Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 7th December 2023, commencing at 9:00am
Lecture Theatre 2, Institute in the Park
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
INVESTIGATION TRAINING (9:00am-11:00am) (To support decision makers, in healthcare, provide an overview of the philosophical and methodological principles which sit behind modern healthcare safety investigations).							
PATIENT STORY (11:00am-11:15am)							
1.	**23/24/197**	**11:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/198**	**11:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/199**	**11:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **9th November 2023.**	**D**	Read enclosure
4.	**23/24/200**	**11:19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**23/24/201**	**11:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**23/24/202**	**11:30 (50 mins)**	• **M8 Flash Report/ Operational Overview.** • **Integrated Performance Report for M7, 2023/24.** • **Finance Update for M7, 2023/24.**	Executives/ Divisions R. Lea	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M7 position.	**A** **A** **A**	Enclosure Read report Presentation
7.	**23/24/203**	**12:20 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report

Lunch (12:30pm-12:50pm)							
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
8.	**23/24/204**	**12:50 (10 mins)**	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report, 2023; including:** • **EPRR Position Report.**	N. Askew	For ratification.	**D**	Read report
9.	**23/24/205**	**13:00 (5 mins)**	**Patient Safety Incident Response Policy.**	N. Askew	For approval.	**D**	Read report
10.	**23/24/206**	**13:05 (5 mins)**	**Brilliant Basics Update.**	N. Askew	To receive an update on the current position.	**A**	Read report
11.	**23/24/207**	**13:10 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
12.	**23/24/208**	**13:15 (10 mins)**	**DIPC Report, Q2.**	B. Larru	To receive an update on the current position.	**A**	Read report *(to follow)*
13.	**23/24/209**	**13:25 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 15.11.23.** - **Approved minutes from the meeting held on the 18.10.23.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 18.10.23.	**A**	Read enclosures
Sustainability Through External Partnerships							
14.	**23/24/210**	**13:30 (10 mins)**	**Neonatal Governance Review.**	A. Bass	To receive an update on the current position.	N	Verbal
Game Changing Research and Innovation							

15.	**23/24/211**	**13:40 (5 mins)**	**Update on the Workshop with the University of Liverpool held on the 6.12.23.**	J. Chester	To provide an update.	**N**	Verbal
16.	**23/24/212**	**13:45 (10 mins)**	**3rd MRI Scanner Business Case.**	J. Chester/ U. Das	For approval.	**D**	Read enclosure
17.	**23/24/213**	**13:55 (5 mins)**	**Research and Innovation Committee:** - **Chair's update from the meeting held on the 6.11.23.** - **Approved minutes from the meeting held on the 10.7.23.**	S. Arora	To escalate any key risks, receive updates and note the approved minutes from the 10.7.23.	**A**	Read enclosure
The Best People Doing Their Best Work							
18.	**23/24/214**	**14:00 (10 mins)**	**People Plan Highlight Report; including:** • **EDI Update.**	M. Swindell	To receive an update on the current position. To provide an update on key areas and updates from the system on the workforce.	**A** **A**	Read report Read report
19.	**23/24/215**	**14:10 (10 mins)**	**Equality Act:** • **WRES report.** • **WDES report.**	M. Swindell	For discussion and approval.	**D**	Read enclosures
20.	**23/24/216**	**14:20 (5 mins)**	**People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 22.11.23.** - **Approved minutes from the meeting held on the 13.9.23.**	F. Marston	To escalate any key risks, receive updates and note the approved minutes from the 13.9.23.	**A**	Read enclosure
Strong Foundations (Board Assurance)							
21.	**23/24/217**	**14:25 (10 mins)**	**Transformation Programme; including:** • **Benefits realisation from transformation**	N. Palin	To receive an update on the current position.	**A**	Read report

			programmes.				
22.	**23/24/218**	**14:35 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 27.11.23.** - **Approved minute from the meeting held on the 23.10.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 23.10.23.	**A**	Read enclosure
23.	**23/24/219**	**14:40 (10 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Items for Information							
24.	**23/24/220**	**14:50 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
25.	**23/24/221**	**14:54 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 11th January 2023, 9:00am, Lecture Theatre 2, Institute in the Park							

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

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M7, 2023/24	R. Lea

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 9th November 2023 at 9:00am**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	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	Director of Strategy, Partnerships and Transformation	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Patient Story	Ms. M. Thomas	Music Therapist	(MT)
Item 23/24/174	Ms. J. Halloran	Acting Deputy Development Director	(JH)
Item 23/24/175	Ms. K. Turner	Freedom to Speak Up Guardian	(KT)
Apologies	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. M. Flannagan	Director of Marketing and Communications	(MF)
	Mr. D. Powell	Development Director	(DP)

Staff Story

The Chair welcomed the Trust's Music Therapist, Mel Thomas who had been invited to attend November's Board to give an overview of the music therapy that takes place at Alder Hey, along with some examples of the impact of the service within a number of domains of paediatric healthcare, including clinical, research and education.

Mel shared a presentation that provided context to the Music Therapy service at Alder Hey, including integration of music therapy within the Clinical Health Psychology department and alignment with AHPs within the Trust; the wider Arts Therapies context, spanning Allied Health Professions and Psychological Professions networks; and the National NHS and Professional network systems. The patient story that was shared with the Board highlighted how music therapy contributes to a wide range of improved outcomes for patients and their families and goes beyond traditional therapeutic methods.

The Chair thanked Mel for providing an insight into the wonderful work of the Music Therapy service. Louise Shepherd reiterated the Chair's words and advised of a meeting that is taking place

with the Arts Council in January. It was suggested that a conversation take place about CYP in this space to enable a discussion with the Arts Council in terms of joining things up.
Action: LS/MT/Veronica Greenwood

23/24/165 Welcome and Apologies

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

23/24/166 Declarations of Interest

There were none to declare.

23/24/167 Minutes of the previous meeting held on Thursday 5th October 2023
Resolved:
The minutes from the meeting held on the 5th of October were agreed as an accurate record of the meeting.

23/24/168 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

23/24/169 Chair's and CEO's Update

The Chair informed the Board of the gala ball that was hosted in the Anglican Cathedral by the LFC Foundation and the Trust's Charity which raised over £950k. Funds raised through the event will support Alder Hey in completing the new Neonatal Unit as well as developing LFC Foundation's 'Move' programme for children with respiratory and endocrine conditions.

The Chair advised that the Trust's governors have made it clear that they wish to fulfil their obligations to hold Non-Executive Directors to account. It was confirmed that work will take place to look at processes for doing this but it was pointed that governors will need to set time aside to contribute to meetings, etc.

It was reported that Jo Revill attended a recent meeting of the Mental Health, Learning Disability and Community (MHLDC) Provider Collaborative. The Board was informed that Non-Executive Directors (NEDs) from seven organisations were invited to participate in the ongoing collaborative taskforce, but concerns were raised during the meeting about NEDs not having an understanding of the programme, budget or the governance involved. It was confirmed that NEDs have offered their support but felt that it is imperative that they have a voice and an understanding of the programme. The Chair asked whether any of the NEDs would be prepared to be a representative on the collaborative.

Since October's Board meeting, the Trust received a visit from the Children's Commissioner, Rachel de Souza who was very positive about the work that Alder Hey is conducting. The Children's Commissioner paid tribute to the staff in Sunflower House and offered thanks to all those involved in the visit, which was very positive. It was reported that the Children's Commissioner wants to support health and education nationally and will re-visit Liverpool as part of this work.

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

23/24/170 NHS England Sexual Safety in Healthcare Organisational Charter

The Board received a report that outlined the plan to improve awareness, reporting and responses to sexual assault, harassment, abuse, and violence across the NHS. The report included an overview of data and statistics, the newly launched NHSE plan to improve sexual safety in the NHS, and a summary of the actions that need to be undertaken to implement the Sexual Safety in Healthcare Organisational Charter.

There is a requirement for each organisation to have a Domestic Abuse and Sexual Violence (DASV) Executive Lead. The DASV Executive Lead for Alder Hey is Nathan Askew, Chief Nursing, AHP and Experience Officer and the Operational Lead is Nichola Osborne, Associate Director Safeguarding and Statutory Services. This information has been provided to NHSE and Designated Professionals for Safeguarding at Cheshire and Merseyside ICB (C&M ICB), as requested. It was reported that an action plan is in the process of being developed and will be monitored via the Safety and Quality Assurance Committee (SQAC).

The Board was advised that the Trust will require a robust communications plan for staff, a process for capturing data whilst having a confidential/strategic oversight of cases. It was pointed out that NHSE has given organisations a deadline of July 2024 to action all ten steps of the plan but Alder Hey has a number of these steps in place already and therefore is looking to launch the charter in December 2023 and implement the standards in January/February 2024.

A discussion took place in which it was suggested that conversations be initiated by the Trust with staff to gather people's experiences, history, etc. and time be set aside to think about the organisation's response to the new question that has been included in the NHS Staff Survey *('In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault.').*

Resolved:
The Board endorsed Alder Hey signing up to the Sexual Safety Charter and approved the steps outlined in developing a robust action plan to fulfil the Trust's statutory safeguarding responsibilities.

23/24/171 Strategy Brochure

The Board received the current version of the strategy brochure. The Director of Strategy, Partnerships and Transformation, Dani Jones thanked Board members for their feedback on the brochure following October's Strategy Board and advised that the Trust is now in a position to upload the brochure onto the organisation's website, therefore sign-off is required.

The Board reviewed the brochure and provided the following comments:

- The Chair felt that the 'Working in Partnership' element of the brochure is strong and the overall look of the brochure is very good.
- Louise Shepherd felt that the brochure will enable confident discussions to take place internally and externally on the Vison 2030 Strategy.

- John Kelly suggested including milestones or a step journey so people can focus on what to expect over the next seven years.
- Jo Revill felt that the last page of the brochure could be clearer in terms of the Trust wanting to hear from people and receive feedback.
- Reference was made to the page that relates to the Trust's journey to 2030 (*looking back*). It was felt that this page portrays a negative picture and would benefit from narrative detailing the real positives of the organisation.
- Fiona Marston felt that; **1.** Reference should be made in terms of what the Trust achieved with its previous strategy and what it's going to achieve with the Vision 2030 Strategy. **2.** The image on page two should be slightly smaller so that people can recognise the issues. **3.** The introduction page gave of an air of negativity.
- Fiona Beveridge suggested including reflections on Covid in terms of the organisation's way of working/delivery and pointed out that there are no characters in the brochure to reflect the organisation's people.
- Garth Dallas referred to the page relating to sustainability and felt that there was too much of an emphasis on pound signs.

It was agreed to follow up the comments that were made during the meeting and for the Executive Team to sign off the brochure in due course.

23/24/171.1 Action: CB/Execs

23/24/172 System Update

It was reported that progress has been made in terms of conversations with NHSE regarding CYP and how they are becoming joined up. The Board was advised of the changes to the original CYP Transformation Programme and the Board that oversaw its work. Following a meeting in September it is now called the CYP Board NHSE. It is committed to the NHS Long Term Plan, is central to the national programme of work and will continue with its transformational work, etc.

In terms of the wider context, work is taking place to co-create a strategy to combine mental health and diversity programmes going forward. It was pointed out that there is a sense of shared purpose that is growing with regard to owning the problem of CYP mental health challenges. There is no joining up of national data at the present time therefore exemplars will have to be developed to change the dynamics of CYP.

The Board was provided with an overview of the CYP regional leads meeting that took place on the 7.11.23. It was reported that there is lot of commitment regionally to work with colleagues to try and ensure CYP are central to the national agenda.

A number of slides were shared that provided an update on the; Children's Health Alliance, Beyond, the C&M CYP Committee Terms of Reference and the CYP Committee's first year plan.

The Chief Medical Officer, Alfie Bass attended the inaugural meeting of the CYP Committee and advised that it was a really positive meeting and well represented. It was reported that the Committee discussed the work that it will be focussing on as part of the first year plan, and a senior person was nominated to be responsible for secondary care. Alfie Bass felt that the Committee will be in charge of the delivery of a number of pieces of work that will also produce data.

Following the update the Board discussed the importance of acquiring financial support for CYP programmes and providing data/evidence to influence the commissioners in the planning rounds.

Resolved:
The Board noted the system update.

23/24/173 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; 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.

M7 Flash Report
Resolved:
The Board received and noted the Flash Report for month 7.

Integrated Performance Report (IPR), M6

The Board received the Integrated Performance Report (IPR) for Month 6. An update was provided on the following areas of the IPR:

Accessible Services - Effective

- *Access to Care*
  - There is an improvement plan in place to address the high level of demand in the Emergency Department (ED). In order to improve the situation the Trust is looking to source additional urgent care capacity in the form of 250 appointments on a weekly basis via a primary care partner, and review emergency care pathways.

- *Access to Elective Care*
  - There has been an increase in RTT patients waiting over 65 weeks for treatment; 236 patients. The Trust is confident that it can eliminate the long waits by March 2024 as long as there is no further industrial action.
  - Activity levels recovered in October with elective activity at 102% of 2019/20 levels. This is up from 85% in September.
  - It was reported that WNB levels aren't improving. An analysis has been conducted after contacting 300 families to understand why they didn't attend the scheduled appointment. Some of the reasons for not attending related to inconvenient appointments/parents did not feel there was any value in the appointment. An action plan is in place and will look towards offering more choice to patients, patient initiated follow-up and improving digital reminders.

The Chair referred to the lack of improvement in WNB figures and asked that this be addressed in greater detail as children are missing appointments and the Trust is losing opportunities in a critical area.

23/24/173.1 Action: AB

Unrivalled Experience - Safety

- A Never Event with harm was reported to StEIS in September, as detailed in the SI report. A Root Cause Analysis (RCA) investigation took place and a high number of restrictive interventions continue, however clear therapeutic plans are now in place.

Community and Mental Health Division

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

Division of Medicine

- Mandatory training is at 93%
- Work is taking place to mitigate performance, address CIP and pathways for moving patients on.

Division of Surgery

It was reported that the issues with Theatre staffing have improved slightly. There are still a number of challenges but waiting lists are under control and numbers have improved significantly. Theatre recruitment is continuing and there is a plan to re-introduce theatre schedules on Saturdays to improve productivity. The Board was advised that the Division is looking at everything possible to save money and is hoping to have a strong plan for 2024/25.

The Chair of RABD, John Kelly advised that the Committee is starting to see some high quality analysis from the Divisions in relation to CIP/savings.

The Chair thanked the Divisions for their updates and assured them that the Board does not underestimate the challenges they are experiencing.

Finance

- The Trust reported an in-month surplus of £1.5m in October (M7) and a £25k surplus YTD which is in line with plan.
- The Board was advised of the challenges that the organisation is facing in relation to CIP, and it was confirmed that work is taking place with the Divisions to address this issue and support some of the Trust's Change Programmes. This work is being prioritised and an analysis will be shared with RABD in the next four weeks. It was reported that CIP is the organisation's biggest challenge at the present time.

Resolved:
The Board received and noted the content of the IPR for Month 6.

Digital, Data and Information Technology Update

The Board was provided with an update on progress against the Digital and Data Futures Strategy, the overall service, key areas of transformation and operational performance, as detailed in the report.

AlderC@re Programme - It was reported that the Trust is in a stable position following the 'Go Live' period of the AlderC@re programme in September, and Digital calls are back to the usual run rate. The team are still working on post 'Go Live' issues but a lot of challenges have already been resolved. In terms of going live with the organisation's Data Warehouse, it was confirmed that the Trust will be moving into this mode on the 9.11.23. Alder Hey has also engaged with NSHE on lessons learnt and is awaiting a response.

InPhase – Progress is being made and six of seven reports have been signed off by the organisation's Governance Leads. There is oversight of the issues and there is a good channel of communication between the Trust and the supplier. As a result of the mitigations in place, it was confirmed that the score for this BAF risk has been reduced from 16 to 12.

Healthier Populations through Digital, Data and Analytics – It was reported that the Trust has a deadline of the 10.11.23 in which to submit 58 external reports. It was confirmed that 90% of reports have been completed. With regard to ED reporting, the Trust is going to work with NHSE to look at addressing this area in an alternative way.

John Grinnell referred to the Trust's robust reporting process and the lessons that have been learnt nationally and asked as to whether a report could be compiled with a focus on these two areas for submission to Board. It was agreed to meet and discuss this request.

23/24/173.2 Action: JG/KW

For noting

The Chair of the Audit and Risk Committee, Kerry Byrne asked to be included in the post implementation review of the AlderC@re programme in order to understand the scope of the review from the lens of the Audit Committee.

Louise Shepherd felt that the Trust should offer thanks to Meditech for their support with the AlderC@re programme as they have been wonderful. It was agreed to formally write to Meditech.

23/24/173.3 Action: KW

Resolved:

The Board received the Digital, Data and Information Technology Update and noted the progress to date.

23/24/174 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 successful meeting that took place with the Friends of Springfield Park which included positive dialogue on the football pitches.
  - The Trust is aiming for a completion date of March 2024 subject to the drainage system being installed. Discussions have commenced with Liverpool City Council about what a handover package will look like.
- *Neonatal and Urgent Care Development* – It was confirmed that progress is being made and the main contract is being prepared for signing in November to enable construction work to commence.
- *Catkin/Sunflower House:*
  - *Finalising Contract Position* - The Trust is still awaiting a response from the contractors regarding a possible contract claim therefore the Trust is going to review its next steps with legal advisors.
  - *Sprinkler System Under-Croft Car Park* – A tender was issued on the 6.10.23 and returns are to be submitted on the 6.11.23. Due to a technical glitch the submission date has been deferred to the 8.11.23.

Garth Dallas referred to the drainage issues and queried as to whether they will be resolved by the end of November. The Board was advised that there have been challenges with installing drainage due to ground conditions therefore the Trust is aiming for a completion date of March 2024. This has been communicated verbally with the FOSP but it was agreed to follow this up with a written communication.

23/24/174.1 Action: JH

Lisa Cooper pointed out that the noise from the construction work taking place on site will affect patients with sensory needs and asked as to whether communications have been shared with parents to raise awareness. Following discussion it was agreed to have a conversation outside of the meeting to think collectively about this issue.

23/24/174.2 Action: LC/JH

For noting

The Chair asked as to whether the final sign off of the Neonatal and Urgent Care Development contract can be delegated to RABD. The Board confirmed their agreement of this.

Resolved

The Board received and noted the Campus Development update provided on the 9.11.23.

23/24/175 Learning from the Letby Case

The Board received a position paper with regard to the learning assimilated to date from the outcome of the Letby trial and the Terms of Reference of the upcoming Public Inquiry. The purpose of the paper is to provide an initial overview of the Trust's current position in relation to the emerging learning from the Letby case from a wider governance perspective and to propose an initial range of actions based upon an analysis of the organisation's existing arrangements and agreed plans.

The Trust's approach is set out in three themes; experience, governance and system issues under the headings of current position and proposed action. It is proposed to update the framework on an ongoing basis to ensure the Trust is fluent with the issues that emerge for families and is learning from the process in real time.

A number of slides on 'Learning from the Letby Case' were shared with Board members and provided the following information:

- How do we know it won't happen again?
  - We need to continuously challenge ourselves to test:
    - The robustness of assurance systems that we rely on.
    - If we are a learning organisation.
    - The culture we have versus the one we need – Are they different?
    - If our leadership style and behaviours promote the culture we need and if not, how do we change?
- Systems of Assurance – Regional/Provider;
  - It was pointed out that systems are in place and data is available but it is about triangulating, analysing and responding. This process will interlink with the organisation's Patient Safety Strategy, challenge the Trust to look at data in a different way and is key in terms of next steps.
- Key areas of the Trust's response;
  - Just and restorative culture.
  - Patient safety systems and processes.
  - Improving learning.
  - Use of data (prospective).
  - Responsiveness.
  - Line of enquiry review.
- Next steps;
  - Formal work plan to be developed from the Trust's initial review of the list of questions linked to the Public Inquiry.
  - Continue to progress work on our just and restorative culture and how we use data prospectively to identify areas of concern.

- Prepare for any involvement in the Public Inquiry.

Board members discussed the content of the report and presentation and raised the following questions/provided the following feedback:

- How does the Board assure families that their children are safe whilst in the care of Alder Hey? It was felt that the Board needs to raise question where there are gaps, understand the different cultures across the Trust, be inquisitive and suspend disbelief in order to answer this question.
- Does the organisation need to conduct a piece of work on Trust culture to ensure it delivers the action relating to 'Safety Culture/Willingness to Speak Up Culture'?
- Should Non-Executive Directors challenge as to whether they are receiving appropriate information, for example, the FTSU report is more number based and doesn't provide narrative to illustrate the data?
- Is there anything that can be done to test as to whether or not the systems of assurance/processes work and that the Trust is compliant with them?
- It was commented that the averaging of data completely masks departments and therefore disaggregation needs to be considered.
- *Systems and Processes* – 1. How does the Trust act on the triangulation of softer intelligence? 2. *Confidentiality versus Openness* – Is the Trust open enough and where is the balance? It was felt that a discussion should take place outside of the meeting regarding confidentiality versus openness.

23/24/175.1 Action: Executive Team

- It was pointed out that there is a lot of focus when an organisation has reached a stage where something has gone wrong and it was felt that the Trust should look towards supporting staff to enable them to request/give a second opinion before reaching this stage.
- What is Just Culture? What does it look like, and what does it mean for the Trust?

The Chair advised that the Board will need to return to this item in February to take a balanced review of what is working and how improvements can be made. It was also pointed out that there is an underlying issue around culture that needs to be addressed. John Grinnell informed the Board that a large piece of work on the organisation's culture is going to take place and updates will be shared with the Board.

23/24/175.2 Action: NA/AB/ES

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

23/24/176 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 1.9.23 to the 30.9.23. The following points were highlighted:

- The Trust declared one Never Event during the reporting period (StEIS Reference No: 2023/12980).
- It was confirmed that there were four Serious Incidents (SIs) opened during the reporting period.

Resolved:
The Board received the Serious Incident report for the period from the 1.9.23 to the 30.9.23.

23/24/177 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 20.9.23 were submitted to the Board for information and assurance purposes. The Board was advised that the Committee is monitoring the outcome of the sepsis training that is taking place.

Resolved:
The Board noted the approved minutes from the meeting held on the 20.9.23 .

23/24/178 Research Update

The Board received an update on research from the Director of Research and Innovation, John Chester. A number of slides were shared that provided information on the following areas:

- Update on large bids.
- Detailed list of grants.
- Top metrics/performance metrics.
- Highlights of November's Research and Innovation Committee.

John Chester responded to a number of questions that were raised about whether lessons have been learnt that will change future bid processes, and whether there are processes in place to reach out to academic partners when a bid is not progressing/make decisions to cease bids.

Resolved:
The Board noted the research update.

23/24/179 People Plan Highlight Report

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

- *Sickness Absence* - It was reported that the total sickness absence for the month of September was 5.33% in line with the Trust's Target of 5.5%. Work is on-going to ensure plans are in place to support staff members on long-term sick leave.
- *Staff Turnover* – Staff turnover has had its sixth consecutive month of reduction, a second month within target, and has dropped to 12% from 13% in July. The Trust has recruited a nurse retention lead, and there is to be a focus on determining the organisation's hotspots.
- *PDRs* - The Trust is beginning to show improvement in respect of PDRs with a September position of 70% against the target of 90%, which represents an increase of 7% since July. It was reported that a question has been included in the PDR template asking staff if they are thinking of leaving the organisation.
- *NHS Staff Survey* – The current response rate to date is 52%. The Board was advised that the survey closes on the 24.11.23.
- *Industrial Action* - Though no future strike dates are currently known, further BMA strike dates for November and December 2023 are expected to be announced after the 3rd November 2023 unless agreement is reached between

BMA and the government. Further Society of Radiographer (SoR) strike dates are also pending.

EDI Update

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

- *North West BAME Assembly Anti-Racist Framework (bronze level of accreditation)* – It was reported that the Trust's ambition is to eradicate racism and is working towards creating a culture that embraces inclusion. The Northwest BAME Assembly's anti-racist framework will support Alder Hey on its journey to becoming intentionally and unapologetically anti-racist.

  The Trust is currently working through the self-assessment tool developed by the Northwest BAME Assembly to identify gaps in the organisation's current performance. Any gaps identified will allow the Trust to formulate a robust action plan and prioritise activities that will help Alder Hey achieve a bronze status in the next twelve months. Work is to take place in collaboration with the REACH staff network and trade union representatives to develop the plan. Once the Trust achieves bronze status it will continue to measure its actions to help Alder Hey progress to silver status.

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

23/24/180 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 25.9.23 were submitted to the Board for information and assurance purposes. During October's meeting there was a focus on the year end forecast, the Cost Improvement Plan and further potential industrial action dates. The second quarterly performance/financial review has taken place with the Divisions and it was felt that progress is being made in terms of divisional accountability and the approach that is being taken to address savings.

Resolved:
The Board noted the approved minutes from the meeting held on the 25.9.23.

23/24/181 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 discussions are taking place to finalise the organisation's strategic risks in the light of the 2030 Vision, which will be included in the next edition of the BAF.
- InPhase have now developed a prototype for the new BAF report which would start to cycle through the assurance committees during November and be presented at the December board meeting.

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

23/24/182 Audit and Risk Committee

The approved minutes from the meeting held on the 13.7.23 were submitted to the Board for information and assurance purposes. During October's meeting there was a focus on risk management training across the Trust, an update from the Chair of the Risk Management Forum and a request from Ernst and Young (E&Y) for additional fees relating to the 2022/23 external audit. The Director of Research and Innovation shared a presentation on the risk management process within the Division, and the Chair of the Audit and Risk Committee (ARC) advised of the positive external audit review that was conducted recently by the Trust. It was reported that a wash up meeting took place between the Trust and E&Y which resulted in a number of actions being agreed by both parties to improve the 2023/24 audit process. The Chair of ARC advised of her attendance at the wash-up meeting.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 13.7.23.

23/24/183 Constitutional Change
Resolved:
The Board:

- Received a proposal to amend the Trust's Constitution in relation to the composition of the Board with specific reference to Non-Executive Directors.
- Approved an amendment to section 23, paragraph 23.2.2. of the Trust's Constitution to increase the maximum number of Non-Executive Directors (by one) to eight.

23/24/184 Any Other Business

Garth Dallas reminded Board members of the Remembrance Day Ceremony that is being hosted by the Trust on Friday the 10th of November.

23/24/185 Review of the Meeting

The Chair thanked everyone for their contributions during the meeting and the work that has taken place to prepare the reports for the meeting. It was felt that a number of important discussions took place about how the Trust keeps its patients safe, but it was pointed out that there are some real challenges in terms of moving forward.

Date and Time of Next Meeting: Thursday the 7th December at 9:00am 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 December 2023							
6.7.23		Staff Story	Meeting to take place with Will Simmons and Christine Hill to discuss the support/resources that the Pathology Service requires to progress the Super Hub model.	L. Shepherd/ J. Grinnell	7.9.23	Dec-23	**7.11.23** - A meeting is in the process of being scheduled. An update will be provided in December. **ACTION TO REMAIN OPEN**
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	
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	Dec-23	
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	Dec-23	
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	Dec-23	
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	Dec-23	
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	Dec-23	
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	
Actions for January 2024							
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	Jan-23	**19.1.23** - This item has been deferred to February's Trust Board. 29.3.23 - This item has been deferred to May's Board. **27.4.23 -** This item has been deferred to June's Board. **3.6.23 -** The ToR will be submitted to the Board in September once they have been reviewed by RABD. **1.9.23** - The ToR will be submitted to the Board in October once they have been reviewed by RABD. **4.10.23** - The ToR will be submitted to the Board in November once they have been reviewed by RABD. **23.10.23** - The ToR will be submitted to the Board in December once they have been reviewed by RABD. **1.12.23** - The ToR will be submitted to the Board in December once they have been reviewed by RABD.**ACTION TO REMAIN OPEN**

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
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	Jan-23	**15.12.22** - A piece of benchmarking work is taking place to ascertain a response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **29.3.23** - This action is linked to new risk system and is unchanged pending the go live of InPhase in April. **27.4.23** - The new risk system is due to go live on the 10.5.23 therefore an update will be provided in June. **1.7.23** - This action has been deferred until September. **1.9.23** - This action has been deferred to October. **4.10.23** - This action has been deferred to November. **23.10.23** - This action has been deferred to December. **1.12.23** - This action has been deferred to January 2024. **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	Jan-23	
Actions for February 2024							
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	
Actions for March 2024							
7.9.23	23/24/106.2	Operational Issues	*Finance* - Submit a half yearly report on the cash share model that is emerging and provide detail in terms of how it is being managed from a risk perspective in the system.	R. Lea	7.3.23	On track March-24	

Status	
Overdue	
On Track	
Closed	

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

Integrated Performance Report | November 2023

Alder Hey Children's NHS Foundation Trust

Flash Report -November 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for November
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0	**1**
		Number of Serious Incidents (Steis reported)	0	**0**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**1**
		FFT - % Recommending Trust	> 95%	**91.0%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Sickness Absence Total	<5%	**5.9%**
		Staff Turnover	*<13%*	***12.0%***
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%	**79.0%**
		Number of RTT Patients waiting >65weeks	0	**192**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,583**
		Elective Recovery (Vol)	> 106%	***102.4%***
		Diagnostic Performance	> 90%	**79.6%**
	Financial sustainability	Revenue position – Year End forecast	13m Surplus	**£13m surplus**
	Aldercare optimisation	Optimisation of Aldercare	TBC	**Metrics to be agreed through new governance structure**

Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary

Published 5 December 2023

Strategic Goals	2023-24 Operational Priorities	Progress in November 2023	Areas of challenge
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• Final policy and plans for PSIRF transition completed and to be ratified by Trust Board • Progress with the development of CYP and families charter to reflect the CYP promises.	• Variability continues in PALS and complaints performance • Delay in appointing to our patient safety investigators • Appointment of patient safety specialist from CYP is ongoing
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Thriving Leaders Management Essentials programme – development in progress and on track • Preceptorship – joint framework in progress and on track	• Capacity & resource remains a challenge due to business case outstanding
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• Clinical Research Facility leadership team established formal links to share "best practice" in early phase clinical trials research with Siriraj Institute of Clinical Research, Faculty of Medicine, Siriraj Hospital, Mahidol University in Thailand. • Top recruiter nationally (8 sites) for the CRESCENT trial (inhaled carbogen as adjunctive treatment of paediatric convulsive status epilepticus). • Successful visit from Black Capital who are supporting a Hirschsprung's disease project via AH Charity. • Successful in the latest round of the Innovation Sites (InSites) programme for a total of £200k.	• Under-achieving against commercial income target and commercial study set up target (relates to national position as well as local challenges) • Increased subscription pressures in year relating to partnership working with Liverpool Health Partners and the Northern Health Science Alliance
Collaborating for CYP	**4. Handover Springfield Park to our community**	• Tree pits prepared for tree planting Dec '23/Jan '24. • Initial seeding of football pitches.	• Areas of residual Trust infrastructure works blocking full site possession for the park contractor.

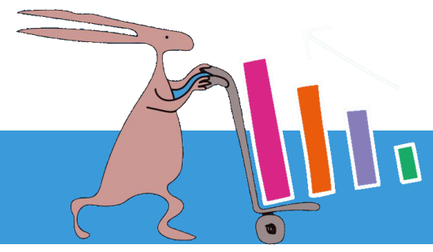
		• Path preparations to complete the path network Jan '24. • Commencement of play equipment & street furniture installation.	• Liverpool City Council taking over areas that are now out of the 2-year maintenance period.
Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Recovered urgent and emergency care performance and achieved the national standard of 76% of patients seen within 4 hrs • Increase in patients and care days in the virtual ward, reducing time spent in hospital • In November, the number of patients waiting over 65 weeks has reduced to less than 200	• **Goal of treating at least 80% of patients within 4 hrs** arrival in the ED from January 2024. We are expanding urgent care capacity and seeking investment in a C&M paediatric virtual urgent care service • **Eliminating 65 week waits for treatment:** ENT and Dentistry capacity support plans, which includes workforce expansion (in ENT) and in-sourcing • **Reducing WNB rate:** trialling evening early morning and evening clinics for height and weight clinics
Smartest ways of Working	**6. Financial sustainability**	• Reporting an in-month surplus of £1.5m in November (M8) and £1.5m year to date. This is in line with plan. • Revised H2 forecast to meet a surplus requirement of £13m (from £12.3m) to support system deficit position. • CIP gap closed in year subject to red & amber schemes delivering (£4m) however we have seen a deterioration to the recurrent position by £1.4m and the gap has now increased to £11.9m. • Benefits being assessed on strategic initiatives and wider change programmes to be reported in Jan.	• Only 25% of CIP has been identified as recurrent which means £11.9m will be carried into 24-25 which is unsustainable. • Divisional forecasts locked in to ensure no deterioration to previously reported positions • Ongoing action including cost control within divisions and manage pressure where possible with non recurrent mitigations • Expenditure Controls being reported to RABD in December • Challenges with activity reporting impacted by implementation of Alder care as well as industrial action impact.
Smartest ways of Working	**7. Optimisation of Aldercare**	• Inaugural AlderCare Phase 2 Programme Board met for the first time in November	• Reporting workstream progressing and working towards full restoration for mid-December

		• Initial list of 'Optimisation Priorities' have been agreed with the Divisions • Work is underway to deliver the first set of priorities • Clinical Digital Design Authority to be established to support future prioritisation	

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: November 2023



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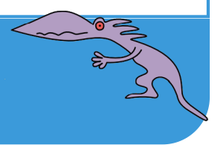


Icon Definitions

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

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

XmR chart

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

Process limits

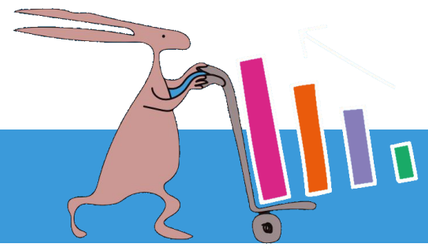
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

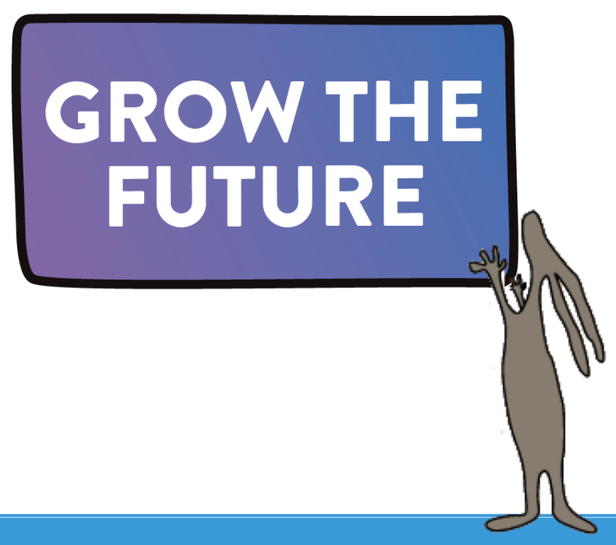
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

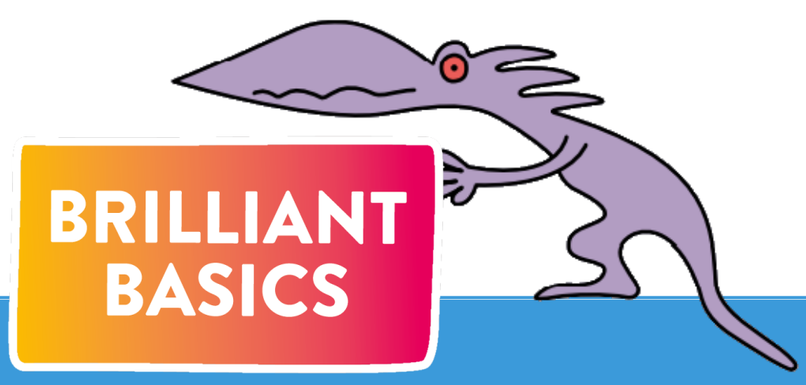
		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Cancer 2-week referrals & C.Difficile demonstrates performance is consistently achieving target with an improving trend	A&E Sepsis, F&F Recommend the Trust, Mandatory training, Deteriorating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

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

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





Unrivalled Experience - Safety

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

Highlights:

No serious incidents or Never events reported. Antibiotics administered within 1 hour on ED 95% and inpatient wards 94% - continued improvement over 4 months in ED. Reduction in unplanned admissions to critical care from inpateint wards

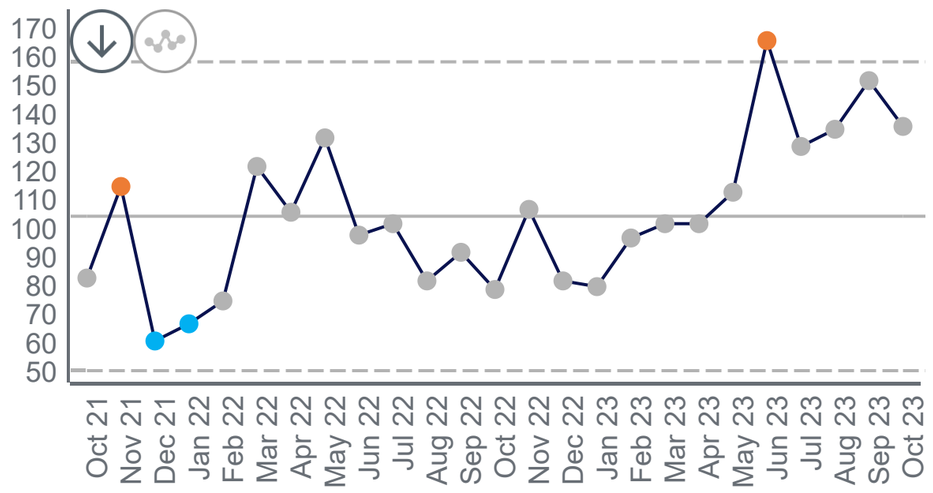
Areas of Concern:

Use of physical restrictive intervention remains comparitively high however specific clinical management plans in place

Forward Look (with actions)

Review separating Category 2 pressure ulcers from Category 3 and 4 pressure ulcers in report

Number of Incidents rated Minor Harm and above



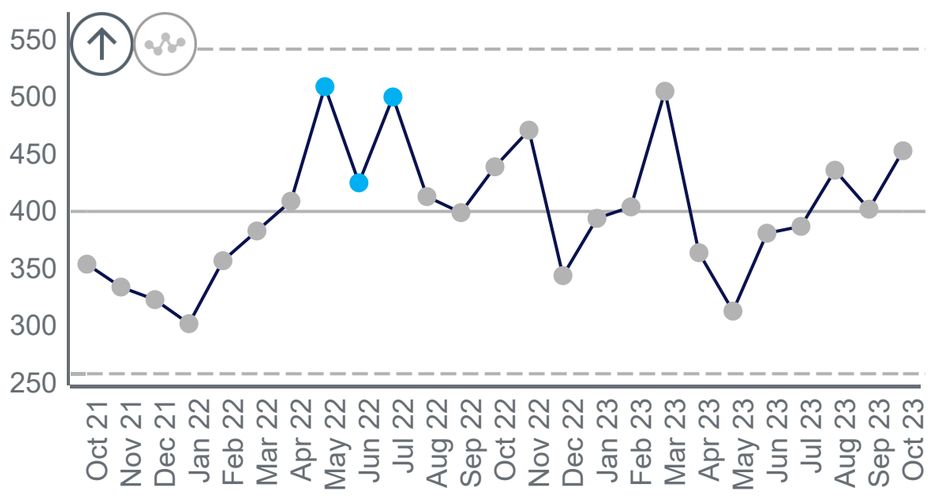
Technical Analysis:

This is interim measure of number of incidents instead of per 1,000 bed days due to data accessible. October 2023 shows 136 patient safety incidents rated as harm which is 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 implemented May 2023.

Actions:

Continue to promote a positive reporting culture through Trust and Divisional Governance structures, weekly Patient safety meeting, and monthly Patient Safety Board with particular focus on PSIRF implementation and availability of patient safety training

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. October 2023 shows 453 patient safety incidents rated as no harm which is an increase from September's performance of 402 incidents. No common cause variation, increase in no harm's mirrors reduction in harms above so steady number of incidents overall still being reported.

Actions:

Continue to identify thematics of reporting which leads to application of the PSIRF methodology for example TPN administration

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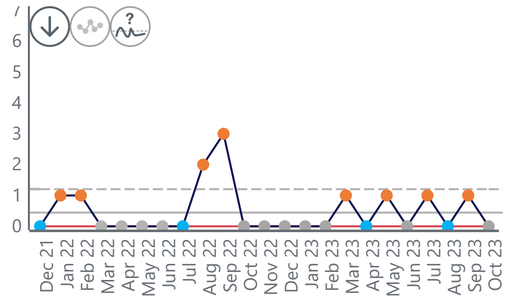
Integrated Performance Report | November 2023

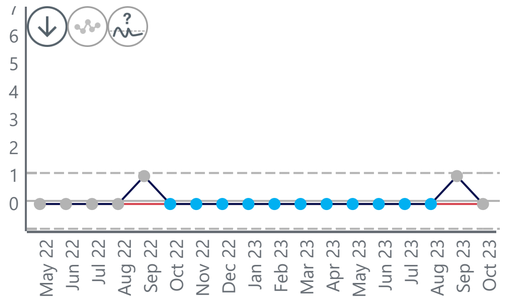
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

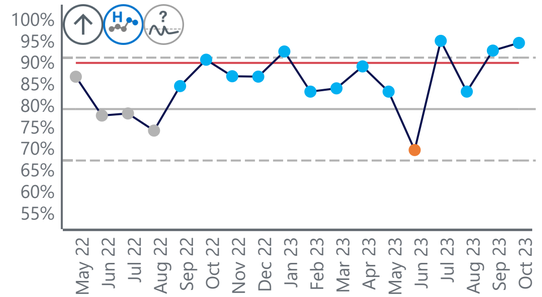
Number of Serious Incidents (Steis reported)



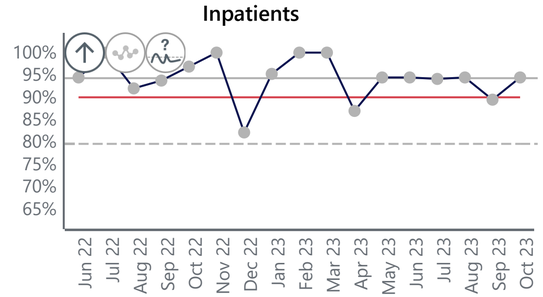
Number of Never Events



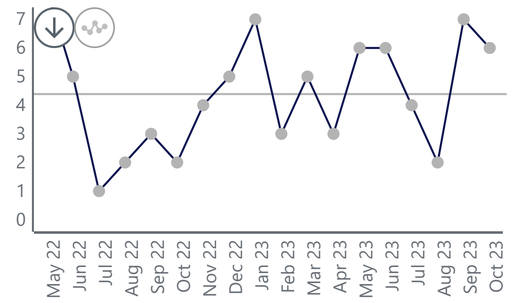
Sepsis % Patients receiving antibiotic within 60 mins for ED



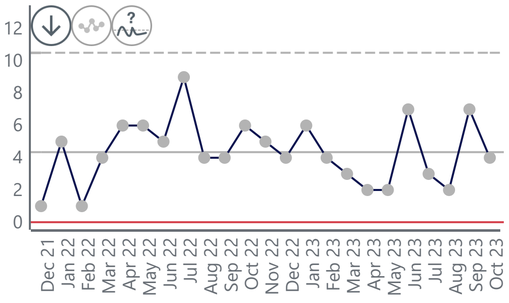
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



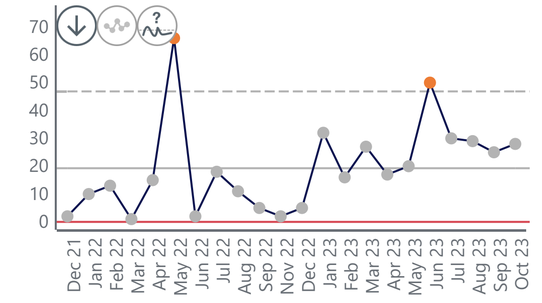
Medication Errors resulting in Harm



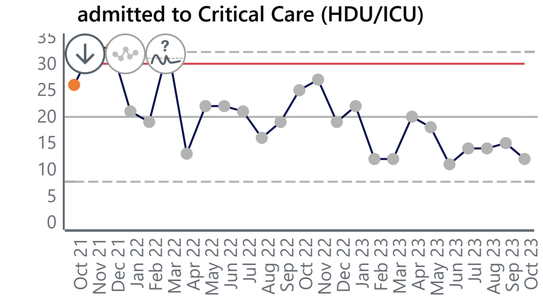
Pressure Ulcers G2-4



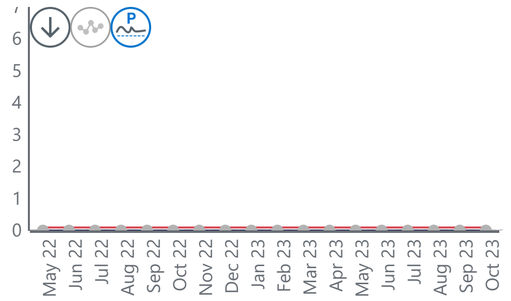
Use of physical restrictive intervention



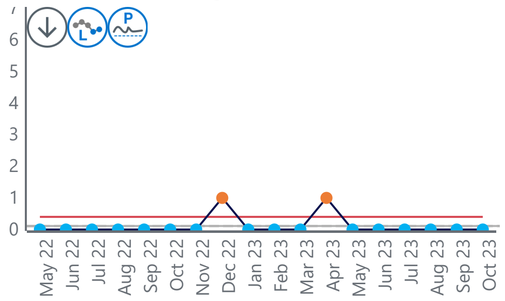
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



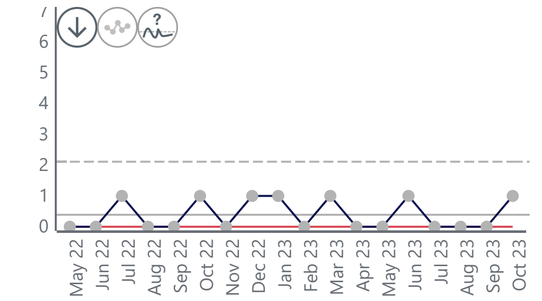
Hospital Acquired Organisms - MRSA (BSI)



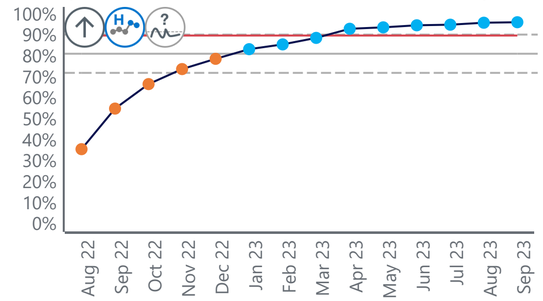
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Integrated Performance Report | November 2023

Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring

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

Highlights:

Patient Experience and Engagement Strategy group progressing all workstreams at pace

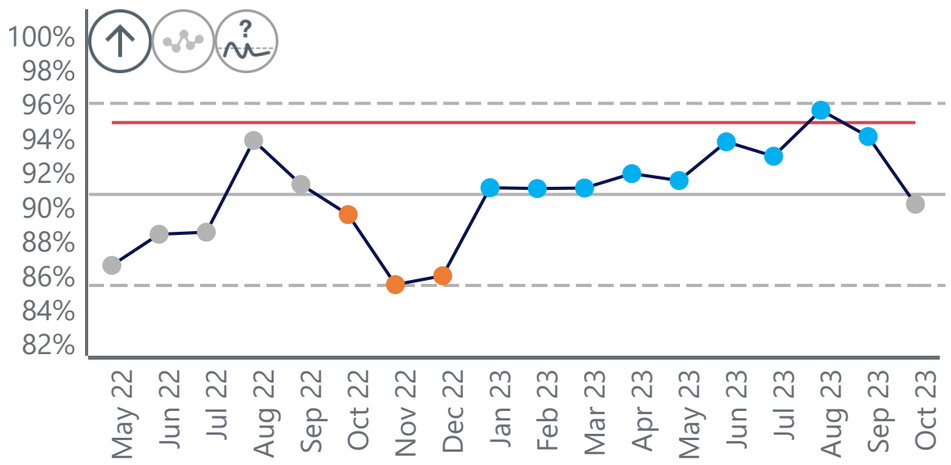
Areas of Concern:

Higher number of PALS contacts received in last 12 months compared to previously; not associated with a decrease in formal complaints

Forward Look (with actions)

Review of FFT questions and methodology underway for capturing CYPF feedback

F&F Test - % Recommend the Trust



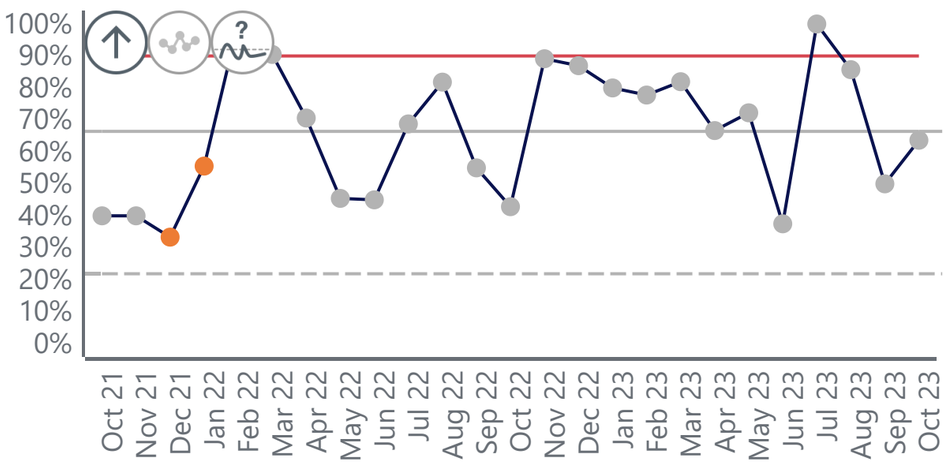
Technical Analysis:

Consistently not achieving the 95% target. Performance of 90% represents lowest point since December 2022, following 9 consecutive months above the 12 month average of 91%.

Actions:

Divisions to conduct a deep dive into their rsponses and feedback to identify areas of concern where improvement could be made

% Complaints Responded to within 25 working days



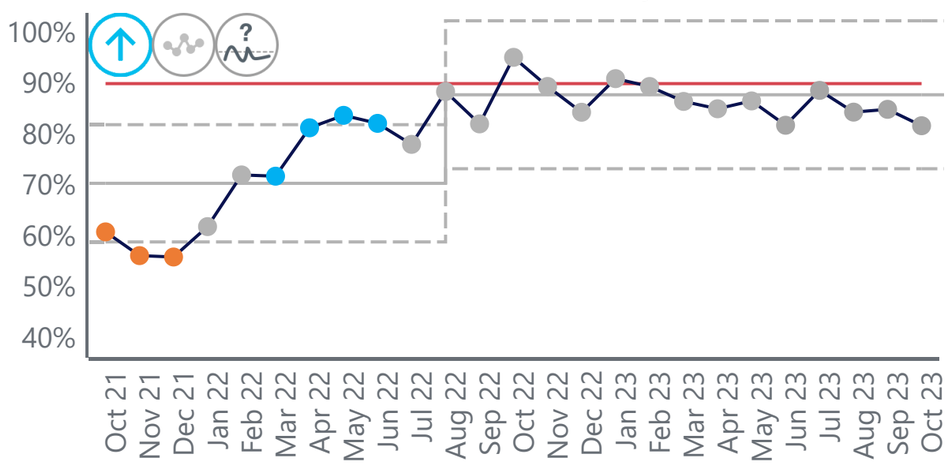
Technical Analysis:

Inconsistently achieving the 90% target with an average of 66% which shows significant fluctuation from month to month. Performance in October 2023 was 64%

Actions:

Divisions to strive towards full response within 25 working days and ensure cross cover arrangements

% PALS Resolved within 5 Days



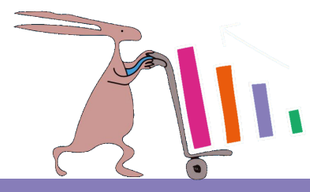
Technical Analysis:

Common cause variation has been observed with a 12 month average of 88%. Inconsistently achieving the 90% target. October 2023 performance was 82%.

Actions:

Sustained improvement in performance over the past 12 months; Divisions to ensure effective cross cover arrangements

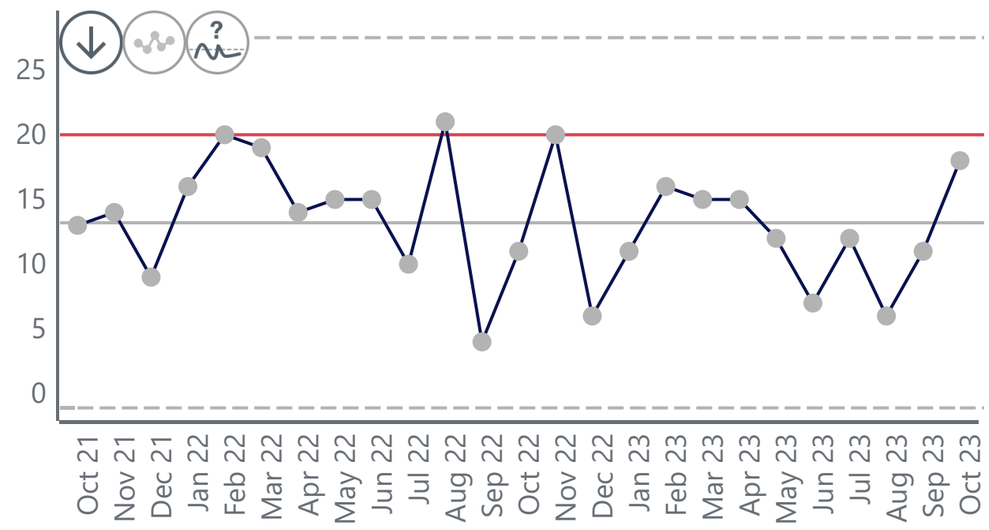
Integrated Performance Report | November 2023



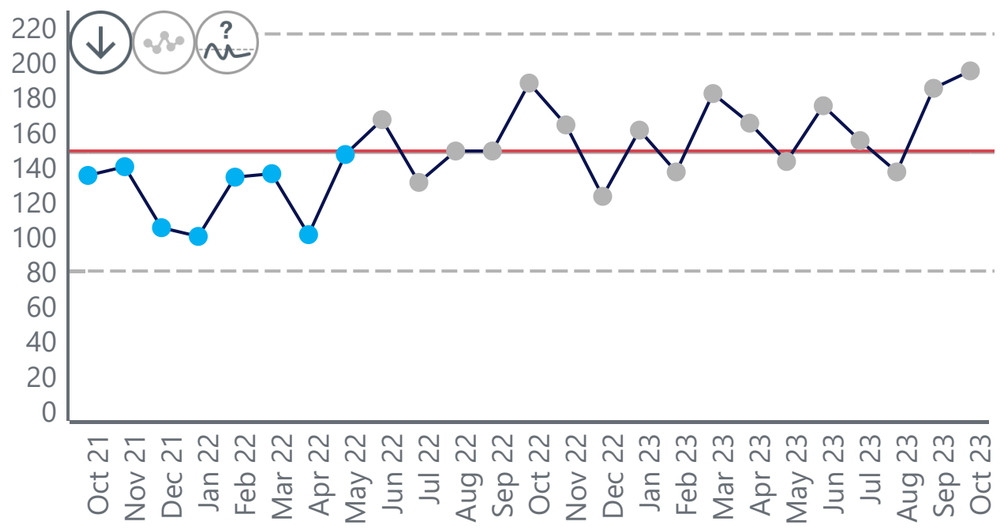
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

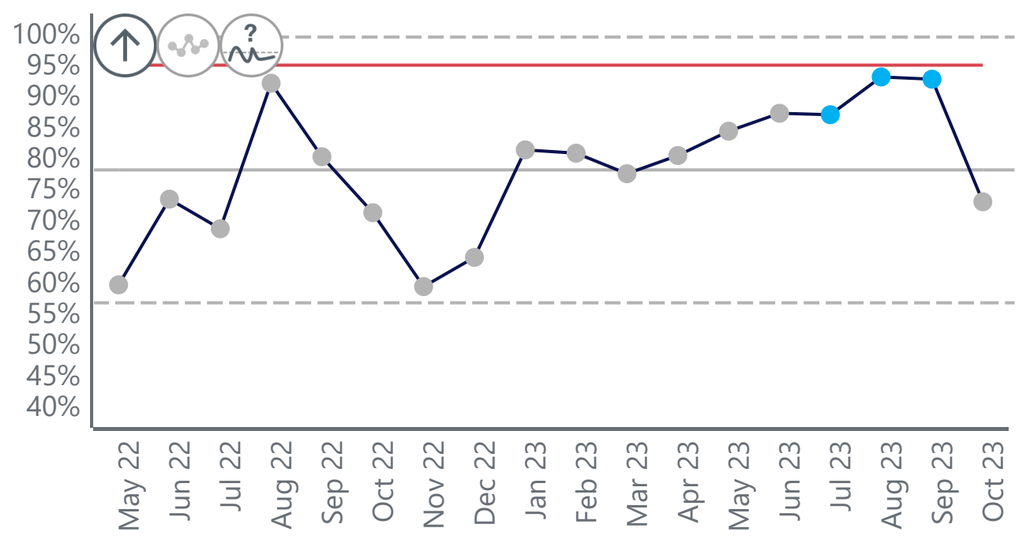
Number of formal complaints received



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:

• Initial improvements demonstrated with fewer Stranded Patients (special cause varation and achieving target between May-Aug); Virtual Ward Bed Days (7 consecutive points above the mean); Theatre Utilisation Touch Time (special cause in May-Aug). All of these areas are pending data for Sep-Oct.

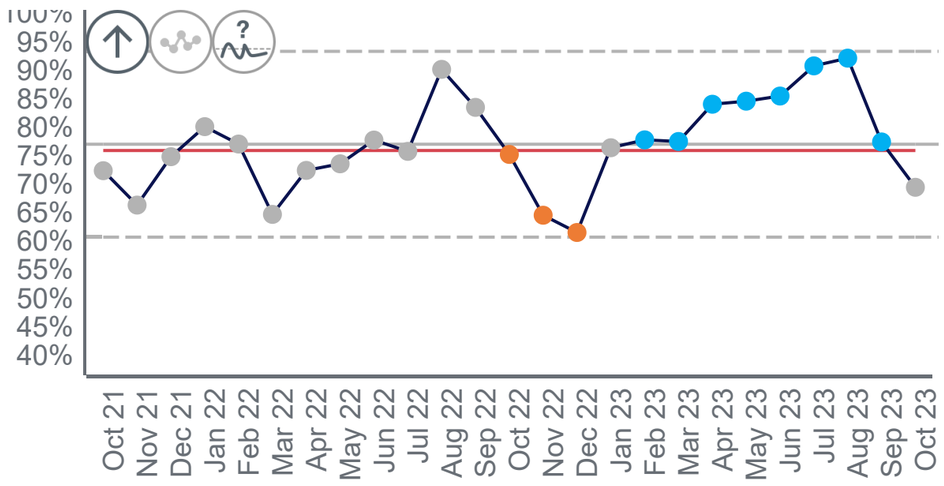
Areas of Concern:

• ED 4 Hour performance was below national standard of 76% in October for the first time this calendar year • WNB rate >10% for five consecutive months (11% in October)

Forward Look (with actions)

• ED performance is top priority internally and externally; improvement actions are in place (see below) • WNB improvement plan being implemented using Brilliant Basics methodology (details below)

ED: % Treated within 4 Hours



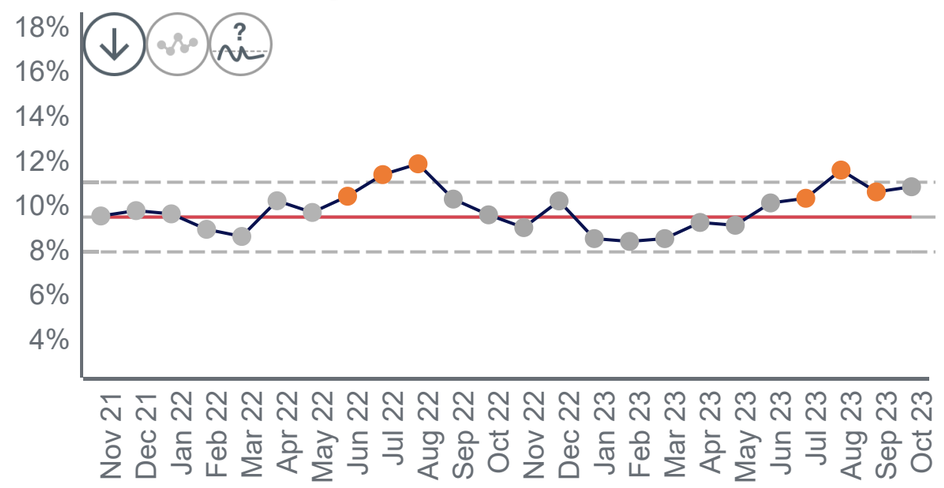
Technical Analysis:

Common cause variation has been observed with performance of 69.5% which is 2nd consecutive reduction in performance following recent improvement. First time trust has not achieved the national target (>76%) since November 2022, although performance is in line with October 2022 which demonstrates seasonality demand.

