Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 7th March 2024, commencing at 9:00am
Lecture Theatre 4, Institute in the Park
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
1.	**23/24/290**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/291**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/292**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **8th February 2024.**	**D**	Read enclosure
4.	**23/24/293**	**9:19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**23/24/294**	**9:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**23/24/295**	**9:30 (20 mins)**	**Beyond Update.**	L. Crabtree	To receive an update on the progress of Beyond.	**N**	Presentation
Operational Issues							
7.	**23/24/296**	**9:50 (50 mins)**	• **Integrated Performance Report for M10, 2023/24.** • **Finance Update for M10, 2023/24.** • **M11 Flash Report/ Operational Overview.**	Executives/ Divisions R. Lea A. Bateman	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M10 position. To receive an update on the current position.	**A** **A** **A**	Read report Presentation Read enclosure

8.	**23/24/297**	**10:40 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell/ J. Halloran	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
The Best People Doing Their Best Work							
9.	**23/24/298**	**10:50 (10 mins)** **11:00 (30 mins)**	**Equality, Diversity and Inclusion – Focusing on Our People 2024/25; including:** **Supporting a culture of equality, diversity and inclusion through learning.**	M. Swindell M. Cox	To receive an update on the current position. To hear about a personal experience.	**A** **N**	Read report Verbal
10.	**23/24/299**	**11:30 (10 mins)**	**2023 NHS Staff Survey.**	M. Swindell	To receive an update on the national results.	**A**	Presentation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
11.	**23/24/300**	**11:40 (10 mins)**	**Brilliant Basics Update.**	N. Palin	To receive an update on the current position.	**A**	Read report
12.	**23/24/301**	**11:50 (10 mins)**	**Safeguarding Children and Adults at Risk Annual Report; 2022/23.**	L. Cooper	To note the content of the 2022/23 Safeguarding Children and Adults as Risk Annual Report.	**A**	Read report
13.	**23/24/302**	**12:00 (10 mins)**	**Gender Development Service (North Programme) Update.**	L. Cooper	To receive an update on the current position.	**A**	Read report
Lunch (12:10pm-12:30pm)							
14.	**23/24/303**	**12:30 (5 mins)**	**Learning from Patient Safety Incidents.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
15.	**23/24/304**	**12:35 (10 mins)**	**Update on Martha's Rule.**	N. Askew	To receive an overview of the implementation plan of Martha's Rule.	**A**	Read report
16.	**23/24/305**	**12:45 (10 mins)**	**DIPC Report, Q3.**	B. Larru	To receive the Q3 DIPC report.	**A**	Read report

17.	**23/24/306**	**12:55 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 21.2.24.** - **Approved minutes from the meeting held on the 17.1.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 17.1.24.	**A**	Read enclosures
Game Changing Research and Innovation							
18.	**23/24/307**	**13:00 (5 mins)**	**Futures Committee Terms of Reference.**	J. Chester	For ratification.	D	Read enclosure
Strong Foundations (Board Assurance)							
19.	**23/24/308**	**13:05 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 26.2.24.** - **Approved minute from the meeting held on the 16.1.24.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 16.1.24.	**A**	Read enclosure
20.	**23/24/309**	**13:10 (10 mins)**	**Board Assurance Framework Report; including:** • **Corporate Risk Register.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
21.	**23/24/310**	**13:20 (5 mins)**	**NHS Leadership Competency Framework for Board Members.**	E. Saunders	For information and to note.	**N**	Read enclosure
Items for Information							
22.	**23/24/311**	**13:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal

23.	**23/24/312**	**13:29 (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 April, 11:00am to 2:00pm, Meeting Room 2 and 3, Liverpool Innovation Park							

REGISTER OF TRUST SEAL
The Trust seal was used in January 2024: • 411:Refurbishment of existing offices (*new community paediatrics department*). 412: Laidrah V.A.T. of land back (*1 and 2 south side*).

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M10, 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 8th February 2024 at 9:00am**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	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. U. Das	Director of Medicine	(UD)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Mr. D. Hawcutt	Clinical Director of Research	(DH)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Observing	Ms. A. Prendergast	Assoc. Director of Strategy and Partnerships	(AP)
Youth Forum	Ms. E. Carragher-Leigh	Trust Governor	(ECL)
Presentation	Ms. L. Priestley	Trust Governor	(LP)
Item 23/24/262	Ms. N. Palin	Assoc. Director of Transformation	(NP)
Item 23/24/264	Ms. J. Halloran	Acting Deputy Development Director	(JH)
Item 23/24/269	Dr. C. Thomas	Clinical Lead for Organ Donation	(CT)
Item 23/24/273	Ms. K. Turner	Freedom To Speak Up Guardian.	(KT)
Apologies	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. M. Flannagan	Director of Marketing and Communications	(MF)
	Mr. D. Powell	Development Director	(DP)

Youth Voice at Alder Hey

The Chair welcomed two of the Trust's young governor's, Emily Carragher-Leigh and Leah Priestly who had been invited to attend February's Board to provide an insight into what it's like being a member of Alder Hey's Youth Forum/Camhelions. A number of slides were shared that provided the following information:

- *Youth Forum* (*feedback from members*);
  - The Forum gives young people a voice and enables them to help other patients.
  - The Forum make everyone feel welcome, part of a team and part of a family.
  - The Forum makes me happy because I make friends and I'm always learning something new.

- Being part of the Forum means that we can help younger people to have their voice heard. Sharing ideas can also help to make someone's day better or help them in a particular way.

- *Camhelions – Youth voice of Sefton CAMHS* (*feedback from members*);
  - Being part of the Camhelions means having a sense of community and purpose.
  - The Camhelions are helping to shape mental health services for the generations to come.
  - Being part of the Camhelions has given me the opportunity to express my own opinions and share my own stories.
- What did we do last year?
  - Life skills, qualifications, public speaking, staff interviews across the Trust, website development, social media, youth participation, sensory film, face painting and Pride celebrations in Alder Hey, MUGA opening and the youth bank.
- An overview of the impact the groups have had on Alder Hey and the things that have been done to make sure children and young people (CYP) are heard in the services provided by the Trust.
- What is gained from youth participation?
  - Experience, new skills, confidence, networking and a rewarding feeling.
- What we want for the future?
  - Improvements on transition, inclusion and diversity, skills opportunities, personal development and for young people to be heard.

The Chair thanked Emily and Leah for their presentation which it was felt was wonderfully put together and drew attention to the Forum's achievements during the year which are having an influence across the Trust. It was pointed out that the Youth Forum has given the Board a list of areas to focus on and it was confirmed that conversations will take place with the support of Youth Forum members to try and progress these matters.

Louise Shepherd advised that the Youth Forum have helped shape the 2030 Strategy and pointed out that the Trust needs their continued input to help make the right changes for CYP.

23/24/254 Welcome and Apologies

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

23/24/255 Declarations of Interest

There were none to declare.

23/24/256 Minutes of the previous meeting held on Thursday 11th January 2024
Resolved:
The minutes from the meeting held on the 11th of January were approved as an accurate record of the meeting.

23/24/257 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 23/24/239.1: *Mortality Report Q2 (Arrange for Fiona Marston to liaise with Julie Grice to discuss the possibility of including more detail in the graph on the first page of the Mortality report)* – A positive meeting took place between Fiona Marston and Julie

Grice and work took place on stats/an alternative approach which enabled the graph to be modified. **ACTION CLOSED**

23/24/258 Chair's and CEO's Update

The Chair advised of her attendance at the Charity's Strategy Day which took place on the 24.2.24. During the day a presentation was received on the new Gender Development Service, along with a patient story. The Chief Executive of the Charity, Fiona Ashcroft agreed that the Board of Trustees needs to hear from young people and connect with them especially as the trustees are working hard to raise money to enhance the lives of CYP. The outcome of the day indicated that the Trust and the Charity are strongly aligned with the 2030 Vision.

National Update - Louise Shepherd informed the Board that the national situation frames a lot of the areas of work that the Board will be discussing during Q4. There is a focus on money with pressure being applied to ICBs and ICSs across systems to close the financial gap before the year end. Planning guidance is yet to be published but it's expected that there will be huge challenges in 2024/25 which will mean less money therefore it is necessary to think about how CYP are positioned thus ensuring they are factored into funding allocations.

The Chief Executive of the NHS Confederation; Matthew Taylor visited Alder Hey on the 2.2.24. Discussions took place about policy and the positioning of CYP. Mr. Taylor sent out a number of Tweets about his visit to the Trust to highlight the importance of the work that Alder Hey is doing. Mr. Taylor advised of the importance of having a needs led service rather than an industrial approach. It was confirmed that the Trust has written to Mr. Taylor to see if he will think about supporting a national round table on CYP.

Local Update – It was reported that Liverpool City Council (LCC) has published its Public Health Report, which has a large section on CYP. Discussions have taken place with the Director of Public Health for LCC, Matt Ashton about developing a strategy for CYP in collaboration. The Board was advised that the Trust has recently appointed a Public Health Consultant.

Further discussions are taking place on the Child of the North Project and a business case is being prepared which will be submitted to Alder Hey's Trust Board and the University of Liverpool Board for approval.

A piece of work is taking place nationally to address the number of CYP awaiting a diagnosis of ADHD/ASD. It was pointed out that Alder Hey are contributing to the national work but attention was drawn to the importance of addressing this issue locally as well.

The Chair felt positive about the developments taking place in Liverpool as a result of partnerships/collaboration and drew attention to the importance of Alder Hey supporting LCC to make a difference for CYP.

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

23/24/259 Collaborate for Children and Young People: Partnerships Update (included in 260)
Resolved:
This item was addressed via agenda item 23/24/260.

23/24/260 System Wide Update

The Board received a CYP system update. A number of slides were shared that provided information on the following areas:

- Visions 2030 deliverables.
- Cheshire and Merseyside (C&M) System: Children and Young People (CYP) population cohort approach.
- Integrated Care Board (ICB) CYP Committee – Year 1 CYP Committee priorities.
- Cheshire and Merseyside Acute and Specialist Trust (CMAST) Alliance.
- MHLDC CYP work programme.
- Developing our Place Programme.
- Conclusion;
  - The Trust's partnerships are paving the way for real impact.
  - There has been a palpable shift in focus on CYP.
  - The Trust is integrated into all its "pitches".
  - The scale of the programme is growing.
  - Alder Hey is looking at innovative ways to support but we can't underestimate the scale alongside operational pressures.
  - The Trust is pursuing a mix of quick wins and some slower burns and focussing on how success is measured.

The Chair queried as to whether transition will be dealt with under mental health via CMAST. The Board was advised that there is a recognition that there's only so much that can be done in the first year. Following discussion, the Chair agreed to liaise with the Chairs of CMAST regarding this matter.

23/24/260.1 Action: DJW

Dan Hawcutt asked about the process in terms of research and innovation feeding into the systems/mechanisms. It was agreed to have a discussion regarding this matter outside of the meeting.

23/24/260.2 Action: DJ/DH/AP

Attention was drawn to the huge variation between the 9 Places and it was reported that a planned piece of work is taking place with the system to look at this very complicated scenario to try and attain the right balance.

Fiona Marston pointed out that the voice of CYP sits at the centre of a complex hierarchy of different requirements, as per the Trust's strategy and felt that it will be challenging to continue to hear that voice whilst the approach is implemented. It was reported that it is an ongoing challenge to keep a complex system focused on listening to children and young people, but the ICB are prioritising children and young people's voice and participation through the ICB CYP Committee; there is strong sponsorship for this from the C&M ICB Chair, alongside system leadership on how to ensure CYP are truly participating from both the Beyond CYP programme and Alder Hey.

Resolved:
The Board noted the system wide update.

23/24/261 Terms of Reference - Women's Hospital Services in Liverpool Programme Board, Women's Hospital Services in Liverpool Committee and the C&M CYPs Committee.

The Board received the Terms of Reference for the Women's Hospital Services in Liverpool Programme Board, the Women's Hospital Services in Liverpool Committee and the C&M CYPs Committee, for noting purposes. An overview was provided to bring Board members up to date on the actions that have taken place following the review of Liverpool Women's Hospital.

A new Programme Board has been established to develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool. It was reported that the role of the ICB Board is to think strategically about women's health care. Work will take place to address the immediate safety issues for adult care and by the end of the year thought will need to be given about the right collaboration of services in the city, of which neonates will be included. It was pointed out that until the safety issues have been resolved the configuration of the service across the city can't be addressed.

It was reported that Alder Hey has been invited to participate in the compilation of a twenty-year strategy for women and babies, and a communications group is to be established, which the Trust's Deputy Director of Marketing and Communications, Colin Beaver will be involved in.

A question was asked about how the Trust can influence the care and treatment for 13 to 18 year olds. The Board was advised that the Clinical Advisory Group is being re-established to ensure that key areas are being addressed and to wrap around key priorities. It will be via this route that this age group will be considered.

Resolved:
The Board noted the Terms of Reference for the Women's Hospital Services in Liverpool Programme Board, the Women's Hospital Services in Liverpool Committee and the C&M CYPs Committee.

23/24/262 Transformation Programme Update

The Board was provided with an update on the progress that has been made in the implementation of the Trust's Vision 2030 Strategic Plan (2023/24), specifically focusing on developments since the last update to Trust Board in December 2023. The following points were highlighted:

- The Trust is continuing to make progress, as detailed in table 3 in the report and key deliverables are starting to be delivered and are making an impact.
- It was reported that the Benefit Case framework is instrumental in pinpointing the baseline position and expected benefits derived from transformational changes. It establishes a solid foundation for monitoring the benefits realised, including those leading to cash releasing savings, enhanced productivity, income generation, and social value return.
- Further work is taking place to match the organisation's ambition in terms of what it wants to deliver.
- A review of resources across the teams has taken place and a way of working has been agreed. It was pointed out that personalised working is a big change programme that the Trust wants to deliver in 2025.
- High level detail is included in the report about what the Trust is proposing to do to support communications around Vision 2030 in terms of what it is and what it sets out to do. The organisation is aiming to launch the Communications Plan on the 1.4.24 to coincide with the switchover of the new planning phase. It will focus on communications to staff and stakeholders.

- The Board was advised that the Transformation team has been shortlisted for a partnership award for the 2030 programme.

John Kelly highlighted the importance of focussing on the 2030 element of the plan and ensuring that **1.** A benefits programme is in place to support it. **2.** A scale of vision remains in place and **3.** The two areas connect. John Kelly felt that the organisation is too focussed on efficiencies rather than the financial benefits of Futures and Personalise My Care and pointed out the significance of connecting them at the present time in order to progress them.

John Grinnell informed the Board that a clinical leaders' event is taking place in April 2024 as there is still a way to go before the organisation as a whole is behind Vision 2030.

Resolved:
The Board noted the Transformation Programme update.

23/24/263 Operational Issues

Integrated Performance Report (IPR), M9

The Board received the Integrated Performance Report (IPR) for Month 9. An update was provided on the following areas of the IPR:

Unrivalled Experience – *Safety*

- There has been a significant increase (*highest figure in a year*) in the number of unplanned admissions to Critical Care from inpatient beds. It was reported that the acuity and occupancy was high at the time on both the inpatient wards and Critical Care. It was confirmed that this issue will be monitored via SQAC.

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

In M9 the Trust reported a £1.5m variance from the revised forecast submitted in November 2023 due to industrial action, incurred costs and lost activity. This has been accepted by the Centre as a variance plan and the Trust is being measured on a reset plan minus industrial action. There is no confirmation to date that the cost of industrial action in December and January will be funded or targets adjusted.

In M10 the Trust is forecasting to achieve an £11.5m surplus but this will be challenging, with the Division of Surgery being one of the areas that the organisation is trying to support. Work is continuing with the divisions to reduce the CIP gap.

Well Led – *Supporting Our People*

- It was reported that PDR compliance remains an area of concern at only 69% against a target of 90%. Managers in all areas have been asked to prioritise the completion of PDRs for all staff.

Community and Mental Health Division

- *Continued impact of national ADHD medication alert and reduced capacity to complete diagnosis pathway for complex young people* – It was reported that this issue should be resolved by April 2024. Until then new medication cannot be prescribed which is having an effect on the number of patients waiting to be seen with figures increasing on a monthly basis. The Board was advised that the Trust has conducted a lot of work in relation to ADHD and is being shared/ adopted across Cheshire and Merseyside (C&M). Discussions are also taking place on referral pathways. The Trust is eager to have a C&M approach to ADHD.

- Attention was drawn to the significant funding issue that has arisen due to the continued increase in referrals. Discussions are taking place with commissioners regarding their intentions to address this matter.
- The Named Doctor for Safeguarding post is due to go out to advert subject to vacancy control.

Reference was made to the increase in referrals and it was queried as to whether the Trust is seeing an increase in patients being diagnosed. It was confirmed that this is the case. The Trust meets the triage deadline for diagnostics (94%) but it's the very complex patients who are waiting longer periods to be seen.

Division of Medicine

- Following a review of the Trust's Neuromuscular Centre, Alder Hey received the Centre of Excellence award from the leading national charity Muscular Dystrophy UK.
- *ED* – There was an increase in ED attendance in January 2024 in comparison to the same period of time in 2023. The shift in attendance is being monitored.
- *Recruitment in Neurology* – A new model of care has been proposed to ensure on call provision is covered until further recruitment is secured. It was reported that concerns have been raised by paediatric colleagues regarding the new model.
- *Diagnostics: issue that radio isotopes are scarce as production has been reduced by LUFT.* The Trust is liaising with Preston who have submitted a bid for additional cabinets so that they can be used in other areas.

Division of Surgery

- The number of patients waiting over 65 weeks has increased slightly in month due to the impact of industrial action and loss of capacity in ENT. It was reported that a new plan has been implemented to address this matter and work is taking place to try and avoid this issue going forward.

John Kelly drew attention to the issues being experienced by the Division of Surgery around coding and felt that this area of financial reporting was quite opaque. It was queried as to whether additional resources are required to help address this matter. The Board was advised that there has been a turnover of staff in the Coding team and that progress is being made with the recovery plan which will be in place by the end of February 2024.

It was reported that the Division of Surgery is being supported to try and help resolve the large variance. The Division has also been invited to attend a future RABD Committee meeting to provide an update.

Resolved:
The Board received and noted the content of the IPR for Month 9.

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. The following points were highlighted:

- Following the outcome of the Liverpool Clinical Services Review a number of discussions have taken place around systems. Further updates will be provided as this area of work develops.
- It was reported that the CMAST and ICB system is starting to take shape.
- *AlderC@re* – The Trust is starting to see some deliverables and the programme has now moved into Phase 2 which is centred around optimising the Electronic

Patient Record (EPR) and planning for future upgrades. An AlderC@re assurance report will be submitted to the Board in April 2024 to provide an update on the current position on AlderC@re reporting and lessons learnt nationally with a specific focus on reports related to safety and quality.

- *Integrated Performance Review (IPR)* - A national review of 208 IPRs has taken place and it was confirmed that Alder Hey's IPR is exemplary. A refresh of the Trust's IPR will take place in 2025.
- *HIMSS 7 accreditation* – It was confirmed that a lot of development that is taking place at the Trust aligns with the HIMSS accreditation criteria.

Resolved:
The Board noted the Digital, Data and Information Technology update.

Operational Plan Progress/M10 Flash Report

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

It was reported that C&M produce a comms briefing on a regular basis to advise about what is going on across the system. It was suggested liaising with C&M to see if the Trust can include a piece on Alder Hey's transformation.

23/24/263.1 Action: AB

John Grinnell advised that the handover of the park is progressing well but there are a couple of issues that need addressing which are causing a delay. The Trust has communicated that it is managing these delays in a meaningful way and is demonstrating that it is listening to the voice of the community. It was reported that the team are looking at a number of opportunities to try and resolve the concerns raised by the Friends of Springfield Park (FOSP) in relation to the drainage system, and the Trust is going to write to Liverpool City Council to make them aware that an inspection of the play areas hasn't taken place to date and therefore cannot be opened in preparation for the February half-term. It was confirmed that a meeting has been scheduled with FOSP w/c 19.2.24. Louise Shepherd congratulated the team for the hard work that has taken place to get the Trust to this position.

It was queried as to whether there is any further industrial action planned by consultants and junior doctors. It was reported that consultants have rejected the pay offer but are in talks with the Government and therefore are not currently looking to take any further action. It is expected that junior doctors will continue to take strike action as there are no open discussions presently, but the Trust hasn't received any dates as of yet.

Resolved:
The Board received and noted the Operational Plan Progress and the Flash Report for M10.

23/24/264 Alder Hey in the Park Campus Development Update

The Board was provided with an update on the progress, risks and actions on the key capital projects as they arise. The following points were highlighted:

- Budget position/forecast by project is to be reported from Q4, 2023/24.

- *Neonatal and Urgent Care Development* – There is a low level of asbestos that needs to be removed which will impact the programme by three weeks. Work has commenced on this issue and updates are being provided during construction progress meetings. It was confirmed that the Trust has given instructions for the under shelling of the Paediatric Assessment Unit (PAU) to begin.
- *Catkin/Sunflower House* – The Trust is in the process of assessing tender submissions for the under-croft car park sprinkler system. The plan is to progress the successful tender if it's accepted.
- *Elective Surgical Day Case* – Feasibility study is due for completion in May 2024.
- *Alder Park* – A strategy has been agreed for the refurbishment of the Lyndhurst Building on the Alder Park site (*former Dewi Jones Unit*). The Trust is looking to appoint a contractor for the construction by the 31.3.23.
- *Master Plan* - A design review session is to be scheduled for the Board to provide an update on the master plan for the wider site at Alder Hey.

The Chair queried as to whether the Trust has received planning permission for the new nursery construction. It was confirmed that notification is imminent. It was agreed to provide an update via e-mail once approval has been received.

23/24/264.1 Action: RL

Resolved:
The Board noted the Alder Hey in the Park Campus Development update.

23/24/265 Response to the Thirwall Inquiry Terms of Reference – Update Organisational Governance Assessment

The Board was provided with a further update following the initial overview of the Trust's assessment of learning from the Letby case from a wider governance perspective. Erica Saunders reported that the focus has now moved to the upcoming Thirlwall Inquiry therefore it is the Trust's intention to continue to mirror the terms of reference that were published on the 19.10.23 until such times as more information is released about the planned approach. The Trust has received a request for information dating back from 2012 from NHS England (NHSE) relating to the Neonatal ODN hosted by Alder Hey.

The Board discussed the content of the report/framework and a number of suggestions were made, as follows:

- Include information in the framework for CYP about the death of their sibling.
- Focus on supporting clinicians further in terms of having a discussion around consent.
- Look at how the Trust captures that a conversation has taken place.
- Have an understanding of the framework to be able to identify an issue before it's recorded that a conversation took place.
- Think about the depth of the work that the Trust does with CYPF and highlight it in the themes as it is felt that this will be a learning piece for the Inquiry.

The Chief Nursing Officer, Nathan Askew thanked Board members for their feedback and offered assurance that their comments would be taken into account.

Resolved:
The Board noted the update on the response to the Thirwall Inquiry Terms of Reference/Update organisational governance assessment and it was agreed to

provide a quarterly update via SQAC. Once the Inquiry officially commences a report will be submitted to the Board on a regular basis.

23/24/266 Gender Development Service (North) Update

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

- *Estates* – Work is progressing to create 13 clinical spaces ahead of the service opening in April 2024. A development session is scheduled for the 13.2.24 to enable CYP to have an input into the selection of furniture.
- *Recruitment* – It was confirmed that the first phase of recruitment for the service has been completed with a positive response, and it is expected that there will be a potential workforce establishment of 18.6 wte clinical and non-clinical staff. It was pointed out that during the first wave of recruitment a positive response was received predominantly from internal staff therefore the organisation will need to be mindful of this as the Community and Mental Health Division will be losing members of its staff. Attention was drawn to the importance of employing staff from the transgender community.
- *Open Case Load* – It has been agreed that 136 CYP will transfer to the new service. Meetings are taking place twice a day to discuss the logistics of data transfer, etc.
- *Finance and Contracting* - The contractual framework is not yet fully agreed. This has been formally escalated to NHSE about what needs to be included ahead of the service going live in April 2024.
- *Regulation* – NHSE has assured the North Programme that they are in consultation with the Quality Care Commission (CQC). The Director of Corporate Affairs, Erica Saunders is focussing on the registration application and will continue to liaise with CQC following its transition to the new approach to inspection.

Kerry Byrne drew attention to the importance of compiling a detailed risk register for the new service and providing a level of assurance around KPIs. A discussion took place regarding this matter and it was agreed to submit an initial draft risk register to the Safety and Quality Assurance Committee (SQAC) in March and the Audit and Risk Committee in April. It was reported that NHSE haven't set any KPIs as yet.

23/24/266.1 Action: LC

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

23/24/267 Learning from Patient Safety Incidents

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

An overview of the contents of the report was provided and the following points were highlighted:

- It was pointed out that this is a new report and feedback from Board members would be welcome.
- The Board was advised that any legacy Serious Incidents (SIs) completed and reported externally to commissioners in 2023 will be presented in the new report until closed.
- StEIS Reference No: 2023/18692 – An RCA investigation was completed and sent to commissioners on the 18.1.24 and a copy of the report was shared with the family at their home.
- It was reported that RCA action monitoring is taking place along with the trialling of a thematic review under PSIRF to test the learning.

A query was raised about the number of harms that were downgraded, as detailed in the report under section 3.1. The Board was advised of the process that is in place to review moderate or above harms which enables the Patient Safety Incident Response Investigation panel (PSIRI) and divisional leads to make a decision about whether an initial reported moderate harm level should be upgraded/downgraded. It was also pointed out that the Learn from Patient Safety Events (LFPSE) service do update some of the incidents that the Trust downgrades. It was advised that a three month learning period has been set aside to monitor the improvements of this process and will be followed by a Board development session in April to look at whether the process can be developed further.

23/24/267.1 Action: NA

Resolved:
The Board received the Learning from Patient Safety Incidents report for the period from the to the 1st to the 31st of January 2024.

23/24/268 PALS and Complaints Report, Q2

The Board was provided with an update and assurance on the performance against complaints and PALS targets in Q2 and a thematic analysis for the top reasons for complaints and PALS. The following points were highlighted:

- There were 32 formal complaints received in Q2. This is consistent with preceding quarters.
- The main complaint theme continues to be in relation to treatment and procedure, access, and admission, discharge and transfer (ADT). This is consistent with the preceding quarters.
- Four second stage complaints were received in Q2.
- It was reported that the Trust has received a number of nice compliments.
- The Board was advised that as part of the 2030 Vision the Trust wants to drive down its formal complaints to informal concerns.

It was pointed out that the PALS and Complaints report has been in the same format for a long period of time and it was queried as to whether it was going to be updated in the near future. It was reported that a different template is going to be used in Q1 of 2024/25 and work is going to take place to make the report more succinct and data driven.

Resolved:
The Board noted the PALS and Complaints report for Q2.

23/24/269 Organ Donation Annual Report, 2022/23

The Board was advised that organ/tissue donation is a big opportunity to save lives.

Following implementation of the Organ Donation Taskforce recommendations in 2008, UK deceased donation has risen and the transplant waiting list has fallen. Although significant positive steps have been taken, there remains a mismatch between donation and transplantation. In children, deceased donation has not grown at the same rate and the same transplant benefits have not occurred. It was reported that nationally there are 7000 patients waiting for a transplant of which 250 are CYP under the age of 16.

Every death on PICU is audited by NHS Blood and Transplant (NHSBT) to assess if best practice is followed in relation to the identification and referral of potential organ donors. In 2022/23 there were 64 audited deaths and the Trust's neurological death testing rate was 40% which is consistent with national benchmarking.

From a performance perspective, the Trust's Donors after brain death (DBD) referral rate in 2022/23 was 100% in comparison to 88.8% in 2021/22. The referral rate for donors after cardiac death (DCD) in 2022/23 was 84% in comparison to 43% in 2021/22. In 2022/23 there was one organ donor which resulted in four transplants and four lives being saved.

In terms of progress, an Organ and Tissue Donation Committee was established in 2022 and is chaired by the Chief Medical Officer, Alfie Bass. Deceased organ donation national policies, guidelines and best practice have also been implemented and work is taking place on the championing and promotion of organ donation at Alder Hey. The Trust is also ensuring that staff who work on donation are adequately trained.

Attention was drawn to the raised visibility of organ donation across the Trust as a result of the work that has been conducted by Dr. Thomas. On behalf of the Board, the Chair thanked Dr. Thomas for the impact she has made since commencing in post.

Resolved:
The Board noted the Organ Donation Annual Report, 2022/23

23/24/270 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 18.12.23 were submitted to the Board for information and assurance purposes. During January's meeting time was set aside to compile a proposal for a revised Quality Assurance Round Process (QAR) with a more engaged and dynamic approach for all stakeholders involved. This proposal is to be submitted to the Exec team and Non-Executive Directors to acquire their feedback.

Resolved:
The Board noted the approved minutes from the meeting held on the 18.12.23.

23/24/271 Research and Innovation Committee

The approved minutes from the meeting held on the 6.11.23 were submitted to the Board for information and assurance purposes. During January's meeting the Research Strategy was presented to the Committee and approved. It was reported that the Committee will receive the Implementation Strategy and the Financial Sustainable Plan in April. There was also a focus on commercial products that have been identified, and an update was received on the Investment Zone funding. It was confirmed that the Strasys partnership has been signed and is progressing well.

A proposal was put forward to evolve the Research and Innovation Committee into a Futures Committee with a broader remit. The Terms of Reference are to be agreed

within the next few weeks and a planning meeting will be scheduled ahead of April's Trust Board.

Resolved:
The Board noted the approved minutes from the meeting held on the 6.11.23.

23/24/272 People Plan Highlight Report

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

Equality, Diversity and Inclusion (EDI) Update

The Board received a progress update on activities relating to EDI throughout the months of December 2023 and January 2024, including an update on the Equality Delivery System and the staff networks. The following points were raised:

- It was reported that February is LGBTQ month.
- There is a real sense of celebration for the Trust's networks and their work.
- It was agreed to submit the EDI Action Plan to the Board in March

23/24/272.1 Action: MS

Resolved:
The Board noted the Equality, Diversity and Inclusion update.

23/24/273 Freedom To Speak Up Update

The Board received a summary of the activities of the Freedom To Speak Up (FTSU) team in the last quarter to outline the actions for the coming period. The following points were highlighted:

- It was reported that of the 38 cases that remain open in Q2 and Q3. Two are due to the individual currently being on sick leave and therefore unable to progress. Two remain open at the request of the individual following changes made. There are eight pending closure, this delay is due to the closure meeting not having taken place. Of the remaining twenty-six cases, progress is being made and closure should occur in early 2024.
- The Board was advised that a questionnaire is sent to individuals once a case has closed to gain their feedback. One of the questions asked is; when people speak up, do things change? Of the responses received; 33.3% strongly agreed, 20% agreed, 26.7% were neutral and 20% disagreed. It was felt that this is a positive outcome and staff are able to see that things do change when they raise concerns, although there is always more we can do.
- The FTSU Guardian Visibility programme is ongoing and is being well received.
- Mersey Internal Audit Agency (MIAA) conducted an audit of the FTSU process recently which received an overall assessment of 'substantial assurance'. Five recommendations arose from the audit; four of which were assessed as low risk and one as medium. The recommendations were presented as 'areas for improvement' given the overall findings with regard to the controls in place.
- Work is taking place in association with the Innovation Hub on the development of an FTSU App which will enable staff to track the progress of the concern they have raised together with a range of other functionality. The app will not identify those using it.

The Non-Executive Lead for FTSU, Kerry Byrne advised that the development of the FTSU report is ongoing and will include trends and more detail behind themes in due course. A question was raised about whether detail on follow-up/closure of a case could be included in the report to provide oversight and a flavour of the impact.

It was pointed out that there are some gaps in terms of recruiting FTSU Champions from certain staff groups, one group in particular is consultants. The Board was advised that Kerry Byrne is going to write to Divisional leads to ask them to work with the FTSU Guardian on this matter.

The Trust is wanting to triangulate discussions on culture and address concerns, and it was queried as to whether there is an opportunity via PAWC to link in with FTSU on this area of work. It was reported that an MDT meeting has been established and looks at routes for triangulating data. This is gaining traction and the group are now able to look at hotspots across the organisation. It was agreed to liaise with Jo Potier to see if a proposal can be compiled and submitted to PAWC for approval.

23/24/273.1 Action: KT/KB

The Chair congratulated Kerry Turner on the outcome of the MIAA review and drew attention to the importance of recruiting more FTSU Champions.

Resolved:
The Board noted the Q2/Q3 Freedom to Speak Up update.

23/24/274 People and Wellbeing Committee

The approved minutes from the meeting held on the 22.11.23 were submitted to the Board for information and assurance purposes. During January's meeting there was a focus on Divisional metrics, apprenticeships and the Gender Pay Gap report. Attention was drawn to the Gender Pay Gap report and it was highlighted that on average in Alder Hey women earn 27% less than men (median gap 19%). This is not a result of paying men and women differently for the same or equivalent role but a reflection on the proportion of women in lower grade roles. The data relating to medical staff also impacts the overall result as there are significantly more male consultants with Clinical Excellence awards than female. The Board was advised that the stated long term goal is to attain gender balance across the Trust's workforce especially at more senior levels. Actions will be implemented to support female medical staff better and encourage them to apply for Clinical Excellence awards.

A discussion took place around pay gap challenges, improvements and culture. Fiona Beveridge pointed out that this is a complex area across the NHS and felt that further work can be done to understand the pay differentials of the organisation's workforce especially in relation to race and disability. Fiona Beveridge agreed to link in with the Chief People Officer, Melissa Swindell regarding this matter.

23/24/274.1 Action: FB

Resolved:
The Board noted the approved minutes from the meeting held on the 22.11.23.

23/24/275 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 20.12.23 were submitted to the Board for information and assurance purposes.

During January's meeting a debate took place on coding, and the Committee held its third face to face business review session with the divisions. It was reported that there has been a marked improvement in reporting and the quality of debates. Attention was drawn to the high quality reporting from the Division of Medicine and the Division of Surgery in terms of how they are linking in with transformation programmes. There was also a focus on the maturity of the vision, KPIs and the transformation benefits that have been achieved to date (4.2%) in comparison to the 1% that was originally expected. It was pointed out that the transformation benefits will help ease the CIP pressure in 2024/25 as the recurring change will have already been embedded.

Resolved:
The Board noted the approved minutes from the meeting held on the 20.12.23.

23/24/276 Board Assurance Framework Report (BAF)

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

- It was reported that the Trust's Assurance Committee agendas continue to be focussed on strategic risks and discussions are identifying risks and getting underneath them, with coding being an example at this month's RABD meeting.

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

23/24/277 Audit and Risk Committee

The approved minutes from the meeting held on the 12.10.23 were submitted to the Board for information and assurance purposes.

The Board was advised that the Committee met in January on a face to face basis for the first time since the beginning of the pandemic. During the meeting there was a focus on the Audit and Risk Committee's 2023/24 effectiveness review, the proposal to conduct an Effectiveness Review of Internal Audit, and the draft Internal Audit Plan for 2024/25. Attention was drawn to the increase in trend for expected audits which is resulting in a reduction in the choice of audits that the Trust will have, therefore a review is going to take place of the number of days that are allocated to specific audits and a benchmarking of this area of work will be conducted across C&M.

Resolved:
The Board noted the approved minutes from the meeting held on the 12.10.23.

23/24/278 Any Other Business

There was none to discuss.

23/24/279 Review of the Meeting

The Chair pointed out that the meeting couldn't have had a better start than being opened by two of the Trust's young governors; Emily and Leah who shared a presentation on the Youth Voice at Alder Hey and provided the Board with a number of

challenges around the enhancement of contributions by young governors, which it was confirmed will be addressed.

It was felt that the agenda items discussed during the meeting demonstrates the in-depth work that is taking place by Alder Hey, and the optimism that is being seen across the system that will help drive the CYP agenda forward.

The Board was advised that February's meeting is Fiona Marston's last in her role as a Non-Executive Director at Alder Hey. On behalf of the Board, the Chair thanked Fiona for her commitment to the Trust and influence which has brought about change to Alder Hey. The Board wished Fiona well for the future and asked her to keep in touch.

Date and Time of Next Meeting: Thursday the 7th March at 9:00am in LT4, Institute in the Park.

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
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	**1.3.24** - An update will be provided on the 7.3.24.
8.2.24	23/24/260.1	System Wide Update	Liaise with the Chairs of CMAST to discuss as to whether transtition will be dealt with under mental health via CMAST.	Dame Jo Williams	7.3.23	On track March-24	
8.2.24	23/24/260.2	System Wide Update	Discuss a way forward for Research and Innovation to feed into systems/mechanisms.	D. Hawcutt/ D. Jones/ A. Prendergast	7.3.23	On track March-24	
8.2.24	23/24/263.1	Operational Plan Progress/M10 Flash Report	Liaise with C&M about the possibility of including a write up about Alder Hey's transformation in the monthly C&M breifing.	A. Bateman	7.3.23	On track March-24	
8.2.24	23/24/264.1	Alder Hey in the Park Campus Development Update	Circulate an e-mail to Board members to advise as to whether the Trust has been granted planning permission for the new nursery.	R. Lea	7.3.24	On track March-24	
8.2.24	23/24/266.1	Gender Development Service (North) Update	Submit an intial draft risk register for the new Gender Development Service to **1.** SQAC in March and **2.** Audit and Risk Committee in April.	L. Cooper	7.3.24	On track March-24	**1.3.24** - The draft Risk Register for the new Gender Development Service will be submitted to SQAC on the 20.3.24.
Actions for April 2024							
9.11.23	23/24/173.2	Digital, Data and Information Technology Update	*External Reporting* - Discuss the possibility of compiling a report that focusses on the Trust's robust reporting processes and the lessons that have been learnt nationally, for submission to the Board.	J. Grinnell/ K. Warriner	11.4.24	Apr-24	**3.1.24** - This item will be included on February's agenda. 11.1.24 - This action has been deferred to April 2024. **ACTION TO REMAIN OPEN**
7.12.23	23/24/210.1	Neonatal Governance Review.	Meeting to take place between Dame Jo Williams, Louise Shepherd, the Chair and CEO of LWH before the Away Day session goes ahead, to look at developing a framework for the partnership. Alfie Bass to provide a briefing ahead of the meeting, detailing the Trust's thoughts for progressing the partnership, for discussion purposes.	Dame Jo Williams/ L. Shepherd/ A. Bass	11.4.24	Apr-24	**5.1.23** - Contact has been made with the CEO of LWH. An update will be provided in February. **30.1.24** - A meeting has been scheduled for the 10.4.24. An update will be provided during April's Trust Board. **ACTION TO REMAIN OPEN**
8.2.24	23/24/273.1	Freedom To Speak Up	Liaise with Jo Pottier to see if there is an opportunity via PAWC to link in with FTSU on the triangulation of discussions on culture and addressing concerns across the Trust. Compile a proposal and submit it to PAWC for approval.	K. Turner/ K. Byrne	11.4.24	On-track April-24	
8.2.24	23/24/274.1	People and Wellbeing Committee	Liaise with Melissa Swindell to look at what can be done to understand the pay differentials of the organisation's workforce, especially in relation to race and disability.	F. Beveridge	11.4.24	On-track April-24	
Actions for June 2024							
8.2.24	23/24/267.1	Learning from Patient Safety Incidents	Schedule a Board Development Session on PSIRF in April 2024.	N. Askew	6.6.24	On-track June-24	**1.3.24** - This session will take place in June 2024.

