changing Research And Innovation		
CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
Well-Led		John Chester	9	6	Research & Innovation Committee

Description
Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries. Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities. Risk of exposure to ethical challenges and national and international reputational risks.

Jan 2024	
Control Description	Control Assurance Internal
Resource and Business Development Committee (RABD) Additional oversight of financial and commercial aspects of R&I activity	Reports to Trust Board
Research Management Board and Innovation Management Board (and subsidiary committees - Sponsorship Oversight Committee, Data Access Panel etc) Delivery and performance measurement of various R&I activities	Reports to R&I Committee
Clear management structures and accountability within each of CRD and IC	Reports to Operational Board
Protection +/- exploitation of intellectual property	Reports to R&I Committee
Strategic commercial partnerships with industry partners and commercial vehicles	Reports to Strategy Board and RABD
Staff probity - via online declaration of interests portal (gifts & hospitality, sponsorship etc.)	Adherence to Trust Policies, Declarations of Interest Register and digital audit trail to audit committee
External communications via internet, social media etc facilitated through Marketing and Communications team	Communications Strategy and Brand Guide
Data governance via Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOP
Risk registers	Reports to Risk Management Forum

Gaps in Controls / Assurance
1. Integration of R&I activities into Futures not yet fully determined. 2. Levels of activity targeted at maintaining and enhancing reputation not yet sustainable. 3. Financial model and levels of income not yet consistent with growth and sustainability. 4. Capacity and capability of clinical staff and services to participate in R&I activities. 5. Comms Strategy for Futures not yet fully described.

Action	Description	January 2024	
		Due Date	Action Update
1. Integration of R&I activities into Futures	Completion of Research Strategy.	31/03/2024	Starting
2. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2024	
3. Activity Levels	Review of CRD trials portfolio	31/03/2024	
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	
5. Financial Model	Case for internal and multi-sector inward investment.	30/06/2024	
6. Financial Model	Development of new commercial partnerships	30/06/2024	
7. Capacity and capability	Greater engagement with and education of R&I communities	30/06/2024	
8. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy	31/03/2024	

Failure to deliver the best experience for Staff, Children and Young People and their Families	
Risk Number	Strategic Objectives
2.2	The Best People Doing Their Best Work

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Safe ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	6	People & Wellbeing Committee

Description
Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision.

Jan 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2021 Staff Survey Report - main report, divisional reports and team level reports
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Thriving Leadership Planning	Strategy implementation as part of the People Plan
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Alder Hey Life Newsletter - keeping staff informed	Internal communications updated to PAWC
Spiritual Care Support	
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC monthly
Health and Wellbeing Conversations launched	HWB Conversations now embedded as part of the PDR process supported by training and support from SALS, OD and Wellbeing Coaches where needed. Key metric currently is %PDR completed but value of HWB conversations also assessed via Quarterly People Pulse
NICE Mental Wellbeing at Work Guideline issued and baseline assessment complemented	Baseline assessment
Regular Schwartz Rounds in place	
Network of SALS Pals recruited to support wellbeing across the organisation	
Staff support plan for all staff to manage social and emotional impacts of strike action. Plan reviewed and communicated as part of tactical command and developed in consultation with nursing community and local strike committee	

Gaps in Controls / Assurance
1. Increase in self-reported rates of burnout and work-related stress as assessment via 2022 Staff Survey and consistent with national picture for NHS staff. 2. Our people have the time, space and opportunity to improve

Action	Description	January 2024	
		Due Date	Action Update
Management essentials training	Develop a Thriving Leaders Framework for the organisation beginning with a management essentials training programme for all new managers to cover core HR and management knowledge and skills and to complement Strong Foundations leadership programme already running	30/05/2024	Management essentials programme in development and to be launched this month to the organisation. Currently 80% of content complete. Group meeting weekly to review and implement
Stress risk assessments	Skills and capacity gap to conduct good quality stress risk assessments for staff affected by work-related stress	28/02/2023	Stress Risk Assessment training to be added into Management Essentials training as part of new Thriving Leaders Framework (Vision 2030)
Suicide Postvention planning and process	Suicide Postvention guidance and team to be developed and establised to provide effective and compassionate response in the event of the death by suicide of a staff member.	11/03/2024	Meeting with Chief People Officer and Deputy CPO on 8.1.24 to discuss next steps. Associate Director of OD/SALS Clinical Lead and Deputy CPO to develop local SOP on 30th January together for consultation with wider group of stakeholders prior to policy amendment and training plan. CPO to table for information at the PAWC. Update to be given to WBG.