Actions:

• Increase urgent care centre capacity (completed)
• ED Consultant winter rota with additional evening and weekend cover
• Embed abdominal pathway to direct book more low acuity patients into acute clinics

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



Technical Analysis:

Provisional data

WNB rates demonstrates common cause variation. Performance in October 2023 of 10.9% is +1.3% compared to October 2022 (9.6%) and now the 5th consecutive month above the target of 10%. Although a number of bookings are still be actioned for the month which could alter October 2023 position.

Actions:

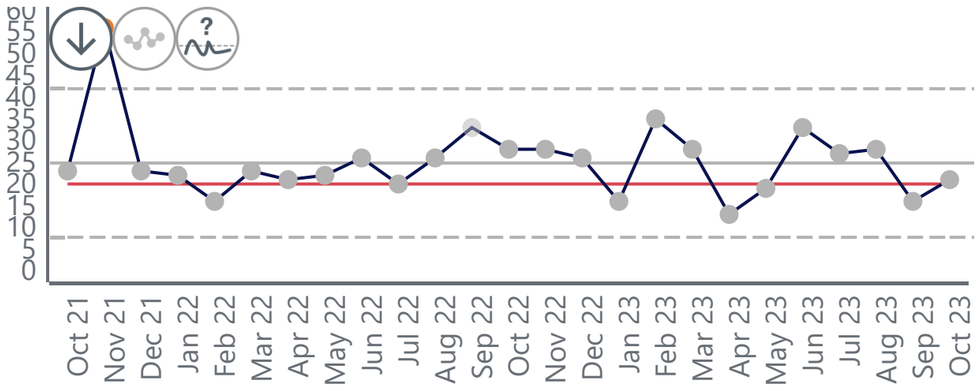
• Specialty-level review of outpatient model and booking process where WNB is greater than 10% • WNB reminder calls now include ADHD and mental health services • Alder Care Optimisation opportunities include relaunch of PDS demographic software, review of automated letter systems and improvements to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

Integrated Performance Report | November 2023

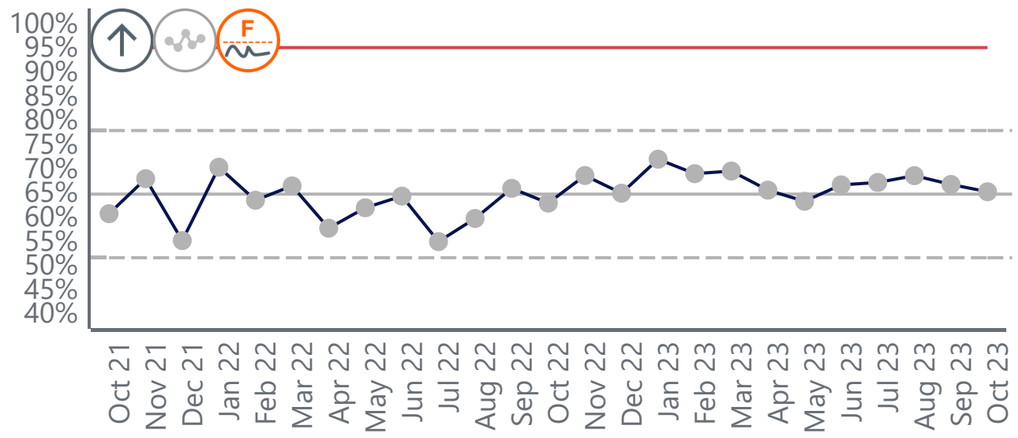
Alder Hey Children's NHS Foundation Trust

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

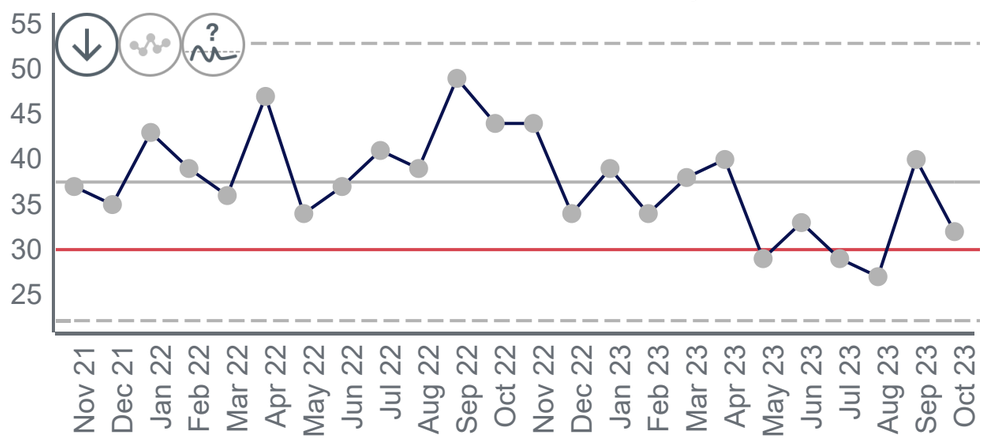
Number of Cancelled Operations (on day of admission for a non-clinical reason)



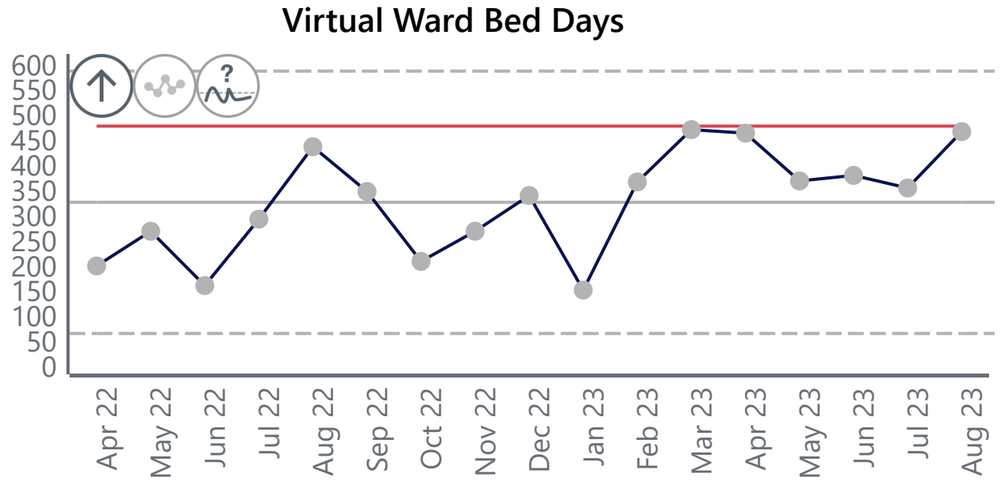
% of Clinical Letters completed within 10 Days



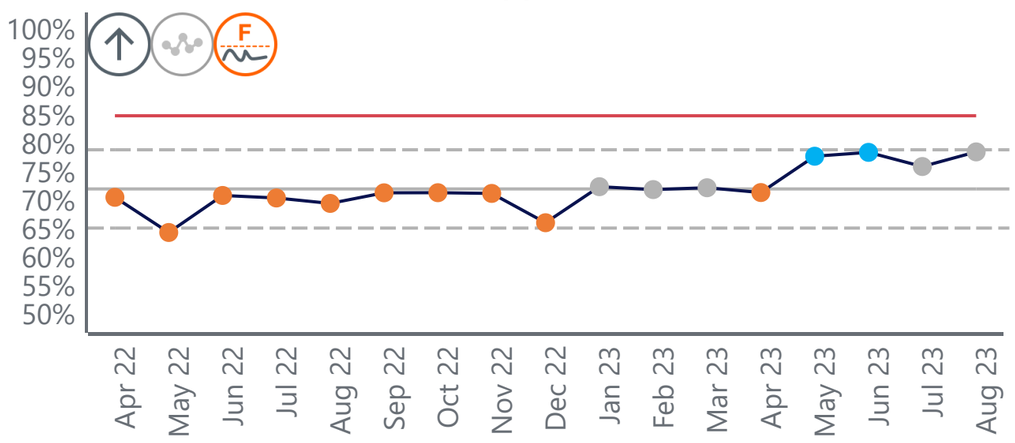
Number of Stranded Patients (21 Days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Integrated Performance Report | December 2023

Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• Activity Recovery at 99% in October, despite impact of Industrial Action • Significant reduction in CAMHS >52weeks • 100% compliance for access to cancer services, exceeding national standards • Diagnostic 6 week waits (DM01) showing sustained special cause variation

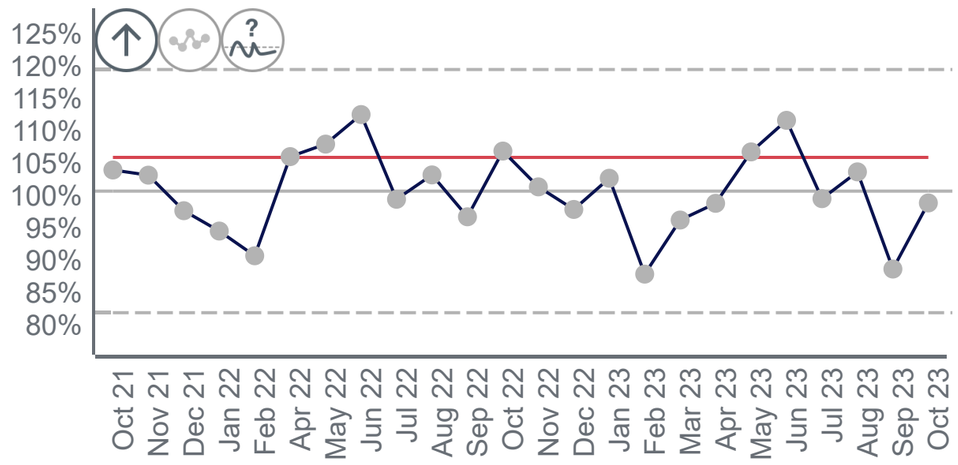
Areas of Concern:

• Increased number of children and young people waiting >65 weeks (RTT), up to 236 primarily in ENT and Dental, tempered by overall reduction in >52week waits • Growing pressure on waiting times >65 weeks in ASD / ADHD pathways, now >1,600 • Ongoing challenges with demand and waiting times for Initial Health Assessments (IHAs)

Forward Look (with actions)

• Recruitment and agency staffing plan will enable theatre sessions to go back up to 139 sessions from February 2024 • Finalise extracontractual rates of pay and increase weekend elective activity in Q4 • Focus on productivity and increased patients per list in Day Case to drive Recovery • Progress improvement plans with ASD and ADHD, and IHAs

% Recovery for DC & Elec Activity Volume



Technical Analysis:

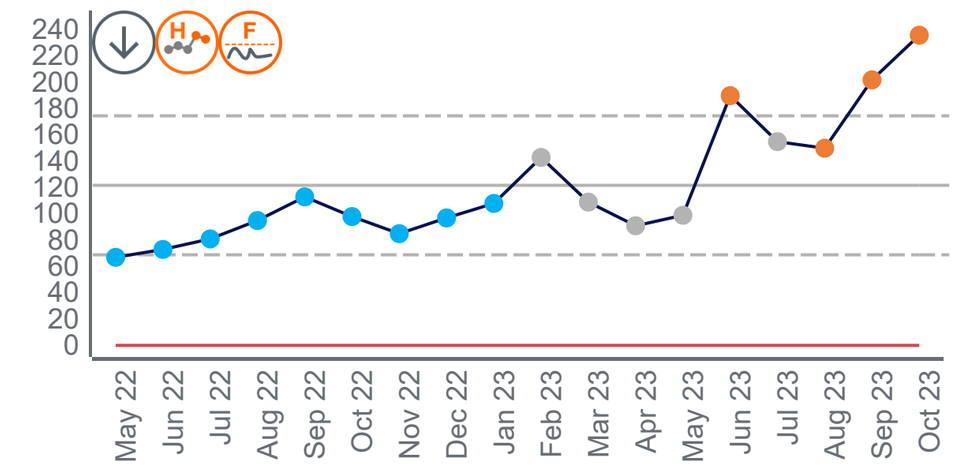
Provisional data

October performance of 99% is a provisional figure due to AlderCare impact on reporting. In October we experienced 3 days of Industrial Action, so in this context 99% Recovery was good performance in month. The data series continues to demonstrate common cause variation.

Actions:

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

Number of RTT Patients waiting >65 weeks



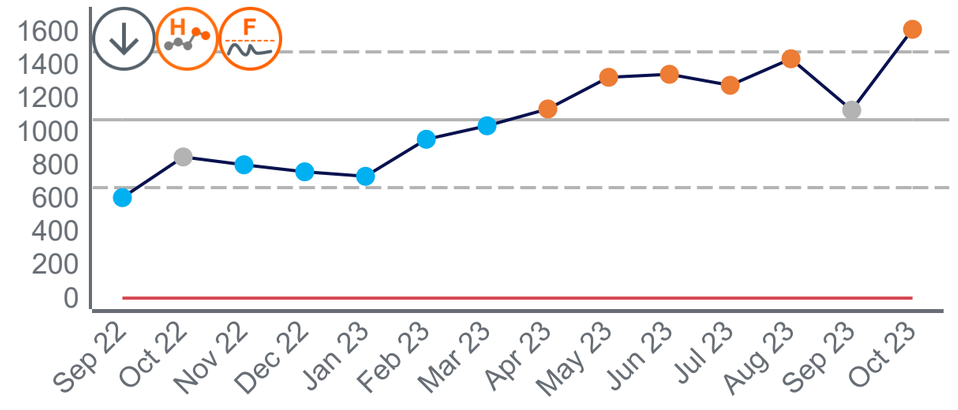
Technical Analysis:

Number of patients waiting > 65 weeks has increased in to 236 in October (202 in September). The current trend is showing special cause variation with an increase in breaches over the last 3 months. Dentistry (n=99) and ENT (n=128) make up 96% of the Trust total.

Actions:

Theatre sessions for ENT, Dental and Spinal surgery are being protected. These three specialties are forecasting increased run rate in Nov-Mar, with Insourcing /LLP model, optimising Day Case productivity and assumption of no further Industrial Action.

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



Technical Analysis:

On average 1070 patients are waiting for an ASD or ADHD diagnosis per month. October shows 1613 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 include: dedicated project manager support, temporary funding for clinical and admin posts, introduction of Clinical Associate in Psychology role into ASD (to mitigate gap of qualified clinical psychologists). Daily huddles remain in place to mitigate impact of global shortage of ADHD medication

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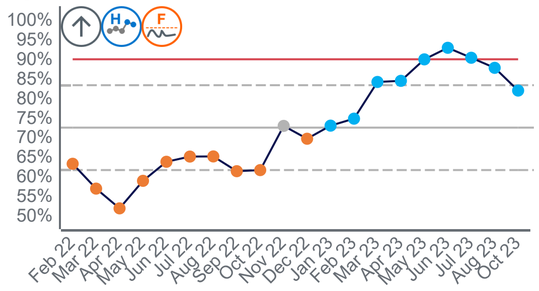
Integrated Performance Report | December 2023

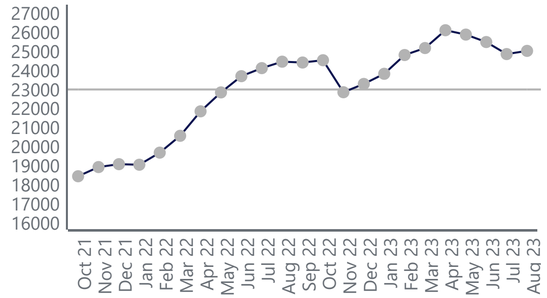
Alder Hey Children's NHS Foundation Trust

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

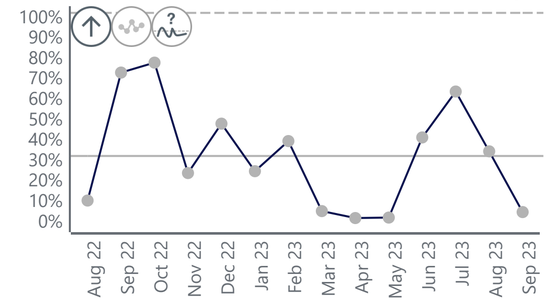
Diagnostics: % Completed Within 6 Weeks of referral



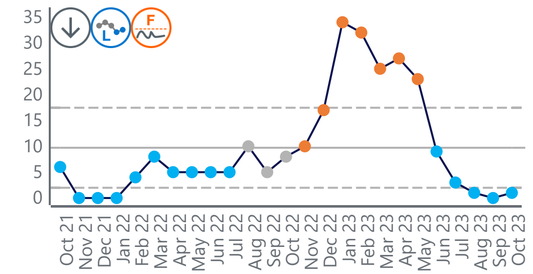
Waiting List Size



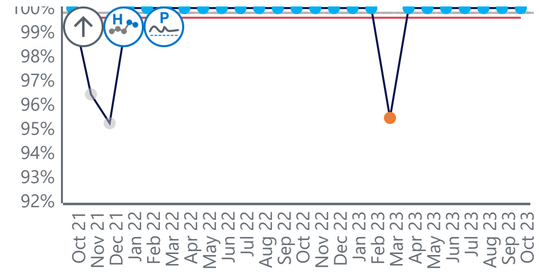
IHA: % complete within 20 days of referral to Alder Hey



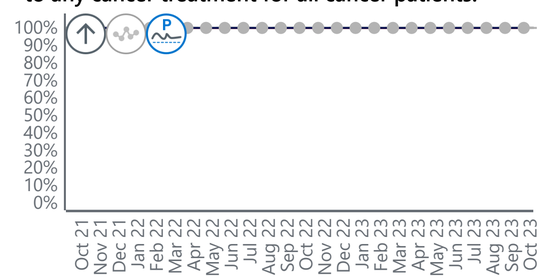
CAMHS: Number of children & young people waiting >52weeks



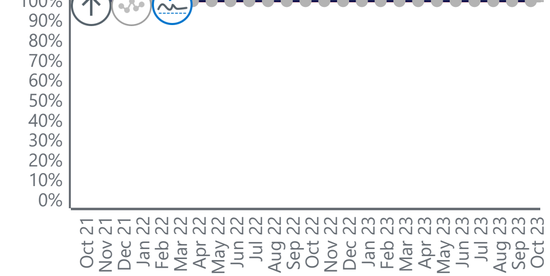
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



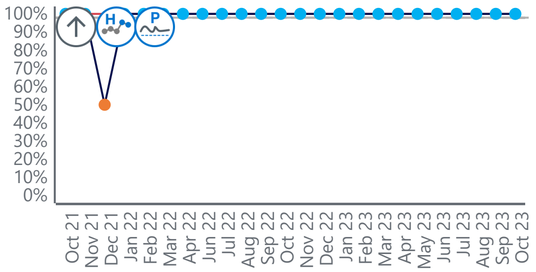
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



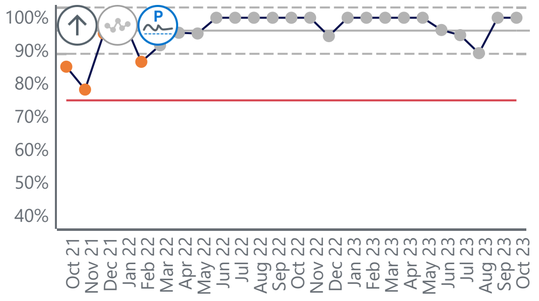
All Cancers: 31 day wait until subsequent treatments



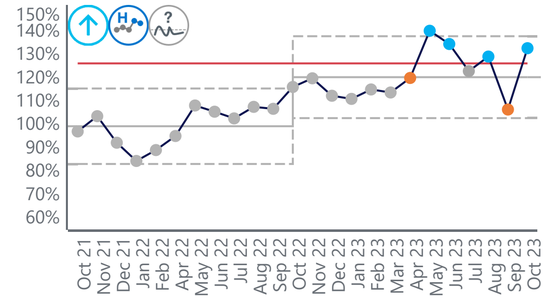
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery - OP New/OPPROC Activity Volume - Provisional data



Integrated Performance Report | November 2023

Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

Sustained reduction in staff turnover with further opportunities to analyse this detail to understand the continuing downward trend. Improved activities within Divisions to tackle Long Term Sickness (LTS) and capture exit information. PDR progress to 75% since September

Areas of Concern:

Overall sickness absence 5.93%, showing a minor increase. Expectation that trend continues due to winter pressure. Ongoing monitoring required if staff availability position is to be improved. PDR progress improved from 15% drop since the summer. Potential to drop again during winter. Attention to encourage quality conversations, including stay discussions, health & wellbeing included in process.

Forward Look (with actions)

Anticipating 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, 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

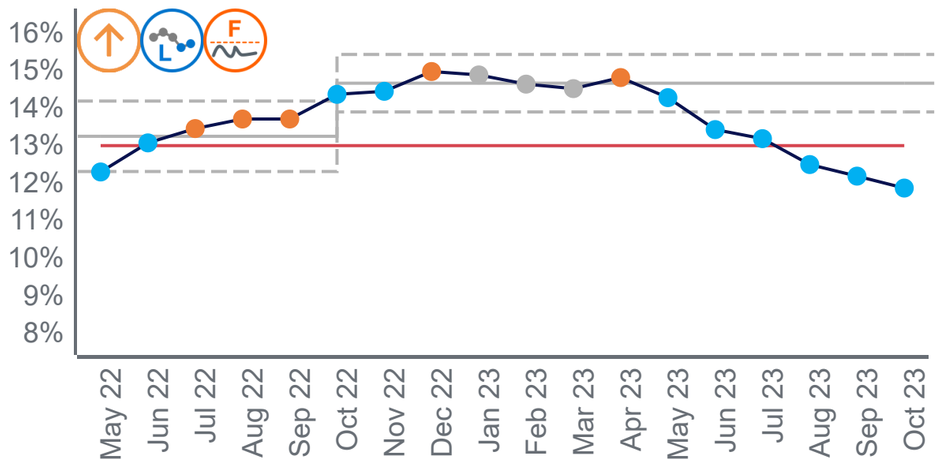
Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

Not applicable – this metric is in development

Staff Turnover



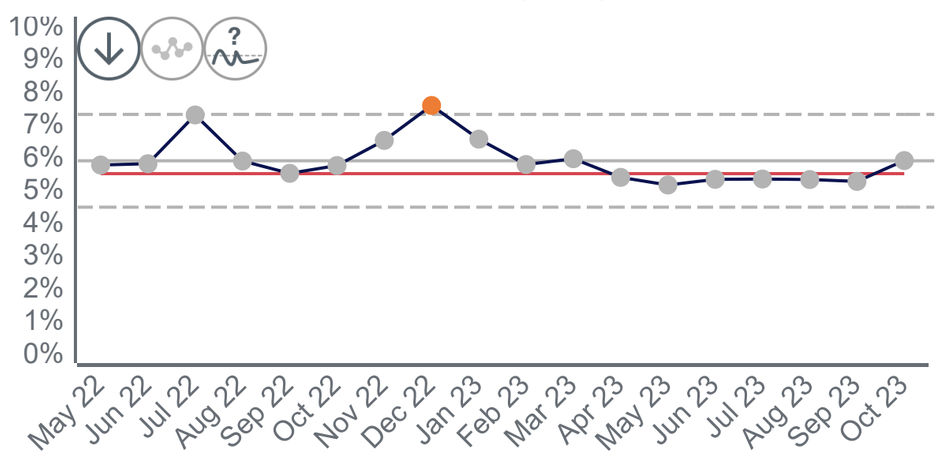
Technical Analysis:

Staff Turnover has demonstrated special cause variation , 11.9% is the 7th consecutive month with a reduction and 3rd consecutive month within target.

Actions:

Relative target for measuring overall turnover adjusted from 15% to 13%. Turnover further reduced since Sept at 11.9%. Exit process is now online to support improved monitoring within divisions and to identify exit patterns & workforce impact. Analysis of divisional use of other resource routes being explored.

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in October is 5.93% which is over the 5.5% target. A increase from September at 5.27%. October performance comprises STS at 2.23% and LTS at 3.69%. Still demonstrating common cause variation and first month above target since March 2023.

Actions:

Onsite discussions and wellbeing activities in Divisions; focus on Stage 3 LTS, resulting in returns or resignations. Return to Work discussions are being reinforced. Proactive winter vaccine programme (flu/covid) onsite now. Wellbeing activities promoted

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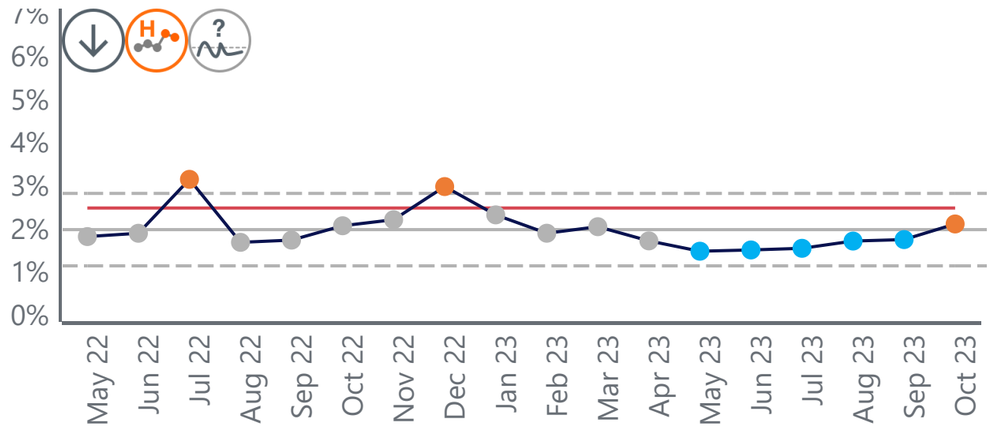
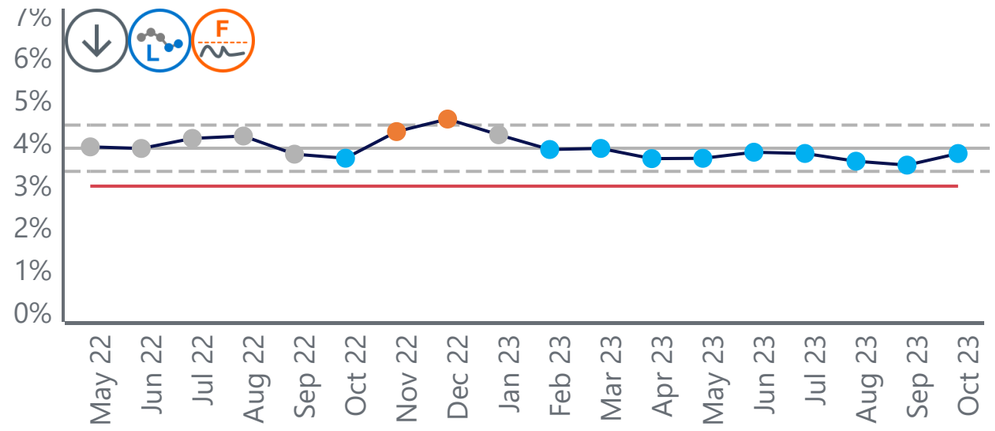
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

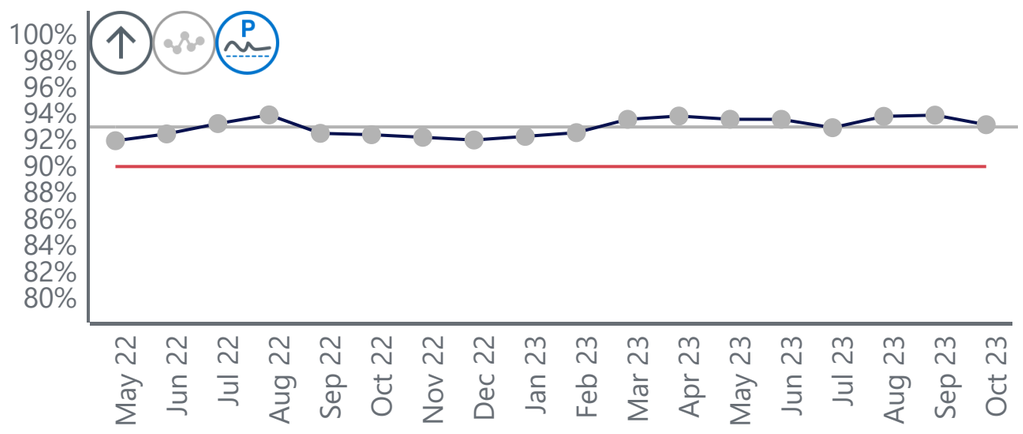
Short Term Sickness



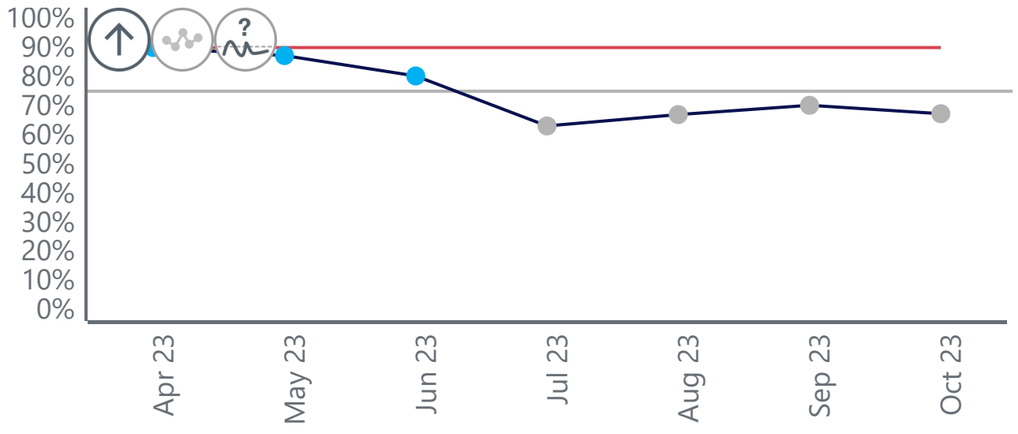
Long Term Sickness



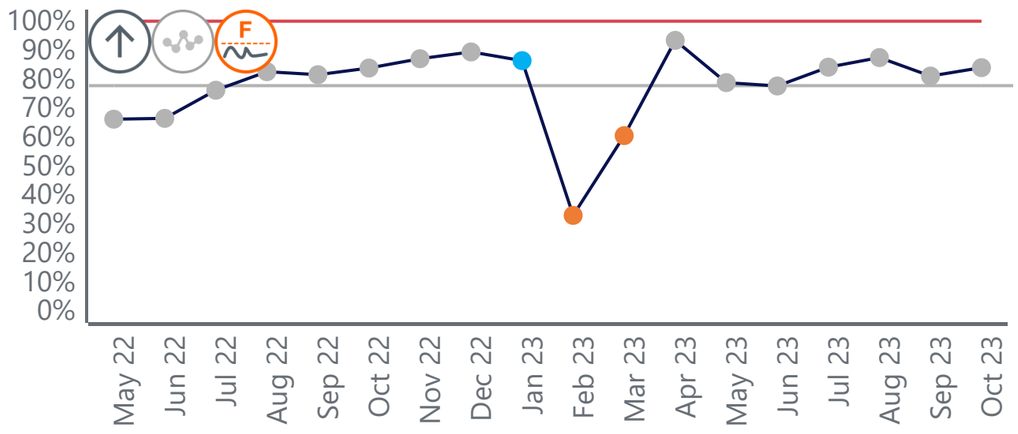
Mandatory Training



% PDRs completed since April



Medical Appraisal



Staff movement / Churn rate - In Development

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Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

In October (M7), the Trust is reporting a £1.5m surplus (£25k ytd) which is in line with plan. Forecasting to achieve £12.3m surplus subject to CIP risk & activity levels. CIP £1.8m behind plan ytd. Overall £11.1m CIP has been transacted with £4.4m in progress. Gap of £2.1m relating to trust wide transformation & transactional schemes. Cash has remained high in line with plan & capital in line with expectations.

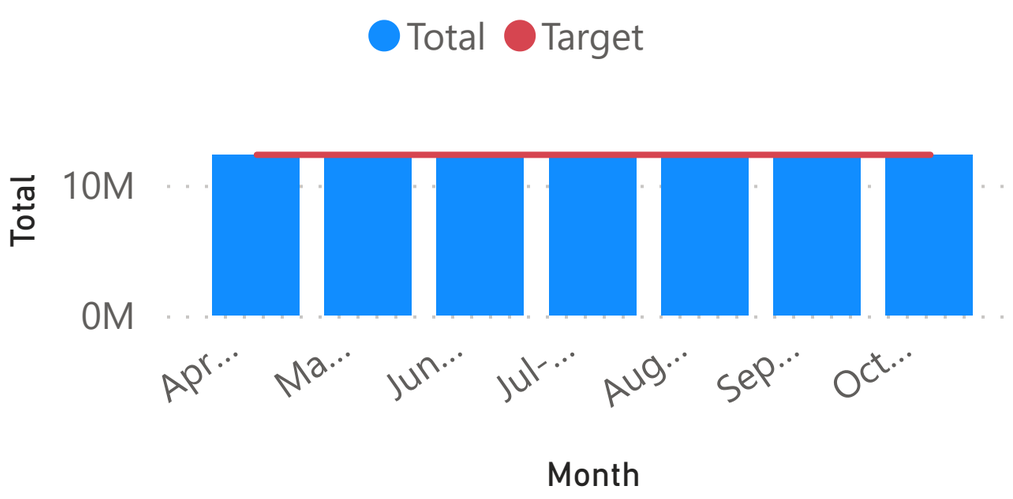
Areas of Concern:

CIP gap closing in year but trust level schemes still progressing and represents a high proportion of the unidentified value. Challenging £12.3m control total surplus plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets. Recurrent CIP also area of concern given the gap recurrently is £10.4m which will be carried into 24-25 if not identified.

Forward Look (with actions)

Continued cost control to reach the £12.3m surplus requirement by end of the financial year. Urgent focus required on recurrent efficiency. Further H2 meetings taking place in November. Work also continues with divisions on transformation schemes to identify recurrent changes and benefits by end of November.

Revenue Position (Year End Forecast)



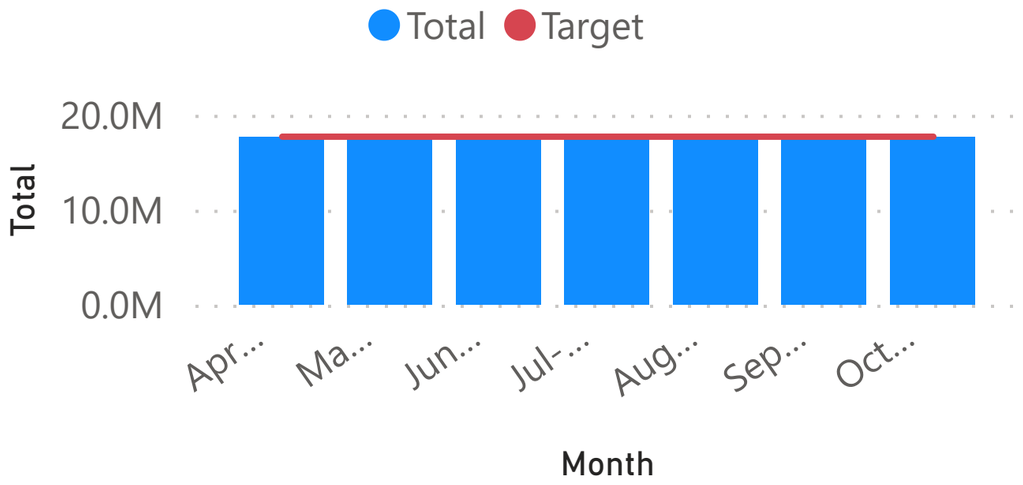
Technical Analysis:

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

Actions:

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

CIP Position (Recurrent Full Year Effect)



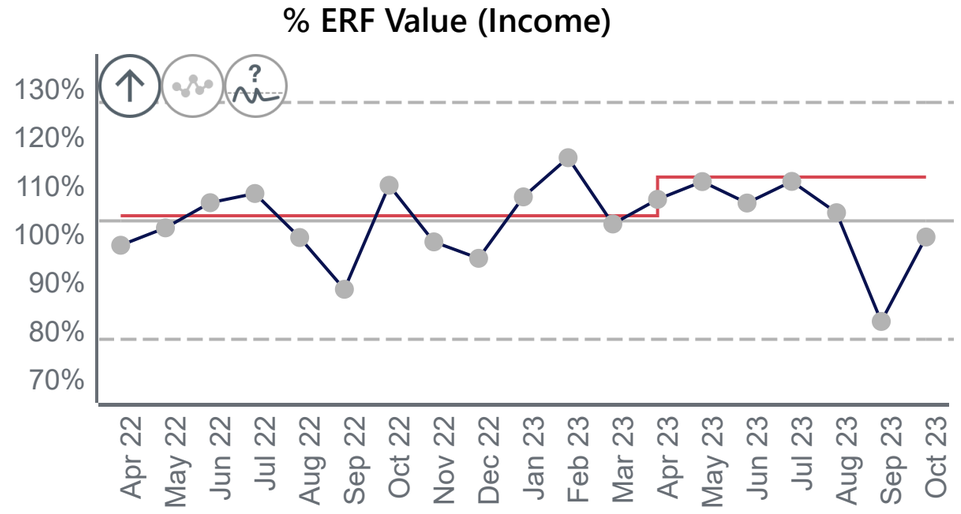
Technical Analysis:

In year CIP identified and in progress is £15.6m. Of this, £7.3m is recurrent.

Actions:

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

% ERF Value (Income)



Technical Analysis:

Provisional data

October performance estimated at 99.6%. YTD performance estimated at 102.8%.

Actions:

Support required with exec leads and transformation to identify the large scale opportunities. Work continues on wider change programmes. Divisions have identified plans to meet their gap in full in year only. Still large gap recurrently of £10.4m.

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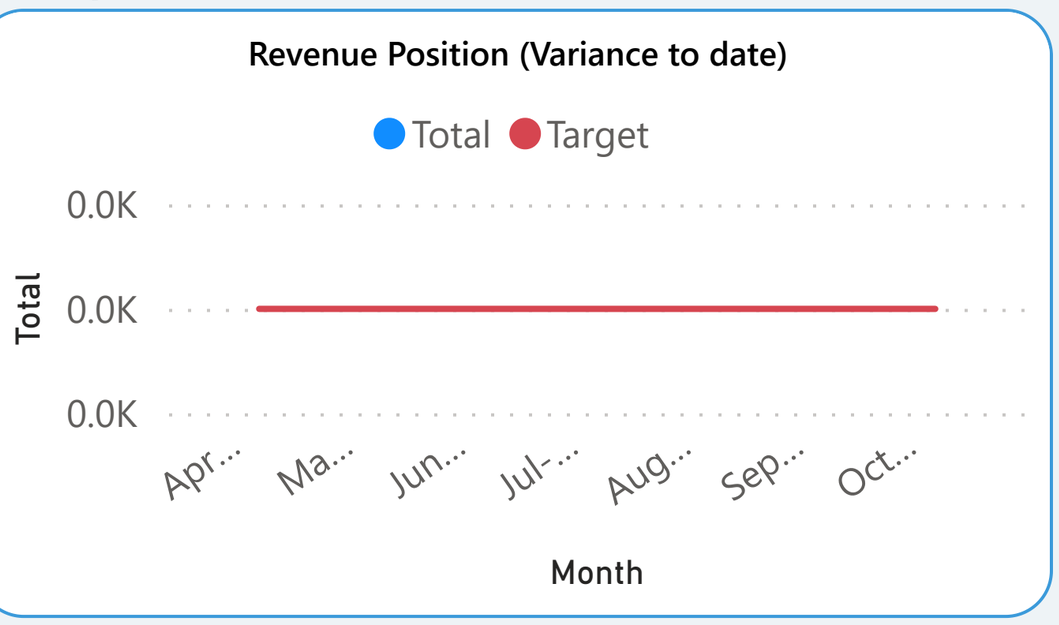
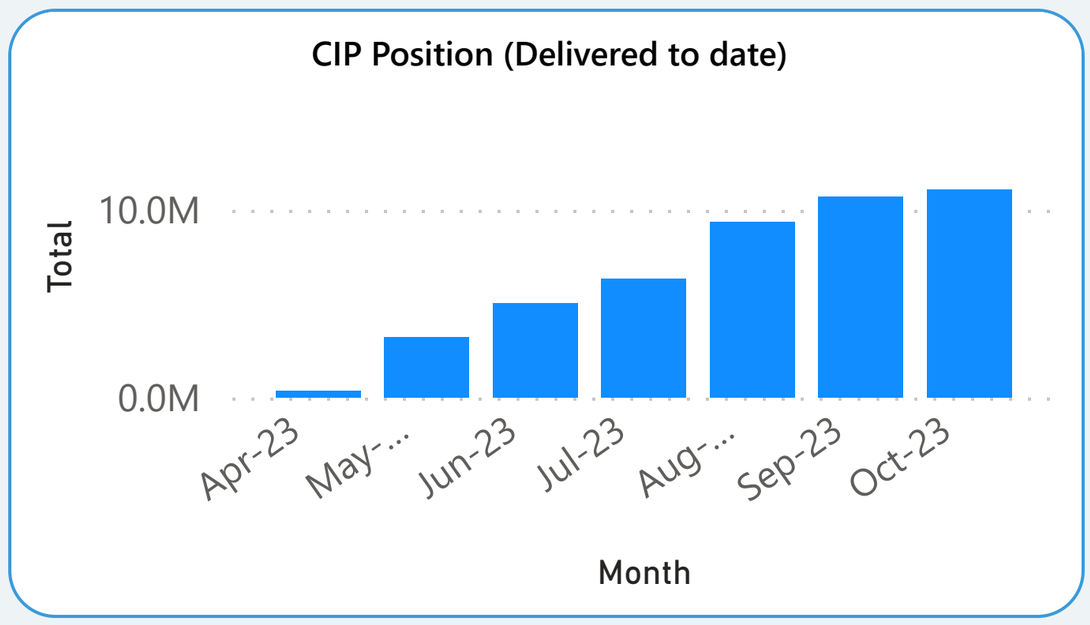
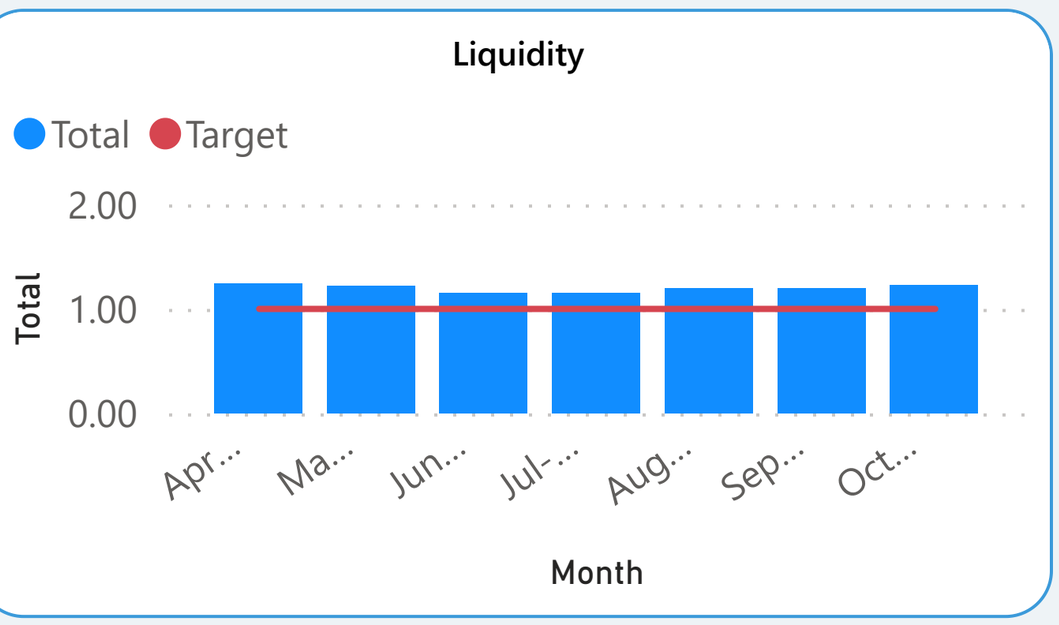
Alder Hey Children's NHS Foundation Trust

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







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Alder Hey Children's NHS Foundation Trust

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. Weekly sitrep for report development status provided by digital team. Automatic notification for upcoming/overdue risk reviews now rectified by InPhase

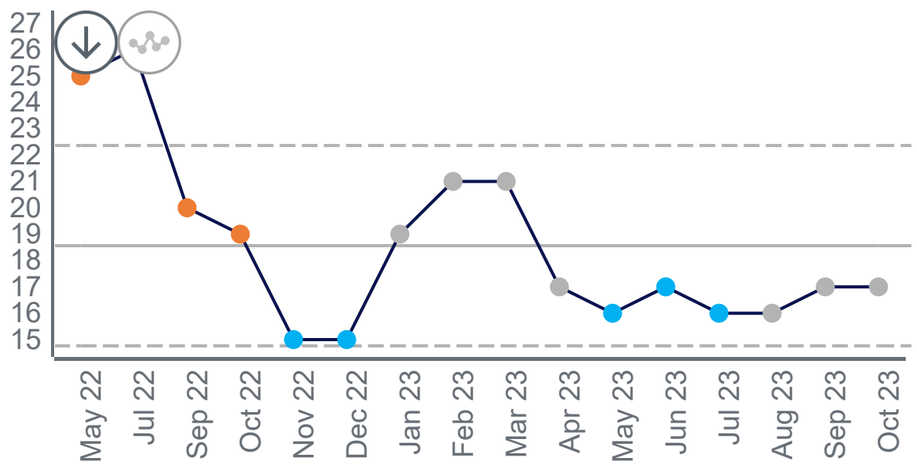
Areas of Concern:

Reporting is improving but still remains a challenge. Support being provided from Digital team to improve visualisation of reports and development of meaningful dashboards. Occasionally some updates to risks are not saving in system-Escalated to InPhase. Number of long standing high moderate risks (>12 months) on register remains static despite several mitigations in place. Escalated to Risk management forum for review with request for a deep dive in Januarys RMF. RISK 22 reviewed and due to a number of mitgations in place risk score reduced from 12 to 9 (3x3).

Forward Look (with actions)

Continue to support staff via the risk oversight meetings / 1:1 basis. Risk 22 remains open with appropriate mitigations in place. Continue to work closely with BI/Analytics on report visualisation. Weekly meeting in place.

Number of High Risks (scored 15 and above)



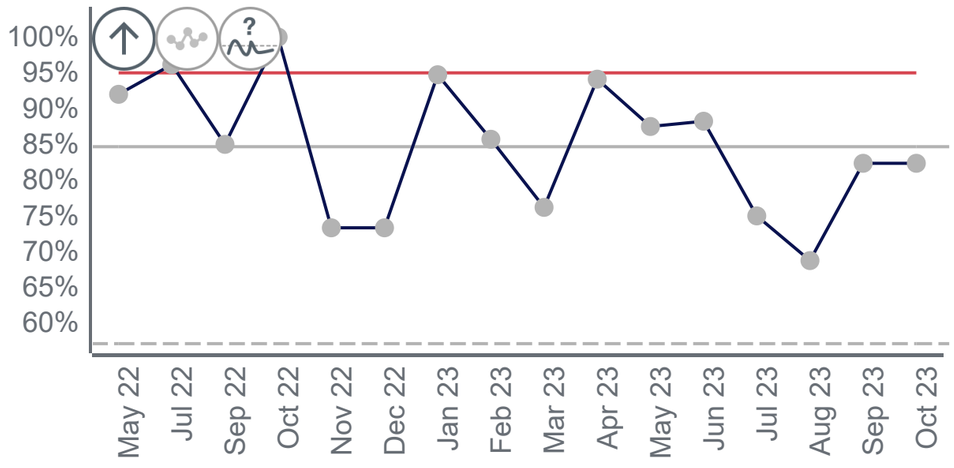
Technical Analysis:

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

Actions:

17 high risks on risk register at the end of October.This remains stable and within the normal range

% of High Risks within review date



Technical Analysis:

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

Actions:

82% (14/17) within review date below the 95% target

3/17 high risks remain overdue and have been escalated to risk owners

Smartest Ways of Working - Safe Digital Systems- Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

Good progress has been made post go live with the AlderCare stabilisation phase of the programme. Theatres and Booking and Scheduling workstreams have now moved into 'Optimisation'. The Aldercare Optimisaiton Programme Board has been established. The development of the Alder Hey Anywhere platform is progressing, Alder Hey have submitted a bid for national funding to support further development and deployment. Operational performance remains good.

Areas of Concern:

Whilst good progress has been made, some challenges remain in the reporting workstream of AlderCare which these will continue to be worked through with internal and external colleagues

Forward Look (with actions)

Phase 2 of AlderCare to commence – including Optimisation and plan for future versions. Alignment of Digital projects to 2030 and New Models of Care including ED Symptom Checker, AlderHeyAnywhere, ISLA and other programmes of work

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:

Gloves off in PICU has started. MOU agreed with Active Travel England and NHSE with Alder Hey as lead site. Initial long term site plan reviewed with Laing's sustainability team.

Areas of Concern:

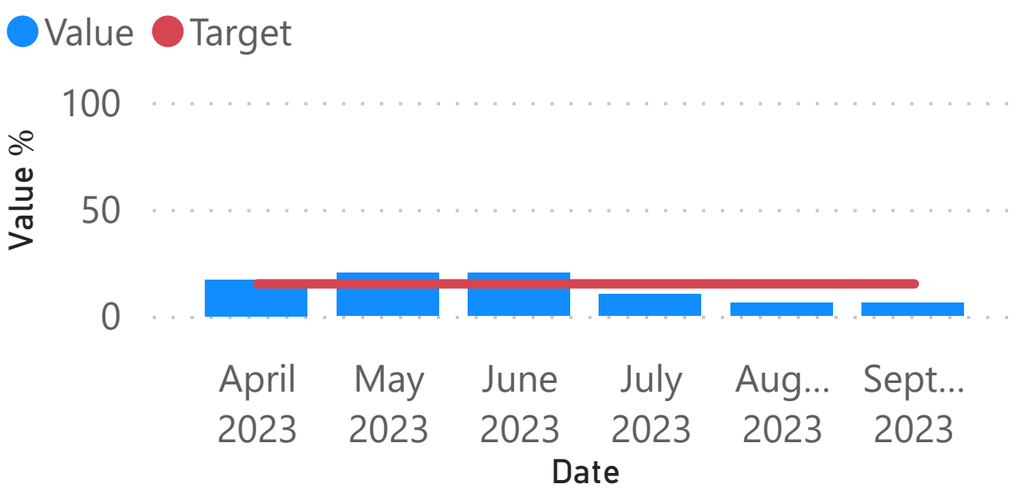
CHP reliability still low. Energy use high while ROCK works are completed.

Forward Look (with actions)

Workshop to resolve heating problems with MITIE and VERCITY.

LED tender being issued. PV business case going to IRG. Circular economy bid being completed with Uni. and LUHFT.

Green Plan: Reduce Carbon Footprint



Technical Analysis:

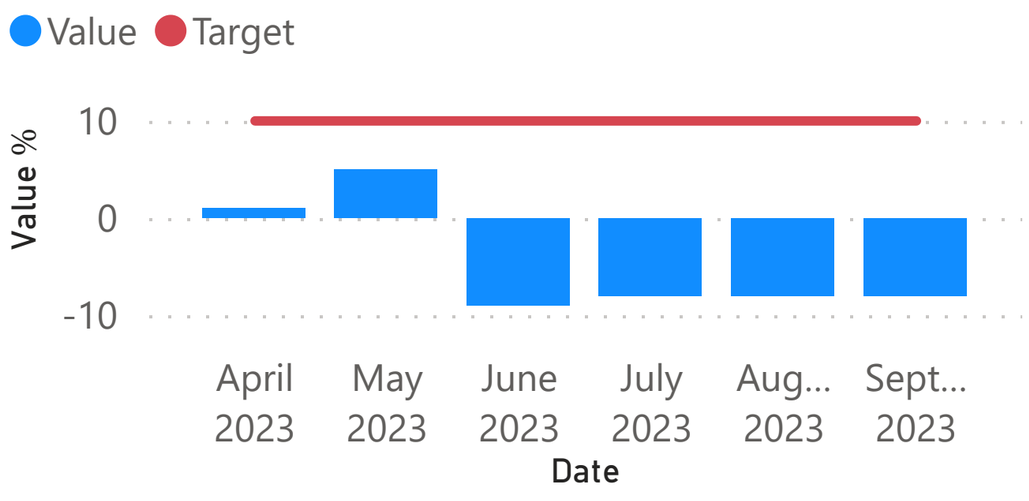
Performance is comparing vs same month last year.

Energy use still high.

Actions:

LED and PV projects.

Green Plan: Reduce Energy Usage



Technical Analysis:

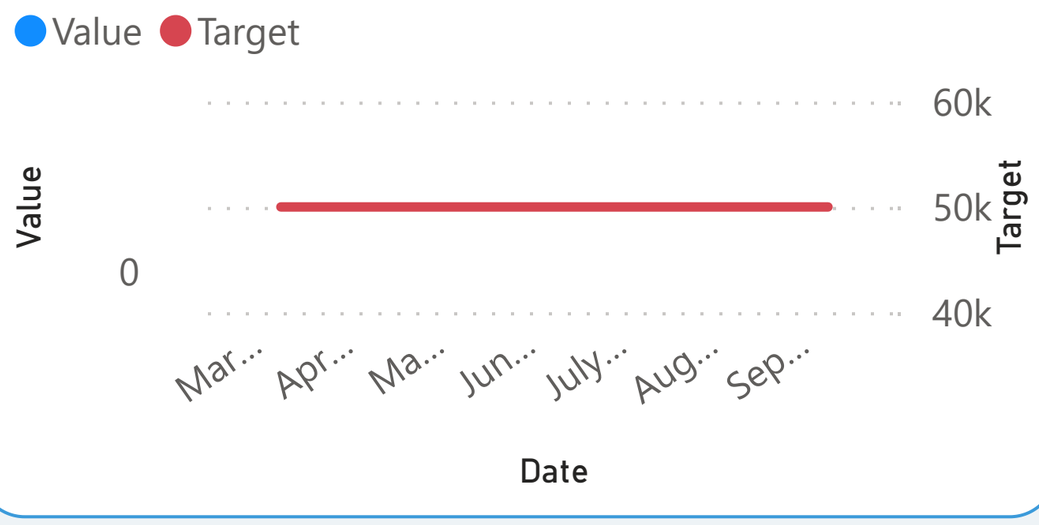
Performance is comparing vs same month last year.

Energy use still high.

Actions:

Heating workshop.

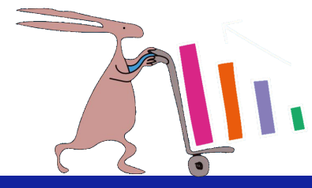
Green Plan: Reduce Waste



Technical Analysis:

Actions:

New compactors arriving this year.



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Continued strong levels of Outpatient activity across the division with volume significantly higher than 2019 (267%)

• Mandatory training remains above 90% at 95%

• Division have significantly reduced the volume of clinical correspondence with a total of 22 letters now over 30 days compared to 67 in September.

• Continued strong financial performance across the Division.

• Confirmation of further funding for the Framework for Integrated Care (FIC) Vanguard programme until end of 2028

• Staff Survey completion rate is 64% (20/11/2023)

Areas of Concern

• Slight increase in sickness absence although in line with seasonal norm for Division

•Slight increase (1%) in staff turnover

•Increase in children and young people waiting over 65 weeks for completion of ASD or ADHD diagnostic pathway. However, there has been a decrease in those waiting over 104 weeks from 29 (August) to 22 (October)

•1 young person waiting over 52 weeks for CAMHS at end of M7. Previous appointments offered, but unable to attend. Young person attended November 2023.

•Continued national lack of ADHD medication.

•Continued risk relating to Named Doctor role within safeguarding team

Forward Look (with actions)

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

•SALT improvement plan in place and monitored through Divisional programme board.

•ASD & ADHD improvement plans in place and monitored through Divisional programme board.