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

Alder Hey Children's NHS
NHS Foundation Trust

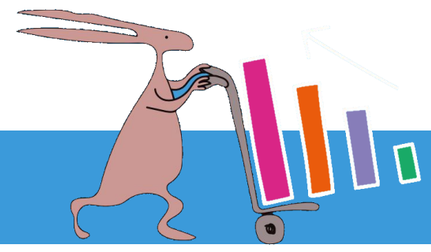
Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Status							
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
6.7.23		Staff Story	Meeting to take place with Will Simmons and Christine Hill to discuss the support/resources that the Pathology Service requires to progress the Super Hub model.	L. Shepherd/ J. Grinnell	7.3.23	Closed	**7.11.23** - A meeting is in the process of being scheduled. An update will be provided in February. **30.1.24** - A meeting is in the process of being scheduled. An update will be provided in March. **1.3.24** - A meeting has taken place. **ACTION CLOSED**
11.1.24	23/24/239.1	Mortality Report, Q2	Arrange for Fiona Marston to liaise with Julie Grice to discuss the possibility of including more detail in the graph on the first page of the Mortality report.	A. Bass	8.2.24	Closed	8.2.24 - A positive meeting took place between Fiona Marston and Julie Grice and work took place on stats/an alternative approach which enabled the graph to be modified. **ACTION CLOSED**
8.2.24	23/24/272.1	EDI Update	Submit the EDI Action Plan to the Board in March 2024.	M. Swindell	7.3.24	Closed	1.3.24 - The item will be submitted to the Board on the 7.3.24. **ACTION CLOSED**

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: February 2024



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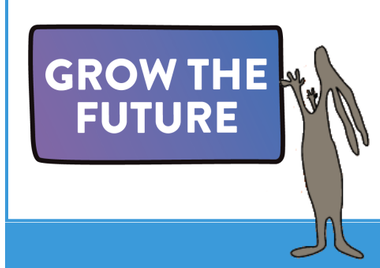
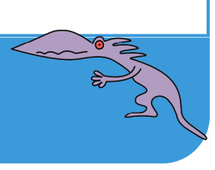




Icon Definitions

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

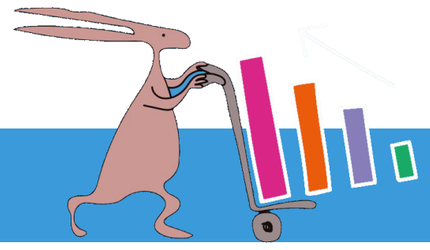
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

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

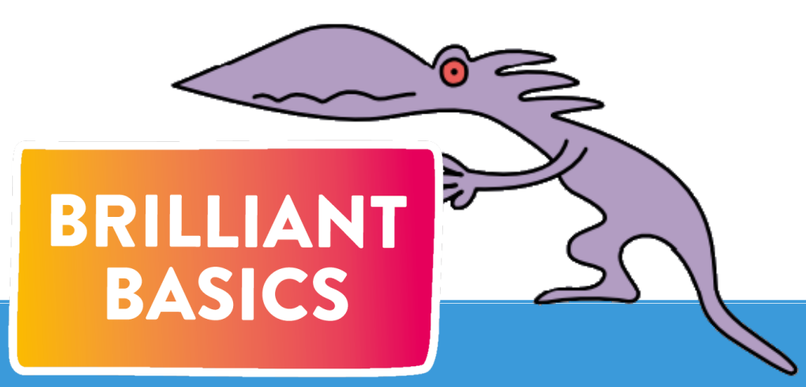
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

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

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

- We are consistently passing 18.2% of our metrics.
- We are achieving 61.4% of our metrics inconsistently.
- We are not achieving the target for 20.4% of our metrics but experiencing improvement in 2 of these metrics.

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



Integrated Performance Report | February 2024

Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety

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

Highlights:

Improved position reported in all safety metrics in January. No serious incidents and no Never Events. No hospital acquired MSSA or C-diff. 100% of inpatients with suspected sepsis, and 93% of patients with suspected sepsis attending ED, received antibiotics within 60 minutes. No Category 3 or 4 pressure ulcers and significantly reduced Category 2 pressure ulcers. Reduction in physical intervention required

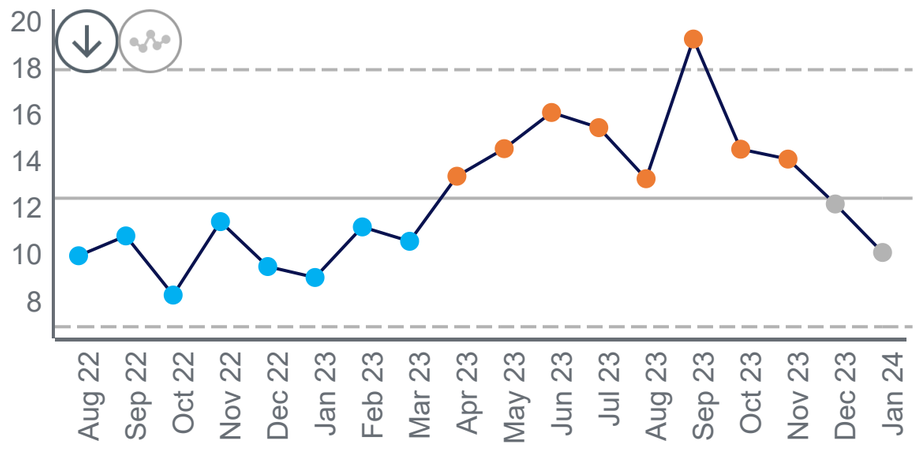
Areas of Concern:

Reduction in unplanned admissions to Critical Care from wards in January however remains relatively high at 25

Forward Look (with actions)

Deep dive of unplanned admissions to Critical Care undertaken by the Response Team in December 2023. Using the preventability framework, the team found that 93% of all episodes of deterioration were deemed predictable but not preventable. Recommendations for practice have been identified

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



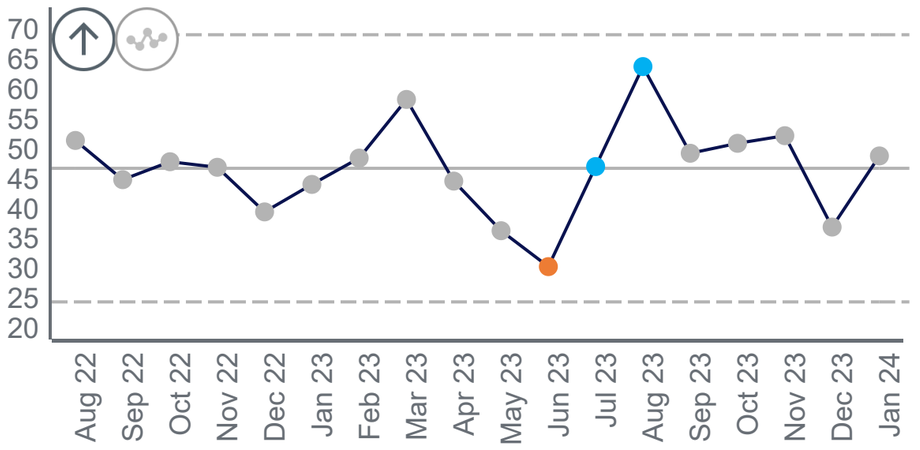
Technical Analysis:

Common cause variation has been observed with performance of 10 incidents of harm per 1,000 bed days, with a monthly average of x12 incidents during the period.
Rates currently assessed on Physical Harm only.

Actions:

All incidents rated Moderate harm or above reviewed at the weekly PSIRI panel

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



Technical Analysis:

Common cause variation has been observed with performance of 49 incidents of no harm per 1000 bed days. With a monthly average of 47 during the period. Of the 464 patient safety incidents resulting in no harm in January 2024, this includes 36 who have no harm assigned as not involving a patient directly.
Rates currently assessed on Physical Harm only

Actions:

All staff encouraged to report incidents of no harm and near miss to enable learning

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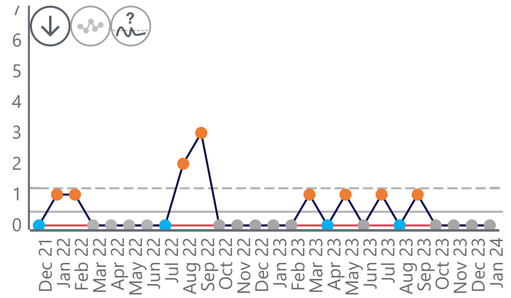
Integrated Performance Report | February 2024

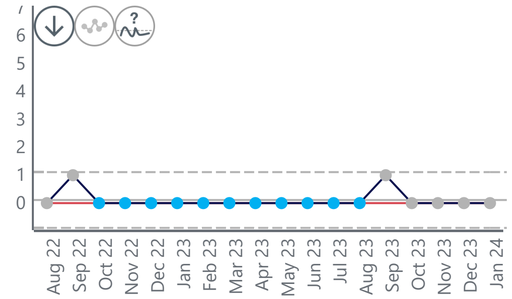
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

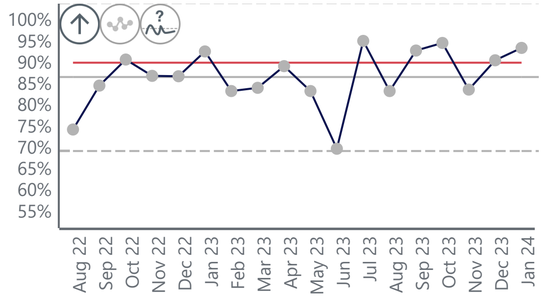
Number of Serious Incidents (Steis reported)



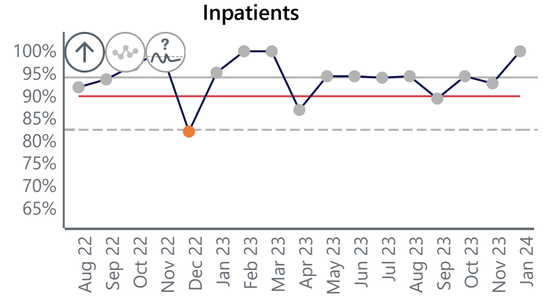
Number of Never Events



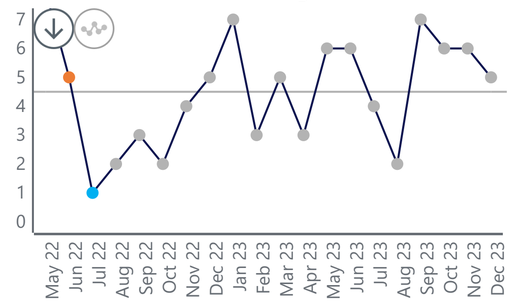
Sepsis % Patients receiving antibiotic within 60 mins for ED



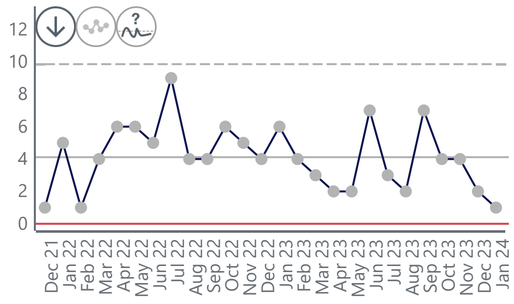
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



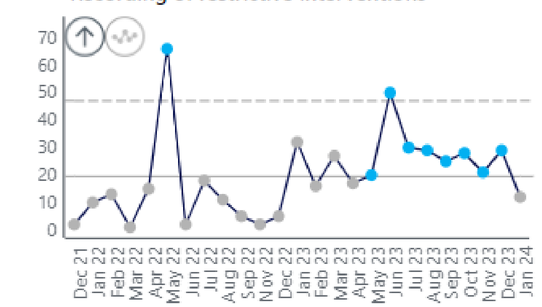
Medication Errors resulting in Harm



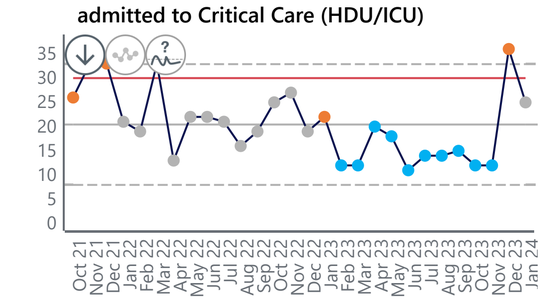
Pressure Ulcers G2-4



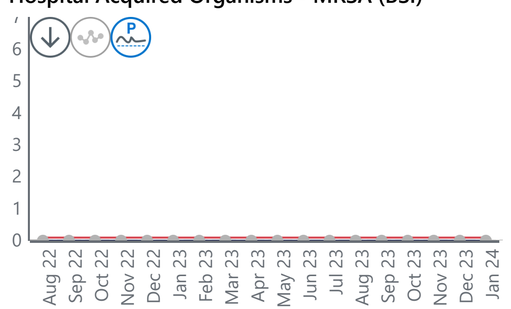
Recording of restrictive interventions



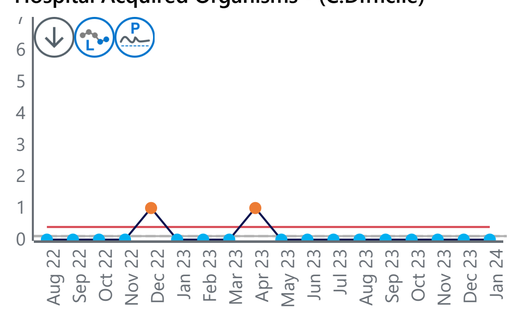
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



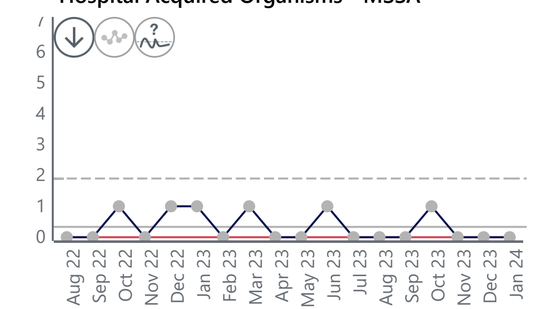
Hospital Acquired Organisms - MRSA (BSI)



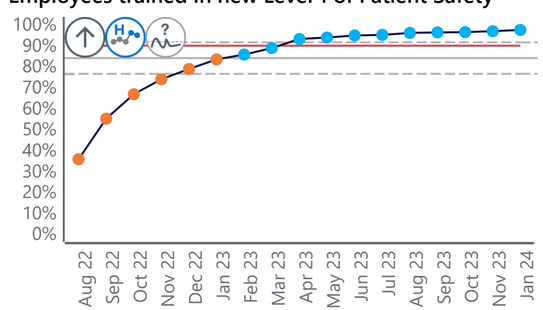
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Unrivalled Experience - Caring

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

Highlights:

80% of formal complaints responded to within 25 working days and 79% of PALS responded to within 5 working days

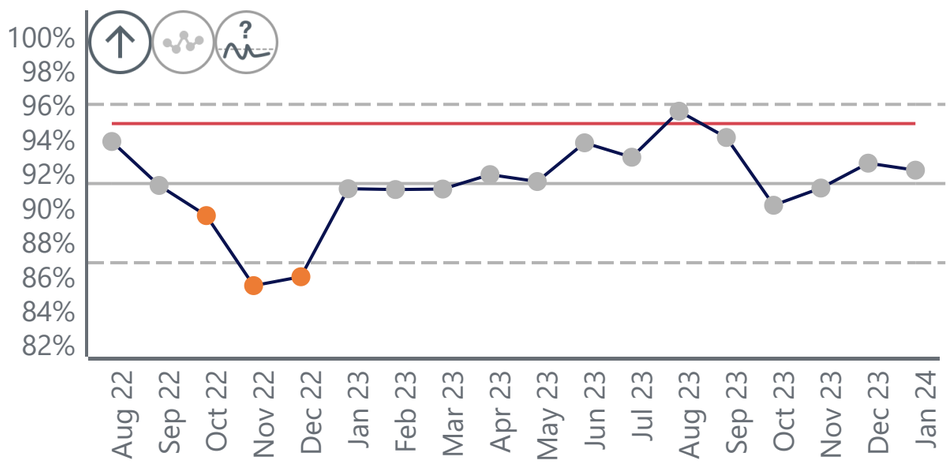
Areas of Concern:

Consistently below the 95% of families who would recommend the trust however consistently above 90%

Forward Look (with actions)

Divisions to ensure complaints are responded to in line with the policy

F&F Test - % Recommend the Trust



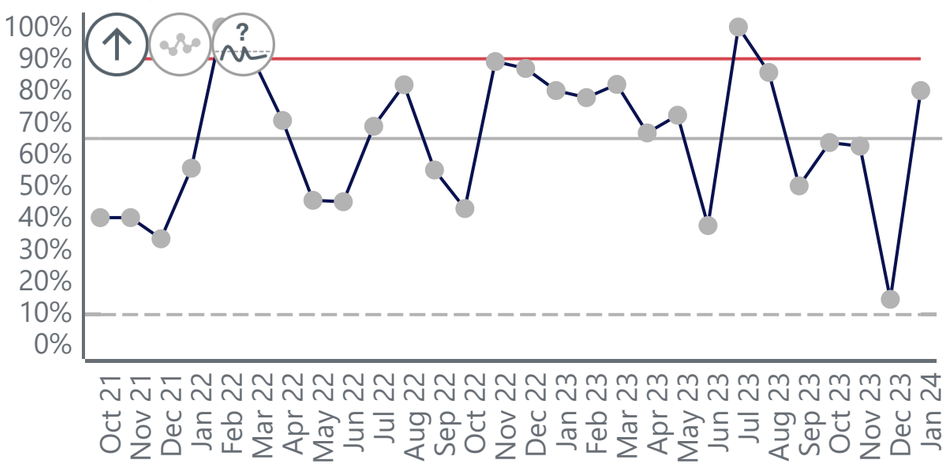
Technical Analysis:

Consistently not achieving the 95% target. January performance of 92.3% represents slight decrease from December performance of 92.7% and represents third consecutive month above average of 91%.

Actions:

Receiving feedback is key workstream in the Patient Experience Strategy Group; review of the FFT system underway

% Complaints Responded to within 25 working days



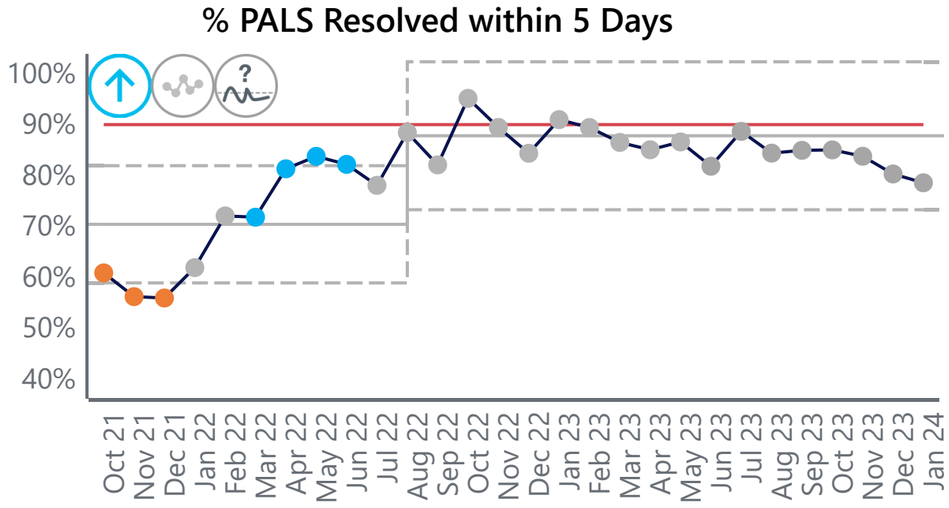
Technical Analysis:

Inconsistently achieving the 90% target with an average of 64% which shows significant fluctuation from month to month. Performance in January 2024 was 80% which represents 3 breaches out of 15 complaints due in the month.

Actions:

The Divisional Governance Teams are working with the BI Team to review how data is analysed to ensure all report in the same way

% PALS Resolved within 5 Days



Technical Analysis:

Common cause variation has been observed. Inconsistently achieving the 90% target however January 2024 performance was 79%

Actions:

Divisions to maintain the excellence performance in January through the governance structures and processes

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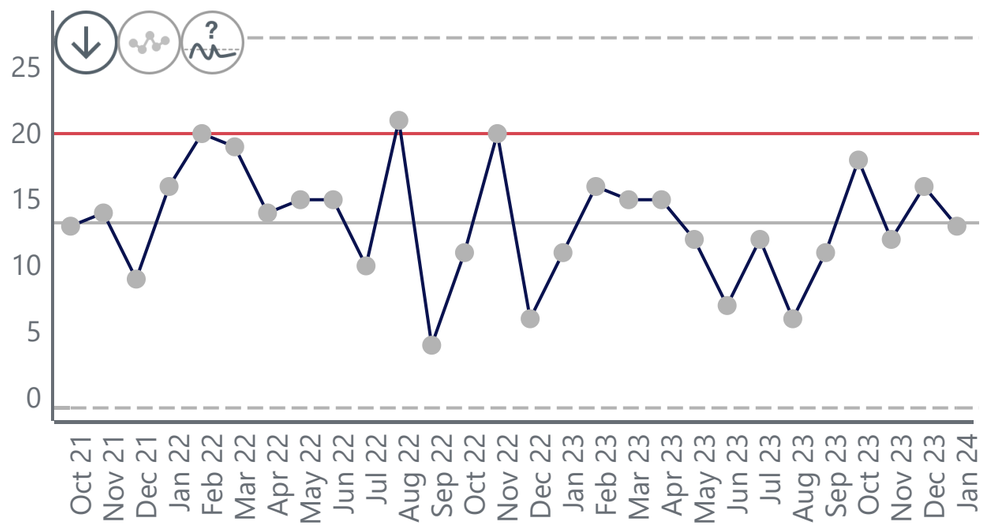
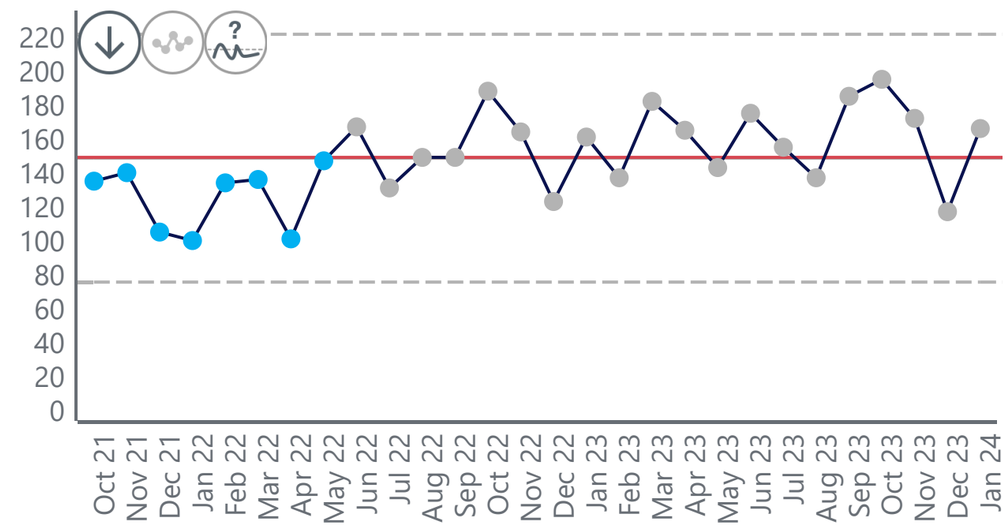
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

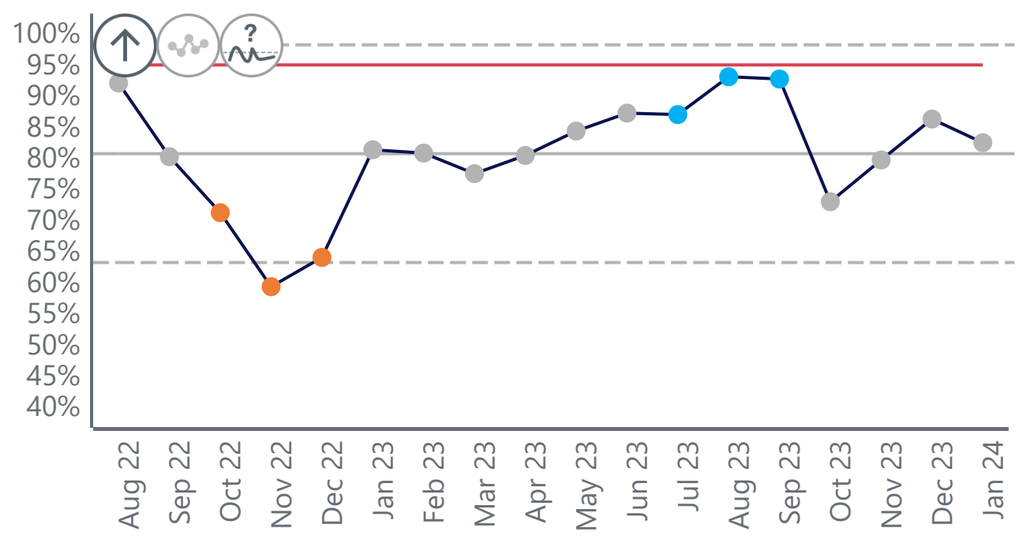
Number of formal complaints received



Number of PALS contacts



F&F ED - % Recommend the Trust



Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• 12 cancelled elective operations in January for non-clinical reasons, significant reduction in month & below average of 20 pcm. • Number of stranded patients decreased for 3rd consecutive month • WNB rate decreased in January to 9.6% but common cause variation remains.

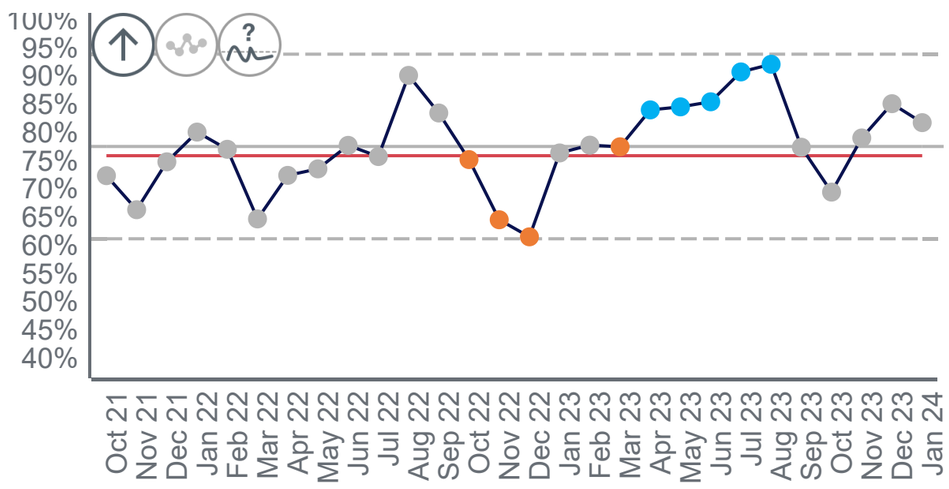
Areas of Concern:

% of clinical letters completed within 10 days remains below target although saw a significant increase in month to 73%.

Forward Look (with actions)

Theatre TT utilisation dashboard now relaunched. Slight increase in month at 75% against 85% target but key actions planned with specialities via theatre productivity programme- including review of opportunities for improving start/finish times based on uncapped utilisation which was 81% in January. Targeted work via A3 approach underway to improve pre-operative pathway and on the day cancellations for both clinical and non-clinical cancellations with clear target metrics in place.

ED: % Treated within 4 Hours



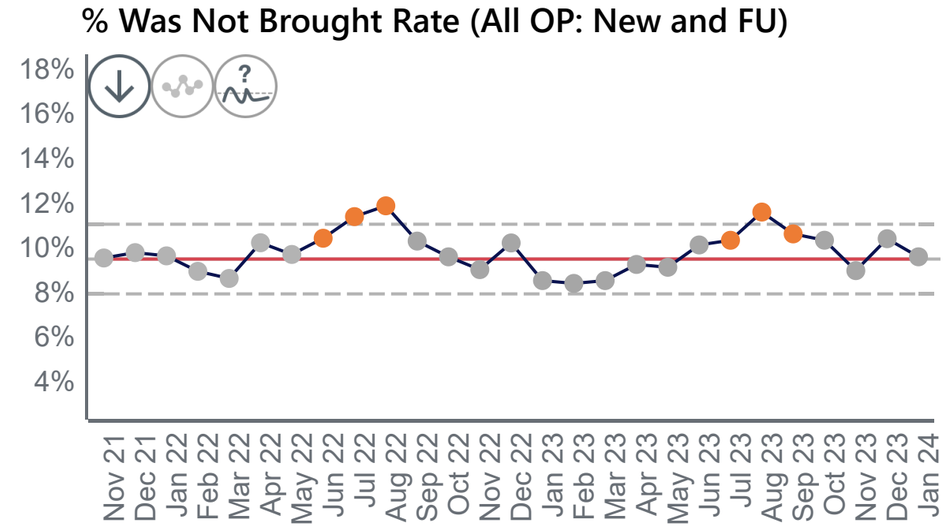
Technical Analysis:

Trust achieving the national target (>76%) in Jan-24. Common cause variation has been observed with performance of 81.9% which is reduction from Dec-23 of 85.2%. However Jan 2024 is +5.4% greater performance compared to Jan-23 (76.5%) whilst also seeing +1,219 extra attendances in Jan-2024 compared to Jan-23. 2023/2024 demonstrating 9/10 months achieving the national standard.

Actions:

Following a slight reduction in performance against the 4-hour standard several actions are underway to improve and sustain performance above 80% for Q4. Actions include: a review of diagnostic pathways from ED, revised escalation plan out of hours & extending senior decision-making shifts during the afternoon & evening.

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



Technical Analysis:

WNB rates demonstrates common cause variation. Performance in January 2024 of 9.6% which is reduction when compared to December 2022 (10.4%) and now the second month below the target of 10% since May 2023 although a number of bookings are still be actioned for the month which could alter January 2024 position.

Actions:

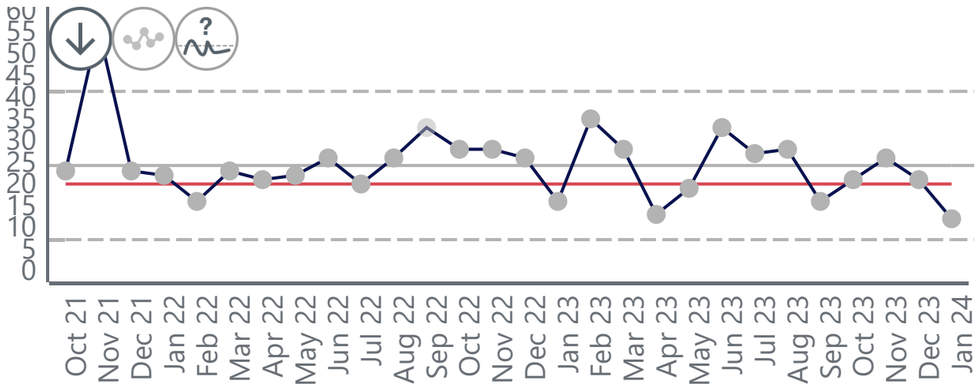
Focused improvement work continues on WNB rate including a hybrid booking pilot within Community Ophthalmology to offer increased patient choice.

Integrated Performance Report | February 2024

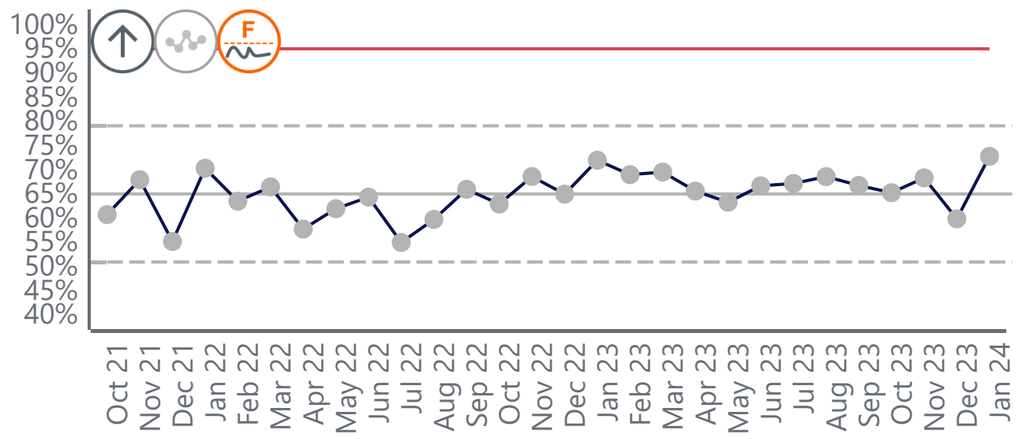
Alder Hey Children's NHS Foundation Trust

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

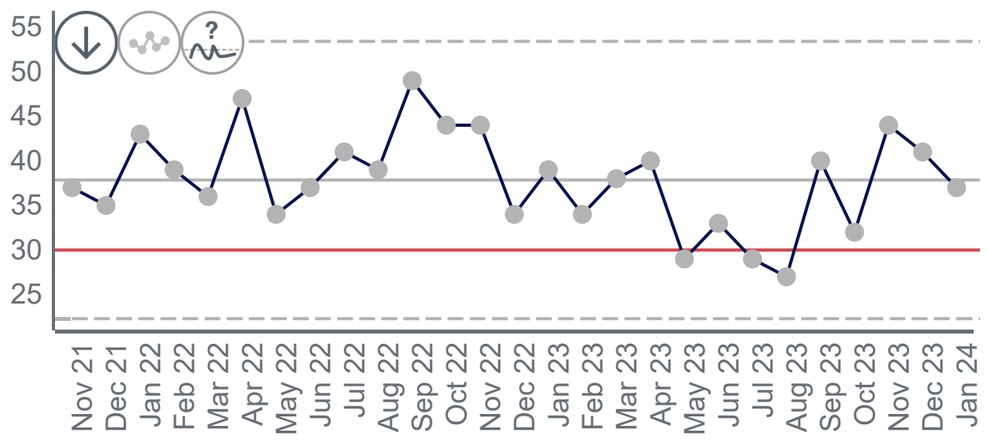
Number of Cancelled Operations (on day of admission for a non-clinical reason)



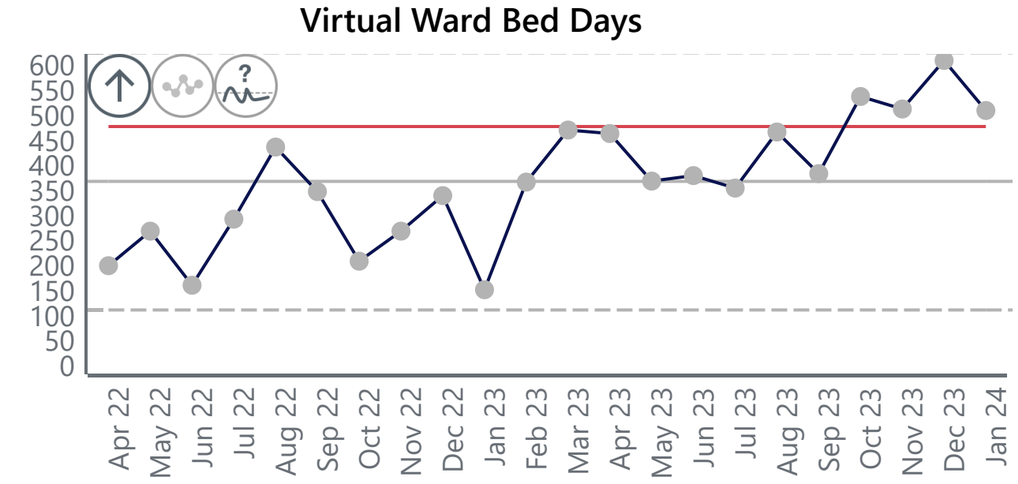
% of Clinical Letters completed within 10 Days



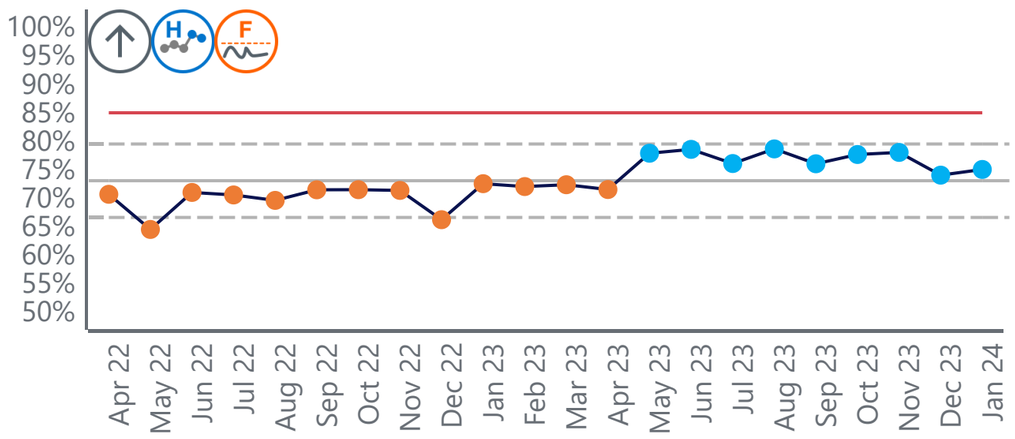
Number of Stranded Patients (21 Days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• % Recovery for DC & Elective Activity volume was +1% than January 2023 despite further industrial action impact 3rd- 9th January & planned theatre schedule reduction.
• % Recovery for OPNEW & OPROC continued to be over target at 130% in January
• 100% compliance sustained against 2 week wait cancer referrals

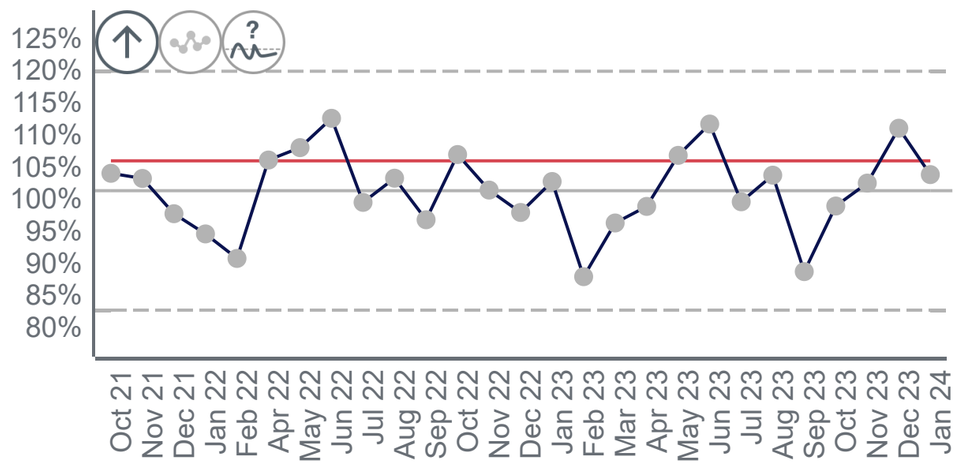
Areas of Concern:

•% Recovery continues to demonstrate common cause variation. •DM01 performance reduced in January and was below target at 80% compliance.