Digital and Data Strategic Development & Delivery	
Risk Number	Strategic Objectives
4.2	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Resource And Business Development Committee

Description
Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.

Jan 2024	
Control Description	Control Assurance Internal
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Achieved Informatics Skills and Development Accreditation Level 3.
Formal change control processes in place	Weekly Change Board in place
Executive level CIO in place	Commenced in post April 2019, Deputy CDIO in place across iDigital Service
Quarterly update to Trust Board on digital developments, Monthly update to RABD	Board agendas, reports and minutes
Digital Oversight Collaborative in place & fully resourced - Chaired by Trust CCIO	Digital Oversight Collaborative tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
External oversight of programme	Strong links to system, regional and national digital governance via internal and external relationships.
Digital Strategy refreshed in 2022. Digital Data and Insights key components of Vision 2030 and associated governance and plans	Digital PID. Digital Oversight Committee. Relationship with Futures. Digital and Insights link as part of revolutionising care strategic initiative.
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Monthly digital performance meeting in place	iDigital performance meeting in place. Performance reported as part of Corporate Collaborative.
Capital investment plan for IT including operational IT, cyber, IT resilience	Capital Plan
iDigital Service Model in Place	iDigital Service Model and Partnership Board Governance
High levels of externally validated digital services	HIMSS 7 Accreditation

Gaps in Controls / Assurance
1. Cyber security investment for additional controls approved - dashboards and specialist resource in place 2. Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs 3. Issues securing experienced resources in some services 4. Alignment with other 2030 initiatives

Action	Description	January 2024	
		Due Date	Action Update
1. Maximising opportunities of collaboration through iDigital	Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	12/12/2023	
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	12/12/2023	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023 Date Entered : 01/09/2022 08:28 Entered By : Kate Warriner ---------- Some issues highlighted with programme, risking dates to delivery. Review underway Date Entered : 02/12/2021 16:45 Entered By : Kate Warriner ---------- Programme progressing, a number of work streams with challenges being progressed. Date Entered : 06/05/2021 08:51 Entered By : Kate Warriner ---------- Programme progressing well against Plan. Progress monitored through digital reports at RABD Date Entered : 11/01/2021 14:20 Entered By : Jill Preece
4. 2030 Initiatives	Ensure programme alignment into new models of care and Futures	12/12/2023	

System working to deliver 2030 Strategy	
Risk Number	Strategic Objectives
3.5	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	9	Trust Strategy Board

Description
Risk of inability to control execution of 2030 Vision due to system complexities and evolving statutory environment. Risk of failure to secure sign up from partners to engage in a new Strategy for CYP given the wider NHS context and competing priorities. Potential failure to land our 2030 Strategy with key partners within the wider system impacting on our reputation and long-term sustainability. Risk of poor relationships and strategic connection at Place, leading to mis-alignment of priorities and inability to execute Vision 2030.

Jan 2024	
Control Description	Control Assurance Internal
Membership of CMAST & MHLDC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST Committee in Common in place and working CMAST - CYP alliance established. MHLDC committed membership from Alder Hey and establishment of a CYP workstream.
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	Beyond Programme recurrently funded by ICS. Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board.
Impact of changing NHS finance regime, commissioning intentions (described in BAF 3.4)	See BAF 3.4 (financial environment)
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.
Joint development of new models of care on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board and Strategy Leadership Group
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings
Maintain effective existing relationships with key system leaders and regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually).
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Reporting through Strategy Board
Implementation of Vision 2030 is dependent on building capability and capacity to deliver in the new system environment. This requires both additional capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	Assessment of central team capacity along with a 24/25+ plan to address gaps to be undertaken with MD & CSPO in December 23. Linked with COO and divisions for wider capacity and capability across clinical teams.