•Transport to appointment pilot will commence in CAMHS in support of programme of work to reduce Was Not Brought rate in CAMHS (15% in August)

•Additional support to be provided to Safeguarding Service develop improvement plan

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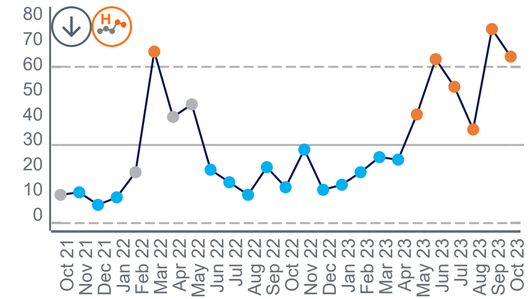
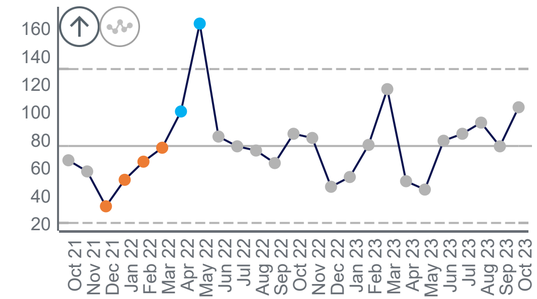
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

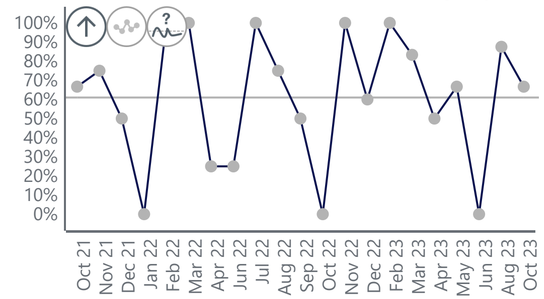
Number of Incidents rated Minor Harm and above



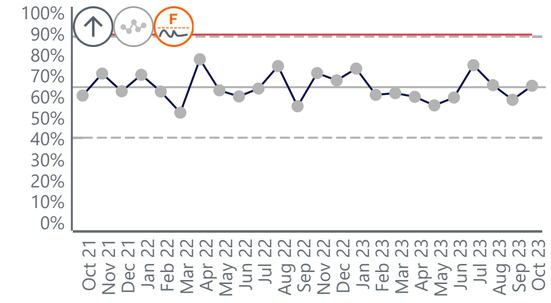
Number of Incidents rated No Harm and Near Miss



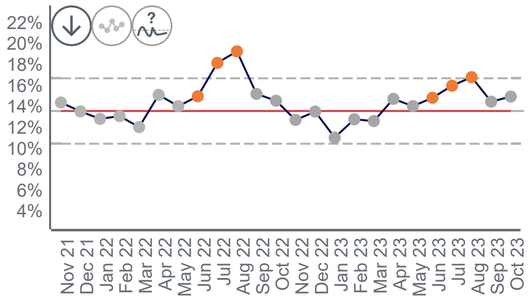
% Complaints Responded to within 25 working days



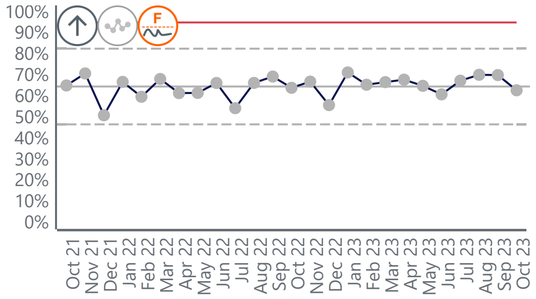
% PALS Resolved within 5 Days



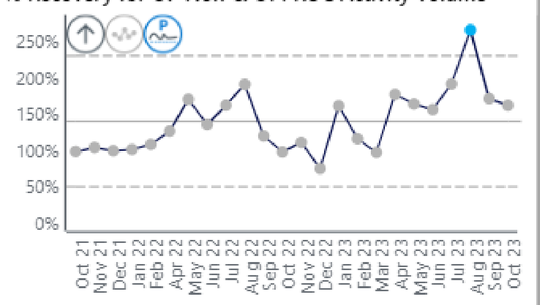
% Was Not Brought Rate (All OP: New and FU)



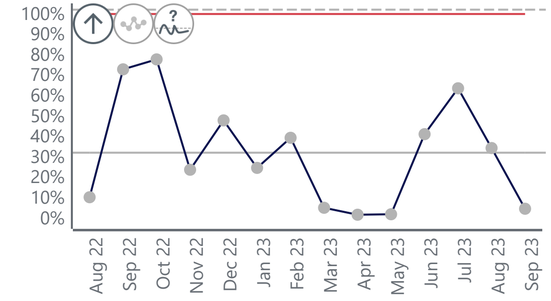
% of Clinical Letters completed within 10 Days



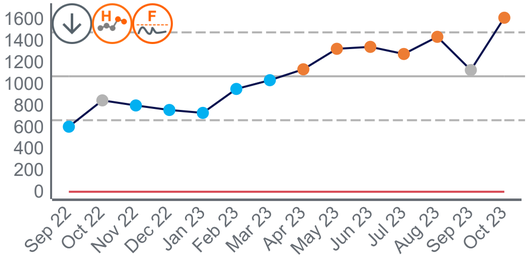
% Recovery for OP New & OPPROC Activity Volume



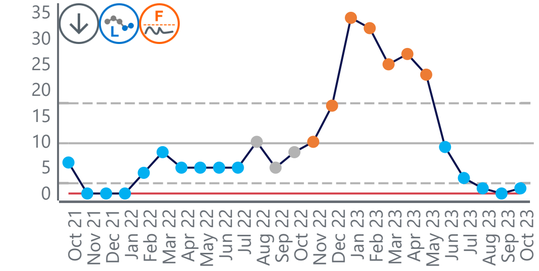
IHA: % complete within 20 days of referral to Alder Hey



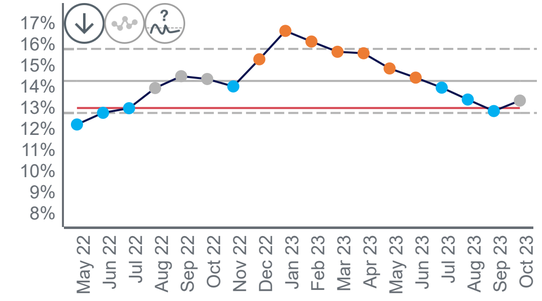
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



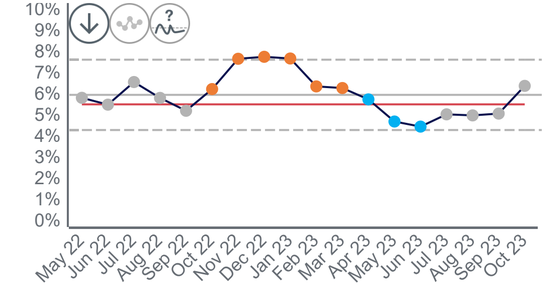
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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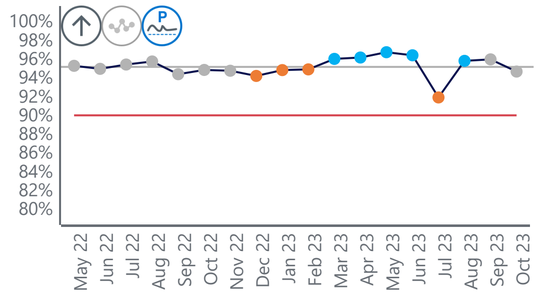
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

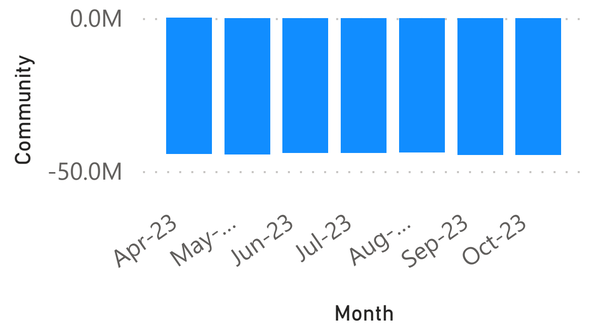
Mandatory Training



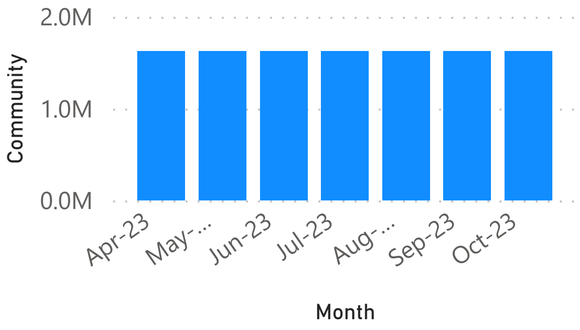
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

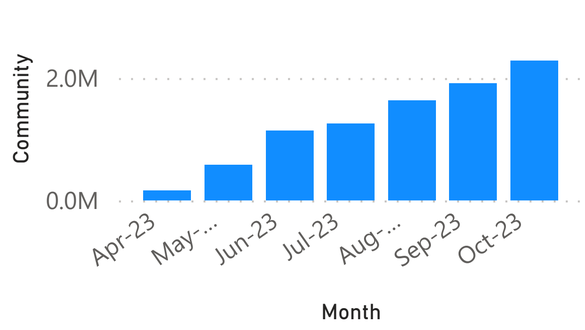
Revenue Position (Year End Forecast)



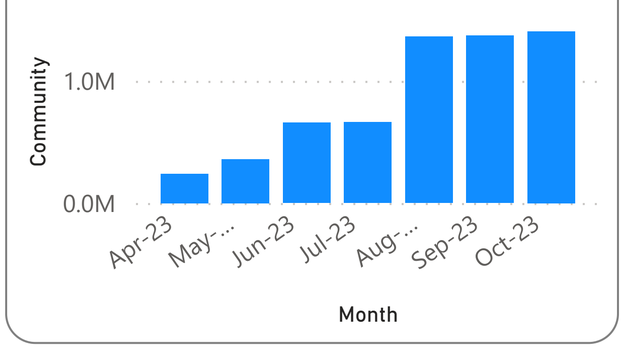
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

•Sustained improvement in Emergency Department Sepsis (delivering antibiotics within 60 minutes) 95% in month

•Sustained reduction in staff turnover of 11%

•Maintained sickness absence of 5.6%.

•Delivery of over 2.5mil CIP YTD.

•Sustained compliance with all standards for cancer care.

•PAU pilot continued throughout October, focusing on improving direct assessment for GP and other health professionals to a Paediatric assessment.

Areas of Concern

•ED performance reduced in month, 71% of CYP were seen and treated within 4 hours, impacted by increased attendances and reduction in UTC capacity to stream out of the department as initially planned.

•Reduction in diagnostic compliance to 85%, significantly impacted by reduced theatre schedule and report visibility following Alder Care implementation.

•Increase in patients waiting over 65 weeks owing to reduction in capacity with Alder Care roll out and reduced theatre capacity.

•F&F ED- significant reduction associated with increased waiting times within the department

•Increase in WNB rate, review of clinic utilisation & scheduling visibility pending access to BI reports post Alder Care

•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

•Improvement in complaints responded within 25 day; however, further improvement anticipated

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

Forward Look (with actions)

•Enhance winter response to address challenges experienced with ED waiting times, collaboration with system partners agreed to achieve a number of high impact actions

•Divisional Health and Wellbeing week scheduled in November, providing staff with an opportunity to engage with a variety of offers while also providing time out to complete mandatory training, staff surveys and PDRs

•Continued enhanced financial controls in place.

•Continue to develop recurrent CIP plans in line with the trust strategy.

•Challenges to elective plan remain due to reduced activity from Alder Care, likelihood of ongoing industrial action and reduction on theatre capacity. Revised recovery plans under review by clinical and operational teams.

•Change in model from EDU to PAU has reduced the number of EDU beds from 12 to 4 which is impacting speciality patients that are waiting longer in ED and may impact overall ED performance. Reviewing scope to create increased EDU capacity during winter months.

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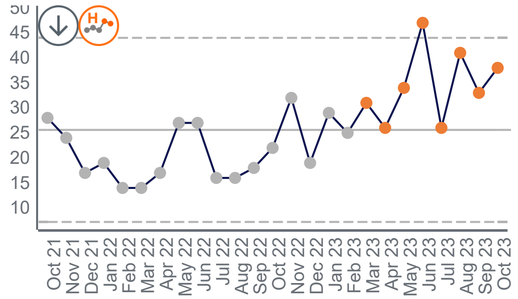
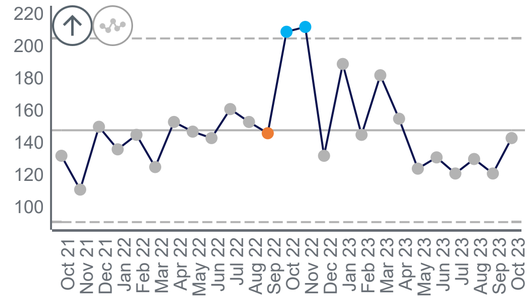
Divisional Performance Summary - Medicine

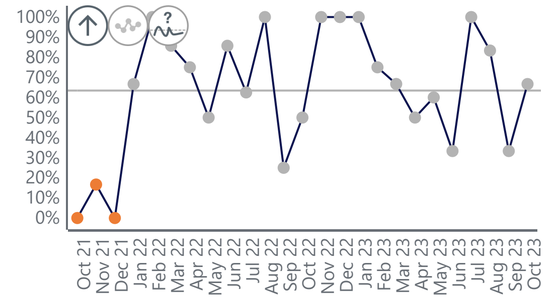
Number of Incidents rated Minor Harm and above



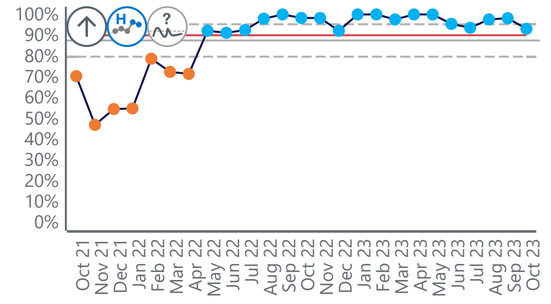
Number of Incidents rated No Harm and Near Miss



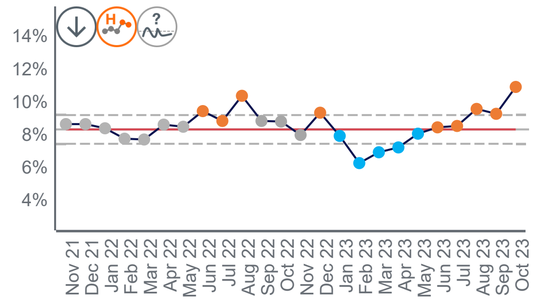
% Complaints Responded to within 25 working days



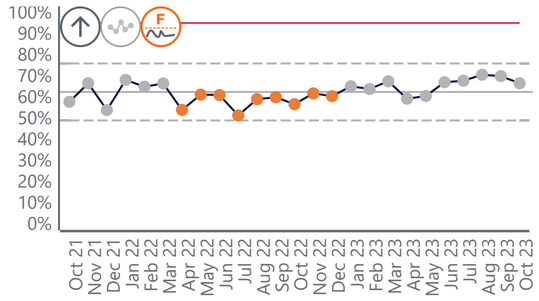
% PALS Resolved within 5 Days



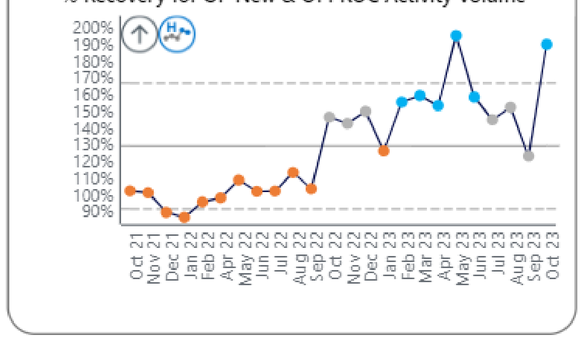
% Was Not Brought Rate (All OP: New and FU)



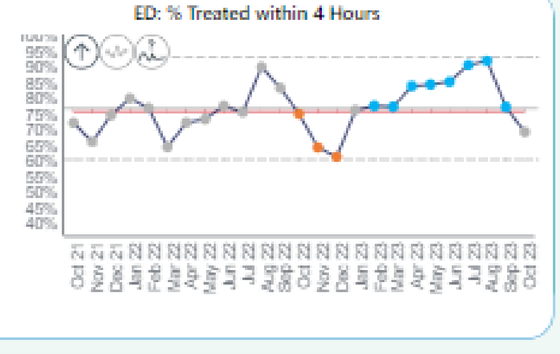
% of Clinical Letters completed within 10 Days



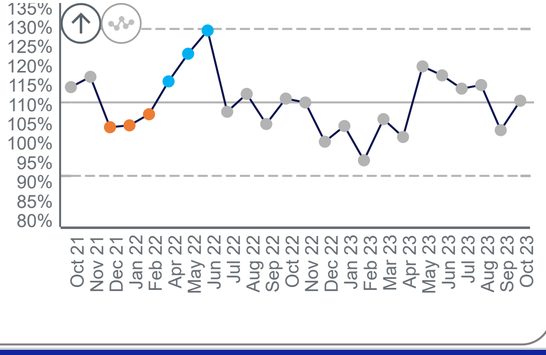
% Recovery for OP New & OPPROC Activity Volume



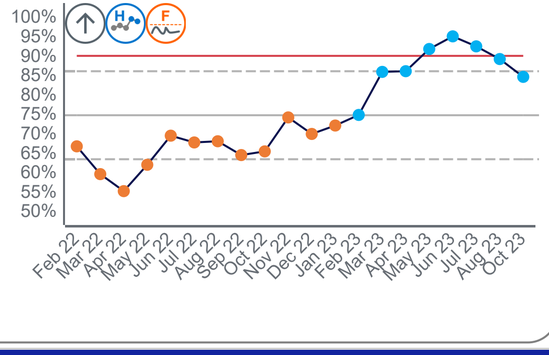
ED: % Treated within 4 Hours



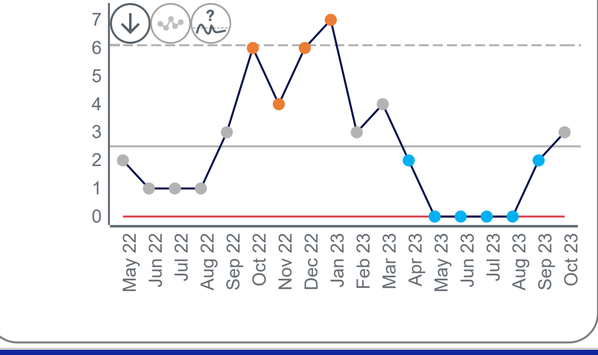
% Recovery for DC & Elec Activity Volume



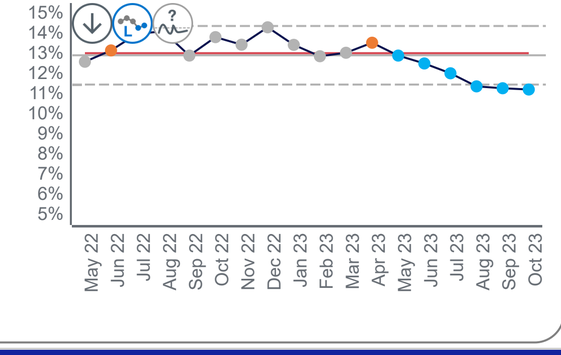
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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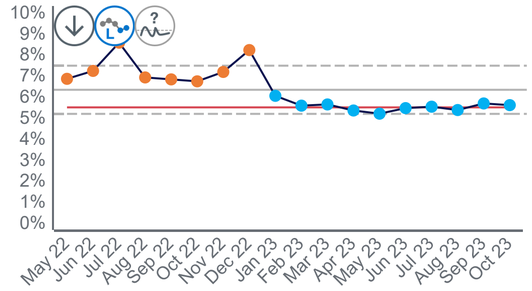
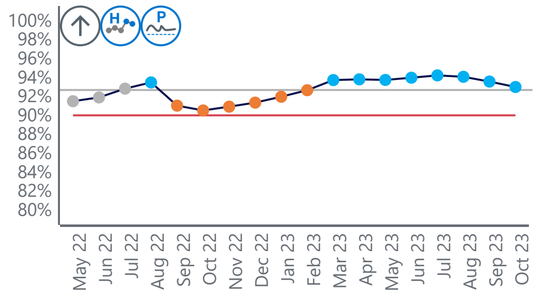
Divisional Performance Summary - Medicine

Sickness Absence (Total)



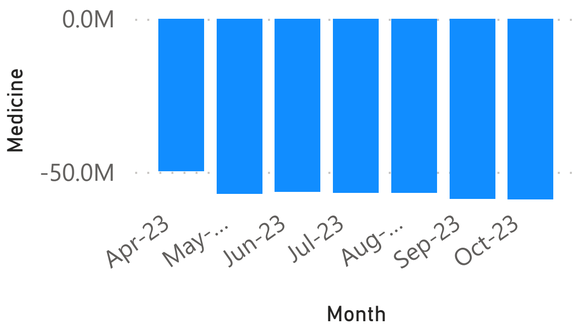
Mandatory Training



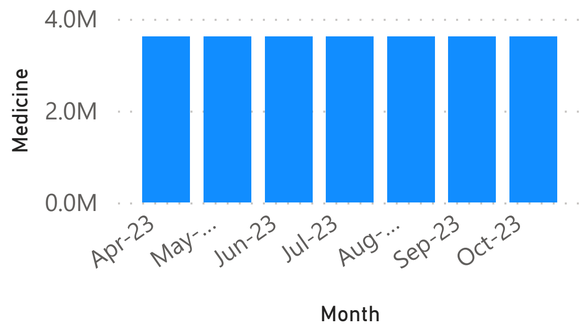
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

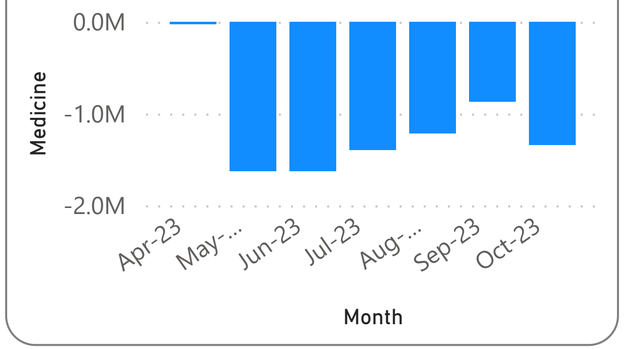
Revenue Position (Year End Forecast)



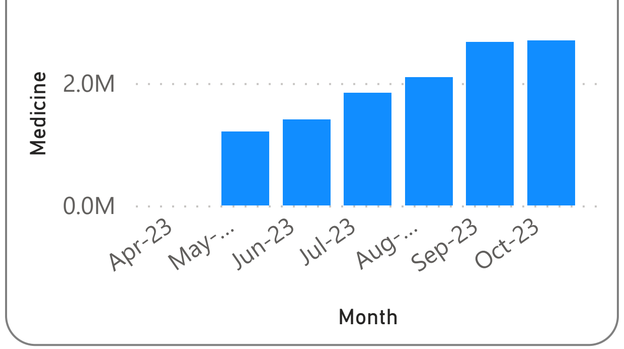
CIP Position (Recurrent Full Year Effect)

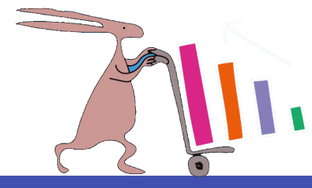


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

•Consistently maintaining 100% compliance with PALS and complaints responses with a model of telephone contact for every family raising a PALS

•Although metrics look static, significant improvement in DM01 performance following BB improvement approach with 4 October breaches in Urodynamics due to IA with 100% for both Gastroscopes & Cystoscopes. Require visible PTL in order to support achieving compliance targets set to achieve by December

•% recovery for OPNEW & OPROC remains above ERF target at 106% although improvement in visibility of capacity required following Expanse go live

•Staff turnover rates continued to reduce for 3rd consecutive month

•Mandatory training continues to be above target

Areas of Concern

•Although elective recovery improved considerably in October, impacted by both IA and planned theatre schedule reduction. Issues post expanse are impacting significantly on reporting data

•WNB rate showing 9.6% for October but significant data issues and so should be taken with caution

•Sickness absence increased in month relating to short term sickness with hotspots in theatres, critical care and Anaesthetics. LTS continues to be well managed

•No. of patients waiting over 65 weeks increased, mainly due to IA and impacts of Expanse on capacity (relating to outpatients), however division is on plan to deliver trajectory and high volume specialties have protected capacity within the theatre schedule

•Unsigned letters remain static

•Delivered £1.3m CIP YTD but remains a considerable risk to the division

Forward Look (with actions)

• Still pending access to data post expanse to monitor theatre utilisation however actions in place to drive productivity & efficiencies

• Plans underway to effectively step up theatre schedule from February with consideration as to which specialities will increase capacity

• Additional short term elective capacity being piloted at Warrington and Halton in ENT, Paediatric Surgery & Plastics

• Even though consistently above target, mandatory training compliance actively being reviewed for those will low compliance

• Close working with Medicine Division to improve surgical pathways within ED

• CIP weekly workshops being held to progress key schemes

• Divisional controls implemented for non-pay and pay expenditure

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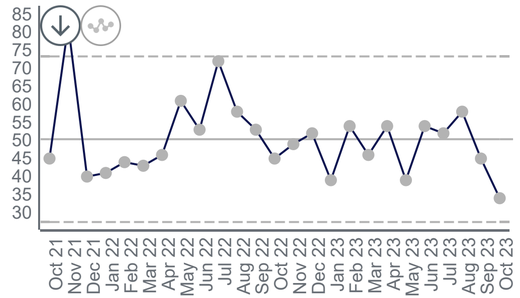
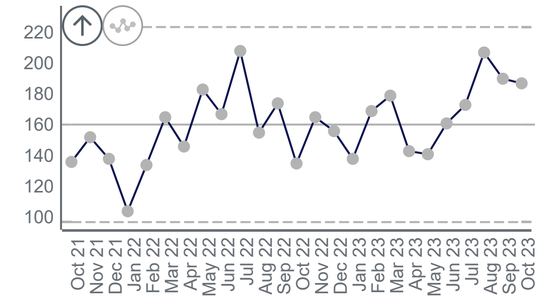
Divisional Performance Summary - Surgery

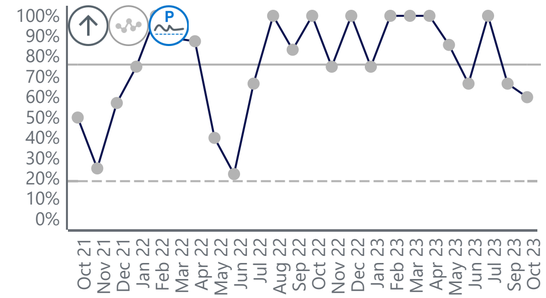
Number of Incidents rated Minor Harm and above



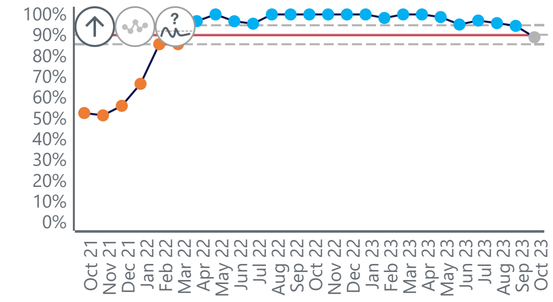
Number of Incidents rated No Harm and Near Miss



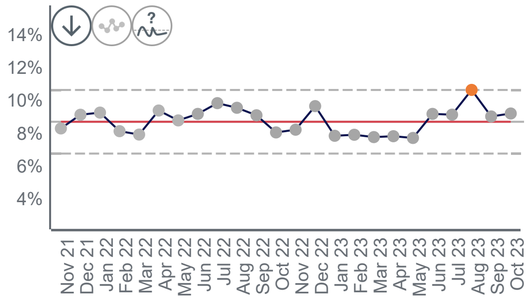
% Complaints Responded to within 25 working days



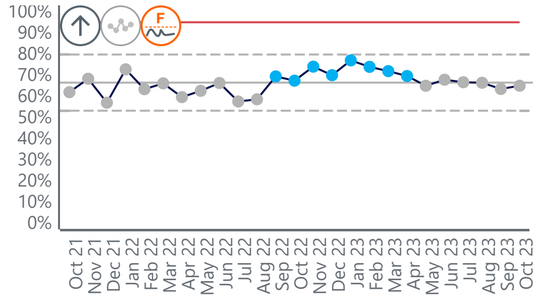
% PALS Resolved within 5 Days



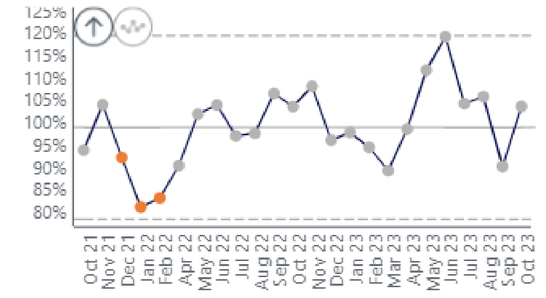
% Was Not Brought Rate (All OP: New and FU)



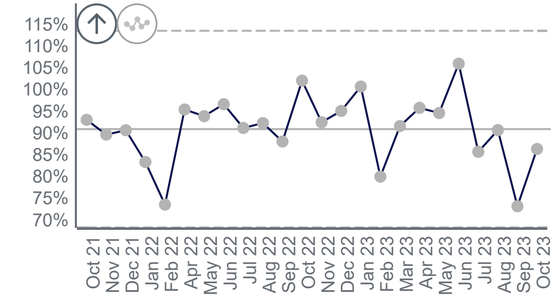
% of Clinical Letters completed within 10 Days



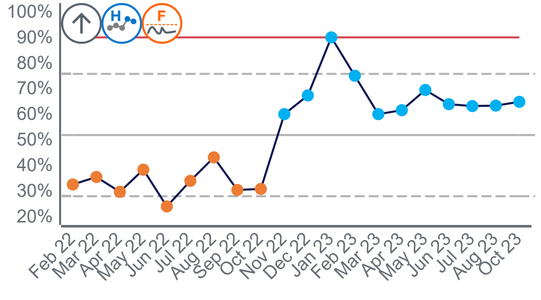
% Recovery for OP New & OPPROC Activity Volume



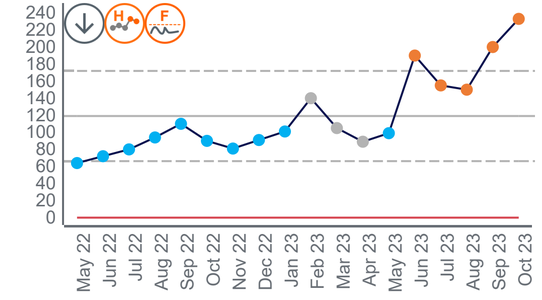
% Recovery for DC & Elec Activity Volume



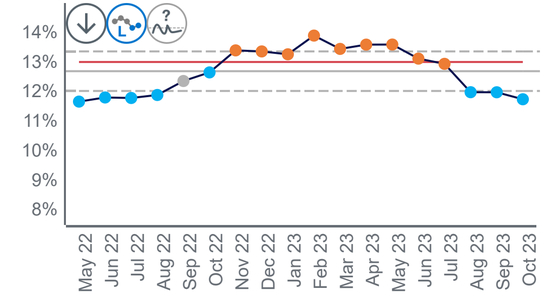
Diagnostics: % Completed Within 6 Weeks of referral



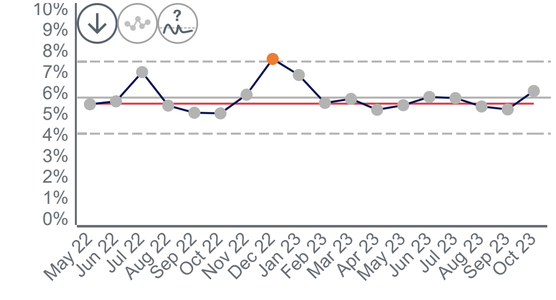
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)



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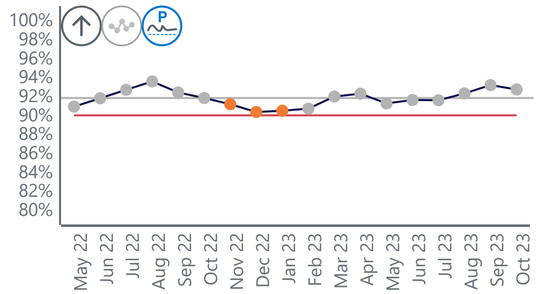
Divisional Performance Summary - Surgery

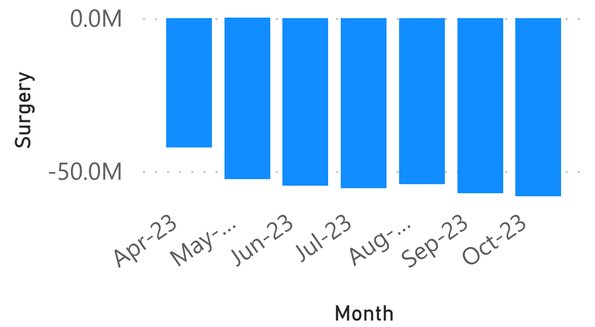
Mandatory Training



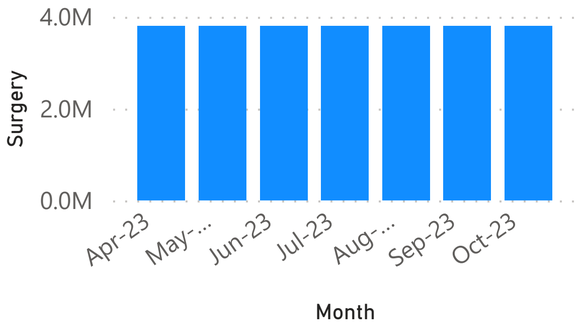
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

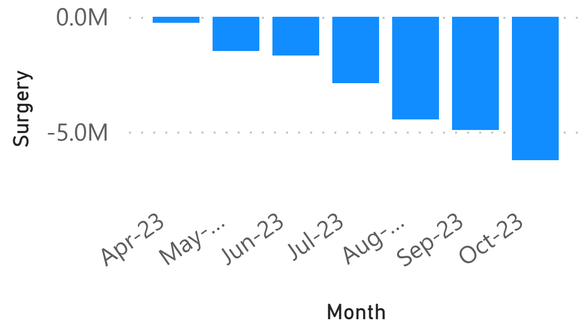
Revenue Position (Year End Forecast)



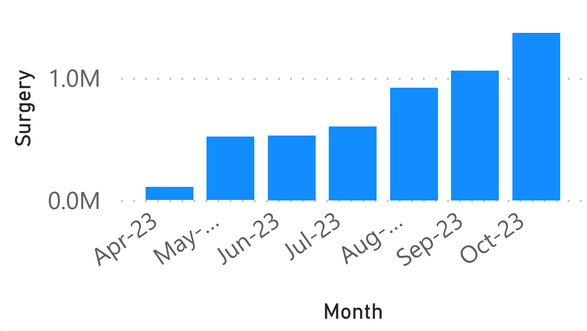
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- CRD staff turnover and sickness absence have both reduced this month and are in line with Trust average
- Mandatory training remains on target
- Appraisal compliance has significantly improved in month
- Participant experience surveys have continued to increase in October with feedback being overwhelmingly positive
- Staff survey completion rate is at 63% and above Trust average
- CRD contributions to Futures leadership and operational meetings

Areas of Concern

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

Forward Look (with actions)

- Focus on ensuring all safeguarding training is complete/booked in
- 3rd MRI business case under review by Exec team and Trust Board
- Research strategy on track to be approved by R&I Committee
- Collaborative meeting with University of Liverpool taking place in Dec

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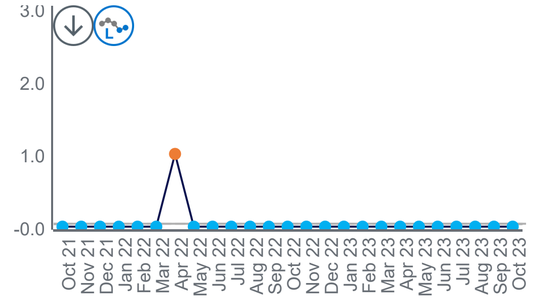
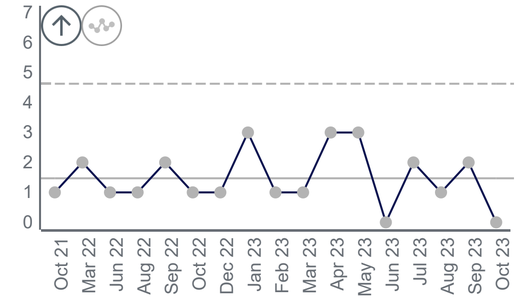
Divisional Performance Summary - Clinical Research

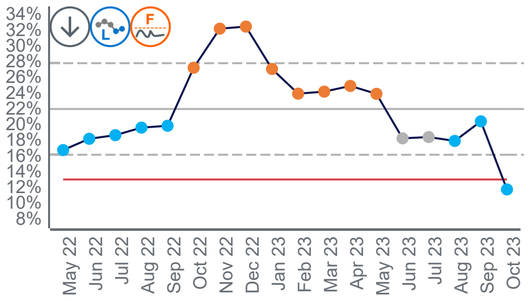
Number of Incidents rated Minor Harm and above



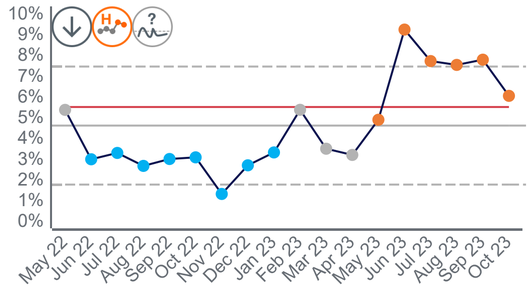
Number of Incidents rated No Harm and Near Miss



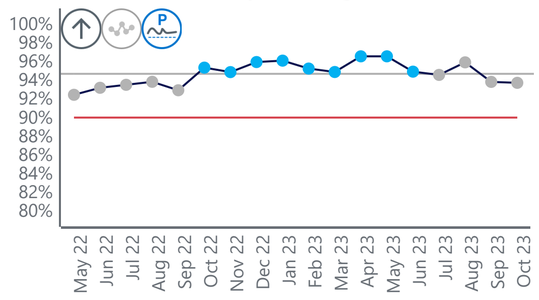
Staff Turnover



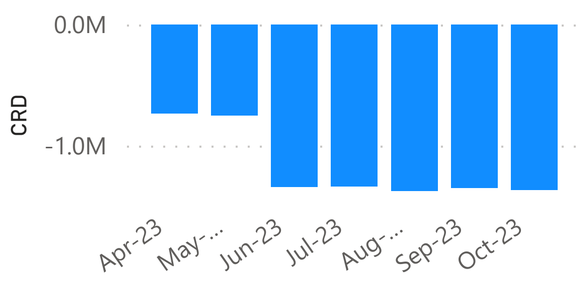
Sickness Absence (Total)



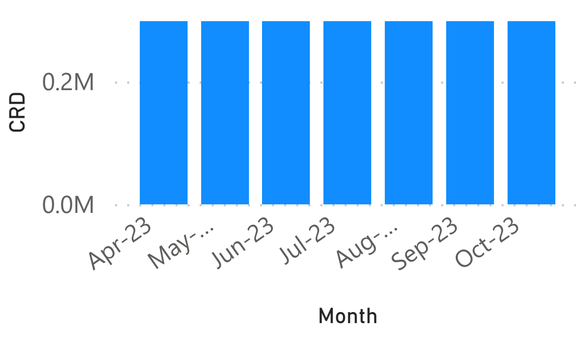
Mandatory Training



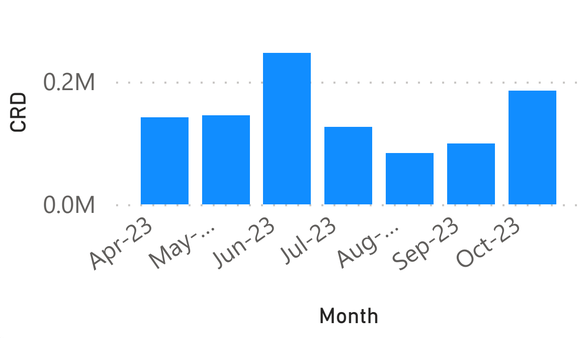
Revenue Position (Year End Forecast)



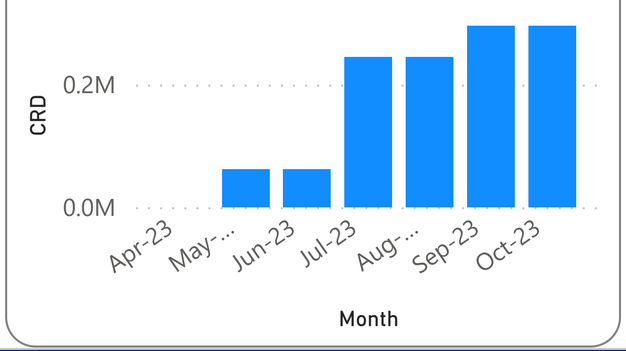
CIP Position (Recurrent Full Year Effect)



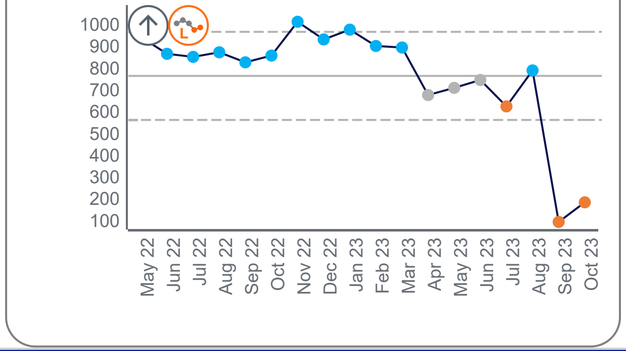
Revenue Position (Variance to date)



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 23rd October are:

•Mandatory training for Corporate Services remains above the 90% target at 94%.

•The collaborative has achieved 98% of its recurrent CIP requirement.

•Short term sickness absence remains below trust target at 1%.

•Reduction in bank spend in month.

Areas of Concern

•PDR compliance for B7 and above was reported at 66% against a target of 90% at the end of September.

•Return to work completion is currently sitting at 72% against a target of 100%. Some recording issues have been identified in terms of the interface with ESR and will be addressed going forward.

•Sickness absence has risen to 6% in month (previously 5% and within Trust target).

•Staff turnover currently sitting at 13%, although this has remained stable remains an area of focus.

Forward Look (with actions)

•Continued focus on bank and agency spend.

•Our Plan 2030 – Supporting our People.

•Green Plan – quarterly updates to CSC going forward.

•Zero Tolerance training programme for corporate services with a particular focus on hotspot areas such as security.

•Proportion of BAME staff in post.

BIG Conversations.

Focus on B7 PDR hotspot areas at November meeting.

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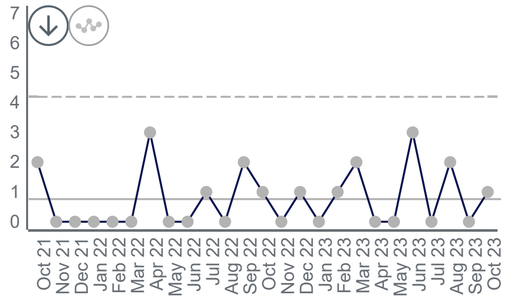
Integrated Performance Report | November 2023

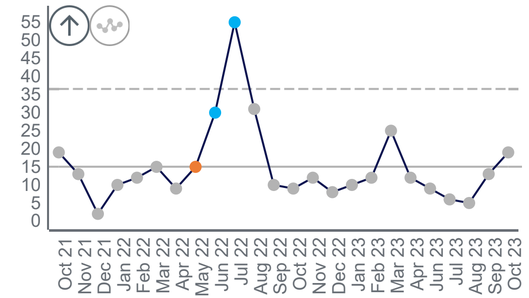
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

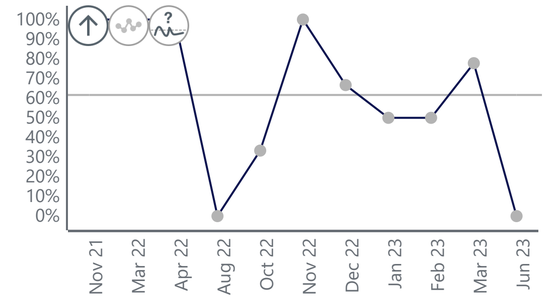
Number of Incidents rated Minor Harm and above



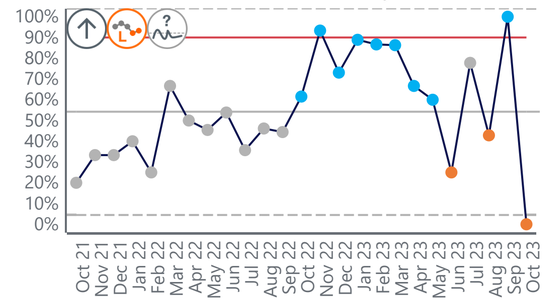
Number of Incidents rated No Harm and Near Miss



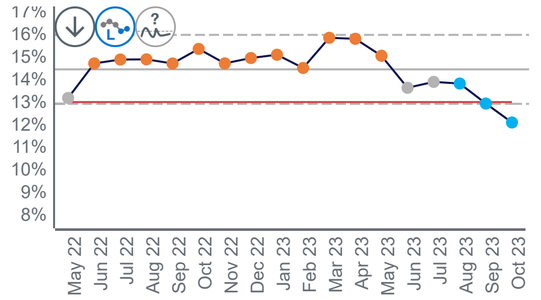
% Complaints Responded to within 25 working days



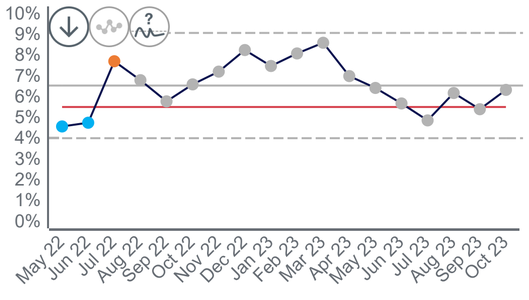
% PALS Resolved within 5 Days



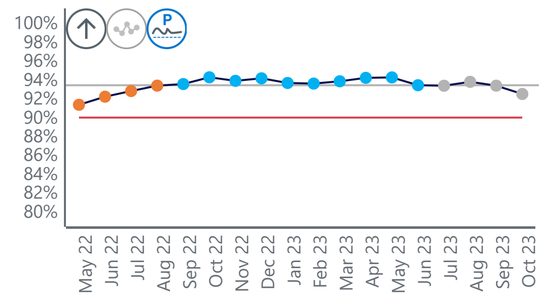
Staff Turnover



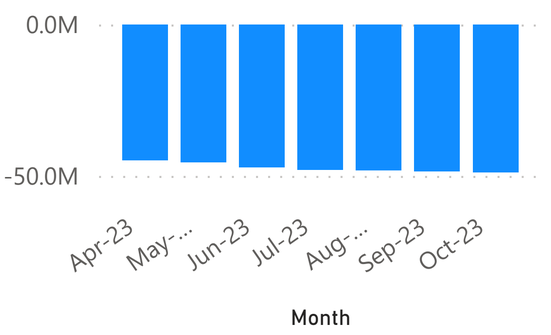
Sickness Absence (Total)



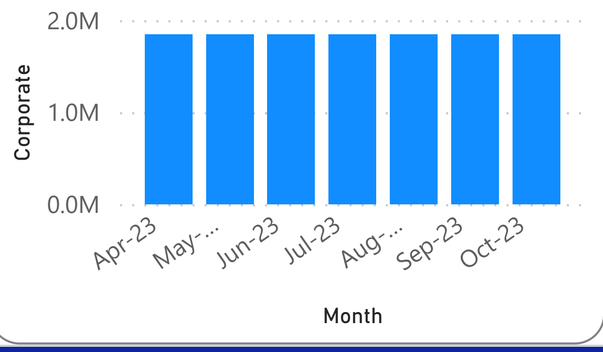
Mandatory Training



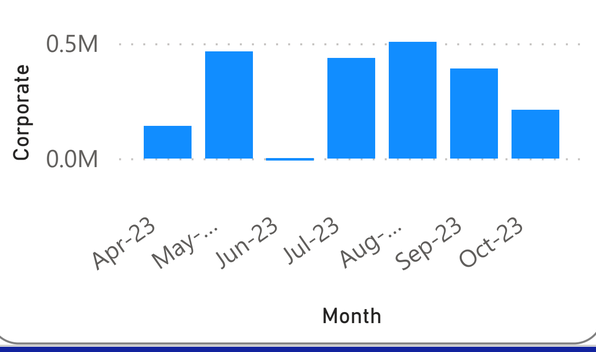
Revenue Position (Year End Forecast)



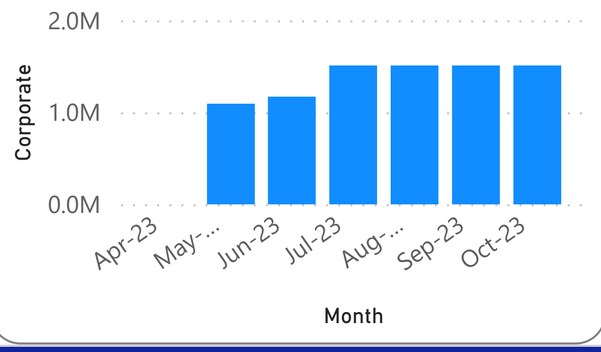
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Safe Staffing & Patient Quality Indicator Report
July Staffing, CHPPD and benchmark
November 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	92%	-	102%	-	101	18.92	14.87	28.00%	0.00%	5.41%	0.00%	1.08%	0.00%	3	20	0	1	11	100%	0	0
HDU	65%	103%	63%	113%	269	26.69	32.22	5.00%	-2.00%	11.76%	0.00%	8.60%	0.00%	8	43	0	2	3	100%	0	0
ICU	81%	129%	80%	47%	361	48.36	32.22	10.00%	2.00%	13.15%	0.00%	6.34%	3.23%	12	77	0	1	9	88.89%	1	0
Ward 1cC	82%	85%	84%	86%	570	11.77	12.31	14.00%	-6.00%	14.41%	0.00%	7.09%	12.34%	3	30	0	6	15	100%	1	0
Ward 1cN	74%	17%	75%	-	224	15.67	13.14	15.00%	-2.00%	7.53%	0.00%	2.85%	0.00%	2	18	0	7	6	100%	1	0
Ward 3A	93%	60%	93%	167%	733	10.64	10.27	-8.00%	5.00%	4.48%	14.15%	5.99%	12.03%	4	26	0	5	72	95.83%	2	0
Ward 3B	75%	91%	82%	-	402	12.16	7.28	2.00%	-33.00%	14.37%	20.49%	8.29%	48.61%	11	19	0	5	2	100%	1	0
Ward 3C	92%	74%	76%	111%	728	11.30	10.31	8.00%	1.00%	4.20%	0.00%	10.58%	26.08%	10	58	0	0	32	96.88%	0	0
Ward 4A	75%	83%	75%	90%	685	11.04	10.19	7.00%	-2.00%	9.81%	17.02%	8.22%	8.72%	5	33	0	1	55	98.18%	1	0
Ward 4B	56%	76%	55%	70%	522	14.22	10.28	8.00%	-3.00%	17.51%	8.84%	6.67%	19.13%	5	48	0	1	25	96%	0	0
Ward 4C	85%	88%	90%	89%	678	10.60	10.36	22.00%	-1.00%	21.68%	9.57%	3.42%	13.90%	11	114	0	2	49	89.80%	1	0

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

<u>Medicine</u>

The over establishment on 3B for unqualified vacancies are the additional supernumerary 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. An additional 2.61 WTE RNs left at the end of July.

Ward 3C have 3.8 WTE on LTS and the ward had an increase in STS during July with no themes reported. 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.

Ward 4B RN sickness levels have continued to reduce to in July, however the HCA sickness has increased again to 19.13% which equates to 6.66 WTE who are on LTS. 2.0 WTE RNs were seconded to cover maternity leave roles on the ward. HR drop-in sessions commenced w/c 13th February and a task and finish group has started to focus on staff wellbeing and retention. The ward has also had 7.37 WTE RNs who are on maternity leave and required backfill.

Ward 4C continue to have a high RN vacancy rate at 22% 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. HCA sickness has decreased in July to 13.90% but equates to 1.2 WTE who are on LTS.

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%, however there is a high number of vacancies. New staff have been recruited but won't be reflected in the numbers until the end of October. The over establishment on the HCA line is due to the band 2 to 3 uplift and funding not yet being received in the budget line. There was a mix of long and short term sickness for RNs. HCA sickness has increased in July with 2 on LTS and 3 on STS.

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

Ward 3A RN fill rate continues over 90%, however they are over recruited on the RN line due to covering 7.45WTE maternity leave posts. The ward had CSWD healthcare trainee posts supporting via NHSP and recruitment for HCA posts is still ongoing. The ward has also had to cover a high number of 1:1 patients, with additional shifts not always being picked up. There was an increase of STS in July and 3.0 WTE on LTS.

Ward 4A continues to have a number of vacancies, and 7.0 WTE on maternity leave. Sickness has reduced slightly in July with a mix of long and short term sickness. 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 continue to have a number of international nurses that are working as band 4 prior to gaining NMC registration. 3 international nurses that started in April were still supernumerary in 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. HDU have ongoing RN vacancies that are slowly filling which is largely why the fill rate is just above 60%. 9.0WTE RNs started in October but will be supernumerary until December. RN sickness has decreased from June to under 10% with 3.98 WTE on LTS and a number of STS.

ICU vacancies remain high in July but improve from 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 July is unavailable, therefore we are benchmarking against June's data.
There are some differences in CHPPD benchmark, Burns, ICU, HDU and wards 1cN, 3B and 4B are notable.

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

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

ICU during the month of July 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.

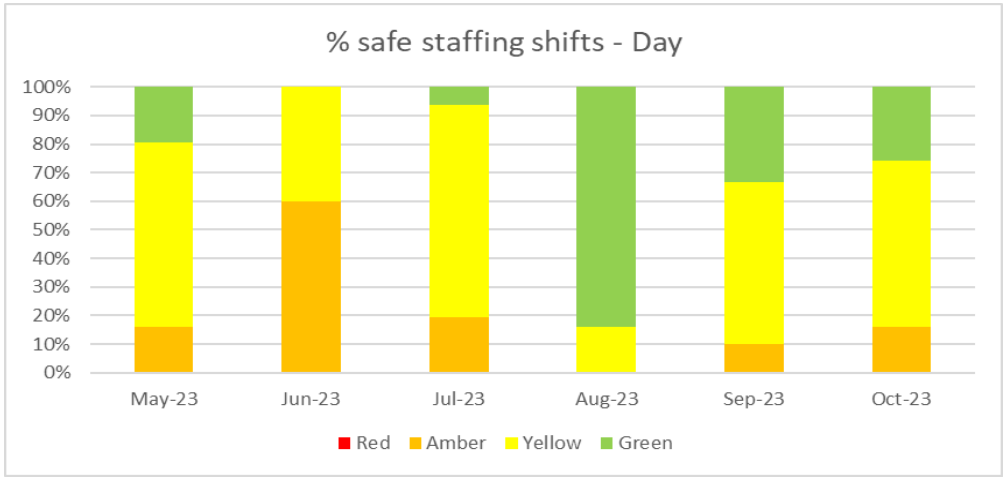
The national benchmark for ward 3B is significantly lower than previous months. The CHPPD for Alder Hey remains consistent with previous months, however due to the decrease national, appears that Alder Hey is an outlier for the month.

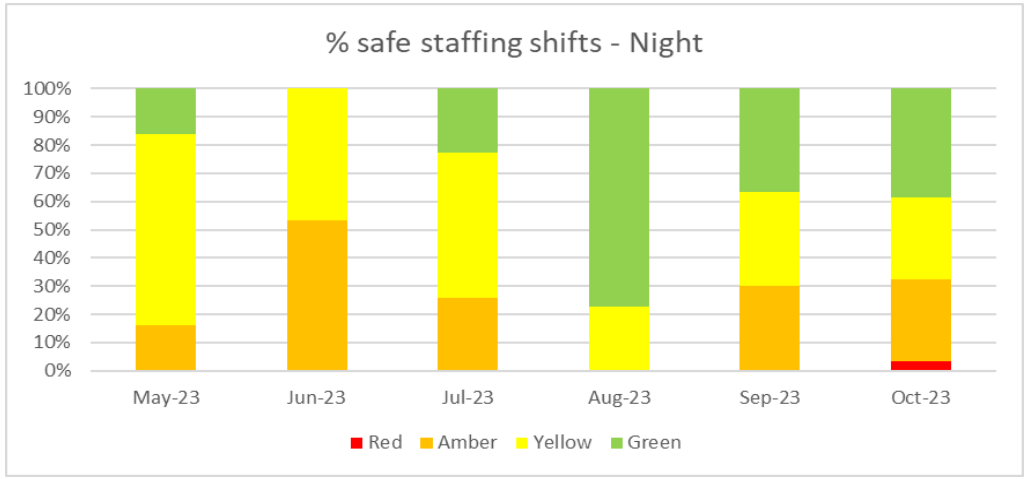
There is a consistent difference from the National benchmark for Ward 4B. Ward 4B has been consistently higher over the last few months. Deep dive into capacity and staffing has been undertaken and a full review of the nursing model is currently being undertaken with the aim to changing the nursing patient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

Ward 4C continues to significantly improve during July, reporting nearly the same as the national benchmark.

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

<u>Summary of October staffing</u>
Staffing RAG has been similar to September, however 1 red night has been recorded on 28th October. This was due to high volumes of unexected sickness. NHSP uptake was minimal in the evening, potentially due to the clocks going back leaving a number of shifts left unfilled. Acuity across the trust was also high.





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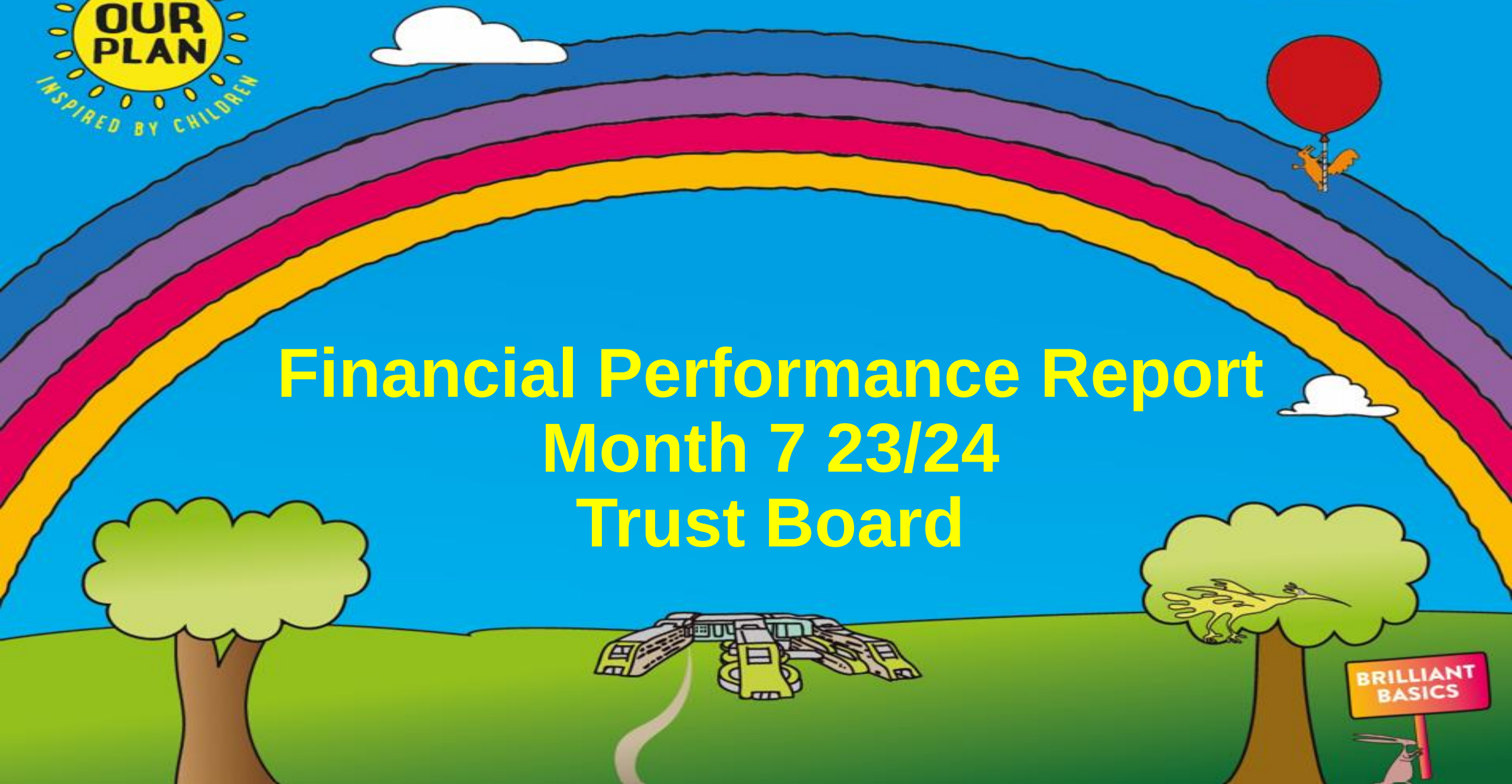
Alder Hey Children's NHS
NHS Foundation Trust

OUR PLAN
INSPIRED BY CHILDREN

Financial Performance Report
Month 7 23/24
Trust Board



Month 7 Trust Financial Position

0060

Alder Hey Children's NHS Foundation Trust

Key Metrics	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Income £000 (Exclude ERF)	24,567	26,642	2,076	173,428	183,983	10,555
Pay Expenditure £000	(19,799)	(21,325)	(1,525)	(139,499)	(145,113)	(5,615)
Non Pay Expenditure £000	(10,947)	(11,308)	(361)	(83,720)	(89,208)	(5,488)
Expenditure £000	**(30,746)**	**(32,632)**	**(1,886)**	**(223,218)**	**(234,321)**	**(11,103)**
Trading Position £000	**(6,179)**	**(5,990)**	**189**	**(49,791)**	**(50,339)**	**(548)**
ERF Income £000	7,679	7,490	(189)	49,791	50,364	573
ERF Expenditure £000	0	0	0	0	0	0
Revised Trading Position £000	**1,500**	**1,500**	**0**	**()**	**25**	**25**
WTE	4,099	3,931	(168)	4,099	3,931	(168)
Cash £000		79,309			79,309	
CAPEX FCT £000	2,048	1,404	(644)	7,495	5,692	(1,803)

Key Headlines:

Reporting a **£25k surplus** to the end of October in line with the plan expected

Cash in bank £79.3m

Our revised plan for the year is to achieve a £13m surplus by the end of March subject to no further industrial action and delivery of activity and financial plans including CIP.

Key Drivers:

Industrial action impact c£4.7m YTD with loss of income and additional costs – c£2m funding received.

Benefit from higher interest rates on cash balance and lower energy usage/price

Pressures in pay relating to junior doctors and HCA cover incl 1:1

CIP posted behind plan by £1.8m, with £11m posted against the £17.7m target.

23/24 Key Risks – M7 Position

Alder Hey Children's NHS

0061

	Initial Risk	Initial RAG	M7 Position	RAG M6	RAG M7	Change
Income	Internal target set above mandated target. Unknown impact of IA and Alder Care Go Live	Medium	M7 continued underachievement of higher internal target ICB performing well but specialist activity is under overall Estimated loss income £3.7m to M7 due to IA. National changes on ERF target compensates for c£2m of this loss. Forecast for H2 assumes no industrial action but challenges in theatre staffing poses risk to delivery.	High	Medium	↓
Inflation	Unknown future levels inflation, variable energy contract	Medium	Recurrent risk on medic pay award £0.7m but manageable in year due to vacancies. No other issues raised	Medium	Low	↓
System Position	Deficit plan with challenging assumptions. Restrictions may be imposed. Retract resources/time to support system position	High	7 providers continue to be off plan at M6 including ICB position. Revised H2 plan assumes financial plans are achieved including delivery of further improvements in some Trusts, ICB Expenditure controls group in place for those trusts reporting a variance to plan. AH not included at this stage but focus on internal cost controls	High	High	↔
CIP	Plan assumes delivery of £17.7m recurrent. Highest level saving and lack of schemes in place.	High	90% CIP identified in year with remaining 10% to be closed asap through final review across all areas. Static 50% recurrent identified. New benefits framework agreed through RABD with 12 areas for immediate financial assessment to be confirmed January and added to recurrent CIP.	High	High	↔
Capital	Limited CDEL allocation 23/24 and 24/25 Significant capital investment and number high risk projects	Medium	Cost pressures continue to emerge in campus (Neonatal/Park) being managed through a review of other schemes that can be delayed. Slippage in other areas in year being managed by reprofile of medical equipment spend to bring forward items in 23.24. Incentive model launched national £150m fund if meet UEC targets	Medium	Medium	↔

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide a Campus and Park progress update. The Board is asked to confirm acceptance of the update and advise if reassurance has been provided.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☑ Game-changing **research and innovation** ☑ **Strong Foundations** ☑
Resource Implications:	None

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

Alder Hey Children's NHS Foundation Trust

Campus Development Report on the Programme for Delivery

December 2023

1. Introduction

The purpose of this report is to keep Trust Board informed of progress, risks and actions on the key capital projects as they arise. Budget position and forecast by project to be reported from January 2024.