Forward Look (with actions)

•Weekly activity reviews in place for specialities working below activity forecast.
•Theatre schedule on track to increase sessional delivery by 7 sessions per week WC 26th February which will increase capacity in key challenged areas.
•Continued improvement work to sustain DM01 compliance across the divisions, key areas for review are Respiratory Physiology, Gastroscopy & Cystoscopy.

% Recovery for DC & Elec Activity Volume



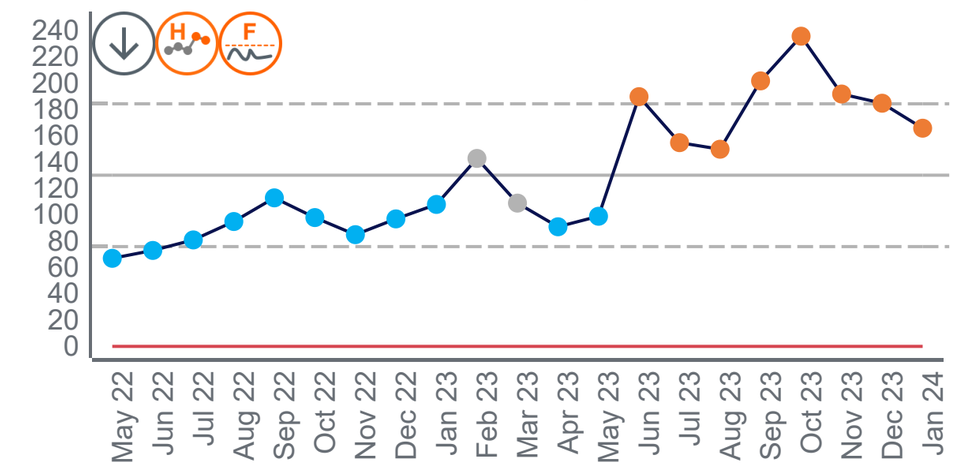
Technical Analysis:

January performance of 103.8% is below target of 106% for 2019/2020 baseline. January 2024 experienced industrial action 3rd-9th Jan however is +1% higher than January 2023 (102.8%) performance. The data series continues to demonstrate common cause variation.

Actions:

Continued improvement work underway within targeted specialities to increase productivity. Theatre sessions per week to increase by 7 sessions Mid-February as planned. Additional capacity will support challenged specialties with 65 week position.

Number of RTT Patients waiting >65 weeks



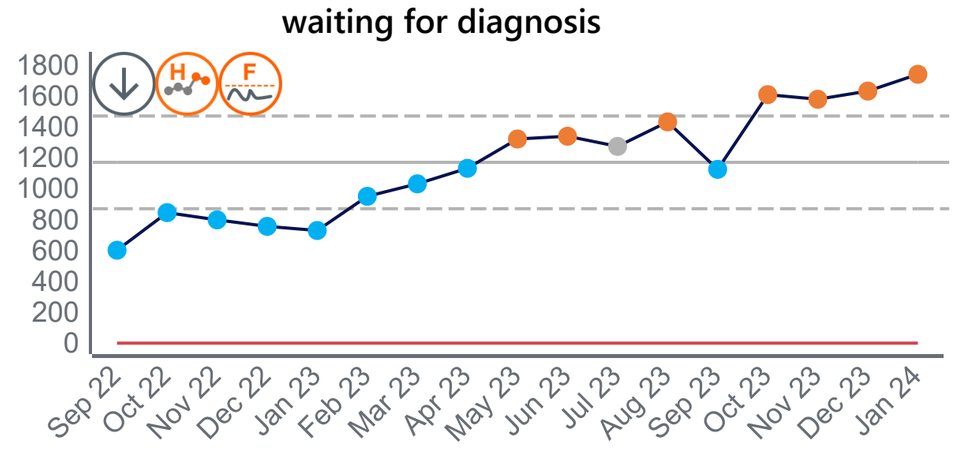
Technical Analysis:

Number of patients waiting > 65 weeks has slightly decreased to 166 in January (185 in December). The current trend is showing special cause variation with an increase in breaches over the last 8 months. Dentistry (n=84) and ENT (n=66) make up 90% of the Trust total.

Actions:

Number of patients waiting > 65 weeks continues to reduce against planned trajectory. ENT & Dentistry make up the majority of the backlog however are on track for 0 > 65 weeks by end of March 2024 with additional capacity & super clinics in place.

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



Technical Analysis:

January 2024 shows 1745 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:

Weekly meetings continuing with ADHD team to manage impact of medication shortages which is impacting on capacity and waiting times. Recruitment is underway for nursing and psychology roles for ASD and ADHD. Digital improvements underway on referral platform which will reduce requirement for paper questionnaires and release clinical and administrative time

Integrated Performance Report | February 2024

NHS
Alder Hey Children's
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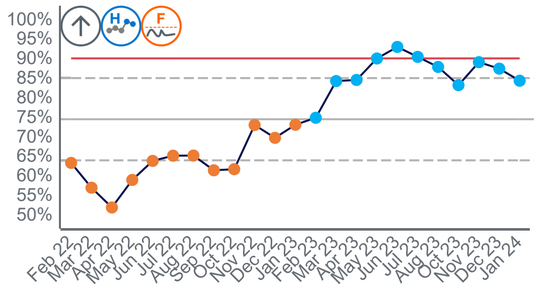
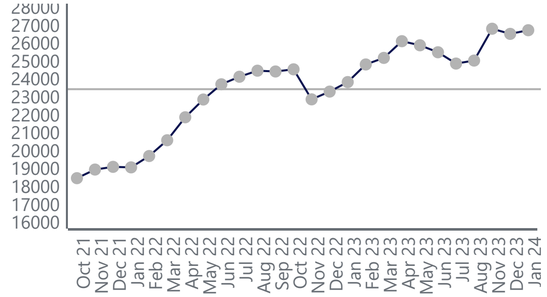
Smartest Ways of Working - Accessible Services: Responsive - Watch Metrics

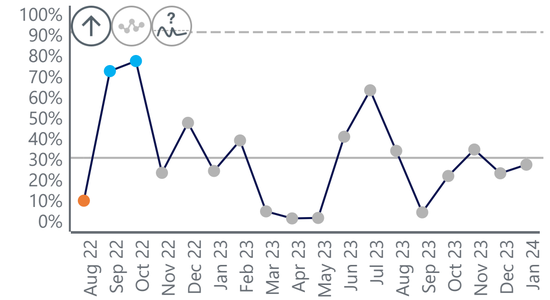
Diagnostics: % Completed Within 6 Weeks of referral



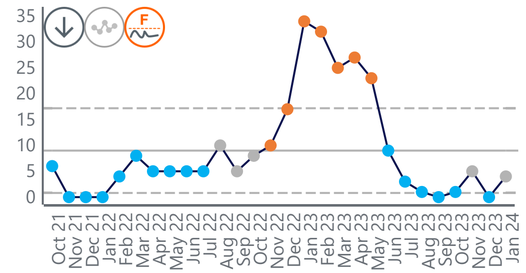
Waiting List Size



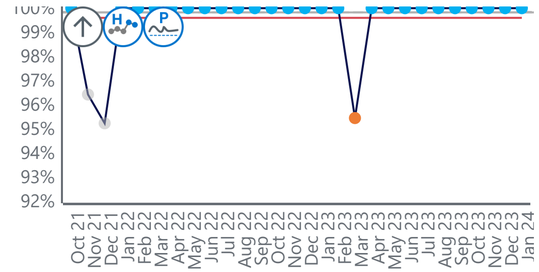
IHA: % complete within 20 days of referral to Alder Hey



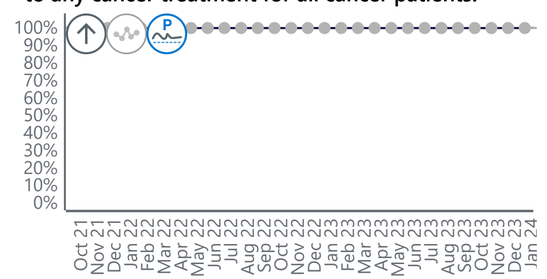
CAMHS: Number of children & young people waiting >52weeks



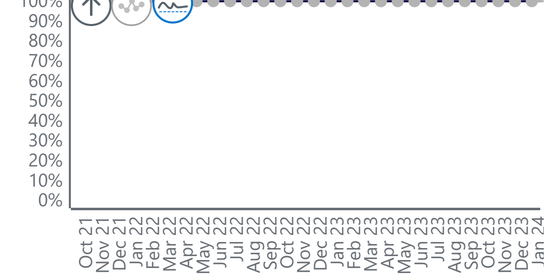
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



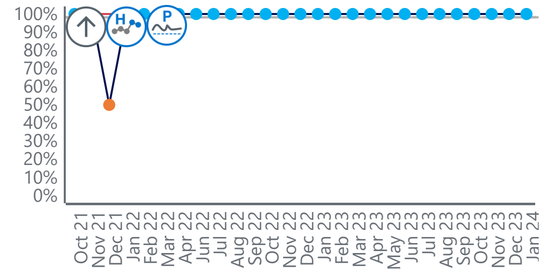
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



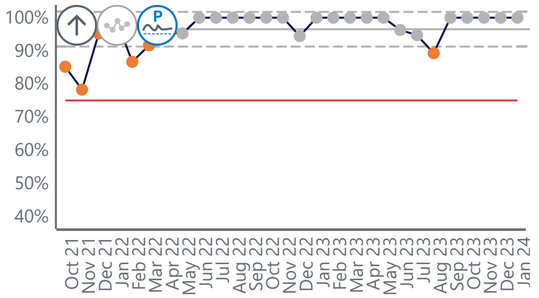
All Cancers: 31 day wait until subsequent treatments



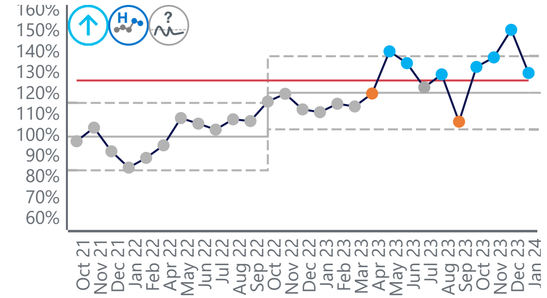
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Integrated Performance Report | February 2024

Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

A continued reduction in staff turnover for the 9th consecutive month. The refreshed exit interview/questionnaire process has been relaunched and shared across the Trust in support of this.
Ongoing and improved activities within Divisions to effectively reduce long term sickness with focus on increased qualitative and timeliness of return-to-work meetings and reduced Occupational health DNA'S to improve sickness absence.

Areas of Concern:

PDR compliance remains an area of concern. However, there are agreed actions in place to address this over the coming months. Medical appraisal compliance has also dropped significantly as they did in January last year, due to work pressures and is being monitored and supported.

Forward Look (with actions)

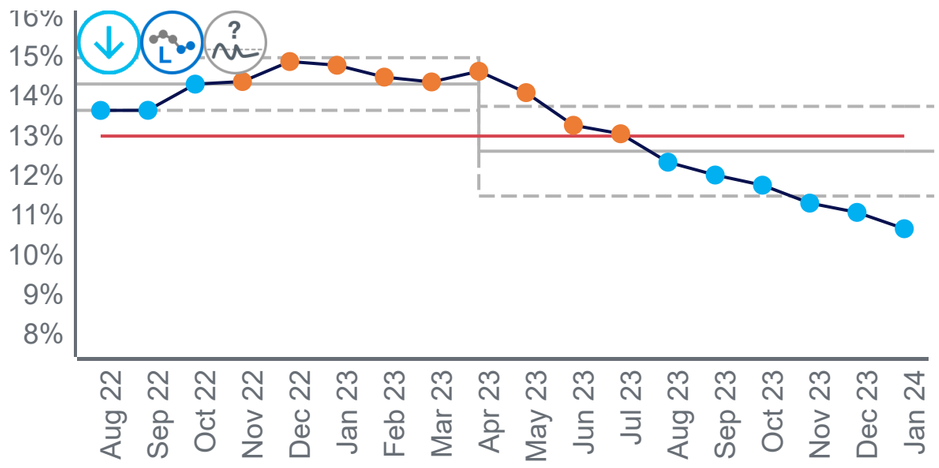
Continued review of PDR data with weekly reporting available.

Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

Staff Turnover



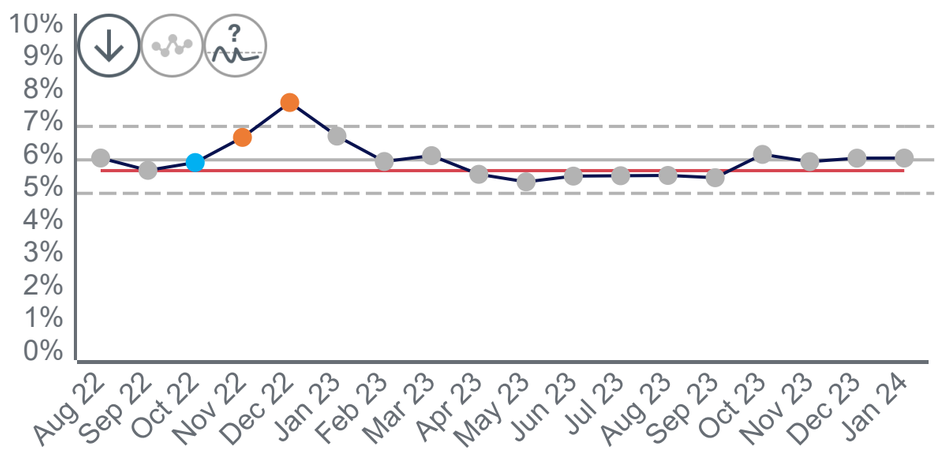
Technical Analysis:

Staff Turnover contonues to demonstrate special cause variation, 10.6% is the 10th consecutive month with a reduction and 6th consecutive month within target.

Actions:

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

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in January is 5.99% which is over the 5.5% target. A slight increase from December at 5.94%. Although a significant decrease compared to January 2023 which was 6.55%. January 2024 performance comprises STS at 2.18% and LTS at 4.09%. Still demonstrating common cause variation, fourth consecutive month above target since March 2023

Actions:

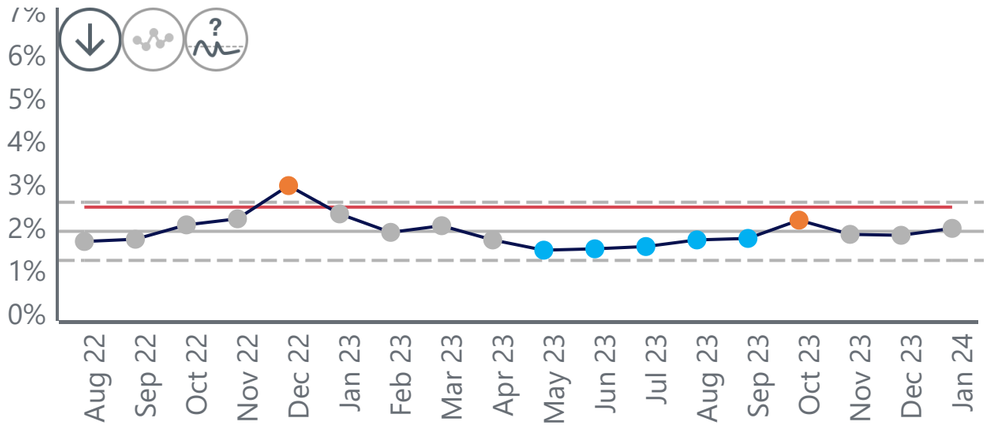
Sickness absence has steadied over winter and remains a targeted area of focus, with;
•Discussions at Divisional Boards
•Management meetings •Divisional wellbeing activities •Focus on Stage 3 LTS •Timely return to work discussions are being reinforced with bespoke training and support in place.

Integrated Performance Report | February 2024

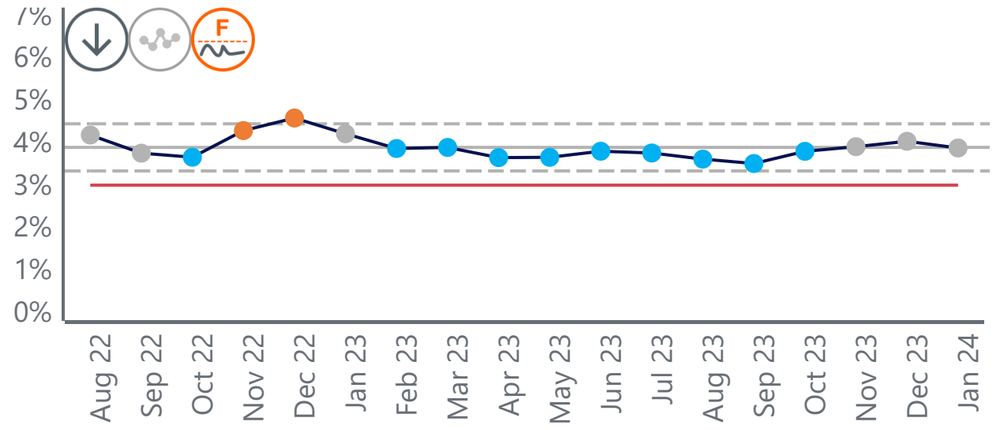
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

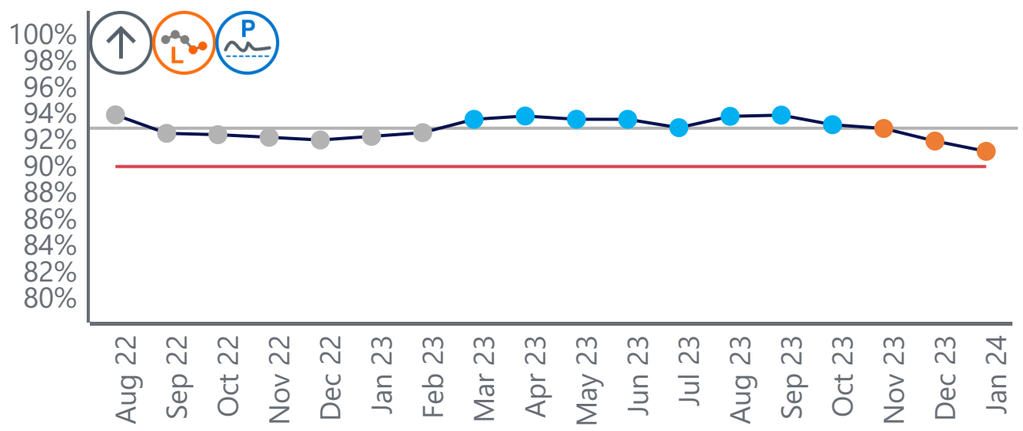
Short Term Sickness



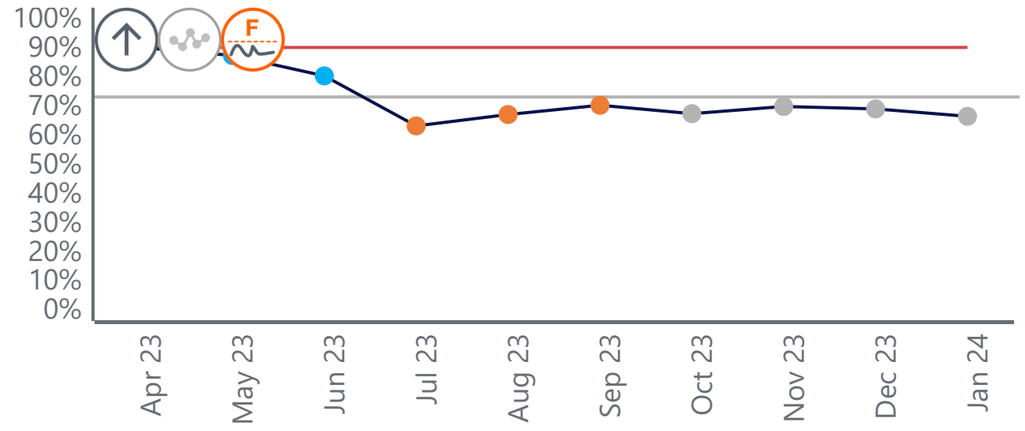
Long Term Sickness



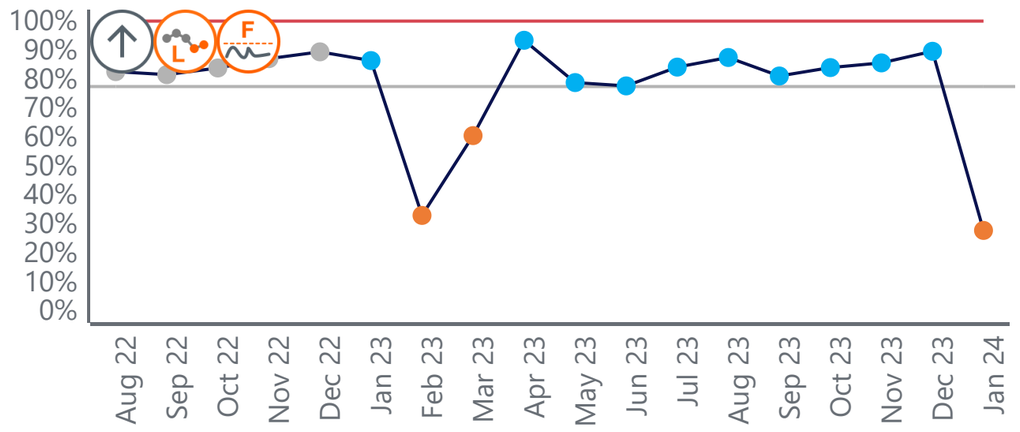
Mandatory Training



% PDRs completed since April



Medical Appraisal



Staff movement / Churn rate - In Development

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

In January (M10), the Trust is reporting a position £1.5m adverse to plan (£4m surplus against a plan of £5.5m YTD). This is due to industrial action. Forecasting to achieve £11.5m surplus. This is £1.5m away from the revised forecast submitted in November. This is due to industrial action and subject to CIP risk. CIP is £0.6m ahead of plan YTD. Overall, £17m CIP has been transacted with £0.6m in progress. On track to deliver subject to amber schemes. Recurrent CIP has decreased slightly in month from £11.7m in M9 to £11.2m in M10. Cash has remained high in line with plan & capital in line with expectations.

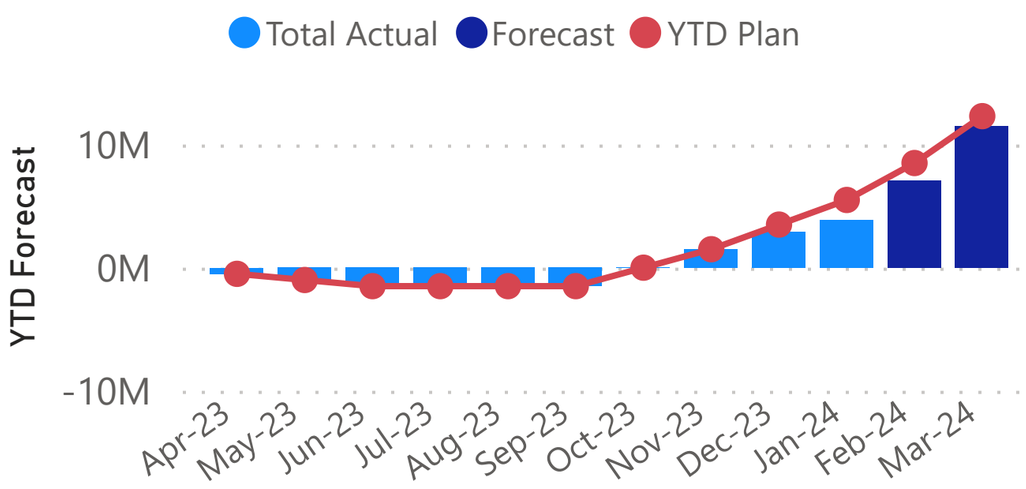
Areas of Concern:

CIP gap is closed in year, subject to delivery of amber schemes £0.6m. Whilst recurrent CIP has decreased slightly in M10 (£11.2m now identified recurrently, down from £11.7m in M9), owing to a more realistic divisional forecast. This remains an area of concern given the gap recurrently is £6.4m which will be carried into 24-25 if not identified. Challenging revised forecast plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets. No confirmation to date that the cost of IA in Dec and Jan will be funded/targets adjusted. Further IA anticipated in Feb, which are not currently reflected in the forecast.

Forward Look (with actions)

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

Revenue Position (Year End Forecast)



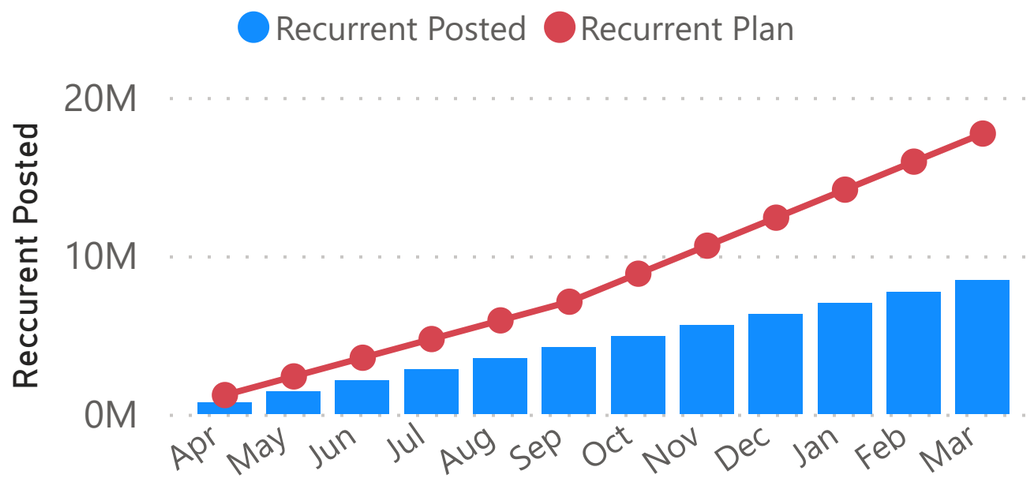
Technical Analysis:

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

Actions:

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

CIP Position (Recurrent Full Year Effect)



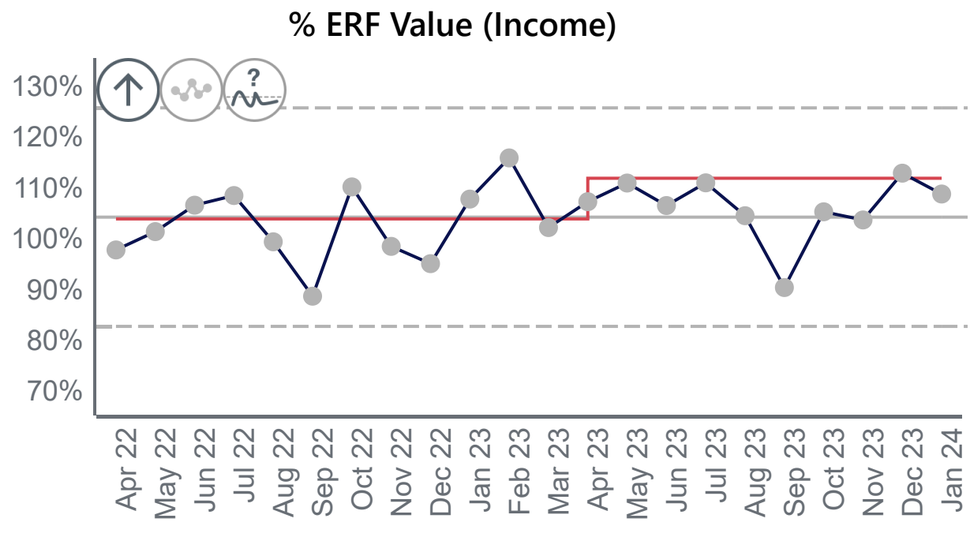
Technical Analysis:

In year CIP identified and in progress is £17.6m so achieved in full. Of this, £11.2m is recurrent.

Actions:

Support required with exec leads and transformation to identify the large scale opportunities. Work continues on wider change programmes to be reported to RABD in Feb. Still large gap recurrently of £6.4m.

% ERF Value (Income)



Technical Analysis:

January performance estimated at 108.9%. YTD performance estimated at 105.9%.

Actions:

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

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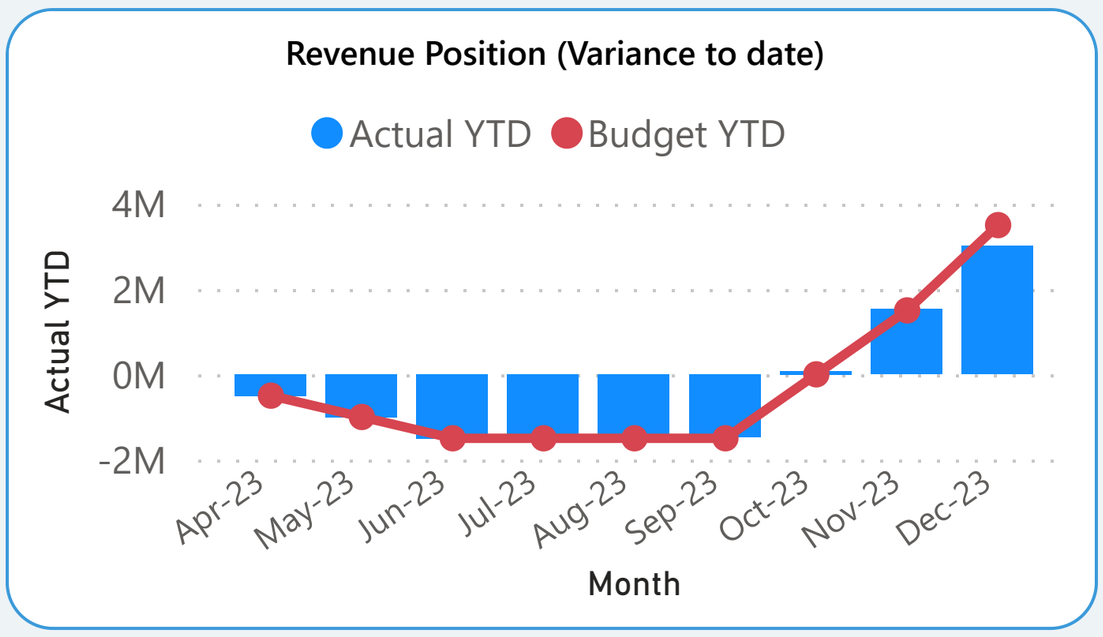
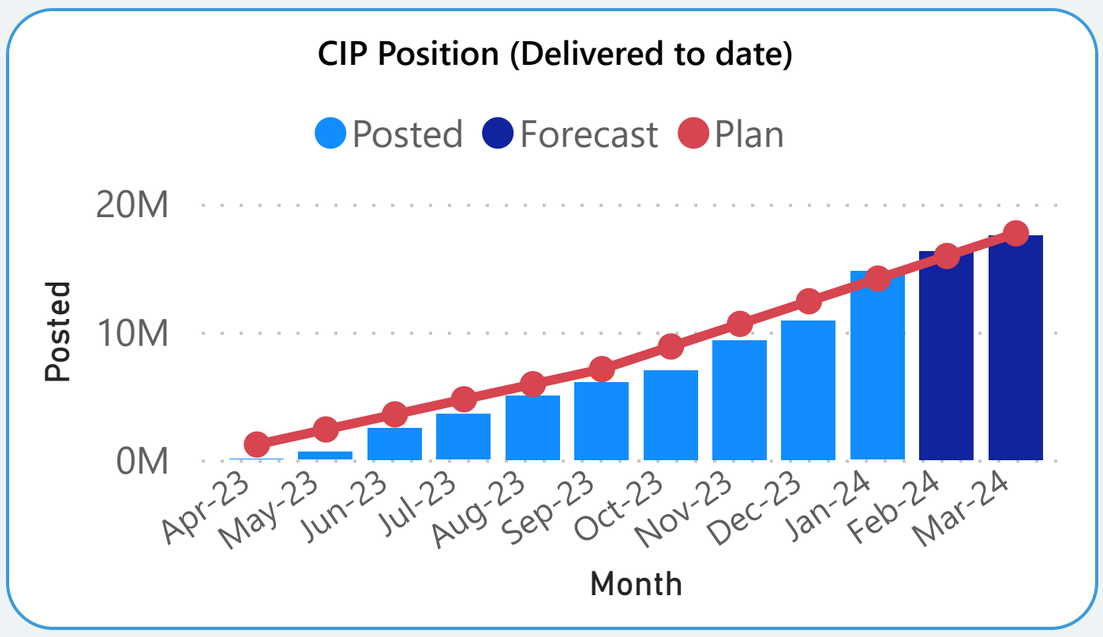
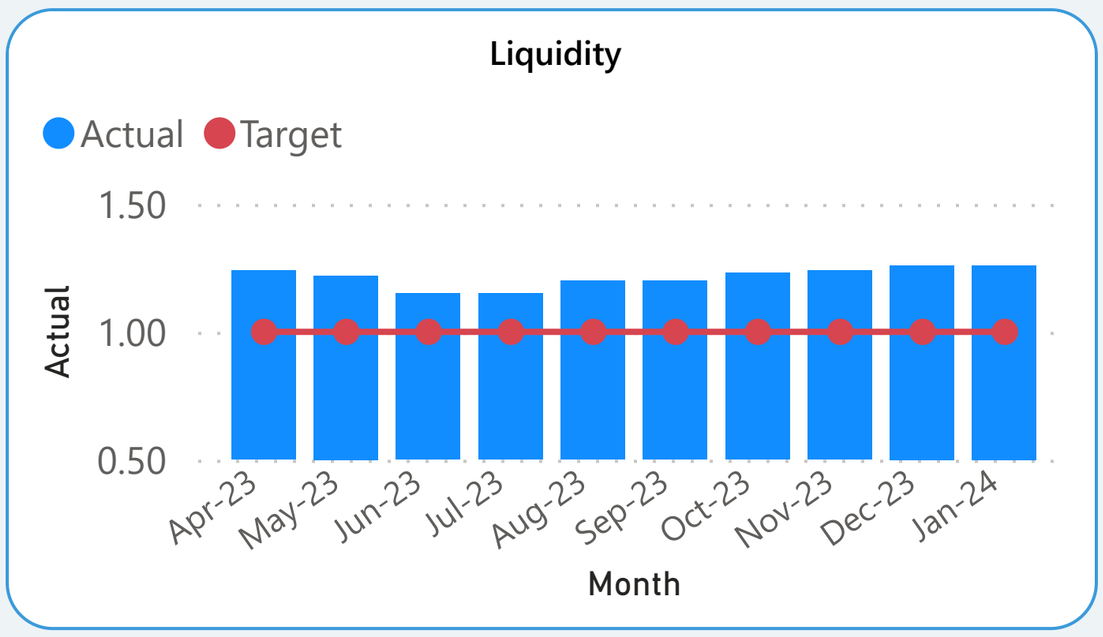
Alder Hey Children's NHS Foundation Trust

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







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Oversight of risk reporting continues to be embedded within InPhase. Risk report functionality and visualisation continues to progress with BI team. Improving trend of high risks within expected date review (94.7%). Workshop held with Kings College London 29/1/24 to showcase full reporting and dashboard functionality of InPhase. Overdue risk notifications now rectified

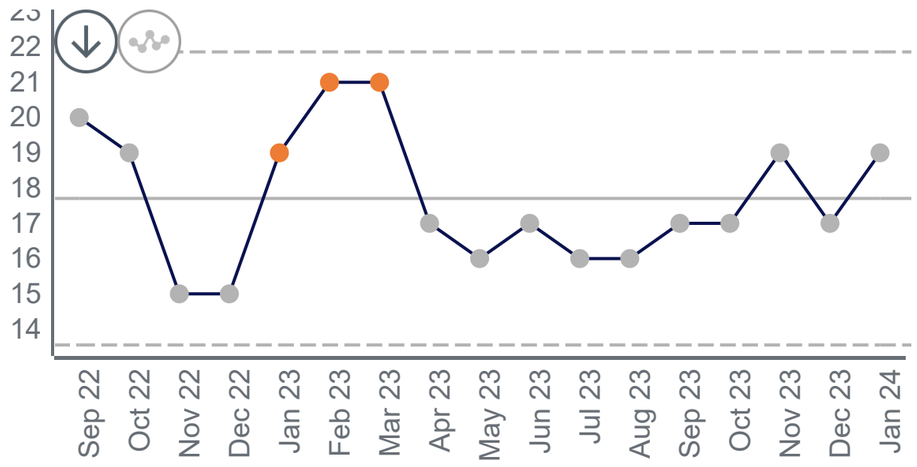
Areas of Concern:

Ongoing delays with development of heatmap visualisation

Forward Look (with actions)

Further development of heatmap visualisation required. Continue to oversee and escalate overdue high risks to relevant division and risk lead

Number of High Risks (scored 15 and above)



Technical Analysis:

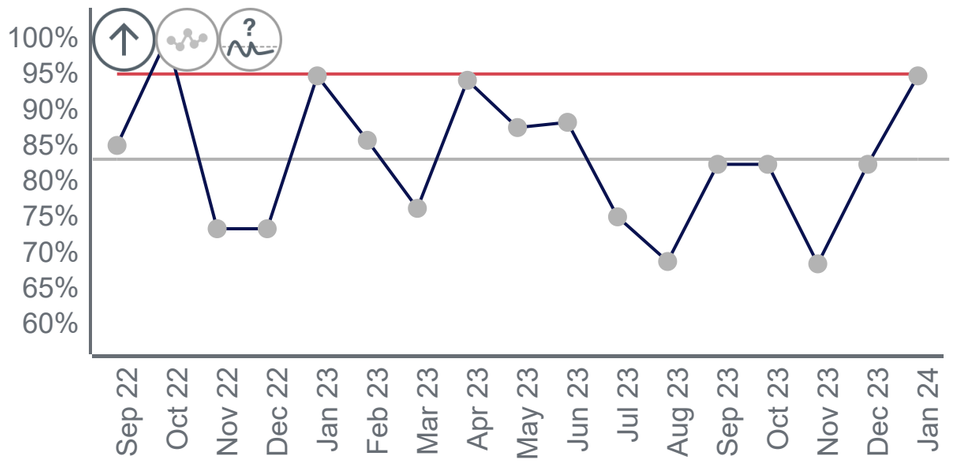
January position of 19 high risks open, demonstrating common cause variation with an average in the period of 18 a month.