Gaps in Controls / Assurance
1. Uncertainty over future commissioning intentions (see BAF 3.4 re finance) 2. Future delegation of Specialist Commissioned services into ICSs – shadow arrangements under definition 3. Executing the comprehensive Stakeholder Engagement Plan 4. National mandates forcing us to prioritise unexpected programmes of work 5. There is currently no sustainable arrangement for Place level capability and capacity within the strategy team, and a need to identify additional clinical leadership in Get Me Well - which is closely linked to the Place agenda. Delivery of 2030 Vision is highly dependent on system working, and an integrated local system partnership approach. Sustainable, consistent and appropriately skilled engagement at Place(s) from clinical and partnership perspectives is required to ensure aligned plans, delivery of agreed programmes of work, attraction of local funding and management of reputational risk.

Action	Description	January 2024	
		Due Date	Action Update
3. Partner Engagement	Complete partner engagement	12/12/2023	
4. Horizon Scanning	4. Horizon scanning	12/12/2023	
Capacity and capability to deploy Vision 2030 at Place(s)	Assessment of central team capacity along with a 24/25+plan to address gaps to be undertaken with MD & CSPO in December 23. Linked with COO and divisions for wider capacity and capability across clinical teams. Capacity and capability for Place especially for Get me Well is needed both in partnerships/strategy team and clinically	28/02/2024	
Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/08/2023	Conversations with NHSE and colleagues within Greater Manchester and South Cumbria continue to support a North West Children's Strategy for delegation of services.
System Developments	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/08/2023	Now have agreement for a Children's Board under the Cheshire & Mersey ICS which will include a children's health network. This will include key stakeholders from across the region with the ability to influence and transform children's services. It will act as a Forum for sharing information across the system to help us keep abreast of the changing landscape.

Strategy Deployment	
Risk Number	Strategic Objectives
3.2	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Trust Strategy Board

Description
Risk of failure to: - translate the 2030 Vision into operational plans and systematically execute. - deliver on the strategic ambitions to make a difference to CYP impacting on the delivery of the NHS Long Term Plan and Trust's reputation.

Jan 2024	
Control Description	Control Assurance Internal
Collaborating in Communities is a key theme in the 2030 Change Programme: assurance received through Strategy Leadership Group and Strategy Board	
2030 Vision: Alder Hey strategy refresh - Q4 23/24 - delivery of brochure and final comms collateral	Council of Governors strategy session (full overview) (Jan 2023) Strategy 2030 - Approved at Trust Board (March 2023) Strategy 2030 wider Staff Launch (May 2023)
CYP System update report to Strategy Board, incorporating partnership assurance periodically throughout the year.	Building upon Growing Great Partnerships report
Operational Plan incorporates Vision 2030 deliverables (2024/25)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
SRO Group established	
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	

Gaps in Controls / Assurance
1. Completion of 2030 Vision communication collateral 2. 2030 delivery programme and plan in development 3. Failure to develop capacity for delivery 4. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy 5. Failure to deprioritise to enable requisite focus on areas of need and transformational change 6. Risk of 'mission creep' associated to the Strategy

		January 2024	
Action	Description	Due Date	Action Update
1. Partner and stakeholder engagement on Vision 2030	Ongoing engagement programme as it is developed, and appropriate circulation/engagement following Board sign off.	30/11/2023	We are in the process of developing an external partner video and working with an external agency on a Vision 2030 'Sales Brochure' which will come to Board in September 2023.
2. 2030 delivery programme and plan		12/12/2023	
3. Developing skills and capacity to deliver the new Strategy		12/12/2023	
4. Sharp focus at Strategy Board on core mission		12/12/2023	
5. Focus on transformational change	Oversight through Strategic Leadership Group and Strategy	12/12/2023	