2. Key Risks

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

Project	Manager	Open Risks	Low	Med	High (15+)
Park	KO	5	2	3	
Eaton Road Frontage	KO	3	2	1	
Fracture/ Dermatology OPD	KO	7		7	
Police Station Refurb	Day PM	15	11	4	
Neonatal & UCC	JOB/Hive	10	2	7	1
Alder Park Phase 1: EDYS	JVH/Day PM	Risk register to be developed			
Elective Surgical Hub	JVH/Day PM	Scope of project TBD			

Key/High Risks Descriptor

* There is an existing inflation risk on InPhase

Project	Description	Ref	Score	Status
Park	Failure to deliver long term vision for park	BAF 3.1	12	Phase 3 to be completed by March 2024 with seeding of pitches to take longer.
Neonatal & UCC	Inflation risk on project due to contract sign delay	Part of overall inflation risk (RL)	20	RABD approval given 14.11.23 to fund inflation costs. Development team to identify mitigation plan for SPV/other costs.

SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Trust has responded to CEs received. No formal claim or arbitration yet submitted by contractor.

Alder Hey Children's NHS Foundation Trust

3. Programme Delivery Timetable (Critical Path)

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

Alder Hey Children's NHS Foundation Trust

4. Programme Delivery Timetable (Associated Projects)

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

5. Project Updates

Neonatal and Urgent Care Centre

Deliverable	RAG	Risks/Issues	Actions/Next Steps
The service diversion works commenced on 02.10.23.		Completion of works ahead of main construction. Management of noise and site access routes during peak works.	Potential work arounds being reviewed including enhanced communications to patients & families. Vinyl information boards/images to be displayed on site hoardings from this month.
Main contract to be signed by 15.12.23.		Increased construction inflation & SPV costs. Delay to unit opening.	Following RABD approval 14.11.23. to fund the £1.4m inflation costs, Development Team are working with the SPV and Mitie to identify mitigation plans in relation to increased SPV / other costs. Agree EDU design and decant plan.
Phase 1 of the neo-look patient monitoring system has been signed off by the clinical team.		Coordination of technologies and flow of patient data between neo-look at the vital signs monitoring systems.	Continue to develop clinical service requirements.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Trust response submitted to contractor 13.10.23 (Compensation Events) and 10.11.23 (associated position paper 1). • No formal claim or arbitration yet submitted by contractor.		Possible contract claim.	Trust to respond this month to associated paper 2 submitted by the contractor.

Deliverable (Catkin & Sunflower Cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Sprinkler System Under-Croft Car Park: • Two tender returns submitted. Both returns have been disallowed due to being incomplete. • Business case completed. • Final works completion estimated 8-12 months.		Fire compliance. Potential loss of overall car park numbers. Budget TBC.	Consider potential next steps regarding procurement options and interim car parking arrangements. Recommendations to be developed for approval to proceed. Dates for funding approvals via IRG and RABD tbc.
Water Safety Issues: To ensure statutory temperatures are maintained.		Continued contamination.	Weekly monitoring meetings between all parties, inc Divisional representation. Valves to be replaced in line with manufacturers recommendations (improved filtration cartridges). Sampling to recommence when temperatures are balanced.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Immediate priorities are being progressed: • Capacity & environment review of clinical/support offices. • Environmental review Institute in the Park. • Revised governance & reporting arrangements. • Allocation of desk numbers for priority staff groups. Two additional projects have been added to the scope of works: • Storage. • Meeting Rooms – main hospital mezzanine. Budget and scope of works to be agreed.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for minor works/kit.	Revised Terms of Reference for the Strategic Space Allocation Group submitted for approval. Updated programme submitted for decision making/progress reporting. Options for meeting rooms and storage being developed.

Deliverable (Modular/Office Buildings Cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Former Police Station Refurb: • Site surveys to be undertaken, structural and asbestos. • Completion expected May 2024.		Operational date currently assessed as May 2024. Increased cost c200K to further extend lease for 3SM.	Mitigation plan being considered.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: Public meeting held 06.12.23. • Main topics for discussion included: the size of the swale and other concerns previously raised by the Friends of Springfield Park.		Inconsistent communications.	Future FOSP meeting dates to be agreed. Continued and maintained input & communications from all key stakeholders. Quarterly newsletters and regular website updates.
Completion Works: On schedule: • Playground opening January 2024. • Lighting, planting, street furniture & signage, path works completion March 2024. • Drainage works and final seeding to the football pitches expected March 2024. .		Delays in completion football pitches. Completion of existing Infrastructure works. One new risk introduced this month in the event that any further water/electrical strikes occur on site. Mitigations are in place.	Continued bi-weekly coordination meeting to closely monitor infrastructure and park development site works to maintain the park programme.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Programme: Revised programme in place following 19.10.23 SPV meeting.		Mitie to adopt timelines proposed. One new risk added this month re: potential impact of Building Safety Act 2022. Delay to completion, impact on operational running of the services.	Regular meetings. Close monitoring of critical risks. Programme to be agreed. Initial discussions with wider estates community re: potential short-term decant facilities to help manage patient activity during works.
Tender Process: Mitie has issued a response and costs to the first part of TVE to complete design and tender documentation: • Tender Issue Date: 08.01.24 • Tender Submission Returns: 23.02.24 • Appoint Construction Contractor: Spring 2024.		Timely appointment of a construction contractor. New PM structure to be managed in terms of response times and contractual relationship.	Regular SPV meetings continuing.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

Deliverable	RAG	Risks/Issues	Actions/Next Steps
High level programme to be fully agreed. Phase 1 scope of works to be agreed. Planning consent condition (section 278) re traffic calming to be satisfied as part of Institute approval 2013.		Phase 1 – planning approval, interface with Catkin/Sunflower building (works and access), and cost of works & section 278. The latter is a new risk introduced this month. Phases 2&3 -Budget to be identified.	Finance to confirm funding options. Meeting LCC & Trust 04.12.23 re section 278 options. Continue to develop wider site master plan for Alder Hey and Alder Park in line with 2030 Strategy.

Elective Surgical Day Case

Deliverable	RAG	Risks/Issues	Actions/Next Steps
First meeting of the Elective Hub Board held 21.11.23 to agree Terms of Reference, and the process for assessment and selection of proposed options.		Programme, available budget.	Revised scope of works to be determined with potential options.

New Nursery

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Planning determination expected mid-January 2024 to allow construction to commence.		Confirmed programme.	Regular meetings continue, key dates currently reported as: • Complete design & instruct main contractor – Feb 2024. • Start on site – Feb 2024. • Works complete – Nov 2024. • Operational – by Jan 2025.

Rainbow Centre Refurbishment

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

6. Conclusion

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 7th December 2023

Paper Title:	Emergency Preparedness, Resilience and Response, Annual Report 2023
Report of:	Nathan Askew - Chief Nursing, AHP and Experience Officer (Accountable Emergency Officer)
Paper Prepared by:	Jacob Gray - Emergency Preparedness, Resilience & Response Manager

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

1. Executive Summary

This report provides an outline of the Trusts overall preparedness relating to an array of emergencies and disruptive events as covered under Emergency Preparedness, Resilience and Response (EPRR).

Last year 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 which relating to all domains across the EPRR portfolio, this is due to 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 submits an assurance rating of non-compliant in line with the requirements set out in the EPRR core standards in the annual assurance process for 2023/2024.

The new approach to check and challenge nationally has seen an overall reduction in assurance ratings, a letter outlining this from the NW EPRR leads is included alongside this report.

The report conclusion and recommendations can be found within Section 6 and Section 7.

Contents

2. Acronyms, Initialisms, Abbreviations, Definitions

AEO – Accountable Emergency Officer
BCP – Business Continuity Plan
BMA – British Medical Association
CCA – Civil Contingencies Act 2004
CBRNe – Chemical, Biological, Radiological, Nuclear, and Explosive materials
CRR – Community Risk Register
CSP – Chartered Society of Physiotherapy
DJU – Dewi Jones Unit
EPG – Emergency Preparedness Group
EPRR – Emergency Preparedness, Resilience and Response
ICB – Integrated Care Board
ICC – Incident Coordination Centre
IRP – Incident Response Plan
LHRP – Local Health Resilience Partnership
RCN – Royal College of Nursing
SoR – Society of Radiographers
TNA – Training Needs Analysis

3. Purpose

This report is to provide an annual assurance report to the Board of Directors on the current position of the Alder Hey Children's NHS Foundation Emergency Preparedness Resilience and Response (EPRR).

It also provides information of the year to date for EPRR including the assurance rating against the NHS England Core Standards for EPRR. It is to inform the Board that the Trust, following a check and challenge process has been rated as non-compliant an overall compliance position of 8%.

4. Background

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006, and Health and Care Act 2022 underpin EPRR for Health.

The Civil Contingencies Act 2004 places statutory duties on the Trust, which is classed as Category 1 responder, as such the full set of civil protection duties apply, requiring it to:

- Complying assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place business continuity management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;

- Co-operate with other local responders to enhance co-ordination and efficiency.

Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England Guidance by:

- Complying with EPRR guidance if and when applicable;
- Identifying and have in place an Accountable Emergency Officer;
- Notifying the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 operational days following:
  - The activation of its Incident Response Plan;
  - Any risk, or any actual disruption to Commissioner Requested Service (CRS) or Essential Services;
  - The activation of its Business Continuity Plan.

5. Annual Assurance Report

5.1. Governance

EPRR within the Trust at the executive level resides under the Chief Nursing, AHP and Experience Officer, who is the Accountable Emergency Officer (AEO). Supported by a Non-Executive Director (NED) who Chairs the Trust Audit Committee.

The Trust AEO has a nominated senior lead for EPRR, this is undertaken by the Director of Nursing, who represents the Trust at the strategic level in the Local Health Resilience Partnership (LHRP) and is the Chair of the Trusts Emergency Preparedness Group (EPG).

The Trusts EPRR Manager operates at a 1.0 WTE 8a who is supported by a Resilience Officer at a 1.0 WTE band 5 currently on a 12 month FTC.

The EPG until recently reported into the Trusts Clinical Quality Steering Group (CQSG), following the CSQG's disbandment the EPG will now report into the Safety and Quality Assurance Committee (SQAC).

The Trusts current position in alignment to the NHS England EPRR Core Standards is assessed as non-compliant across 64 core standards within 10 domains, being:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous materials (HAZMAT).

5.2. Risk Assessment

5.2.1. Community Risk Register

The Trust EPRR Manager reviews the Merseyside Community Risk Register on an annual basis to inform the incorporation of any local risks onto the Trusts EPRR risk register.

5.2.2. Trust EPRR Risk Register

The Trust EPRR team controls 3 current risks on the risk register:

InPhase ID	Risk Title	Current Rating
00002763	Unprepared staff CBRNE or HazMat substances	9
00002764	Business continuity plans for services, including new services to are not current or centrally stored	6
00002765	Patients with complex care needs unexpectedly due to an external major incident creating casualties	12

Division associated EPRR risks are owned by the Division and monitored through Divisional board with updates on risk mitigation and appetite presented to the EPG.

5.3. Maintaining Policies, Plans, Procedures

The Trust has an array of Incident Response Plans (IRP's) in order to respond to and mitigate the impact of common consequence and generic incidents. To ensure one version of Trust all IRPs are now stored on the Trusts Document Management System (DMS), with all digital versions on SharePoint also linking back to DMS by default.

The full list of IRPs can be found in Appendix 2, a summary of EPRR related Policies, Plans, and Procedures reviewed this last year can be found in Appendix 3.

5.3.1. Divisional and Departmental Business Continuity Planning

The last year has seen a focussed effort to ensuring divisional and departmental Business Continuity Plans (BCP's) are compliant with current standards: ISO22301 and the NHS England business continuity management toolkit.

All divisional plans are being reviewed in line with: Resource C, Business Continuity Plan, Checklist whilst the Trust adopts and incorporates the NHS England provided Business Continuity Management System (BCMS).

From March 2023 to date the EPRR team have audited a total of 63 BCPs with an outstanding 114 awaiting audit.

Common themes found during audits conclude that local BCP owners and authors:

- Would benefit from attending the EPRR led Business Continuity workshops to support their wider understanding about the topic and resources available to them;
- Require the inclusion of documented risk assessments aligned to the business continuity plan,
- Formal BCMS led audit programme to ensure all plans remain in date, are signed off divisionally, and tested on a regular basis with the resources provided on the EPRR SharePoint.

5.4. Training and Exercising

The Trust has an established EPRR training needs analysis (TNA), with a complimenting annual training and exercising programme.

All training and exercising opportunities are designed in alignment with Minimum Occupational Standards for Emergency Preparedness, Resilience and Response.

In alignment with the NHS Emergency Preparedness, Resilience and Response Framework the Trust is required to hold the following as a minimum:

- Communications exercise – minimum frequency – every six months
    - *Satisfied with Exercise Cascade 20231 – 28th April 2023*

- Table-top exercise – minimum frequency – every 12 months
    - *Satisfied with Exercise Sunbird – 10th July 2023*

- Live play exercise – minimum frequency – every three years
    - *To be planned 2024*

- Command post exercise – minimum frequency – every three years
    - *Satisfied with Industrial Action – Numerous 2022/23*
    - *Satisfied with Alder Care Cutover and Go Live – September 2023*

It is acknowledged several training and exercising events have been stood down due to the Trusts responses and resource allocation to industrial action.

Local Emergency Department Chemical, Biological, Radiological, Nuclear, and Explosive materials (CBRNe) and Hazardous Materials (HazMat) including the use of Powered Respirator Protective Suits (PRPS) and the Trusts decontamination facilities are conducted locally by Emergency Department Staff.

The full list of training and exercising opportunities can be found listed in Appendix 1

5.5. Significant incidents and Events

No formal incident declarations have been made to Co-ordinating Commissioners from the Trust; however, the Trust has had experienced and responded to the following internal incidents:

- Industrial Action - RCN: Numerous 2022
- Industrial Action - RCN: Numerous 2023
- Industrial Action - CSP: 26th January 2023
- Major Incident Standby: 28th March 2023
- Industrial Action - BMA: Numerous 2023 ongoing
- Patient relocation from DJU to Sunflower: 17th May 2023
- Industrial Action – SoR: 25th July-25th July 2023
- Labs Chiller System Failure: 12th August 2023
- Industrial Action - BMA: 14th-17th June 2023
- Industrial Action - BMA: 24-25th August 2023
- Electronic Patient Record (EPG) downtime and cutover: 09th-11th September 2023
- Major Incident – M53 bus crash 29th September 2023

5.6. Warning and Informing

The Trust has a well-established Communications Team, they work regularly with partner stakeholders, including NHS England and the ICB, to ensure communications with the public, where required, are consistent and align with the national and regional messaging, most notably over the last year during the ongoing industrial action.

5.7. Cooperation

5.7.1. Partnership working - Local Health Resilience Partnership

The EPRR Manager represents the Trust at the Cheshire and Merseyside Local Health Resilience Partnership (LHRP), this forum chaired by the ICB EPRR Lead is the formal collaborative where a wide range of partner stakeholders and agencies meet through regular meetings to support joined up planning and information sharing.

The Strategic group hosted quarterly by the ICB is attended by either the AEO or nominated senior officer in order to represent the Trust in an Executive decision making role.

5.7.2. Partnership working - Local Health Resilience Partnership Sub-Groups

The EPRR manager represents the Trust at the LHRP Training and Exercising sub-group, following the same process of the LHRP, the sub-group holds a focus on the development, coordination, and support of all aspects of EPRR related training.

5.8. Audit

In June 2023 MIAA undertook an Audit of the Trusts EPRR arrangements and determined a moderate level of assurance, highlighting adequate system of internal control, however, in weaknesses in some areas of design and inconsistent application of controls puts the achievement of some aspects of the system objectives at risk. They provided 7 recommendations that are being monitored through the EPG.

In August 2023 NHS England Regional EPRR attended for a scheduled visit, they noted a number of concerns relating to the Trusts preparedness around the Emergency Departments decontamination capabilities, issuing guidance and notice to the Trust on corrective measures. This work stream has been sponsored by the AEO and is being controlled and monitored through an EPRR led action plan.

6. Conclusion

The past year has presented the Trust with opportunities of development and challenge. Whilst this document highlights the continuing achievements and progression the Trust is making with the EPRR portfolio it is essential to acknowledge there are areas that require further development.

The new model of annual assurance gathering through NHS England provides the Trust with an opportunity of a soft 'reset' to navigate back to a fully compliant process around EPRR. By addressing the highlighted areas of improvement within this document and subsequent action plans the Trust can capitalise on its strengths and navigate to an elevated assurance in the year ahead.

The AEO has commenced a weekly oversight group to drive the action plan associated with this year's non-compliant position of the Trust and will for an interim period chair EPG, giving executive level direction and leadership to the improvement work required.

The Boards endorsement of this report demonstrates an understanding of the Trusts strengths and challenges, it signifies the Trusts ongoing steadfastness in the face of transparency and accountability to our commissioners and the community we serve.

7. Recommendations

The Alder Hey Children's NHS Foundation Trust Board of Directors is requested to note the annual EPRR assurance report and approve the self-assessment assurance rating of non-compliance in line with the NHS England EPRR core standards for 2023.

8. Appendix

8.1. Appendix 1 – Training and Exercising

Training and exercising year to date.

Title	Description	Who should attend?	Session type	Start date and time	Lead(s)
On-Call EPRR Incident Management Training	Suitably trained commanders at the Tactical level	Colleagues who would respond to an incident at a Tactical level	Training - Face to Face	01/11/2022 10:00	Jacob Gray;
Exercise IA	Business continuity exercise stress testing staff absence on services during periods of industrial action.	Colleagues who would support industrial action at the Tactical and Operational level	Tabletop	04/11/2022 10:00	Jacob Gray;
On-Call EPRR Incident Management Training	Suitably trained commanders at the Tactical level	Colleagues who would respond to an incident at a Tactical level	Training - Face to Face	14/11/2022 10:00	Jacob Gray;
Loggist Training	Loggist training to support Strategic and Tactical commanders during major, critical, or business continuity incidents	Colleagues who have put their name forward to respond to incidents as a dedicated loggist	Training - Face to Face	22/11/2022 13:00	Jacob Gray;
Exercise Cascade 20231 - In Hours	Communications Cascade - Major Incident. Support switchboard staff with exposure to major incident simulation and test Trust response	Colleagues who would coordinate the cascade from the Trust Switchboard	Cascade	28/04/2023 14:00	Doyle Thomas; Jacob Gray
Business Continuity Workshop	Workshop to support local business continuity plan owners aligned to the NHS England business continuity management toolkit	Colleagues who are business continuity plan authors / owners	Training - Face to Face	31/05/2023 09:00	Jacob Gray;
Exercise Elpis (External multi-agency)	Multi-Agency measles outbreak exercise - UKHSA Led	Colleagues who would be involved in incident response involving a regional measles outbreak	Tabletop	07/06/2023 09:30	UKHSA
Decontamination PRPS Train the Trainer	NWAS certified Train the Trainer session in decontamination and PRPS use	Colleagues who may be required to deliver local Emergency Department Decontamination PRPS Training sessions	Training - Face to Face	19/06/2023 09:30	Tony Shryane
On-Call EPRR Incident Management Training	Suitably trained commanders at the Tactical level	Colleagues who would respond to an incident at Tactical level	Training - Remote	28/06/2023 13:00	Jacob Gray
Exercise Sunbird	Business Continuity Incident (Cyber Attack)	Colleagues who would respond to an incident at a Strategic, Tactical, or Operational level	Tabletop	10/07/2023 09:00	Jacob Gray; Andrew Edogun
Decontamination Exercise	Decontamination Exercise	ED and Trust 2222 colleagues who would respond to a contaminated self-presenter in the ED	Live	31/08/2023	Sarah Clipson

8.2. Appendix 2 – List of Trust IRPs

Name	Document Type	Review Date
Bomb Threat Plan.docx	Plans	23/09/2024
Business Continuity Plan.docx	Plans	14/08/2024
Cold Weather Plan.docx	Plans	15/09/2024
Critical Incident Plan.docx	Plans	15/09/2024
Emergency Preparedness, Resilience and Response Policy - M28.docx	Policy	14/07/2025
Escalation Plan.docx	Plans	14/08/2023
Flood Plan.docx	Other / Miscellaneous	31/08/2023
HAZMAT and CBRNE Incident Management Plan.docx	Other / Miscellaneous	14/08/2024
Heatwave Escalation Plan.docx	Plans	14/02/2024
Hospital Evacuation Plan.docx	Plans	31/10/2023
Local Business Continuity Plan Template.docx	Plans	14/07/2025
Lockdown Action Cards.docx	Other / Miscellaneous	18/01/2026
Lockdown Policy - RM22.docx	Policy	18/01/2026
Major Incident Action Cards.docx	Other / Miscellaneous	31/05/2023
Major Incident Command and Control Plan.docx	Plans	31/05/2023
Management of Mass Casualties (Burns Annex) NHS England.pdf	Other / Miscellaneous	03/04/2025
On Call Manager Policy - M32.docx	Policy	25/05/2025

8.3. Appendix 3 – Summary of Policy and Plan updates

Name	Version	Status	Comments
EPRR Policy	1.2	Draft	Review following MIAA audit
Major Incident Plan	7.5	Draft	Annual review
Flood Plan	4	Draft	Annual review and changed to estate
Hospital Evacuation Plan	3.2	Current	Updates following exercise and changes to estate
Debriefing Guidance	#	Draft	New document
HCID Plan	#	Draft	New document

8.4. Appendix 4 – Divisional Business Continuity Plans

Division	Service
Medicine	Emergency Department
Medicine	Burns Unit
Medicine	Mortuary
Medicine	Critical Care
Medicine	Ultrasound
Medicine	Diagnostic Imaging (Radiology)
Medicine	Nuclear Medicine (Action Cards)
Medicine	Medical Photography
Medicine	Ward 1c
Medicine	Laboratory Medicine
Medicine	Pead Lab Medicine Patho (Action Card)
Medicine	Lab Meds Disruption to Logistics (Action Card)
Medicine	Newborn Screening Service
Medicine	Blood Stock Management
Medicine	Patient Flow Team
Medicine	Renal Unit
Medicine	Ward 3c
Medicine	Ward 3b (Oncology)
Medicine	Pharmacy
Medicine	Haematology Blood Transfusion App A
Medicine	Haematology New Born Screening App C
Medicine	Mortuary Services App D
Medicine	Urgent Microbiology App E
Medicine	Histology Urgent Frozen App F
Medicine	Routine Pathology All Depts App G
Medicine	Bereavement Care and Alder Centre
Surgery	Theatres
Surgery	Interventional and Theatres
Surgery	Critical Care Ward
Surgery	Ward 3a
Surgery	Ward 4a
Surgery	Audiology
Surgery	Medical Engineering
Surgery	Burns Unit
Community	Childrens Community Nursing Team (CCNT)
Community	Sefton CAMHS
Community	Outpatients Services, (OPD Build CHP)
Community	Liverpool CAMH Services
Community	Community Speech and Language Therapy
Estates and Facilities	Switchboard
Estates and Facilities	Security
Estates and Facilities	Porters
Estates and Facilities	Linen Services
Estates and Facilities	Facilities
Estates and Facilities	Domestics
Estates and Facilities	Catering Team

Research	Biomedical Research
Research	Clinical Research

Corporate	Procurement
Corporate	HR
Corporate	Finance

Mitie	Mitie Alder Hey

8.5. Core Standards Compliance

8.5.1. *High Level Compliance Report*

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non-Compliant
Governance	6	1	5	0
Duty to risk assess	2	0	2	0
Duty to maintain plans	11	0	11	0
Command and control	2	0	2	0
Training and exercising	4	0	3	0
Response	7	2	4	0
Warning and informing	4	0	5	0
Cooperation	4	1	6	0
Business continuity	10	1	2	0
Hazmat/CBRN	12	0	12	0
Total	**62**	**5**	**57**	**0**

8.5.2. *Partially Compliant Standards and actions*

Ref	Domain	Standard	Detail	RAG	Action
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent	Partially Compliant	Governance all the way from EPG to Board. Reference to financial and resourcing arrangements for EPRR. Inclusion of CBRN Clinical lead. Update to scope arrangements for key suppliers and contractors relating to BC expectations and requirements.
3	Governance	EPRR Board Reports	The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Partially Compliant	Detailed outline of incidents, training and exercises conducted to be highlighted from EPG to parent committee, further highlight to board for awareness.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: - current guidance and good practice - lessons identified from incidents and exercises - identified risks - outcomes of any assurance and audit processes	Partially Compliant	Restructure of EPRR work programme inc COB for EPG. Link training and exercising programme to Trust Risks.
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Partially Compliant	EPRR policy to include EPRR resource requirements. EPRR policy to incorporate specific processes around CBRNe, HazMat, and PRPS preparedness and governance.
6	Governance	Continuous Improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Partially Compliant	Draft Trust debriefing document to be approved at EPG and ratified by parent Committee.
7	Duty to risk assess	Risk Assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Partially Compliant	Link all individual risks to IRP's. Table risk review into EPRR work programme. Align Trust EPRR risk to health risk linked within Merseyside community risk register, national risk register, and internal In Phase risk dashboard.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Partially Compliant	Inclusion of risk appetite relating to EPRR risks being adopted into Trust Risk Management Policy.
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working	Partially Compliant	IRP template to be enhanced to include collaboration segment in document ratification process. All IRPs to include stakeholder and partnerships working, IRP's to be shared with stakeholders for comment prior to approval.

			arrangements and to ensure the whole patient pathway is considered.		
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Partially Compliant	To incorporate comment above to bring in line with latest good practice and legislation. Working group to be established following M53 major incident response. Plan to be reviewed on annual basis. Trusts Major Incident plan requires Board endorsement on annual basis.
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Partially Compliant	Outline how staff will be managed during periods of weather response (e.g., absence policy for snow) or safety assessments for severe weather. include adaptation planning arrangements for climate change. Areas at risk of overheating etc included on risk register and updated regularly.
12	Duty to maintain plans	Infectious Disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Partially Compliant	The Trusts HCID plan remains in draft. There have been large updates to the Trusts entire HCID programme to ensure safety and compliance is met. Sign off and ratification of HCID plan.
13	Duty to maintain plans	New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Partially Compliant	Update Pandemic plan in line with legislation and good practise following Trust learning and national profile. Link to risk registers for pandemic.
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Partially Compliant	Creation of mass countermeasures plan
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Partially Compliant	Review of P1 and P2 number Trust can receive -Major Trauma Network, Cas distribution workstream. Review of 10% bed base discharge in 6 hrs and 20% in 12hrs. Outline service changes when dealing with casualties and service reconfiguration. Formal plans to include doubling of L3 vent capacity for up to 96hrs. Temp review of emergency burns team as part of MI response.
16	Duty to maintain plans	Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Partially Compliant	Revision of ICB involvement. Review and inclusion of NHS Evacuation and Shelter guidance May 2023. Review and inclusion of national evacuation guidance.
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff	Partially Compliant	Document rename. Review of NHS security management service 20b lockdown guidance. Review of LSMS lockdown checklist.

			and visitors to and from the organisation's premises and key assets in an incident.		
18	Duty to maintain plans	Protected Individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Partially Compliant	Document rename. Review of terminology. Reference to other IRPs as appropriate. Link to on call pages.
19	Duty to maintain plans	Excess Fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Partially Compliant	Review into excess fatalities preparedness into rising tide and sudden events. Review into capacity requirements and expansion requirements. Review into MOU's and mutual aid agreements with other organisations.
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Partially Compliant	Review into escalation processes: Trust should be in position to escalate incident to ICB on call within 15 minutes of incident occurring. Testing and documenting, lessons learned and further continuous improvement action plan and information shared through EPG. Review into on call policy on expectations of on call mechanisms and incident response. Review of EPRR framework including the on call mechanisms.
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Partially Compliant	All SMOC as minimum requirement to maintain MOS records. Review into EPRR policy - on call SMOC staff as Tactical commander. Review into EPRR policy on Response team being on site 24/7 service with initial escalation / incident response. On call resource clearly outlines decision making process; including and enhancing on the JDM.
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partially Compliant	The Trust was using a locally created portfolio process for recording staff incident and training. This is to be transferred to the documentation process that NHS England shared with the Trust in July 2023.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Partially Compliant	Review and revision of exercise pack including master events list criteria. Include risk assessment evidence with each exercise. Debrief report master template creation.
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum	Partially Compliant	The Trust was using a locally created portfolio process for recording staff incident and training. This is to be transferred to the documentation process that NHS England shared with the Trust in July 2023.

			Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role		
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Partially Compliant	Collate staff training and exercising information, report compliance standards via EPG.
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required.	Partially Compliant	Create SOP for backup ICC. Create SOP for virtual ICC. Include external stakeholders for location awareness and collaboration.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Partially Compliant	Update IRP template and all IRPs to include removal process of outdated IRPs
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Partially Compliant	Review Trust BCP and update in line with NHSE BC Toolkit. Review Trust departmental BCP template and update in line with NHSE BCP Toolkit.
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Partially Compliant	Procurement of additional hard copy log books for ICC and back up ICC Review and update process for calling out loggists 24/7 and for protracted incidents.
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the	Partially Compliant	Adopt formal processes, create information directory within on call SharePoint

			response to incidents including bespoke or incident dependent formats.		
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Partially Compliant	Incorporation of ICB and NHSE comms planning arrangements. Formalisation of roles and structures and escalation processes.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Partially Compliant	Incorporation of ICB and NHSE comms planning arrangements. Creation of action cards, templates, training needs analysis for who needs training. Formalisation of roles and structures and escalation processes.
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Partially Compliant	Formalisation of communications during incidents.
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media.	Partially Compliant	Creation of holding statements (generic). Establish training requirements for Strategic commanders and Tactical commanders. Secure media training for Strat commanders.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Partially Compliant	Formalise Trust representation via ICB at LRF meetings, to be reflected in EPRR policy.
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Partially Compliant	Link in with ICB on regional templates. Link actions with CBRNe HazMat MAA MOU's. Create MOU/MAA for use of MACA via NHSE.
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Partially Compliant	Establish, test and embed: ICC and SPOC have clear processes for ensuring information is not shared unnecessarily or without protections in place. Authorisation processes for information are clear and reflected within incident roles and descriptions.
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business	Partially Compliant	To be included into EPRR policy statement for business continuity, EPRR policy to be reviewed and approved by board

			continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.		
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Partially Compliant	Formalise BCMS, align to NHSE BC Toolkit.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Partially Compliant	Senior leadership team to undertake annual business impact assessment on critical services and record governance decision on rankings within organisation on critical and non-critical services.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially Compliant	Review Trust BCP into new IRP template, align to NHSE Toolkit.
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Partially Compliant	Completion and approval of local BCPs to require local exercising to demonstrate plan resilience. To be adopted into divisional governance processes and reported via EPG.
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Partially Compliant	BCMS programme to be formally included into board packs. Additional board reports to include EPRR status'
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Partially Compliant	Resilience Officer to get CBCI accredited to support governance and compliance of auditing requirements. Creation of rolling audit programme.

			The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.		Common themes and findings consolidated by division, reported through EPG with assurance on action monitoring.
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Partially Compliant	Review into BCMS process, updating of terminology as required.
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Partially Compliant	Create Template for providers / suppliers. Have all areas within organisation review their BCP for any external providers. All areas with external reliance on providers to request BCP arrangements and assurance from suppliers to incorporate into their own BCP arrangements. All to be audited as part of the BCMS.
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Partially Compliant	Incorporate governance and role responsibilities under CBRNe HazMat capability section within EPRR Policy.
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Partially Compliant	Review - local ED risk assessments in line with core standard and ensure compliance is shared with EPG.
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Partially Compliant	Establish and embed process within ED.
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Partially Compliant	Review of full CBRNe HazMat plan, update, align with current good practise and legislation. Exercise plan with external stakeholders involved in incident response (NWAS, etc). Create MOU with partner Trusts on obtaining PRPS during incidents/ awaiting re-delivery from Respirex following recertification or repurchase of PRPS.
59	Hazmat/CBRN	Decontamination capability	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24	Partially Compliant	Create risk assessment on protracted incidents for continuation of decontamination.

		availability 24 /7	hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.		
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients	Partially Compliant	Create risk assessment for non-ambulant contaminated patients. Review roller / trolley capabilities and test. Review and align to NHS reequipment checklist as required.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable.	Partially Compliant	Formalise role of checks to be included into EPRR Policy. Establish risk assessment on loss of equipment / decontamination facility.
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Partially Compliant	Confirmation with Estates team, Mitie, and Viola on waste disposal contracts, waste management, waste storage including: Effluent water PPE Business continuity implications of suppliers
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Partially Compliant	NOS records for PRPS instructors to be established and maintained. Risk assess and establish formal number of PRPS Trainers within the organisation to meet requirements against sickness, leave, etc.

64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Partially Compliant	ED reception staff to be included in CBRNe HazMat awareness training, IOR specifically. Supporting staff included within IRP to receive additional awareness training linked to EPRR TNA.
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Partially Compliant	All PPE available catalogued and maintained with monthly checklist and statement of assurance delivered to EPG.
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Partially Compliant	Monitoring of ED HazMat CBRN assurance and actions following exercise or response. Reported through EPG.

8.5.3. *Fully Compliant Core Standards*

1	Governance	Senior Leadership	"The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Fully Compliant
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Fully Compliant
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Fully Compliant
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Fully Compliant
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Fully Compliant

8.5.4. *Statement of Compliance*

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

Alder Hey Children's NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Alder Hey will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

14/11/2023

Date signed

07/12/2023	07/12/2023	
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 7th December 2023

Paper Title:	**Emergency Preparedness, Resilience & Response – 2023 Position Report**
Report of:	**Chief Nursing Officer, Accountable Emergency Officer**
Paper Prepared by:	**Emergency Preparedness, Resilience & Response Manager**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☑
Summary / supporting information	Civil Contingencies Act 2004. Health and Care Act 2022. NHS Standard Contract Service Conditions (SC30). NHS Emergency Preparedness, Resilience and Response Framework.
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:	Permanent Resilience Officer Post, additional administrative and project management support, fixed term.

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1. Purpose

The purpose of this report is to provide the Trust Board with oversight of Emergency preparedness, Resilience and Response (EPRR) challenges during the 2023 year to date and updated compliance rating for EPRR.

2. Background

During 2023 the Trust faced a series of disruptive events that have challenged its EPRR processes. Multiple instances of industrial action strained hospital resources, requiring a continuous rise and fall in strategic, tactical, and operational management to ensure minimal impact on patient care and staff wellbeing.

The introduction of Alder Care while now in a promising and stabilised position, caused a protracted period of disruption that coincided with the Trust EPRR assurance collation.

Response to the M53 major incident tested the effectiveness of the framework within the Trusts current major incident planning arrangements.

Several local and divisional business continuity incidents, albeit managed with proficiency and in a well-coordinated manner, revealed gaps in the Trusts overall business continuity management governance and processes.

The EPRR Core Standards assurance modelling undertook a comprehensive review into the Trusts EPRR processes, despite organisational effort in the delivery of EPRR the Trusts original submission of partial-compliance has decreased to non-compliance.

3. Learning

The previous year has created opportunities for learning within the Trusts approach to EPRR, an emphasis on strategic planning to ensure an organisational approach to disruptive events. The response to the major incident highlights foundational aspects from national planning arrangements that can be further embedded within the Trust.

Local business continuity incidents have revealed critical processes around awareness and governance of command and control, and business continuity good practises.

Notably events during 2023 have identified the critical requirement of robust governance, stakeholder engagement, awareness, training and exercising, debriefing processes, strengthened support of competence and confidence for colleagues during incident response.

4. EPRR Compliance Planning

To address reduced compliance rating and enhance general governance of EPRR within the Trust the following oversight, accountability, and strategic collaboration is recommended.

a. Immediate Actions

i. The Accountable Emergency Officer (AEO) to oversee the Trusts Emergency Preparedness Group (EPG) with the AEO as the chair to ensure a dedicated focus on compliance.
ii. The formulation of a weekly oversight inrpovement group lead by the AEO, to monitor and drive the improvement action plan.

iii. Allocate resource to expand the EPRR Team with dedicated project management and administrative support.

iv. Fornal review of the EPRR function structure and associated resources, including mechanisms of cascade and communication.

b. Enhanced EPRR Overview

i. Monthly Meetings with the Integrated Care Board (ICB) EPRR Lead to provide ongoing assurance regarding compliance efforts, share progress, and align with broader regional objectives.

ii. Bi-Monthly Meetings with AEO, Non-Executive Director (NED), and EPRR Manager to discuss, and review barriers to progress on the assurance and compliance status.

iii. Formal Quarterly Action Plan Update to NHSE EPRR following Board review including action plans detailing specific measures taken to improve compliance.

c. EPG Engagement

i. Elevate the EPG's presence, conducting monthly meetings for the next 12 months with a focused comprehensive review of core standards, aligning efforts with the NHS England framework.

ii. Ensure that the EPG serves as a critical driver for achieving, as a minimum, partial compliance within the 2024 EPRR cycle.

d. Competence Building and Training

i. Investment in training programs to enhance staff capabilities related to compliance and emergency response.

ii. Foster a culture of continuous learning and improvement throughout the organisation.

iii. Explict role expectations and associated training in line with the national occupational standards for all roles who undertake a tactical or strategic on call role in the organisaiton.

e. Governance Review

i. Conduct a thorough review of the Trusts EPRR governance structures.

ii. Identify and address gaps in governance practices, ensuring alignment with EPRR good practices.

iii. Allignment of the formal reporting route through Safety and Quality Assurance Committee (SQAC) rather than the current route through ARC.

f. Performance Metrics

i. Establish key performance indicators (KPIs) linked to each individual partial compliant standard.

ii. Monitor and report on these metrics on a weekly basis to the AEO to track progress, identify areas for improvement, and barriers to progress.

g. Continuous Improvement Cycle

i. Implement standard EPRR continuous improvement cycles, regularly revisiting and refining the compliance plan based on evolving challenges and insights.

5. EPRR Resourcing Requirements

To ensure the effective implementation of the EPRR compliance to the enhanced standard now required going forward, it is essential to enhance the current capacity structure within the EPRR team. The following positions are recommended to support the Trusts EPRR compliance capabilities and address EPRR challenges.

i. Substantiate the current 12 month FTC to a permanent position, dedicated to coordinating and executing various elements of EPRR with a continued lead on the Trust Business Continuity portfolio.

ii. Create a 12 month FTC dedicated admin support for EPRR to facilitate streamlined database monitoring, documentation, and cross team coordination.

iii. Create a 12 month FTC part time project management support to ensure effective planning, execution, and monitoring of initiatives.

The above have been approved by the AEO for immeadiate effect whilst a formal review is undertaken as part of the response to the reduced assurance rating.

6. Recommendations

The Board is asked to note and approve the approach outlined in this report.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	**Patient Safety Incident Response Policy**
Report of:	Associate Director of Nursing Governance
Paper Prepared by:	Associate Director of Nursing Governance

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	For Trust Board to formally sign off the Patient Safety Incident Response Policy presented and approved/ratified at Patient Safety Programme Board 19 October 23 and at SQAC 15 November 23 prior to submission to ICS December 2023
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☑ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☑						
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

Patient safety incident response policy

Effective date: November 2023

Estimated refresh date: November 2025

	NAME	TITLE	SIGNATURE	DATE
Author	Jackie Rooney	Associate Director of Nursing Governance and Risk		
Reviewer	Chris Talbot	Trust Patient Safety Specialist		
Authoriser	Alfie Bass Nathan Askew	Chief Medical Officer Chief Nursing Officer		

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1. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Alder Hey Children's NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with our current patient safety incident response plan (PSIRP), which sets out how this policy is to be implemented.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3. Our patient safety culture

Safety culture is one of the two key foundations of Alder Hey's and the wider NHS Patient Safety Strategy. We define a positive safety culture as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all.

Within safety culture, context is everything and improving safety culture is not just about what interventions happen, it is also about how these interventions happen i.e., how change is implemented.

With the introduction of PSIRF, there is continued emphasis on engaging and involving patients, families and staff following a patient safety incident. This supports the Just culture guide which encourages the treatment of staff involved in a patient safety incident in an open, consistent, constructive, and fair way.

We know that positive patient safety and healthy organisational culture are two sides of the same coin. A culture in which staff are valued, well supported, and engaged in their work leads to safe, high-quality care. We are exploring how a focus on staff safety can support patient safety. This means both psychological safety and physical safety, including considering staff wellbeing, engagement, fatigue, burn-out, presenteeism, and the impact these can have on risks to patients and staff alike.

It does not matter whether a staff member is clinical or non-clinical; everyone has a right to feel safe from harm, and to feel safe about speaking up. It's paramount that we move on from a more traditional focus on failure, to also learning from what goes well. In this way, and in the context of a psychologically safe culture, we can all hear more, learn more, and act together to improve patient care.

The Alder Hey staff voice can be viewed as an early warning system where leaders are given an opportunity to understand in detail where improvements can be made and where best practice can be shared.

Psychological Safety, which is explicitly measured in the Staff Survey (and smaller, more safety focused derivatives of it), will therefore play a critical role in helping us to continuously improve. We will extrapolate our findings from the survey metrics to determine if we are sustaining our ongoing progress in improving our safety culture.

By embedding Psychological Safety across Alder Hey, with open discussion, and support from one another, we can take the next step to achieving a safer working environment for our staff and safer care for our patients.

4. Patient safety partners

At Alder Hey Children's NHS Foundation Trust, we are excited to welcome Patient Safety Partners (PSP) who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services.

PSPs can be patients, young people, carers, or family members and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

At Alder Hey Children's NHS Foundation Trust the main purpose of the role is to be a voice for our children and young people who utilise our services and ensure that patient safety is at the forefront of all that we do.

The Trust is currently in a process to recruit Patient Safety Partners in line with the NHSE (NHS England) guidance Framework for involving patients in patient safety .

Patient Safety Partners (PSP) will have a fundamental role in supporting PSIRF providing a perspective through a patient lens to support developments and innovations to drive continuous improvement in respect of quality and safety of services.

The PSP will be involved in the designing of safer healthcare at all levels in the organisation, to promote safety in the Trust and maximise opportunities for effective and embedded learning. They will use their experience as a patient, patient representative or member of the local community to provide support, guidance, and challenge.

PSPs will be part of the Alder Hey family and will work alongside all staff, volunteers, and patients. They will attend quality and safety focussed meetings (face-to-face and online) and be intrinsically involved in patient safety and quality initiatives.

Full role descriptions have been developed and will be provided for PSPs along with any training and support requirements identified so that they can fulfil their role to its' full potential and ensure the best patient safety outcomes for all patients.

We will ensure that we use available tools such as easy read, translation and interpretation services and other methods such as age-appropriate feedback and literature to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

4.1 Addressing health inequalities.

Alder Hey Children's NHS Foundation Trust is one of Europe's biggest and busiest children's Trust, caring for over 330,000 children, young people, and their families every year.

As a specialist provider of health care, Alder Hey has a key role to play in tackling health inequalities in partnership with local partner agencies and services. Through the implementation of PSIRF, we will seek to utilise data gained from our incident reporting system and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these.

The more holistic, integrated approach to patient safety under PSIRF will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

Our engagement with children, young people and their families following a patient safety investigation must also recognise the diverse needs of the communities that the Trust serves and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Alder Hey recognises that some groups of society can experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, sex, race, religion or belief, sexual orientation, transgender, pregnancy/maternity, and marriage/civil partnership. However, the Trust also acknowledges that other minority groups may also experience unfair treatment and discrimination.

When considering our safety actions in response to any incident we will consider if there are any inequalities, and this will be built into our governance and action planning process. We will use our reporting systems to monitor and identify any variations that identify any inequalities. By doing this we can identify any safety improvement work.

4.2 Engaging and involving patients, families and staff following a patient safety incident.

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including our children, young people, their families, carers, and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. Those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of our duty of care. Meeting people's needs not only helps alleviate the harm experienced, but also helps avoid compounding the harm. While we cannot change the fact that an incident has happened, it is always within our gift to compassionately engage with those affected, listen to, and answer their questions and try to meet their needs.

Processes for engaging and involving those affected by patient safety incidents will be applied as follows:

- Apologies are meaningful. Apologising is a crucial part of the Duty of Candour.
- Approach is individualised.
- Timing is sensitive.
- Those affected are treated with respect and compassion.
- Guidance and clarity are provided. Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing.
- Those affected are heard. Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience.
- Approach is collaborative and open.
- Subjectivity is accepted.
- Strive for equity.

4.3 Involving Patients, Families and Patient Representatives

The Trust is committed to involving children, young people, their families, and carers following patient safety incidents, engaging them at the earliest opportunity and throughout in the ongoing investigation process, fulfil the duty of candour statutory and non-statutory requirements.

Children, young people their families and carers often provide a unique, or different perspective to the circumstances around patient safety incidents and may have questions or needs to that of the organisation that will need to be incorporated into the investigation ensuring that the process is patient centred throughout.

This policy prioritises the existing guidance relating to the Duty of Candour and 'being open and honest' and recognises the need to involve children, young people their families and carers as soon as possible in all stages of any investigation, or improvement planning, unless they express a wish not to be involved.

Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE here.

A network of staff acting as Family Support Leads within our Divisions will continue to guide children and young people their families and carers through any investigation or learning review.

Anyone with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their care team in the first instance.

We are committed to providing safe compassionate and joined up care for all our children, young people and their families and will work to achieve compliance with recommendations [1 and 2] outlined in Marthas Rule .

In addition, Alder Hey Children's NHS Foundation Trust has a patient advice and liaison service (PALS). Should the care team be unable to resolve the concern then PALS can provide support and advice to our children, young people their families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing concerns raised by our children, young people, and their family/carer or friends. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS, located in the Trusts atrium near the Treehouse, is available from 9am to 5pm, Monday to Friday.

Or you can:

- Call 0151 252 5161
- Write to PALS, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP.

If the team are helping other families, they may not be able to answer the phone and you may need to leave a voicemail and they will return your call as soon as they are able to.

We also recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with our children, young people their families, and carers to signpost to their preferred source for this.

4.4 National guidance for NHS trusts

Marthas Rule

Engaging with bereaved families

Learning from deaths - Information for families

Child death support

Child Bereavement UK

Lullaby Trust

Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings, and review information given during the complaints

Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.

Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

4.5 Involving Staff and Partner Agencies

Involvement of staff and partner agencies at the earliest opportunity and throughout an investigation is fundamental when responding to a patient safety incident ensuring that there is a process of openness and transparency throughout.

The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

Alder Hey Children's NHS Foundation Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We have embedded these principles into our procedures for the review of incidents.

4.6 Corporate teams

The Trust's Patient Safety and Corporate Risk and Governance Teams will advise, and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.

4.7 Staff Advise and Liaison Service

SALs is an open access listening service available to all staff and learners at Alder Hey Children's NHS Foundation Trust. The service has been developed and is delivered by Alder Hey staff for Alder Hey staff and is underpinned by the principles of person-centred compassionate care whereby staff are provided with the experience of being listened to, understood, empowered, and supported to take intelligent action.

4.8 Occupational Health service

The Occupational Health service for Alder Hey is provided by Team Prevent UK Ltd, who have a dedicated team of Occupational Health professionals based on site on the interim site to help protect and promote the health and wellbeing of staff in the workplace.

4.9 Schwartz Rounds

Schwartz Rounds provide a structured forum and safe space where staff come together to discuss the emotional and social impact of working in healthcare. You can join the conversation, share your experience, or simply listen to their stories. Sessions are themed with invites to Trust wide Schwartz rounds distributed by the Communications Team.

4.10 Freedom to Speak Up

Freedom to Speak Up (FTSU) is an NHS England wide programme that supports you to identify issues and find ways to resolve them.

We know that an open and responsive raising concerns culture, where all our staff feel confident to speak up when things go wrong, is a huge part of what makes Alder Hey the caring organisation it is, every day. Freedom to Speak up Guardians can be contacted via FTSU@alderhey.nhs.uk

4.11 Support from Patient Safety Incident Investigators

All staff with knowledge of the events being reviewed are encouraged to actively participate in the learning response. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team.

Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised.

Staff in engagement roles will be trained in line with the PSIRF standards as outlined in section 7.1.

5. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

By taking this approach we can focus on our resources, or groups of incidents that provide the greatest opportunities for learning and improving patient safety. Planning needs to consider other sources of information such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that the Trust plans should reflect:

- A thorough analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type.

They will be:

- Updated as required and in accordance with emerging intelligence and improvement efforts.
- Published on the Trust external facing website.

5.1 Resources and training to support patient safety incident responses.

It is essential that Alder Hey Children's NHS Foundation Trust ensures that it uses capacity and resources effectively to deliver the plan. The PSIR Plan provides the current level of resource required for Patient Safety Responses (PSRs) to be undertaken.

Currently the Patient Safety Leadership Team, led executively by the Chief Nursing and Chief Medical Officers has the following posts to support and facilitate delivery and embedding of the PSIRF framework:

- Patient Safety Specialist
- Associate Director of Nursing Governance and Risk
- Medical Services Director
- Programme Manager

In addition, the following posts support the Patient Safety Leadership Team:

- Governance Risk Manager
- Divisional Governance Managers
- Head of Quality/Quality Hub

There is a pool of trained investigators, working in substantive clinical or governance roles, who can undertake comprehensive investigations. Appropriate allocation of time to allow for completion learning responses will be given to trained staff.

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England Patient Safety Incident Response Standards (2022) to frame the resources and training required to allow for this to happen.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division.

A learning response lead for a PSII will be nominated by Patient Safety Review Panel and should have an appropriate level of seniority and influence within the Trust – this may depend on the nature and complexity of the incident and response required and will be staff at Band 8a and above.

The Patient Safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All staff will work within our Just Culture principles. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise and advice.

5.2 Training

All staff are aware of their responsibilities in reporting and responding to patient safety incidents.

The Trust has, following approval by Alder Hey Education Governance Committee, mandated the completion of NHSE Patient Safety Training Syllabus Level one – essentials for patient safety for all clinical and non-clinical staff within the Trust.

Furthermore, Level one – essentials of patient safety for board and senior leadership teams has been mandated to all executive members of the Trust.

Level one is a standalone module with currently no expiry/renewal date set for staff. This module is available as an eLearning package via ESR (Electronic Staff Record) access. The overall Trust compliance is monitored through the Integrated Performance Report.

Any future iterations, and national recommendations will be considered and implemented, as necessary.

5.3 Learning response leads training and competencies.

Training: Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response.

Records of such training will be maintained the Patient Safety Leadership Team.

Learning response leads must have completed Levels one and two of the national patient safety syllabus.

Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all learning response leads via our Trust-wide leadership forums.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional risk and Governance teams and the Patient Safety team will support this.

Competencies: As a Trust we expect that those staff leading learning responses will:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from Divisional senior managers, Divisional risk and Governance teams and the Patient Safety Leadership team.

5.4 Engagement and involvement training and competencies

Training: Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.

Records of such training will be maintained the Patient Safety Leadership Team.

Engagement leads must have complete Level one and two of the national patient safety syllabus.

Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all engagement leads via our Trust-wide leadership forums.

Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety team and supported by Divisional Risk and Governance leads.

Competencies: As a Trust we expect that those staff who are engagement leads to be able to:

- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
- Listen and hear the distress of others in a measured and supportive way.
- Maintain clear records of information gathered and contact those affected.
- Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

5.5 Oversight roles training and competencies

Training: All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents.

At least six hours of training in involving those affected by patient safety incidents in the learning process is also required.

Records of such training will be maintained by the Patient Safety Leadership Team.

Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus; Level one – essentials for patient safety and essentials of patient safety for boards and senior leadership teams.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Competency: As a Trust we expect staff with oversight roles to be able to:

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- Apply human factors and systems thinking principles.
- Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report form.

6. Our patient safety incident response plan

Our plan sets out how Alder Hey Children's NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent set of rules that cannot be changed.

We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The current PSIRF is based on a thorough analysis of themes, patterns, and trends from:

- Patient safety incident reports
- Clinical and non-clinical incident data
- Top 10 incident cause groups
- Complaint's themes
- Legal claims
- Staff survey results
- Mortality and in patient death thematic reviews
- Trust wide quality improvement and harm reduction workstreams

Additional resources reviewed included: Freedom to Speak up reports, Annual Quality Accounts, Trust wide Quality Round and Quality Assurance Round insight reports and presentations, complaints and PALs reports, child deaths and mortality review reports, safeguarding data, patient safety quality improvement dashboards via our quality improvement programme Brilliant Basics, risk data, and direct consultation with children, young people and their families via open forums and through a range of children and young person's forums that we have in place.

A copy of our current plan can be found at (link to website when live)

6.1 Reviewing our patient safety incident response policy and plan.

Our patient safety incident response policy and plan are 'living documents' that will be appropriately amended and updated as we use it to respond to patient safety incidents.

We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every 2 years and more frequently if appropriate (as agreed with our integrated care board (ICB) to ensure efforts continue to be balanced between learning and improvement.

This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

7. Responding to patient safety incidents

7.1 Safety incident reporting arrangements

Patient safety incident reporting will follow the Trust Incident Reporting and Management Policy. All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system InPhase and will record the level of harm they know has been experienced by the person affected (Appendix B).

These reports will then be routinely uploaded to the national data base (Learning from Patient Safety Events-LFPSE) to support national learning. Locally, support is available on how to report an incident via the Trust intranet or with the Risk and Governance team.

Reporting of serious incidents (SIs) to the Strategic Executive Information System (StEIS) will also be superseded by LfPSE (Learn from Patient Safety Events). However, to reduce complexity during the transition period and to maintain data flows it has been agreed nationally that organisations will continue to use StEIS to record any incidents that are subject to PSII. A new incident type has been added to StEIS that allows organisations to record incidents which are responded to using PSII.

Daily Divisional incident review mechanisms are currently in place to ensure that patient safety incidents can be responded to proportionately and in a timely manner. This includes consideration and prompting to service teams where Duty of Candour applies.

Whilst the statutory obligation for the Trust to complete Duty of Candour (DoC) for moderate harm and above remains, under PSIRF, the timescale for DoC to be completed within 10 days has been removed: however, Alder Hey will continue to adhere to the 10-day timescale to ensure compliance with DoC legislation.

Most incidents will only require local review within the Divisions/services, but in line with our approved governance process (Appendix A), all incidents reported as moderate physical harm or above, together with any local rapid review undertaken in the preceding week, plus any patient safety incident where it is felt that the opportunity for learning and improvement is significant, will be presented by the relevant Division and reviewed collectively at the weekly Patient Safety Incident Response Investigation (PSIRI) Panel to determine the appropriate learning response required (PSII or PSR). Divisions will also escalate any identified trends, clusters or patient safety risks which cannot be actioned, plus any incident which appears to meet the criteria to be reported eternally to the weekly PSIRI panel.

Patient Safety Incident Investigations (PSIIs) include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents. Any PSII undertaken by our organisation will use the national PSII template (Appendix C).

All PSRs are conducted locally by our organisation with different PSR techniques adopted depending on the intended aim and required outcome. There are five broad categories of PSRs agreed with stakeholders to be utilised at Alder Hey Childrens NHS Foundation Trust (Appendix C)

- Rapid Review
- Situation, Background Assessment, Recommendation (SBAR) review
- Thematic Review
- Multi-disciplinary team (MDT) review
- Safety Huddle incorporating a Hot/Cold debrief.

Our approved governance process allows the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

7.2 Patient safety incident response decision-making

In line with our approved PSRIF governance arrangements the Trust has arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRP.

The Trust has established governance and assurance systems in place to ensure oversight of patient safety incidents at both Divisional and Trust wide level allowing for a clear 'Ward to Board' oversight of incident management and our PSIRF response.

Corporate and Divisional Governance teams will continue to work collaboratively to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends, or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (e.g. – CQC (Care Quality Commission) concerns)
- Identification of any incidents requiring external reporting or scrutiny (e.g. – Never Events, Neonatal deaths, RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrence Regulations))
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures.

This data will be reviewed regularly against the identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Patient Safety Board and Safety Quality Assurance Committee if required.

The process for completion of a Patient Safety Incident Review, currently identified as a rapid review, to determine further investigation or escalation required will remain with other tools as outlined in section 7.1 and available in Appendix C.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP and this will be considered on a case-by-case basis with justification where necessary.

7.3 Responding to cross-system incidents/issues.

If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and actions. All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate.

The PSIRI Panel and Corporate Governance team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust via the following email address: governanceandqualityassurance@alderhey.nhs.uk

The ICS (Integrated Care Systems) should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

We will also continue to collaborate with our paediatric peers to share any-cross paediatric patient safety themes and trends for learning purposes.

7.4 Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

Our PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident reported but initial investigation should be started within 5 working days of being reported.

PSIIs: Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and the time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision.

However, all PSIIs should be completed within three months of their start date with no local PSII taking longer than six months.

PSRs: Where other forms of PSRs should be started within 5 working days of being reported and completed within one month of their start date.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the PSII leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later should new information indicate the need for further investigative activity.

In some incidences, longer timeframes may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

7.5 Safety action development and monitoring improvement.

PSIRF moves away from the identification of ‘recommendations’ and shifts its focus to describing ‘areas for improvement.’

The Trust will use the process for development of safety actions as outlined in the NHS England safety action development guide as follows:

- Agree areas for improvement.
- Define the context.
- Define safety actions to address areas of improvement.
- Prioritise safety actions.
- Define safety measures to demonstrate improvement.

Safety actions will be written following the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and have a named designated owner.

Completion and effectiveness of safety actions will continue to be monitored through established organisational and divisional governance processes. Divisional reporting on the progress with safety actions will be made to Patient Safety Board and were applicable Quality Safety Assurance Committee.

The Corporate Governance Team will maintain an overview across the organisation to identify themes, patterns, and trends via the Aggregated Analysis Report on a quarterly basis.

Areas for improvement will be identified via the Patient Safety Board. In collaboration with our Brilliant Basics quality improvement team, service or teams will be supported using our A3 Quality Improvement methodology to identify and embed learning and improvement following a patient safety investigation to improving patient safety outcomes.

7.6 Safety improvement plans

As referred to throughout the policy, the Trust has developed a plan (PSIRP) that clarifies what our improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

The Trust has several overarching safety quality improvements plans already in place including individual safety improvement plans that focus on specific services.

Where overarching system issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan may be developed. These will be identified through the weekly Divisional patient Safety Meetings and PSIRI panel. Monitoring of progress will be overseen by the Patient Safety Group with oversight and reporting to Safety Quality and Assurance Committee.

7.7 Oversight roles and responsibilities

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board as outlined in the Oversight roles and responsibilities specification

At Alder Hey the Board through the Executive Medical Director and Chief Nurse have joint responsibility for the effective monitoring and oversight of PSIRF.

As designated Trust Executive Patient Safety Leads, the Chief Nursing Officer and Chief Medical Officer will:

- Delegate all incidences reported as moderate harm or above to the Patient Safety Incident Response Investigation (PSIRI) Panel for review and agreement of action as per agreed Trust PSRIF process.
- Delegate authority for the approval of downgrading of any moderate harm incident following divisional review of rapid review findings to the PSIRI panel.
- Receive a weekly tracker from PSIRI of all incidences received by PSIRI panel, including the decisions made for each incident presented plus any areas/incidences for escalation.
- Receive all completed PSIIs for oversight and approval for presentation to Trust Board

It is important that under PSIRF there is a paradigm shift from monitoring of process, timescales, and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients.

It should be noted that similarly the ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' an SI (Serious Incident) and have individual patient safety responses 'signed off' by commissioners.

However, they will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures (objective and subjective) and evidence required to do this will need to be defined within the PSIRP for each priority which will be agreed in discussion with the ICB.

8. Mortality Issues

Our Trust has an established monthly Mortality Review Group (MRG) to provide oversight of compliance with the mortality review process and will provide the Trust with the assurance that causes, and contributory factors of the inpatient deaths of all children and young people including neonates have been reviewed, considered, and are appropriately responded to in an open and transparent manner.