Actions:

19 high risks identified and themed as follows:

Quality-Safety (6 risks)
Workforce/Staffing &HR (6 risks)
Compliance & Regulatory (3 risks),
Financial (1 risks) Operational (1 risk)
Quality effectiveness (1 risk)
Reputational (1 risks)

% of High Risks within review date



Technical Analysis:

January performance of 94.7% (18/19) of risks are within expected review date. Demonstrating common cause variation. Januayr 2024, first month inline with target since April 2023.

Actions:

94.7% (18/19) of risks are within expected review date

Smartest Ways of Working - Safe Digital Systems - Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

The development of the Alder Hey Anywhere platform is progressing well following the £306,000 of Patient engagement Portal (PEP) national funding received by the Trust. This funding will be used to support the enhancement plans to integrate the Anywhere portal with Healthcare Communications portal. The AlderCare Optimisation January spring saw 10 out of 14 Divisional priorities delivered with highlights including Ward Discharge Review, Abdominal Pain Pathway and Measles documentation. The development of the Insight Led Care PID has continued to progress well.

Areas of Concern:

Some challenges obtaining timelines for delivery with Meditech regarding priority developments raised through Optimisation.

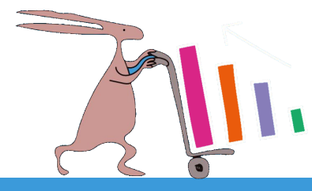
Forward Look (with actions)

Further delivery of AlderCare Optimisation priorities including closer working with Meditech around timescales for developments. Completion of AlderHey Anywhere Business Case. Delivery of actions from the improvement plan around the Data and Analytics service following a review with operational colleagues in January.

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:

New centralised NHS procurement for energy agreed, starting in Alder Hey from April 26. Work started on ICB level strategy, aligning with new estates plan.

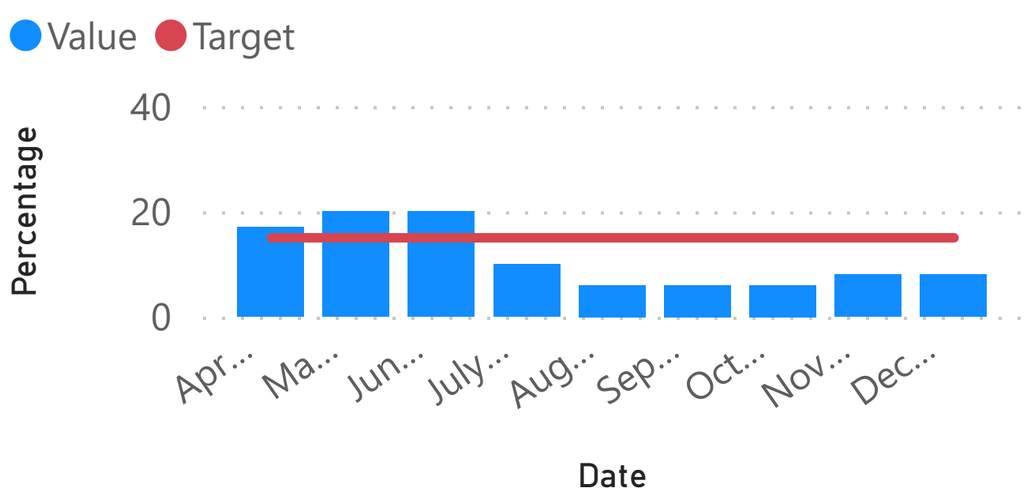
Areas of Concern:

•£2m funding bid we made in Jan was unsuccessful.
•CHP reliability still poor.
•Heating plan not finished
•Slow delivery of agreed projects e g car park LED

Forward Look (with actions)

•Complete heating plan.
•Gloves off campaign starting soon
•Bin project being developed

Green Plan: Reduce Carbon Footprint

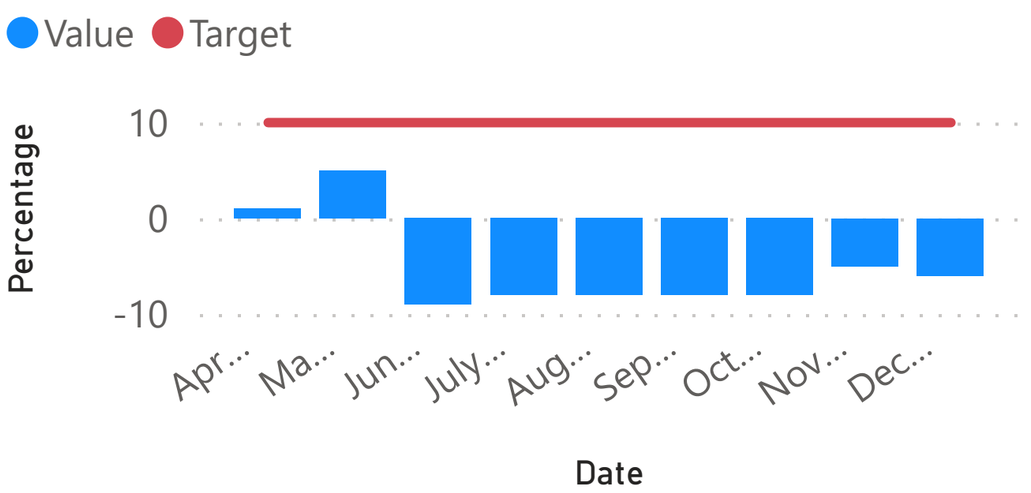


Technical Analysis:

8% saved in December 2023 compared to December 2022

Actions:

Green Plan: Reduce Energy Usage



Technical Analysis:

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

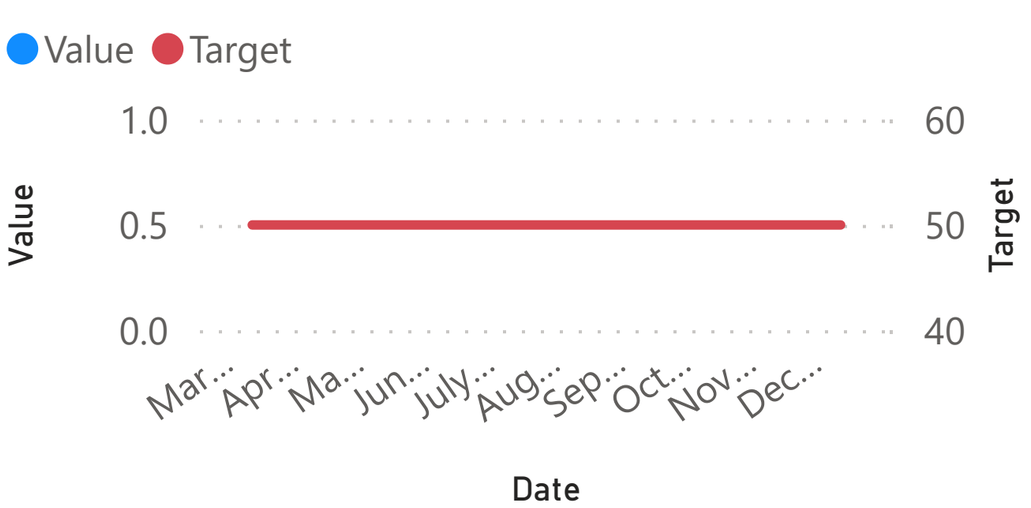
Actions:

•Complete CHP and LED plans

•Finish Heating plan

•Complete water project

Green Plan: Reduce Waste



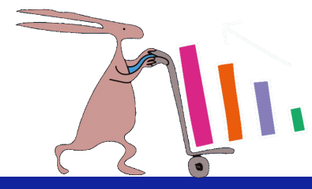
Technical Analysis:

No reduction in performance visual

Actions:

•Complete compactor project review.

•Finish bin project scoping



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

•Continued decrease in staff turnover (12%)

•Compliance with mandatory training continues to remain high (93%)

•Reduction in sickness absence (5.7%)

•Significant improvement in number of outstanding ePPFs (9 over 45 days)

•Appointment of Consultant Psychiatrist for Sunflower House

•Appointment of 4 Speciality Doctors for Developmental Paediatrics

•Work started on refurbishment of Police Station as part of relocation of staff from 3SM with planned move date of June 2024

•Training places received (x3) for Senior Wellbeing Practitioner course to aid development and retention within MHSTs

•Department for Education visit to Liverpool MHST

•Community Neonatal Liaison Nurse (iCCNT) recognised in published research article for service provided to babies and families after discharge from Neonatal Unit.

Areas of Concern

•Slight reduction in EHCP reports completed within timescale for January due to increase demand and increased sickness, but due to improve February.

•1x 52+ week waits for CAMHS. Impact of vacancies and reduced capacity expected to impact during February but stabilise from March onwards. Young person has been seen.

•Impact of recruitment for Gender Service on Locality CAMHS teams

•Continued increase in number of young people waiting for conclusion of ASD/ADHD diagnostic pathway and continued challenges with ADHD medication shortages.

•Continued risk relating to lack of a Named Doctor Safeguarding within safeguarding team (post in recruitment phase).

Forward Look (with actions)

•Task and finish group commenced to review pathways for NHS 111 Support for young people experiencing mental health crisis – National go live due April 2024.

•Review of Divisional letter and text reminders commenced with planned completion date of 31 March 2024

•Improvement in timescale to log referrals (reduced from approx. ten days to five days) further work ongoing to further reduce in line with KPI

•Clinic room utilisation SOP approved, implemented from January 2024 with a view to proactively reallocate un-utilised rooms to capacity challenged services from March 2024

•Focussed work on Psychiatry Waiting times and improvement plan in place.

•Regional work supporting Appropriate Places of Care

0044

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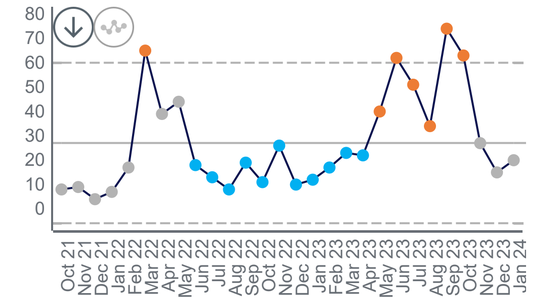
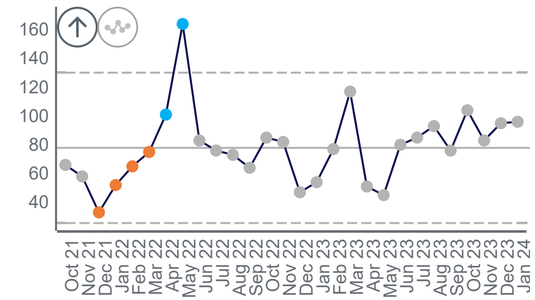
Divisional Performance Summary - Community & Mental Health

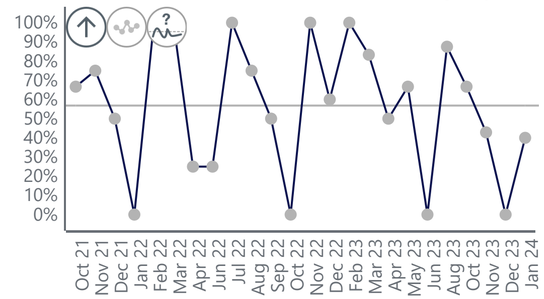
Number of Incidents rated Minor Harm and above



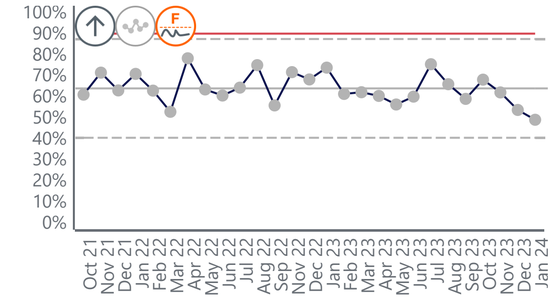
Number of Incidents rated No Harm and Near Miss



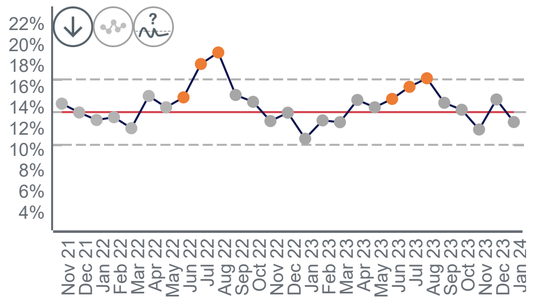
% Complaints Responded to within 25 working days



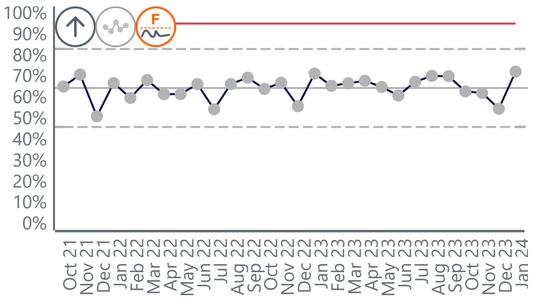
% PALS Resolved within 5 Days



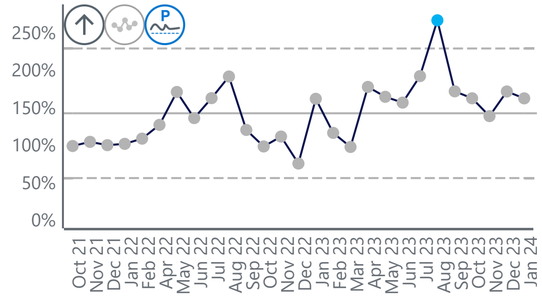
% Was Not Brought Rate (All OP: New and FU)



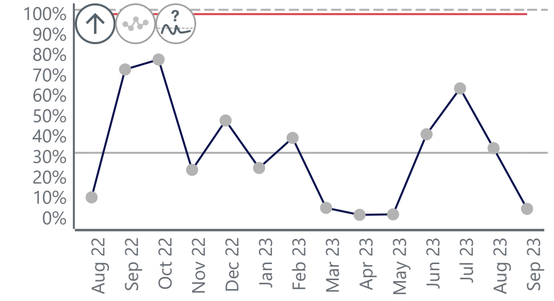
% of Clinical Letters completed within 10 Days



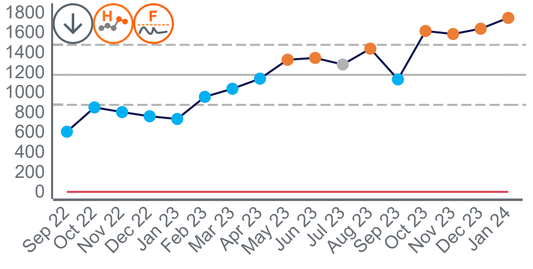
% Recovery for OP New & OPPROC Activity Volume



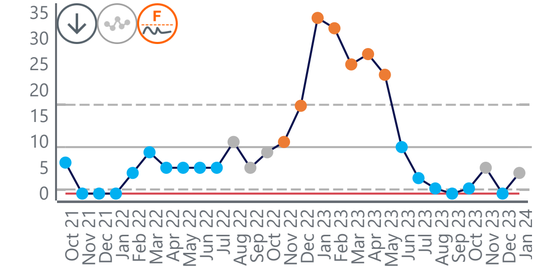
IHA: % complete within 20 days of referral to Alder Hey



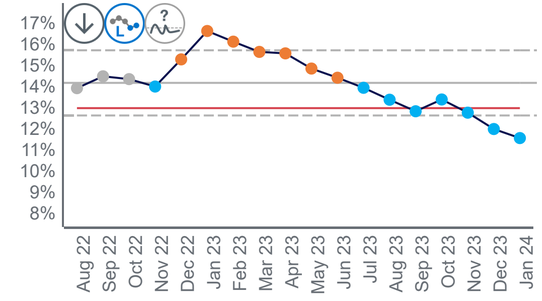
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



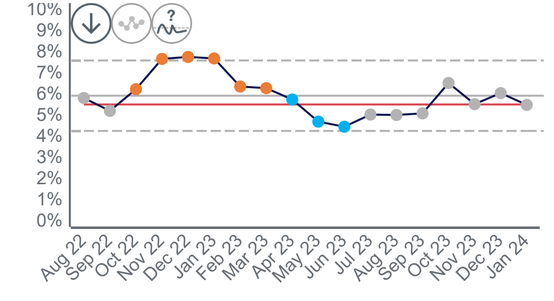
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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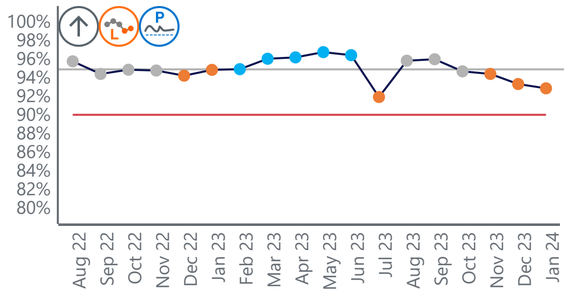
Divisional Performance Summary - Community & Mental Health

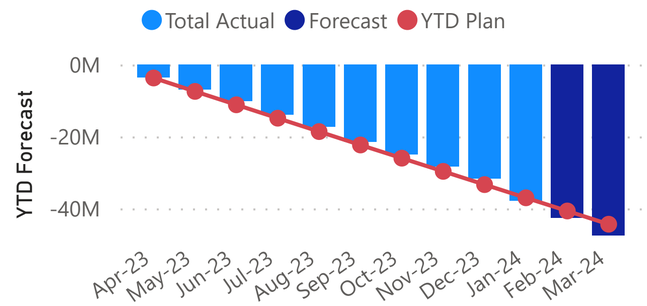
Mandatory Training



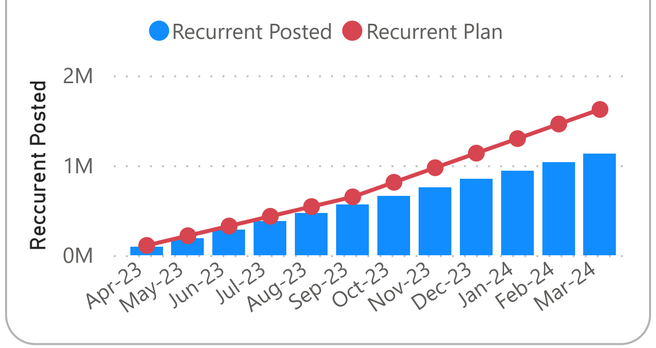
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

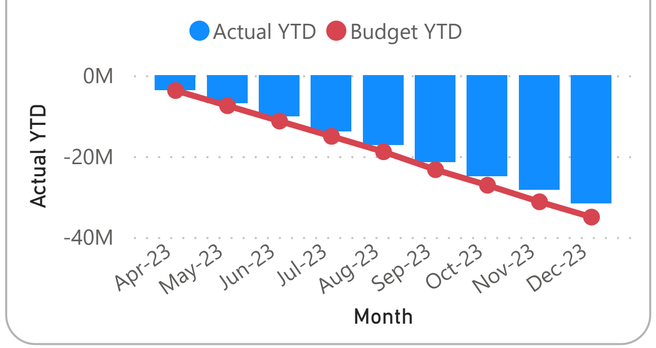
Revenue Position (Year End Forecast)



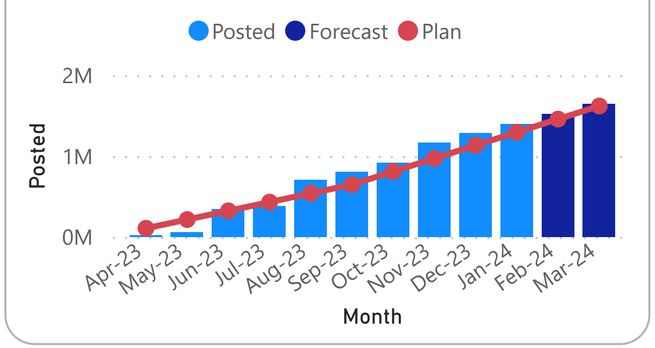
CIP Position (Recurrent Full Year Effect)

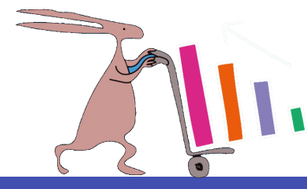


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

•Two clinical teams recognised for clinical excellence awards- •Oncology and Neuromuscular service
•Sustained reduction in WNB rate, now 7% achieving the Trust target
•Second consecutive month improved Emergency Department Sepsis, delivery of antibiotics within 60 minutes, achieving 93%, all delays were reviewed by the clinical team
•100% compliance in responding to formal complaints within 25 days
•97% of PALS closed within 5 Days, achieving Trust target
•Continued reduction in staff turnover now at 9%
•Reduction in incidents reported for minor harm & above and no harm & near miss, in line with Dec 22 reporting
•Delivery in year CIP 3.6M and recurrent 2.3M posted
•Improvement of clinic letter completed within 10 days following a number of improvement actions

Areas of Concern

•Reduction in ED 4 hours performance from 85%, to 81%, still maintaining national standard
•Continued focus on accommodating all CYP who have waited over a year for treatment, working closely with team who are at risk of having CYP who will have waited over65 weeks
•Diagnostic compliance reduced slightly in January, Gastro & LTV remaining the areas of key challenge within the division. Review of gastro theatre list underway to improve on productivity opportunity
•Slight increase in sickness, first time during winter months sickness reached 6%
•Slight reduction in ED F&F associated with slight increase in waiting times
•Continued challenging financial position. Despite achieving in year CIP target long term sustainability plans remain in place
•Slight reduction in mandatory training figures which teams are reviewing with targeted approaches per area

Forward Look (with actions)

•ED action plan in place to address reduction in performance to ensure Q4 80% achievement
•Improvement in PDR compliance with robust plans in place to ensure all staff receive a PDR by 31st of March
•Review of PAU pilot to establish impact this winter and consider long term implementation
•Urgent & Emergency Care Liverpool Place workshop established to improve collaborative approach to improving access and service provision across Liverpool
Focus on coding review to support income and CIP opportunity

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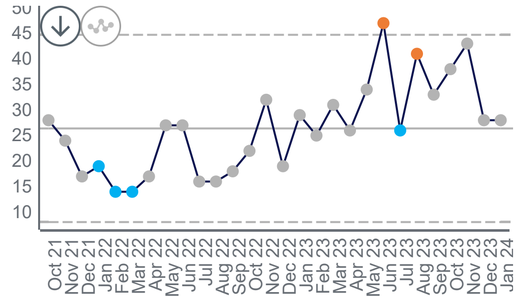
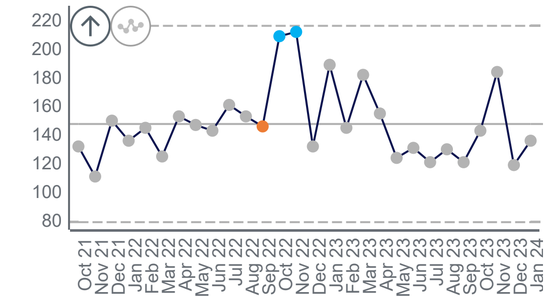
Divisional Performance Summary - Medicine

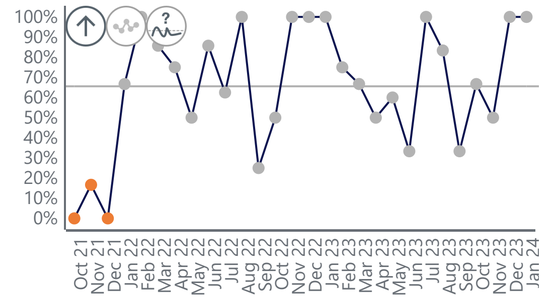
Number of Incidents rated Minor Harm and above



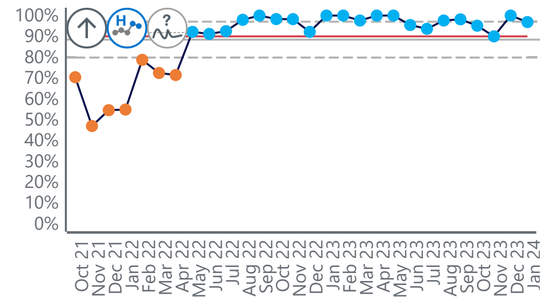
Number of Incidents rated No Harm and Near Miss



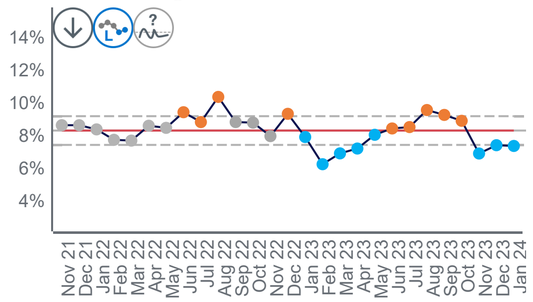
% Complaints Responded to within 25 working days



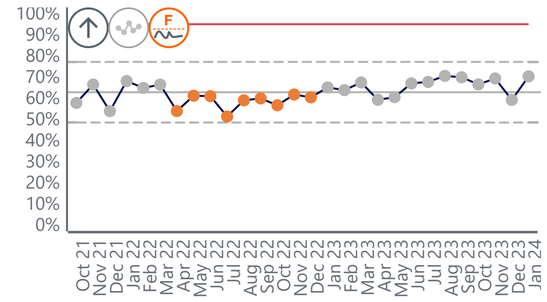
% PALS Resolved within 5 Days



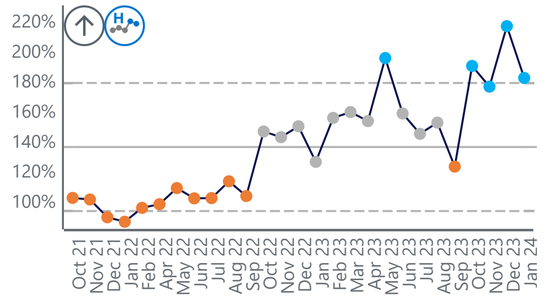
% Was Not Brought Rate (All OP: New and FU)



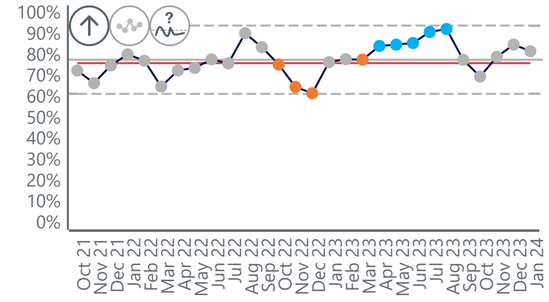
% of Clinical Letters completed within 10 Days



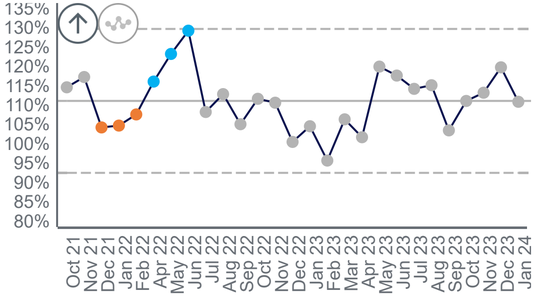
% Recovery for OP New & OPPROC Activity Volume



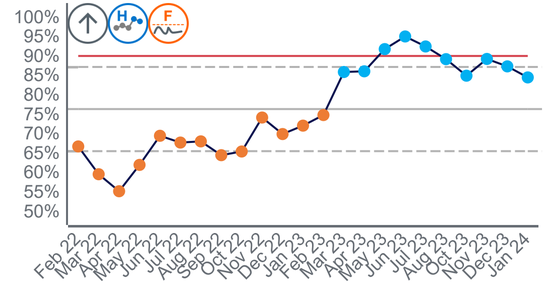
ED: % treated within 4 Hours



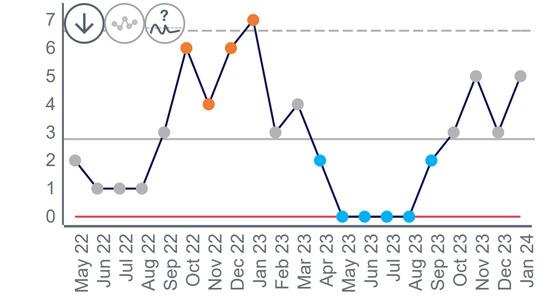
% Recovery for DC & Elec Activity Volume



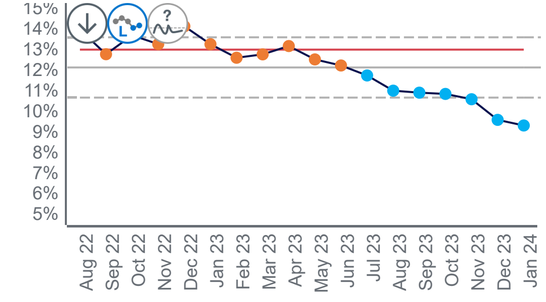
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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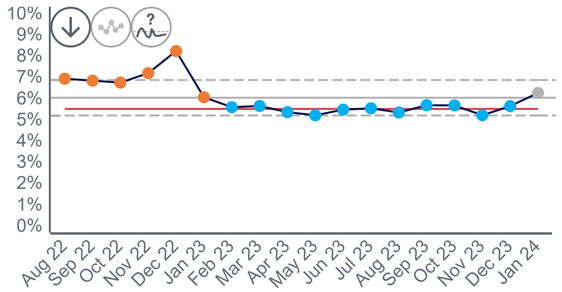
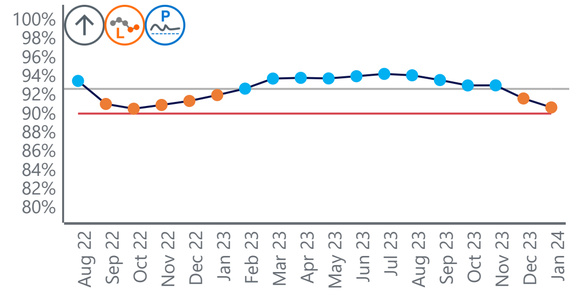
Divisional Performance Summary - Medicine

Sickness Absence (Total)



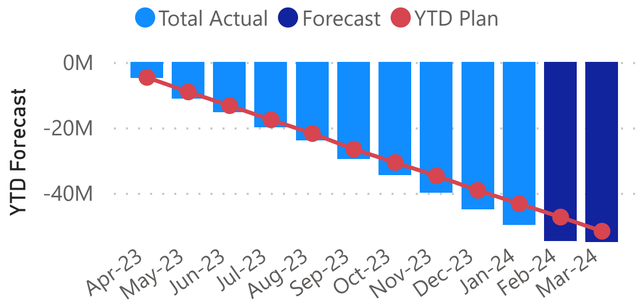
Mandatory Training



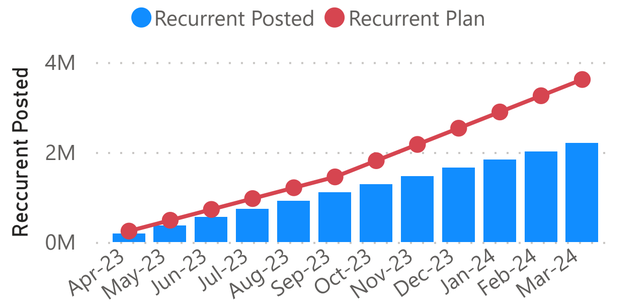
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

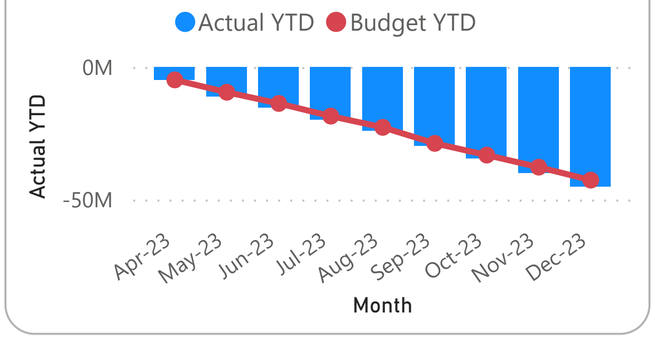
Revenue Position (Year End Forecast)



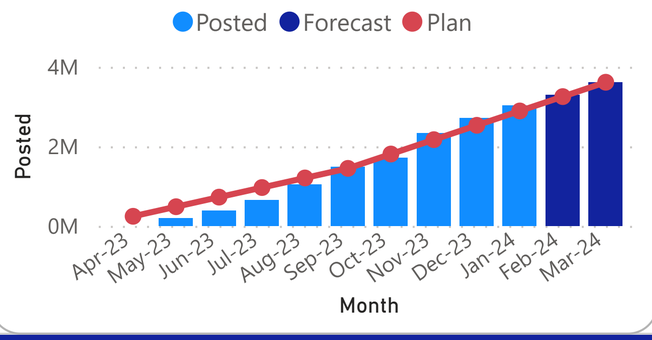
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

•Number of patients waiting > 65 weeks continues to reduce against trajectory. ENT & Dentistry make up the majority of the backlog however are on track for 0 > 65 weeks by end of March 2024.

•100% Urodynamics compliance. Overall DM01 compliance was 90% due to 1 patient breach.

•Staff turnover continues to improve for the 6th consecutive month and is below target at 10%.

•100% of complaints and PALs were responded to within the agreed timescale.

•Cancelled electives on the day (non-clinical) significantly below target of 20 (12).

•Super Paediatric Dentistry week held with triple the normal amount of new patients seen with those requiring elective treatment appointed the same day.

Areas of Concern

•Recovery % in DC/IP and OP below target in month with impact from both further Industrial Action and the reduced theatre schedule. There are ongoing issues post expanse with activity & income data which is also impacting overall position.

•WNB rate reduced in month to 9% but remains below target. Hybrid booking pilot commenced in December however families opted for appointment dates from 12th February onwards so impact not felt in January.

•Community Ophthalmology WNB rate reduced in month from 22% to 17% as a result of increased reminder calls to families prior to appointments.

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

Forward Look (with actions)

•Launched a WNB programme of work within division to target those specialities who would have the most impact via improvement programme.

•WNB pilot to continue in Community Ophthalmology & is being closely tracked via A3 approach- initial results in February are positive on attendance.

•Continued focused work on increasing Theatre productivity now that Dashboard has been relaunched along with plans for HVLC lists & implementation of recommendations from GIRFT Further Faster Programme.

•Agreed start date of 15th March to pilot usage of Warrington & Halton Hospital as an elective hub site.

•Ongoing joined up work with income & coding team to ensure capturing all divisional activity post expanse go live.