If relevant, any child death will be referred to the child death overview panel (CDOP) via the Trust's safeguarding team for investigation in line with statutory and operational guidance.

Our Safeguarding team will liaise with CDOP as locally led PSII may be required and respond to recommendations from external parties for learning purposes.

If a PSII is undertaken regarding a death that will be reviewed by a coroner, the coroner will receive the PSII report. If a different learning response is undertaken, the output from the response will also be shared with the coroner.

Any neonatal death will be referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation (https://www.hsib.org.uk/maternity/)

All perinatal deaths will be referred to MBRRACE and any relevant recommendations and/or actions from external referred agency will feed into the Patient Safety Board to be considered as part of QI process.

9. Complaints and appeals.

The Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust. When this occurs, they may wish to raise a local concern, an informal PALS concern or a formal complaint and the Trust has a duty to listen to their concerns, investigate them fully in a timely and responsive manner, provide a full and appropriate response, and seek a resolution.

Formal complaints from children, young people or families can be lodged through the Trust's complaints procedure. The Quick Reference Guide provides flow charts for the management of complaints which should be used in conjunction with the Complaints and Concerns Policy.

Any complaints relating to this policy, or its implementation can be raised informally with the Corporate Governance team, initially, who will aim to resolve any concerns as appropriate.

10. Appendices

Appendix A – PSIRF Governance Process

A PSIRF Governance Process.docx

Appendix B – Alder Hey Harm Grading Guidance

B Alder Hey Harm Grading Guidance.pdf

Appendix C – PSIRF Tools

PSII report Template

C PSII Report Template.docx

Terms of Reference (ToR) for investigation

Terms of Reference for investigation.docx

Rapid review template

C Rapid Review Template.doc

Situation, Background Assessment, Recommendation (SBAR) review

C SBAR Template.docx

Thematic Review

C Thematic Review Guide.pdf

Multi-disciplinary team (MDT) review

C MDT Review Guide.pdf

Safety Huddle incorporating a Hot/Cold debrief

C - Safety Huddle incorporating a Hot C

System Engineering Initiative for Patient Safety (SEIPS)

SEIPS Worksheet and Guide.pptx

Timeline Mapping

Time-line-mapping-v1-FINALSept 23.xls

Safety Investigations Worksheet

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This report provides assurance on the progress of the Brilliant Basics Delivery Plan 2023/2024.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
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

[0126]1. Executive Summary

The aim of this paper is to provide Trust Board assurance and oversight of the Brilliant Basics (BB) Delivery Plan 2023/2024. The paper details the progress towards the development of a culture of continuous improvement.

The paper also provides an outline of NHS IMPACT direction and alignment to current and future BB plans.

Within the current BB Plan **100%** of the milestones are **on track.**

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

The key messages highlighted in this report are: -

- Progress is in line with approved BB Delivery Plan.
- Progress on BB puts Alder Hey in a strong position as leaders in the improvement community both locally and nationally.

2. Background and current state

Brilliant Basics Programme

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

Table 1: Plan on a page

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

Table 2 below provides high-level current state on progress of program milestones.

Table 2: Current Milestone progress

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

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

Table 3 below details progress against driver and watch metrics. The driver metric has **increased** and the trust have moved into quartile 4 (highest 25%) for the staff survey involvement score compared to all national providers.

Table 3: Progress of Driver and Watch metrics.

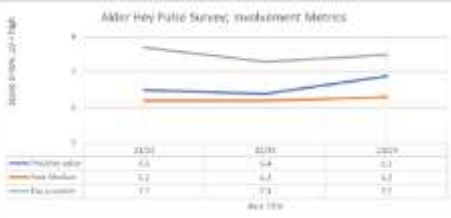
Summary Progress Report (Page 1)
Title: Brillant Basics – November 2023

Presented by: Nathan Askew

Alder Hey Children's

We are data driven to inform change and demonstrate improvement	Analysis and Insight: what does the data tell us?

Driver Metric: Trend and current performance data vs Target

Driver	Current	Insight
NHS Staff Survey Involvement Question: The degree to which staff feel that they are involved in making improvements within their organisation		**What the data tell us:** Alder Hey has **increased** the involvement score and has now moved into quartile 4 (highest 25%) compared to all national providers. Within Cheshire and Merseyside ICS, Alder Hey are 3 rd from top with a difference in score of 0.2 compared to the top provider. Within the North West Region, Alder Hey are 4 th from top with a difference in score of 0.2 compared to the top provider This data will be updated in line with national reporting frequency; end of quarter in the pulse survey and annually in the NHS staff survey. *Data source: Model Hospital. Comparator: Staff survey benchmarking group. Category: Involvement (Q 3D, E, F) Analysis: 0=low, 10=high.
Target		
Brilliant Basics will **contribute** to increasing the numerical value of this survey result.		

Watch Metrics: Trend and current performance data vs Target

Watch	Target	YTD (current)	Measured how	On / Off Track	Insight
Impact and outcome of CYP&F involvement	Strategic and local level	Both in motion	Case studies		Involvement evidenced within all teams that have worked with BB. Co -design planned for New Models Strategic Initiative.
16 teams coached	16	14	Local database		This measure includes a combination of previous teams and new teams as part of sustainability work the QH team are undertaking . 4 teams recruited for January start. 7 teams in pipeline for readiness assessment
Evaluation of delivery of learning	5 out of 5	4.7 out of 5	Learning evaluation		All learning provided by the QH team continues to evaluate consistently highly.
12 case studies that evidence impact over 12 months	12	2	Case studies		Case studies featured in Alder Hey Life and monthly communications emails. Further work planned as part of New Models of Care Initiative.

Version 1.4

NHS IMPACT

NHS IMPACT has set out five key areas of focus which, when implemented together, build a systematic organisation wide approach to improvement and high performance:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

A self-assessment has been published by NHS IMPACT that allows providers to assess their own position against the national standards. An initial draft assessment for Alder Hey is being developed. Alongside the review of the BB plan for 23/24 and the stakeholder feedback currently being sought, this assessment will inform the BB plan for 24/25. This is due to be presented to Board in quarter 4.

There is national and system interest in Brilliant Basics which gives the organisation an opportunity to celebrate and demonstrate the impact that has been made and support other organisations through shared learning and peer support. The opportunity for us to share our journey enables us to showcase our improvement system, the tools and approaches that have been successful and demonstrate real impact of out continuous improvement (for example the safety board).

3. Conclusion

This paper provides assurance on:

- Consistent progress to date against BB Delivery Plan.
- The trusts positive position against NHS IMPACT recommendations.

4. Recommendations & proposed next steps.

Recommendations are:

- Trust Board to note progress in line with the approved BB Delivery Plan.
- Trust Board to receive assessment of BB plan delivery in quarter 4 alongside detailed NHS IMPACT self-assessment and BB plan for 24/25.

ENDS

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	Serious Incident, Learning and Improvement report. 1st – 31st October 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	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required	☐	**Not Assured** Evidence indicates poor

		applied and effective in practice		to improve their effectiveness		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 – 31st October 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.

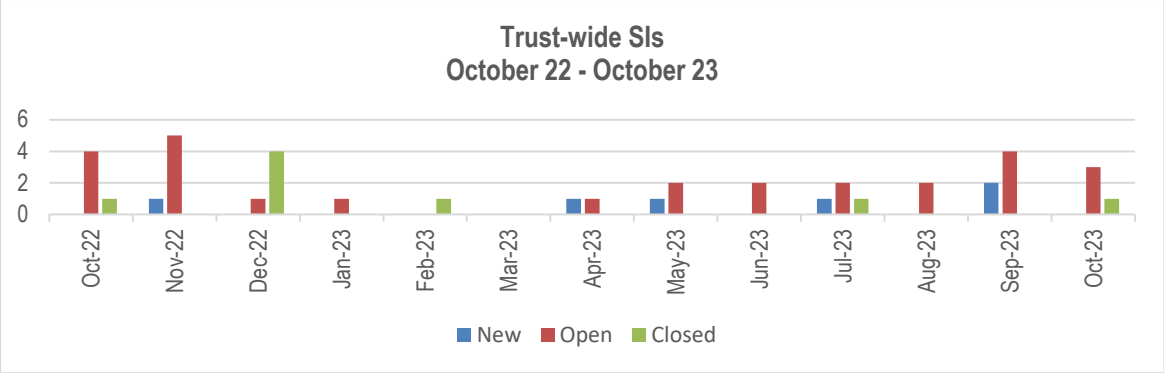
3. Local context

3.1 Never Events

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

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status October 2023



3.2.1 Declared Serious Incidents

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

3.2.2 Open Serious Incidents

3 SIs were open during the reporting period as outlined in table 1.
1 SI investigation was completed in this reporting period (1st – 31st October 2023) (SI 2023/10739 – Delayed diagnosis of bone malignancy).

Table 1 Open SIs October 2023

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

3.2.3 Serious incident reports

3.2.4 SI action plans

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

1 SI action plan remained open and is within its 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 **0** internal level 2 RCA investigations during the reporting period (1st –31st October 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.

4 initial and 1 final Duty of Candour responses were required.

3 initial duty of candour responses were completed within the required timeframes.
1 initial duty of candour response breached by 1 day. The breach related to InPhase incident ID 4773 regarding a patient with a history of ketotic hypoglycemia who had a very low blood sugar and was unresponsive. His blood sugar was normal in triage, but was not rechecked again, and he was discharged within 2 hours with a diagnosis of tonsillitis. The patient was subsequently treated and admitted to HDU in Whiston for 3 days.

1 final duty of candour response was completed within expected deadlines during the reporting period (1st – 31st October 2023).

4. Learning from serious incidents

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

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

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

Recommendations

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

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2023/ 10739 **InPhase ID - 783**	Delayed diagnosis of bone malignancy.	Limping child guidelines should be followed. Number of attendances should be reviewed and taken into consideration. Multiple attendances resulted in no clear diagnosis even though there were ongoing symptoms.	Referred to Orthopaedics. Child has now been referred to the oncologist for a biopsy, staging and subsequent treatment. Potential amputation required as the tumour is extensive. **October 2023:** RCA investigation completed and sent to commissioners 12/10/2023. Scheduled to be presented at North Mersey SI Panel 17/01/2024.
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. **October 2023:** Second extension requested 10/11/2023 due to ongoing clinical discussions. Final report subsequently completed and sent to commissioners 03/11/2023.
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.	Separating out of consent forms for individual procedures. Making lines list calendar visible to all consultants and registrars completing the lines list. Include lines list request form as part of lines list huddle.

		Need separate E-consent form for tunnelled CVL/port/haemodialysis line. Better system for Line Requests necessary – Should be on Expanse with Ambulatory Order to allow for end-to-end audit of process. IT Equipment should be available for the forms to be viewed correctly. The Line Request forms should be easier to read. The selection should be more clearly visible.	**October 2023:** Draft report circulated to panel members for comments. On track for completion by the submission deadline of 14/12/2023.
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. **October 2023:** Interviews completed. Panel held. Draft report is being written. Extension to report completion requested due to ongoing external subject matter expert opinion. On track for completion by the submission deadline of 18/01/2024.

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 8 actions completed.	31/12/2023		0

END

Alder Hey Children's NHS Foundation Trust

TRUST BOARD DIPC REPORT

December 2023

Paper Title:	Infection prevention & control quarterly report Quarter 2, July – Sept 2023
Report of:	Infection Prevention and Control Team
Paper Prepared by:	Dr. Beatriz Larru, Director of Infection Prevention & Control

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

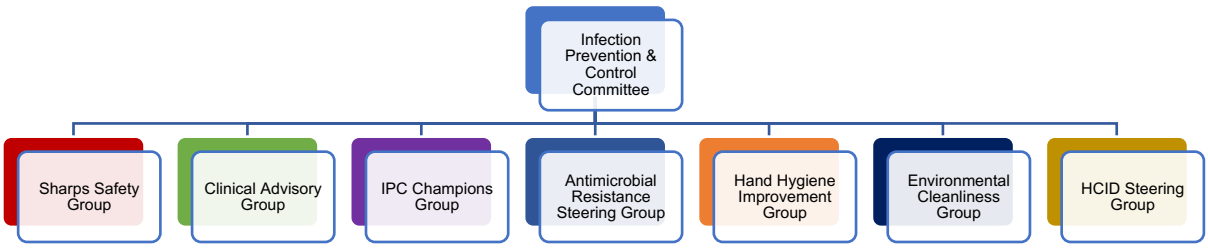
1. Introduction

The purpose of this report is to provide the Trust Board with oversight of Infection Prevention Control (IPC) activity and reporting for the Q2 period (1 Jul-30 Sept 2023) ensuring the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

The Trust recognises that the effective prevention and control of healthcare-associated infections (HAIs) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently by everyone working directly with patients to ensure their safety. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

2. Infection Prevention & Control Department

During Q2, IPC committee became operational with reporting from the following subgroups.



Sharp Safety Group: On 15.08.23, the workplan for sharp safety strategy was presented to the group. Unfortunately, attendance to the group was limited with absence of key stakeholders such as medical engineering or occupational health, hence the workplan could not be approved since the meeting was not quorate. *Action*: ongoing discussions with Health & Safety appropriate leadership for this operational group.

Clinical Advisory Group:
On 17.08.23, CAG welcomed guest speaker, Dr Kristina Bryant: epidemiologist and ID physician at Norton Children's Hospital, Louisville, Kentucky, and President-elect of Pediatric Infectious Diseases Society in the US. Discussion centred around evidence-based measure for CLABSI prevention (central line associated blood stream infections). *Action:* establish the CLABSI Steering Group to align preventative measures and CLABSI monitoring across the Trust.

IPC Champions Group:
On 25.07.23, discussion centred around barriers to implementing IPC practices. Responses identified lack of resources as an issue, as well as lack of engagement from medical staff. *Action:* DIPC attended divisional IPC sub-committees to request medical support for IPC initiatives.

Antimicrobial Resistance Steering Group:
On 13.07.23, discussion centred around the need for additional dedicated time for group members to move projects forward to tackle AMR. The need for project management support was recognised by group members. It was announced that we are working towards GAMSAS (Global Antimicrobial Stewardship Accreditation Scheme). *Action:* IPC programme coordinator is now providing project support and close collaborating with Patient Safety programme manager.

Hand Hygiene Improvement Group:
On 26.09.23, the terms of references for this subgroup were approved. Lack of multidisciplinary engagement was identified as a barrier for an effective hand hygiene strategy for the Trust. *Action*: involve CYP and families in our hand hygiene audits and collaborate with the Innovation to explore automatic hand hygiene audit and feedback.

Environmental Cleanliness Group:
On 17.08.23, the group was re-launched to agree on the updated Hospital Cleaning policy and design a workplan to meet the national standards of healthcare cleanliness. *Action:* Hospital Cleaning policy RM49 was approved on 15.11.23 IPCC and a comprehensive list of SOP for cleaning reusable medical equipment is being develop by the decontamination and medical engineering teams.

HCID Steering Group: no meetings held in Q2.

3- Infection Prevention & Control Metrics

3.1 Bacteraemia Surveillance

3.1.1 Healthcare-associated Gram-negative Bloodstream Infections

Preventing healthcare-associated Gram-negative blood stream infections (GNBI) is a priority for NHS England, as these infections are associated with severe clinical outcomes, prolonged hospital stays and antimicrobial resistance. While CYP have different risk factors to developing GNBI and require focused preventive measures*, surveillance of GNBI is a key component of the multifaceted approach proposed by NHSE to achieve GNBI reductions. Hence, the IPC team reports all cases of healthcare-associated bloodstream infections to UKHSA monthly.

A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA is shown below in Table-1.

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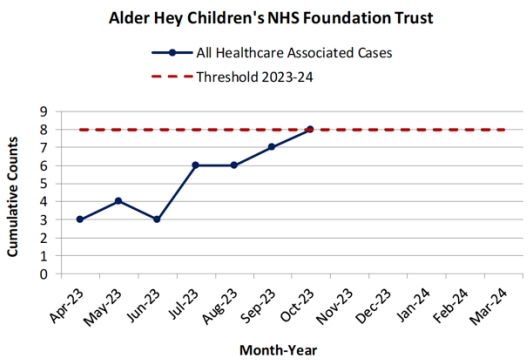
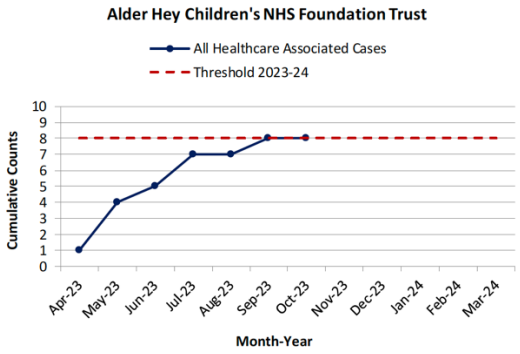
*The main difference between children and adults is that the pathophysiology of the Gram-negative bacteraemia's is very different. Elderly patients get Gram-negative CLABSI after they had a urinary tract infection (mainly because inappropriate use of foleys and lack of hydration) but children do get Gram-negative bacteraemia's mainly because of gastrointestinal insufficiency (short gut, prolonged TPN, abnormal GI tracts due to gastroschisis, volvulus ...) so UTI preventive efforts have minimum impact.

***E. coli* bloodstream infections**



***Klebsiella spp*. bloodstream infecitons**



***P. aeruginosa* bloodstream infections**

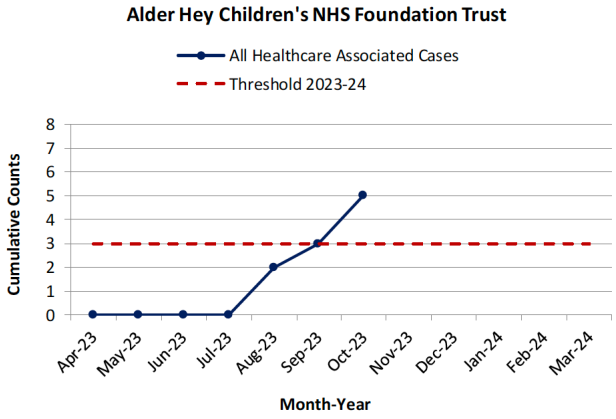


Table-1: UKHSA HAIs monthly tables for Gram-negative bloodstream infections.

Note: Healthcare-associated infections includes: 1) Hospital Onset-Healthcare acquired (**HOHA**) *(i.e.*, occurs in patients admitted >48Hr) and 2) Community Onset-Healthcare acquired (**COHA**) (*i.e.,* occurred in patients who have received healthcare in either the community or hospital in the previous 28 days).

3.1.2 Post Infection Review (PIR) findings for GNBI:

PIRs identified that the source of most of the Trusts Gram-negative bloodstream infections were due to vascular access devices as noted below together with plan of improvements aimed at reducing Central line related line infections (CLABSI).

- Active babies /toddlers getting access to lines if lines not secure.
  - Tuck vest designed for use on young children with lines used on patients with multiple episodes of line infection.
  - Fidget board has been ordered to support safe play for children and provide distraction to playing with line.
  - Availability of clamps in case of line breakage.

- ANTT compliance to be improved.
  - IV have agreed to support by completing ANTT assessments on wards.

- Practice educators to support staff on all shifts and repeat ANTT assessments.
- More staff identified to be trained in assessing ANTT.
- PICU /HDU retraining of all staff in ANTT practice.
- Increasing compliance with ANTT update training and observational audit Trust wide.

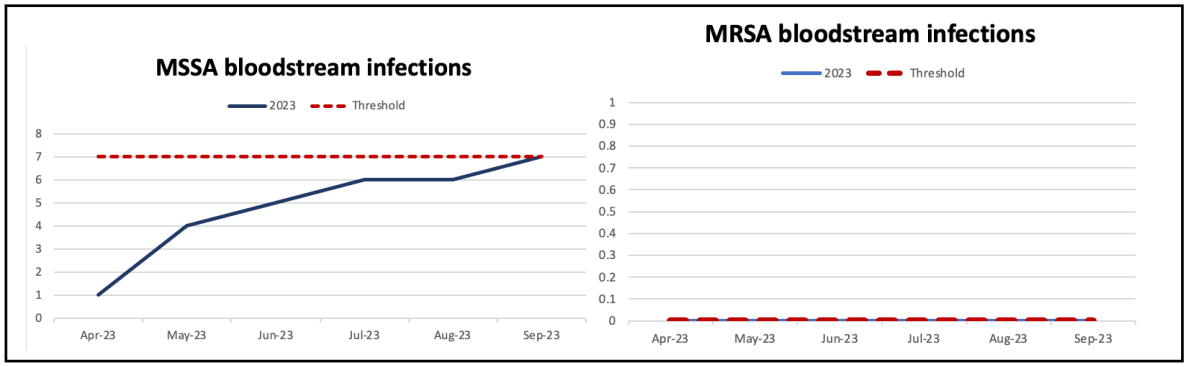
- Frequent IV access
  - Surgical SOP/ Guideline developed.
  - Surgical ANTT used throughout.
  - Skin bundle documentation.
  - Sli fix dressing approved by IV, IPC and ID team to add extra layer of protection to central line hub.

- IPC practices -Improve Hand hygiene.
  - Additional hand hygiene assessments wards.
  - Ensure all cleaning checks are done.
  - Staff challenged where appropriate.
  - Hand hygiene subgroup of the IPCC launched to lead trust strategy on improving hand hygiene compliance. The group is looking at reducing the gap between self- reported and quality control hand hygiene audits.

Monitoring/Policy development

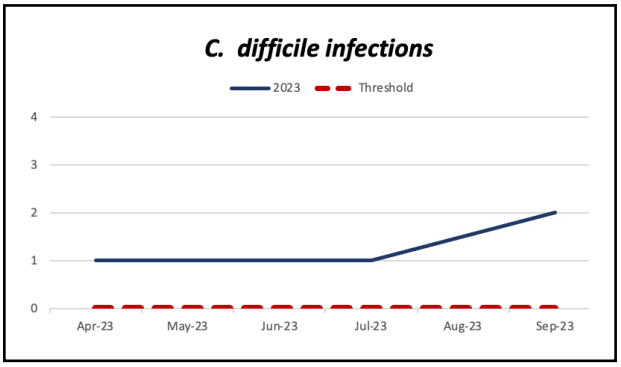
- Production of Trust CLABSI rates with plans to produce ward level CLABSI rates to feedback to ward teams. This is already in place in critical care. Feedback of rates is key to improving practice.
- Saving lives MDT group that review line management in complex patients.
- New Isolation Policy – with an emphasis on the reduction of inappropriate use of PPE which can result in cross infection. This is also being supported by the roll out of the 'gloves off 'campaign in PICU before it is rolled out Trust wide.

3.1.3 Healthcare-associated *Staphylococcus aureus* bloodstream infections



PIR of the MSSA bacteraemias identified similar findings and actions plans as GNBI.

3.2 *C. difficile* Infection



The PIR did not identify any lapse in care, although it identified the importance of communicating the requirement for sampling at onset of diarrhoea to all bank and non-oncology staff that had been assigned to work on the oncology ward.

3.3 Healthcare acquired viral infections.

3.3.1 Respiratory viral infections

During Q2 23/24 there was 1 case of healthcare acquired Adenovirus infection and 1 case of HAI COVID-19 reported.

From May 2023, all nosocomial viral infections have been included in our PIR framework, which has identified the following common themes and learning points:

- Lack of staff awareness to use PPE accordingly to patient's symptoms, not just testing results
- Lack of staff awareness of the burden of nosocomial viral infections in hospitalised paediatric patients
- Previous visits from a friend or relative with symptoms
- Frequent contact outside the ward in families with long-term patients (particularly in 1C cardiac ward).
- Patients being frequently exposed to multiple visitors

The IPC team also performs daily "isolation walks" among all areas of the Trust to communicate to staff the appropriate IPC precautions and has developed visual graphics to identify contagious patients.

3.3.2 Gastrointestinal viral infections

1 case of healthcare-associated Norovirus infection reported in Q2 23/24. No staff were affected, and no beds were closed.

3.4 Other Notable Infections

3.4.1 Group A *Streptococcus*

1 case of healthcare associated Group A *Streptococcus* was identified during Q2 23/24 in a patient who underwent surgery within the previous week.

An investigation of the case did not identify epidemiological link with other patients but identified that the IPC team weren't notified about Group A *Streptococcus* case unless the child is an inpatient meaning that opportunities to prevent transmission could be missed. A review of the microbiology test reported to the IPC team is ongoing.

3.4.2 Measles

Zero positive measles cases reported during Q2 23/24.

4 Infection Prevention & Control Associated Risks

See Table-2 at the end of report.

5 Discussion and next steps

During Q2, the Infection Prevention & Control team has continued to work with Brilliant Basics to streamline a number of processes, allowing the team to work more efficiently whilst increasing visibility around the hospital. One of the notable changes has been moving from an isolation spreadsheet to a daily IPC ward round, which has been positively received by staff. We have also approved terms of refences and approved workplans for the IPC committee operational groups to establish successful collaborations with key stakeholders across the Trust and ensure a multidisciplinary engagement with IPC interventions.

As highlighted in previous DIPC reports, we continue to struggle to perform as a data-driven programme due to the absence of an electronic surveillance system.

6 Recommendations

The Trusty Board is asked to note the content of this report

4. Table-2: Infection Prevention & Control associated Risks

Risk Number InPhase ID	Ulysses ID	Risk Description	Initial Risk score	Target risk score	Risk score Q2 23/24	Risk movement	Mitigations in place Q2
00002754	2788	Non-compliant with FIT testing for clinical staff in scope	12	2	12		Secondment of 1 band 6 Nurse to provide FIT testing and vaccinations . Additional key trainers in PICU.
00002713	2747	Inability to maintain IPC standards due to limited availability of curtains and lack of timely response to the rapid cleaning pathway	9	4	9		Agreed with Domestic manager to leave window curtains for amber clean. Trial of wall mounted Screens on 4C to replace bay privacy curtains agreed by Kwik screen. Business case in development.. On workplan for Environmental cleanliness IPCC subgroup.
00002714	2748	IPC Policies are not up to date and not reflective of current IPC practice	9	4	6		Policies approved at IPCC in July and September . Recovery plan in place for outstanding out of date policies
00002715	2749	Lack of advanced data skills within IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data	12	3	12		Risk linked with Micro lab and AMS – escalated to Medical Director to discuss ICNET solution Charity application made.
00000063	N/A	Inadequate number of staff trained to deal with patients presenting with high consequence infectious diseases(HCID)	12	2	12	NEW RISK	8 Key trainers trained by HCID network lead .Development of training programme. Training commenced w/c 29/09/23
00002710	2744	Non delivery of IPC standards due to insufficient IPC staffing levels	12	6	9		Successful recruitment of Band 6 IPC practitioner Brilliant Basic team 5 interventions to review processes. 5 projects in progress. 2 nearing completion at end of QTR 2
00002682	2716	Confidential information could be accessed and used inappropriately – patient letters stored on the K drive and not in Medisec.	12	3	3		Migration of patient letters completed . Risk to be closed in November 2023 when all medisec letters on K drive are deleted.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 15th November 2023, along with the approved minutes from the 18th October 2023 meeting.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐

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

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

0145 **1. Executive Summary**

The Safety Quality Assurance Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

2. Agenda items received, discussed / approved at the meeting

- SQAC received a 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

0146 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.

4. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 18th October 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 Hanger	Associate Chief Nurse, Surgery Division	(RH)
	Beatrice Larru	Director of Infection Prevention Control	(BL)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Jacqui Pointon	Associate Chief Nurse–Community & Mental Health Division	(JP)
	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)
23/24/114	Peter White	Chief Nursing Information Officer	(PW)
23/24/115	Will Weston	Medical Services Director	(WW)
	Jayne Guy	Head of Nursing & AHP's for Clinical and Diagnostic Services	(JG)
	Kim Hewitson	Sepsis Nurse Specialist, Infectious Diseases & Immunology	(KH)
23/24/118	Julie Grice	Mortality Lead	(JG)
23/24/118	David Porter	Consultant Infection & Immunology, Infectious Diseases	(DP)
23/24/118	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)
	Clare Ellis	Head of Operations – Laboratory Medicine	(CE)
	Jo Revill	Non-Executive Director	(JR)
	Catherine Wardell	Associate Chief Nurse – Medicine Division	(CW)

23/24/111 Welcome and Apologies

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

23/24/112 Declarations of Interest

None

23/24/113 Minutes of the Previous Meeting

Committee members were content to APPROVE the notes of the meeting held on 20th September 2023.

23/24/114 Matters Arising and Action log.

Inphase update report - JR had presented an Inphase update report that has been shared with the Audit & Risk Committee meeting on 12th October 2023. There had been challenges with the volume of reports requested from the Trust and these had now been streamlined from 10 to 7. There had been issues with regards to reporting functionality, which is included on the Risk Register, this is

improving. All reports had been signed off, with the exception of the complaints report which would be completed on 31st October 2023. Alder Hey had met with Inphase and Inphase are due to be on site on 31.10.23, aim that a number of these issues would be resolved. JR advised that the Trust has manual mitigation in place to extract data, however this is not ideal, as the reports are not as sufficiently detailed, and that manual extraction of data is not sustainable in the longer term.

FB acknowledged the considerable progress made to date, whilst noting the manual intervention required.

FB welcomed comments and observations from SQAC and sought feedback whether SQAC were satisfied with progress made.

JG sought clarity from JR regarding the level of confidence that issues are going to be resolved. JR described some of the issues that related to the Trust implementation and some fundamental issues with the system. Inphase next iteration is due to be uploaded on 19.10.23, this is being discussed at Governance meeting on the afternoon of 18.10.23.

JG sought clarity from colleagues with regards to whether there had been sufficient communication to teams across the organisation to ensure that teams are aware of the issues and know what actions the Trust is taking to address issues. JR confirmed that there is a weekly meeting with governance leads who relay the information to service leads, with the main frustrations for colleagues regarding compiling reports.

RH stated that within the Division of Surgery, the Division are aware of the issue, and the division understand the issue. The Division of Surgery have a local process in place regarding notifications in terms of risks and updating the risks. RH stated that the issue is causing a delay with regards to some of the risks being reviewed and updated on the system. The Division had established a weekly risk review meeting and inform staff to advise them that their risks are due to be reviewed should they not have received a notification. Division of Surgery had been working closely with Governance Team to ensure that there is a local process in place to receive assurance within the Division of Surgery, which is being well managed.

NA stated that for the end user the system is working as needed, and entering information is not an issue. NA advised that the support and communication is primarily with the divisional and governance teams.

JR stated that the Trust had not seen a decrease in incident reporting, and that the Trust continue to have a really good culture of reporting, with the total risks across the Trust averaging 256/260 which had also not decreased.

PS advised that the Trust had not seen a reduction in medication incident reporting through the transition to Inphase. PS stated that the Trust is seeing an increase in near miss reporting which suggests that the reporting culture remains really strong in terms of incidents and the system is easy to use.

FB alluded to the criticality of the current deadlines which colleagues are working to and requested a further Inphase update to SQAC at the November 2023 meeting.

FB acknowledge the assurance SQAC had received with regards to the reporting culture which remained good, with robust workarounds in place. SQAC **NOTED** the issues regarding aggregate reporting, which is still happening, but not as quickly as colleagues would like.
FB expressed her thanks to colleagues for ongoing contributions to ensuring that the Inphase system becomes embedded across the organisation.

Resolved: SQAC received and **NOTED** the Inphase update. SQAC welcomed an Inphase update report at the November SQAC meeting.

Assurance on Key Risks
23/24/115 *Delivery of Outstanding Care*
Safe

Patient Safety update

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

- Patient Safety Strategy colleagues had applied careful scrutiny to workstreams 1, 6, 8, 10, 17 and 22.
- Safety metrics – workstream 1 – there had been no statistically significant concerning trends to note, pleasing to see the number of incidents raised as no harm or near miss continuing to rise, which is a good indication of improved reporting culture.
- WW advised that at a previous SQAC meeting colleagues had briefly discussed incorporating measures of staff safety culture into the high level metrics and advised that C Talbot and J Pottier would be discussing this issue further at an Executive Team away day scheduled to take place on 19.10.23.
- WW advised that a claims and litigation event had been hosted by C Talbot in September 2023, and from reviewing the feedback the event was well received and highlighted the link between patient safety and fewer claims. Each of the divisions would now have greater insight regarding litigation as they would now receive regular monthly reports on the topic.
- Patient safety training continues to show high levels of level 1 training, although a Business Case for higher levels of training would be circulated imminently to enable specific groups of staff receiving more advanced training if they would like.
- The PSURP and Governance plan had been presented to the Board of Directors on 5.10.23 and the PSIRF policy is due to be submitted to the Board of Directors at 9.11.23 meeting for approval.
- Antimicrobial resistance continues to make progress with four out of the six workstreams due to close over the coming months.
- Patient Safety Strategy welcomed a positive update regarding Unacknowledged Notices workstream which had resulted in an extremely robust and streamlined interface for clinicians.
- WW advised that whilst Patient Safety Strategy colleagues still have ongoing work with regards to re measuring workstream benefits, Patient Safety Strategy had made significant progress in governance resulting in an improvement in the overall rating of the programme from Amber to Green, all required EIA and QIA's had been completed. Risk management is up to date and high level milestones had been identified.
- Achieving the green overall rating is pivotal for the programme, as it allows to a further focus to driving improvement.
- WW stated that at the last SQAC meeting there was a welcomed suggestion to identify ways in which benefits could be realised before workstreams had been closed down, with an example included in the meeting pack relating to medication safety where the teams involved had used data to demonstrate those improvements. Patient Safety Strategy colleagues would continue with this approach and would ensure a comprehensive closure report is discussed prior to determining whether a workstream could be closed.
- Patient Safety Strategy Colleagues are looking forward to the approval of 2 Patient Safety related Business Cases, 1 of which involves the recruitment of 2 trained Patient Safety Investigators and the second Business Case relates to Patient Safety Training.

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

FB referred to the Unacknowledged notices and providing an extremely easy to use clinical interface and sought clarity whether WW had received any systematic feedback from clinicians and requested detail of the evidence base in reaching that conclusion. WW stated that Matt Neame is in the process of collecting this feedback and that this would be shared at November SQAC meeting, however anecdotally this had been well received by clinicians.

JG commended WW on the exemplary report and stated that the report had really evolved over time.

JG alluded to negligence and litigation and referred to whether this should feature for a future discussion at SQAC, as JG is keen to review drivers and the metrics that create litigation, and to review outcome measures.

FB stated that it is interesting to know whether other Trusts had been able to manage very effectively and how far you could go.

FB stated that colleagues could reflect on this outside of the meeting and advised that ES may have some thoughts.

ABA stated that the Patient Safety Strategy Group are really mature now, and serves two functions, and also receives assurance reports regarding the safety agenda and what SQAC receive is the quality improvement part of the meeting.

ABA referred to the Result acknowledgements and advised that they had significantly improved and had been really well received by clinicians, there are some slight adjustments to be made for certain groups and Matt Neame is working extremely hard to make these adjustments in a timely way.

ABA referred to Antimicrobial resistance and more widely regarding the Infection Prevention Control agenda. ABA referenced ICNET software that colleagues would like to purchase, and that a Business Case is being established, this would greatly enable infection control, antimicrobial resistance, antibiotic monitoring for the Trust in an automatic way. ABA sought support from SQAC regarding the Business Case. FB stated that it was a surprise to see that something so fundamental to safety monitoring was going to the Charity, rather than being seen as a core hospital expense, and given the staff time that is being utilised to cleaning up the data etc. FB stated that she would be surprised if the Business Case did not identify really positive savings regarding staff time.
Resolved: FB requested if JG could review this in terms of identifying the best route for submission of Business Case, JG agreed he would follow this up offline.

NA expressed his thanks to the safety teams for ongoing work regarding governance. NA stated that the closure report is really comprehensive and covers all of the elements and describes the benefits in this way.

NA referred to litigation and stated that the Trust would always have a level of litigation and highlighted on the need for improved learning. NA provided an example of a recent litigation claim whereby the Trust had recently paid out £100,000 for a child with a pressure sore underneath the plaster cast, this all centred around that the Trust did not have evidence that the Trust had provided a leaflet. NA advised on the importance of the need for resource or mechanisms to draw out learning, and how the organisation embraces the learning when the relatively rare events happen both at the time and post outcome of the investigation.

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.

23/24/116 ED MH attendance & ED @ its best update report

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

- During the month of September 2023 there had been higher than average daily attendances, this is due to winter and is common across all of the ED's in the country.
- Division do not have a complete report this month due to accessibility issues, following Alder care roll out.
- 78% of patients were treated within 4 hours, this had decreased from August 2023, and still within national standards. The Division had undertaken a deep dive, findings related that this is due to short notice staff sickness mainly within GP stream, and therefore these patients are being seen in the main ED.

FB referred to those mitigations which are due to commence in November 2023 and stated that it is highlighted in the report that it is problematic getting GP cover, FB sought clarity from UD whether there any specific concerns in those actions. UD stated that during discussions with Executive Team colleagues earlier this week, the Division may need to go out and employ directly ourselves -ANP's, with a variety of work undertaken to review.
Resolved: SQAC received and **NOTED** the ED MH attendance & ED @ its best update report.

23/24/117 DIPC Report

BL presented the DIPC Report

- There had been 2 cases of C Difficile in Oncology, 1 case in Quarter 1 and 1 case in Quarter 2, there had been no identified lapses in care in both cases. BL advised that there was no other cases, IPC colleagues had tested other patients in the unit, and there was no other spread, problem is due to the issue that some of these cases are not preventable.

BL stated that the Trust had not formally passed the threshold of blood gram negative infections, however the Trust is likely to have more than the 23 which is the allocation for the Trust. This infection mainly occurs in short gut patients, patients requiring TPN, patients requiring a central line, with multiple episodes on the same patient. IPC team are working extremely closely with the TPN team to understand the use of TPN and how this has led to gram negative infections in the Trust, this is being reported to the Patient Safety Strategy Board. BL envisaged that she would provide further data regarding the use of TPN and how this is linked in our patient population in future SQAC reports.

- Transmission of multi resistant organisms - BL referred to Oncology and that IPC had commenced screening of patients prior to admission for Vancomycin Resistant Enterococci (VRE). IPC team noted that there were eight patients identified between June 2023 – September 2023, and out of these identified that 6 out of the 8 were similar strains, UKSA have since stopped the typing therefore the Trust cannot access information. This prompted discussions with oncology, regarding how these patients can be identified, and isolated from other patients and this had been a common theme, as IPC are working with clinical areas to further improve isolation care.
- During Quarter 2 there was 1 case of healthcare acquired Adenovirus infection and 1 case of HAI Covid 19.
- BL advised on the importance of the Business Case and referred to the proposal to the Charity, which was submitted in 2021, and highlighted the importance of the need for the data.

KB stated that the DIPC report had changed significantly containing further information, KB stated that it is useful to see the Risks in Section 6 and that there are a lot of Risks at 12. KB stated that she had struggled to extract the key points and to understand the impact on whether issues were really serious or not so serious.

FB echoed KB comments and stated that the conclusions were very factual. FB stated it would be helpful to think about the summary and the purpose of the report, and whether there are just 2 or 3 highlights contained within the summary which would be helpful, and to reflect information within the body of the DIPC report. BL stated that colleagues would work on this for future reports.
FB referred to issues regarding providing isolation bays for day case patients, and whether progress is being made on this.

LB stated that progress is being made, LB advised that there is a meeting scheduled on the afternoon of 19.10.23 with all the clinical areas who have a problem, colleagues are trying to have a unified solution. BL stated that curtains in the Trust are a problem, they are out of expiry life, they are problematic for the domestics and they delay the flow of patients. A Business Case had been prepared and would be submitted, which is needed to provide the care for the patients that need it, it is a particular problem in areas such as dialysis and oncology which have open areas. AB stated that if there is a proposal to forward this to AB, with the aim of reaching a decision on the new equipment or arrangement.

Resolved: BL to forward proposal to AB following meeting on 19.10.23.

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

23/24/118 Sepsis update

DP presented the Sepsis update

- DP advised that Sepsis Dashboard, and ED/Inpatient working – Harmonisation of data collection and analysis (with limitations) and cross cover arrangements is currently on hold with the changes of Meditech and Expanse reporting.
- Inpatient Antibiotic administration < 60 min for inpatients – during the last year this had been above 90% on wards.
- Inpatient Antibiotic administration <90 min target used as a secondary target – no figures could be provided on this currently as DP is unable to obtain this within the Integrated report.
- ED Antibiotic administration < 60 mins antibiotic administration for Quarter 2 this is the first quarter that the Trust is above the 90% target – (90.5%), with caveat regarding the difficulty of reporting and recording of data in ED that contribute to the figures.

JGr presented update on Sepsis deep dive

JGr advised that the Trust usually see a decrease during the summer as the attendance figures decrease, and the Trust have less sepsis cases. There were 51 cases in June 2023, 14 cases where antibiotics were given more than 60 minutes after a sepsis diagnosis. On review of the data all of the antibiotics were administered within 2 hours, which is unusual as there are usually cases that sometimes take longer than this. Of the 14 cases, 3 received antibiotics just over timeframe, 1 was a difficult case, and 6 issues with IV access. JG referred to 1 case which child had a central line, child was extremely well, issue as colleagues could not get the blood culture out of line, and this took time to get blood out of line, prior to commencing antibiotics and sourcing specialist advice regarding choice of antibiotics.

JGr stated that in future reports the Resus cases would be included as these are the patients that are defined as the sickest in the department. There were 3 resus patients, 1 received antibiotics before the patient had been booked in, 1 patient was within 8 minutes and the other was within 32 minutes, which was a fibral convulsion, conclusion was that it was a typical seizure and decision was made thereafter, this entailed clear decisions making.

JGr stated that all antibiotics were provided within 2 hours, with logical decision making.

FB sought clarity regarding where the broader discussions are taking place to ensure oversight and thinking on broader national/international good practice context.

DP stated that the 60 minute target is a useful target, originally from CQUIN many years ago and was then withdrawn, DP stated that the target is not based on data, the data supports a 3 hour window when colleagues can see clear harm more rapidly at this point. DP stated that the 60 minute target is a useful target to indicate that clinicians are doing something rapidly, and that in most cases colleagues should be able to administer antibiotics within 1 hour of concern that this is sepsis. DP stated it is a useful figure but needed to be considered in context.

KB stated that when she joined the Trust in 2018 colleagues were concerned regarding sepsis, and the graph within the report shows a definite step stage around 2020. KB stated that SQAC had seen a number of Sepsis quarterly reports and that she felt much more assured as a NED regarding visibility of issues and recognised that a small number of cases result in an erratic line, however at a higher review level.

KB stated that JGr deep dive is also assuring, and that JGr had described very well the decision making process being a very proactive process.

Resolved: SQAC welcomed an update at the next meeting regarding whether the reports and data which is currently missing due to Expanse is resolved.

Resolved: SQAC received and **NOTED** the Sepsis update and welcomed an update at November 2023 meeting with regards to the reports and data which is currently missing from Sepsis report due to Expanse issues had been resolved.

Caring
Effective

23/24/119 Drugs & Therapeutics Committee quarterly report

PS presented the Drugs & Therapeutics Committee Quarterly Report

- No issues to highlight regarding any concerns in terms of safety and Drugs & Therapeutics
- PS is continuing to focus on expenditure presented to SDG
- PS referred to the new Drugs & Therapeutic Committee Structure, PS is obtaining Executive approval separately, once approval is provided, PS would then formally start to think about what the committee would look like.
- PS advised that he had been supporting the Patient Safety Board regarding all aspects of medication safety.
- Parental Nutrition errors identified as Patient Safety Incident Reporting Framework (PSIRF) project for the Trust with involvement from SA Gill and the Safety Team.
- A Non-Medical Prescribing Committee had been developed to oversee the governance arrangements for the management and approval of Non Medical Prescribers within the Trust. PS advised that the Governance is much improved.
- PS stated that he had overlooked the request regarding deep dive report which was highlighted in July 2023 and sought clarity whether it would be beneficial to share the report undertaken for October 2023 Patient Safety Strategy Board which highlights the work undertaken regarding incidents, with a deep dive relating to harm, or whether this should be submitted at November SQAC. FB stated that given that the report is being presented to Patient Safety Strategy that there is no need to duplicate work. FB stated that SQAC wanted to know that there was a follow up process in place, and with the new structure in place that the follow up does not need to be through SQAC. PS would liaise offline with ABA & NA to ascertain whether any further update is required at future SQAC meetings.

FB thanked PS for informative update and welcomed the update regarding the proposed structure and the outline of the roles of the different groups and how this is being shaped, FB stated that it was also useful to see how the risks are set out as set out in the report.

Resolved: SQAC received and **NOTED** the Drugs & Therapeutics quarterly report

23/24/120 Mental Health Act 1983 (MHA) monitoring visit

LC presented the Mental Health Act 1983 (MHA) monitoring visit report.
LC advised that as part of the annual requirements Sunflower House had an unannounced CQC inspection for the use of its Mental Health Act. CQC spoke to one child who was detained under the Mental Health Act, CQC undertook a tour of Sunflower House and there were no issues required in relation to use of Mental Health Act at Sunflower House
FB expressed congratulations to LC and to the team, ES echoed FB comments.

Resolved: SQAC received and **NOTED** the Mental Health Act 1983 (MHA) monitoring visit.

23/24/121 Board Assurance Framework

ES presented the Board Assurance Framework
Colleagues are continuing to ensure all of the updates are completed, with the scores and controls being reviewed. There is ongoing work taking place to refresh the entire document, including a very intense and critical review regarding controls and reviewing any gaps in assurance.
Following the last Trust Board Discussion LC is required to review how ADHD features in Risk 1.4 or whether this requires a separate risk.
Medication issue continue to be a risk nationally and would continue for some time, this would need to be included. LC advised that this is on the Divisional Risk Register at a high scoring risk, with a whole action plan in place to mitigate.

ES stated that JP had been updating colleagues on the Daily safety briefing meetings, therefore there is also general awareness across the organisation on the impact.
Resolved FB highlighted the importance of ensuring the medication risk is properly represented as a risk and the offline discussion required, ES confirmed this would be discussed offline.

23/24/122 Quarter 1 PALS & Complaints Quarterly Report

NA presented the PALS & Complaints Quarterly Report
NA expressed his apologies to SQAC for presenting Quarter 1 PALS & Complaints Report out of synch as the report had been presented to the previous Trust Board Meeting, as the data was not available for October 2023 SQAC meeting.

NA advised that the report does not contain the usual level of learning due to the ongoing issues regarding reporting from the system. NA referred to the ongoing work of Kelly Black, Surgery Division, last month, Surgery had changed process of formal complaints, and colleagues have had a conversation with each complainant as the complaint had been received, this had resulted in the four complaints received in the last quarter being withdrawn and being managed in a rapid process. NA stated that it may be worth other divisions considering whether this would work for other divisional complaints. NA advised that feedback from parents is that this was well received and resulted in a prompt resolution for those families.

NA advised that the variability in performance related to a lower reduction of complaints, with a number of complaints which had been very complex which required an extension to timeframe, parents had been fully updated.

KB referred to the timing of the report given that it is a June report being received in October and envisaged that the data for September is not available at this point, and queried whether it would have been better moving this report to next month.
NA expressed apologies and stated that in Quarter 1 was when the Trust changed from Ulysses to Inphase, and that the report should have been available for the August 2023. NA stated that future PALS & Complaints reports should be on trajectory for the remainder of the year. NA advised that he and colleagues had hoped that the reporting issues would have been resolved earlier, this would be addressed in the future to ensure timeliness of reporting.

Resolved: SQAC received and **NOTED** the Quarter 1 PALS & Complaints Quarterly Report

23/24/123 Patient & Family Feedback Quarterly Report

NA presented the Patient & Family Feedback Quarterly Report
Team had worked hard to condense the report, with further work to do with the Patient Experience Group to mirror the same process used for patient safety and clinical effectiveness. NA stated that he is really proud that the parent forum had restarted, both in a way to consult with parents and to receive feedback from them to help shape the work of patient experience under the traditional model as the Trust moves forward. Report would continue to be shaped as the year progresses and through into next year regarding the new experience section of the Patient strategy.

Further work is required with regards to the Friends and Family Test, although there had been some improvements, the work required regarding response numbers.

FB referred to quality and building on ways to receive feedback from Friends and Families and when families have made suggestions and provided feedback with some thought on how the Trust engage, and also to ensure that families know that they had been heard and things they raised had changed.
NA referred to the formal complaints route and stated that the Trust now include a set of actions in responses, with positive feedback from parents in this regard.
JR stated that she is keen to receive details regarding the Patient Forum, NA advised that P Brown would link in with JR to provide further detail.

Resolved: SQAC received and **NOTED** the Patient and Family Feedback Quarterly Report.

23/24/124 Divisional Update and Deep Dive regarding Outstanding NICE Compliance

Division of Surgery - RH provided Divisional update:

- Key challenge within the division related to waiting time for follow up patients, together with the lost to follow up patients, there is a clear process going forward to manage any harms.
- Incidents, the division had seen consistent number of incidents.
- Division had 2 Catastrophic harms - one which related to a neonatal sepsis death, and the other death related to a child who sadly had a cardiac arrest following an extensive craniofacial surgery – both deaths had been STEIS reported, and are at various stages of investigation, both are on trajectory to report within timeframes, both families have family liaison officers assigned who are linking really closely with those families to ensure that they are part of the investigations. RH advised that the Craniofacial patient had requested to be interviewed as part of experience to provide reflections, division would facilitate this.
- Sepsis – division had experienced difficulty as the dashboard reporting had not come back online since the implementation of Expanse, the division continue to work through the daily sepsis reviews which is the divisions standard. There had been 7 cases, 5 of which were within the 60 minutes and 2 were not, those individual actions are being worked through. The division are now reviewing how they report those actions as a collective to enable review of any themes into the Divisional Governance meeting, to enable review of noncompliance.
- RH alluded to the good work regarding complaints, with 5 formal complaints in September 2023, 100% compliance in PALS which is a significant improvement in complaints management. RH acknowledgement credit to K Black for her ongoing support which had resulted in significant improvement with regards to complaints.

RH provided update on Deep Dive regarding line infections that had occurred from September 2022 – September 2023.

RH advised that the line data was extracted from the IPR report and cross referenced with the Hospital Acquired Infection spreadsheet this is reviewed on a monthly basis through challenge boards in terms of clinical departments, there is more work to do to ensure an enhanced robust process and in widening surveillance, there is a really good surveillance team who work on surgical site surveillance, RH queried whether the division could replicate this and survey all lines more closely to ensure richer data.

RH stated that there is also an issue regarding the per 1,000 days and stated that there is a mechanism in Expanse to do this and this needed to be initiated. There is a review process within the Division of Surgery.

RH reflected on the good practice in PICU reporting per 1,000 lines and had been reviewing the CLABSIS in a really focussed way for a significant period of time, which forms part of the monthly governance review.

FB stated that she is inferring from the report that there is some assurance in the process in surgery and also partly a request for help from those colleagues who can help getting these reports to ensure surveillance is in better shape, FB requested colleagues to think about what is the best way forward.

KB requested that were RH updates on risk for RH to be guided by the Community Report regarding the additional information provided regarding the risk.

Community & MH – JP provided Divisional update:

- Division noted that there were a significant number of open incidents within Development Paediatrics, there is an Action Plan in place to address issues. This links also with the nonclinical moderate incidents relating to a member of staff who had tripped and fallen around Catkin and Sunflower Building, unfortunately the staff member had to go to ED and had been off work for some time, this had been raised with the Facilities team and had been included for escalation. This remains a challenge which requires a solution.
- Issue of logging of actions on Inphase had been resolved, the division still have a number of delayed inputting of actions onto Inphase, with work ongoing to address.

- Sepsis training, the division are continuing to increase compliance.
- A new risk had been added regarding the shortage of ADHD medications, currently standing at 12, there are daily escalation meetings to manage this, envisaged to continue until at the least December and possibly until April 2024, division are working with Pharmacy colleagues to manage this.
- Inphase review dates-although showing a high number of risks that had not been reviewed, division provided assurance that 40% had been reviewed and that this was a glitch with Inphase with the next review date on Inphase not saving, this has been escalated and is being managed in regular meetings.

NP alluded to the table within the report regarding incidents and the data for this financial year and sought clarity whether this is an improving trend or static, and use of run charts to determine whether it is an improving trajectory or whether progress is static over comparable years. NA stated that as the Trust move forward the Trust would definitely want to move towards using a run chart model and this would evolve over time.

JG alluded to the sense of scale of demand on the ASD services and the ability to ensure families are being well communicated and the scale of those families waiting, and whether there were more administration risks. JG stated that LC was going to review this and sought clarity whether the division are coping with this and requested a sense of assurance from LC.

FB sought clarity whether colleagues have information regarding how many children who start on the waiting list, and how many children are treated as opposing to giving a diagnosis that they can take back to get adjustments in other areas of their life.

LC stated that for both ASD and ADHD they are assessment and diagnostic pathways, and stated that the Trust is not commissioned to provide information before or after, however we do this in partnership with 3rd sector organisations who then support children and young people and families. LC stated that this should be an end to end pathway in partnership with Local Authorities.

LC referred to queries regarding complaints and stated that the division could always do more, LC would follow up on the outcome following the deep dive with colleagues.

JP referred to complaints and stated that the platform is a new addition and part of the process is that families have control and can access.

JG stated that it is about raising the awareness partly - the inevitability of scale and demand and the impact on admin and scheduling services and keeping families updated. JG requested update from LC on the Deep Dive. LC agreed to follow this up with her team.

Resolved: LC to liaise with her team to receive an update on Deep Dive.

Medicine – JGu provided Divisional update:
JGu presented Divisional update

- Division have ongoing challenges regarding winter pressures, with increased ED attendances and strategies are in place to address winter pressures.
- Incidents are static since the implementation of Inphase.
- There had been no moderate harm or above within the division, division had 0 STEIS reportable incidents.
- Sepsis - 100% compliance within inpatients of the Medical Division, this had been difficult to extract this data, colleagues are hopeful of the Sepsis dashboard returning soon.
- Division had 0 pressure sores.
- Complaints - division have a couple of really complex complaints open with involvement with Hill Dickinson solicitors.
- PALS – 96%
- Friends and Families test responses had deceased in month; the division had implemented a monthly reminder for Ward Managers with the aim of increasing responses with comments/rather than yes/no responses to ensure improved data.

- Risks are static, there are processes in place to review risks and review any new risks in the Rapid Review weekly meetings.

Resolved: KB requested the division to review the data within the incidents table, as there appeared to be 57 missing this month, there are 204 total reported, however the breakdown by category does not add up to 204. JG and Medicine colleagues to review for future reporting.
Resolved: FB requested Medicine & Surgery Divisions to raise the Sepsis Mandatory Training Compliance issue within the relative subdivisions in order to improve compliance.

JG presented Deep Dive regarding line infections that have occurred from September 2022-September 2023

- JG alluded to those areas of really good practice in 4B & 4C both of which had limited line infections.
- Ongoing work had progressed on Ward3C, five of the infections reported on 3C related to the same patient, with extensive work undertaken with the wider MDT, there had not been any further incidents. Ongoing work had taken place to improve education, and the IV team completing ANTT assessment, IPC team had been involved in increasing the amount of hand hygiene.
- Similar with Ward 3B there training had been increase for ANTT, lots of additional ward entrance hand sanitisers and bed cleaning charts, with a definite improvement in both areas.
- The division had previously never recorded CLABSI rates per 1,000 line days, and moving forward working with AVAD team and as a division colleagues would work closely with Surgery Division to extract information from within Expanse.

FB stated that it is a general piece of work to move a number of indicators to the per 1,000 bed days standard and there would be a number of issues regarding the shift.
NA confirmed this would be the case for a number of indicators.

Research Division
LR presented the Research Divisional update:-

- LR alluded to the division supporting wellbeing for staff which is having a positive impact on service, with less disruption to patients and a positive culture to quality and safety.
- Division has an overview on incidents regarding muscle biopsies since implementation of the new Standard Operating Procedure, with good catches/near misses, currently reviewing and working closely with the Surgery Division.
- Significant challenge is regarding access to research and the capacity regarding pathology support, as Research fund a post in the laboratories and there is a current gap, post had been recruited to however the postholder would not commence in post until April 2024 which is likely to have a significant impact on studies which the division can offer, D Hawcutt is working with the laboratory leads, to ensure that time critical studies are progressed, this does mean that the division have a list of nonpriority studies that cannot proceed with at present.
- Sepsis training - division are having the same issues regarding ESR and that although reporting 100% from review of Research records there are a number of nursing staff missing, division are working with ESR and Sepsis team to correct ESR records.

FB welcomed the progress in terms of staffing.

JG referred to the format of the Divisional updates and stated that the format really helps in drawing out key issues.

JG referred to talking at aggregate level whether corporate or divisional level and challenges regarding insight or risks that may be held at team level, and whether the Trust need to be bolder and going further regarding discussions about these risks/where they may sit. JG alluded to whether the committee could come back to this in the future as this approach evolves in the future.

FB stated that part of the thinking regarding not leading on the data but leading on the highlights and challenges, and for SQAC it is knowing about that the discussions are taking place at Risk and Governance meetings and that maybe a further refinement in the reports to ensure clarity that sometimes a large amount of progress in one small area could be the highlight or challenge and

encouraging people to share discussions they are having with teams. FB stated that this is a committee that welcomes hearing localised challenges. JG stated that he felt this is extremely helpful. FB expressed her thanks to Divisions for Divisional updates and for the Deep Dive updates.

Resolved SQAC received and **NOTED** the Divisional updates and the Deep Dive regarding the line infections that had occurred from September 2022 – September 2023.

23/23/125 *Well Led*
Responsive

Transition Report
JP presented the Transition Report

- Reduction in >18 outpatients – 2594 outpatients aged 18+ were seen in July 2023. Data cleansing is required, as some of these numbers included adults who were tested in the garage, or parents who were tested for genetic testing.
- JP advised on assurance month on month decrease since July 2023.
- Following review of the data JP discovered a clinical code for transition appointment, across 12 months 1174 had attended a clinic code entitled transition. JP stated that at present not all staff use this code. JP advised that an audit would be undertaken to establish who is using the code, the audit would also serve as a secondary gain as one of the CPOD standards is about additional time being given to transition clinic appointments, from the audit responses this will aid answering the CPOD standards question regarding allocating additional time of transition appointments.
- Standards – the NICE guidance regarding Healthcare transition training advised to be mandatory - the division had a useful meeting with the Academy and colleagues, and rather than making a mandatory training model, the aim is to establish a focussed and targeted approach towards people such as nurse specialists, matrons, Heads of Nursing at medical induction and student nurse induction, aim is also to add as a competency for those staff requiring this, which would be added and would flag when the competency required refreshing.
- JP advised that there are no issues to escalate, and that colleagues are working closely with Peter White and Business Intelligence colleagues.

FB stated that she found the report extremely interesting and thanked JP for ongoing support.
KB echoed FB comments, KB stated that she felt assured that the issue is being reviewed methodically and acknowledged the longevity.

NA thanked FB & KB for comments and advised on assurance that the whole group are working to improve the process to ensure quality transition for children and young people. NA expressed his thanks to JP for ongoing work.
Resolved: SQAC received, **NOTED** the Transition Report

23/24/126 Any other business

23/24/127 Review the key assurances and highlights to report to the Board.

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

- SQAC received the DIPC report, SQAC highlighted issues for future DIPC reports to assist with the navigation of the DIPC report and queried whether progress was being made to provide appropriate isolation for day-care patients with infections.
- SQAC received the Sepsis update which included an ED Sepsis Deep, SQAC noted the progress being made with regards to Sepsis, however further improvements are required regarding Sepsis mandatory training. Divisions were requested to focus on improved Sepsis mandatory training compliance. SQAC noted that there had been 1 sepsis death. SQAC noted the push towards implementation of Martha's rule. SQAC noted that the meditech/expanse implementation had delayed progress in addressing a number of sepsis reporting improvements
- SQAC welcomed the Drugs & Therapeutics Committee Quarterly Report and acknowledged the real sense of progress made in terms of establishing the Committee and the Drugs & Therapeutics Committee structure which is emerging.
- SQAC were delighted to receive the very positive report of the Mental Health Act 1983 (MHA) Monitoring visit following CQC visit to Sunflower House.
- SQAC received the belated Complaints, PALS and Compliments report which had previously been shared at the Board of Directors meeting.
- SQAC received the Patient and Family Feedback Quarterly report. SQAC noted expanse issues impacting on the content of the report.
- SQAC received Divisional updates which also included a deep dive regarding line infections that had occurred from September 2022 – September 2023. FB thanked colleagues for deep dive line infections.
  - Community and Mental Health colleagues drew attention to work undertaken to address the number of open incidents, and risks being pro-actively managed with Pharmacy regarding ADHD medication availability. Discussion took place on the complaints arising from access delays to ADHD and AHD Assessment and Diagnostic service, and steps taken to keep patients and carers informed of their situation.
  - Research division highlighted improved staffing position and focus on sepsis training.
  - Surgery highlighted successful work with NHS England on a pilot study on ear health and hearing screening in residential schools, pointed to use of a patient input relating to a particular incident to highlight how the new PSIRF approach is being adopted.
  - Medicine identified a number of challenges arising from growing winter pressures. Two particularly complex complaints are receiving input from legal advisers, so taking some time. The learning and action plans relating to line infections seemed specific and strong and appear to be having a positive impact.
- SQAC received the Transition report and noted the good progress made.

Date and Time of Next Meeting: 15th November at 9.30 -11.30 am via Microsoft teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	**Research/Clinical 3rd MRI Scanner**
Report of:	**Research and Medicine**
Paper Prepared by:	Gemmel Johnston/Emily Kirkpatrick/Jason Taylor

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	This paper request approval to purchase 3rd MRI scanner, funded by NIHR Grant, and appropriate staffing and non pay costs to run and maintain the scanner, with the ambition that this will be funded through increased income (research and NHS).
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:	Capital costs funded by NIHR grant. The ambition is that ongoing costs will be funded by increased income.

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

1. Executive Summary

This agenda item concerns the purchase of a new 3T research/clinical MRI scanner (funded via a NIHR grant) and subsequent running costs of the scanner. The business case attached has been reviewed by IRG (24th Oct 2023), Executive Group (16th Nov 2023) and RABD, and the final version reflects the changes recommended through this process.

All capital costs will be covered by the NIHR grant. Ongoing costs as been drafted to set out the case for the purchase of the MRI, and was presented to the Executive Group on 16th Nov 2023, ahead of presentation at RABD on 27th November, and Board on 7th Dec 2023.

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.

There is a potential cost to the Trust in years one to three (23/24 to 26/27) ranging from £29k to £313k per annum whilst the research portfolio is developed, however, it is possible this cost could be mitigated if spare capacity on the new scanner can be used in alternative ways, for example for adult NHS and research patients or private patient work. A 'stretch' income target has been included in the business case to reflect this.

2. Background and current state

The NIHR invited applications for capital funding (£5K – 5M) from organisations hosting a NIHR Infrastructure award. Alder Hey was eligible to apply on the grounds that we hold a contract with the NIHR for the Clinical Research Facility (CRF). In June 2023 the Trust was awarded funding of £3.3M, which includes provision for a new MRI scanner, and associated building works, and equipment (e.g. -80 Freezer).

The Trust has very limited research MRI capacity, capped at approximately ½ day per week. An increase in research capacity, coupled with a robust strategy to grow research collaboration and partnership, will accelerate the pace and volume of research delivery, expand opportunities for children and young people to participate in clinical research, and enable Alder Hey to become a research imaging hub of excellence for the North of England. We have partnered with the University of Liverpool MRI research team (LIMRIC, Director Professor Graham Kemp) to ensure that children will be included in new MRI research that is academically led, as well as commercial opportunities.

Clinically, this revolutionary imaging technology of the new 3T MRI Scanner resource will significantly increase opportunities for the development and delivery of cutting-edge clinical services, placing Alder Hey well for applications to host centrally commissioned, highly specialist services that require more advanced technology than is available in the region.

The introduction of these new imaging modalities will significantly reduce children's exposure to radiation and address unmet regional demand for imaging.

3. Main body of report

See attached business case

4. Recommendations & proposed next steps

The Board is asked to approve the purchase of the MRI scanner, and associated equipment, funded via the NIHR grant, and approve ongoing costs to allow for running and maintenance of this scanner – noting an annual review of staffing costs will be undertaken to ensure that the MRI is staffed only to the capacity required based on activity.

Alder Hey Children's NHS
NHS Foundation Trust

Research 3rd MRI Business Case

Version 1

Business Case Form

1. Summary Information

Division:	Divisions of Medicine & Clinical Research
Clinical Director:	Urmi Das
Associate COO:	Sian Calderwood, Sarah Leo
Accountant:	Audrey Chindiya/Emily Kirkpatrick
Prepared by:	Gemmell Johnston, Shivaram Avula, Jason Taylor, Jo Blair
Clinical Lead:	Dr Musa Kaleem, Dr Dan Hawcutt
Executive Sponsor:	John Chester
Accountant Authorisation Code:	*Accountant to provide authorisation before submitting*
Date:	17/10/2023/ Updated for RABD 27/11/2023

2. Stakeholder Support

Business cases must be sent to the named Divisional contact if the Division will be affected by the case and approval received prior to business case submission.

Medicine Division	*Sian Calderwood / 17.10.23*
Surgery Division	*n/a*
Community Division	*n/a*
Estates	*Chris Gildea tbc*
Head of IM&T	*Ian Gilbertson tbc*
Head of Contracts & Financial Planning	*Gary Wadeson tbc*

Capital Accountant	*Neil Morris tbc*

3. Approval Stage

Divisional Accountant	Audrey Chindiya/Emily Kirkpatrick
Divisional Board	*SMT for divisional support on 18th Oct)*
Investment Review Group	*Oct 23 – Approved subject to return in 6 months with firmer income forecast*
Operational Delivery Board/Executive	*16th Nov 23*
R&BD / Trust Board	*Confirm approval/date*

Investment Value	Divisional Board	IRG	ODB	R&BD Committee	Trust Board
Up to £50k	✓				
£50k - £100k	Recommend	✓			
£100k - £0.5	Support	Recommend	✓		
£0.5 - £1m	Support	Review	Recommend	✓	
>£1m	Support	Review	Recommend	Recommend	✓

(✓ = Approval point)

Summary of the Case	This case requests Board 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. There is a potential cost to the Trust in years one to three (23/24 to 26/27) ranging from £29k to £313k per annum whilst we develop the research portfolio. However, it is possible this cost could be mitigated if spare capacity on the new scanner can be used in alternative ways, for example for adult NHS and research patients or private patient work. A 'stretch' income target has been included in the business case to reflect this. In order to mitigate the risk around whether this stretch target it is met, gateway reviews will occur annually to determine whether activity justifies the projected uplift in associated staff numbers. As an absolute case of last resort, if activity does not ramp up as hoped for, there would be an opportunity to choose not to replace existing MRI scanners when they come up in the capital replacement programme (in 24/25 and 25/26). This would require the NIHR grant to be returned (and the CDEL in the capital replacement programme would be used to fund the scanner retrospectively). This would obviously be an option of last resort, and would come with reputational and operational risks, but would be a fall back if activity was not as forecasted. Once research activity ramps up it is believed that from 27/28 onwards the MRI will make a contribution to the trust bottom line of circa £0.1m per annum. This investment will enable a significant expansion of the Trust's advanced imaging capabilities and provide key infrastructure and momentum towards delivery of our goal of becoming the children's imaging hub for the north of England. Income is based on forecast activity provided by the Divisions of Medicine (NHS scans) and Clinical Research (research scans) and the average tariff for NHS and research work. The assumption for research activity has been developed following a consultation process with leading MRI researchers, researchers from fields that could benefit from expanding use of the MRI and industry partners. This consultation included reviewing both active trials and trials on the horizon, which has given the Trust reasonable assurance that the increase in MRI capacity will be utilised. For the Division of Medicine, activity is based on the assumption that the Trust will take on paediatric MRI scans from other trusts in the North West. Discussions are in the early stages with Royal Manchester Children's Hospital around this. The capital costs are met fully following a successful bid to the NIHR (£3.3m), this will sit outside of the CDEL (Capital Delegated Limit) limit, and PDC (Public Dividend Capital) funding will be granted to cover these costs. The staffing costs include radiography staff, who will support both research and NHS scans. These staff will also support the clinical expansion of the MRI service, plans for the conversion of some patients from CT service, and will contribute to out of hours work, thereby reducing the demands on existing radiographer staff. Based on predicted activity, the WTE for the new consultant is increased from 24/25 (5 PA) to 26/27 (10 PA). The consultant will be integral to oversight of MRI setup, initial quality assurance, writing grants and developing research collaborations.

Non-pay costs include maintenance of the scanner and equipment after warranty expiration, energy costs, cost of consumables, drugs and contrast, and PACs storage costs. Capital charges (PDC and depreciation) have also been included in the non-pay forecast as required.

In this brief document, we will outline the potential benefits of an increase in MRI capacity for both research and clinical services, the initial investment required from the Trust, and our projections for income generation and financial self-sufficiency within three years.

Background	The NIHR invited applications for capital funding (£5K – 5M) from organisations hosting a NIHR Infrastructure award. Alder Hey was eligible to apply on the grounds that we hold a contract with the NIHR for the Clinical Research Facility (CRF). In June 2023 the Trust was awarded funding of £3.3M, which includes provision for a new MRI scanner, and associated building works, and equipment (e.g. -80 Freezer). The Trust has very limited research MRI capacity, capped at approximately ½ day per week. An increase in research capacity, coupled with a robust strategy to grow research collaboration and partnership, will accelerate the pace and volume of research delivery, expand opportunities for children and young people to participate in clinical research, and enable Alder Hey to become a research imaging hub of excellence for the North of England. We have partnered with the University of Liverpool MRI research team (LIMRIC, Director Professor Graham Kemp) to ensure that children will be included in new MRI research that is academically led, as well as commercial opportunities. Clinically, this revolutionary imaging technology of the new 3T MRI Scanner resource will significantly increase opportunities for the development and delivery of cutting-edge clinical services, placing Alder Hey well for applications to host centrally commissioned, highly specialist services that require more advanced technology than is available in the region. The introduction of these new imaging modalities will significantly reduce children's exposure to radiation and address unmet regional demand for imaging. When the 'new' Alder Hey Children's Hospital was planned, it was recognised that the need for advanced imaging would increase in the coming years, requiring expansion in MRI capacity. A room was built that meets the specifications required for accommodating an MRI scanner, costing approximately £500,000 capital costs to ensure appropriate infrastructure was in place e.g. Faraday cages. This facility remains available but is currently used as a changing area.

Strategic Context / Corporate Objectives	**NHS opportunities** Advances in imaging technology such as multivoxel spectroscopy, functional MRI, perfusion imaging including arterial spin labelling and diffusion tractography, improve the quality of image analysis and enhance diagnostic accuracy, prognostication and treatment planning, resulting in more targeted interventions with better outcomes and fewer side effects. Cutting edge interventions are also evolving at a rapid pace, for example Laser Interstitial Thermal Therapy (LITT), laser ablation of epileptic foci for children with intractable epilepsy. It is anticipated that this technology will also be used for the treatment of brain tumours in the future. If the Trust is to exploit these new opportunities, and to be well placed to compete for nationally commissioned services for rare and complex disease, an increase in imaging capacity is essential. There is no current backlog of MRI cases for the Trust. However it is anticipated that changes in clinical practice are likely to further drive demand for MRI as the Trust adopts non-radiating imaging techniques that are already standard of care in other children's hospitals, for example a move from nuclear medicine isotope scans to MRI for children with urological disorders. At Alder Hey, approximately 300 head CT scans a year are performed in children with hydrocephalus. An expansion in MRI capacity would eliminate the need for CT and eliminate cranial irradiation during imaging. A study published in January 2023 reported a radiation dose dependent increased risk of brain tumour after head CT in childhood. The income target for NHS scans is based on the assumption that other trusts within the North West will utilise the new scanner in order to address their own backlog. Whilst this is not a current requirement for other trusts in the ICB, Manchester have flagged a potential requirement, and conversations are currently ongoing in this regard. At Alder Hey we have internationally respected experts who are developing new MRI protocols to enhance patient experience and imaging utility. Alder Hey already offers highly specialised MRI to children in the North West of England, with a particular focus on brain tumours, epilepsy and congenital heart disease. We anticipate increasing demand for these services as our capacity, and novel developments advance. **Research opportunities** Research undertaken in the North of England is limited by access to MRI imaging. One half a day per week is protected for research purposes at the Trust. This significantly limits both the number and breadth of studies that can be delivered, and the number of children that can participate. It is the shared ambition of the North West Alliance of NIHR CRFs, and other NIHR Clinical Research Network partners, to deliver a coordinated portfolio of research in diseases that have the greatest impact in the regional population across the life course, from prenatal life, through infancy, childhood and adult life. Research MRI capacity and the associated clinical expertise, located in Alder Hey but available to NIHR partner organisations, would facilitate this coordinated approach while offering increased imaging capacity to all of our research partners. Some illustrative examples of established and evolving areas of research are given below.

Alder Hey has a strong track record in the theme of **Duchenne's Muscular Dystrophy** (DMD), a condition universally fatal by young adult life and for which therapeutic interventions are limited. Imaging protocols for these studies are highly complex and require specialist facilities and staff. Investment in MRI facilities at Alder Hey would enable the development of a Northern imaging hub for DMD research, increasing access to experimental therapies for boys with this universally fatal condition and accelerating the pace and volume of research. The national DMD charity (DMDhub) have worked with us in creating this application and are very supportive of this model.

The Wellcome Trust funded study, C-GULL (Children Growing Up in Liverpool), has a strong focus on cognitive development. MRI imaging is central to study protocols, led by Shivaram Avula in collaboration with Prof David Taylor-Robinson, designed to learn more about brain development and environmental factors that influence it. Adequate MRI capacity is essential for this unique opportunity to be exploited fully.

Preservation and optimisation of neurological function is a key theme of the Alder Hey CRF strategy. Brain injury from trauma, tumour, inflammation and infection has a profound impact on individuals, families and society. **The BRAINLIFE partnership** between academic and clinical partners in Liverpool was formed to create a Life Course Connected Bio/Data Repository for Neurology and Mental Health. The partnership will seek funding through the MRC partnership funding programme for £2.2M to establish a shared research resource, with the intention of mapping prospective clinical, neuroimaging (MRI) and socio-demographic information, together with bio sample collection, across the life course of a population presenting with neurological or mental health problems.

We plan to fully exploit the research potential of the MRI by working with academic partners, to support basic research in imaging sciences. **Professor Poptani is Chair of the centre for Preclinical Imaging at the University of Liverpool** and an international expert in advanced MRI. He has developed novel methods of MRI that can be applied to the paediatric population including conductivity imaging, multi-slice spectroscopy, diffusion tensor imaging and quantitative susceptibility mapping. There is an opportunity to apply these techniques in areas such as brain tumours, developmental brain disorders, metabolic brain disorders and traumatic brain injury

We are also actively exploring new research themes including **head trauma and concussion in children** playing football and other sports at an elite level e.g. partnering with Liverpool Academy. Data generated from this programme of research will be generalisable to a wider population of children and young people.

Professor Simon Keller UoL Chair in Neuroimaging and Director of the Brain Research using Advanced Imaging in Neurology (BRAIN) lab UoL. He will be submitting a NIHR professorship application "Understanding and improving health outcomes in epilepsy across the lifecourse" Using MRI and blood biomarkers at both ends of the spectrum – onset through to refractory/surgery in peadiatric and adult population. In addition to a collaboration with University Manchester to seek funding from The Epilepsy Research Institute Doctoral Training Centre (DTC) Grant scheme for capacity building of UK epilepsy research environment, PhD studentships to commence 2024-2026.

Alder Hey Innovation Centre & NIHR Clinical Research Facility

	We anticipate that the supplier of the MRI will enter into a strategic partnership with Alder Hey to be their flagship site in Europe. They are highly likely to offer support for grant applications and opportunities for match funding for PhD studentships. This will have a significant impact on our health technology innovations through our Alder Hey Innovation Centre and NIHR Clinical Research Facility.
Quality and Equality Impact Assessment	***Please see the attached Equality Impact and Assessment form below:***

Risks Mitigated	If we do not increase our MRI capacity, then we will be exposed to the following risks: 1) Inability to fulfill the ambitions of the nascent research strategy 2) Unable to fully explore, and exploit, advanced imaging methods for clinical care and advancing research 3) Failure to move children from radiation-based imaging to MRI protocols, exposing them to ongoing risks (and in many cases, lower quality imaging) 4) Significant reduction in the Trust's aspirations to attract highly specialized services that would require 3T MRI imaging 5) Limited MRI scanner resilience 6) Unable to transfer some capacity from CT scanner to extend equipment lifetime 7) Reputational risk having been awarded the grant

Financial Impact

A summary of the most likely scenario is as follows;

Financial Summary of MRI Scanner	WTE	Year 0 23/24	Year 1 24/25	Year 2 25/26	Year 3 26/27	Year 4 27/28	Year 5 onwards (average)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Funding							
NIHR Grant		657	2,627				
CAMRIN Bid		0	-				
Total Capital Funding		**657**	**2,627**				
Capital Expenditure							
MRI Machine		-	(2,208)				
Staff costs		(15)	(28)				
Equipment & Other Capital costs		(579)	(10)				
Building Works		(63)	(381)				
Total Capital Costs		**(657)**	**(2,627)**				
Total Capital Funding Required		**0**	**0**				
Revenue Expenditure							
Income Receivable		-	344	536	796	1,056	1,057
Revenue Expenditure - Pay	3.50	-	(103)	(168)	(274)	(274)	(274)
Revenue Expenditure - Non Pay		(11)	(286)	(681)	(675)	(670)	(653)
Total Operating Profit/(Loss)	**3.50**	**(11)**	**(44)**	**(313)**	**(153)**	**113**	**130**
Total Revenue Funding Required		**(11)**	**(44)**	**(313)**	**(153)**	**113**	**130**
Budget headroom created by Rev to cap transfer of exisiting medicine staff		**15**	**15**				
Stretch income target		**0**	**29**	**313**	**153**	**0**	**0**
Contribution/(Budget pressure)		**4**	**0**	**0**	**0**	**113**	**130**

Table above shows that based on current (conservative) activity assumptions, with a stretch income target included for years 1-3.

The MRI becoming self-funding by year 4.

The assumptions utilised are as below;

<u>General</u>

Inflation excluded from income and expenditure

Maintenance costs begin in Y2 as Y1 is covered by warranty
Go live date - Aug 2024 = 8 months (MRI installed in July and ready for go live in August)
Scanner used 37.5 hours a week
No weekend or unsociable hours assumed
50 weeks in year
1 hour per scan

Research income

Year 1 and year 2 capacity 30% as assumed time required for training, and feasibility studies to pump prime grant applications, ramping up to 50% in 26/27 and 70% from 27/28 onwards
Non commercial research scans - £550 per scan
Commercial - £750 per scan

Research income only includes MRI income. Assume that all other costs (consumables, reporting, nurses etc) would be covered by individual grant. Costs and income excluded from summary above. Income also excludes capacity fund and overhead income that would come from commercial trials as hard to predict as full income from grant unknown (e.g. for non MRI income)
Removed cost of drugs/contrast as assume would receive higher income tariff for scans with contrast.

NHS income

Assumes no unsociable hours/weekend
NHS work assumed to be coming from ;

a) other trusts in region (e.g. Manchester). This assumption is being tested.

b) Transfer of x-ray scans to MRI for for better patient outcome (Without reduction in xray income, as bundled in outpatient tariff - assumed outpatient slots continue to be filled at same level)

Based on average of NHS tariff, with equal split for OP imaging and day-case/elective

Pay

Assume consultant is needed to manage/direct MRI strategy, and build links in order to generate research activity (5 PA in year 1, 6 PA in year 2, 10 PA from year 3)
1 Band 6 radiographer assumed for years 1 and 2, increasing to 2 in year 3
0.5 Band 8a medical physist required from year 1 onwards.
Assumes booking and scheduling and MRI admin covered by existing CRD Band 3 resource

Assumes in addition to pay forecast included above, the following resources within CRD existing budget will be utilised to support the MRI strategy;

Existing CRD budget	Band	WTE	Annual salary	£
Senior Programme Manager	Band 8B	0.40	86,922	34,769
Senior R&I Project Manager	Band 7	0.20	58,707	11,741
Booking & Scheduling Admin / Research Programme Administrator	Band 3	1.00	29,082	29,082
		1.60		**75,592**

Also assumes existing medicine resource will be redirected to facilitate installation of the MRI as per below (these costs will be capitalized if sufficient headroom in capital budget – see below);

Contribution from existing medicine division workforce	Band	WTE	23/24 cost	24/25 cost
Radiology management time	Band 8B	0.20	5,794.80	5,794.80
Radiographer	Band 8a	0.20	4,561.67	4,561.67
Clinical Director	Consultant	0.10	4,777.47	4,777.47
		0.50	**15,134**	**15,134**

Non pay

Equipment costs currently assumed at 10% of total equipment cost. Under review by estates

Maintenance cost based on quote from GE. Includes smart package

Capital

NIHR grant assumed high MRI cost (£2.7m) and lower equipment costs. Business case assumes NIHR will agree to allow reallocation of funding.

Assumes VAT is payable on MRI.

MRI cost based on quote from GE

Building works and equipment costs based on high level estimate. Both under review with estates/SPV.

Medicine staff costs of £15k a year in 23/24 and 24/25 will be capitalized to create headroom in Medicine budget to meet new costs of new staff, if room is available in the capital budget (dependent on final estimates on building works and equipment as per above)

Activity

The above assumptions are based on the following activity predictions;

New activity	24/25 (8 months)	25/26	26/27	27/28 onwards
Research - non comercial/academic	267	400	600	800
Research - commercial	133	200	400	600
Potential NHS - OP Imaging	50	100	100	100
Potential NHS - Daycase/ Elective	50	100	100	100
Total	**500**	**800**	**1,200**	**1,600**
Total new capacity	**1,333**	**2,000**	**2,000**	**2,000**
Total spare capacity	**833**	**1,200**	**800**	**400**

The stretch target would require the following levels of activity (or a mix and match of types of activity below) in order to be met;

	24/25	25/26	26/27
Number of scans needed to fill financial gap at NHS rates (direct access/unbundled image)	131	1432*	700
Number of scans needed to fill financial gap at NHS rates (MRI day case tariff)	32	350	171
Number of scans needed to fill financial gap at Non commercial research rates	52	569	278
Number of scans needed to fill financial gap at Commercial rates	38	417	204

*NB this is over the spare capacity available in 25/26 of 1020.

The stretch income target is likely to be met through a combination of;

- Research activity over and above prudent estimate
- NHS activity over and above prudent estimate
- Private Patient income – to be explore as part of wider business case on private patients (but recognizing private patient income increase already assumed as part of neonate business case)
- Adult patient income – governance to be explored. Current need in the system is in the regions of 200-400 scans, although not all will be appropriate for Alder Hey to deliver. The feasibility of this could be worked up if this was something the Board were minded to progress.
- CT to MRI switch – to reduce the CT backlog. This would generate marginal additional income due to the tariff difference.

If the spare capacity were utilised, the potential income to be generated could be as follows, depending on usage (nb – Private Patient income likely to be broadly comparable with commercial income rate following initial review of market rates;

Additioanl Income if spare capacity used	24/25 (8 months)	25/26	26/27	27/28 onwards
	£'000	£'000	£'000	£'000
Income if spare capacity utilised at NHS rates	182	262	175	87
Income if spare capacity utilised at Non commercial research rates	458	660	440	220
Income if spare capacity utlised at Commercial rates	625	900	600	300

As this scanner would represent a material increase in research capacity, it is recognised that there is a risk around the ability of the trust to ramp up research activity in the trajectory planned, although noting that it is believed the forecast used is conservative.

The assumption for research activity has been developed following a consultation process with leading MRI researchers, researchers from fields that could benefit from expanding use of the MRI and industry partners. This consultation included a round table discussion (held on 18/10/23) in which lead figures in MRI research in the region discussed the opportunities that were likely to arise in the short to medium term. On this basis it is believed the forecast is conservative. Appendix 2 shows the forecast if research activity was reduced by 50% in year 1. **This would increase the pressure, before stretch income target in year 1 from £29k to £160k**

It should also be noted that the business case assumes that all research income would be in addition to the current research income target within the research budget. It should be noted that CRD are not forecasting to meet their commercial income target in year, and this is being reviewed as part of business planning. Appendix 3 shows the forecast if the first £0.3m of MRI income were required to help CRD meet their existing income target. **This would create an ongoing average pressure of £171k per year from year 5, with the highest pressure falling in year 2 at £613k.**

Activity and Capacity Impact

All activity numbers are estimates at this stage. If activity does not ramp up in the way articulated in the paper, there is an opportunity to review the requirement for a third MRI as part of the capital replacement programme for the existing two scanner (due to be replaced in 25/26 and 26/27). Not replacing an existing scanner would be an option of last resort, as would come with high operational and reputational risks, but the option to review the number of scanners would be there as a back stop if activity does not increase.

Table 3: Summary of new activity assumed in the business case

New activity	24/25 (8 months)	25/26	26/27	27/28 onwards
Research - non comercial/academic	267	400	600	800
Research - commercial	133	200	400	600
Potential NHS - OP Imaging	50	100	100	100
Potential NHS - Daycase/ Elective	50	100	100	100
Total	**500**	**800**	**1,200**	**1,600**
Total new capacity	**1,333**	**2,000**	**2,000**	**2,000**
Total spare capacity	**833**	**1,200**	**800**	**400**

The stretch target would require the following levels of activity (or a mix and match of types of activity below) in order to be met;

	24/25	25/26	26/27
Number of scans needed to fill financial gap at NHS rates (direct access/unbundled image)	131	1432*	700
Number of scans needed to fill financial gap at NHS rates (MRI day case tariff)	32	350	171
Number of scans needed to fill financial gap at Non commercial research rates	52	569	278
Number of scans needed to fill financial gap at Commercial rates	38	417	204

*NB this is over the spare capacity available in 25/26 of 1020.

Workforce

Current Workforce would not be able to staff the 3rd MRI, and henceforth further workforce funding as detailed below is required:

New workforce

Description	Band	24/25 WTE	25/26	26/27 onwards
Consultant Radiologist	Consultant	0.50	0.60	1.00
Medical Physicist	Band 8a	0.50	0.50	0.50
Radiographer	Band 6	1.00	1.00	2.00
Total		**2.00**	**2.10**	**3.50**

24/25 resource to begin in July 24 with July costs being capitalized, and costs going to revenue from August 24.

It is proposed that throughout implementation of the business case staffing is reviewed annually as part of business planning to determine whether it is appropriate to uplift staffing between years based on a more accurate forecast of activity at that point in time.

In addition to the posts above, it should be noted that the following posts will be utilised within the existing budget to support the MRI strategy;

Research

Existing CRD budget	Band	WTE
Senior Programme Manager	Band 8B	0.40
Senior R&I Project Manager	Band 7	0.20
Booking & Scheduling Admin / Research Programme Administrator	Band 3	1.00
		1.60

Medicine – from Dec 23 (assumed business case sign off) until July 24 to facilitate installation of MRI (assumed these costs will be capitalized)

Contribution from existing medicine division workforce	Band	WTE
Radiology management time	Band 8B	0.20
Radiographer	Band 8a	0.20
Clinical Director	Consultant	0.10
		0.50

4.

Impact on Services **This list to be reviewed by divisions.**	**Changing Room facilities** - There will be an impact on changing room facilities, and the department would need to revert back to Covid staffing, this would mean no changing room for staff in the radiology department, and the need for staff to be in Uniform on arrival at work, the other option would be the use of A&E staff room, but this is to small to accommodate both A&E staff as well as there has been an increase of 10% in A& E staffing. The only option would be to move the current plant room at the back of MRI to the current domestic area situated next door the entrance of the 3rd MRI, This would have significant costs associated with this, and a full brief will be given once we know if this is feasible . **ED Hub Escaltion (Hub2)** Currently the recovery room for the 3rd MRI is an escalation area for ED, also called Hub 2, which is used in winter pressures and has already been used several times this month alone. There would be no Place for Escalation of ED, as there is no full mitigation in place until the new build is established in 2025.

5. Milestones for Implementation and Delivery

Highlight timeframe and milestones for implementation, along with any risks which need to be managed to ensure successful benefits delivery

Milestone	Lead	Target Date
Approval of business case by Divisional Board	Sian Calderwood	18 th October 2023 (TBC)
Approval of business case by IRG		24 October 2023
Approval by exec		16nd November 2023
Approval by Board		Dec 2023
Procurement	Via SPVdirect award to Tender November 2023	Dec 2023 - post board
Installation		July 2024
Go live of MRI		August 2024
Annual review to confirm staffing increase		Annually as part of business planning for 25/26, 26/27, 27/28
Review of overall MRI capacity required		As part of capital replacement programme for current two scanners (likely 25/26 and 26/27)

6. Benefits to be achieved

Highlight benefits that will be achieved as a result of support/investment, including current KPI levels and expected targets.

Financial benefits highlighted in finance section. Increase in Research income budget subject to finalization of Research strategy.

The research MRI, and associated research programme, offers Alder Hey an opportunity to be the leading Children's MRI Research Centre in the North of England, and potentially an internationally respected centre of imaging excellence. Patients referred to Alder Hey, and experts in imaging research, will have access to the most advanced MRI imaging technology currently available. We have an opportunity to work with an industry partner, giving our patients the earliest access to the newest and most advanced imaging modalities and generating research income. This will serve to advance the Trust's goal of improving the quality of care for our children and young people.

Clinicians at Alder Hey are known internationally for their leadership in neuroradiology research, and there is untapped potential in evolving themes including cardiology, rheumatology, sports injuries and acute and emergency work. We will offer research active NHS clinicians an opportunity to explore opportunities to develop new programmes of work, and attract established researchers in this field to partner with us. While some of our work will be 'early phase', much will align closely to clinical care with the potential for rapid translation to clinical services and improved patient experience and clinical outcomes. There have been widely publicised developments in the place of Artificial Intelligence (AI) in reading scan images with high levels of accuracy without minimal human intervention. As pressures with specialist human resources continue to increase, there is a significant opportunity to capitalize upon research opportunities in this area. We anticipate that this field of research will now evolve rapidly and we will be well placed to host such programmes of work and benefit from their advances.

We will strengthen our partnership with other NIHR facilities and in doing so, we will help realise the Alder Hey ambitions of excellence in paediatric research (Alder Hey is a partner in the NIHR funded Children's Biomedical Research Catalyst), in parallel with a life course programme of work that address the health needs of the regional population (NIHR CRF Northern Alliance).

APPENDIX 1 – Detailed income and cost breakdown

Detailed Income & Expenditure Impact		Year 0 23/24	Year 1 24/25	Year 2 25/26	Year 3 26/27	Year 4 27/28	Year 5 onwards (average)
		£'000	£'000	£'000	£'000	£'000	£'000
Income							
Research & Commercial Income		0	263	386	646	906	906
NHS Income		0	82	150	150	150	150
Total Income		-	344	536	796	1,056	1,057
Expenditure	WTE	Actual					
Consultant Radiologist	1.00	-	(48)	(86)	(143)	(143)	(143)
Medical Physicist (Band 8a)	0.50	-	(23)	(34)	(34)	(34)	(34)
Radiographer (Band 6)	2.00	-	(32)	(48)	(96)	(96)	(96)
Total Pay Expenditure	3.50	-	(103)	(168)	(274)	(274)	(274)
Maintenance - MRI Scanner & Equipment		-	-	(215)	(220)	(224)	(243)
Outsource scan review (OPCSI)		0	0	0	0	0	0
Consumables & Other Non Pay		-	(45)	(70)	(70)	(70)	(71)
Depreciation		-	(175)	(292)	(292)	(292)	(292)
PDC Dividend		(11)	(66)	(104)	(93)	(83)	(47)
Total Non Pay Costs		(11)	(286)	(681)	(675)	(670)	(653)
Total Revenue Costs		(11)	(388)	(849)	(949)	(944)	(927)
Operating Profit/(Loss)		(11)	(44)	(313)	(153)	113	130
Budget headroom created by Rev to cap transfer of		15	15	0	0	0	0
Stretch income target		0	29	313	153	0	0
Contribution/Budget pressure		4	0	0	0	113	130

Appendix 2 – Detailed income and costing - 50% reduction in income activity in year 1

Detailed Income & Expenditure Impact		Year 0 23/24	Year 1 24/25	Year 2 25/26	Year 3 26/27	Year 4 27/28	Year 5 onwards (average)
		£'000	£'000	£'000	£'000	£'000	£'000
Income							
Research & Commercial Income		-	131	386	646	906	906
NHS Income		-	82	150	150	150	150
Total Income		**0**	**213**	**536**	**796**	**1,056**	**1,056**
Expenditure	**WTE**	**Actual**					
Consultant Radiologist	1.00	-	(48)	(86)	(143)	(143)	(143)
Medical Physicist (Band 8a)	0.50	-	(23)	(34)	(34)	(34)	(34)
Radiographer (Band 6)	2.00	-	(32)	(48)	(96)	(96)	(96)
Total Pay Expenditure	3.80	**0**	**(103)**	**(168)**	**(274)**	**(274)**	**(274)**
Maintenance - MRI Scanner & Equipment		-	-	(215)	(220)	(224)	(243)
Outsource scan review (OPCSI)		-	0	0	-	-	-
Consumables & Other Non Pay		-	(45)	(70)	(70)	(70)	(71)
Depreciation		-	(175)	(292)	(292)	(292)	(292)
PDC Dividend		(11)	(66)	(104)	(93)	(83)	(47)
Total Non Pay Costs		**(11)**	**(286)**	**(681)**	**(675)**	**(670)**	**(653)**
Total Revenue Costs		**(11)**	**(388)**	**(849)**	**(949)**	**(944)**	**(927)**
Operating Profit/(Loss)		**(11)**	**(175)**	**(313)**	**(153)**	**113**	**129**
Budget headroom created by Rev to cap transfer of		**15**	**15**				
Stretch income target		**0**	**160**	**313**	**153**	**0**	**0**
Contribution/Budget pressure		**4**	**(0)**	**0**	**0**	**113**	**129**

Appendix 3 – Cost and income detail – assuming £0.3m of income contributes to existing budget

Detailed Income & Expenditure Impact		Year 0 23/24	Year 1 24/25	Year 2 25/26	Year 3 26/27	Year 4 27/28	Year 5 onwards (average)
		£'000	£'000	£'000	£'000	£'000	£'000
Income							
Research & Commercial Income		0	0	86	346	606	606
NHS Income		0	82	150	150	150	150
Stretch income target							
Total Income		-	**82**	**236**	**496**	**756**	**756**
Expenditure	**WTE**	**Actual**					
Consultant Radiologist	1	0	(48)	(86)	(143)	(143)	(143)
Medical Physicist (Band 8a)	0.5	0	(23)	(34)	(34)	(34)	(34)
Booking and Scheduling (Band 3)	0	0	0	0	0	0	0
Total Pay Expenditure	3.50	-	(103)	(168)	(274)	(274)	(274)
Maintenance - MRI Scanner & Equipment		0	0	(215)	(220)	(224)	(243)
Outsource scan review (OPCSI)		0	0	0	0	0	0
Consumables & Other Non Pay		0	(45)	(70)	(70)	(70)	(71)
Depreciation		0	(175)	(292)	(292)	(292)	(292)
PDC Dividend		(11)	(66)	(104)	(93)	(83)	(47)
Total Non Pay Costs		**(11)**	**(286)**	**(681)**	**(675)**	**(670)**	**(653)**
Total Revenue Costs		**(11)**	**(388)**	**(849)**	**(949)**	**(944)**	**(927)**
Operating Profit/(Loss)		**(11)**	**(306)**	**(613)**	**(453)**	**(187)**	**(171)**
Budget headroom created by Rev to cap transfer of exisiting medicine staff		**15**	**15**				
Stretch income target		**0**	**291**	**613**	**453**	**187**	**171**
Contribution/Budget pressure		**4**	**(0)**	**0**	**0**	**(0)**	**(0)**

Alder Hey Children's NHS Foundation Trust

Research and Innovation Committee

Confirmed Minutes of the meeting held on **Monday the 10th July 2023**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. K. Bell	Business Intelligence Lead	(KB)
	Mr. D. Hawcutt	Clinical Director of Research	(DH)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr. J. Taylor	General Manager, CRD	(JT)
Observing:	Ms. F. Ashcroft	CEO of the Charity	(FA)
Item 23/24/33	Dr. F Marston	Non-Executive Director	(FM)
Apologies:	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Ms. K. Birch	Academy Director	(KB)
	Mr. D. Cole	Senior Project Advisor	(DC)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. L. Rad	Lead Research Nurse	(LR)

23/24/017 Apologies

The Chair noted the apologies that were received.

23/24/18 Declarations of Interest

There were none to declare.

23/24/19 Minutes of the previous Meeting

The minutes from the meeting held on the 18.4.23 were agreed as an accurate record of the meeting.

23/24/20 Matter Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

Action 23/24/05.1: *How Research and Innovation fit into the Vision 2030 Strategy (Streamlining of the Innovation Pipeline - Conduct a spring clean of the pipeline to halt progress on projects that won't fit into the Futures Strategy thus freeing resources to enable the Trust to deliver the strategy from Q1 onwards)* – An update will be provided during the agenda item relating to the Performance Report item. **ACTION CLOSED**

Action 23/24/06.1: *Research Performance 2022/23 and Annual Planning Report 2023/24 (liaise with Kate Warriner to see if lessons learned can be built into the Research Work Programme for research studies)* – Kate Warriner agreed to liaise with Asia Bibi regarding this matter. **ACTION TO REMAIN OPEN**

Action 23/24/09.1: *2022/23 YTD Financial Update and 2023/24 Financial Plan (report to be submitted on the development of a Financial Strategy for R&I that supports the direction of travel)* – This item will be addressed via the agenda. **ACTION CLOSED**

Action 23/24/09.2: *2022/23 YTD Financial Update and 2023/24 Financial Plan (meeting to take place to discuss the development of a new joint vehicle)* – This action has been addressed. **ACTION CLOSED**

Action 23/24/09.3: *2022/23 YTD Financial Update and 2023/24 Financial Plan (provide feedback on the outcome of the 'Benefits and Costs Workshop' during July's meeting)* – An update will be provided during the agenda item relating to the Innovation Strategy Evolution. **ACTION CLOSED**

Action 23/24/10.1: *Grants and Proposals Tracker, Q4 (Look into the query raised by Fiona Ashcroft relating to the Jules Thorn bid for funding for Innovation in Improvement in Health)* – This action has been addressed. **ACTION CLOSED**

Action 23/24/11.1: *Strategic Outline Case (Meeting to take place with Louise Shepherd, John Grinnell and Emma Hughes to discuss the pitch of the Strategic Outline Case for a national Children's Innovation Centre)* – This action has been addressed. **ACTION CLOSED**

Action 23/24/11.2: *Strategic Outline Case (Meeting to take place with Louise Shepherd, John Grinnell and Emma Hughes to discuss the work that is required to create a compelling economic case)* – This action has been addressed. **ACTION CLOSED**

Action 23/24/11.3: *Strategic Outline Case (submit a specific outline case proposal for a national Children's Innovation Centre detailing objectives, impact and outcomes) – Submit a specific outline case proposal for a national Children's Innovation Centre detailing objectives, impact and outcomes* – This item has been included on July's agenda. **ACTION CLOSED**

Action 23/24/12.1: *Commercial Partnerships Agreements and Business Development Prospects (meeting to take place with Execs, David Cole and Emma Hughes to discuss an approach for a marketing and commercial offer for the sale of products)* – A meeting with the Execs took place w/c 3.7.23. Further work is required in terms of the marketing aspect but an update will be provided during agenda item relating to commercial activity in terms of what can be expected in wave 1. **ACTION CLOSED**

23/24/21 Research Strategy Outline

The Committee was provided with an outline of the Trust's draft Research Strategy. It was reported that work is taking place with a number of groups to ensure the strategy is meaningful, and attention was drawn to the importance of aligning it with the Trust's Vision 2030 Strategy, the University of Liverpool (UoL) strategy and broader research strategies across the patch. There are a number of areas that need to be included in the strategy, for example; imaging, and the Trust also needs to hone in on areas it wishes to drive forward to agree **1.** The level of maturity of existing developments. **2.** The rationale for future developments and improvements. The Committee was advised that the strategy is progressing and the goal for October is to have a robust Research Strategy that has been fully socialised.

A discussion took place about the importance of aligning the language and ambition of Vision 2030 with the strategy in terms of having further detail and top line research ambitions that will stretch the organisation. It was also felt that it is imperative that the strategy allows the Trust to make choices so it can genuinely be different.

Attention was drawn to the work that the Histopathology department is conducting on the examination of placentas, which has increased immensely. It was pointed out that a number of years ago there was going to be a large amount of research carried out around pregnancy and it was queried as to whether this is something that is going to be progressed. The Committee was advised of the links that are being made with the new Director of Research at the Liverpool Women's Hospital and it was agreed to link in with the Histopathology department regarding the placental work that is taking place.

23/24/21.1 Action: DH

The Chair thanked the Director of Research, Dan Hawcutt for the update and the work that is taking place to produce the strategy that is scheduled to be submitted to the Committee in October 2023.

23/24/21.2 Action: DH

Resolved:
The Research and Innovation Committee noted the update on the Research Strategy.

23/24/22 Innovation Strategy Evolution

A presentation was submitted to the Committee on the evolution of innovation at the Trust. A number of slides were shared that provided information on the following areas:

- Innovation evolution (pre *2017 through to 2023/24 and evolving into Futures*).

- Organisational model.
- Current Innovation Portfolio.
- Portfolio evolution for Futures.
- Financial Strategy.
- Innovation commercial models into Futures ventures.
- Next steps.

A discussion ensued and points were raised about 1. The opportunities for the Research and Innovation Strategies to come together to address some of the themes set out in the presentation, 2. Ensuring the Trust is challenging itself in terms of its AI ambitions, 3. The importance of quantifying the impact of the current innovation portfolio and 4. The importance of conducting a piece of work on greater commercial opportunities.

Feedback on the content of the presentation was provided by Committee members and attention was drawn to the importance of linking the recommendations of the Consultancy Project report with this work, developing a Partnership Strategy and having additional business development staff to enable the Trust to engage with partners and bring in new investment.

The Chair referred to the comments that were made about additional resources required for AI/business development and felt that it would be beneficial for the Committee to receive an investment case that provides detail on what needs to be done for innovation to enable the Trust to progress to the next stage. Following a discussion it was agreed to submit a report that sets out the joint work of Research and Innovation (R&I) and how both departments are being supported to deliver the strategy that is to be agreed.

23/24/22.1 Action: JC/EH

The Chair queried the progress with cost benefits and asked as to whether an analysis is ready to be submitted yet. It was reported that work has commenced with key projects/RPA and the Finance team are going to look at some of these projects from a benefits perspective to ascertain the linkage with each of the Divisions/Departments. The Chair highlighted the importance of building this framework into each project as part of the Trust's business development process going forward.

It was felt that a broader discussion needs to place about creating an environment for trial and error especially in relation to the Trust's pioneering ambitions/Futures, and the appropriate time for raising a business case when exploring innovation. It was agreed that further work will need to take place in line with the Consultancy Project report to approve a decision making process for the input of resources and time for the projects that the Trust wishes to progress.

John Kelly drew attention to the importance of having a single Trust wide process for tracking benefits and offered his support with this area of work. It was reported that the Transformation team and the Divisions are attending a workshop w/c 17.7.23 that will lay out the principles for capturing benefits and the processes that need to be implemented at the start of each project. The Committee was advised that work is being undertaken to develop a Trust wide investment framework that will help provide an understanding of the reasons for choosing to invest in particular projects. Once complete, innovation will be able to use this framework too.

For noting

It was agreed that innovation should be involved in models of care workshops.

Resolved:
The Research and Innovation Committee noted the presentation on the Innovation Strategy evolution.

23/24/23 Innovation Financial Sustainability – Strategic Outline Case and Investment Zone Update

The Committee received an update on the development of the Strategic Outline Case (SOC) for investment and the recent investment zone funding opportunity within the Liverpool City Region (LCR) Combined Authority.

It was reported that groundwork is taking place in association with the LCR Combined Authority to establish what the project will look like in line with the available funding. This will also provide an opportunity for the Trust to address the challenges raised during today's meeting in relation to the Trust's strategic partnership approach, creating commercial revenue streams, and looking at ways to bring in new health tech to the market. During August and September work will take place to develop a business case ahead of the submission deadline.

The Chair queried as to whether the team will require support from the Committee to review the business case prior to it being submitted. It was felt that this would be beneficial therefore it was agreed to arrange an Extraordinary meeting towards the end of September.

23/24/23.1 Action: EH/KMC

For noting

A conversation took place about the governance process for signing off grants that are contentious or deliver corporate risk. Following discussion it was agreed that the Research Management Board (RMB) and the Innovation Management Board (IMB) will liaise with the respective teams to address any grants that are material, have performance impact or risks associated with them and then escalate those that require R&I Committee oversight.

The Committee was advised that the Trust's Standing Financial Instructions (SFI's) are to be reviewed during the summer period and greater clarity is to be provided in the document around the signing off of grants. The Chair asked as to whether the risks associated with the performance for the funding detailed in the SOC will need to be captured on the risk register. It was confirmed that this will be captured via the normal risk process.

Resolved:
The Research and Innovation Committee noted the Strategic Outline Case and Investment Zone Update.

23/24/24 Innovation Finance - Management Accounts, Q1

The Committee received a Q1 finance update for Innovation department. A number of slides were shared that provided information on the following areas:

- Financial summary (key points).
- Total innovation position for 2023/24 by spend type.
- Total innovation position for 2023/24 by capital/revenue split.
- Innovation run rate.
- Draft quantifiable benefits identified.
- Innovation growth (grants to date and 2023/24 forecast).
- Next steps.

It was reported that a lot more information has been included in the update than previously but will be reduced once a decision has been made about what the Committee would benefit from seeing. The Chair thanked the team for compiling the financial information and asked that the format of the update remain the same for the present time to provide greater transparency.

A conversation took place around the issues of tracking benefits when they sit elsewhere within the organisation, the importance of having consistency across the Trust in the form of a single cost benefits process to ensure costs and benefits are brought together under the same umbrella, the work that is taking place to implement an investment/benefits framework that ensures reinvestment takes place and innovation don't bear the overall and ongoing cost, and the sustainability issues/cost pressures that innovation experience when the funding for a project has ended.

Following discussion Adam Bateman agreed to engage with the Divisions and the Innovation team to look at finding a solution to the handover of the cost of products and services from innovation to the beneficiary dept. . It was also suggested that engagement take place with other paediatric trusts to discuss the ongoing access to the AI WNB tool.

23/24/24.1 Action: AB

The Chair felt that thought needs to be given to the deployment and transition of projects out of innovation and into the Divisions. Attention was also drawn to the importance of progressing this area of work in order to see how the Trust is delivering against its strategies as key decisions are made with regard to the projects that Alder Hey wishes to invest in, and how the organisation is going to deliver on Futures and commercial opportunities.

Resolved:
The Research and Innovation Committee noted the Q1 finance update for the Innovation department.

23/24/25 Research Finance - Management Accounts, Q1.

The Committee received a Q1 finance update for the Research Division. A number of slides were shared that provided information on the following areas:

- Financial summary (key points).
- Total research position for 2023/24 by spend type.
- Total research position for 2023/24 by activity.
- Research run rate.
- Grants to date for 2023/24 that were successful and submitted.
- Next steps.

A point was raised about the importance of resolving the CIP related issue for the Research Division. It was felt that it is imperative to understand the opportunities in research, the form they take and the contributions that can be made.

A discussion took place and concerns were raised about the impact of CIP on delivery within the Research Division, increasing commercial research trials to make a contribution to the Trust, and the constraints of the NIHR finance model. It was agreed that the Research Division needs to be creative and must find other streams of funding to generate game changing pioneering. Dan Hawcutt agreed to reflect on CIP targets and provide an update during October's meeting.

23/24/25.1 Action: DH

Resolved:
The Research and Innovation Committee received and noted the Q1 finance update for the Research Division.

23/24/26 Research Performance Report for Q1 and EDI/University Updates.

The Committee was received an update on the performance of the Clinical Research Division during Q1, 2023/24. An overview of the following areas was provided:

- Highlights and successes.
- Research Pipeline.
- Improvement priorities.
- Research workforce.
- Research themes/units.
- Service Improvement.

Attention was drawn to the successful bid which has provided the Trust with the funding to purchase a 3T MRI scanner, predominantly for clinical research. Louise Shepherd paid tribute to the team who enabled this to happen.

A query was raised about the impact of the Enitan Study as it comes to a close and the effect it will have on funding in terms of the number of patients recruited to take part in this study. It was confirmed that there will be a different recruitment picture in 2024/25 but work is taking place to ensure that the things that led the Trust to be in a position to attain large studies are still there and are being promoted in the strategy.

A discussion took place on the Seed Corn Fund initiative, the criteria for awarding the funding and how it will fit into the strategy. The Committee was also advised of the organisational changes that NIHR are going through at the present time. As a result of the changes the objectives that research activity is measured on are yet to confirmed and will evolve over time.

EDI Strategy

The Research Division is in the process of developing an EDI strategy that will formally link in with the Research Strategy. The CRF within the Research Division has already developed an EDI Strategy as this was an NIHR mandated objective. The two are virtually synonyms as they both speak to the need of having recruitment that is representative of the organisation's patient population to ensure that the Trust obtains the right answers to research studies, having equity to access

of studies and making sure research is delivered in the local communities. The EDI Strategy will also ensure that staff members are representative of people who see people like themselves doing research, which links in with the Vision 2030 Strategy concept.

University Update

It was reported that other NIHR groups have submitted bids as part of the capital infrastructure costs. One of those groups has been successful and has been awarded four mobile research units. It was confirmed that the Trust will link in with this organisation to discuss having access to the Research Bus so that Alder Hey can deliver research across the patch.

Resolved:
The Research and Innovation Committee received and noted the Research Performance Report for Q1 and the EDI/University Updates.

23/24/27 Innovation Performance Report for Q1.

The Committee received the Innovation Performance Report for Q1, 2023/24. An overview of the following areas was provided:

- 2023/24 operational plan KPIs.
- Innovation People Plan Progress in Q1.
- HR update.
- Risk summary.
- Strategy Deployment;
  - Total number of problems identified in Q1 and their current stage.
  - Current total innovation by pipeline by stage (Q1).
  - New active projects.
  - New deployed projects.
  - Innovation growth (grants to date and 2023/24 forecast).
  - Growth (Grants and proposals tracker 2023/24).
  - Brand and reputation highlights.
  - Ecosystem partnership update.

Louise Shepherd referred to the brand and reputation element of the update and drew attention to the importance of having clear strategic narrative to promote the Trust's strategies, especially in terms of Futures going forward.

Questions were raised and responded to about the plans for sharing Alder Hey Anywhere more widely from a PR/publications perspective, the timeline in which clinicians will start to see the benefits of the platform, and the resources in place to support the two year plan for developing the platform

The Chair felt that Alder Hey Anywhere is a good case study in terms of how projects transition out of innovation and are deployed into the Trust. A discussion took place on the funding remit for additional functionalities of the platform, the business case that will underpin this area of work and the approval process.

Resolved:
The Research and Innovation Committee received and noted the Innovation Performance Report for Q1, 2023/24

23/24/28 Data Access Committee Terms of Reference (ToR)

The Committee received the ToR for the Data Access Committee for approval purposes. An overview was provided on the purpose of meetings and the duties that will be carried out by the Data Access Committee.

Reference was made to the membership and it was suggested that the Trust's Senior Information Risk Owner (SIRO) and Data Protection Officer be included in the membership as these roles along with the Caldicot Guardian role address data and information risk management across the Trust and will help strengthen the ToR.

23/24/28.1 Action: DH

A conversation took place about the process for assigning fair value to data for complex projects and a query was raised about the governance route for reporting on the decisions that the Data Access Committee make. Following discussion it was agreed to look into this matter and provide a recommendation for the implementation of a decision making/reporting process from a finance, information governance and expertise perspective.

23/24/28.2 Action: RL

Resolved:
The Research and Innovation Committee noted the Terms of Reference for the Data Access Committee.

23/24/29 Commercial Partnerships Agreements and Business Development Prospects

The Committee received a high level update on commercial activities. A number of slides were shared that provided information on the following areas:

- Commercial product opportunities.
- Alder Hey's Innovation process for impact and sustainability.
- Identified commercial products.
- Product selection criteria.
- Case Studies.
- Awards.
- Evaluation.
- Benefits.
- NHS vision for RPA.
- Global trends in RPA.
- Marketing Plan.
- Next steps.

The Chair pointed out that this agenda item is meant to address agreements that require approval/signing therefore it was suggested including information on commercial activities in the quarterly performance report going forward to enable the Committee to focus on agreements during this element of the meeting.

Resolved:
The Research and Innovation Committee noted the update on commercial activity.

23/24/30 3rd MRI Scanner

The Committee was advised of the caveats involved in terms of how the funding for an MRI scanner are spent following a successful bid. A business case has been compiled which details how the money will be spent, and it was reported that the Trust is looking to participle in a very robust procurement process for the purchase of a scanner. It was suggested that the business case may need to be submitted to the Resources and Business Development Committee for approval.

Resolved:
The Research and Innovation Committee noted the update.

23/24/31 Board Assurance Framework (BAF) Report

The Committee received the Board Assurance Framework Report (BAF) for May 2023. The following points were raised:

- It was reported that discussions have taken place regarding BAF Risk 4.1 *(Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People)* and it was agreed that the risk in its current state doesn't reflect the activity that is taking place. There is a clear idea of what an interim state of that risk will look like and this will be uploaded onto the system once InPhase is fully operational. Mitigations and actions are being taken around identification of risks and the Trust is starting to make inroads with data which has been a big risk theme for some time for the Innovation department.

The Chair referred to the discussion that took place earlier on in the meeting around data and asked the Director of Corporate Affairs, Erica Saunders if she was comfortable with the outcome of the conversation. Erica Saunders confirmed that she was but highlighted the importance of the involvement of the Data Protection Officer with the Research and Innovation Management Boards and potentially the Risk Management Forum (RMF) on a periodic basis. The Committee was advised that the Trust has processes in place for new projects and programs that have to be followed.

Resolved:
The Research and Innovation Committee noted the contents of the BAF report for May 2023.

23/24/32 Futures Update

The Committee received an update on Alder Hey Futures detailing the progress that has been made and the next steps. Information was shared on the following areas:

- What is Alder Hey Futures.
- How Alder Hey Futures will work.
- The proposed five areas of focus.
- Delivery models.
- Internal commercial structure and commercial partnerships.
- International work.

Resolved:
The Research and Innovation Committee noted the Futures update.

23/24/33 Alder Hey Research, Innovations and the Futures Strategy

Fiona Marston presented the findings of the consultancy project that was conducted on Alder Hey's Research and Innovations and the Futures Strategy. A number of slides were submitted that detailed the drivers for the review of research and innovations, the question that was used to acquire information and the process used to collate it. The conclusion of the project was that Alder Hey can deliver on the Futures Strategy by reorganising and refocussing on research and innovation activities, and detail on the how and supporting evidence was shared.
Committee members shared their feedback on the report and the following actions were agreed in terms of next steps:

- Provide a report in January determining how the three identified areas; developing the management of internal/external relationships and a Partnership Strategy are going to be different and what they will look like.

23/24/33.1 **Action: JC**
For noting

- The recommendation about invigorating and refocussing the development of research and innovation pipelines and staying aligned to the Future Strategy will be the remit of the Research and Innovation Management Boards who will build this area of work into their management of the respective Divisions. The outcome of this work will feed into the Research and Innovation Committee.
- *Business Model* - Task Force meeting to take place to finalise and agree a business model ensuring that it fits into the plans for the delivery of the Futures Strategy.

23/24/33.2 ***Action:*** **KMC**

- *Financial Strategy and Commercial Activity* – Task Force meetings to continue to discuss the Financial Strategy and the various models for commercial activity, taking into account the model recommended in the Consultancy Project Report.

23/24/33.3 **Action: KMC**

The Chair thanked Fiona Marston for joining the Committee to present the findings of the report.

Resolved:
The Research and Innovation Committee received and noted the Consultancy Project Report on Alder Hey Research, Innovations and the Futures Strategy.

23/24/34 Any Other Business

The Chair requested that future Committee meetings take place on a face to face basis.

23/24/34.1 **Action: KMC**

23/24/35 Review of the meeting

The Chair advised of the decision to have a blended approach of the agenda to ensure that research and innovation aren't discussed in isolation. Committee members were asked to forward their ideas if they felt that the agenda should be approached in a different way. A suggestion was made about having the important elements of business at the beginning of the agenda as this may help to frame the discussion for other items. Attention was also drawn to the importance of bringing

research and innovation together in respect to the commercial elements of the agenda.

John Chester thanked everybody for the work that went into preparing the papers and felt that the Committee is starting to see a difference in terms of the progress that is being made.

Date and Time of the Next Meeting: Monday 16th October, 1:00pm-5:00pm, Room 2/3, LIP.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 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 during October/November 2023
Action/Decision Required:	To note ■ To approve ■
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

1. Introduction

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 October/ November 2023.

2. People Metrics

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

- Total sickness absence is at 6%, above the Trust target of 5.5%. This sickness absence comprises, Short-Term Sickness (STS) of 2% and Long-Term Sickness (LTS) of 4%.
- Turnover has had its 7th consecutive month of reduction and has dropped to 12% from 13% in July.
- A focused effort from the whole Trust is beginning to show some improvement in respect of PDRs with a November position of 67% against the target of 90%

3. Industrial Action

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

The government and unions representing **consultant doctors** in England have reached an agreement to put an offer to union members following constructive negotiations. The headlines of the offer are:

- Change in consultant payscales, reducing the number of pay points within the scale, and increasing the starting and top salary point.
- New pay progression process to mirror those in place for the AFC workforce.
- Withdrawal of the BMA advocating the BMA rate card.
- Amendment to SPA (Supporting Programme Activity) guidance.
- Changes to Local Clinical Excellence Awards, including permanently closing the scheme to applicants.
- Enhancing shared parental leave for match AFC provision.
- Review of the pay review processes (DDRB)

If accepted implementation will be April 2024, backdated to January 2024. The pay review round for 2024/25 will continue as planned. Strike action continues to pause whilst union members are balloted on the offer. Details of ballot processes will be published in due course.

The **consultant doctors** are currently being re-balloted by the BMA to extend their mandate to strike should the offer not be accepted. In addition, **SAS** doctors are being balloted for the first time for industrial action; both ballots close at 12 noon on 18*th* December 2023.

The Society of **Radiographers** (SoR) have not yet announced further strike dates; their mandate for strike action runs until the end of December 2023. They have not yet issued a re-ballot of members to extend this.

No further strike dates from **junior doctors** have been announced as they are in talks with the government. Their mandate for strike action continues until the end of February 2024.

4. Annual Staff Survey 2023

The 2023/24 Staff Survey has now closed as of the 24th of November 2023. This year we had more staff than ever complete the survey with over 2,500 Alder Hey staff sharing their thoughts, opinions and experiences of working at Alder Hey. We are currently awaiting the official % after all validation checks are completed, but at present this looks likely to be 60% of all eligible staff. We are currently working with our BI colleagues to develop a way to ensure that results, once released, are available to divisions and departments much sooner than ever before, allowing them utilise their results and have more meaningful Big Conversations.

5. Summary Highlights

- **Turnover** - Sustained reduction in staff turnover with further opportunities to analyse this detail to understand the continuing downward trend.
- **Sickness Absence** - Overall sickness absence 6%, showing a minor increase.
    - Improved activities within Divisions to address Long Term Sickness (LTS) and capture exit information. Anticipating increase in sickness absence over the winter period as per trend of previous years. Ongoing monitoring required if staff availability position is to be improved.

PDR progress improved from 15% drop since the summer. Potential to drop again during winter. Attention to encourage quality conversations, including stay discussions, health & wellbeing included in process.

6. Actions:

- Ongoing presence around absence support/advice continues in each division, 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.

Amanda Harrison
Head of HR Business Partnering
28th November 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

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

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This report provides the Board with a high-level overview of the current equality, diversity, and inclusion work
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

1. Executive Summary

The purpose of this paper is to provide the Board with a high-level overview of the critical strategic and operational activity regarding Equality, Diversity, and Inclusion (ED&I) during October/November 2023, including an update on the progress of implementing the North West BAME Assembly Anti-Racist Framework.

2. Equality Delivery System 2022 update

The Integrated Care Board have continued to support the implementation of the EDS22 at a regional level providing NHS providers with information and support to ensure success delivery of the EDS2022. Engagement has been protracted due to operational pressures, although the report will be completed in December. Health Watch have supported the implementation, providing the Trust with critical feedback assistance to ensure that we successfully implement EDS22 at Alder Hey.

3. Staff Networks

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

- The **LGBTQIA+** staff network organised an engagement stand in the Atrium, providing staff with information about the network and how to join. Their last meeting was well attended, and they have started to develop an action plan that will support the implementation of the wider Navajo action plan. The network is working on developing an Ally training package, alongside the Head of ED&I which will be delivered initially to the Finance Team in the new year. This will be evaluated and rolled out to staff trust wide, if deemed successful.