•Draft CIP Programme underway for 2024/25 to align with strategic programmes of work with a focus on recurrent CIP.

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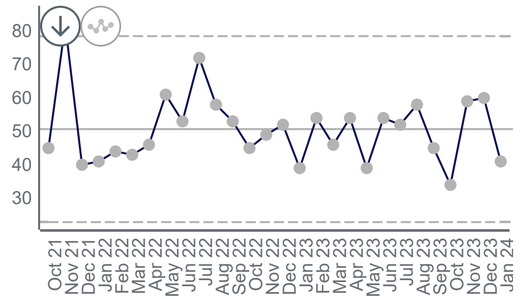
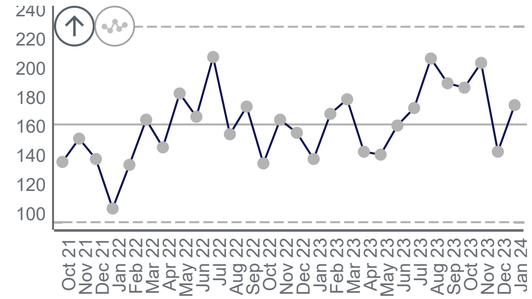
Divisional Performance Summary - Surgery

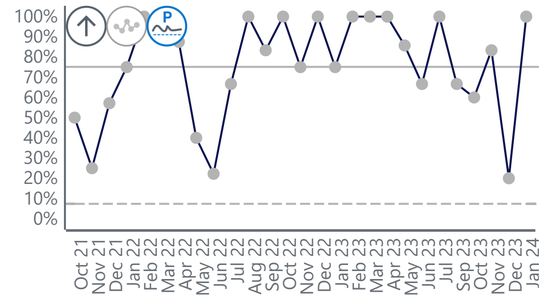
Number of Incidents rated Minor Harm and above



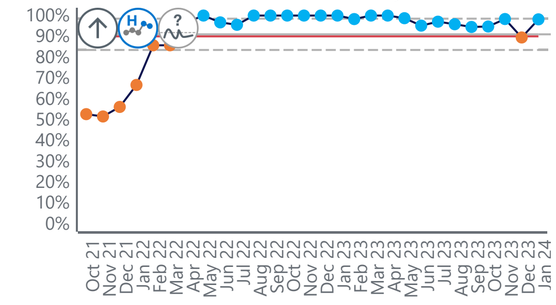
Number of Incidents rated No Harm and Near Miss



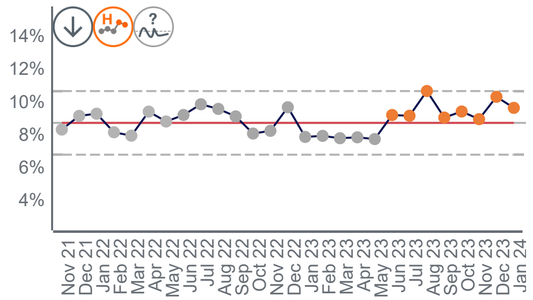
% Complaints Responded to within 25 working days



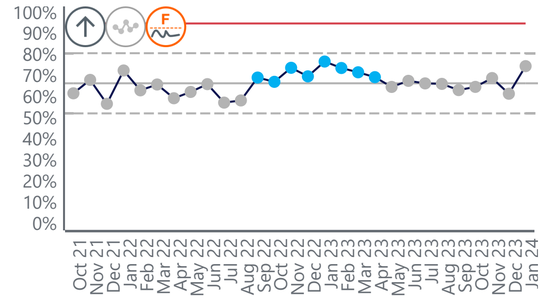
% PALS Resolved within 5 Days



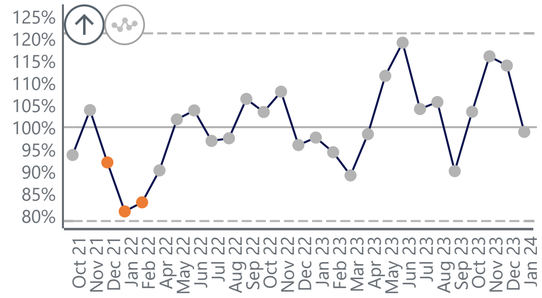
% Was Not Brought Rate (All OP: New and FU)



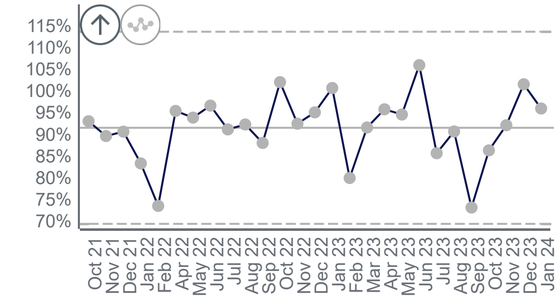
% of Clinical Letters completed within 10 Days



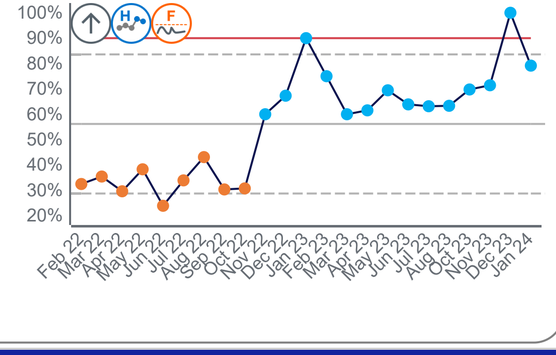
% Recovery for OP New & OPPROC Activity Volume



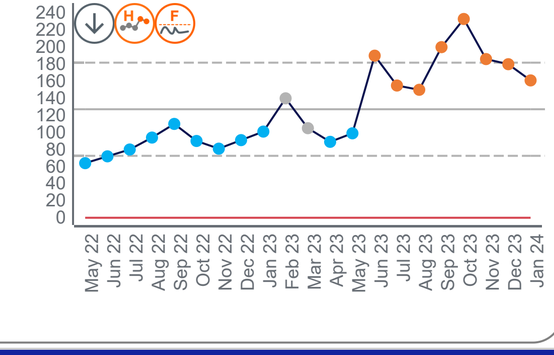
% Recovery for DC & Elec Activity Volume



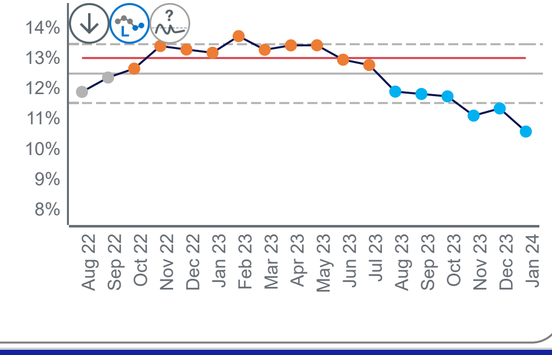
Diagnostics: % Completed Within 6 Weeks of referral



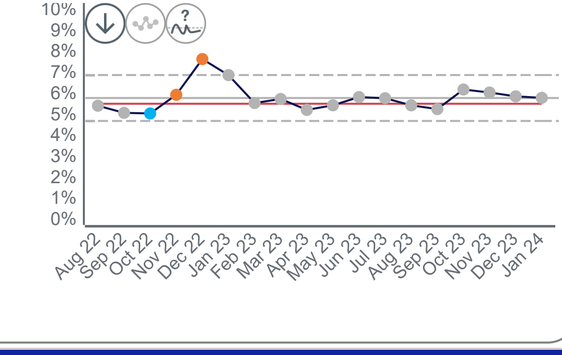
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)



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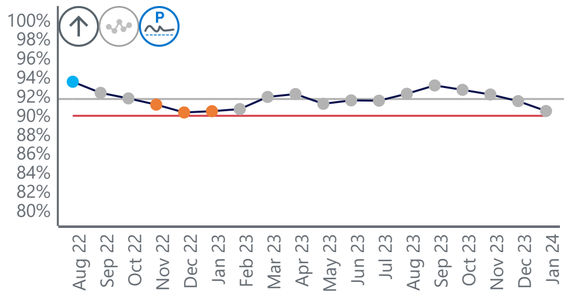
Divisional Performance Summary - Surgery

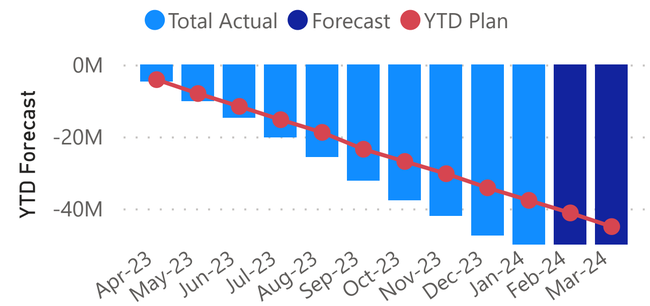
Mandatory Training



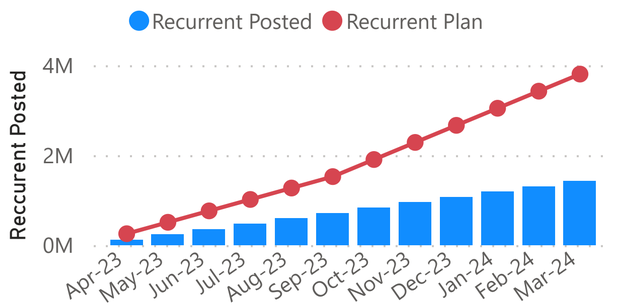
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

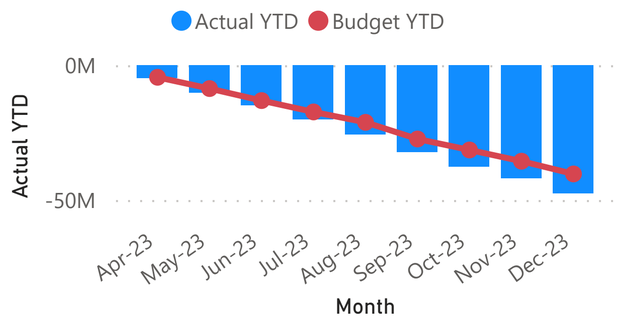
Revenue Position (Year End Forecast)



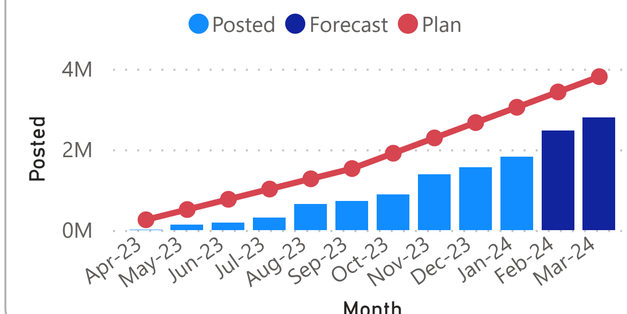
CIP Position (Recurrent Full Year Effect)

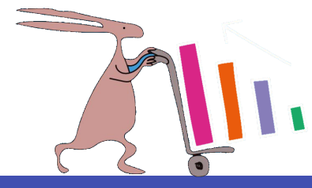


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

•Alder Hey Research Strategy provisionally approved by R&I Committee

•AH Clinical Research Facility annual report rated 'green' in all areas.

•First UK participant for CURLY (a multi-centre, pragmatic, randomised trial to determine the optimal duration of cefalexin therapy for the treatment of febrile UTIs in children) led by Dr Shrouk Messahel

•Staff turnover remains low and mandatory training is on track

•Commercial research income is back on track to achieve target for 24/25

•Successful CRD away day with 95% Clinical Research Division (CRD) staff saying they would recommend CRD as a place to work.

•Starting Well Programme governance structure agreed with Liverpool Women's

Areas of Concern

•Staff sickness levels have increased mainly related to short-term sickness

•Commercial trial activity remains a concern with sponsors withdrawing studies from UK set-up.

Forward Look (with actions)

•Research Strategy to be finalised and launched with associated implementation plan being developed following action planning at away day

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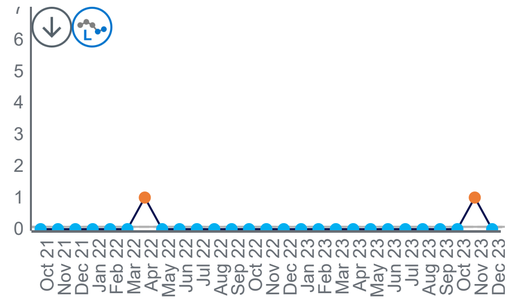
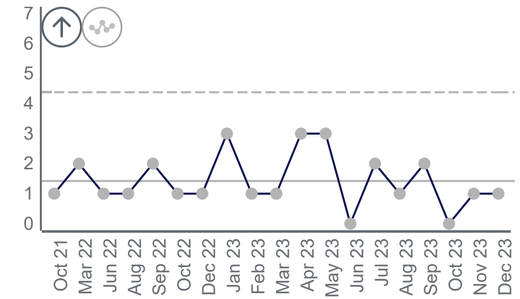
Divisional Performance Summary - Clinical Research

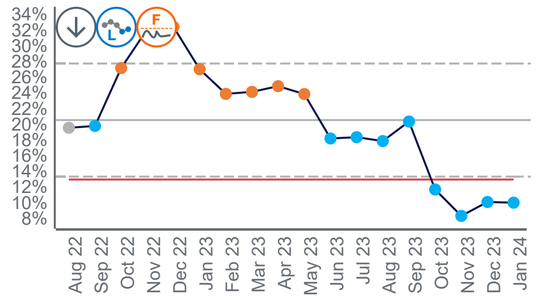
Number of Incidents rated Minor Harm and above



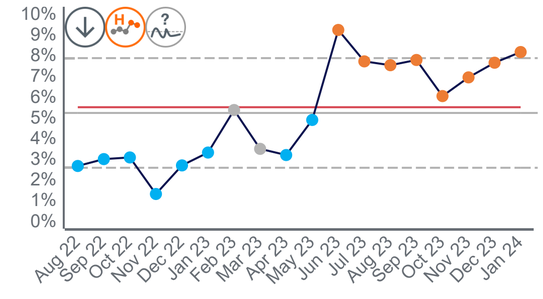
Number of Incidents rated No Harm and Near Miss



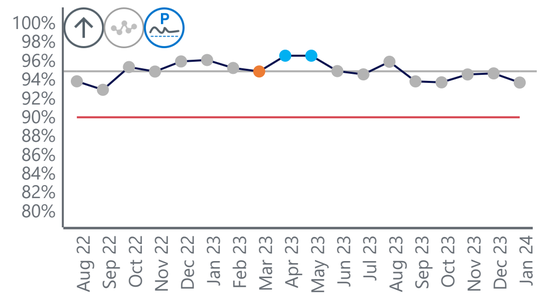
Staff Turnover



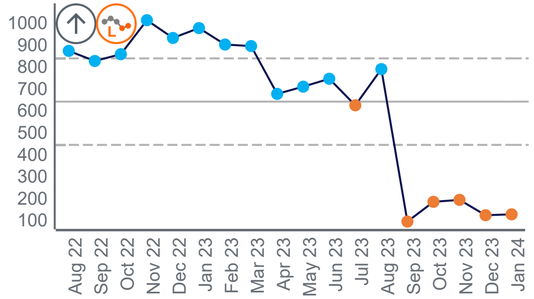
Sickness Absence (Total)



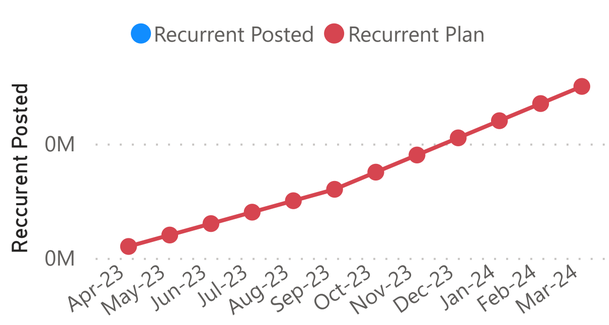
Mandatory Training



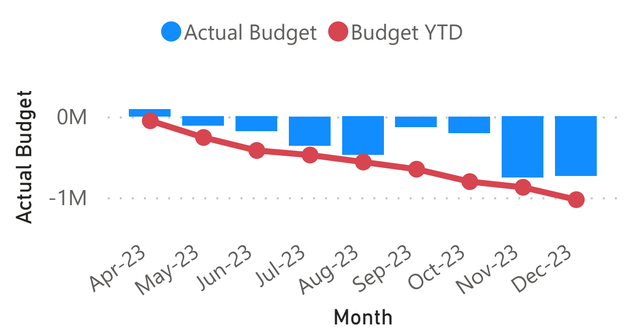
Number of Patients Recruited into Research Studies



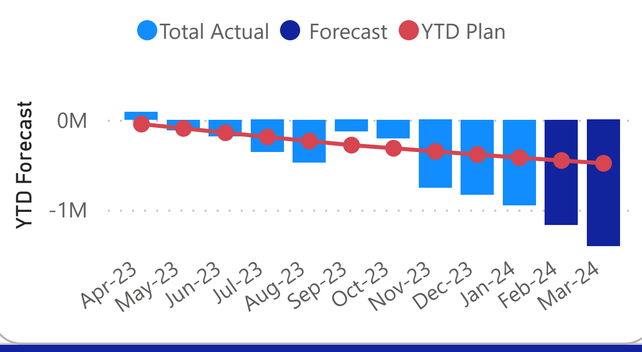
CIP Position (Recurrent Full Year Effect)



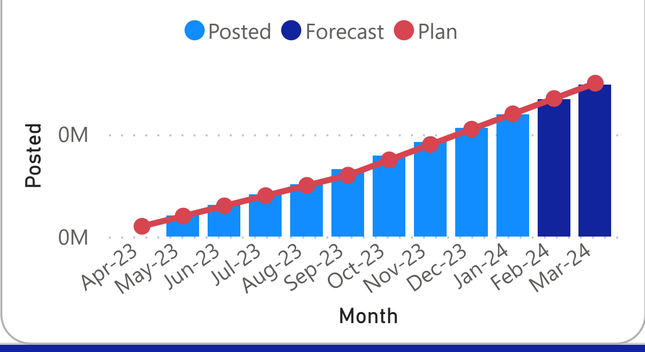
Revenue Position (Variance to date)

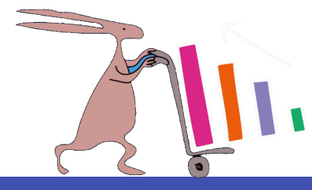


Revenue Position (Year End Forecast)



CIP Position (Delivered to date)





Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative continues to meet monthly with good attendance and engagement. Highlights from the meeting held on 19th February are:

•Mandatory training for Corporate Services remains just above the 90% target at 91%. Mandatory Training us being directly discussed and action plans have now been requested for any areas of repeated non-compliance.

•Short term sickness remains at 2% and continues to below Trust target (2.5%).

•100% of CIP already identified and/or delivered at M10.

•Staff Turnover remains steady at 12% which is below Trust target.

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

Areas of Concern

•Long term sickness has increased in month and is currently sitting at 5% - current cases are being managed in line with Trust policy.

•Overall PDR completion rate is 58% and for B7+ is 78%

Forward Look (with actions)

Annual planning underway including alignment with Trust areas of need and associated strategic programmes

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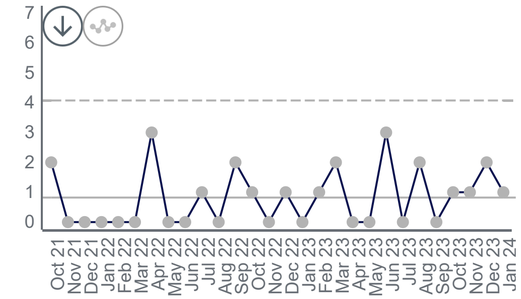
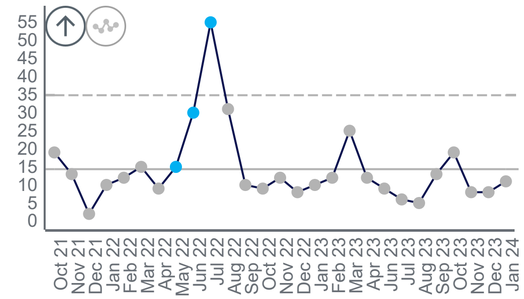
Divisional Performance Summary - Corporate

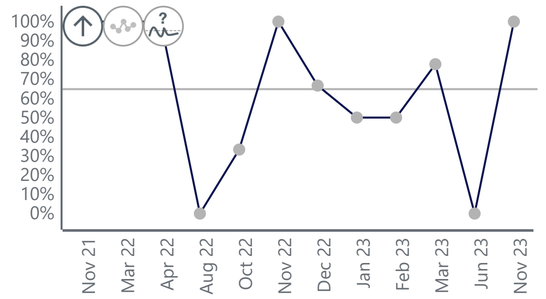
Number of Incidents rated Minor Harm and above



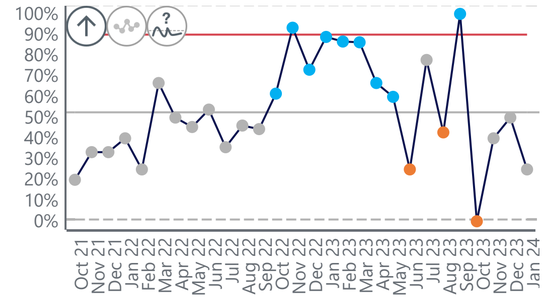
Number of Incidents rated No Harm and Near Miss



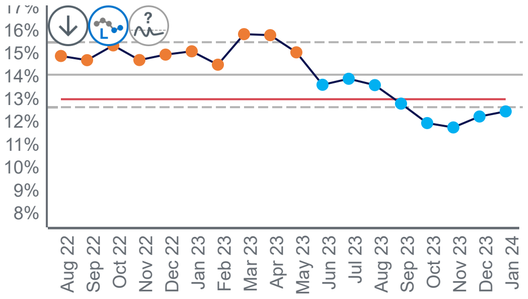
% Complaints Responded to within 25 working days



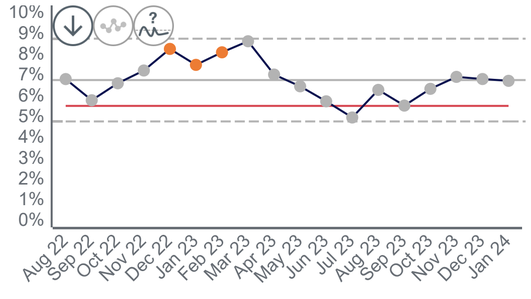
% PALS Resolved within 5 Days



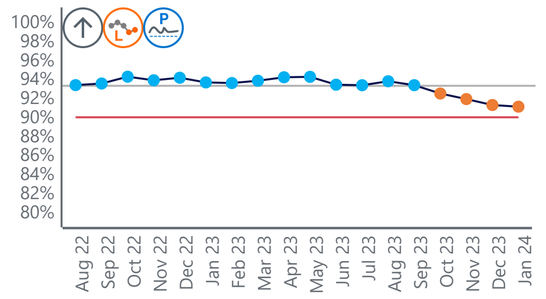
Staff Turnover



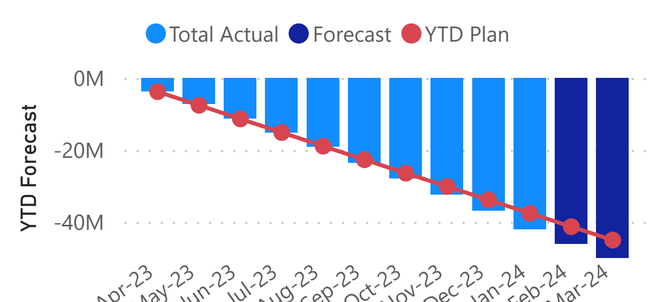
Sickness Absence (Total)



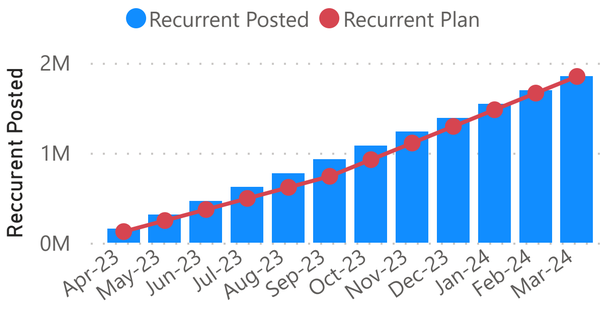
Mandatory Training



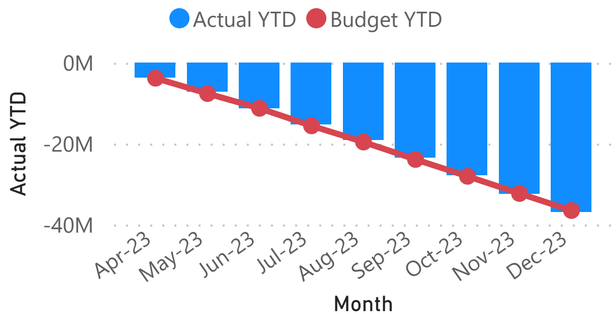
Revenue Position (Year End Forecast)



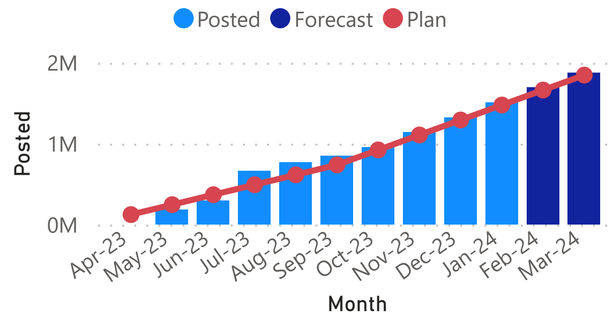
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



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

	Day		Night		Patients	CHPPD	National benchmark	Availablity		Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registere	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients	CHPPD Rate		RN - FTE	HCA - FTE	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of response	% Very good and good		
Burns Unit	80%	-	97%	-	66	28.9	19.43	514.84	0.00	16.34	-2%	16.34	6%	0.00	0.00%	0.00	0.00%	29.76	5.78%	0.00	0.00%	5	29	0	1	7	100%	0	0
HDU	69%	103%	66%	110%	296	25.4	34.24	4,907.10	107.72	160.87	1%	160.87	2%	1.43	0.92%	0.00	0.00%	251.13	5.12%	0.00	0.00%	18	73	0	3	3	100%	0	0
ICU	74%	73%	70%	61%	306	48.8	34.24	2,510.68	248.27	75.66	-7%	75.66	0%	1.00	1.30%	0.00	0.00%	160.74	6.40%	35.42	14.27%	33	133	0	1	1	100%	1	0
Ward 1cC	82%	78%	82%	91%	339	19.4	18.64	1,898.28	226.53	58.44	-4%	58.44	-3%	0.00	0.00%	0.00	0.00%	36.68	1.93%	49.25	21.74%	14	62	6	13	16	93.75%	0	0
Ward 1cN	59%	0%	67%	-	138	21.0	21.18	977.95	108.00	35.21	12%	35.21	-5%	0.00	0.00%	0.00	0.00%	51.64	5.28%	11.00	10.19%	11	41	0	7	5	100%	0	0
Ward 3A	95%	82%	95%	151%	695	11.7	11.99	1,719.91	381.36	48.23	-13%	48.23	7%	0.00	0.00%	0.00	0.00%	92.51	5.38%	57.13	14.98%	8	43	0	11	47	93.62%	0	0
Ward 3B	71%	103%	75%	-	311	15.9	15.07	1,162.41	177.32	43.14	17%	43.14	1%	0.00	0.00%	0.00	0.00%	141.32	12.16%	45.12	25.45%	15	55	1	6	10	80%	0	0
Ward 3C	89%	98%	77%	155%	642	13.4	11.32	1,926.55	322.08	66.19	9%	66.19	0%	0.00	0.00%	0.00	0.00%	104.75	5.44%	18.80	5.84%	2	84	0	1	22	95.45%	0	0
Ward 4A	80%	74%	82%	109%	646	12.5	12.03	2,103.87	239.15	66.53	-2%	66.53	0%	1.00	1.54%	15.38	18.50%	175.10	8.32%	1.84	0.77%	6	46	0	3			1	0
Ward 4B	57%	80%	54%	75%	429	16.8	12.74	1,309.16	1,197.31	43.57	5%	43.57	3%	0.00	0.00%	0.00	0.00%	125.53	9.59%	165.61	13.83%	5	61	1	4	20	100%	1	0
Ward 4C	93%	92%	90%	102%	736	10.3	11.85	1,786.54	311.59	59.54	2%	59.54	12%	0.00	0.00%	0.00	0.00%	45.21	2.53%	86.99	27.92%	13	162	0	2	34	97.06%	0	0

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

<u>Medicine</u>

3B: Fill rate for RN's is below 80% due to an increase in short term sickness to 12.16%. The ward was supported at this time via safer staffing to ensure patient safety maintained. Turnover in this period has seen a significant improvement.

3C: Fill rate for RNs on night duty is below 80% due to an increase in short term sickness and the ward had a patient requiring an RN 1:1 at this time.
The HCA sickness equates to 1.0 WTE and due to low numbers of HCA's within the overall ward establishment the percentage is high. The ward is also supporting 3 x HCA 1:1 on a long-term basis. There was an increase in overall 1:1 for HCA's overnight. The ward had no leavers during this period.

4B: RN sickness levels continued to be monitored and there has been an increase in short term sickness within this period. The numbers of 1:1 patient had reduced therefore the percentage fill rate was decreased for that month. The ward has undergone a remodelling and ratios of RN's required had changed.

4C: Have seen a significant improvement in fill rate and had 3 WTE new starers in this reporting period. HCA sickness had increased with 2 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.

<u>Surgery</u>

Ward 1cNeo staffing is overseen by safer staffing and supported by the Liverpool Neonatal Partnership, with nurses being deployed from LWH if required. Recruitment and training for the new neonatal unit is ongoing for the number of cots. Supernumerary staff are allocated on to most shifts during the initial training period. Issues relating to

staffing are discussed with the Surgical Matrons and support is offered where needed. All patients are nursed in line with BAPM standards, acuity information shared at all safer staffing meetings to ensure that staffing levels are supportive of patient acuity.

Ward 3A RN fill rate continues over 80%. The ward has also had to cover a high number of 1:1 patients, therefore contributing to the overfill on that line.

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

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

Critical Care

HDU: average fill rate is less than 80% is due to the Band 4s that are in post awaiting NMC pins and other supernumerary staff. In October 1 WTE RN on LTS. A new cohort of 12.37 WTE staff commenced, however were supernumery and not included within the fill rate.

ICU: Had LTS and staff redeployment in this reporting period

Both ICU and HDU have made some changes to their Healthroster and the way shifts are allocated which may explain the underfill rates

Summary

The National benchmark from the model hospital is November data

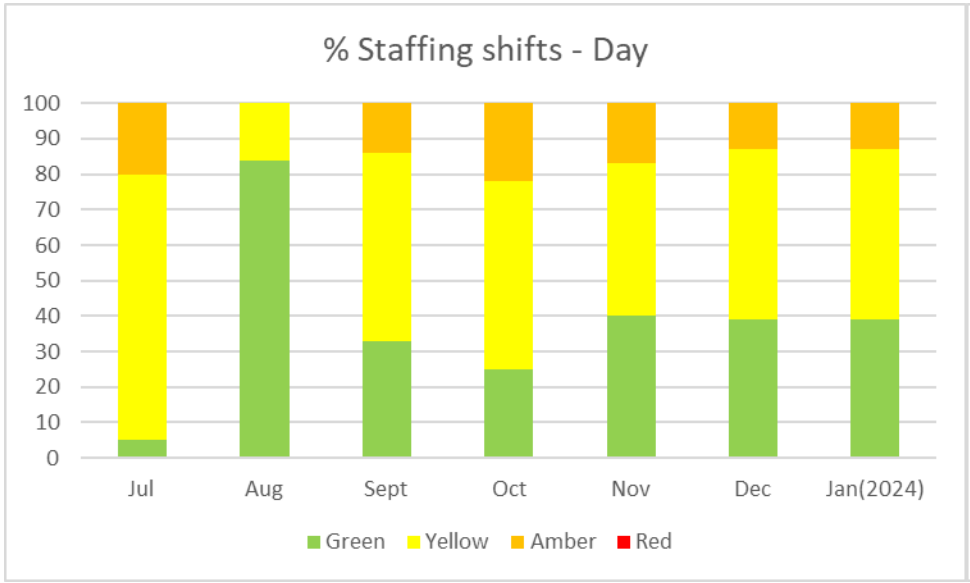
Alder Hey are above the National Benchmark in wards 4B, 3C, 1C cardiac and within critical care whilst the other areas are comparable.

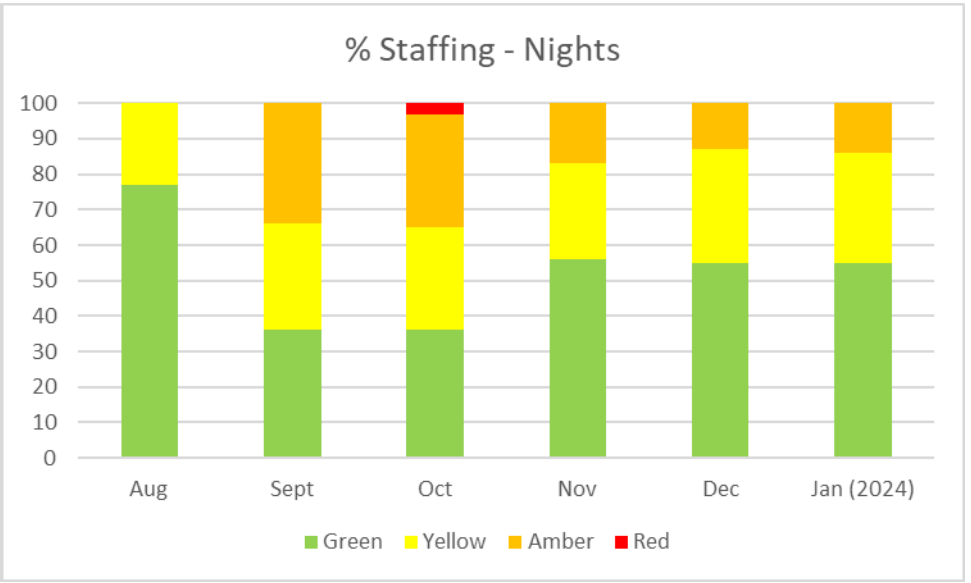
There is a consistent difference from the National benchmark for Ward 4B. Ward 4B has been consistently higher over the last few months. Deep dive into capacity and staffing has been undertaken and a full review of the nursing model has been undertaken and currently being trialled. There is a consistent difference from the National benchmark for Ward 4B. Ward 4B has been consistently higher over the last few months. Deep dive into capacity and staffing has been undertaken and a full review of the nursing model has been undertaken with the aim to changing the nursing patient ratio from 1-4 to 1-6 This was a successfully piloted in August 2023 for a 3-month period. Following review of the pilot and approved by Chief Nurse the qualified nursing staffing establishment on 4B will be 1-6. This will be reflected formally in the establishment and will commence April 1st.

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

Summary of Staffing models Jul 2023 – Jan 2024

Staffing RAG has been similar to previous months, however 0 red days or nights reported since October. To note the percentage of night shifts that are staffed to a green nursing model has improved consistently from November.


% Staffing shifts - Day
100
90
80
70
60
50
40
30
20
10
0
Jul
Aug
Sept
Oct
Nov
Dec
Jan(2024)
Green
Yellow
Amber
Red


% Staffing - Nights
100
90
80
70
60
50
40
30
20
10
0
Aug
Sept
Oct
Nov
Dec
Jan (2024)
Green
Yellow
Amber
Red

Electronic Roster KPI Report

January Board Paper

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

January 2024 KPI Summary Table

KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owes)		The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shits in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days **(8 January - 4th February)**	% Changed Since Approval	Net Hours (1 pro rated day per person)	Net Hours	Bank / Agency Use %	Bank / Agency Usage Hours	Additional Duties	Unfilled Roster %	Annual Leave %	Study Day %	Other Leave %	Sickness %	Parenting %	Total Unavailability %
Accident & Emergency - APNP (912201)	49	26.71%	80.00	385.61	0.00%	0	3	33.28%	10.92%	7.68%	0.00%	9.98%	0.00%	28.59%
Accident & Emergency - Nursing (912201)	32	49.18%	720.00	-153.6	20.57%	2628.5	13	11.86%	16.56%	4.82%	2.90%	10.61%	5.15%	40.40%
Burns Unit (915208)	20	24.03%	140.00	371.29	13.69%	330	2	5.17%	21.04%	0.76%	1.26%	6.18%	0.00%	33.30%
Critical Care Ward (913208)	46	32.12%	1200.00	5988.69	9.64%	2105.75	49	17.39%	14.37%	0.00%	0.21%	6.17%	5.86%	26.61%
High Dependancy Unit (HDU) (913210)	38	29.85%	640.00	2789.65	8.65%	889.5	77	29.38%	14.71%	2.12%	0.13%	5.08%	13.19%	37.67%
Medical Daycase Unit (911314)	18	20.83%	50.00	318.76	7.06%	76	6	22.51%	11.99%	0.23%	0.00%	2.20%	0.00%	14.42%
Outpatients (916503)	25	46.86%	420.00	911.31	13.91%	998	2	48.88%	14.00%	0.88%	2.58%	14.49%	3.90%	36.18%
Sunflower House (912310)	18	48.90%	190.00	936.67	28.77%	1358	9	9.73%	12.68%	0.00%	0.00%	6.16%	14.42%	36.13%
Surgical Daycase Unit (915418)	19	42.06%	85.00	396.08	12.91%	438.75	1	32.71%	17.76%	0.00%	2.42%	13.01%	0.00%	34.12%
Theatres - Cardiac & Cardiology (915405)	30	27.34%	130.00	2069.07	14.54%	225	15	25.48%	17.03%	0.00%	7.53%	2.59%	0.00%	27.55%
Theatres - Emergency (915420)	34	30.95%	230.00	-86.94	6.10%	145.5	2	3.10%	22.62%	0.00%	0.00%	1.69%	0.00%	24.31%
Theatres - IP Anaesthetics (915423)	27	23.67%	82.00	-165.48	6.18%	274.25	85	0.90%	20.23%	1.65%	2.61%	2.55%	3.56%	30.59%
Theatres - IP Porters (915435)	24	44.72%	101.00	-160.61	15.34%	228.75	2	31.20%	24.39%	0.00%	0.23%	13.43%	0.00%	38.04%
Theatres - IP Recovery (915422)	27	41.20%	103.00	205.73	12.71%	260.58	20	13.00%	15.40%	0.76%	5.44%	1.30%	0.00%	22.89%
Theatres - IP Scrub (915424)	34	30.56%	128.00	-99.07	20.49%	392.75	0	14.03%	17.85%	1.53%	0.00%	18.65%	0.00%	42.86%
Theatres - Ortho & Neuro Scrub (915436)	34	47.21%	37.80	-115.5	15.99%	414.5	4	7.45%	14.28%	0.00%	3.03%	6.79%	5.02%	33.14%
Theatres - SDC Anaesthetics (915429)	33	36.04%	58.40	9.24	32.13%	325	6	22.20%	6.74%	1.07%	7.92%	8.53%	0.00%	24.25%
Theatres - SDC Recovery (915430)	33	49.67%	177.30	235.86	8.00%	108.5	1	19.21%	16.34%	1.51%	8.15%	6.27%	0.00%	32.28%
Theatres - SDC Scrub (915421)	34	36.41%	532.00	346.14	9.22%	279.25	28	58.22%	8.07%	1.81%	2.49%	27.34%	0.00%	39.71%
Ward 1C Cardiac (913307)	20	31.33%	361.00	1935.6	8.41%	605.75	0	17.57%	14.74%	3.58%	2.45%	6.96%	10.73%	45.15%
Ward 1C Neonatal (913310)	39	29.68%	556.00	77.49	0.90%	46	0	32.51%	14.24%	4.60%	0.44%	10.51%	0.94%	33.14%
Ward 3A (915309)	38	36.35%	371.00	-185.38	13.31%	1228.42	30	7.55%	15.33%	1.63%	1.24%	11.80%	2.85%	33.92%
Ward 3B - Oncology (911208)	31	35.70%	555.00	2607.18	21.54%	1250.25	15	15.83%	17.20%	4.20%	2.59%	8.67%	5.49%	41.26%
Ward 3C (911313)	33	38.75%	607.00	1614.71	25.61%	2614.75	27	23.77%	18.13%	5.25%	0.77%	10.80%	2.96%	39.91%
Ward 4A (914210)	20	32.64%	634.00	1106.4	16.74%	1421	1	23.75%	19.18%	6.03%	1.65%	7.02%	10.89%	47.16%
Ward 4B (914211)	33	30.67%	533.00	7765.53	9.19%	764	9	29.77%	16.39%	3.38%	2.21%	12.98%	7.42%	44.24%
Ward 4C (912207)	40	27.70%	280.00	10.15	15.55%	1334	2	16.56%	15.62%	2.75%	0.48%	8.37%	1.68%	31.88%

Summary Narrative

This is the second E Roster KPI data set and therefore it is difficult to focus on any immediate trends, but we can start to look at some comparator data to provide some information for Managers to concentrate on in the months ahead. Managers will then be able to ‘deep dive’ into the reasons for indicator data outside of the set targets and identify improvements. The key elements that have been highlighted from the January KPI data are summarised below:

Lead time remains around 30 days – Our KPI is 42 days so further work is required around this target. Staff are only receiving on average 30 days' notice of shifts to be worked. There continues to be the potential for impact on work life balance and the ability to reduce NHSP temporary staff bookings and associated spend with good lead times. The Roster team have recently coordinated the development of Divisional roster sign off meetings, where the ability to influence improved lead times occurs. As rosters prior to the sign off meetings have already been completed, it is anticipated that we will start to see improvement in this area from around April/May.

Net hours 28,745 – These are hours in the roster that are unaccounted for. The January position has improved in this area by around 30% in month or by 10,000 hours. The E Roster team continue to work with the Departmental Managers to correct any administrative errors so we can achieve full assurance that the data is correct, and a true reflection of what colleagues owe or are owed. This work is reflected in the improved position in M10 and show further assurance that data is correct. These hours can be used in place of booking temporary staffing via NHSP when Managers are confident that they are correct.

Bank/Agency use 11% - This figure relates to the fact that 11% of all shifts are identified through NHSP. The impact of this is twofold. Firstly cost, if it totals over the budgeted establishment. Also, it could impact on the quality of care if the fill is from staff that are not familiar with the ward, compared to regular workers. Managers are now only able to cancel and direct book shifts via roster. This month's average is 22% which is significant in relation to our gaps. Work is ongoing to ensure all available hours are being used appropriately as part of the roster and wider pieces of work are ongoing in relation to temporary staff management across the Divisions.

Additional Duties 411 – These hours reflect staff booked over the funded establishment. Significant improvement has been seen in month and additional duties have reduced by over 200. This shows that Managers are using established shifts before creating additional shifts which could then result in an overspend against budget. The E Roster team are working with Managers to ensure additional duties are only being created and used for legitimate reasons and if they aren't used, they are deleted (Many of these shifts remain unfilled)

Unfilled roster 25% - is high. This could indicate either the templates need to be amended or a safety issue with low fill rates. It is more probable the former as shifts are not removed to reflect occupancy. The E Roster team continue to work with Managers to review templates. It is worth noting that there are some areas consistently ensuring that their roster is meeting this standard, and the regular sign off meetings will start to address the non-compliant areas with the Managers.

Sickness 9.4%- continues to be high but is managed by the senior ward teams and is used for Roster KPI purposes to reflect total unavailability. Some of the data is a little skewed by areas where there are small teams and therefore percentage may be higher as a proportion.

Total unavailability is 34% - slightly over target. This could indicate there are too many people not on clinical duties/counted as being able to deliver care. This indicator covers sickness, suspension, maternity leave, study leave etc. With 34% of our staff unavailable ward staffing becomes a challenge and the potential quality and safety issues are raised, as well as bank costs.

Progress

- Annual leave, other leave, maternity/paternity leave and study leave are generally within target.
- Roster sign off meetings are live in Surgery. Medical Division have now started their sign off meetings, with Community next to be set up.

Integrated Performance Report | February 2024

Alder Hey Children's NHS Foundation Trust

Flash Report -February 2024

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for February
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0	**4**
		Number of Serious Incidents (Steis reported)	0	**0**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**0**
		FFT - % Recommending Trust	> 95%	**91.1%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Staff Turnover	*<13%*	***10.5%***
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 Spring 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%	**78.0%**
		Number of RTT Patients waiting >65weeks	0	**113**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,908**
		Elective Recovery (Vol)	> 106%	***98.0%***
		Diagnostic Performance	> 90%	**82.5%**
	Financial sustainability	Revenue position – Year End forecast	13m Surplus	**10.9m**
	Aldercare optimisation	Optimisation of Aldercare	Optimisation programme has been scoped and is being initiated	**Metrics to be agreed through newly established governance**

Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary -

Published March 2024

Strategic Goals	2023-24 Operational Priorities	Progress in February 2024	Areas of challenge
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• In month improvement in all safety indicators • PSIRF panels providing oversight to incident learning • Positive progress with Martha's rule implementation	• End to end digital solution required for observation to messaging and alerting as part of national PEWS
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Improvements in turnover continue	• Continued risk of industrial action (junior doctors re-balloting) • Increased level of sickness absence over winter
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• The working pipeline is 23 Launchpad; 14 AI and 13 Automation • Hartree CDA signed and MoU in progress • Launch of 200k annual NHS clinical entrepreneur Insites programme • Anywhere patient portal workshop scheduled across divisions and aligned with Personalise my Care strategy. • CYP As One platform being deployed in C&M, Somerset and Hertfordshire. • LHAH Southampton and Dublin trial sites agreed.	• Risk of further, and significant, Investment Zone funding delay • Skills and team continuity due to recent departures. • Continued concerns about commercial research landscape in UK • Capacity issues in Liverpool Joint Research Office (impacting on support for grant applications and contract review)

		• RCPCH-NIHR Paediatric Involvement and Engagement in Research Prize awarded to Paediatric Medicines Research Unit • NIHR Senior Research Leader award to support embedding research in clinical areas awarded to Laura Rad (currently embargoed)	
Collaborating for CYP	**4. Handover Springfield Park to our community**	• Tree planting continues. • Path works on-going. • Playground opening w/e 08.03.24.	• Areas of residual Trust infrastructure works blocking full site possession for park contractor. • Poor weather conditions.
Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Reduction in waiting list backlog: down to 113 patients at the end of February. • Positive statistical improvement trend in use of theatre time and access to diagnostics • High utilisation of the virtual ward	• Real focus on treating at least 80% of patients across Q4, after a drop to 78% in February. • Impact of industrial action on recovery levels in February.
Smartest ways of Working	**6. Financial sustainability**	• £2.3m surplus in month, £0.6m adverse to plan due to impact of industrial action during the month. • YTD surplus £6.4m with forecast to achieve £10.9m, £2.1m adverse to revised plan due to industrial action. • £16.3m CIP posted YTD with remaining due to be posted in March to achieve plan in year.	• Work on productivity data underway to inform elective recovery and financial sustainability plans. • Planning for 24/25 at draft submission stage. • Focus on 24/25 efficiency programme

Smartest ways of Working	**7. Optimisation of Aldercare**	• 9 developments were prioritised through clinical design authority for Feb • 5 were completed in the month • 4 planned developments not completed due to resource being pulled to support priority issues and funding/ operational requirements • Highlights include: Gender Identity Service package and standard operation coding for another speciality	• Number of priority development requests outstanding with Meditech • Some P1 issues required development resource leading to some delays in optimisation developments this month

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

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

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

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

Alder Hey Children's NHS Foundation Trust

Campus Development Report on the Programme for Delivery

March 2024

1. Executive Summary

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

Good progress has continued to be made to deliver projects:

2024/25 Q1 & Q2 Planned Completion:

- Neo-Natal/SDEC Service Diversions
- Springfield Park
- Gender Development Service
- Police Station Refurbishment
- Base Camp

2024/25 Q3 & Q4 Planned Completion:

- Elective Surgical Hub (priority scope of works)
- Phase 1 Alder Park
- Fracture/Dermatology Outpatients
- New Nursery (not directly managed by the Trust)

2. Key Risks

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

The next review of the full risk register by the Development Team is scheduled for 03.04.24.

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

Elective Surgical Hub	JVH/Day PM	Scope of project TBD			
Gender Development Services (GDS)	JVH/Day PM	4	1	3	

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Park	Failure to deliver long term vision for park	BAF 3.1	12	Phase 3 to be completed by May 2024. Programme currently being assessed for mitigations/improvement.
Neonatal & UCC	Inflation risk on project due to contract sign delay	Part of overall inflation risk (RL)*	16	RABD approval given 14.11.23 to fund inflation costs. Development team to identify mitigation plan for SPV/other costs. An update paper will be shared with March ’24 RABD.
SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Trust has responded to CEs and associated correspondence received. An update paper was shared with RABD members 06.03.24.

* There is an existing inflation risk on InPhase.

Alder Hey Children's NHS Foundation Trust

3. Programme Delivery Timetable (Critical Path)

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

Alder Hey Children's NHS Foundation Trust

4. Programme Delivery Timetable (Associated Projects)

Project	Deliverable	2024												2025												2026+
		Jan	Feb	Ma	Apr	Ma	Jun	Jul	Aug	Sep	Oct	No	Dec	Jan	Feb	Ma	Apr	Ma	Jun	July	Aug	Sep	Oct	No	Dec	
Base Camp	Install																									
Alder Park	Construction Phase 1 (EDYS & Therapies)																									
	Construction Phase 2 TBD (Sefton CAMHS)																									
Elective Surgical Hub	Refurbishment TBD (feasibility study May '24)																									
Fracture/ Dermatology OPD	Refurb Construction																									
New Nursery	Construction																									
Rainbow Centre	Rainbow Suite Refurb TBD																									
PALS	Refurb Feasibility TBC																									
North-East Plot	TBD – site master planning																									
GDS North Hub Estates Solution Design, Refurb, Commissioning & 'Go Live'	Phase 1 (First Floor)																									
	Phase 2 (Ground Floor)																									

5. Project Updates

Neonatal and Urgent Care Centre

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Service Diversion Works: • Essential works on the rusty main - to cut back pipework in the way of construction - delayed by two weeks to put measures in place to satisfy requirements set out within the water safety policy.		Completion of works ahead of main construction. Impact on budget. Management of noise and site access routes during peak works.	Monitor via Construction Progress meeting; dedicated meeting to review impact 06.03.24 & overall programme position 18.03.24. On-going site management plan, including enhanced communications to patients & families.
Full final phase of construction contract signed 21.12.23. • Instruction issued to MSC to complete full ground floor layout works ie: to include construction completion of the 'shelled' space (Urgent Care Centre/SDEC).		Increased construction & SPV costs. Delay to unit opening.	Development Team are working with the SPV and Mitie to identify mitigation plans in relation to increased SPV / other costs. An update report will be shared with RABD March '24. Agree EDU design and decant plan.
Equipment Specification & Procurement: • Incubator specification agreed, final quantities required to be confirmed.		Coordination of technologies and flow of patient data between component systems: incubator, monitoring, alarms and line of sight elements.	Finalise equipment 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), 10.11.23 (associated position paper 1) and 15.12.23 (associated position paper 2).		Possible contract claim.	Meeting between Trust (DP & RL) & contractor 06.03.24. Update paper to 06.03.24 RABD.

Deliverable (Catkin & Sunflower Cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Sprinkler System Under-Croft Car Park: • Tender period closed 01.02.24. • No compliant responses received. • Alternative option being developed.		Fire compliance. Potential loss of overall car park numbers. Budget TBC.	Develop potential option to appoint a principal contractor to undertake works and installation.
Water Safety Issues: • To ensure statutory temperatures are maintained.		Continued contamination.	Microbiological sampling will continue.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Immediate priorities are being progressed: • Space utilisation study clinical office functions (levels 1 & 2 main hospital and Institute in the Park) 22.01.24 - 02.02.24. Report received and is currently being assessed. • Permanent solutions for those staff currently accommodated on a 'temporary' basis as the result of an arising shorter-term pressure. • Potential increased scope: meeting rooms and storage. • To agree the Governance framework and guiding principles for managing mid-long term space utilisation.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for works/kit.	Share outputs from space utilisation study & proposed recommended next steps with Divisions. Space pressure plan (inc early demolition of Histopathology building) being developed for Executive Director support & approval. Budget and scope of works tba.
Former Police Station Refurbishment: • Enabling works completed on site 23.02.24. Asbestos survey results to first floor walls confirmed no asbestos present. • Main contract signed with contractor 12.02.24 and works commenced for completion June 2024. • Car parking provision available as required to support patient/visitor overflow and potential additional staff spaces.		Operational date currently assessed as June 2024.	Robust programme and cost management: • bi-weekly senior Principals' meeting; • bi-weekly site meeting; • monthly pre-move planning user meeting.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: • FOSP have accepted a site walkabout invitation; to be scheduled for mid-March '24.		Inconsistent communications.	Continued and maintained input & communications from all key stakeholders. Quarterly newsletters and regular website updates.
Completion Works: • New playground safety inspection 16 February 2024; one snag identified for rectification to allow the playground to open w/e 08.03.24. • Drainage works and final seeding to the football pitches expected April 2024 (followed by 12-month establishment period). • Lighting, planting, street furniture & signage, path works completion May 2024.		Delays in completion football pitches. Completion of existing Infrastructure works.	Programme currently being assessed to develop potential options for bringing forward work package handovers where possible. Trust discussions on-going with LCC to confirm and gather required documentation for the handover of Springfield Park to LCC.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Tender Process: • Tender Issue Date: 16.02.24 • Tender Submission Returns: 15.03.24 • Appoint Construction Contractor: Spring 2024 • Start on Site: 03.06.24 • Construction Completion: 16.12.24		Timely appointment of a construction contractor. Delay to completion, impact on operational running of the services.	Regular meetings. Close monitoring of critical risks. Initial discussions with wider estates community re: potential short-term decant facilities to help manage patient activity during works.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

Deliverable	RAG	Risks/Issues	Actions/Next Steps
High level programme to be fully agreed: • Phase 1 scope of works to be agreed. Planning consent condition (section 278) re traffic calming to be satisfied as part of Institute approval 2013. • Phase 2&3 to be reviewed as part of the wider estate strategy (inc NE plot and boundary treatments) and development of site master planning options.		Phase 1 – planning approval, interface with Catkin/Sunflower building (works and access), and cost of works & section 278. Trust has identified a mitigation to satisfy 278 requirements, to be submitted as part of the planning consent. Budget to be identified.	LCC to continue and complete the current application for Eaton Road Frontage. Proposals will be shared with the Executive Design Review Committee March '24 and with Trust Board in April '24.

Elective Surgical Day Case

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Trust Variation Enquiry (TVE) response received from the Special Purpose Vehicle (SPV). Feasibility study completion May 2024.		Programme, available budget.	Fee proposal has been provided by the SPV; this is currently being assessed. Regular meetings established between Trust and SPV.

New Nursery

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Based on a planning determination 16.02.24 to allow construction to commence: • Complete design & instruct main contractor – Mar/April 2024 • Start on site – April 2024 • Works complete – Jan 2025 • Operational – by Jan/Feb 2025		Confirmed programme.	Regular meetings continue.

Rainbow Centre Refurbishment

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Room layouts signed off by clinical / leadership team 15.09.23.		Programme, available budget.	TVE response awaited from SPV.

Gender Development Services (GDS) – Estates Solution

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Lease agreed and in place 23.01.24. LOI signed 01.02.24. Furniture order placed. Strip out and early construction works have commenced.		Programme, available budget. Suppliers lead in times. Fire stopping protection to be assessed for compliance. Potential requirement to rectify current installation. Likely to impact completion by up to 6 weeks tbc.	Construction contract signing by mid-March '24. Non-furniture equipment & sundries procurement. Programme & budget mitigation plan being prepared, as required.

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

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

6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 7 March 2024.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	Equality, Diversity and Inclusion – Focusing on Our People 2024/25
Report of:	Chief People Officer
Paper Prepared by:	Chief People Officer

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score
2.3	Workforce Equality, Diversity & Inclusion	3 x 5 (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. Purpose of the report

The purpose of this report is to provide the Board with:

a. assurance that the Trust is meeting its obligations against the national NHS frameworks for Equality, Diversity and Inclusion (EDI), including all required statutory compliance.
b. Progress made by the EDI Steering Group and an overview of its achievements.
c. A Trust wide EDI action plan

2. Background

Every NHS organisation is required to comply with a range of nationally and locally defined EDI frameworks, action plans and statutory reporting duties. These are designed to ensure that NHS organisations are mandated to consider and support all those groups with 'protected characteristics' (as defined by the Equality Act 2010) and have actions in place to improve the diversity of the workforce, improve the experience of staff and improve access to employment and opportunities. These frameworks are:

- NHS Equality, Diversity and Inclusion (EDI) Improvement Action Plan[1]
- Workforce Race Equality Scheme (WRES)[2]
- Workforce Disability Equality Scheme (WDES)[3]
- Gender Pay Gap (GPG)[4]
- EDS 22[5]
- NHS North West Anti-Racist Framework [6]

The requirements of these frameworks are complex, detailed and require significant input from those working in both EDI and Human Resources to ensure actions are identified and, more importantly, things are actually happening to support improvement. The role that managers across the organisation play in supporting this agenda should also not be underestimated. At Alder Hey, the People and Wellbeing Committee are responsible for all aspects of the EDI workforce agenda, and ratify all actions plans associated with the above 6 areas of focus. Operationally, the EDI Steering Group is the forum where action plans are monitored.

3. Achievements over the last 18 months

In Spring 2022, the Board supported the establishment of the EDI Steering Group, chaired by Garth Dallas, Non-Executive Director and EDI Champion. The EDI Steering Group has been the forum for overseeing the development of the action plans in relation to the frameworks referenced above and in addition, has been driving a number of other improvements, which are detailed below:

- Supported the development of a business plan to secure additional funding within the EDI Team, to work alongside the Head of EDI. Resource for an EDI Adviser has been secured and this post will be advertised in March 2024

[1] NHS England » NHS equality, diversity and inclusion (EDI) improvement plan
[2] NHS England » NHS Workforce Race Equality Standard
[3] NHS England » Workforce Disability Equality Standard
[4] NHS England » Gender pay gap report 2022: A combined report for NHS England and NHS Improvement
[5] NHS England » Equality Delivery System 2022
[6] The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf (england.nhs.uk)

- Supported the establishment of four new staff networks; REACH network (Race, Ethnicity and Cultural Heritage), ACE Network (for colleagues with a disability or long-term condition), LGBTQIA+ Network, Armed Forces Network and we also have a well established menopause support group. Chairs of each network have been successfully appointed and the Trust is supporting those staff with paid time to undertake this role. Through the staff networks we have:
    - Been awarded the Navajo Charter Mark. The Navajo Merseyside & Cheshire LGBTIQA+ Charter Mark is an equality mark sponsored by In-Trust Merseyside and supported by the LGBTIQA+ Community networks across Merseyside– a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA+ people in Merseyside
    - Alder Hey and its network members took part in another fantastic Liverpool Pride event in Summer 2023
    - Working alongside HR, successfully launched the Reasonable Adjustments Policy
    - Developed of a suite of resources to support managers
    - Produced excellent communication campaigns from all of the networks, including Black History Month, Disability History Month, LGBTQIA+ History Month and delivery of a moving Remembrance Day service in the Atrium In November 2023.
    - Achieved the Armed Forces Covenant Silver Employer Recognition Scheme (ERS) award in 2023
    - Accreditation with the Veterans Covenant Healthcare Alliance (VCHA)

4. Workforce Demographics

Through the EDI Steering Group and the staff networks, we have been focusing on two key areas of improvement:

i. To improve the numbers of colleagues self-reporting their status through ESR to help provide a more accurate picture of the workforce demographics. The table below shows the changes since last year in the numbers of staff self-reporting:

	Reporting	**2023**	**2024**
Disability	Staff reporting they have a disability	4.6%	6.2%
	Staff reporting they do not have a disability	71.9%	77.8%
	Staff not disclosing their disability status	23.3%	15.9%
Sexual Orientation	Staff reporting their sexual orientation	80.5%	83.5%
	Staff not disclosing their sexual orientation	19.4%	16.4%
Ethnicity	Staff reporting their ethnicity (white and BME)	98.8%	99.2%
	Staff reporting their ethnicity (BME only)	10.8%	12.7%
	Staff not disclosing their ethnicity	1.1%	0.73%

The table above shows small, but positive, improvements since last year. The networks have been supporting this agenda and communications have been shared widely across the organisation to encourage more self-reporting. This matters as 1) it allows us to understand our workforce better and focus our actions on where we can make a difference and 2) improved self-reporting can indicate that staff have increased confidence on an organisation to feel able to share this personal data.

ii. The second area we have focused on has been to increase ethnicity and diversity within the workforce. There have been positive improvements in this data, as ethnicity within the workforce has increased from 10.8% (March 2023) to 12.7% in (March 2024), bringing us closer to our long held aim of reaching a level of diversity within the organisation which aligns to the local population we serve. However, this improvement has mostly been augmented by international recruitment in both medical and nursing staff and such improvements have not been seen within lower graded staff, admin and support services and senior staff. We are very aware that this is an area we will need to continue to focus on.

5. Staff survey 2023

The results from the 2023 staff survey shows some positive improvement in a number of areas. Overall, only 3.17% of those who completed the survey said they had experienced discrimination from patient/service users (down slightly from 2022). This was the lowest (best) score across the comparator group. 5.93% of staff reported they had experienced discrimination at work from managers/team leaders and other colleagues. This is down from 6.96% in 2022 (the average score for the comparator group was 9.2%). More staff than in 2022 reported that they thought the organisation respects individual differences (76.73% vs 75.74% in 2022). The Trust takes a zero tolerance approach to any sort of discrimination against staff, so whilst this data is encouraging, we know we have more work to do to reduce this even further.

It was concerning to see that, of those staff who said they had experienced discrimination, discrimination on the grounds of ethnic background rose markedly from 19.5% in 2022 to 30.7% in 2023. This increase can also be seen nationally. Discrimination on the grounds of other protected characteristics such as disability, age and gender have all decreased. This will be an area of focus for the Trust, in particular we will work with the REACH network to better understand and reduce racism; implementing the Anti-Racist Framework will be key to this.

Both the WRES and the WDES use data from the staff survey to inform the Trust position, and both saw marginal improvements in the scores from 2022 to 2023.

6. Trust Objectives and EDI Goals

As referenced in Section 2 of this report, each framework and initiative requires the Trust to develop bespoke action plans which are monitored through the EDI Steering Group and then through the People and Wellbeing Committee.

The wide range, and volume, of actions involved in this do not lend themselves to simplicity; there is currently no one set of actions which can easily be shared across the organisation to allow for meaningful, and simple, communication of those things we are focusing on as a Trust which matter, and which will truly make a difference to colleagues.

To simplify matters and to be able to identify, and communicate, an overarching action plan for the Trust, it is proposed that the actions from the national NHS Equality, Diversity and Inclusion (EDI) Improvement Action Plan are used as the action plan for the Trust. [7] The national plan, by its very design, ensures Trusts are focused on all aspects of EDI, and provides us with a clear set of objectives which can be regularly monitored at Trust Board, and shared with colleagues across the organisation as a demonstration of commitment and progress.

[7] NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

The national plan overlaps with many elements of the other frameworks previously referenced, including Freedom to Speak Up (FTSU), which provides a support function to staff who may need to report issues relating to EDI to the FTSU Guardian. All of the Trust's internal actions are already aligned to this national plan. There are some specified deadlines attached to this plan, and so it is proposed that these are monitored and reported to Trust Board on a regular basis (Appendix 1)

7. Recommendations

- For the Trust Board to endorse the contents of this report
- For the Trust Board to support the approach outlined above, and receive regular updates on progress
- For Trust Board members to fully support High Impact Action 1, and to work with their respective appraiser to identify specific and measurable EDI objectives.

Appendix 1 - Trust Action Plan – the Six High Impact Changes

	High Impact Action	What are the success metrics?
1	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable	Annual chair and chief executive appraisals on EDI objectives (Board Assurance Framework)
2	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity	-Relative likelihood of staff being appointed from shortlisting across all posts (WRES and WDES) -Access to career progression, training and development opportunities (NHS Staff Survey) -Year-on-year improvement in race and disability representation leading to parity over the life of the plan (WRES and WDES) -Year-on- year improvement in representation of senior leadership (Band 8C and above) over the life of the plan (WRES and WDES) -HEE National Education and Training Survey (NETS) Score metric on quality of training (NETS) -Diversity in shortlisted candidates (To be developed in year two)
3	Develop and implement an improvement plan to eliminate pay gaps	-Year-on-year reductions in the gender, race and disability pay gaps
4	Develop and implement an improvement plan to address health inequalities within the workforce	-Organisation action on staff health and wellbeing. (NHS Staff Survey) -HEE National Education & Training Survey (NETS) Separate Indicator Score metric on quality of training (NETS)
5	Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.	-Sense of belonging for internationally recruited staff (NHS Staff Survey) -Reduction in instances of bullying and harassment from team/line manager experienced by (internationally recruited staff). (NHS Staff Survey)
6	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur	-Year-on-year reduction in incidents of bullying and harassment from line managers or teams. (NHS Staff Survey) -National Education and Training Survey (NETS) bullying and harassment score metric (NHS professional groups) (NETS survey data) Year-on-year reduction in incidents of discrimination from line managers or teams. (NHS Staff Survey)

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

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

Purpose of Paper:	Decision ☑ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☑
Summary / supporting information	This report provides assurance on: - progress of the Brilliant Basics Delivery Plan 2023/2024 - Alder Hey involvement in Cheshire and Merseyside Improvement Network - progress against NHS IMPACT standards The report also defines the Brilliant Basics Delivery Plan for 2024/2025.
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

Alder Hey Children's NHS Foundation Trust

1. Executive Summary

The aim of this paper is to provide Trust Board assurance on:

- progress of the Brilliant Basics (BB) Delivery Plan 2023/2024
- Alder Hey involvement in Cheshire and Merseyside Improvement Network
- progress against NHS IMPACT standards.

The report also defines the Brilliant Basics Delivery Plan for 2024/2025 for approval.

There are **no risks or issues** to escalate to Board.

The key message in this report is that accumulative progress is being made, year on year, towards the development of a culture of continuous improvement.

2. Background and current state

Progress on BB Delivery Plan 2023/2024

Trust Board approved the BB Delivery Plan (March 2023) and has received quarterly updates for assurance against progress.

Table 1 and 2 below detail 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.

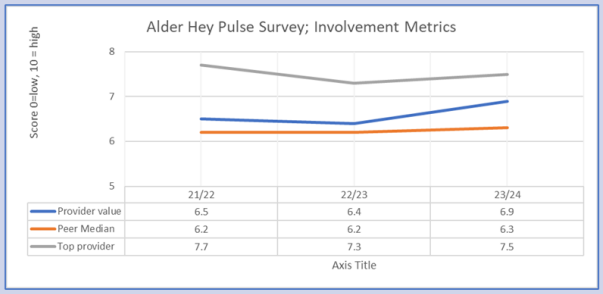
Alder Hey Children's NHS Foundation Trust

Watch	Target	YTD (current)	Measured by	On / Off Track	Insight

Driver	Target
NHS Staff Survey Involvement Question: The degree to which staff feel that they are involved in making improvements within their organisation.	Brilliant Basics will **contribute** to increasing the numerical value of this survey result.

Current Data & Insight

Graph 1. Pulse Survey Metrics.



Graph 1 above illustrates the Pulse Survey. 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 3rd from top with a difference in score of 0.2 compared to the top provider.
Within the North West Region, Alder Hey are 4th from top with a difference in score of 0.2 compared to the top provider.

*Data source: Model Hospital.
Comparator: Staff survey benchmarking group. Category: Involvement (Q 3D,E,F) Analysis: 0=low, 10=high.

Graph 2. Annual Staff Survey Metrics

Graph 2 above illustrates the Annual Staff Survey Data.
Alder Hey has increased the involvement scores and this is positive against comparator sites.
*Data source: Annual Staff Survey.

Table 1: Progress of Driver metric.

Table 2: Progress of Watch metrics.

Appendix 1, (2023/24) Plan Assessment, provides an overview of the assessment of the achievement of the current year 'Delivery Objectives'. The assessment of progress was based on review of evidence and was undertaken with stakeholder feedback during December 2023.

- Ten objectives (83%) have been completed and closed.
- Two objectives (17%) did not meet the evidence threshold for completion/closure and will be carried forward into 24/25.

The SRO has been accountable for all decisions regarding milestone completion and change control during 2023/24.

Alder Hey involvement in Cheshire and Merseyside Improvement Network

The first formal Cheshire and Merseyside Improvement Network was convened on 8th November 2023 and has met a total of 3 times. Alder Hey has been represented at all meetings and makes an active contribution; agreeing network principles, sharing

learning, and more latterly starting to identify areas for collaboration at scale. There are no formal plans in place for collaboration at present and any decisions will be discussed with the BB SRO and at strategic executives.

A Cheshire and Merseyside 'Leading for Improvement' Conference has been scheduled to take place on 30th April 2024. This will bring together a range of senior leaders involved in improvement from across the system. The purpose of the event is to create a space for leaders to consider where they are on the NHS IMPACT journey and to reflect upon the critical conditions for success, to learn from each other about successes and explore opportunities to accelerate system-wide adoption.

Progress on NHS IMPACT standards

NHS IMPACT has set out five key components which, when implemented together, build a systematic organisation wide approach to improvement and high performance. The self-assessment against these standards was initially completed in November 2023 and discussed at Strategic Executives. The update for this report can be found in table 3 below.

Table 3: Updated self-assessment against NHS IMPACT standards.

Component	Starting	Developing	Progressing	Spreading	Improving& Sustaining
Building a shared purpose and vision	➢	➢ I	II	I	
Investing in people and culture			➢ III	I	
Developing leadership behaviours		II	II		I
Building improvement capability and capacity		I	I	III	
Embedding improvement into management systems and processes			➢ I	III	

The tally indicates the number of criteria at each level.

- ➢ The arrow indicates where there has been a positive shift in position against the standards.

Further achievement / progression of the standards will develop as the BB approach becomes further embedded within the organisation and greater scale is reached alongside the focus and refocus annually through the BB delivery plan.

3. Future State – BB Delivery Plan 2024/2025

In accordance with continuous improvement, we have developed the 2024/25 priorities and approach, taking into consideration learning to date, stakeholder feedback, NHS Impact standards and the international evidence base.

Brilliant Basics methodology will support the delivery of the annual plan and the specific objectives in the 24/25 plan will target the development and maturity of the improvement system.

It is recognised that this plan may need to flex and adapt in line with requirements from the local health care system to balance short term needs against longer term transformational plans.

Table 4 below details four high impact objectives, key outcomes, and measures for 24/25.

OBJECTIVES	DELIVERED THROUGH	KEY OUTCOMES	MEASURES
Bringing what matters most to life at all levels of the organisation so you can see and feel it, collectively and accumulatively delivering the outcomes desired in a systematic and consistent way.	Strategy deployment	• Strategic initiatives that are directly translated into local implementation • Ward to board reporting with clear measures of improvement locally contributing to the driver metric	BB Driver Percentage of staff who feel they can make improvements in their work. • Strategic driver metric improvements • Clear line of sight from ward to board for 3 strategic initiatives/workstreams • Leader standard work; process confirmation and impact statements • Meeting hygiene; process confirmation and impact statements • 12 case studies that evidence impact across all objectives • Number and quality of A3 thinking taking place
Leaders developing problem solving using A3 thinking and coaching conversations during 'go, see' with frontline teams.	Leader Standard Work	• A shift from command and control to humility and coaching style • Teams that are empowered to make improvements • Unblocking barriers to improvement at the frontline	
Effective and productive meetings using standardised meeting hygiene.	Meeting Hygiene Standard work	• Effective use of time in sub-board committees • Succinct and clearly written papers • Assurance and improvement evident throughout	
Supporting priority teams/services to deliver productivity improvements using Brilliant Basics methodology.	BB Improvement System; tools, routines, behaviours	• A3 thinking used throughout • Teams that are empowered to make improvements • Productivity improvement in priority teams / services	

Table 4: Brilliant Basics – 24/25 Delivery Plan

The continued monitoring of the measures will be the responsibility of Strategy Leadership Group and the BB SRO is accountable for achievement.

4. Conclusion and Recommendations

Brilliant Basics continues to go from strength to strength in its delivery of a culture of continuous improvement in a systematic and consistent way and the Executive team remain committed to making BB the way we work at Alder Hey.

The delivery plan for 2024/2025 will specifically build the improvement system further, supporting the delivery of Vision 2030 alongside immediate needs of the organisation.

In accordance with working in a continuous improvement manner, we will continue to seek feedback, incorporate learning, and maintain an agile approach to delivery.

The board is asked to:

1. Consider the level of assurance gained on the embedding on the Brilliant Basics Improvement System in line with organisational ambition and national standards.
2. How frequently board is to receive future update reports going forwards and
3. Approve the BB Delivery Plan for 24/25.

Alder Hey Children's NHS Foundation Trust

Appendix One: 2023/2024 Plan Assessment.

Work Stream	Milestone	Progress Rating*	Comment
Leading	Executive Leader Standard Work (LSW) Review		Executive standard work reviewed and refreshed with a focus on meeting hygiene focussed on PAWC. This will continue into 24/25 plan and scale to all sub-board committees.
	Board Development Plan		Board development has been aligned to Vision 2030 with BB being an enabling factor.
	Divisional LSW		In plan for 2024/2025.
Learning	Online learning resource		Online learning resource live on Moodle. Detailed testing with teams and now utilised in a blended learning approach.
	BB approach to support strategy deployment		In plan for 2024/2025.
	Leadership for Improvement offer		Quarterly Improvement Leaders collaborative in place, co-designed approach, evaluated highly. Leading through Change Session developed and schedule to become part of Strong Foundations from next cohort. Managers Essentials offer live with 13 bookings onto first session scheduled for 18th March.
	Teams coached through BB		16 teams planned, achieved 24. The flexible approach and B7 WTE role being filled in February 23 has contributed to this achievement.
	SharePoint site development		Completed. Planned review to maintain the site is scheduled in BB team standard work.
	Health Inequalities embedded in learning		Content included in module one and key question embedded in A3 current state assessment to prompt thinking.
Delivering	BB in the DNA of the organisation		There are 22 improvement connectors trained in facilitating change using BB across the organisation – both clinical and non-clinical roles. BB questions were implemented in ward accreditation in September 23 and are now being scored towards the overall rating for departments. BB questions have been included in the staff survey improvement process for 24.
	CYP&F Involvement in Strategy and BB waves		Dedicated coaching from youth engagement leads for all BB teams during 23/24. Case studies produced evidencing impact.
	BB approach utilised in Patient Safety Board		Patient Safety Board established from the outset utilising BB methodology; strategy, A3 thinking, data driven assurance and decisions, involvement and sharing learning.

*Key: Blue = completed and closed. Green = in progress, requires further work therefore moved into 24/25 plan.