- The **REACH** staff network continue to put plans in place to support the implementation of actions related to the Workforce Race Equality Standard and the NW BAME Assembly Anti-Racist Framework. They supported delivery of a programme of events to support Black History Month including several communications celebrating inspirational Black individuals who have impacted some of Alder Hey staff. The Trust received a visit from Patrick Graham, a UK-born writer, actor and poet of Jamaican parents, where he displayed his Liverpool Black History exhibition: The Black History & Heritage Exhibition: Iceberg Month, which is part of World Museums History, in the Atrium. The exhibition was well received by colleagues, our children and young people and their relatives. There was also a Diwali celebration which was supported by Raji Thomas, the deputy chair of the network. The celebrations took part on the Intensive Care unit and staff came together to share food and mark the Hindu festival of light.

0202
- The **Armed Forces** staff network held a poignant remembrance service on Friday 10th November to honour and pay tribute to those who selflessly served their countries. The network, supported by our Chaplaincy Team and members of the local armed forces cadets, held the service in the Atrium which was well attended by staff, children and young people and their families. The network would like to thank the Trust Chair, Dame Jo Williams, for her support and participation in the service.

- The **ACE-Disabilities and Long-Term Conditions** staff network continues to grow. They are working on a series of events to celebrate Disability History Month and will be in the Atrium on Monday 4th December talking to staff and providing them with information about the network. In December they will be holding a staff Christmas wellbeing meeting.

4. NW BAME Assembly Anti-Racist Framework

We have now completed the self-assessment tool developed by the North West BAME Assembly to identify gaps in our current performance. These gaps have allowed us to formulate a robust action plan, prioritising activities that will help us achieve a Bronze status in the next 12 months. The North West BAME Assembly and the Integrated Care System are supporting us in implementing the direct deliverables and achieving Bronze status in the next 12 months.

5. Conclusion

The Trust is making good progress with all equality objectives and the staff networks continue to grow, engaging and supporting the wider workforce. We will continue working though our action plans to ensure the delivery of our agreed goals.

6. Recommendations & proposed next steps

We are currently reviewing the gaps identified in the NW BAME Assembly Anti-Racist Framework self-assessment and developed an action plan to support our actions. We will engage with all our equality staff networks and trade union representatives to ensure they contribute to the development of the action plan. We will also align the actions identified to support the improvement of our WRES data and action plan, integrating the National NHS Equality, Diversity, and Inclusion Improvement Plan. A quarterly update will be provided to the People and Wellbeing Committee to offer assurance of progress.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
August 2023

Appendix 1 NW BAME Assembly Self-Assessment tool Bronze status

Direct Deliverables	Progress so far	Next Steps	Timescale
The appointment of a senior director-level EDI lead with a commitment to advancing anti-racism within the organisation	The Chief People Officer will be the named lead	• The senior director-level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report progress to the People and Wellbeing Committee quarterly providing assurance on the deliverable actions to support and change racial equity.	**April 2024**
Evidence of how the organisation has acted to make anti-racism work mission-critical in the past year.	• Executive members need to have a specific EDI objective identified in their annual appraisal • The Zero Tolerance and Preventing and Managing Violence and Aggression at Work policies are currently under review and will be combined into one policy	• Develop an anti-racism statement to be produced and published detailing organisational commitment to racial equity • Training and development of a toolkit to support the relaunch of the reviewed and combined policies.	**April 2024** **April 2024**
An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance framework compliance	• Area identified for development	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities	**June 2024**
The organisation can demonstrate progress over the last 12 months in reducing an	• Working to develop stronger relationships with the health inequalities team to ensure objectives are linked	• The organisation can demonstrate working in partnership to reduce specific health inequality through an anti-racism lens and publish	**April 2024**

identified health inequality.	into the wider organisational vision • Continue to work closely with the Staff Advice and Liaison team, Freedom to Speak up Guardian and REACH staff network to identify areas which we can support the health and wellbeing of our ethnic minority colleagues	progress within the organisational annual report.	
The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members	• Workforce Race Equality Standard data and action plan linked to the National EDI Improvement plan • Relaunch and support the new and revised Zero Tolerance policy • Work with the REACH staff network and Freedom to Speak Up Guardian to support staff from ethnic minority backgrounds	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures	**April 2024**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	Workforce Race Equality Standard
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Angie Ditchfield, Head of Equality, Diversity, and Inclusion

Purpose of Paper:	Decision ☑ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The Workforce Race Equality Standard (WRES) is a requirement for all NHS organisations to publish data and action plans against 9 indicators of workforce race equality, 2023 is its eighth year. It aims to facilitate an inclusive supportive, and fair culture in organisations to ensure that every member of the NHS's diverse workforce has a sense of belonging and a positive working experience. This report presents Alder Hey's latest workforce race equality data (as of 31st March 2023) and identifies where improvements have been made and where data has remained static and/or deteriorated. The report contains the Trust's performance against these indicators using data from the Electronic Staff Records (ESR) system and relevant results from the 2020 National Staff Survey.
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** ☑

0296

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 Foundation Trust

Workforce Race Equality Standard (WRES)

2023

Accessibility Statement

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For further information contact:

General Enquiries telephone : 0151 228 4811

Email: alder.centre@alderhey.nhs.uk

Website address: https://www.alderhey.nhs.uk

Workforce Race Equality Standard (WRES) Introduction

The Workforce Race Equality Standard (WRES) is a requirement for all NHS organisations to publish data and action plans against 9 indicators of workforce race equality, 2023 is its eighth year. It aims to facilitate an inclusive supportive, and fair culture in organisations to ensure that every member of the NHS diverse workforce has a sense of belonging and a positive working experience.

This report presents Alder Hey's latest workforce race equality data (as of 31st March 2023) and identifies where improvements have been made and where data has remained static and/or deteriorated. The report contains the Trust's performance against these indicators using data from the Electronic Staff Records (ESR) system and relevant results from the 2020 National Staff Survey. The data from the WRES report is important, as research demonstrates that a motivated, included, and valued workforce helps to deliver high-quality patient care, increase patient satisfaction, and improve patient safety. The data will also enable us to better understand the experiences of our Black minority ethnic staff so that we can target support and implement positive change thereby creating a more inclusive environment.

Alder Hey continues to make significant progress and is committed to tackling workplace inequalities between Black minority ethnic and White staff. Four of the nine indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on Board level representation. The report shows that Alder Hey has made progress in two of the nine WRES indicators, however there is immobility and/or regression in the remaining seven indicators. In general, Black minority ethnic staff have poorer work experience than White staff – this has been the trend since the WRES was mandated in 2015.

A note on language: When referring to ethnicity, we will use the term Black and minority ethnic (BME) to be consistent with National NHS Workforce Race Equality Standard terminology.

Workforce Race Equality Standard Progress in 2022/23

We are pleased to note that we have made improvements in two out of the nine indicators of race equality and remain static in one:

- Increase in the percentage of BME staff employed at Alder Hey
- Static in the likelihood of White applicants being appointed compared to ethnic minority applicants
- Decrease in the number of BME staff who have experienced harassment, bullying or abuse from staff

Several actions have been taken over the last twelve months that are likely to have attributed to the above improvements, include:

- Supporting the development of the new REACH staff network
- Appointment of Head of Equality, Diversity, and Inclusion
- Communications regarding celebration days and events
- Supporting recruitment to reduce inequality in the recruitment processes
- Promotion of Learning and Development opportunities for BME staff

Indicator 1 – Percentage of staff in each AfC Bands 1 to 9 and VSM compared with the percentage of Black minority ethnic staff in overall workforce

Total Workforce	BME	White	Missing or Unknown
4224	485 (11.5%)	3699 (87.6%)	40(0.9%)

	BME			White			Missing or Unknown		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
Cluster 1 (Bands 1 - 4)	0.44% (19)	0.59% (25)	0.59% (25)	16.3% (690)	17.0% (720)	16.3% (691)	0.14% (6)	0.16% (7)	0.14% (6)
Cluster 2 (Band 5 - 7)	0.30% (13)	0.26% (11)	0.33% (14)	4.90% (207)	5.87% (248)	5.96% (252)	0.02% (1)	0.04% (2)	0.02% (2)
Cluster 3 (Bands 8a - 8b)	0.11% (5)	0.16% (7)	0.14% (6)	1.89% (80)	2.22% (94)	2.24% (95)	0.07% (3)	0.09% (4)	0.02% (2)
Cluster 4 (Bands 8c – 9 & VSM)	0.56% (24)	0.02% (1)	0.09% (4)	0.00% (0)	0.99% (42)	0.97% (41)	0.00% (0)	0.02% (1)	0.00% (0)

Table 1: Non-Clinical Workforce Cohort (data source ESR)

The data shown in Table 1 shows that at Alder Hey we have 485 staff (11.5% of the workforce) who recorded that they are from a Black minority ethnic background on our electronic staff record (ESR). The data from the non-clinical workforce group shows an increase in Black minority ethnic staff in Cluster 2 (Band 5-7) and in Cluster 4 (Band 8c-VSM). Although there has been an increase in BME staff being appointed in Cluster 4 (Band 8c-VSM) over the last 12 months.

Table 2 presents the clinical cohort data. The data shows an overall increase in all Clusters except Cluster 4 (Band 8c-VSM) with the most significant increase in Cluster 2 (Band 5-7). This could be associated with the international recruitment programme and the employment of internationally educated staff. We have also seen a positive increase in Cluster 5 (Medical and Dental staff, Consultants) and Cluster 6 (Medical and Dental staff, non-consultant career grade). We need to ensure that we are supporting our BME staff to develop and progress. Over the next 12 months we will work closely with the Organisational Development team and the REACH staff network to identify strategies to improve our BME staff appointments into senior leadership roles.

Whilst we have seen improvements which are encouraging, Alder Hey acknowledges the need to work hard if we are to achieve race equity within the workforce. We need to encourage staff to record their ethnicity in ESR so that we have a true composition of our workforce, and we can better support the needs of our staff.

	BME			White			Missing or Unknown		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
Cluster 1 (Bands 1 - 4)	0.80% (34)	0.52% (22)	1.44% (61)	12.8% (542)	11.6% (491)	12.4% (526)	0.09% (4)	0.21% (9)	0.16% (7)
Cluster 2 (Band 5 - 7)	2.62% (111)	3.45% (146)	4.56% (193)	38.9% (1643)	38.1% (1611)	38.2% (1617)	0.28% (12)	0.42% (18)	0.28% (12)
Cluster 3 (Bands 8a - 8b)	0.23% (10)	0.18% (8)	0.23% (10)	5.04% (213)	5.82% (246)	6.08% (257)	0.07% (3)	0.07% (3)	0.04% (2)
Cluster 4 (Bands 8c – 9 & VSM)	0.00% (0)	0.04% (2)	0.04% (2)	0.56% (24)	0.52% (22)	0.54% (23)	0.00% (0)	0.00% (0)	0.00% (0)
Cluster 5 (Medical and Dental staff, Consultants)	2.27% (96)	2.32% (98)	2.55% (108)	3.66% (155)	3.83% (162)	3.95% (167)	0.09% (4)	0.07% (3)	0.09% (4)
Cluster 6 (Medical and Dental staff, non-consultant career grade)	0.26% (11)	0.37% (16)	0.68% (29)	0.28% (12)	0.28% (12)	0.21% (9)	0.04% (2)	0.04% (2)	0.04% (2)
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	0.23% (10)	0.71% (30)	0.78% (33)	0.73% (31)	0.56% (24)	0.49% (21)	0.26% (11)	0.21% (9)	0.07% (3)

Table 2: Clinical Workforce (data source ESR)

Indicator 2 – Relative likelihood of staff being appointed from shortlisting

This metric compares the data regarding the relative likelihood of White applicants being appointed from shortlisting compared to BME applicants. The metric includes both internal and external recruitment

(Data source: Trust's Recruitment data)

WRES Indicator	DESCRIPTOR	2021/22	2022/23
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants	0.90	1.45

Table 3: Relative likelihood of appointment from shortlisting

As of March 2023, the likelihood ratio was 1.45; higher than 1.0 or equity to a small degree. More specifically, 541 (25.3%) out of 2141 white candidates were appointed from shortlisting compared to 64 (17.4%) out of 368 BME candidates.

As an NHS Trust, Alder Hey performed better than 60% of other national NHS Trusts.

Recruitment from interview remains the most difficult to change metric, with the likelihood ratio not having changed nationally since the inception of the WRES. We will continue to work to ensure that our processes are inclusive, working with recruitment and our REACH staff network to explore and align initiatives that strengthen our recruitment practices, supporting our People Plan.

Indicator 3 – Relative likelihood of staff entering the formal disciplinary process

Relative likelihood of BME staff compared to White staff entering the formal disciplinary process, as measured by entry into the formal disciplinary procedure.

(Data source: Trust's HR data)

WRES Indicator	DESCRIPTOR	2021/22	2022/23
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	**0.91**	**1.36**

Table 4: Relative likelihood of entering formal capability process

The data from Table 4 indicates that the disparity in the likelihood of BME staff and White staff entering the formal disciplinary process has slightly increased over the past 12 months, with BME staff being more likely to be involved in a disciplinary. More specifically, 5 (1. 03%) out of 485 BME staff entered formal disciplinary proceedings compared to 28 (0.76%) out of 3699 White staff.

Indicator 4 – Relative likelihood of staff accessing non-mandatory training and CPD

Relative likelihood of White staff accessing non-mandatory and CPD training compared to BME staff.

(Data source: Trust's HR data)

WRES Indicator	DESCRIPTOR	2021/22	2022/23
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff	0.32	1.77

Table 5: Relative likelihood of staff accessing non-mandatory training and CPD

The data in Table 5 shows that White staff are 1.77 times more likely to access non-mandatory training and continuous professional development than Black, minority ethnic staff. Specifically, 270 (7.3%) out of 3699 White staff undertook non-mandatory training compared to 20 (4.1%) out of 485 BME staff. This difference is discouraging, and we will monitor the diversity of all applicants for training and professional development to assess for any bias in our processes.

Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public

WRES Indicator	DESCRIPTOR	BME 2021	White 2021	BME 2022	White 2022
5 NHS Staff Survey	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	16.9%	20.7%	24.6%	21.1%

Table 6: Harassment, bullying or abuse in the last 12 months (patients, relatives & public)

The data in Table 6 illustrates that 24.6% of Black minority ethnic staff have experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months than white staff. There is a worrying 7.7%-point increase from the previous year. No staff should experience harassment, bullying or abuse when at work. The trust acknowledges the urgency in tackling harassment, bullying and/or abuse of staff and we are working in collaboration with the Northwest BAME Assembly to implement their Anti-Racist Framework. Despite the increase, Alder Hey performed better than 82% of NHS Trusts.

Indicator 6 – Percentage of staff experiencing harassment, bullying or abuse from staff

WRES Indicator	DESCRIPTOR	BME 2021	White 2021	BME 2022	White 2022
6 NHS Staff Survey	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20.1%	16.9%	19.8%	18.5%

Table 7: Harassment, bullying or abuse in the last 12 months (staff)

There is a very slight decrease in the percentage of BME staff who have experienced harassment, bullying or abuse from their colleagues. Alder Hey performed better than 91% of NHS Trusts nationally. This is a positive move in the right direction, although we will continue to work hard to prevent staff from experiencing any form of harassment, bullying or abuse, building a culture where staff feel safe and a sense of belonging.

Indicator 7 – Percentage of staff believing the Trust provides equal opportunities for career progression or promotion

WRES Indicator	DESCRIPTOR	BME 2021	White 2021	BME 2022	White 2022
7 NHS Staff Survey	Percentage of staff believing that the organisation provides equal opportunities for career progression and/or promotion	51.0%	63.9%	49.3%	61.1%

Table 8: Opportunities for career progression or promotion

The data in Table 8 indicates that 49.3% of Black minority ethnic staff believe that Alder Hey provides them with equal opportunities for career progression or promotion compared to 61.1% of White staff. There is a 1.7%-point deterioration from the previous year and remains higher than the national average of 47.0%. We will explore our opportunities for staff progression and or internal promotion processes to equalise experiences.

Indicator 8 – Percentage of staff personally experiencing discrimination at work from their manager/team leader or colleagues

WRES Indicator	DESCRIPTOR	BME 2021	White 2021	BME 2022	White 2022
8 NHS Staff Survey	Percentage of staff experienced discrimination at work from manager/team leader or other colleagues in the last 12 months	10.5%	5.6%	12.5%	6.1%

Table 9: Experience of discrimination at work from manager/team leader or colleagues

The data in Table 9 reveals that 12.5% of Black minority ethnic staff at Alder Hey have directly experienced discrimination at work from either their manager, team leader or colleagues in comparison to 6.1% of White staff. The trust is committed to tackling harassment, bullying and/or abuse and over the next 12 months we will work with the REACH staff network and our trade union representatives to implement the Northwest BAME Assembly Anti-Racist Framework, developing strategies to help combat intolerable behaviour. Despite this, Alder Hey performed better than 84% of other national NHS Trusts.

Indicator 9 – Percentage difference between Board voting membership and its overall workforce

Percentage difference between the organisations' Board voting membership (Data source: NHS ESR and/or trust's local data)

WRES Indicator	DESCRIPTOR	BME 2021/22	White 2021/22	BME 2022/23	White 2022/23
9 Board Representation	Percentage difference between the organisation's Board voting membership and its overall workforce	**13.3%**	**-17.4%**	**10.7%**	**-15.3%**

Table: 10 Board representation

The percentage difference between the organisation's Board voting membership and its overall workforce has declined by 2.6% points for Black minority ethnic staff and -2.1% points for White staff. The current percentage of BME Board members is 22.2% (4) in comparison to 72.2% (13) White Board members. There are 28.6% (4) BME voting Board members compared to 64.3% (9) White voting Board members and 7.1% (1) voting Board member who has not declared their ethnicity.

The board representation indicator is calculated by deducting the percentage of BME staff in the workforce from the percentage of BME members on the board of directors. A positive value means that the percentage of BME members on the board of directors is higher than in the workforce, and a negative value means that the percentage of BME members on the board of directors is lower than in the workforce.

Conclusions and next steps

The report provides an assessment of the Trusts current position regarding the experiences of Black minority ethnic staff working at Alder Hey. Based on the 2022/23 data presented in this report, and the recommendations from NHS England the following have been identified as areas that the trust must focus on for improvement:

- Career progression in clinical roles (lower to middle level)
- Career progression in clinical roles (lower to upper levels)
- Board representation (overall and voting members)

With the support and involvement of the REACH staff network, the WRES action plan (Appendix 1) has been developed in response to the WRES data and we will work together to make improvements against the themes identified as concerns. We will, where possible, link our actions to the NHS Equality, Diversity, and Inclusion Improvement Framework to ensure we our activities are robust, align, and work towards improving the experience of our staff.

Appendix 1: WRES Improvement Plan

Action	Objective	Progress	Next Steps	Timescales
Provide inclusive career progression opportunities for development	Inequalities and differentials in experience	• Work with the REACH staff network to proactively address areas of concern, improving our understanding about the experiences of our BME staff • Continue to work closely with our Freedom to Speak Up Guardian • Continue to promote and support inclusive access to training, learning and development opportunities	• Ensure that career conversations are embedded into staff annual appraisal process • Develop inclusive leadership training programme **(link to HI action 1)** • Use the intelligence from staff network members to identify any specific gaps requiring the development of bespoke training • Make sure that our Internationally educated staff are encouraged and have access to development opportunities **(link to HI action 5)** • Develop a talent management plan looking to improve the diversity of	December 2023 March 2024 March 2024 December 2023 July 2024

			executive and senior leadership teams **(link to HI action 2)** • Review starter, leaver data triangulating this with exit interviews to identify any themes related to career progression **(link to HI action 2)**	December 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	Workforce Disability Equality Standard
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Angie Ditchfield, Head of Equality, Diversity, and Inclusion

Purpose of Paper:	Decision ☑ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The Workforce Disability Equality Standard (WDES) was introduced in 2019 and is a requirement for all NHS organisations to publish data and action plans set against the ten specific measures 'Metrics' of workforce disability equality. Each of these metrics compares the experiences of disabled and non-disabled staff in the NHS. This report provides us with information relating to our staff at Alder Hey, 2022/23. The data provided which is taken from the national electronic staff record (ESR) and the national staff survey, will help us to better understand the experiences of our disabled staff so that we can support the development of an action plan to demonstrate progress against the metrics to improve equality and inclusion for disabled staff. The intention of the WDES data is to help improve the experiences of disabled staff working in the NHS.
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** ☑

0226	
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 Foundation Trust

Alder Hey Children's Hospital NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

2023

Accessibility Statement

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For further information contact:

General Enquiries telephone : 0151 228 4811

Email: alder.centre@alderhey.nhs.uk

Website address: https://www.alderhey.nhs.uk

INTRODUCTION

The Workforce Disability Equality Standard (WDES) was introduced in 2019 and is a requirement for all NHS organisations to publish data and action plans set against the ten specific measures 'Metrics' of workforce disability equality. Each of these metrics compares the experiences of disabled and non-disabled staff in the NHS. This report provides us with information relating to our staff at Alder Hey Children's Hospital 2022/23. The data provided which is taken from the national electronic staff record and the national staff survey, will help us to better understand the experiences of our disabled staff so that we can support the development of an action plan to demonstrate progress against the metrics to improve equality and inclusion for disabled staff. The intention of the WDES data is to help improve the experiences of disabled staff working in the NHS.

This report aims to outline the performance of the trust against the WDES metrics, identifying where improvements have been made and where there has been little or no improvement and/or a decline. The analysis of the data and development of the action plan have been completed together with the ACE Network members: (Ability, Celebrate, Educate - Disability and Long-Term Conditions Staff Network).

A note on language: In this report we use the term 'disability' as defined in the Equality Act 2010. However, we do recognise that 'disability' is a dynamic term, within which terms such as 'neurodivergence' and 'neurodiversity' are emerging and changing.

Ability
Celebrate
Educate

Disabilities & Long-Term Conditions Staff Network

ACE Staff Network

Alder Hey Children's NHS Foundation Trust ACE staff network aims to support staff with disabilities, long-term conditions, mental health conditions, neurodivergence, carers, or staff with family members with a long term health condition. We want our staff members to have the ability to work within their roles, feeling supported, valued, and respected, free from harm or discrimination. We want to celebrate the brilliance of our staff, learning and growing together. We want to educate our colleagues to help them better understand how they can support and encourage staff with disabilities. This year's Workforce Disability Equality Standard report provides us all with an understanding about what it feels like to work at Alder Hey NHS Foundation Trust. We want to improve on the results, working together to develop opportunities for our staff to grow and thrive at Alder Hey. We want managers to feel supported and confident to be able to provide reasonable adjustments and assistance to their staff with disabilities so that they flourish, feeling that they can come to work and be their whole selves without holding anything back.

We will spend the next 12 months working hard to ensure staff feel safe and supported and are able to be open and honest. We want to see an improvement in the self-declaration rates so that Alder Hey can accurately support all staff with disabilities. We have supported the development of an ambitious action plan that we will help to implement, making positive changes to improve the experiences of staff with disabilities. We want everyone to feel that they belong at Alder Hey, making it a great place to work.

Helen Russell Chair of the ACE Staff Network

Workforce Disability Equality Standard

Progress made in 2022/23

We are pleased to note that we have made improvements in 4 out of the 10 indicators of disability equality:

- There is an increase in staff working at Alder Hey who had declared a disability
- There has been a positive decrease in the relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff
- There has been a slight decrease in the percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months
- The percentage of staff saying that they or a colleague reported harassment, bullying or abuse has increased over the past 12 months

Several actions have been taken in the last 12 months that may well have contributed to the above improvements, these include:

- Developing, supporting, and growing the ACE, Disabilities and Long-Term Conditions staff network
- Working alongside the communications team to raise awareness of the staff network and disabilities
- Launch of the Reasonable Adjustments Policy
- Development of resources to support managers

We will continue to work closely with the ACE staff network to identify areas for improvement, listening to the lived experiences of staff at Alder Hey Children's Hospital to inform and influence decision making.

Metric 1: Percentage of staff AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce

Total Workforce	Disabled	Non-Disabled	Missing or Unknown
4231	207(4.89%)	3064 (72.42%)	960 (22.69%)

	Disabled			Non-Disabled			Missing or Unknown		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
Cluster 1 (under Band 1, Bands 1-4	3.90%	5.20%	6.6%	63.40%	63.50%	66.30%	32.70%	31.20%	27.00%
Cluster 2 (Bands5-7)	5.00%	5.4%	6.00%	73.30%	77.40%	82.80%	21.70%	17.20%	11.200%
Cluster 3 (Bands 8a-8b)	3.40%	4.8%	6.80%	78.4%	76.20%	79.60%	18.20%	19.00%	13.60%
Cluster 4 (Bands 8c-9 & VSM)	0.00%	0.00%	6.70%	80.00%	88.40%	82.20%	20.00%	11.60%	11.10%

Table 1: Non-Clinical Workforce Cohort (data source ESR)

The data shown in Table 1 shows that at Alder Hey we have 207 staff (4.89% of the workforce) who have declared a disability on the electronic staff record (ESR). The declaration rate has increased year on year; however, we still need to raise awareness of the importance of self-recording disability so that we can better support our staff. The non-declaration rate is high at 22.69% with 960 of staff having not declared their disability status on ESR. Non-declaration rates are a national issue, although here at Alder Hey we are working to try and improve this as we want our staff to feel comfortable with declaring their disability status, knowing that we will value and support them. We will therefore continue to work closely with the ACE staff network to promote understanding of self-declaration and why the organisation needs this information to better support staff. The data also shows the numbers of disabled and non-disabled staff employed by Alder Hey at various Agenda for Change (AFC) pay bands. There has been an increase in all Clusters for non-clinical staff, and a positive increase in Cluster 4 (Band 8c-9 VSM) with only band 8c with no declared disabled staff. Whilst this is a positive step forward, we will continue to focus on supporting and developing our staff to progress into higher bands.

Table 2 presents the clinical cohort data. Staff declaring a disability in Cluster 2, and 3 has increased over the last 12 months. Cluster 4, 5, 6, and 7 cohorts do not have any staff who have declared a disability. This highlights the need to explore and understand why the higher AfC bands, medical, dental and consultant groups have no staff who have declared a disability. The non-declaration rates from all these clusters remain high despite decreasing year on year. We need to better understand why this group may be reluctant to self-declare and put measures in place to enable them to feel comfortable, safe, and supported.

	Disabled			Non-Disabled			Missing or Unknown		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
Cluster 1 (Bands 1 - 4)	4.70%	4.60%	4.70%	63.30%	65.3%	68.80%	32.10%	30.10%	26.50%
Cluster 2 (Band 5 - 7)	3.10%	3.90%	5.00%	70.20%	71.70%	74.30%	26.70%	24.30%	20.70%
Cluster 3 (Bands 8a - 8b)	2.70%	2.30%	3.70%	59.70%	61.90%	69.90%	37.60%	35.80%	26.40%
Cluster 4 (Bands 8c – 9 & VSM)	4.2%	0.00%	0.00%	75.00%	83.30%	84.00%	20.80%	16.70%	16.00%
Cluster 5 (Medical and Dental staff, Consultants)	0.78%	0.76%	1.08%	63.14%	66.92%	71.68%	36.08%	32.32%	27.24%
Cluster 6 (Medical and Dental staff, non-consultant career grade)	0.00%	0.00%	0.00%	64.00%	56.57%	70.00%	36.00%	43.33%	30.00%
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	0.00%	0.00%	1.69%	73.08%	61.90%	69.49%	26.92%	38.10%	28.81%

Table 2: Clinical Workforce (data source ESR)

WDES Metric 2 – Relative likelihood of appointment from shortlisting

This metric compares the data for non-disabled and disabled staff regarding the relative likelihood of being appointed. The metric includes both internal and external recruitment.

(Data source: Trust's Recruitment data)

WDES METRIC	DESCRIPTOR	2021/22	2022/23
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts	**1.89**	**1.16**

Table 3: Relative likelihood of appointment from shortlisting

The data in Table 3 shows that the figure has decreased, suggesting a positive step in the right direction, although it must be noted that not all shortlisted candidates will disclose that they have a disability at this stage.

- A relative likelihood of 1 indicates that there is no difference: i.e., non-disabled applicants are equally as likely to be appointed from shortlisting as Disabled applicants.
- A relative likelihood above 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to Disabled applicants: e.g., a likelihood ratio of 2 indicates non-disabled applicants are twice as likely to be appointed from shortlisting compared to Disabled applicants.
- A relative likelihood below 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to Disabled applicants: e.g., a likelihood ratio of 0.5 indicates non-disabled applicants are half (0.5 times) as likely to be appointed from shortlisting as Disabled applicants.

WDES Metric 3 – Relative likelihood of entering formal capability process

WDES METRIC	DESCRIPTOR	2021/22	2022/23
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	**0.0**	**2.03**

Table 4: Relative likelihood of entering formal capability process

The data in Table 4 shows as of March 2023 the likelihood ratio was 2.03; specifically 0.5 (0.26%) out of 189 Disabled staff entered formal capability process compared to 4 (0.13%) out of 3,064 non-disabled staff.

We will continue to monitor this data, working closely with the ACE staff network and implementing adequate support and guidance for staff and managers.

WDES Metric 4 – Harassment, bullying or abuse in the last 12 months

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months.

(Data source: Question 13, NHS Staff Survey)

WDES METRIC	DESCRIPTOR: Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from:	Disabled staff 2021/22	Non-disable staff 2021/22	Disabled staff 2022/23	Non-disabled staff 2022/23
4 NHS Staff Survey results	I. Patients/Service users, their relatives or other members of the public	23.8%	19.2%	28.7%	18.8%
	II. Managers	14.6%	6.9%	15.2%	7.2%
	III. Other colleagues	21.4%	10.7%	21.0%	11.8%
	IV. Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	53.5%	47.3%	61.4%	52.0%

Table 5: Harassment, bullying or abuse in the last 12 months

Table 5 demonstrates that the percentage of disabled staff saying they have experienced harassment, bullying or abuse at work in the last 12 months:

I. From patients/service/users, their relatives or other members of the public has increased by 4.9% points and is 9.9% points higher than non-disabled staff

II. From managers the percentage has slightly increased by 0.6% points

III. From other colleagues it has reduced by 0.4% points

IV. The data regarding reporting has positively increased by 7.9% points

WDES Metric 5 – opportunities for career progression or promotion

WDES METRIC	DESCRIPTOR	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
5 NHS Staff Survey results	Percentage of disabled staff compared to non-disabled staff believing that Alder Hey Children's Hospital provides equal opportunities for career progression or promotion	**54.9%**	**65.2%**	**51.3%**	**62.7%**

Table 6: Opportunities for career progression or promotion

The data presented in Table 6 indicates that the percentage of disabled staff at Alder Hey Children's Hospital believe that the Trust provides equal opportunities for career progression or promotion has decreased since last year by 3.6%. This figure is around the national average which is 51.4%

WDES Metric 6 – Presenteeism

WDES METRIC	DESCRIPTOR	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
6 NHS Staff Survey results	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**23.4%**	**19.5%**	**28.5%**	**17.4%**

Table 7: Presenteeism

The data in Table 7 highlights that disabled staff feel more pressure from their managers to come to work, despite not feeling well enough to perform their duties. This figure has increased by 5.1% points over the last 12 months, we must work to ensure that staff can be open with managers about how they are feeling without sensing any pressure to come to work when they do not feel well enough. In addition to supporting our staff, we want to make sure managers are equipped and confident in providing their staff with the correct information, resources, and support.

WDES Metric 7 – Satisfaction rate on how the organisation values staff

WDES METRIC	DESCRIPTOR	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
7 NHS Staff Survey results	Percentage of disabled staff compared to non-disabled staff saying that are satisfied with the extent to which Alder Hey Children's Hospital values their work	**42.6%**	**50.0%**	**37.4%**	**49.9%**

Table 8: Satisfaction rate on how the organisation values staff work

The data in Table 8 show that 37.4% of disabled staff are satisfied with the extent to which Alder Hey values their work, however, this is 12.5% less than non-disabled staff. This clearly indicates the need to provide our workforce with the assurance that their contribution is valued, and they are respected.

WDES Metric 8 – Reasonable Adjustments

WDES METRIC	DESCRIPTOR	2021/22	2022/23
8 NHS Staff Survey results	Percentage of disabled staff saying Alder Hey Children's Hospital has made an adequate reasonable adjustment(s) to enable them to carry out their work	**74.3%**	**70.3%**

Table 9: Reasonable Adjustments

Table 9 indicates that 70.3% of disabled staff say that Alder Hey has made adequate adjustments to enable them to carry out their work. This figure is just below the national average. There is a 4% point decrease from 2021/22. We will continue to work closely with the ACE staff network to promote our reasonable adjustments policy, building on our current work to ensure that staff and managers have the correct guidance.

WDES Metric 9 – The Engagement of disabled staff

WDES METRIC	DESCRIPTOR	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
9 NHS Staff Survey Results Engagement Score	I. The staff engagement scores for disabled and non-disabled staff	**6.9**	**7.4**	**6.8**	**7.3**
	II. Has Alder Hey Children's Hospital taken action to facilitate the voices of disabled staff in your organisation to be heard	**Yes**		**Yes**	

Table 10: The Engagement of disabled staff

Table 10 shows that the staff engagement score for disabled staff has decreased slightly since last year. The Trust has answered 'Yes' to the question regarding taking action to facilitate the voices of disabled staff to be heard owing to staff listening events which have taken place and the development of the ACE staff network. The voices of our disabled staff have been heard at People Committee and the network works closely with the Head of EDI to ensure that any initiatives are co-produced and that their lived experiences are informing the development of the Trust's strategic objectives.

WDES Metric 10 – Board representation

WDES METRIC	DESCRIPTOR	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
10 Board Representation	Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:				
	• By voting membership of the Board	**0.00%**	**64.29%**	**0.00%**	**71.43%%**
	• By Executive membership of the Board	**0.00%**	**81.82%**	**0.00%**	**81.82%**

Table 11: Board Representation

The data in Table 11 remains the same as last year with 0.00% of voting members or executive members of the Board declaring to have a disability. There is also a high percentage of Board members who have not completed their status on ESR. We will aim to address this through the Trust wide work on encouraging staff with a disability to declare it, thus ensuring all appropriate support is in place if needed.

Conclusions and next steps

The report provides an assessment of our current position regarding the experiences of staff with disabilities working at Alder Hey. Based on the 2022/23 data presented in this report, the following have been identified as areas that the trust must focus on for improvement:

- Staff declaring their disability status
- Disabled staff experiencing harassment, bullying or abuse from patients, service users, relatives, or members of the public and managers
- Disabled staff satisfied that the Trust provides opportunities for career progression and promotion
- Disabled staff feel pressure from their managers to come to work despite not feeling well enough
- Disabled staff feeling that the Trust values their work
- Disabled staff feeling that the Trust has made adequate reasonable adjustments
- Staff engagement score
- Disabled staff represented at Board

With the support and involvement of the ACE staff network, the WDES action plan (Appendix 1) has been developed in response to the WDES data and we will work together to make improvements against the themes identified as concerns.

Appendix 1: WDES Improvement Plan

Action	Objective	Progress	Next Steps	Timescales
Continue to increase disability declaration rates on ESR	Staff engagement Declaration rates and accurate personal information held	• Work with staff network to support initiatives to raise awareness of the importance of self-declaration	• Share granular data with each division **(link to HI action 1)** • Continue to promote Reasonable Adjustments Policy • Develop a communications strategy to raise awareness about ESR data	November 2023 December 2023 November 2023
Continue to monitor and take action to prevent staff from experiencing harassment, bullying or abuse from patients, service users, relatives or public and managers	Inequalities and differentials in staff experiences	• Raise awareness for reporting and support mechanisms to ensure colleagues have the confidence to speak up safely about issues. • Work closely with Freedom to Speak Up Guardian • Zero Tolerance of Racist, Homophobic Prejudice or Discriminatory Behaviour Policy revised and relaunched across the Trust	• Work with the staff network to develop a communications campaign which sends a positive message to patients, service users, relatives, or the public. Stressing our Zero Tolerance approach in order to reduce harassment, bullying or abuse of staff **(link to HI action 6)** • Relaunch Zero Tolerance of Racist, Homophobic Prejudice or Discriminatory Behaviour Policy making sure managers are supported/trained and have access to resources to better support their staff **(link to HI action 6)** • Managers will be provided with training to undertake	December 2023 November 2023

			compassionate conversations and will have the resources and correct documentation and policies to ensure that their staff are supported **(link to HI action 4)**	March 2024
Provide inclusive career progression opportunities for development	Inequalities and differentials in experience	• Use of reliable and robust data – to understand the experiences of our staff and proactively use data to address areas of concern. Work with the ACE staff network to improve our use of soft intelligence about people's experiences, in combination with data from Human Resources, Organisational Development, EDI Team and Freedom to Speak Up processes	• Career conversations embedded into the annual appraisal process • Work with ACE staff network to identify and develop specific gaps in process/opportunities requiring targeted or bespoke training **(link to HI action 2)** • Continue to promote inclusive access to the national training offers • Work collaboratively with regional Trusts to develop shared training opportunities	January 2024 March 2024 December 2023 March 2024
Support staff and managers to ensure staff feel they can be open about how they feel without pressure, they feel valued,	Inequalities and differentials in experience Staff Survey Results	• Work closely with Freedom to Speak up Guardian • Provide Lunch & Learn sessions to raise awareness of topics related to ACE staff network • Pilot the Empowerment Passports to support managers and staff in ensuring the correct	• Promote ACE staff network, growing membership and awareness • Develop a bespoke training package for managers, designed to provide information on how best to support their staff with disabilities	January 2024 March 2024

supported and respected		reasonable adjustments are in place and staff feel comfortable with sharing information	• Work with ACE staff network to implement and improve experiences for staff	December 2023 March 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	People and Wellbeing Committee
Report of:	Fiona Marston, Non-Executive Director
Paper Prepared by:	Fiona Marston, Non-Executive Director

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent People and Wellbeing Committee that took place on 22nd of November 2023, along with the approved minutes from the meeting held on the 13th of September 2023.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? ☑ No ☐

Risk Number	Risk Description	Score
2.1	Workforce Sustainability and Development	15
2.2	Employee Wellbeing	9
2.3	Workforce Equality, Diversity and Inclusion	15

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

1. Executive Summary

The People and Wellbeing Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

2. Agenda items received, discussed / approved at the meeting

- **Strategy Update:** Progress towards delivery of the 2030 Strategy (People Plan) continues. The Committee held a long discussion around staff turnover and agreed to ensure we reflect the need to have a small amount of (good) turnover and also to focus on whether the right people leaving/staying.

  Going forward a focus on succession planning would be included in this piece of work as well as diversity.

- **Freedom to Speak Up Update:** A detailed overview was provided to the committee noting good progress is underway with making FTSU Champions more visible going forward.

- **Divisional Metrics Update:** Divisional metrics – very encouraged by positive trends particularly in staff turnover.

  Big conversations continue taking place in line with exit interviews/uestionnaires.

  Wellbeing Week was very well received by staff with really positive engagement throughout the Trust and impact on staff morale. It was really encouraging to see that people are doing this in a way that suits their areas.

  There are some emerging trends with regards to staff sickness which could be directly related to winter cold/flu.

- **Staff Survey Report:** Staff Survey reported 59% to date with a trust target of achieving 60% by close at the end of the week following the PAWC meeting.

- **Health & Safety Dashboard:** A comprehensive overview of activities within the H&S department received with some really positive themes identified in terms of training and assurances to ensure safety across Alder Hey.

- **North West BAME Assembly Anti-Racist Framework:** The Committee noted good progress being made to the Anti Race Framework with plans in place to support the next 12 months.

- **WRES/WDES Update:** WRES/WDES reports highlighted good progress being made. The committee Approved both sets of documentation.

4. Recommendations and proposed next steps

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

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 13th September 2023
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director **(Chair)**	(FM)
	Fiona Beveridge	Non-Executive Director	(FB)
	Garth Dallas	Non-Executive Director	(GD)
	John Grinnell	Managing Director/CFO	(JG)
	John Kelly	Non-Executive Director	(JK)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MSW)
	Sarah Leo	Head of Research	(SL)
	Rachel Greer	ACOO, Community & Mental Health	(RG)
	Rachel Hanger	Associate Chief Nurse – Surgery	(RH)
	Gill Foden	HR Manager (representing Medicine)	(GF)
In attendance:	Kathryn Allsopp	Head of Operational HR	(KA)
	Colin Beaver	Deputy Director of Communications	(CB)
	Katie Jones	HRBP – Surgery	(KJ)
	Phil McNamara	Internal Communications Manager	(PMc)
	Sharon Owen	Deputy Chief People Officer	(SO)
	Jo Potier	Associate Director of Organisational Development	(JP)
	Jill Preece	Governance Manager	(JP)
	Darren Shaw	Head of Organisational Development	(DS)
	Kerry Turner	FTSU Guardian	(KT)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Observing:	Bethany Richards	Quality Improvement Manager	(BR)
Apologies:	Adam Bateman	Chief Operating Officer	(AB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(AB)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	Katherine Birch	Director, Alder Hey Academy	(KB)
	Julie Worthington	Staff Side Rep	(JW)

22/23/188 **Declarations of Interest**
No declarations were declared.

22/23/189 **Minutes of the previous meeting held on 11th July 2023.**
The minutes of the last meeting were approved as an accurate record.

22/23/190 **Matters Arising and Action Log**
Action log was updated accordingly.

22/23/191 **Annual Workplan & Terms of Reference**
The Committee received the Annual Workplan 2023/24 and noted the recent updates.

The Committee reviewed and approved the Terms of Reference subject to the following amendment displayed on page 18:

- Authority section will be updated to reflect the new language barrier in line with the people strategy progression.

ES informed Committee members that following implementation of the new Trust Strategy Board some further changes to committee governance may take place in the near future.

Resolved:
The committee reviewed and **APPROVED** the Terms of Reference and workplan 2023/24.

22/23/192 **Strategy Progress Update**

MS presented a detailed overview of the progress of the strategy development which continues on course in line with progressing Vision 2030.

Development of the people plan remains underway with focus on 'Thriving at Alder Hey'.

JK suggested that it would be helpful to share some data analysis of the figures within the benefits column for oversight to the committee. MS commented that the Finance Team are supporting with that information and will further review this in terms of data reporting going forward.

The Chair acknowledged the strategy development is making good progress.

Resolved: Committee received and noted progress made to date.

22/23/193 **Monitor progress against the Internal Communications Plan**

CB provided a summary overview on the internal communication plan noting the first phase of engagement has been achieved in line with vision 2030 and continues to progress forward.

Next steps

- Vision 2030 phase 2 continues to progress forward.
- There are a variety of good engagement opportunities in development across the organisation.
- Further developments are being reviewed and explored around Freedom to Speak Up to encourage colleagues to raise concerns and provide assurance to safe staffing while in the work. Non-Executive Directors will be involved to help support.

Resolved: Committee noted good progress being made.

22/23/194 **Monitor Progress against the People Plan – Divisional Metrics**

Surgery Division:

The Committee received the Surgery Division metrics report (July data 2023) and noted progress to date. RH highlighted the following:

- Turnover reports 13% to date. Face to face conversations continue to take place to help improve retention.
- PDR compliance has slightly decreased for B7 and above. Division will explore a deep dive to ensure focus on improvement.
- Mandatory Training reports 92% above trust target.
- Return to Work compliance: further developments continue to improving compliance with support from HR colleagues.

Big Conversations
Division continues to capture all data around action plans to ensure documentation is being recorded, and feedback is given across the division.

Survey Update
Division produced 35 packs to services within all clinical areas. Divisions continues to collect that data and will report back once actions plans are in place.

KJ announced a new Exit Questionnaire process is due to launch over the next couple of weeks introducing a new online process available via Alder Hey Intranet. Feedback will be obtained following the launch to help improve and provide assurance across the organisation – date to be confirmed.

Resolved: Team continues to monitor data progression and drive improvements across the division.

Research Division:
The Committee received the Research Division metrics report (July 2023 data) and noted progress to date. SL highlighted the following:

- Turnover reports 13% following April 2023 data which shows an increase.
- Mandatory Training is above trust target and is making good progress.
- Long term sickness continues to be well managed support by divisions HRBP.
- PDR compliance remains stable.

Big Conversations
Division developed good action plans following a divisional staff survey conversation led by Head of Nursing which articulated some good themes. Division continues to progress forward.

Resolved: Division continues to drive forward.

Medicine Division:
The Committee received the Medicine Divisional metrics report (July data 2023) and noted progress to date. GF highlighted the following:

- Turnover reports 13% and continues a work in progress.
- PDR compliance is showing a decline. Division has developed robust approach with senior leadership.
- Mandatory Training reports 91% displaying a decrease. A renewed focus is being explored across the division and continues to drive forward.

Big Conversation
Division declared 25 conversations have taken place to date including in support of listening events. Action plans are still be collated and will be shared with the committee with due course.

Survey Update
MS asked the division of Medicine to feedback the staff survey data for the committee's oversight and assurance next time. Division will continue to collect data and explore all of feedback themes and will share once information has been completed.

Resolved: Divisions continues to progress forward.

Community & Mental Health Division:
The Committee received the Community and Mental Health division metrics report (July data 2023) and noted progress to date. RG highlighted the following:

- Turnover reports 14% to date which shows a reduction. A deep dive was completed in connection to recruitment pathways in terms of recruitment & retention supported by HRBPs.
- PDR compliance remains a challenge across services. Action plans in place for B7 and above to meet trust target.
- Sickness Absence remains low with an increase in short term sickness – HRBP continue to support leaderships.
- Time to Hire shows an increase. Plans are in place to maintain and support across the workforce.

Staff Survey
Committee received assurance; there are action plans in place following good themes, recognition, and communication between colleagues across departments.

Resolved: Team continue to monitor data and drive improvements across the division.

Corporate Metrics:
Committee received the corporate metrics and noted progress to date. ES highlighted the following:

ES presented, as Chair of the Corporate Services Collaborative, who recently met with 12 different areas to review data and reported an improvement.

- Turnover reports 17% to date. Corporate is stabilising in comparison with other divisions. An ongoing deep dive is being explored to achieve a consistent approach to performance to align with clinical activity across divisions.
- Reason for leaving; will be conducting a piece of work to review vacancy control procedures to investigate reasons behind resignations and what can the trust do to help keep and support colleagues at Alder Hey.
- PDR compliance remains stable with plans to keep at pace in line with trust target.
- Mandatory Training remains stable.
- Sickness absence continues to be well managed with plans in place to help control capacity and continues to be monitored.

ES provided the committee with assurance that all ongoing projects remains controlled and monitored throughout divisions to ensure a more manageable focus is embedded.

Big Conversations

The Chair asked for some assurance around action plans following discussions with individuals across the organisation. ES provided assurance this will be picked up in the next Corporate Service Collaborative meeting planned for next week in terms of collating that data and will report back at November committee for oversight.

Action: Big Conversations data to be updated at the next meeting.

JK suggested to add some alternative data in terms of showcasing an overall divisional summary detailing high level actions and areas of focus.

Action: The Chair agreed to explore all alternative options relating to reporting metrics to the committee mindful this does not add to individual workloads.

Resolved: Team continues to monitor data and drive improvements across the division.

22/23/195 **Turnover Report**

Committee received the Turnover report - Quarter 1 and noted progress made. KJ highlighted the following key points:

- Turnover rate for quarter 1 has decreased month on month reporting at 14.88%.
- Reasons for leaving in comparison against quarter 4 identified minor changes and will undertake further development in line with the online process due to launch.
- The number of leavers identified Nursing and Admin/Clerical as the highest.
- Length of service review captured figures improving now reporting 2-3 years compared to the first 1-2 years of individual leaving the trust – improvement.
- Turnover by division declared Research as the highest – month on month each division reported less turnover rate since June 2023.
- Leavers by division was broken down and continues to make good progress with one leaver in June 2023 for Research.

Next steps:

- HRBP continue to provide quarterly divisional turnover report for board meetings and continue to support divisions with promoting exit interviews/questionnaires.
- A new employee resignation process has been developed supported by Innovation Team will launch in due course which will be accessible via trust intranet.

JG noted this was a good progress update of turnover and asked if the medical and dental could be explored across the organisation workforce in terms of reviewing Nursing retention.

Action: JG suggested conducting a deep dive into exploring all areas as part of the data capture reporting for turnover. KJ recently met with the Nurse Retention Lead to review focus around this and agreed to review further and report back to the committee.

The Chair noted good progress report received and importance of understanding how much of the turnover data is inevitable and good use of time to reduce and understanding those reasons why colleagues are leaving. FM suggested to it may be helpful for committee assurance and oversight to review what data would be helpful to take the fix term contract out and review the full-time permanent contracts.

JK asked to consider a potential exercise of identifying resignation destinations using the reference platform as a key part of information to use as part of our data collection which may lead to further understanding behind reasons for leaving.

Action: KJ will explore all alternatives of gathering destination information from leavers in terms of identifying from references as part of collating that data.

Next steps:

- Turnover report quarter 1 will be present to Trust Board in October 2023
- Exit Interviews will continue as a key priority supported by HRBP colleagues.
- New resignation process will launch in due course available via Trust Intranet.

Resolved: Committee noted good progress being made.

22/23/196 **Staff Survey 2023**

Committee received the staff survey 2023 information and noted the following progress presented by DS:

- Staff survey will launch on Wednesday 20th September 2023 until Friday 24th November 2023. All colleagues are encouraged to take part in helping to drive improvements across the organisation.
- Health and wellbeing questions have been added to help measure that data reporting.
- There have been 3 identified working groups formed to help deliver best practice.
- All colleagues who complete the survey will be entered into a prize draw for a chance to win an iPad.

Next Steps:

Senior leaders are asked to encourage colleagues across the organisation to take part in completion of the staff survey. Chocolate bars will be given to colleagues who complete the staff survey and entered into a prize drawer for a chance to win an iPad.

Learning & Development Team continue working closely with divisional leads across departments around continuing to conduct big conversations.

.

MS made reference to the news coverage relating to the recent survey which indicated the prevalence of sexual misconduct within the surgical workforce of the NHS, and noted that, for 2023, there is an additional question in the survey about this.

MS also noted that JG will be discussing this issue at the next Medical Board Meeting to provide an open forum on the matter with clinical colleagues. c

MS thanked DS for the data and work around this. FM agreed in support.

Resolved: Committee noted good progress being made.

22/23/197 **Pulse Report**

Committee received the pulse report (January 2022 to July 2023) data and noted progress within the report.

DS presented the pulse report to the committee, highlighting to:

- 1426 responses received.
- 12% of colleagues feel well informed and supported in terms of health & wellbeing.
- In terms of advocacy for friends & family 27% of colleagues would recommend Alder Hey as a good place to work.
- Rest breaks received the lowest responses and will be investigated in support for improvement across the trust.
- Engagement shows no change and remains a challenge, senior leaders continue to support.
- A “You Said, We Did” project has been formed to provide assurance of colleagues being heard and action plans put into place.

Next Steps:

DS provided the committee with an overall update to the current figures of the pulse report highlighting the next report is due in February 2024 and will provide a further update to the committee for oversight on progression.

The Chair noted there is an extremely low number in terms of non-responses and asked for assurance on how this is being manged effectively. JP commented advising the trust is mandated to participate in the national Pulse Checks– she has been working with teams and seen a lot more interest in connection to the listening events which is providing good data and gave assurance to the committee this continues to be an area of focus for improvement.

Resolved: Team continues to effectively manage risks.

22/23/198 **SALS Research Proposal**

Committee received the SALS Research proposal and noted progress.

- Alder Hey was successful in gaining the Seedcorn funding through clinical research division, support by the Charity.
- This funding will provide a 2-day a week research opportunity within SALS for a 9-month period to review a high volume of data which is held in SALS and will make use of our intelligence.
- This will help to align the evidence and hard to measure impact and collect that feedback.
- Plan will be to review that data and report back into PAWC – ES suggested the need to use this data more broadly to provide greater board assurance.

The Chair congratulated on the success of gaining the seedcorn grant and noted good progress being made in terms of future developments.

Resolved: Team remains making good progress and continue to push through ongoing projects.

22/23/199 **An Approach to Celebrate & Recognition**

Committee received the Celebration & Recognition presentation and noted progress made within the data. GF highlighted the following:

- A collaborative working group has been established supported by HR, FTSU Guardian, SALS and staffside colleagues and is making good headway.
- The Recognition Event will re-commence in October 2023 and take place quarterly and will apply to individuals taking full retirement and leaving the organisation. Employees who meet the long service criteria will receive an award and formal letter sent to their home address.

<u>Next Steps:</u>

-
- An initial piece of work will be conducted relating to reviewing longservice criteria and potential ways around cost savings.
- 'Star of the month' will be explored improvement.
- Gill Kennedy, Event & Engagement Officer, will be supporting a review of communications around this piece of work.

The Chair noted good progress being made to the long service award event and 'Star of the month' and formally thanked GF for the report.

Resolved: Committee noted the report acknowledging is making good progress.

22/23/200 **Forthcoming Pension Changes**

Committee received the report and noted the recent updates. KA highlighted the following:

- In October 2023 there will be a revised national pension change following the last update of changes in April 2023.
- Main focus incudes additional flexibly for individuals towards the end of their careers
- Partial retirement in connection to the 2008-2015 scheme; there is an internal application process while the trust awaits national guidance confirmation.
- Online briefing sessions continue to take place to support Senior Leadership.

Next Steps

- Pensions information has been shared across the organisation and will continue to be communicated, supported by HRBPs.
- ELFs will also be of conducting sessions with colleagues and will continue to provide guidance for better understanding.

Resolved: Committee took note of the recent pension changes update and thanked KA for the updated report.

22/23/201 **Board Assurance Framework**

Committee received the Board Assurance Framework reflecting the July 2023 position.

ES informed the committee all risks are being updated to reflect the step changes required to deliver the 2030 Strategy. From September onwards, the risks will reflect a wider perspective in the context of the strategy. The proposal is to close the 'Wellbeing Risk' and replace with something more strategically focussed to reflect the changes needed regards the organisational culture to achieve Vision 2030.

Resolved: Committee received and noted the board assurance framework.

22/23/202 **Social Media Policy**

The social media policy was introduced as a new policy to the Committee. An overview had been submitted to the Committee and assurance was provided that the Policy had previously been reviewed by the Resources and Business Development Committee.

Committee noted the submission of the policy and agreed produce further assurance on the emphasis around the safeguarding aspect in line with the process and has non-Executive oversight.

Action: Committee noted further clarity within the policy is needed to capture the importance of confidentiality and safeguarding considerations.

Resolved: Committee considered the social media policy and deemed further insight is needed before ratification.

22/23/203 **Special Leave Policy**

The special leave policy was introduced to the Committee. An overview had been submitted to the Committee and assurance was provided that the Policy had previously been reviewed by HR and Staffside colleagues.

- Update on Volunteer work has been added to the policy.

Resolved: Committee received and approved the special leave policy.

22/23/204 **Health & Safety Committee (HSC)**

The Committee received the approved minutes of the HSC meeting held on (April 2023).

22/23/205 **Joint Consultative and Negotiation Committee (JCNC)**

The Committee received the approved minutes of the JCNC meeting held on (June 2023).

22/23/206 **Local Negotiation Committee (LNC)**

The Committee received the approved minutes of the JCNC meeting held on (April 2023).

22/23/207 **Education Governance Steering Group (EGSG)**

The Committee received the approved minutes of the JCNC meeting held on (April 2023).

22/23/208 **Any Other Business**

Nursery Update

MS announced the Nursery Inspection Report has been received highlighting the report revealed an overall "good" rating which is an excellent achievement, and a copy of the report will be shared with the Committee.

MS formally thanked Sharon Owen, Deputy Chief People Officer, and all colleagues within the nursery for this fantastic achievement.

22/23/209 **Review of Meeting – Chair's Report to Board**

- Annual Workplan & Terms of Reference was received and approved by the committee.
- Strategy Update: Committee noted the current progress of the strategy relating to the 6 identified deliverables which continues aligned to the 2030 vision.
- Divisional Metrics Update: Divisional metrics remains stable and on track. Challenges remain a focus and divisions have plans in place to address and

stabilise. PDRs / Turnover & Sickness Absence remains a key area of focus with plans in place to monitor.

- Internal Communications Update: Committee noted completion of phase 1 strategy development while moving into the second phase which is making good headway.
- Turnover Report: Committee welcomed the quarter 1 report and noted progress.
- Staff Survey Report: Committee noted the development of the staff survey which plans to launch on 20/09/2023 – 24/11/2023 and looks forward to receiving the data results.
- Pulse Report: Committee noted progress made detailed within the report.
- SALS Update: Committee noted the successful awarding of the seedcorn funding.
- Celebration & Recognition Update: Committee noted progress being made.
- Forthcoming Pension Changes: Committee noted recent changes to the pension update following April 2023.
- Social Media Policy: Submitted to the committee noting further developments have been identified before committee ratification.
- Special Leave Policy: Submitted and approved by the Committee.

The Chair thanked the Committee for today's insightful discussion and challenging questions and comments and welcomed any feedback on content and discussion of the meeting.

Date and Time of Next meeting

Wednesday 24th January 2024 at 2pm via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	**Transformation Programme**
Report of:	Natalie Palin, Director of Transformation and Change
Paper Prepared by:	Natalie Palin, Director of Transformation and Change

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	**Trust Board 22/23/06**: Operational Plan 22/23 Trust Integrated Performance Report **Strategy Board** – Strategic Scorecard (July 23)
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☑ Game-changing **research and innovation** ☑ **Strong Foundations** ☑
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☐

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

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

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

1. Executive Summary

The primary purpose of this report is to provide the Trust Board with an update on the progress of the delivery of our Vision 2030 Strategic Plan (23/24). Significant progress has been sustained across the year (April - Oct 23) and we have moved forward in the mobilisation of Vision 2030 despite a challenging operational environment, and the inevitable impact on leadership capacity resulting from periods of industrial action. During this period, we have 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 1. The active leadership of all SROs (Senior Responsible Officer) in recent months is allowing the translation of the programmes of work into deliverable plans, which is a real positive.

This report is designed to highlight progress against the below areas: -

- ✓ Initiation and delivery of our Strategic Initiatives
- ✓ The progress made in developing our Benefit Realisation approach.
- ✓ Strategic Governance
- ✓ Highlights areas of progress and good practice.

A key risk arising from the development and deployment of the Vision 2030 Strategic Plan is ensuring that we are organising ourselves for success and are not restricted by traditional organisational silos. Our success in delivery will be equally attributed to our ability to utilise and empower the widest range of organisational talent; with that in mind the key recommendations arising from this report are listed below: -

a) Development of a Single Integrated Plan for 2024/25, including both strategic and operational important change areas.
b) Governance and assurance reporting into Trust Board
c) Reviewing our Change Resources, to ensure that these are suitably aligned to our strategic priorities.

Please note: *As detailed in the May 2023 paper, governance and assurance has not been undertaken for any of the strategic initiatives thus far, but this will commence from the end of quarter 3. This also includes an action detailed to provide assurance around how our change approach is values led (Strategy Update, Sept: Trust Board).*

2. Background and Current State

Initiation and delivery of our Strategic Initiatives

Background: The approval of vision 2030 signals a significant shift in how we organise ourselves around CYPF areas of need, and development of an integrated programme of change. Our engine room for supporting the required new capabilities is through our Strategic Initiatives. There are 9 strategic initiatives, and these are high priority programmes that align with the overall vision and are crucial for achieving our long-term goals.

The strategic initiative mandates (March 23) were designed to illustrate the desired future state; delivered across a long-term multi-year programme. The Trust Delivery Management

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Office have played a pivotal role in establishing the mechanisms for the development of the strategic initiatives into formal programmes that support a shift from the current state into the proposed future state. Our Trust Brilliant Basics approach has underpinned our designed principles to ensure the voice of CYPF, our people and a cadence towards delivery were appropriate.

Current state: The below table illustrates our position regarding the initiation phase of our strategic initiatives (Nov 23). As detailed within the below status position, the effective management of a portfolio of programmes, inevitably means that programmes will be at different stages in their project life cycle, hence the importance of a strategic and adaptable approach.