ENDS

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	**Safeguarding Children and Adults at Risk Annual Report 2022-2023**
Report of:	**Nathan Askew** **Chief Nursing, AHP and Experience Officer**
Paper Prepared by:	**Nichola Osborne** **Associate Director for Safeguarding and Statutory Services**

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
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts.					20
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
2393	There is a risk that staff will not understand policies and procedures to follow or may not identify safeguarding risk (Safeguarding Training Compliance)					9
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Alder Hey Children's
NHS Foundation Trust

Safeguarding Children and Adults at Risk Annual Report 2022-2023

Safeguarding and Statutory Services

Executive Summary

The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2022 to 31 March 2023, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

The work activities undertaken by the Alder Hey Safeguarding Team during 2022/23 have been comprehensively documented within the quarterly safeguarding assurance reports received by the Safety and Quality Assurance (SQAC) Committee. This report is intended to provide an overview and 'snapshot' of that work.

Whilst there are good safeguarding systems in place across Alder Hey, there continues to be challenges as safeguarding continues to evolve, in both complexity and scope. With new and emerging risks in respect of contextual safeguarding being identified. As a result, Alder Hey must ensure that its safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee its safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in its care.

The Safeguarding Team remains committed to ensuring that children, young people, and adults at risk using Alder Hey services are safe, and that their health needs are met. The Safeguarding Team will continue to work collaboratively with Trust colleagues and key partners to continuously improve systems to safeguard children, young people, and adults at risk.

Introduction

1. The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2022 to 31 March 2023, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

2. As such a condensed overview of the work activities undertaken by the Alder Hey Safeguarding Team during 2022/2023 are included in this report. These have previously been included in the quarterly safeguarding assurance reports received by the Safeguarding and Statutory Services Assurance Group (SASSAG), the Clinical Quality Steering Group (CQSG) and Safety and Quality Assurance (SQAC) Committee. This report is intended to provide an overview and 'snapshot' of that work.

3. The content of this report will be used to inform and assure Commissioners and may be used to inform and assure Local Safeguarding Children Partnerships (LSCPs) and Local Safeguarding Adult Boards (LSABs).

4. The report outlines the Alder Hey safeguarding governance arrangements and safeguarding activities within and relating to the Trust. It is designed to highlight key issues, working arrangements and recent developments.

5. Safeguarding is 'everybody's business' and the Alder Hey Safeguarding Team works to ensure that it continues to be the 'golden thread' running through all our services.

6. NHS England (2022) state in the Safeguarding Accountability and Assurance Framework (SAAF) that "*Fundamentally, it remains the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the wellbeing of those children and adults is at the heart of what we do*".

7. The Safeguarding Team works collaboratively with divisional colleagues and multi-agency partners to safeguard children and adults in our care who have been harmed or are at risk of harm.

Alder Hey and Safeguarding Commissioning Arrangements

8. Alder Hey is one of four stand-alone children's specialist providers in the country. Alder Hey provides a full range of secondary services to its local paediatric population as well as tertiary and quaternary care for a footprint stretching across the Northwest of England and beyond.

9. NHS England principally commission the Trust for tertiary and quaternary care with the commissioning of secondary care services, across a wide population base, via several Place areas within the Cheshire and Merseyside region.

10. Alder Hey provides care for approximately 330,000 children and families each year. The Trust became a Foundation Trust in August 2008 and leads research into children's medicines, infection, inflammatory diseases, and oncology. The Trust has a broad range

of hospital and community services, including many accessed directly via primary care referral. The Trust is a recognised Major Trauma Centre and is one of four national Children's Epilepsy Surgery Service centres. The Trust is a designated national centre for head and facial surgery as well as a centre of excellence for heart, cancer, spinal and brain disease. Alder Hey is the only national centre of excellence for childhood lupus and the only experimental arthritis treatment centre for children.

11. The Trust employs a workforce of 4,115 staff who work across our community and hospital sites. The Safeguarding Team support the training and development of our workforce in respect of safeguarding.

12. Liverpool Place is the lead commissioner for the Alder Hey Safeguarding and Statutory Services across Liverpool, Sefton, and Knowsley. Liverpool Place undertakes a coordinating role on behalf of NHS South Sefton, NHS Southport and Formby and NHS Knowsley Places.

13. The Rainbow Centre is situated on the ground floor near the Emergency Department and provides a 'hub' for the co-ordination of the safeguarding service across the whole of Alder Hey. The facilities include office space, and an Achieving Best Evidence (ABE) interview suite, as well as two dedicated examination suites, which provide a calm, caring environment where children who are suspected of being abused can be medically examined and interviewed.

14. The Safeguarding Team works closely with Unscheduled Care, Burns and Plastics, Critical Care, Gastroenterology, Orthopaedics, Paediatric Surgery, Neurosurgery, Oncology, Ophthalmology, Radiology, CAMHS and Medical Photography colleagues in the management of some of the most complex child protection investigations within the region.

Legislative Frameworks - Safeguarding Children, Young People & Adults at Risk

Safeguarding Children and Young People

15. Safeguarding children and young people and promoting their welfare is defined as:

- Protecting children from maltreatment.
- Preventing wherever possible impairment of children's health or development.
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable all children to have the best outcomes.

16. Child protection is defined as being part of safeguarding and promoting welfare. It is the work done to protect specific children who are suffering, or are likely to suffer, significant harm.

17. The Working Together to Safeguard Children (2018) guidance states that*: 'Children are best protected when professionals are clear about what is required of them individually, and how they need to work together.'*

18. In addition, the guidance states that *'effective safeguarding of children can only be achieved by putting children at the centre of the system and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.'*

Safeguarding Adults at Risk

19. Safeguarding Adults at Risk of Abuse is defined in the Care Act (2014) as meaning:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, wishes, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances and therefore potential risks to their safety or wellbeing.

20. Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be some challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

21. Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice.

22. Regardless of the developing context, all health organisations are required to adhere to the following arrangements and legislation (NHS England, 2022):

Legislation for All
▪ The Crime and Disorder Act 1998 ▪ Female Genital Mutilation Act 2003 ▪ Mental Capacity Act 2005 ▪ Convention on the Rights of Persons with Disabilities 2006 ▪ Mental Health Act 2007 ▪ Children and Families Act 2014 ▪ Modern Slavery Act 2015 ▪ Serious Crime Act 2015 ▪ Mental Capacity (Amendment) Act 2019 ▪ NHS Constitution and Values (Updated January 2021) ▪ Domestic Abuse Act 2021 ▪ Serious Violence Duty: Draft Guidance 2021 ▪ Prevent Duty 2015

Safeguarding Legislation Specific to Children	Safeguarding Legislation Specific to Young People Transitioning into Adults, including Children in Care	Safeguarding Legislation Specific to Adults
▪ United Nations Convention on the Rights of the Child 1989 ▪ Children Act 1989 and 2004 ▪ Promoting the Health of Looked After Children Statutory Guidance 2015 ▪ Children and Social Work Act 2017 ▪ Working Together to Safeguard Children Statutory Guidance 2018		▪ European Convention on Human Rights ▪ The Care Act 2014 ▪ Care and Support Statutory Guidance – Section 14 Safeguarding
Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019	Looked After Children: Knowledge, skills, and competencies of health care staff 2020	Adult Safeguarding: Roles and Competencies for Health Care Staff 2018
Framework Specific to both Children and Adults		
Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2022		

Alder Hey Safeguarding Governance Arrangements

23. The Chief Nursing, AHP & Experience Officer is the Board Executive Lead for safeguarding children and safeguarding adults at risk, with the Chief Executive retaining overall statutory responsibility. The Alder Hey Safeguarding Team forms part of Safeguarding and Statutory Services which sits within the Community and Mental Health Division. Day to day Director support for Safeguarding is the responsibility of the Director Community & Mental Health Services.

24. There were significant changes within the leadership of Safeguarding and Statutory Services throughout 2022. In May 2022, a new Associate Director for Safeguarding and Statutory Services commenced in post, shortly followed by a new Named Nurse for Safeguarding Children, Young People and Adults in August 2022.

25. The Associate Director for Safeguarding and Statutory Services is the identified statutory lead for Child Sexual Abuse and Exploitation, Forced Marriage, Prevent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Lead as required by the Standard NHS Contract.

26. The Associate Director for Safeguarding and Statutory Services meets with the Chief Nursing Officer regularly in relation to safeguarding matters, providing briefings to the Senior Leadership Team as appropriate to discuss issues such as serious safeguarding incidents, Acute Life-Threatening Events (ALTEs), Unexpected Deaths in Childhood (SUDiCs) and allegations against staff members.

27. In October 2022 the Associate Director for Safeguarding and Statutory Services established the Safeguarding and Statutory Services Assurance Group (SASSAG) to improve governance in ensuring Alder Hey effectively discharges the Trust's statutory

responsibilities relating to safeguarding children, young people and adults and those patients where additional vulnerabilities have been identified.

28. In addition, SASSAG provides assurance to the Trust Board via SQAC that Safeguarding mechanisms and processes are integral to the work of the Trust regarding all service provision to ensure safety and better outcomes for children and young people.

Named Professionals for Safeguarding

29. Alder Hey has both a Named Nurse and Named Doctor for Safeguarding in line with the requirements of all NHS Providers as set out in the NHS Safeguarding Accountability and Assurance Framework (SAAF) (2022). The Associate Director for Safeguarding and Statutory Services leads the Named Professionals in their statutory responsibilities to ensure Trust safeguarding arrangements are robust.

30. Alder Hey's Named Professionals have a key role in promoting good professional practice within the Trust, supporting the local safeguarding system and processes, providing advice and expertise for staff, and ensuring safeguarding training is in place. They work closely with the Associate Director for Safeguarding and Statutory Services, Designated Professionals for Safeguarding in the relevant Place areas, and the LSCPs and LSABs.

Internal and External Assurance Reporting Arrangements

Internal Safeguarding Reporting and Assurance

31. Health Providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working (NHS England, 2022).

32. A Safeguarding Annual Report is provided to Trust Board following approval at SASSAG, CQSG and SQAC. The Safeguarding Quarterly Reports are provided to the SASSAG, the CQSG and the SQAC for scrutiny and oversight as part of our safeguarding governance arrangements.

33. Briefing papers are completed by the Associate Director for Safeguarding and Statutory Services as appropriate to advise CQSG, SQAC or Trust Board on new and emerging safeguarding issues as appropriate.

Cheshire & Merseyside Integrated Care Board Safeguarding Assurance

34. Data and quality analysis is provided quarterly to Designated Safeguarding Professionals at Liverpool Place who act as 'Lead Commissioner' in line with commissioning arrangement and safeguarding contractual standards. Regular feedback regarding the level of assurance and quality of KPI submissions are provided by Designated Safeguarding Professionals at quarterly Business Meetings with the Associate Director for Safeguarding & Statutory Services and Named Professionals.

35. Designated Professionals for Safeguarding at C&M ICB are invited to attend SASSAG where there is discussion regarding the quality of KPI submissions. Their attendance at SASSAG supports openness, transparency and good working relationships between the Trust and our Commissioners.

Local Safeguarding Children Partnership Safeguarding Assurance

36. Working Together to Safeguard Children (2018) places a statutory duty on organisations and professionals working with children and families to promote the welfare of children and ensure they are protected from harm. Section 11 of the Children Act 2004 addresses this and places duties on a range of organisations, agencies, and individuals to ensure their functions, and any services that they contract out to others, are safely discharged with regard to the need to safeguard and promote the welfare of children.

37. Liverpool Safeguarding Children Partnership conducted a Section 11 Scrutiny Visit in March 2023 to gain assurance required in accordance with their Local Multi-Agency Safeguarding Arrangements (MASA). Visitors representing the LSCP Scrutiny, Audit, and Review Group (SARG), met with the Associate Director for Safeguarding and Statutory Services along with Named Safeguarding Professionals and conducted a panel discussion with frontline practitioners from the Trust.

38. The feedback following this visit was as follows:
- "*All standards have been effectively evidenced*".
- "*The Trust submitted a strong Section 11 return with evidence to support answers provided, with clear direction on application of internal systems*".
- During the visit, Safeguarding Leaders "…*demonstrated clear knowledge and expertise in the role. They were honest in the assessment of where they want to go to improve practices further, including stronger evaluation of training, and shared good examples of multiagency working together*".
- "*Practitioners interviewed all demonstrated knowledge of how and where to find policies and procedures. They spoke positively about the training and support they receive".*
- *"Visitors felt confident the staff within Alder Hey understood and demonstrated sound knowledge of Working Together 2018. They were very knowledgeable of working practices to ensure safeguarding of children".*
- *"Staff were very positive about roles and recognising partnership working. They service 5 Local Authorities, all of whom operate slightly differently. Practitioner discussions harmonised with the evidence provided by safeguarding leads*".

39. The Liverpool Safeguarding Children Partnership Section 11 Compliance Report for Alder Hey stated "*Visitors and agency representatives identified no areas to improve practice against the standards*".

Alder Hey Safeguarding Service Structure

40. The Safeguarding Team works from the Rainbow Centre and is known widely across the Trust as the 'Rainbow Team'.

41. The Rainbow Centre is a dedicated Examination Centre and child protection service. Our Doctors and Physician Associates (PAs), supported by Health Care Assistants and Nurses, examine, and advise on the medical aspects of suspected or actual child abuse. This includes physical and sexual abuse, presenting in the community, Emergency Department (ED), or in our inpatient wards or Outpatients Departments.

42. The Rainbow Centre offers a multi-agency approach to the treatment of abused children with close liaison between Police, Children's Social Care, and Alder Hey staff.

43. Alder Hey has a large catchment area and provides secondary health care for the boroughs of Liverpool, Knowsley and Sefton. It is also a tertiary referral centre for specialist services with a specialist Paediatric Intensive Care Unit and Major Trauma Team which receives patients from the local and regional areas, e.g., North Wales, Cheshire and Merseyside, and across the wider Northwest.

44. By arrangement with those Boroughs, Police and Children's Social Care, any children requiring medical examination, are referred as per protocol to the Rainbow Centre at Alder Hey, to be seen by a member of the specialist safeguarding on call team. This includes a first on call specialist trainee/specialty doctor/physician associate and second on call Safeguarding Consultant. Children and young people are admitted to hospital by the team as required.

45. For those children and young people who are inpatients and concerns of possible abuse are raised, the Consultant with responsibility for the child will follow the relevant Alder Hey safeguarding procedure and make a referral to the Consultant on call for the Safeguarding Team.

46. The Safeguarding Team provides the paediatric input for joint examinations with Forensic Medical Examiners (FME) for examination of children with suspected sexual abuse. A Consultant takes the role of Forensic Lead for the children's Sexual Assault Referral Centre (SARC), located within the Rainbow Centre, to ensure that high standards are maintained, and that existing staff have regular training updates.

47. The Safeguarding Team is also required to attend multi-agency meetings to discuss findings of medical assessments, produce confidential medical and or Court reports. They also respond to information requests from both partner agencies and the LSCPs in relation to significant safeguarding incidents or other safeguarding partnership functions, such as multi-agency audit or performance management.

48. The Safeguarding Nursing and Practitioner element of the Team is an integral part of the Trust Safeguarding Service, providing leadership, support, and training across the organisation. They play a central role in supporting the medical team, and children, young people, adults at risk and their families involved in safeguarding investigations.

49. The Team also receives a significant number of safeguarding orders via our Electronic Patient Record System (EPRS) Meditech from across the Trust in relation to safeguarding issues which require specialist support and guidance. These may include concerns regarding parental substance misuse or parental mental health concerns, domestic abuse, chronic neglect, self-harm, Perplexing Presentations/Fabricated and Induced Illness, non-attendance known as 'Was Not Brought', non-compliance, or complex discharge issues.

50. The Safeguarding Team attend multi-agency meetings including strategy meetings, professional meetings, pre-discharge meetings, Initial and Review Child Protection Case Conferences, and Court hearings where appropriate.

51. The Safeguarding Nurses and Practitioners within the team provide safeguarding supervision to nursing and allied professional groups on all aspects of safeguarding. They also provide support should staff be required to produce a Court report or attend Court.

52. The team also deliver all face-to-face Level 3 safeguarding mandatory training across the Trust.

53. The Safeguarding Team follows the good practice principles highlighted in the National Service Framework for Children (2004), Working Together to Safeguard Children document (2018), the Children Act (1989, 2004) and the Care Act (2014) and aims to promote child and adult centred care, whilst helping and supporting families through the safeguarding process. The Team supports the safeguarding of vulnerable adults whilst recognising the Mental Capacity Act (2005) and the need to 'Make Safeguarding Personal'.

Safeguarding Peer Reviews

54. Peer Review is the evaluation of work by colleagues in the same field in order to maintain or enhance the quality of the work or performance. It is a process to ensure that a child protection assessment and the medical opinion are as robust, accurate and evidence based as possible.

Child Protection Peer Review

55. Child Protection Peer Review Meetings are the forum within which the findings and examining clinicians' opinions of child protection medical assessments are reviewed. It applies to both planned child protection medical assessment (those examinations booked by Children's Social Care or the Police expressly for the purpose of child protection assessment) and unplanned child protection assessment (where the child protection concern has arisen following the child's presentation to the hospital or paediatric setting).

56. Relevant members of the Safeguarding Team meet via Microsoft Teams on a weekly basis to discuss, and quality assure child protection cases being managed within Alder Hey.

57. Guidance for 'Peer Review in Child Protection' from the Royal College of Paediatrics and Child Health (RCPCH) (2023) states that for Paediatricians, "*Peer Review in Child Protection has become an established component of the Clinical Governance Framework, providing a safe learning environment. Effective clinical governance 'ensures that risks are mitigated, adverse events are rapidly detected and investigated openly, and lessons are learned'. Child Protection Peer Review is expected by the judiciary, GMC, and professional bodies. Evidence of participation should be presented at appraisal and revalidation*."

58. In addition, safeguarding clinicians attend six monthly joint Peer Review with the Safeguarding Service from Manchester Children's Hospital which ensures there is a

consistent approach to the medical safeguarding investigation process by the specialist tertiary services within the Northwest (Northern Heads).

Child Sexual Abuse Peer Review

59. The Sexual Assault & Referral Centre (SARC) Child Sexual Abuse (CSA) Peer Review aims provides a proactive culture of learning where Forensic Health Professionals (FHP), paediatricians and clinical SARC staff can review cases, discuss procedures, process and evidence bases, underpinning diagnosis and management and in doing so, provide a supportive environment to debrief cases with peers undertaking similar work. In turn this will help prevent professional isolation and aid sharing of best practice.

60. CSA Peer Reviews are face to face and held bi-monthly face with the Safeguarding Clinical Team and the Forensic Medical Examiners (FMEs).

Rainbow Multi-Agency Management Meeting

61. In January 2023 the Rainbow Multi-Agency Management Meeting was re-established.

62. The aim of the meeting is to:

- Ensure high standards of care and multi-agency management of the children and young people using the Rainbow Centre.
- Ensure appropriate oversight and clinical governance of the Rainbow Centre and promote high quality care and improved outcomes for children and young people.
- Ensure good communication and excellent multi-agency working in line with Multi-Agency Statutory Guidance.
- Review compliments and complaints in relation to multi-agency processes regarding children who have attended the Rainbow Centre.
- To support and strengthen multi-agency working and highlight any issue regarding poor communication and areas for improvement.
- To discuss cases for the purposes of identifying learning or strengthening multi-agency processes.
- To discuss any new documents, legislation, and research in relation to safeguarding relevant to the work of the Rainbow Centre.
- To share the outcomes of single and multi-agency audits for the purposes of improving knowledge and service delivery.
- To share information regarding inspections, commissioner visits or Peer Reviews in relation to Rainbow and multi-agency partners.

63. Chaired by the Associate Director for Safeguarding and Statutory Services, this meeting brings together key safeguarding leaders from a range of agencies including Alder Hey Safeguarding and Statutory Services, Children's Social Care (Liverpool, Sefton,

Knowsley, Halton, St. Helen's, and Wirral), SAFE Place Merseyside, St Mary's SARC, Merseyside Police, Rape and Sexual Abuse Service (RASA), and Rape and Sexual Abuse Service Cheshire (RASASC).

64. Re-establishing this forum has helped to build good multi-agency relationships and ensure continuous quality improvement.

Safer Recruitment Practices and Managing Allegations Against Staff

65. A vital element of the Trust's safeguarding arrangements is our safer recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults.

66. Alder Hey has a robust Recruitment and Selection Policy, this includes the requirement for Disclosure and Barring Service (DBS) checks as part of our safer recruitment arrangements in line with the NHS Standard Contract General Conditions.

67. Offers of employment at Alder Hey are made on a conditional basis as they are subject to satisfactory NHS safer recruitment pre-employment checks, including verification of identity, right to work, references, qualifications, professional registration (where appropriate), a DBS check and occupational health check.

68. Once employed, all staff are subject to DBS checks every three years during their employment with the Trust.

69. Alder Hey Standard Operating Procedures for Safeguarding Children and Vulnerable Adults have been written in line with the Children Act (1989, 2004), Working Together to Safeguard Children, a guide to inter-agency working to safeguard and promote the welfare of children (2018), LSCPs and LSABs policies and procedures.

70. Section 18 of the Procedures for Safeguarding Children and Vulnerable Adults is used when allegations are made against a person who works with children and their own family has been subject to child protection investigations or criminal prosecution.

71. It is essential that any allegation of abuse made against a professional who works at Alder Hey is dealt with fairly, quickly, and consistently, in a way that provides effective protection for the child or adult at risk and at the same time supports the person who is the subject of the allegation.

72. Allegations may relate to a person who has:

- Behaved in a way that has harmed, or may have harmed, a child or children/ or an adult with care and support needs.
- Possibly committed a criminal offense against children or related to a child, or an adult with care and support needs.
- Behaved towards a child or children or an adult in need of safeguarding in a way that indicates they may pose a risk of harm to children or adults with care and support needs.

- Behaved or may have behaved in a way that indicates they may be unsuitable to work with children or adults with care and support needs.

- Behaved in a way which raises questions about their ability to provide a service to an adult with care and support needs which must be reviewed, for example a conviction for grievous bodily harm against a person who does not have care and support needs.

73. The above-named procedures clearly identify the relevant senior leaders who must be informed in the event of a concern. Senior leaders then make a determination regarding whether a referral should be made to the Local Authority Designated Officer (LADO) under the 'Allegations against people who work with children LADO procedures' or to the LSAB under the 'People in a Position of Trust (PiPoT) with adults with care and support needs protocol'.

Safeguarding Policies

74. The Trust has a suite of safeguarding policies which include all relevant thematic areas of safeguarding which are in line with legislation and local, regional, and national guidance.

75. All safeguarding policies and procedures are ratified by the SQAC. An overview of all safeguarding policies and procedures is detailed below including the date issued and the date of review:

Policy Name	Date Issued	Review Date
M2 – Safeguarding Adults Policy	November 2021	November 2024
M3 – Safeguarding Children Policy	November 2021	November 2024
M70 - Domestic Abuse and Violence Policy	September 2020	September 2023
M69 – Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) Policy	January 2021	May 2023
RM19 – Prevent Policy	June 2021	June 2024
C69 – Chaperone Policy	February 2020	February 2023
Merseyside Joint Agency Protocol – Sudden Unexpected Death in Childhood (SUDIC)	June 2020	
Standard Operating Procedure Name	**Date Issued**	**Review Date**
Procedures for Safeguarding Children and Vulnerable Adults (Version 14)	January 2020	November 2023

76. Standard Operating Procedures for Safeguarding Children and Vulnerable Adults outline processes in relation to Child Protection of Children in Specific Circumstances:

- Abuse by children and young people.
- Bullying.
- Children and Young People presenting with Deliberate Self Harm Behaviour.
- Children At Risk of Sexual Exploitation (CSE).
- Out of Area Looked After Children.
- Emotional Support for Victims of CSE And Sexual Abuse.
- Organised or Multiple Abuse.

- Harmful Practices.
- Forced or early marriage.
- So-called ‘honour’-based violence.
- Female Genital Mutilation (FGM).
- Child Abuse linked to a belief in spirit possession or witchcraft or other spiritual or religious belief.
- Dog Bites.

77. All policies and procedures are reviewed and updated in line with any changes in legislation or guidance.

Safeguarding Training

78. Safeguarding is a key part of our Trust mandatory training requirements to develop and embed a culture that ensures safeguarding is acknowledged to be everybody’s business and the ‘Golden Thread’ throughout all services.

79. The Trust is required to maintain safeguarding training for all staff at 90% and this forms part of safeguarding KPIs overseen by Designated Safeguarding Professionals at Liverpool Place on behalf of Cheshire and Merseyside Integrated Care Board (ICB).

80. The NHS England SAAF (2022) outlines that all health providers must have effective arrangements in place to train all staff commensurate with their role and in accordance with the following intercollegiate documents:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).

- Looked After Children: Roles and Competencies of Healthcare Staff (2020)

- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).

81. In addition, the SAAF states that safeguarding must be included in induction programmes for all staff and volunteers. In 2023 it was agreed with Workforce and Development colleagues that safeguarding would be added to the face-to-face induction day for all new staff.

82. The Safeguarding Team provides mandatory safeguarding training for both clinical and non-clinical staff in accordance with the Royal College of Paediatrics and Child Health (RCPCH) standards, Royal College of Nursing (RCN), General Medical Council (GMC), Nursing & Midwifery Council (NMC) and Working Together (2018).

83. The Intercollegiate Documents, provide a framework to indicate the level of safeguarding training required for individual staff groups. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth Edition Intercollegiate Document (January 2019) suggests specialist trusts such as Alder Hey should be accessing additional mandatory training, which would include more in-depth safeguarding children knowledge, safeguarding adults and Looked After Children.

84. Level 1 and 2 safeguarding children training is completed via e-learning (with additional face to face sessions for staff unable to access online learning). Staff requiring level 3

safeguarding children and level 2 safeguarding adults were being offered training face to face in person or via Microsoft Teams to maintain their compliance.

85. Compliance for safeguarding and prevent training has been as follows throughout 2022/2023:

Training (Target: 90%)	2022/23			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Safeguarding Children Level 1	91.1%	94.3%	91%	94.9%
Safeguarding Children Level 2	91.1%	90%	85.3%	91%
Safeguarding Children Level 3	85.3%	87.4%	81.5%	88%
Safeguarding Children Level 4	100%	100%	100%	100%
Safeguarding Adults Level 1	92.02%	92.9%	89.9%	92.4%
Safeguarding Adults Level 2	89.41%	90%	85%	88%
Safeguarding Adults Level 3	100%	100%	81.5%	100%
Safeguarding Adults Level 4	100%	100%	100%	100%
MCA & DoLS	85.3%	87.4%	81.5%	84.8%
Prevent – Basic Awareness (Volunteers)	92.1%	72.3%	78%	74%
Prevent - WRAP	85.3%	93.1%	91%	95.6%
Domestic Abuse Awareness	92.1%	94.3%	91%	94.9%
Criminal Exploitation Awareness	92.1%	94.3%	91%	94.9%
Criminal Exploitation Targeted	85.3%	87.4%	81.5%	88%

86. The Safeguarding Team have continued to provide additional safeguarding training sessions in a bid to recover the compliance targets which were affected by the Covid 19 pandemic. Training figures for safeguarding mandatory training have reduced to below the 90% compliance target set by Liverpool Place during the year for some training sessions.

87. The Safeguarding Team have continued to highlight the reduction in staff compliance to senior leads, team leaders and individual staff. Training compliance continues to be shared with Designated Professionals at Liverpool as part of the KPI quarterly reporting submission.

88. The establishment of the SASSAG has helped the Safeguarding Team to have a more focused discussion regarding safeguarding training compliance and work more effectively with Divisional colleagues to address areas with poor compliance.

89. Training is also included in the safeguarding quarterly report submitted to SQAC to ensure senior oversight and action regarding supporting non-compliant staff to access mandatory training. The Safeguarding Team work closely with the Learning and Development Team and receive regular reports identifying all staff that are within 90 days of becoming non-compliant.

90. In addition, the Safeguarding Team has delivered additional internal targeted training, with topics reflecting Multi Agency ‘Spotlight on’.

Statutory Safeguarding Inquiries and Reviews

91. The Safeguarding Team are required to contribute to the following statutory safeguarding reviews which are commissioned by LSCPs and LSABs:

Domestic Homicide Reviews (DHRs)

92. A DHR is convened by the Local Community Safety Partnership Board, is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Safeguarding Adult Reviews (SARs)

93. A SAR is a multi-agency process that considers whether serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

Local Child Safeguarding Practice Reviews (LCSPRs)

94. A LCSPR is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death and there is cause for concern as to the way in which the relevant authority or persons have worked together to safeguard the child. LCSPRs replaced Serious Case Reviews.

95. This area of work is extremely time consuming, complex and involves reviewing distressing information. As a result, this has a significant impact on the capacity of the Safeguarding Team.

96. The Safeguarding Team also contribute to the review of cases of concern or ‘near miss’ scenarios which do not meet the threshold for a statutory safeguarding review.

97. The Safeguarding Team have a statutory responsibility to ensure that recommendation for the Trust from reviews are appropriately actioned. This involves embedding learning and providing evidence to give assurance to Designated Professionals, LSCPs and LSABs that learning has been embedded.

98. The Team have not contributed to any SARs or DHRs during 2022/2023.

99. Themes in respect of safeguarding children reviews included domestic abuse, parental and child mental health, neglect, substance misuse, adverse childhood experiences (ACEs), suicide, child sexual abuse (CSA), child sexual exploitation (CSE) and child criminal exploitation (CCE).

100. Key learning themes from all safeguarding reviews across the life course include communication and information sharing between agencies, service user engagement, lack of professional curiosity and professional challenge and the need for improved record keeping.

Channel Panel

101. The Channel Panel is an early intervention safeguarding programme and the element of the national Prevent strategy that provides bespoke support to children and adults identified as being vulnerable to radicalisation, before their vulnerabilities are exploited by terrorist recruiters who would encourage them to support terrorism, and before they become involved in criminal terrorist related activity.

102. Like other safeguarding interventions, Channel Panel works by identifying individuals at risk of radicalisation via referral, assessing the nature and extent of the risk and then developing a support plan for the individual concerned. It is a confidential and voluntary programme. Referrals come from a wide range of partners including the police, health professionals, schools, youth offending teams, children and adult services as well as members of the public.

103. The Channel Panel takes a multi-agency approach tailoring support to individual need. The type of support available is both bespoke and wide ranging and includes help with accessing mainstream services such as education, career advice, dealing with mental or emotional health issues, drug/alcohol abuse and theological or ideological mentoring from a specialist Channel Intervention Provider who works with the individual on a one-to-one basis.

104. As with other safeguarding work streams, Channel Panel is fluid in terms of the number and complexity of cases at any given time. The Associate Director for Safeguarding and Statutory Services and Named Nurse for Safeguarding has supported the Channel Panel during the period of this report not just by attending and contributing to the meetings but also by information sharing, acting as a conduit between Channel Panel and Alder Hey Services.

Contributions to Local Safeguarding Adult Boards (LSABs) and Local Safeguarding Children's Partnership (LSCPs)

105. The Alder Hey Safeguarding Team continue to work with Designated Professionals to support the work of the LSCPs and LSABs (Liverpool, Sefton, and Knowsley) where appropriate. This has included developing action plans in response to recommendations and findings from Rapid Reviews/Critical Incident Meetings and Local Child Safeguarding Practice Reviews (LCSPRs) and Safeguarding Adult Reviews (SARs), ensuring they are robust and actively address any areas for practice improvement.

106. The Safeguarding Team has a vital role in embedding findings, recommendations and learning in front line practice; and ensuring Alder Hey can evidence impact of intervention. The team also takes a lead role in identifying wider thematic learning and ensuring that these themes inform our planning for workforce development, training, and quality assurance processes.

107. The introduction of the Children and Social Work Act (2017) brought about significant changes for safeguarding children. Local Safeguarding Children Board were abolished, and Local Safeguarding Children Partnerships were created. These changes resulted in NHS Provider Trusts being asked to step back from attendance at various LSCP forums Executives and Sub-Groups.

108. During 2022/23 Alder Hey Safeguarding Team were invited to again participate in LSCPs Sub-Groups and work with Children's Social Care partners in their improvement journeys. This has been a welcome development and has allowed the Trust to better contribute to multi-agency safeguarding work, however it has impacted on the capacity of the Safeguarding Team.

Alder Hey Safeguarding Review by Liverpool Place (CCG)

109. The Director of Community and Mental Health Services made a request for the Safeguarding Service at Liverpool Clinical Commissioning Group (CCG) to conduct a review of safeguarding services at Alder Hey Children's NHS Foundation Trust. The request followed a previous review that had been completed into the provision of services around Children in Care.

110. The review commenced in September 2021 and was originally predicted to finish in December 2021 but eventually concluded in April 2022 due to staff capacity issues. The intention of the Safeguarding review was to elicit how to deliver the safeguarding function at Alder Hey whilst achieving effectiveness and value for money.

111. During 2022/23 new Leadership Team for the service has been working on implementing the recommendations from this review and developed an action plan to address them within the Safeguarding Team.

112. Papers were submitted to the Contract and Quality Review Meeting (CQRM) and SQAC in June 2022 to give an overview of the review and the action plan created to address the recommendations. In addition, the Associate Director for Safeguarding and Statutory Services attended the Alder Hey Children and Young People Forum who had participated in the review to give feedback to the group.

113. Oversight of the action plan has been via the SASSAG meetings.

Successes During 2022/2023

Implementing Safeguarding Safety Huddles

114. In August 2022 the Safeguarding Team introduced twice daily Safeguarding Safety Huddles. The aim of the Safety Huddles is to provide a daily focus across clinical and operational aspects of safeguarding care delivery. Safety Huddles support safe communication and support the team to improve patient safety, flow, and communication.

115. The Safety Huddles include discussion of the following themes:
- Workforce and Staffing
- Updates, Capacity and Flow
- Safety Issues & Daily Checks
- Post-Safety Huddle Actions
- Any issues to escalate to Trust Wide Daily Safety Briefing

Establishment of SASSAG

116. As outlined above in paragraph 27 in October 2022 the SASSAG was established to improve governance and oversight in relation to safeguarding children, young people, and adults.

117. The SASSAG provides safeguarding assurance to the Trust Board via SQAC and has also strengthened openness and transparency with our Commissioners who are invited to attend.

Challenges During 2022/2023

Embedding the New Leadership Team

118. There were several significant changes within the leadership team for Safeguarding and Statutory Services at the start of 2022/23. The Assistant Director for Safeguarding and Clinical Director for Statutory Services left the Trust after 25 years in post. A new Associate Director for Safeguarding and Statutory Services was recruited and commenced in post in May 2022.

119. The Named Nurse for Safeguarding Children, Young People and Adults at Risk also left the Trust in May 2022. A new Named Nurse was appointed and commenced in post in August 2022.

120. In addition, a new Named Nurse for Children in Care commenced in post in March 2022. This was a new role within the Trust.

121. The above significant changes within the leadership of the team meant that the team experienced a lot of change in a short space of time, however this provided an opportunity for a fresh look at the Service. A priority for 2022/2023 was to embed the new leadership team and produce a comprehensive workplan for the Service.

Safeguarding Capacity and Staffing

122. During the last quarter of 2022/23 there were gaps in both the 1st On Call and 2nd on Call (Consultant) medical rotas for Safeguarding. The usual 1 in 7 Safeguarding Consultant Rota was reduced to 1 in 4 due to long term sickness and changed work patterns. The Named Doctor for Safeguarding was also absent from work. Both issues were added to the risk register and risk was successfully mitigated to safely staff the Service.

Safeguarding Priorities for 2023/2024

Review of Safeguarding Level 3 Training

123. During 2023/2024, the Safeguarding Team will review and update the Level 3 safeguarding training to ensure the Trust safeguarding training offer fully complies with the intercollegiate documents. This is likely to require an increase in the face-to-face component of level 3 training.

124. The Safeguarding Team will work with Learning and Development colleagues to develop and present a proposal to the Education Governance Meeting regarding the number of

hours needed. The Team will also review and develop the content of the training to ensure it reflects learning from local and national safeguarding reviews and engages staff.

Creating a Safeguarding Operational Group

125. To build on the improved governance arrangements for safeguarding in respect of the creation of SASSAG, the Safeguarding Team intend to establish a Safeguarding Operational Group (SOG) in 2023/24.

126. Its primary purpose will be to ensure that safeguarding children and adults is a Trust wide priority, involving monitoring compliance with all safeguarding concerns such as training, incident trends, Safeguarding Inspection Reports, Root Cause Analysis, Safeguarding Reviews, allegations against staff and safeguarding activity.

127. The Safeguarding Operational Group will be accountable to the SASSAG and minutes from each meeting will be submitted to SASSAG.

Planning for Transition to Liberty Protection Safeguards

128. The implementation of the new Liberty Protection Safeguards (LPS) continues to remain on hold nationally. Alder Hey Safeguarding Team will continue to plan for the transition to LPS and continue to attend the Cheshire and Mersey LPS Provider Forum.

Safeguarding and Statutory Services Resource Review

129. In 2023/24 the Associate Director for Safeguarding and Statutory Services will work with Named Professionals for Safeguarding to review existing resource within the team with a view to developing business cases if additional resource is required.

Conclusion

130. The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee Trust safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in our care.

131. Work continues to train and develop the Alder Hey workforce to recognise and respond to abuse to safeguarding children, young people, and adults at risk in the Trust's care at the earliest opportunity.

132. There are good safeguarding systems in place across the Trust. However, there continues to be challenges as safeguarding continues to evolve, in both complexity and scope, and with new and emerging risks in respect of contextual safeguarding. As a result, the Trust must ensure that all safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

133. The Safeguarding Team remains committed to ensuring that children, young people, and adults at risk using our services are safe, and that their health needs are met. The

Safeguarding Team will continue to work collaboratively with all Trust colleagues and key partners to continuously improve systems to safeguard.

134. This Safeguarding Annual Report for 2022/2023 has focused on the governance arrangements in place to deliver the safeguarding agenda; and the role that the Safeguarding Team plays in providing assurance, both internally and externally, so that the Trust fulfils its statutory safeguarding responsibilities.