Table 1: Strategic Initiative Initiation Phase

PHASE 1 INITIATION					
Strategic Theme	Senior Responsible Officer (SRO)	ID	Strategic Initiative	Initiation Date	Initiation Phase Completion
Unrivalled Experience	Chief Nurse and Experience Officer	1.1	CYP&F Engagement & Experience	Qtr 1 (23/24)	100%
Supporting our People	Chief People Officer	2.1	Thriving at Alder Hey	Qtr 1 (23/24)	95%
Supporting our People	Chief People Officer	2.2	Professional Development Hub	Qtr 4 (23/24)	20%
Supporting our People	Chief People Officer	2.3	Future Workforce	Qtr 4 (23/24)	10%
Pioneers Breakthroughs	Chief Futures Officer	3.1	Futures	Qtr 2 (23/24)	50%
Collaborating for CYP	Chief Strategy and Partnerships	4.1	Collaborating in Communities	Qtr 1 (23/24)	95%
Collaborating for CYP	Chief Strategy and Partnerships	4.2	CYP'S System	Qtr 2	10%
Revolutionising Care	Chief Digital and Transformation	5.1	New Models of Care	Qtr (23/24)	70%
Revolutionising Care	Chief Digital and Transformation	5.2	Digital	Qtr 1 (23/24)	95%
Revolutionising Care	Chief Digital and Transformation	5.3	Insight Led Decisions	Qtr 3 (23/24)	10%
*It has been agreed that the strategic initiative 'Futures', 'Professional Development Hub', 'Future Workforce' and 'New Models of Care' will be initiated in Qtr 4 rather than Qtr 2. In addition CYP's System startegic initiative has also been aligned and restrucutred under the Collaborating in Communities strategic initiative.					

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

Table 2: Strategic Initiative Implementation Phase

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

Our Benefit Realisation approach

Background: Benefit management gets to the heart of why we are delivering change to improve outcomes for CYPF. Being clear about measurable benefits is essential to effective planning, making it easier to align our strategic Initiatives and our ability to evaluate and understand that our changes are having the desired impact. A benefit driven culture is also critical in fostering accountability and enables data driven decision making and ultimately contributes to the design and development of robust programmes of change.

Vision 2030 proposed 12 new measures (Strategic Score Card: July 23, Trust Strategy Board) with the intended advantage of an improved capability in our decision making through precision and more accurate understanding of the impact of change mapped against the NHS Quadruple Aim. Whilst these new measures are in development, we are continuing to utilise some of our existing measures.

Current state: Shifting our benefit realisation approach has been a significant area of focus across quarter 2-3 (2023/24). Understanding our starting position around our benefit realisation approach is important, as it helps frame the progress achieved in context. We are moving from pockets of good practice in individual services, to a trust wide approach which allows the widest understanding of the impact of change. Progress in advancing our benefit approach is being reported through RABD, which has helped to drive forward our benefit method, ensuring transparency and accountability.

A key shift has been the development of a Benefit Case framework, which not only identifies the baseline position and anticipated benefits achieved our process level change; it creates a robust framework for identification and tracking benefits achieved as result of our planned activities including those generating a cash releasing saving, efficiency, income generation and social value return. Moving forward all investment decisions and programmes of change will require a benefit case at initiation/ approval; diagram 1 details our initial starting point for the development of series of benefit cases, with monitoring and tracking into RABD (Appendix 1 – includes an example benefit case).

Diagram 1: Benefit Case Plan

	Benefit Cases					Cash Releasing - Benefit target			Efficiency Releasing			Revenue Income		
	SRO	Status	Primary Driver	Baseline Position	Target	Cash Releasing - target	YTD	Variance	Efficiency Releasing - Target	YTD	Variance	Efficiency Releasing - Target	YTD	Variance
To improve trust wide FFT scores by 6%	N. Askew	Draft	Patient Experience FFT	89%	95%				£8,396.00					
To reduce patient harm by 25%	N. Askew / A. Bass	To be developed	Number of incidents rated as Minor Harm or above per 1,000 bed days	1,159	873				£111,627.00					
1% Reduction in Staff Turnover	M. Swindell	Draft	Staff Turnover	12.60%	5.5%	589000			£1,386,000.00					
Our people Thriving: To improve retention *(targeted to workforce segments)*	M. Swindell	To be developed	Thriving Index	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC			
To reduce the average length of stay – Personalised Care by 10%	K. Warriner	Draft	Number of Co-ordinated care clinics	TBC	TBC	10% reduction of patient cost	TBC		10% Reduction in waste steps	TBC				
Get me well: To achieve an 8% WNB rate	A. Bateman	Draft	Reduction of WNB Rate	9.82%	8%	TBC	TBC	TBC	TBC	TBC	TBC			
Get mew well: To improve timely access into Urgent Care >76%	A. Bateman	To be developed	%76> 4 hours urgent care access		>76%									
To increase our elective capacity (virtual ward)	A. Bateman	To be developed	tbc		TBC	TBC	TBC	TBC	TBC	TBC	TBC			
Futures – Deployment*	A. Bateman	To be developed		TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC			
Reduce Variation in Health Outcomes	D. Jones	To be developed	tbc		TBC	TBC	TBC	TBC	TBC	TBC	TBC			
Achieve New Zero	R. Lea	To be developed	Achieve net Zero by 2030	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC			
						£589,000.00	0	0	£1,506,023.00		0	£0.00		0

Governance and Assurance of our Integrated Plan

Background: Effective programme governance is important as not only does it provide a structure to manage change, but it also ensures accountability for the leadership of change. In establishing our Vision 2030 Integrated Programme a new structure of internal governance and delivery forums where developed (Vision 2030: April 23, Trust Board). Table 2 is designed to provide assurance to the Board that we have established these forums and have invested a significant leadership capacity in supporting the mobilisation of these structures.

Table 2: Strategic Plan Governance Structure

Governance forum	Frequency	Chair	No. YTD
Strategy Leadership Board	Quarterly	Trust – Chair	2
Strategy Leadership Group – Scrutiny Areas of Need	Quarterly	CEO	1
Strategy Leadership Group	Twice monthly	Managing Director	3 (Stepped down August and Sept)
Strategic Initiatives – Programmes	Weekly / Fortnightly	SRO	1
Strategy Delivery Group	Weekly	Director of Transformation	21

A positive shift during quarter 3 in our governance approach has been the increased leadership capacity that SROs have been able to provide to their specific strategic initiatives. This has positively impacted on the frequency of our Strategic Initiatives operational meetings, in accordance with an Agile/Prince 2 methodologies we have sought to strike the balance of effective oversight whilst achieving the minimal viable bureaucracy. A key component of this working principle is frequent short meetings, opposed to committee style programme meetings, this is designed to engender a delivery cadence.

As with any newly established process testing and learning is crucial for driving impact and overall effectiveness; to that end Table 3, details the proposed changes to the governance arrangements. An effect of the outlined amendments is the inclusion of specific reporting into the Trust Board, on a by-monthly frequency.

Table 3: Revised Governance Arrangements

Governance forum	Purpose	Frequency	Chair
Trust Board	Strategic Plan – Governance and Assurance	By-monthly	Trust -Chair
Strategy Leadership Board	Strategic Direction and Outcome achievement	Quarterly	Trust – Chair
Scrutiny Areas of Need	To review our success and progress in organising ourselves around CYPF Need.	Quarterly	CEO
SROs – Strategic Initiatives Programmes	Alignment: align our initiatives, resources, and priorities, ensuring that they remain in sync with our overarching strategy.	Monthly	Managing Director
Strategic Initiative Programmes	Programme Board - for our Strategic Deployment, with accountability for achieving the 2030 vision.	Monthly	Managing Director
Strategic Initiatives – Programmes	Weekly / Fortnightly	Weekly / Fortnightly	SRO

Strategy Delivery Group	Weekly	Weekly	Director of Transformation

3. Assessment of Progress

Substantial progress has been made in a relevantly short period of time, sustaining, and signaling a more fundamental shift in our approach to the management of change and our journey towards Vision 2030. Table 4 highlights key achievement and good practice, against our milestone plan (appendix 2).

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

Table 4: Key Achievements and Area of Good Practice

Strategic Objective	Baseline / Target	Highlights	Area of good practice
Experience & Engagement	Target – 95% CYPF Satisfaction Score (FFT) YTD – 93% (FFT)	- **Experience driving the entire organisation** - Launch CYPF Promises and Warm Welcome Standards, co designed with CYP. - £21k investment secured from charity grant towards development of virtual tours. - Experience and Engagement Week (Oct-23) Next one scheduled (Feb-24) - New monthly experience celebration email to embed experience standards	- Warm Welcome working group (Chair by Laura Strachan) and recruited as an internal development opportunity. - Utilising expertise of industry experts in 'customer service management' advancing our approach.
Our people	1% reduction in staff sickness rates 5.5% 1% reduce staff turnover to 13% YTD - 13%	- **Thriving Leaders** – Managers Essential Programme defined and in-development. - **Preceptorships:** PID approved, current policies and procedures reviewed, surveys and focus groups - Stay conversations embedded into our peoples' PDRs - Targeted interventions with Divisions and HR-BPs improving scrutiny and oversight.	- Pivoting the collective resource around Precentorships and Development of a Managers Essentials Offer. - Churn methodology defined.
Futures	No. Of solutions deployed to care +/- to market	- Strategy advancing well, being socialised and feedback incorporated - Futures Leadership Group established - 1st commercial partnership developed, and nearly ready for sign-off	- 124 staff members contributed to our thinking around the Futures strategy via engagement sessions.
Collaboration in communities	Reduce variation in health outcomes YTD – position impacted through reporting	- Family Hub offer & pathway agreed, CAB partnership in development. - x2 B5 posts secured for support expansion of employment initiatives - Advocacy working group in place, year 1 focus agreed - Development of our Social Value Calculator	- Opportunity to create a Social Value Fund (annual charge to suppliers) potential to generate £360,000 per annum (£250x40% of suppliers) • Get Me Well: Further partnerships established across the system around respiratory pathway – VIP lane in development link to LCC and CAB

Strategic Objective	Baseline / Target	Highlights	Area of good practice
Revolutionising Care	Efficiency / productivity Clinical Capacity (Elective Capacity) To be baselined	- The Go Live of MEDITECH Expanse 2.1 (Alderc@re) successfully took place in September 2023 - Development of the Alder Hey Anywhere at testing phase **Operational Improvement** - Virtual ward pilot started, following successful lobbing to invest in paediatric care £200k investment secured. - Development of PAU – aligned to 'Get Me Well'	- Virtual ward, contributing to our areas of Need for both Get me Well and Personalised Care. Biggest paediatric virtual ward in country and consistent achieving 80% occupancy. - Clinical Summits (2) - **Personalised Care**: Clinical workshops (3) consensus on the definition of the level of complexity that warrants coordination as a starting point.

Opportunities for further enhancement: -

a) Development of a single Integrated Plan for 2024/25, including both strategic and operational important change areas. Moving towards an Integrated Plan for 2024/25 is a component of an effective quality management system (Brilliant Basics), creating a streamlined focus.

b) Our current centralised Delivery Management Office (4.5 FTEs) resource is allocated to support the deployment of our vision 2030 strategic plan. There are however other colleagues appointed in 'project, programme and change roles' across the Trust. We are recommending a review of our trust wide resources to ensure that these are suitably aligned to our strategic priorities.

4. Conclusion

In conclusion, this paper details a significant progress in the development and implementation of our vision 2030 Strategic plan (23/24). A key cross cutting theme throughout this report has been how we organise ourselves for success, and ensuring we have established robust systems of control. The report has also highlighted opportunities for further enhancement to ensure appropriate resource management aligned to a single Integrated Plan for 24/25. The paper provides a high level of assurance around the system of control, the highlighted areas of opportunity are designed to address key risks in delivering the level of organisational and cultural change outlined through vision 2030.

4. Recommendations & proposed next steps

The key recommendations arising from this paper is to note the significant progress made to date. To approve the below areas, with reporting of progress to be included in the next board report Feb 2023.

a) Development of a Single Integrated Plan for 2024/25, including both strategic and operational important change areas.
b) Enhancement of assurance ratings to include assessments on whether we are making and embedding change in the 'right way' as per change management methodologies.

0269c) Introduction of by-monthly reporting into Trust Board.

d) Reviewing our Change Resources, to ensure that these are suitably aligned to our strategic priorities.

Appendix 1: Benefit Case Example

Benefit Case

VISION 2030

Benefit Case – 1% Reduction in Staff Turnover (23/24)

Alder Hey Children's NHS Foundation Trust

Benefit Owner	M. Swindell	
Strategic Objective	People - Thriving	
Finance Lead	Esme Evans	
Driver	Baseline 22/23	Target 23/24
Staff Turnover	**12.6%**	**11.6%**
Sickness	**6.5%**	**5.5%**

Impact of Staff Turnover and Sickness

What is the impact

- Unsurprisingly a high level of turnover, impacts on other colleagues, due workforce gaps, leading to increase staff burn out leading to sickness, reduced morale and agency spend.
- It impacts on the attractiveness of the organisation and our ability to retain our people.
- Gaps in our workforce and recruitment of less experience staff also impacts on productivity.

Strategic Initiative programme

Workstream Improvement Activities

Preceptorship: To develop a meaningful and effective preceptorship that provides a structured start for newly qualified practitioners to support their transition into the workplace .

Thriving Leaders: To develop and enhance the skills of our leaders across the organisation, to support our people to thrive.

1 Doing well (In work)

Measure	Baseline 22/23	Target 23/24	£ releasing Efficiency
Reduce sickness rate – 1%	6.5%	5.5%	**£894k** (Cost of absence)
Reduction in FTE days lost to absence	87,053	78,347.91	
Reduction in bank/agency spend - % 1	£308k Av. monthly spend	£259k	**£589k annual** **£49k pm**

2 Retain

Measure	Baseline 22/23	Target 23/24	£ releasing / Efficiency
Reduction in staff turnover (Permanent FTE)	413 – 12.6%	372 11%	**£492,000** (£12k to replace – recruitment and on boarding)
Reduction in Staff Churn	34.85%	33.85%	
Improve nurse retention (FTE)	12.13% (137)	11%	
Improve AHP retention	14.49 % (42.6)	10.2%	

3 Productivity (Cross Cutting – SI)

Measure	Baseline 22/23	Target 23/24	£ releasing / Efficiency
Productivity shift of 0.04 in income to cost ratio through new ways of working	0.97	0.94	Efficiency
Cancelled clinical activity due to sickness	Awaiting data		*- Impact on productivity (due to Churn?) cancelled clinical / converted*

Centrally Tracked 6 months

- Include on the benefit register, CIP tracker
- IPR and Stategic Score Card

Strategic Initiatives : Cash Releasing	Actual Tracked (6 m)
Savings from reduction in bank/agency spend	Monthly average YTD £308k

Strategic Initiatives : Cash Releasing

Budget Adjustment – Allocations to Divisions

Appendix 2: Milestone Plan 2023/24-2024/25

			23/24			24/25				25/26			
	Driver Metrics	**CYPF Need**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Experience	CYPF Effort Score	All	Interim target to reach a 95% CYPF Experience Score				Baseline to be established		Reduce CYPF Effort Score				
	Patient Harm	All	25% Reduction in Patient Harm			Need Measure							
Our people	Staff Turnover	All	1% Reduction in staff turnover			2% reduction in staff turnover							
	Staff Thriving Score	All	Interim target to reduce sickness by 1%			Baseline to be established		Improve Staff Thriving Score					
Pioneering	Innovation Adoption (revenue / investment)	Bring me the future	Baseline being established					Number of solutions deployed to care +/- to market					
Collobrating	Social Value Generated	Improve my life chances	Baseline being established			£159k of Social Value generated							
	Reduce variation in health outcomes (Core 20+Plus)	Improve my life chances	Dentistry-0 CYP < 10 yrs waiting > 52 weeks; CAHMS-No. of CYP referred from BAME increases; LD-Reduce waiting times in line with non-LD										
Revolutionising Care	Efficiency / Productivity Target (Resource Optimisation)	All	3% Efficiency Target (Resource Optimisation)			5% Efficiency Target (Resource Optimation)							
	To reduce avoidable missed education	All				Baseline Measures to be established							
	To improve timely access to care (Urgent and Elective)	Get me Well	Incr. Virtual Ward capacity from 15 to 20										

			Q2			Q3			Q4			Q1			Q2			Q3			Q4			Q1	Q2	Q3	Q4
	Workstreams	**CYPF Need**	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	J-M	A-J	J-S	O-D
1.1	**CYP&F Engagement & Experience**	**All**																									
1.1/1	All CYPF receive a 'warm Alder Hey welcome'	All										✶															
1.1/2	Staff are recognised for providing outstanding experience	All									✶																
1.1/3	Suite of 'Experience Standards' launched	All								✶																	
1.1/4	Seeking the voice of CYP&F	All																		✶							
1.1/5	Hotel & Customer Services providing outstanding customer service	All													✶												
1.2	**Thriving at Alder Hey**	**All**																									
1.2/1	Accessible and Diverse Recruitment	All																		✶							
1.2/2	Enhanced Induction and Orientation	All														✶											
1.2/3	Thriving Leaders Framework	All														✶											
1.2/4	Enhancing Preceptorships	All													✶												
1.3	**Professional Development Hub**	**All**	To be initiated Q4 (23/24)																								
1.4	**Future Workforce**	**All**	To be initiated Q4 (23/24)																								
1.5	**Futures**	**Bring me the future**	To be initiated Jan 24																								
1.6	**Collaborating in Communities**	**Improve my life chances**																									
1.6/1	Establish Health Inequalities & Prevention Programme	Improve my life chances									✶																
1.6/2	Further embed Greener Initiatives	Improve my life chances									✶																
1.6/3	Renowed advocates for CYP healthcare need	Improve my life chances																		✶							
1.6/4	Creating opportunities with social value for CYP	Improve my life chances																	✶								
1.8	**New Models of Care**																										
1.8/1	**Get me well -** Transfroming Respiratory	Get me Well																					✶				
1.8/2	**Get me well (Winter Priorities) -** New pathway created for virtual UEC pathway	Get me Well						✶																			
1.8/3	**Personalised Care - C**omplex Care Care Co-ordinator	Personalised Care																		✶							
01/08/2004	**Digital Communication Optimisation**																										
Ops	**Ops** - Enhancement of Virtual Ward Offer	All									✶																
1.9	**Digital Centre of Excellence**	**All**																									
1.9/1	**Digital Centre of Excellence** - Alderc@re optimisation	All														✶											
1.9/2	**Digital Centre of Excellence -** Launch infrastructure strategy	All																									
1.9/3	**Digitally Enabled Personalised Care -** Launch Alder Hey Anywhere Phase 1	All																									
1.9/4	**Digitally Enabled Personalised Care -** Symptom checker expansion and Virtual Urgent Care Model	Get me Well																									
1.10	**Insight Led Decisions**		To be initiated Jan 24																								

✶ Planned activity to be finished

Planned activity not started

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 23rd October 2023 at 13:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	John Grinnell	Deputy CEO/CFO	
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nurse	
	Audrey Chindiya	Business Accountant for Medicine	
	Jenny Dalzell	Deputy Director of Strategy and Partnerships	(DJ)
	Esme Evans	Business Accountant, CAMHS	
	Rachel Greer	ACCO, CAMHS	
	Hannah Grierson	Divisional Accountant for the Division of Medicine	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Chloe Lee	ACCO, Surgery	
	Graeme Montgomery	Business Accountant for Surgery	
	Sian Calderwood	ACCO, Medicine	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda Item:	Jane Halloran	Acting Deputy Development Director	

23/24/107 Apologies:

Adam Bateman	Chief Operating Officer	
Fiona Marston	Non-Executive Director	
Dani Jones	Director of Strategy and Partnerships	(DJ)
Catherine Kilcoyne	Deputy Director Business Development	
Emma Hughes	Acting Manging Director for Innovation	
Clare Shelley	Associate Director Operational Finance	
Melissa Swindell	Director of HR & OD	(MS)

23/24/108 Minutes from the meeting held 25th September 2023
The above minutes were approved as a true and accurate record.

23/24/109 Matters Arising and Action log
All actions for this month have been included on the agenda.

23/24/110 Declarations of Interest
There were no declarations of interest.

23/24/111 Finance Report
Month 6 Financial Position
The Trust is reporting in line with plan, this includes £0.7m contingency, £1m released from divisional reviewed provisions, £1.4m vacancies and £2m benefit from further unutilised provisions & non-operating items.

RABD noted the continued finance pressures. The Chair asked for an update on the impact this will have in 2024/25, the finance team agreed to look into and provide an update at the November RABD.
Action: Finance Team

Cheshire and Merseyside remains under considerable financial pressure, with 7 providers falling behind their planned position. The impact of Industrial Action is an

area of focus across the ICS, recognising the impact this is likely to have on the ability to achieve activity plans and recovery.

Resolved:
RABD received and noted the M6 Finance report.

23/24/112 Month 6 Integrated Performance Report

RG highlighted:

- 4 Hour Performance in ED remains above national standard despite a challenging month in Sept, higher attendance continues of an evening.
- A safety alert in relation to a national shortage of an ADHD drug had been covered in the News, AH are working through any risks.

SA asked for details on the highlighted areas under Was Not Brought. RG advised there are speciality hot spots within community, teams are working with families to provide support for them to attend appointments.

Resolved:
M6 IPR report was received.

An introduction was given to the second quarterly divisional review.

23/24/113 Surgery Division

CL highlighted:

- Division continues to be significantly affected by Industrial Action, 291 elective theatre sessions lost YTD at end of August
- Trauma Orthopaedics are extending sessions from half to a full day.
- Continued requests for Theatre to staff to work additional shifts is becoming an issue or staff, SD are working closely with staff to review working patterns and reduce requests.

A discussion was held on the main three concerns with coding and different approaches being tested to resolve the issues.

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

23/24/114 Medicine Division

SC highlighted**:**

- OPFU activity is significantly above plan mainly in Gastro, Endo, Paeds, Therapies and Allergy – work is in progress to address this.

AC went through the key drivers of the adverse YTD position including; Consultant premium costs related to maternity leave, restricted duties & sickness (14 WTE) in core medical specialties, (£0.7m) and the impact of Industrial Action (£0.3m).

RABD discussed the £3.6m recurrent CIP for 23/24 noting the risks and actions going forward.

The Chair asked for further details from both Surgery and Medicine on high and low income areas, deficit and plans. RL noted Finance has recently recruited to the SLR team who should create some additional capacity to work through this.
Action: Medicine/ Surgery Finance, SLR teams
Resolved:

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

23/24/115 Community and Mental Health Division

RG highlighted:

- Community Paediatric activity is ahead of plan year to date, however Clinical Health Psychology is slightly behind plan.

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

23/24/116 Corporative Collaborative

ES highlighted:

- Ahead of plan due to extra income in Resus and Finance which offsets income in Catering, Car Parking and Academy
- Going forward legacy of legal fees are being worked through.

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

23/24/117 2023/24 Year End Forecast

As discussed at the last RABD, using the forecast from the month 6 position. This has been built up from the divisional position and then overlaid with Trust level assumptions. Three scenarios have been worked through; Best, Worst Case, Most Likely. Most likely forecasted position as at M6 is a £12.3m surplus . In line with the planned control total requirement to C&M ICB.

Resolved:
RABD received details of next steps noting a update would be received at the November 2023 Trust Board before submitting final plans to ICB on 20th November 2023.

23/24/118 Benefit Realisation

Resolved:
Due to the meeting running overtime it was agreed this item would be deferred to the November RABD.

23/24/119 Campus Update

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

JH noted an update on the costing for the Neonatal unit will be presented to RABD on 27th November 2023.

Construction is due to start on the new nursery January 2024 – October 2024.

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

23/24/120 Aldercare

The AlderC@re system went live for all services over the period 8th to 12th September 2023. The old Meditech EPR was taken out of service from 23:00 on 8th September and the system was then upgraded to Meditech Expanse.

An overview of main challenges in the immediate post go live period was received noting they had been resolved and the good progress in service desk tickets reducing each week.

Lessons learnt included more time to be spent with admin teams.

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

23/24/121 PFI

Resolved:
RABD received and noted the current position.

23/24/122 Board Assurance Framework

Resolved:
RABD received and noted the Strategic Risks.

23/24/124 Any Other Business

No further business was reported.

23/24/125 Review of Meeting

RABD discussed the second quarterly face to face meeting.

Date and Time of Next Meeting: Monday 27th November 2023, 1300, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th December 2023

Paper Title:	**Board Assurance Framework Report 2023/24 (October)**
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 October 2023.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2023/24

1. Purpose

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

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

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

2. Review of the BAF

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

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Resources and Business Development Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Resources and Business Development Committee
1.4	Access to Children & Young People's Mental Health	Resources and Business Development Committee
		Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	Resources and Business Development Committee
3.2	Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment	Trust Board
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	Research & Innovation Committee

3. Summary of BAF at 8th November 2023

Ref, Owner	Risk Title	Board Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC PILLAR: Delivery of Outstanding Care				
1.1 NA	**Inability to deliver safe and high-quality services**	SQAC	3x3	2x2
1.2 AB	**Children and young people waiting beyond the national standard to access planned care and urgent care**	RABD / SQAC	**4x5**	3x3
1.3 AB	**Building and infrastructure defects that could affect quality and provision of services**	RABD	4x3	2x3
1.4 LC	**Access to Children and Young People's Mental Health**	RABD / SQAC	**3x5**	3x3
STRATEGIC PILLAR: The Best People Doing Their Best Work				
2.1 MS	**Workforce Sustainability and Development**	PAWC	**4x5**	3x2
2.2 MS	**Employee Wellbeing**	PAWC	3x3	3x2
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC	**3x5**	4x1
STRATEGIC PILLAR: Sustainability Through External Partnerships				
3.1 DP	**Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus**	RABD	3x4	3x2
3.2 DJ	**Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.**	RABD	4x3	4x2
3.4 JG	**Financial Environment**	RABD	**4x4**	4x3
3.5 DJ	**ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment**	Board	**4x4**	3 x3
STRATEGIC PILLAR: Game-Changing Research and Innovation				
4.1 CL	**Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People**	Research & Innovation	3x3	3x2
4.2 KW	**Digital Strategic Development & Delivery**	RABD	3x4	2x4

4. Summary of October 2023 updates:

- ***Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. (DJ).***
  Risk reviewed - BAF refresh approved by Strategy Board Oct 23 and going to Trust Board in Nov 23. After which this will be refreshed to reflect Vision 2030 and associated delivery/execution thereof. No change to existing risk score in month.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed in light of Vision 2030 BAF refresh; recommendation to change approved by Strategy Board Oct 23 and going to Trust Board Nov 23. ICS CYP Committee has had its inaugural meet in Oct 23. Current risk evidence, actions and controls assessed and no change to score in month.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Additional EDI resource sought through the Trust's Business Case process. All networks fully established action plans in place.

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

  The second phase of improving water quality within the closed loop system is ongoing with the program due to complete in October 2023. It is hoped that this will prevent further pipework from corroding. Full report on corroded pipe issues has been requested from Project Co by the end of November. Mitie have also revisited all the distribution board covers to ensure the mitigation is still effective (protection from water).

  Out-of-range water temperatures continue to be monitored and local mitigation's 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.

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

  ED leak has been cause of concern. Plan to reinstate issued 27/10.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in October was exceptionally challenging, with significant volume of attendances (regularly >200 per day). In month performance against the 4 hour target was 70%, missing the national standard of 76%.
  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 expect >90% compliance during October (pending confirmation of finalised figures).

Capacity to reduce long waits (RTT) has also been challenged, with agreement to reduce the number of sessions per week in the Theatre schedule from end of October to mitigate pressures including staff absence. There has been a subsequent increase in 65ww from 202 to 236 (pending validation). Division of Surgery continue to actively manage this with focus on ENT, Dental and Spinal (all of which have protected theatre sessions). There is also an ongoing risk that future Industrial Action will be announced which is a threat to elimination of 65ww by March 2024

- ***Inability to deliver safe and high-quality services (NA).***
  This risk has been reviewed as we transition to align the BAF to 2030 Vision.

- ***Access to Children and Young People's Mental Health (LC)***
  Review undertaken and new actions included in action plan following service review with Clinical Leads.

- ***Financial Environment (JG).***
  Risk reviewed and score remains at 16 as despite Alder Hey remaining on plan in year, the uncertainty of the system financial position and the future funding arrangements for industrial action places a high risk on the ongoing sustainability. CIP delivery remains at significant gap recurrently and becoming more of a challenge through the winter period.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (DP).***
  Works to the new park are progressing as per the revised programme agreed with Liverpool City Council. Risk reviewed, score static given the ongoing works requirement for the remainder of the Campus.

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed. Score reduced following Aldercare go live in terms of impact reduction from likely to possible. Optimisation programme to commence imminently with wider digital change programmes recommencing post go live.

- ***Workforce Sustainability and Development (MS).***
  Risk reviewed, risk score remains unchanged. All associated actions on track.

- ***Employee Wellbeing (MS).***
  Risk reviewed and actions updated. No change to risk rating,

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  Risk reviewed, no change to score in month and all actions remain on track.

5. Recommendation

The Board is asked to:

- note the 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.

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.

Nov 2023

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

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	November 2023	
		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.
NICE Guidance	2. Each divisional governance lead will be responsible for ensuring this process is reviewed and progress made within the divisional structures	31/01/2024	There has been significant improvement in overdue reviews, work continues to focus on the implementation of nice guidance and is monitored through CEOG and escalated via SQAC. Deep dive undertaken into overdue long standing NICE guidance's by divisional clinical governance leads Sept 23

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.

Nov 2023	
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

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	November 2023	
		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

Nov 2023	
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
Remedial Works not yet completed; lack of confidence in timescales being met.

Action	Description	November 2023	
		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.

Nov 2023	
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

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to outstanding confirmation on new investment.

Action	Description	November 2023	
		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	31/10/2023	
Approach to management of clinically urgent appointments to be reviewed	Clinical leads to review approach to management of clinical urgent appointments	31/12/2023	
Clinical Job Planning	Review of job plans to be completed to agree standardised job plans for banding across services. To include: - number of expected contacts - typical case load size	31/12/2023	
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	31/12/2023	
Data / BI - case load monitoring	Case load size reporting and monitoring to be improved including: - BI dashboard to be created - validation of data	31/10/2023	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/12/2023	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/10/2023	- 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	31/12/2023	
Recruitment - timely recruitment to vacancies using 2023/24 funding	Timely recruitment to vacancies to include - meet with finance to review skill mix for services	31/12/2023	
Referral triage process to be reviewed	To review referral triage process across CAMHS	31/10/2023	
Review of KPIs and Reporting Measures	Review of KPIs and reporting measures for Sefton & Liverpool place	13/10/2023	
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	30/11/2023	Ongoing management of this is via the Weekly Performance Meeting with admin, service manager and operational manager
Staff survey completion	To ensure completion of staff survey	31/10/2023	

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
20	6	People & Wellbeing Committee

Description
Failure to deliver consistent, high quality services for children and young people due to: 1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation.

Nov 2023	
Control Description	Control Assurance Internal
Workforce KPIs tracked through the corporate report and divisional dashboards	Corporate Report and KPI Report to PAWC
Bi-monthly Divisional Performance Meetings.	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR	monthly reporting to the Board via the Corporate report -@reporting at Ward level which supports Ward to Board
Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.	ESR self-service rolled out
HR Workforce Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group established	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	New Learning and & development Prospectus Launched - June 2019
Apprenticeship Strategy implemented	Bi-monthly reports to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation	People Strategy report monthly to Board
International Nurse Recruitment	78 international nurses recruited since 2019
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to PAWC OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to PAWC
Recruitment and Apprenticeship strategy currently in development	progress to be reported to BAME task force and People and Wellbeing Committee
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

GAPs
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness Absence levels higher than target. 3. Lack of workforce planning across the organisation 4. Talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation 7. COVID related sickness impacting upon service delivery 8. Increasing turnover rates 9. Industrial action planned

Action	Description	November 2023	
		Due Date	Action Update
1. Not meeting compliance target in relation to some mandatory training topics	Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	30/04/2023	Work continues to monitor sickness absence through the divisions and will all of the relevant support through OH and SALS
2.1/95/KLE - ACT5	3. Development of a methodology to roll-out across the organisation.	30/04/2023	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.

Nov 2023	
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
HR Workforce Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@ Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	Diversity and Inclusion Action Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked until Nov 2020
EDI Steering Group now established - Chaired by NED	Minutes reported into PAWC

GAPs
EDI under resourced to deliver significant EDI agenda

Action	Description	November 2023	
		Due Date	Action Update
2.3/86/LLE - ACT1	Create Action Plan	31/03/2023	
2.3/86/LLE - ACT2	Create Action Plan	01/07/2023	work required to further develop the networks - led by Head of EDI Angela Ditchfield Date Entered : 13/04/2023 13:00 Entered By : Melissa Swindell

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
		David Powell

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

Nov 2023	
Control Description	Control Assurance Internal
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision.
Weekly Programme Check.	The Project Team run a weekly programme check.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group
Programme and plan (agreed with LCC and LPA) to return the park back by November 2023.	Updates on progress through Campus report .

GAPs
PARK: 1. Adoption of the SWALE by United Utilities 2. Residual infrastructure works delaying possession of land 3. Delays on bespoke items from supply chains 4. Weather conditions causing potential delays CAMPUS: 1. Planning approvals for modular buildings to allow demo of Catkin and continuation of park works. 2. Successful realisation of the moves plan. 3. Funding availability and potential market inflation.

Action	Description	November 2023	
		Due Date	Action Update
Park Handover	Establish Programme Board for handover for Park to LCC	31/12/2023	Meetings will continue with LCC until full legal agreement of transfer of Park to the Council.
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
Successful realisation of the moves plan	Establish timeline and plan for the Police station upgrade and conversion	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.

Nov 2023

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

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	November 2023	
		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	

0290

Failure to deliver against the trust strategy and deliver 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
Well-Led		Claire Liddy

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	6	Research & Innovation Committee

Description

The trust strategy requires the growth of game changing research and innovation activities to enable an increase in R&D investment levels and generate commercial opportunity. The failure to deliver R&I strategies could result in an inability to achieve growth and new partnerships plans which will limit R&D investments and delay new discoveries.

The delivery of the R&I activities may also expose the Trust to contractual and reputation risks due to the need to enter into legal agreements with academia, large corporate's, SMEs and investors.

The delivery of the R&I activities will lead to industry data collaborations and AI with commercial contracts which will require robust data governance and ethics.

Nov 2023

Control Description	Control Assurance Internal
R&I: RABD review of commercial issues per Corporate governance manuals, oversight of Innovation Ltd Corporate governance manual and oversight of deal diligence (commercial and reputational) . Trust Board oversight of shareholding and equity investments and intellectual property.	Reports to RABD / Trust Board and associated minutes
R: Establishment of Research Management Board	Research Management Board papers.
I: Innovation Committee and RABD Committee	Committee oversight of Innovation strategy with NED expertise
I: Clear Management Structure and accountability within Innovation Division	ESR Divisional Hierarchies
R&I: Plans for joint research & innovation clinical leadership	Job Description and Hierarchy
R: Clinical trials Covid recovery plan operational.	Trust Board papers
R: Research Division monthly focus on research at the Research Management Board to support strategy delivery.	Research Management Board papers
I: Legal Partner now in contract to advise on partnership structure and intellectual property	Letter of engagement
R&I: Trust Policies and online declaration portal (gifts & hospitality, sponsorship etc.)	Trust Policies and digital audit trail to audit committee
R&I: Formal Press Releases and external communications facilitated through communications department	Communications Strategy and Brand Guide
R&I: Industry Partner and AI Data governance. To adopt Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOPs
New Commercial partnerships SOP approved at IC and RABD OCT/NOV 22	
Innovation risk register expanded and included in Risk Management Group (RMG)	

GAPs

1. Availability and incentivisation model for resources to deliver strategy.
2. Capacity for business development and inward investment.
3. External factors such a Covid and Brexit creating delays in expansion plans.
4. Capacity of clinical staff to participate in research/innovation activity.
5. Capacity of clinical services to support research/innovation activity.
6. Availability of space for expansion of commercial research/innovation growth.

Action	Description	November 2023	
		Due Date	Action Update
4.1/63/n E - ACT4	3. Agree coordinated plan with LCR and other national R&D funders eg UKRI to bring investment into child health innovation	30/04/2024	Bid is progressing through approvals governance, funding anticipated Apr 2024
Agree plan with LCR and other national R&D finders re investment for child health	Raise external investment into the innovation programme	30/04/2024	The SOC submitted and accepted by LCR CA. Funding is being progressed via the investment zone bid

Employee Wellbeing	
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 effectively support employee health and wellbeing and address mental ill health which can impact upon the delivery of care and achievement of strategic aims.

Nov 2023	
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 relaunched after being on hold during the peak of the pandemic	Celebration and Recognition Meetings established; reports to HWB Steering Group
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Counselling and Psychological support - Alder Centre	
Trust Briefs - keeping staff informed	
Spiritual Care Support	
Clinical Health Psychology service support for staff (including ICU)	
Resilience hub now live offering additional psychoeducational support to all staff in the region and taking self-referrals from frontline staff since 12th April	
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC monthly
Health and Wellbeing Conversations launched	HWB Conversations now embedded as part of the PDR process supported by training and support from SALS, OD and Wellbeing Coaches where needed. Key metric currently is %PDR completed but value of HWB conversations also assessed via Quarterly People Pulse
Ground TRUTH session at execs (monthly) to feedback outcomes of team debriefings, surveys and targeted listening events, agree actions and communicate to the organisation via briefings and Ground Truth bulletin	Minutes of exec meetings
NICE Mental Wellbeing at Work Guideline issued and baseline assessment complemented	Baseline assessment
Regular Schwartz Rounds in place and Team Time in development in high pressure areas (e.g. ED and ICU)	
Network of SALS Pals recruited to support wellbeing across the organisation	
Drop in support sessions offered to ED staff during high pressure times to help to manage rising levels of moral distress and burnout	
Staff support plan for all staff to manage social and emotional impacts of strike action. Plan reviewed and communicated as part of tactical command and developed in consultation with nursing community and local strike committee	

GAPs

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of the pandemic and its impacts (PTSD, anxiety and depression rates nationally show significant rise amongst health care staff and suicide rates also rising among healthcare staff; cost of living crisis further increasing pressure for staff and poverty a known determinant of mental ill health).
2. Increase in significant mental health difficulties in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and difficulties in accessing secondary mental health provision in the community in a timely way
3. Increase in self-reported rates of burnout and work-related stress as assessed via 2022 Staff Survey and consistent with national picture for NHS staff
5. Lack of private space to support staff and wellbeing activities
6. Likely psychological impacts on staff due to impacts of industrial action

Action	Description	November 2023	
		Due Date	Action Update
2.2/126/dKE - ACT11	A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	01/05/2023	Meeting with EPR lead held. Agreed actions to develop Debriefing policy and guide. He will lead of draft policy and toolkit using materials developed in SALS and we will meet again to progress
2.2/126/dKE - ACT13	Increased space to be developed for staff support and staff wellbeing. This includes SALS specific space and also space to be more widely available to staff. Consider also specific HWB budget which departments can use to enhance current wellbeing spaces	30/06/2023	Date amended as action not closed
2.2/126/dKE - ACT14	Task & finish group established, led by SALS Manager and with mixed role attendance across the Trust to develop an action plan. Outputs to report to HWB Steering Group	30/06/2023	Task & finish group established and an initial action plan drafted to be reported to the HWB Steering Group in April for initial feedback
Debriefing pathway to be established to support staff following traumatic clinical incidents	Debriefing processes and pathways unclear across the Trust leading to inconsistency or lack of provision following traumatic clinical incidents	04/12/2023	Meetings with EPRR lead postponed due to industrial action. To be reconvened in order to finalise guidance
Increased space to be developed for staff support and staff wellbeing.	Insufficient access to private space to support staff wellbeing and wellbeing activities	04/12/2023	No update. Proposal still awaiting sign off with execs as planning permission declined
Stress risk assessments	Skills and capacity gap to conduct good quality stress risk assessments for staff affected by work-related stress	04/12/2023	Awaiting response from Chief People Officer. Stress Risk Assessment training to be added into Management Essentials training as part of new Thriving Leaders framework (Vision 2030).

Digital 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 Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare, failure to provide high quality, resilient digital and Information Technology services to staff.

Nov 2023	
Control Description	Control Assurance Internal
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Working towards Informatics Skills and Development Accreditation (Aug 2019). Training improvements identified through refreshed Digital Strategy Update Sept: ISD Excellence in Informatics Level 1 accreditation achieved
Formal change control processes in place	Exec agreed change process for IT and Clinical System Changes
Executive level CIO in place	Commenced in post April 2019
Quarterly update to Trust Board on digital developments, Monthly update to RABD	Board agendas, reports and minutes
Digital Oversight Collaborative in place & fully resourced - Chaired by Medical Director	Digital Oversight Collaborative tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Implementation of fortnightly huddle with divisions from April 2019. Divisional CCIOs recruited. Divisional IT Leads in place.
NHSE & NHS Digital external oversight of programme	NHSD tracking of Programme through attendance at Programme Board and bi-monthly assurance reports.
Digital Strategy approved by Board July 2019, mobilisation in place to new governance and implementation arrangements	Digital Futures Strategy
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Monthly digital performance SMT meeting in place	ToRs, performance reports (standard agenda items) KPIs developed
Capital investment plan for IT including operational IT, cyber, IT resilience	Capital Plan
iDigital Service Model in Place	iDigital Service Model and Partnership Board Governance

GAPs
Cyber security investment for additional controls approved - dashboards and specialist resource in place Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs Issues securing experienced resources in some services Anticipated delays with major programme delivery

Action	Description	November 2023	
		Due Date	Action Update
4.2/111/sKE - ACT10	Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	03/04/2023	
4.2/111/sKE - ACT11	Mobilisation of Y1 of Digital and Data Futures Strategy	01/06/2023	Programmes in progress, some key deployments progressed Date Entered : 31/03/2023 07:21 Entered By : Kate Warriner ---------- Mobilisation plans in development Date Entered : 08/06/2022 17:16 Entered By : Kate Warriner
4.2/111/sKE - ACT12	1. Proposed change freeze of all digital programmes from April particularly in the context of preparation for Aldercare go live 2. Review of all other programmes with implementation to be achieved before April	01/05/2023	Change Freeze from May discussed with Programme Board and Execs, other programmes under review Date Entered : 07/03/2023 08:38 Entered By : Kate Warriner ---------- Change freeze proposal in development, review of programmes to be initiated Date Entered : 06/12/2022 12:23 Entered By : Kate Warriner
4.2/111/sKE - ACT8	Implementation of Alder Care 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
warriner katherine	Mobilisation of Y1 of Digital and Data Futures Strategy in progress	01/04/2024	

ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment	
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 Board

Description

NHS White Paper Innovation and Integration creating Integrated Care Systems (ICSs) and new statutory NHS body, including transformed system governance, finance, quality, provider collaboratives etc. - under definition & rapidly evolving. Uncertainty of governance arrangements at system level and implications for providers.

Nov 2023

Control Description	Control Assurance Internal
Membership of CMAST & LDMHC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST - Governance paper and TOR for Committee in Common approach presented to Trust Board in September 22 and approved. CMAST - paper to CEO's group scheduled for May to outline CYP system proposals (attach as evidence once finalised) Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21) CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21) Due to Omicron wave, CMAST collaborative has focused on Hospital Cell / recovery and mutual aid approach during Dec/Jan
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	ICS Programme Highlight Report Further evidence attached to BAF 3.2 Confirmation of funding for Y2 of programme received April 22 Beyond Impact Assessment submitted to ICS Feb 23 Beyond update included in Trust Board Growing Great Partnerships paper May 23 (attached as evidence to Trust Board control line)
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete Update to Trust Board April 22 Update to Council of Governors June 22 Update to Trust Board June 22 Update to Trust Board July 22 Update to Council of Governors Sept 22 Update to Trust Board Sept 22 Update to Trust Board Nov 22 Jan 23 Growing Great Partnerships Trust Board report incorporated HCP and ICS update Update to Trust Board March 23 May 23 - Growing Great Partnerships Trust Board report inclusive of all ICS developments
C&M CEO Provider Collaborative - Membership - sustain collaborative working arrangements with C&M-wide colleagues to shape system and ensure influence	
C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services	TOR & System Finance Principles in development (to be attached once finalised)
Maintain effective existing relationships with key system leaders and regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Lead Provider and partnership arrangements; development of new models of care	ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development) C&M CMAST Provider Collaborative proposals (under development) May 23 - Update on Delegation of Specialist services included in Growing Great partnerships Board report Joint letter of response to Specialist Commissioners from Alder Hey and Manchester Children's in August 22 Deputy CEO represents Alder Hey at the C&M Specialist Delegation group Likely delegation will not take place until April 24 - though work will continue through DoF, DoS and partners inc. CHA and NWPPB to shape the direction for CYP specialist services
Monitoring and influencing the direction of SpecCom delegation into ICSs	Joint letter to SpecCom from NW - AH & RMCH outlining the need to work at a NW footprint Nov 22 - Development of joint NW SpecCom delegation plan with Alder Hey and RMCH - outline shared position discussed at NWPPB Nov 22 - to be jointly developed further during Dec/Jan
ICS CYP Board - under development, to enable single oversight of CYP at ICS level and coalescing CYP priorities, resource and delivery	

GAPs

Uncertainty over future commissioning intentions (see BAF 3.4 re finance)
Future delegation of Specialist Commissioned services into ICSs - shadow arrangements under definition

Action	Description	November 2023	
		Due Date	Action Update
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.

Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.	
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	Resource And Business Development Committee

Description

Risk of failure to:
- Deliver care close to home, in partnerships
- Develop our excellent services to their optimum and grow our services sustainably
- Contribute to the Public Health and economic prosperity of Liverpool / Cheshire & Merseyside

Nov 2023

Control Description	Control Assurance Internal
Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board.
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly). Partnership update & refresh of North West Paediatric Partnership Board schedule and arrangements undertaken Feb 22 Sept 22 - NWPPB Chairs Report to Trust Board attached
'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019 2030 Vision development underway with Trust Board - will succeed Our Plan once approved in early 23/24
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Implementation of the 'Healthy Children and Families' partnership group for One Liverpool.SRO Dani Jones jointly with Melisa Campbell LCC PH confirmed.	Inaugural HC&F meeting held 24.1.23 - pack attached
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities. Healthy Children & Families - Segment agreed at Provider Alliance Summit March 23
C&M "Beyond" Children's Transformation Programme - AH host and lead for C&M	Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS) 4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway. 9.11.21 - Presentation to ICS (HCP) Board - successful. Confirmation of funding for Y2 of programme received. 25.11.21 - Presentation of programme to Alder Hey Board. Fully endorsed. 27.1.22 - Presentation of Beyond programme to HCP Programme Board. ICS CEO in attendance. Programme progress accepted. 8.6.22 - C&M CYP Programme Board minutes (May) and documentation for June meeting attached for assurance of effective progress Sept 22 - Beyond Assurance Group established and reporting to Beyond Board - minutes and agendas attached Nov 22 - Presentation to ICB Chair (Children's Champion) at St Helens Town Hall; supported to cement further the CYP governance at ICB level - proposal under development Dec 22 - Beyond presented to Alder Hey Trust Board
2030 Vision: Alder Hey strategy refresh - Q4 21/22 - alignment with system objectives and trust ambitions	-Trust Board Strategy / 2030 Vision session scheduled Jan 22 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention - Pop Health plan developed in conjunction with Strasys to inform 2030 vision - working group established. Initial Exec session 21st April, Trust Board session 28th April - Completed Sessions underscehduling with NEDs, Governors and Working Group during May - May 22 Informal Governors Vision 2030 / Strasys session completed (attached) - May 22 Trust Board Strategy Session Vision 2030 / Strasys & futures strategies completed - June 22 Trust Board strategy session / Vision 2030 strasys session completed. - Sept 22 - Trust Board approved strategy overview / baseline paper - agreed next steps to begin wider engagement (see attached evidence) - Jan 23 - 2030 Vision update paper to Trust Board, and Trust Board Strategy session (update & Futures) - Jan 23 - Council of Governors strategy session (full overview) - Jan & Feb 23 - Divisional Strategy 'tester' sessions - Surgery, MH & Community, Medicine - all completed to date. Excellent feedback, iterating. Strategy 2030 - Approved at Trust Board March 23 Strategy 2030 wider Staff Launch - 3rd May 23
Growing Great Partnerships - Quarterly Trust Board assurance report	- June 22 - Sept 22 - Jan 23 - May 23

GAPs

1. Inability to recruit to highly specialist roles due to skill shortages nationally.
2. Full completion of 2030 Vision and delivery plan

Action	Description	November 2023	
		Due Date	Action Update
3.2/113/6KE - ACT10	Partner and stakeholder engagement on Vision 2030 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.
3.2/113/6KE - ACT4	1. Developing a stronger understanding of paediatric workforce requirements through the Trust's 2030 Vision refresh work with Strasys - to enable trust and system workforce planning led through HRD	30/06/2023	Incorporated into 2030 People Plan developments
3.2/113/6KE - ACT9	6.Develop Operational and Business Model to support International and Private Patients	30/06/2023	Incorporated into Futures 2030 development plans

Alder Hey Children's NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2023/24

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: 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: Support our people				
2.1 MS	Workforce Sustainability and Development	PAWC	**4x5**	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: 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: 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 Strategic Development & Delivery	RABD	**4x4**	4x1

Inability to deliver safe and high quality services					
Risk Number			**Strategic Objective**		
1.1			Outstanding care and experience		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Safe		Nathan Askew	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.

Control Description	Assurance Internal
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 includes 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 the 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.
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.
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.

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	Due date	Action update
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	Continue to monitor KPIs 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.
2. NICE Guidance	Each divisional governance lead will be responsible for ensuring this process is reviewed and progress made within the divisional structures	31/01/2024	There has been significant improvement in overdue reviews, work continues to focus on the implementation of nice guidance and is monitored through CEOG and escalated via SQAC. Deep dive undertaken into overdue long standing NICE guidance's by divisional clinical governance leads Sept 23
3. Medication errors and near misses	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.

4. Industrial Action	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
5. New CQC Assessment Framework	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
6. Delivery of 2030 Vision	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.
7. New Models of Care	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.
8. Alder Care (Expanse)	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.

Children and young people waiting beyond the national standard to access planned care and urgent care					
Risk Number			**Strategic Objective**		
1.2			Outstanding care and experience		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Effective Responsive		Adam Bateman	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. Thesefactors 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.

Control Description	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	- Monthly performance report to Operational Delivery Group - Corporate report and Divisional Dashboards

- Weekly oversight and management of long wait patients	
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	Due date	Action update
1. 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	31/01/2024	Investments in capacity including insourcing have been deployed with reduction in number of long waiters in ENT and dental

	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		
1. 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

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus					
Risk Number			**Strategic Objective**		
1.3			Outstanding care and experience		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Safe		Adam Bateman	12	6	Resources and Business Development Committee

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

Control Description	**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
1. Remedial Works not yet completed; lack of confidence in timescales being met.

Action	**Description**	**Due date**	**Action update**
1. Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve	30/1//2023	
2. 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 Objective**		
1.4			Outstanding care and experience		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Caring Effective Responsive Safe Well-Led		Lisa Cooper	15	9	Resources 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.

Control Description	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
Business case for investment submitted to Liverpool and Sefton CCG's. This is also included in the Cheshire & Merseyside ICB submission.	Business case
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 are 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.	Bimonthly 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 Recruitment processes present through Trac software retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software

Gaps in Controls / Assurance

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to outstanding confirmation on new investment.

Action	Description	Due date	Action update
1. 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	31/10/2023	
2. Approach to management of clinically urgent appointments to be reviewed	Clinical leads to review approach to management of clinical urgent appointments	31/12/2023	
3. Clinical job planning	Review of job plans to be completed to agree standardised job plans for banding across services. To include: - number of expected contacts - typical case load size	31/12/2023	
4. 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	31/12/2023	
5. Data / BI case load monitoring	Case load size reporting and monitoring to be improved including: - BI dashboard to be created - validation of data	31/10/2023	
6. Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/12/2023	
7. Introduction of PIFU discharge pathway	Introduction of PIFU pathway ongoing	31/10/2023	- 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
8. 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	31/12/2023	
9. Recruitment	Timely recruitment to vacancies to include meet with finance to review skill mix for services	31/12/2023	
10. Referral to triage process to be reviewed	To review referral to triage process across CAMHS	31/10/2023	
11. Review of KPIs and reporting measures	Review of KPIs and reporting measures for Sefton & Liverpool place	13/10/2023	
12. 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	31/11/2023	Ongoing management of this is via the Weekly Performance Meeting with admin, service manager and operational manager
13. Staff Survey	To ensure completion of staff survey	31/10/2023	

Workforce Sustainability and Development					
Risk Number			**Strategic Objective**		
2.1			Support our People / Outstanding Care and Experience		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Safe Well-Led		Melissa Swindell	15	6	People and Wellbeing Committee

Description
Failure to deliver consistent, high quality services for children and young people due to: 1. Not having the right workforce planning in place to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not having the right measures in place to support a healthy turnover 3. 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.

Control Description	Assurance Internal
Workforce KPIs tracked through the Integrated Performance Report and divisional dashboards	Integrated Performance Report and divisional KPI Reports to PAWC
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 portal enables all staff to see their compliance on 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 intranet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Education Governance Committee	Education Governance Committee ToRs and associated minutes
Training Needs Analysis linked to CPD requirements	Reports to Education Governance 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 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	People Strategy report monthly to Board.

• Professional Development Hub • Thriving Workstream Workforce Planning Workstream	
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to PAWC and Board
Nursing Workforce Report	Reports to PAWC, SQAC and Board
Nurse Retention Lead	Reports to PAWC, SQAC
Recruitment Strategy currently in development	progress to be reported to People and Wellbeing Committee
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance

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

Action	Description	Due date	Action update
1. Mandatory training compliance	Process in place to monitor take up of training by topic; subject matter experts engaged in the process	ongoing	
2. Management of sickness absence	Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	30/04/2023	May 2023: Work continues to monitor sickness absence through the divisions and will all of the relevant support through OH and SALS
3. Workforce planning	Workforce planning across the organisation		May 2023: Establishment control project close to completion before commencing the wider workforce planning project.
4. Talent and succession planning	Being developed alongside the Thriving Leaders workstream	31/05/2024	
5. Recruitment Strategy	Recruitment Strategy currently being developed in line with the actions set out in the NHS people plan	30/06/2023	May 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.
6. Increase diversity across the organisation	Action plans in place to support the WRES, WDES, EDS22 and Anti-racism framework		

Failure to deliver the best experience for Staff, Children and Young People and their Families (cultural conditions)					
Risk Number			**Strategic Objective**		
2.2			Support our People / Outstanding Care and Experience		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Safe Well-Led Caring		Melissa Swindell	9	6	Trust Strategy Board

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

Control Description	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 minutes
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	Annual Staff Survey Reports - 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 Staff Newsletter - keeping staff informed	Internal communications updates 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.
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	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 assessed 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	Due date	Action update
1. Staff burnout	Skills and capacity gap to conduct good quality stress risk assessments for staff affected by work-related stress	30/11/2023	Stress Risk Assessment training to be added into Management Essentials training as part of new Thriving Leaders framework (Vision 2030).
2. Room for improvement	Develop a Thriving Leaders Framework for the organisation	30/05/2024	Thriving leaders programme in development

Workforce Equality, Diversity and Inclusion					
Risk Number			**Strategic Objective**		
2.3			Support our People / Outstanding Care and Experience		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Effective Well-Led		Melissa Swindell	15	4	People and 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.

Control Description	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	At the end of 2022/23, over 400 staff had attended our in-house leadership development programme across 25 cohorts and we have over 130 staff on the waiting list.
EDI Steering Group now established - Chaired by NED	Minutes reported into PAWC

Staff networks established	Networks report into the EDI Steering Group

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

Action	Description	Due date	Action update
1. EDI resource	Business case requires further development	Jan 2024	November 23: Business case completed

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus					
Risk Number			**Strategic Objective**		
3.1			Collaborate for children and young people		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
		Rachel Lea	12	6	Resources 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

Control Description	Assurance Internal
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision.
Weekly Programme Check.	The Project Team run a weekly programme check.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group
Programme and plan (agreed with LCC and LPA) to return the park back by November 2023.	Updates on progress through Campus report .

Gaps in Controls / Assurance

PARK:

1. Adoption of the SWALE by United Utilities
2. Residual infrastructure works delaying possession of land
3. Delays on bespoke items from supply chains
4. Weather conditions causing potential delays

CAMPUS:

1. Planning approvals for modular buildings to allow demo of Catkin and continuation of park works.
2. Successful realisation of the moves plan.

3. Funding availability and potential market inflation.			
Action	**Description**	**Due date**	**Action update**
1. Park Handover	Establish Programme Board for handover for Park to LCC	31/12/2023	Meetings continue with LCC until full legal agreement of transfer of Park to the Council
2. 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
3. Successful realisation of the moves plan	Establish timeline and plan for the Police Station upgrade and conversion	30/04/2024	Initial plan created, now in delay. Re-work required

Strategy Deployment (direct)					
Risk Number			**Strategic Objective**		
3.2			Collaborate for children and young people		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Well Led		Dani Jones	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.

Control Description	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

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	Final brochure to Trust Board in Oct subject to executive sign off – publication

			expected Nov 2023. Presentation to CoG in Dec 2023.
2. 2030 delivery programme and plan	Link with Kate Warriner		
3. Developing skills and capacity to deliver the new Strategy	MS to populate		
4. Building in skills and capacity to deliver the new Strategy	2030 strategic resource investment plan	30/09/2023	
5. Focus on transformational change	Oversight through Strategic Leadership Group and Strategy	30/04/2024	
6. Sharp focus at Strategy Board on core mission	Sharp focus at Strategy Board on core mission	30/04/2024	

Financial Environment					
Risk Number			**Strategic Objective**		
3.4			Collaborate for children and young people		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Effective Responsive Safe Well Led		John Grinnell	16	12	Resources and Business Development

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

Control Description	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 annually 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. - Financial training sessions launched across trust
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/Board 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 DOF 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**	**Due date**	**Action update**
1. Changing financial regime	Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2024	
2. Delivery of 5 year programme	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.
3. Devolved specialist commissioning	Regular reporting to strategic execs and assurance to RABD and Trust Board Financial Analysis required to understand risk	31/03/2024	
4. High risk current CIP programme	Ensure procurement processes followed to obtain value for money	31/03/2024	
5. Inflationary pressures	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.
6. Shortfall against LTP	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.

7. Underfunding of Long Term tariff arrangements for complex children	Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2024	

System working to deliver 2030 Strategy (alignment)					
Risk Number			**Strategic Objective**		
3.5			Collaborate for children and young people		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Well Led		Dani Jones	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.

Control Description	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.
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.
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.
Joint development of new models of care on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool
Impact of changing NHS finance regime, commissioning intentions (described in BAF 3.4)	See BAF 3.4 (financial environment)
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

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

Action	Description	Due date	Action update
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services		31/08/2024	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.
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)		31/03/2024	Conversations with NHSE and colleagues within Greater Manchester and South Cumbria continue to support a North West Children's Strategy for delegation of services.

3. Complete partner engagement		28/02/2024	CYPF and our people phases complete (albeit ongoing engagement) partner phase commencing Nov 23-Feb 24
4. Horizon scanning		31/03/2024	Horizon scanning built into Strategy Board and strategy Leadership Group formal agenda and work plan

Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.					
Risk Number			**Strategic Objective**		
4.1			Pioneering breakthroughs		
CQC Domains	**Linked Risks**	**Owner**	**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.

Control Description	Assurance Internal
Research and Innovation Committee. Primary oversight mechanism with overall responsibility for strategic development and implementation in the Division of Clinical Research (CRD) and the Innovation Centre (IC), with Non-Executive Director involvement.	Reports to Trust Board
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 SOPs
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	Due date	Action update
1. Integration of R&I activities into Futures	Completion of Research Strategy.	31/03/2024	Commencing Q3 2023/24
2. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2024	Commencing Q3 2023/24
3. Sustainable activity levels	Review of CRD trials portfolio	31/03/2024	Commencing Q3 2023/24
4. Sustainable activity levels	Review of IC product pipeline	31/03/2024	Commencing Q3 2023/24
5. Financial model	Case for internal and multi-sector inward investment.	30/06/2024	Commencing Q3 2023/24
6. Financial model	Development of new commercial partnerships	30/06/2024	Commencing Q3 2023/24
7. Capacity and capability	Greater engagement with and education of R&I communities	30/06/2024	Commencing Q3 2023/24
8. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy	31/03/2024	Commencing Q3 2023/24

Digital and Data Strategic Development & Delivery					
Risk Number			**Strategic Objective**		
4.2			Revolutionise care		
CQC Domains	**Linked Risks**	**Owner**	**Risk Rating**		
			Actual	**Target**	**Assurance Committee**
Well Led		Kate Warriner	12	8	Resources 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.

Control Description	Assurance Internal
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Achieved Informatics Skills and Development Accreditation Level 3.
High levels of externally validated digital services	HIMSS 7 Accreditation
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 and Data 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

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	Due date	Action update
1. Maximising opportunities of collaboration through iDigital	Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	31/03/2024	iDigital spans two specialists Trusts operating at scale
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2024	Programmes in progress, some key deployments progressed
3. Alder Care	Implementation of Alder Care optimisation programme	31/10/2024	Programme to commence Nov 2023
4. 2030 Initiatives	Ensure programme alignment into new models of care and Futures	31/03/2024	Governance and plans in progress