135. Trust Board and the SQAC are asked to note the content of this report and accept assurances that systems and processes are in place to ensure Alder Hey Children's NHS Foundation Trust fulfills its statutory safeguarding responsibilities.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

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

Purpose of Paper	Decision ☐ Assurance ☒ Information ☐ Regulation ☐
Summary / Supporting information	Previous Trust Board papers (2023 & 2024)
Action required	To Approve ☐ To Note ☒
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
132	Gender Service Capacity: There is a risk that clinical and/or contractual responsibility is held by Alder Hey prior to having adequate resource in place to deliver the agreed CYP Gender Service.	16
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	16

1. Purpose of report

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

2. Background

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

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

Following a public consultation, the updated interim service specification has been released, along with the public consultation report. The final service specification is due to be released following the publication of the final report from the Cass Review, which is expected in March 2024.

3. Summary of progress

The Children and Young People's Gender Service (North West) is due to start on the 01 April 2024, and the programme is within the final weeks of preparation. Significant progress has been made to facilitate the commencement of the service, though there remain significant risks to be managed.

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

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

4. Estates

Renovation works have commenced at premises in Warrington, and following a session with children and young people, furniture for the premises has been ordered and interior design selected.

An unexpected issue with fire stopping in the building has resulted in a delay to the renovation works, due to a requirement of utilising a specialist provider for replacement works. Whilst this is not expected to impact the final completion date previously reported of July 2024, there is a requirement for the service to utilise alternative space for the first six weeks of the service being operational. Following a review of potential options, space on existing Alder Hey and Manchester

sites will be utilised whilst the premises are completed. This is not expected to impact the start of the service.

5. Workforce and Recruitment

Whilst workforce for the service has been an ongoing critical risk, recruitment campaigns continue to generate substantial interest from internal and external applicants. All posts will continue to be advertised until workforce establishment has been met, keeping under review any additional incentives or alternative approaches that could be utilised to bolster applicant numbers. The service continues to be on track for 5.8wte of senior clinical staff in place on 01 April 2024, this cohort of staff will be sufficient to provide a safe transfer from the current service and ongoing risk management. The service has recruited 15.3wte staff overall.

6. Open Case Load

The initial transfer of data took place on 21 February 2024. The current service provider confirmed that all eligible children and young people were written to and given a 2-week window in which they could ‘opt out’ of their data being transferred to the Gender Service. The North hub has received files for 105 children and young people, who will now be triaged by either desktop review, or a face-to-face meeting with their current clinician and potentially the child or young person. This will allow the Gender Service to prioritise clinical workload from April 2024. The number of children and young people due to transfer is lower than anticipated and the programme is working with the current service provider to understand the rationale for the reduction.

The current service provider will continue to be responsible for the care of the children and young people until 31 March 2024, at which point on 01 April 2024 clinical responsibility transfers to the new Gender Service providers. As agreed with NHS England, the Gender Service will focus on the safe transfer of children and young people. When clinical capacity permits, unlikely to be before July 2024, children and young people will be placed as appropriate on the new clinical pathway.

7. Finance and Contracting

There are no current financial risks within the programme to raise, expenditure remains on track.

The North and South hubs have sent the contractual letter to NHS England as updated in February 2024. There is a risk that there remains no written agreement around contractual expectations for the service commencement. Linked to the contract, NHS England have been unable to identify key data collection points for hubs to incorporate into EPR builds. Within the contractual letter, hubs have been clear that there may be a delay to data requests due to this.

8. Regulation

Alder Hey has commenced required processes with CQC to ensure that the premises in Warrington are sufficiently registered. The programme is awaiting further insight from NHS England around national engagement with CQC.

9. Recommendations

It is recommended that Trust Board note the programme is within the final stage of preparation ahead of service commencement. Implementation is in line with the national interim service specification, the programme will continue to mitigate noted risks and challenges. The

0115
programme will provide an update to Trust Board in April 2024, following service commencement.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	Learning from Patient Safety Incidents 1st-29th February 2024
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	All NHS Trusts were contractually required to transition to the Patient Safety Incident Response Framework (PSIRF) prior to end of Q4 2023-24. PSIRF replaces the current Serious Incident Framework, and the Trust transitioned on the 1st of January 2024. The purpose of this report is to provide the Trust Board with a summary of activity and patient safety learning following the transition to PSIRF and next steps, noting that this is an iterative process as we continue our journey of transition and embedding of PSIRF.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	

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

		applied and effective in practice				

1. Purpose

The purpose of this paper is to provide the Trust Board with a summary of activity following the transition to Patient Safety Incident Response Framework (PSIRF), including oversight of those incidents that have been reviewed in line with the Trusts and Patient Safety Incident Response Plan (PSRIP), highlighting any identified areas of patient safety learning and improvement for the reporting timeframe 1st – 29th February 2024.

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

2. Background

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

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

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

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

3. Local context

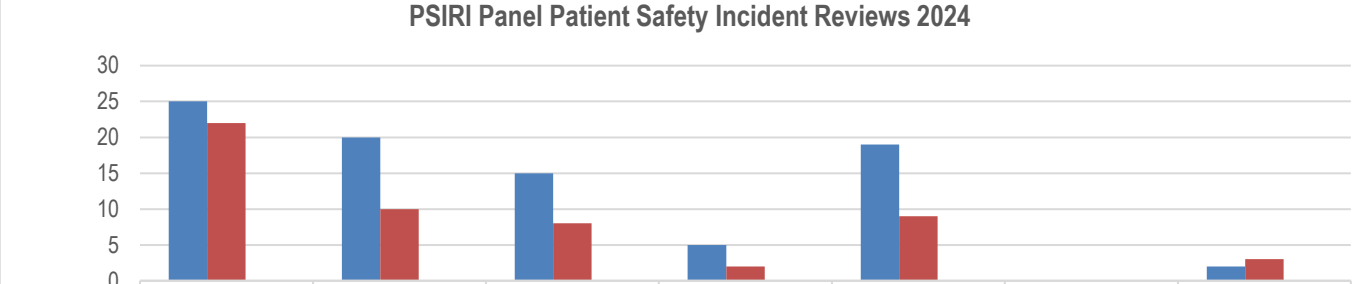
PSIRF replaces the methodology of root cause analysis with a systems-based patient safety incident investigation (PSII) approach or more locally a Patient Safety Response (PSR).

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

3.1 Patient Safety Incidents.

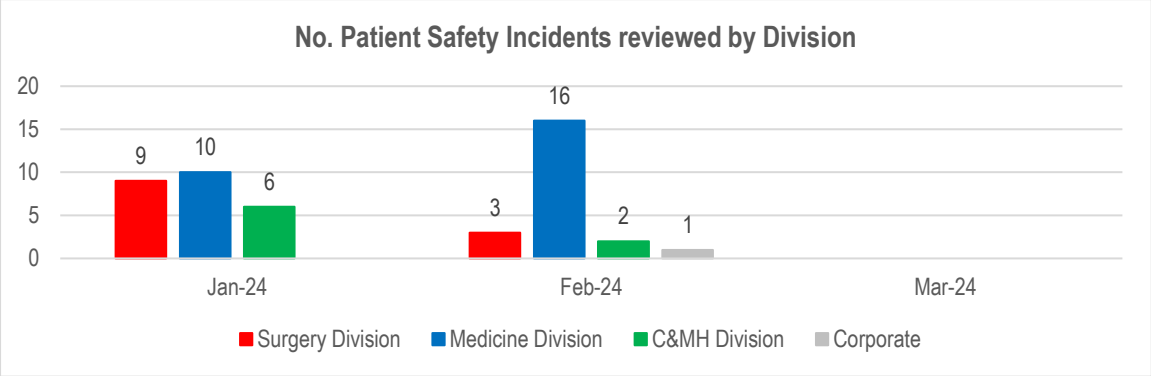
Table 1 below notes the number of patient safety incidents reviewed at PSIRI panel throughout February 2024. Table 2 notes the number of patient safety incidents presented and reviewed by division.

Table 1



	Total No Pt Safety incidents reviewed	No.Incidents initally reported as moderate harm and above	No. physical moderate harm and above reported	No. psychological moderate harm and above reported	No. moderate and above harms downgraded	No. moderate harms progressed to PSIIs	No. incidents progressed to PSR
Jan-24	25	20	15	5	19	0	2
Feb-24	22	10	8	2	9	0	3
Mar-24							

Table 2



A total of 22 incidents were reviewed at the weekly PSIRI panel during the reporting period 1st -29th February 2024, of which 10 incidents had been initially reported as either moderate and above physical or psychological harm. The remaining 12 had been presented by divisional leads for discussion or potential learning purposes.

Following discussion and review of the reported incidents presented a collective decision was made by PSIRI panel and divisional leads to downgrade the initial reported moderate harm levels for 9 incidents based on incident findings and use of the NHS England harm grading table (Appendix 1).

3.2 Patient Safety Incident Investigations (PSIIs)

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

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

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

3.3 Patient Safety Responses (PSRs)

3 PSRs were commissioned in February 24 to investigate the reported incidents as outlined below:

3.3.1 PSR 1

- # 7544 Moderate physical harm (Surgery Division) – *Child with developmental delay and autism presented with abdominal pain and fever. A request for surgical clinical opinion (ANP) was rejected due to lack of blood results not in keeping with abdominal pain pathway despite explanations that this was not possible in this case. An ultrasound scan was performed which could not visualise appendix but did note some pelvic fluid and ovarian changes. The patient was discharged with safety net advice.*

- *The patient reattended on 04/02/24 with ongoing abdominal pain and clinical evidence of peritonism. Taken directly to theatre following CT scan.*

PSIRI panel discussion: SBAR findings presented and discussed. Child returned to ED with peritonitis resulting in emergency surgery and removal of ovary. Ultrasound scan not reviewed by surgeon prior to discharge from ED with safety netting. Following emergency surgery child had 1 week in patient stay in ICU.

Learning noted: Abdominal pain pathway not followed in ED. Lack of communication between ED/Surgeons. Unsure if ultrasound scan had been reviewed by surgeon in ED if admission would have been sooner and ovary saved.

PSIRI panel decision: Moderate harm to remain. Duty of Candour applies. MDT learning response to be completed with feedback of learning and areas for improvement in 3 months. Family liaison officer (FLO) appointed to liaise with the family and involvement them in the learning process.

3.3.2 PSR 2

- # 5492 No physical harm (Surgery Division) - *Neuroblastoma resection undertaken on 7/7/23. Request for ovarian harvest on consent form but no laterally noted. Ovarian harvest took place 11/8/23, right ovary taken. Potential that incorrect ovary was harvested.*

PSIRI panel discussion: Incident had been reviewed at the time of reporting by the oncology and surgical MDT and reported as no harm. However, following discussion with oncologist in January 24 the parents queried and subsequently formally complained that they had been given incorrect information regarding the ovary retrieval i.e., left ovary, not right ovary was to be harvested.

SBAR presented by the oncology consultant and surgery division for further discussion. Based on clinical presentation following radiotherapy and MDT discussion it was felt that the correct ovary had been harvested.

Learning noted: Lack of robust process for following the national specification for oncology/surgery MDT attendance and documentation; lack of laterality on consent form with this clinical pathway; limited written documentation for ovarian harvest pathway and lack of communication between clinical teams.

PSIRI panel decision: MDT learning response to be undertaken jointly between surgery and medicine division with a focus: MDT attendance, recording of laterality on consent form, review of pathway with John Radcliffe Hospitals Oxford (research centre for ovarian harvest) and improved communication between clinical teams. Feedback of learning and areas for improvement in 3 months. FLO appointed to liaise with the family and involvement them in the learning process.

3.3.2 PSR 3

Cluster of no harm incidents (Medicine Division) - *7 reported incidents related to supply of liquid antimicrobial medicines out of hours from the Urgent Care Centre at AlderHey managed by Go2Doc on behalf of the Trust via SLA.*

PSIRI panel discussion: SBAR presented and no evidence that any patient had come to harm. Further issues identified lack of recording of consultations and medication prescribing, potential inappropriate prescribing, and reconstitution of antimicrobials.

Learning noted: Competencies and guidelines in relation to prescribing, documentation and supply of medicines are not robust. No monitoring and oversight of SLA. Ongoing audit of prescriptions dispensed compared with clinical indication on discharge letter.

PSIRI panel decision: MDT learning response to be undertaken jointly between Medicine and Go2Doc representatives to explore current SLA requirements and ongoing monitoring. Review and audit of UTC service in line with SLA to be undertaken. Risk to be added to risk register. MDT learning response to be completed with feedback of learning and areas for improvement within 3 months.

4. Duty of Candour

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

1 Duty of Candour response was required during the reporting period.

5. Learning from patient safety incidents

5.1 System learning

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

Table 3

Brief incident description	PSIRI Panel findings /Learning	PSIRI Panel Recommendations
Medicine Division		
#s 7756, 7755, 7744 Patient attended ED in sickle cell crisis. Delay in administration of analgesia	Poor patient experience. MDT involved in patients care was uncoordinated. Lack of coordination between pain team, bed management and patient flow resulting in delay in administration of analgesia. Planned huddle between relevant professionals to allow for clear decision making. Haematology nurses to add all care plans on Expanse under general management plan section to allow for easy access for ED staff	Incident review to be shared as part of the Sickle Cell peer review taking place Feb 24. Seek feedback from child and parent on experience Voice of CYP/Parent to be added to SBAR template
Community & Mental Health Division		
#7388 Patient admitted to Sunflower House T4 CAMHS with escalating self-harm tendencies	Wider review of ligature Policy needed as any suspension ligature would normally result in ED attendance, medical assessment and X-ray of neck and spine. This pathway currently not in place at Trust for in patient suspension ligatures	Review of ligature pathway and policy via suicide prevention group and feedback into panel once completed.

5.2 PSIRI panel follow up.

1 PSR was commissioned in January 24 to investigate the reported incident and share associated learning as outlined below in table 4:

Table 4

Brief incident description	Learning noted
Surgery Division	
# 6771 moderate physical harm *Gastro clinic review due to take place end of October but delayed by 4 months due to backlog of follow up appointments*) had not been reviewed by the clinical team.	Feedback noted that incident initially thought to be a delay in referral, but on review the letter had been dictated and sent to the Surgeon. No learning noted from the incident and incident downgraded to no harm.

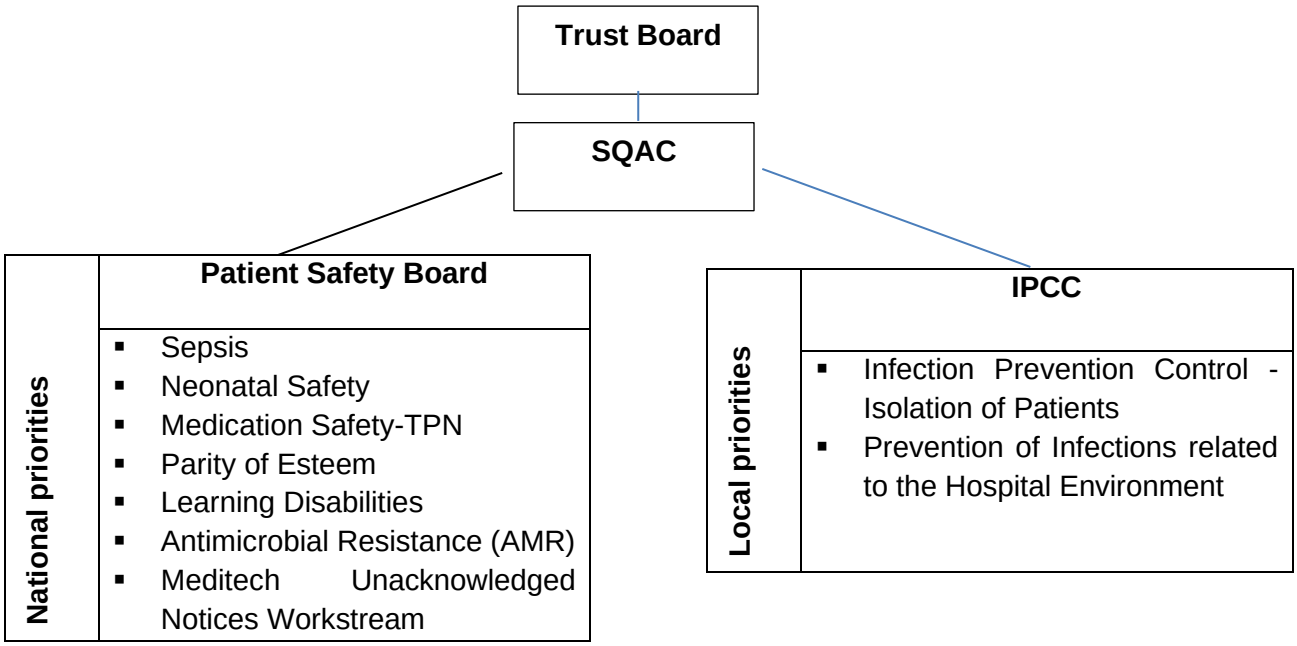
5.2 Quality Improvement (QI)

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

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

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

Figure 1



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

6. Training and Education

6.1 Patient Safety E-Learning

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

E-Learning Modules	%Compliance
Level 1a Essentials for Patient Safety (All staff)	**97%**
Level 1b: Essentials of patient safety for boards and senior leadership teams	**100%**

7.Legacy Serious Incidents (SIs)

All legacy SI investigations have now concluded, the findings of which will be presented at SQAC in March 24 . Please refer to appendices 2-4 for full details.

8. Next Steps

As we continue to adopt this new way of managing our patient safety incidents and learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to.

Areas of focus include the following:

- **Patient Safety Investigators:** Business case for 2 Patient safety investigators approved. Recruitment pending

- **Bespoke Training:** Bespoke training for all staff involved in undertaking learning responses and acting in Family Liaison roles (FLOs) is being sought and procured in line with the NHSE national procurement training framework.

- **Learning Response Templates:** Ongoing review and updates of our learning response templates continues. Section added to capture the voice of the child/young person and parents/family involved in the incident and/or learning review.

- **Psychological harm:** Associate Director of Organisational Development/Clinical Psychologist to explore with staff their understanding and rationale for reporting of psychological harm.

8. Recommendations

The Trust Board is asked to note the activity undertaken following the Trusts transition to PSIRF, the patient safety learning noted to date, and the level of assurance provided in Learning from Patient Safety Incidents report under the new PSIRF framework.

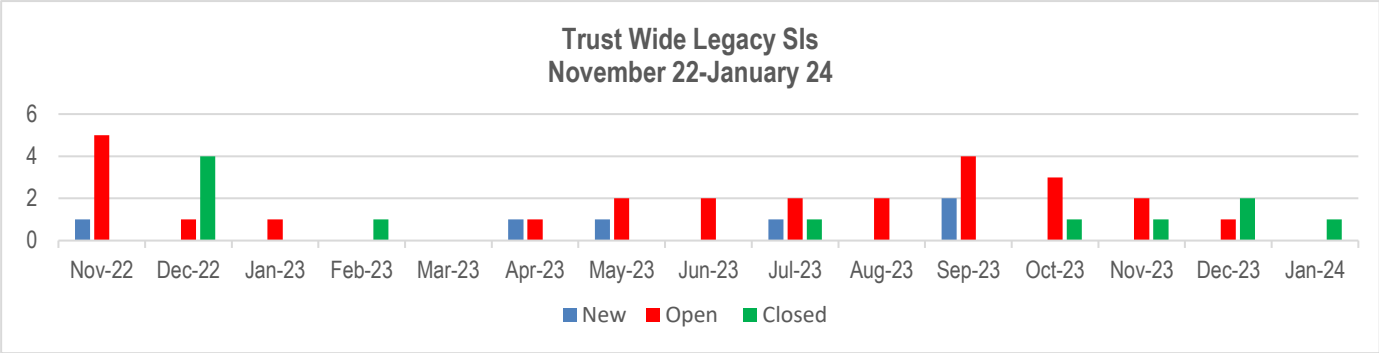
Appendix 1 Harm Grading Guidance for Clinical Incident Reporting

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

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

Appendix 2 Legacy Serious Incidents (SIs)

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



Legacy SI reports

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

Immediate lessons learnt are outlined where applicable in appendix 3.

Legacy SI action plans: During the reporting period (1st-29th February 2024) **4** SI action plans remain open and within their expected date of completion. Full details of the SI action plan position can be found at appendix 4.

Appendix 3

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2023/1862 **InPhase ID - 4287**	1 year 9 months female admitted for elective craniofacial surgery 29/09/2023. Cardiac arrest on ward post-operatively, transferred to PICU. Patient sadly died 02/10/2023.	SUDIC protocol not triggered, safeguarding team since aware, social work referral made and discussion took place with Merseyside Police 04.10.23, log number 406041023. Airvo implemented but plan of care not documented. Inconsistency in completion and documentation of observations.	Planned debrief with medical and nursing staff completed. Joint morbidity and mortality meeting to be coordinated between medical teams caring for the patient. **February 2024:** RCA investigation completed sent to commissioners 18/1/24.Report shared with parents. RCA to be presented at North Mersey SI Panel 28/02/2024. Weekly oversight meeting established with Executives to monitor action plan.Wider learning review to be undertaken
2023/1771	Wrong implant / prosthesis used.	Request form needs to be visible to all staff (needs to be uploaded to EPR and printed as part of the preop paperwork). The Lines List Calendar should be more widely visible. Code/description for listing post and CVL on Meditech v6 were the same. On Expanse the procedures have their own descriptions on the ambulatory order. This process changed the Monday preceding the operation. Need separate E-consent form for tunnelled CVL/port/haemodialysis line. Better system for Line Requests necessary – Should be on Expanse with Ambulatory Order to allow for end-to-end audit of process.	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. **February 2024:** RCA investigation completed and sent to commissioners 18/12/2023. RCA to be presented at North Mersey SI Panel 28/02/2024. Action plan monitoring ongoing and action plan is on track for completion.

		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.	

Appendix 4

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Number of extensions
2022/10739	23/05/2023	31/05/2023	Medicine	Delayed diagnosis of bone malignancy	17 16 actions completed.	31/12/2023	29/02/2024	1
2023/12980	02/07/2023	05/07/2023	Surgery	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	10 5 actions completed.	31/01/2024	22/03/2024 – TBC with ICB	1
2023/17791	15/09/2023	21/09/2023	Surgery	Never Event – Wrong implant / prosthesis used.	9 1 action completed.	01/05/2024		0
2023/18692	29/09/2023		Surgery	Death of a patient on PICU 02/10/2023 – Elective craniofacial surgery 29/09/2023. Cardiac arrest on ward 4A post-operatively, transferred to PICU. Cardiac arrest secondary to tension pneumothorax.	11 4 actions completed. NB action plan under review	29/02/2024		0

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	Martha's Rule Update
Report of:	Nathan Askew, Chief Nursing Officer Alfie Bass, Chief Medical Officer
Paper Prepared by:	Nathan Askew.

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides an overview of the implementation plan of Martha's Rule. Significant progress has been made and will continue to be monitored through the working group. The key risks to delivery are outlined in the paper. A pilot of the response is planned for April and the Trust intend to submit an expression of interest to be one of the first 100 trusts nationally to implement the full requirements of Martha's Rule.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	

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

1. Purpose

The purpose of this paper is to review our compliance with the recommendations from Martha's Rule and to update the board on progress against implementation.

It is proposed that: -

- **The implemented Martha's Rule, be connected through the 2030 Vision (Experience Management) and Patient Safety**. The connection with the strategy will directly align with our emerging CYPF Promises and our concern raising channels; both of which are in development
- **Culture Barometer**: Ensuring that we use the 'triggering' of a response also as an indicator to explore the culture and behaviours of the team (as the Martha's case also details deep behavioural norms, that impact on a safety culture).

A task and finish group has been working on the development of approach and implementation, this is the first update to the board on the work of the group to date.

2. Background

Martha Mills died aged 13 in the summer of 2021 after sustaining a pancreatic injury from an everyday bike accident while on holiday with her family. The inquest into her death heard that she would likely have survived the sepsis that killed her had consultants made a decision to move her to intensive care sooner. Martha's family have worked with Demos and explored the breadth of international evidence and as a result outlined a set of recommendations for adoption throughout the NHS Marthas-Rule_finalversion.pdf (demos.co.uk).

Martha's Rule has generated a significant amount of media exposure and the Government has backed the intentions to roll out across the NHS.

Government backs Martha's rule on right to second medical opinion in England | Health | The Guardian

Purpose of Martha's Rule

Martha's rule is primary aim is to create new ways for patients and their families to trigger an urgent clinical review from a different team, if they are in hospital, are deteriorating rapidly and feel they are not getting the care that they need.

In October 2023 the Secretary of State agreed to implement the three recommendations below:

- We must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least on a daily basis. In the first instance this will cover all in-patients in acute and specialist Trusts.
- All staff in those Trusts must have 24/7 access to a rapid review from a critical care outreach team who they can contact should they have concerns about a patient.
- All patients, their families, carers and advocates must also have access to the same 24/7 rapid review from a critical care outreach team which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient's condition. **This is Martha's Rule.**

In February 2024 NHS England announced it would be seeking expressions of interest from 100 acute providers to launch Martha's Rule. Alder Hey intends to complete an expression of interest to be part of this first wave to formally adopt the process.

Benefits

Beyond the immediate safety benefits, the wider benefits could also include building, enhanced relationships with our families and capturing wider experience concerns / good practice.

3. Current State

The working group undertook an analysis of our readiness against the three recommendations and concluded that we are currently not compliant. There was a consensus from the subject matter expert group that we should not wait for the formal requirements from NHS England and should instead progress for enhancing our 'systems of control in line' with the recommendations. It was also noted that there is a breadth of knowledge from other organisations, including Royal Berkshire Hospital but we would need to adapt any approach to our own organisation. The group made a commitment to ensure that CYPF engagement should underpin the design and development approach.

A rage of workstreams were initiated and the project group chaired by the Chief Nurse meet monthly to review progress. A full project plan and DMO support underpins the program along with EQIA. The programme has 3 overarching parts:

1. How you raise a concern (related to Experience and Involvement).
2. Response to a concern (Patient Safety)
3. Monitoring and understanding of 'culture and behaviours' post trigger (Patient safety / Clinical Leadership)

4. Summary of progress to date

a. How to raise a concern

<u>Call for concern</u>

We have been exploring the use of What'sApp as a mechanism for families with an inpatient. Unfortunately, the recommended supplier through META was not EU based and would not therefore be compliant with GDPR, this inevitably created a delay. An alternative UK based supplier has been identified who meets procurement standards.

We are completing the final due diligence and hope to be able to test during March 2024. With a roll out in April 2024 – subject to the effective testing. A QIA/EIA is in preparation. This won't be the only method to request a Matha's Rule review, recognising that some families /carers may not have a smart phone.

What's app will allow for filtering question through a chat bot which will assist the Response Team in prioritisation and will differentiate between clinical concerns and families who are raising pals or complaints concerns whilst an inpatient. This will allow the early intervention and de-scalation of clinical and experience concerns by the Trust Response Team.

<u>National PEWS</u>

In January 2024 NHS England launched the new national PEWS with a standardised scoring system and response pathway across England. This is to be implemented in all acute providers throughout 2024-25.

The Alder Hey system will be required to be updated to reflect the national PEWS and offers additional benefits to address the needs of Martha's Rule and systemic learning from patient safety incidents.

The current DETECT system requires user input for observations, the working group are currently exploring the automation of this process through device integration, automated messaging and escalation, this would be the ideal system for alerting and responding to patient deterioration which is not fully available as an end-to-end service in the current system.

In addition with each set of observation the 'nurse concern' and 'family concern' trigger will be mandated, which will increase the recording, and response to, concerns form bedside staff and family members. This will meet the requirements 1 and 3 of Martha's Rule.

Once the technical side of this work is complete the trust will utilise the national e-learning as part of the roll out plan.

b) Response to a concern

The response team will fulfil the role of the initial assessment and triage of both experience and clinical concerns raised by families or bedside staff. This is a fundamental aspect of their role and will fulfil the requirement of Martha's rule.

A draft escalation framework has been produced. Further consultation with clinical colleagues is required as there are still some gaps in agreement of the independent clinical review and how this process will work throughout the 24-hour period.

At present the response team are in place and do have access to, and authority to, contact relevant clinicians to review deteriorating patients. Their interventions, such as ordering urgent diagnostic x-rays, are being expanded through training and development with the team.

c) Monitoring and understanding our culture and behaviours post concern

It's now possible to record a Martha's Rule – review incident in InPhase and a post incident review template 'SBAR' has been developed to ensure key learning and themes can be captured. This will enable ongoing analysis of any concerns raised and will ensure tracking of themes and trends. Over time this will enable learning and targeted work in relation to where issues arise.

Experience concerns will also be monitored through InPhase, and additional support offered to wards or individuals where disagreements frequently arise. This should have a positive impact on families who raise concerns out of hours with a more immediate response, leading to a more supportive approach when families are concerned.

5. Risks to delivery

- Assurance regarding GDPR compliance of whats app required
- Capability of the digital solution to meet the end-to-end requirements for implantation
- Agreement on routes of escalation throughout the 24-hour period.

6. Recommendations

The Trust Board is asked to note the contents of this report and to advise on a time frame for future updates.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	Infection prevention & control quarterly report Quarter 3, Oct –Dec 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:	IPC service continues to struggle to perform as a data-driven programme due to the absence of an electronic surveillance system.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
	See risks noted in Appendix 1 of the paper					
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 Q3 period (1st Oct-31st Dec 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 Q3, IPC committee received reports from the following subgroups.

2.1 Clinical Advisory Group: On 23.11.23, CAG welcomed Prof. Rachel Isba, consultant in Public Health, who gave an updated on the unmeet vaccination need in children in the North West. Discussion centered around her experience setting up vaccination clinics in the Emergency Department and promoting vaccine education among healthcare providers. *Action:* submission to NHSE of a proposal to develop a vaccination service at Alder Hey.

2.2 IPC Champions Group: On 28.11.23, discussion centred around increase in RSV cases across the Trust and the recent measles rise in the UK. The group identified challenges in accessing fit testing, particularly due to night shifts work pattern and difficulties releasing staff to be fit tested due to the acuity of patients on wards. *Action:* IPC recommended to the fit testing team to held twilight fit testing sessions to capture more staff.

2.3 Antimicrobial Resistance Steering Group: On 12.10.23, discussion centred around the appropriate use respiratory viral testing in the ED and EDU. *Action:* A flowchart diagram was devised to aid staff in the appropriate use of rapid respiratory viral test (Biofire filmarray®). On 09.11.23, discussion centred around the new Allergy De-labelling Service. DR. C Parry and AMS nurses have identified a higher than anticipated number of patients out-of-area as well as the need for a more automated way of referring patients. *Action:* Expand referral process to all pharmacists. *Action:* IPC programme coordinator is now providing project support and close collaborating with Patient Safety programme manager.

2.4 Hand Hygiene Improvement Group: On 23.01.24, a meeting was held with Innovation to discuss automatic Hand Hygiene audit methods to effectively change behavior through hand hygiene audits. *Action*: current hand hygiene audit results (by direct observation) are reported back to teams immediately (rather than monthly in IPC dashboards).

2.5 Environmental Cleanliness Group: On 28.11.23, discussion centred around Hospital Cleaning policy RM49. Responses identified issues around frequency of cleanliness audits. *Action:* Cleanliness Forum was set up to establish cleanliness audit frequency. Hospital Cleaning policy RM49 was approved on 15.11.23 IPCC and a comprehensive list of SOPs for cleaning reusable medical equipment is being developed by the decontamination and medical engineering teams.

2.7 High Consequences Infection Diseases (HCID Steering Group): On 26.10.23 the group has its inaugural meeting with approval of its term of references. Building works and training/simulation schedule planned for the Trust to became and independent airborne HCID center were shared with the group.

2.8 Sharp Safety Group: no meetings held in Q3 as there are still ongoing discussions with Health & Safety appropriate leadership for this operational group.

3. Infection Prevention & Control Metrics

3.1 Bacteraemia Surveillance

3.1.1 Healthcare-associated Gram-negative Bloodstream Infections

A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA is shown below in Table-1. During Q3, 4 patients had healthcare -associated Gram-negative blood stream infections (3 has *Pseudomonas* and 1 had *Klebsiella*). Out of the 4 patients, 2 were oncology patients, 1 was in ICU and 1 had intestinal insufficiency.

The post-infection reviews (PIR) of these cases identified previous antibiotic exposure, critical illness and significant patient comorbidities as predisposing factors, which are well known high-risk factors for Gram-negative blood stream infections.
All of these patients had central vascular catheters in place when they develop bacteraemia so the workplan to reduce Central Line Related Line Infections (CLABSI) across the Trust has continued during Q3, with a closer collaboration between IPC and the Microbiology laboratory to include in our PIR all significant blood stream infections (not just those subject to mandatory UKHSA reporting such as *E. coli, Pseudomonas* or *Klebsiella*) to engage with all stakeholders in the development of the CALBSI steering group.

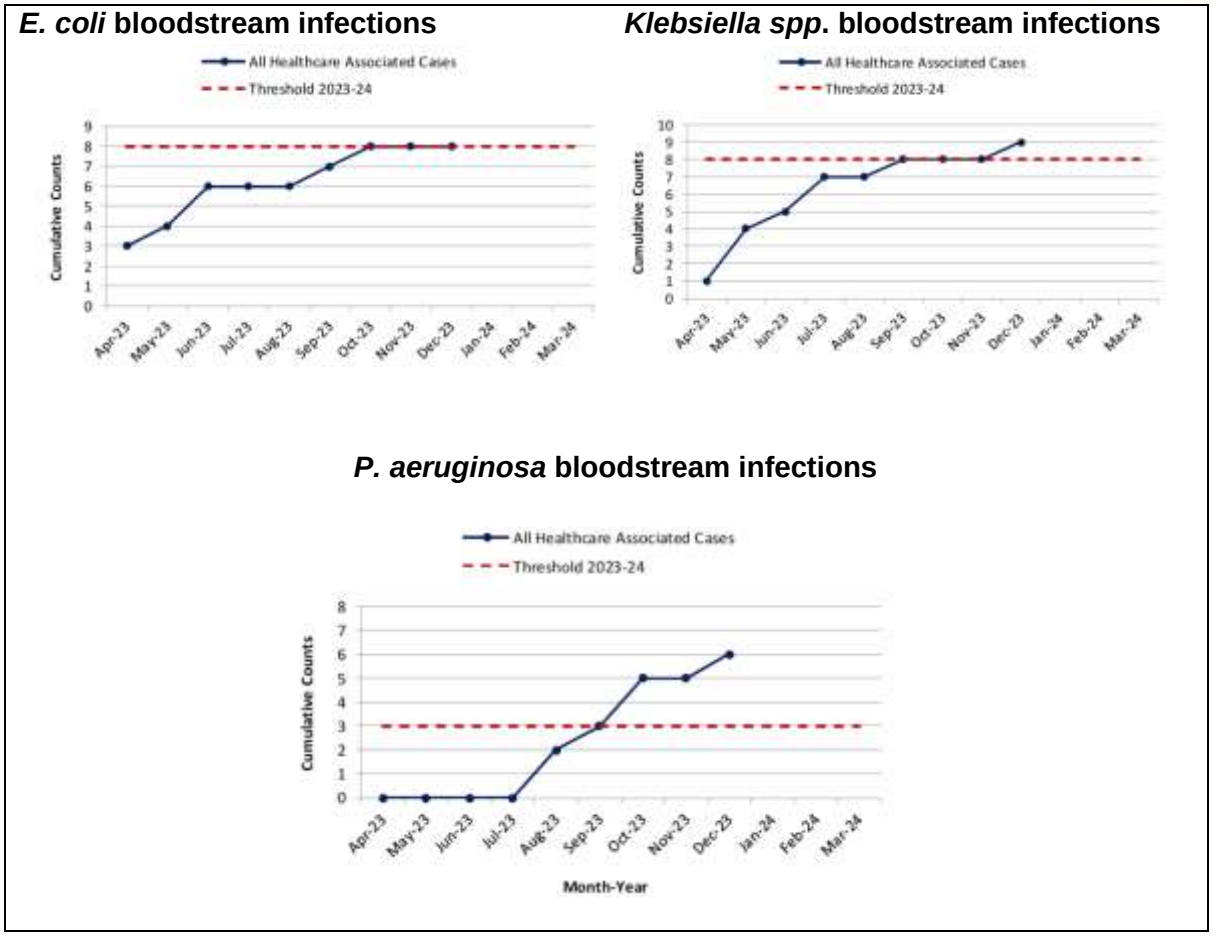
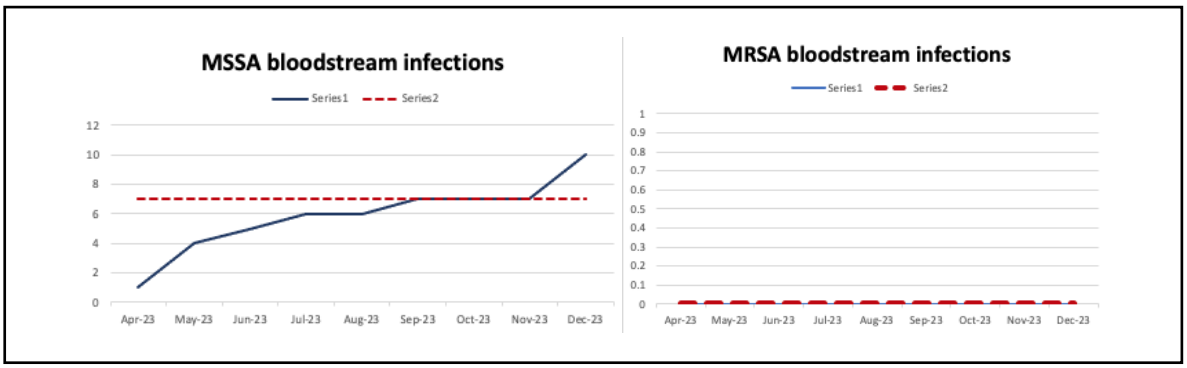


Table-1: UKHSA HAIs monthly tables for Gram-negative bloodstream infections.

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 Healthcare-associated *Staphylococcus aureus* bloodstream infections

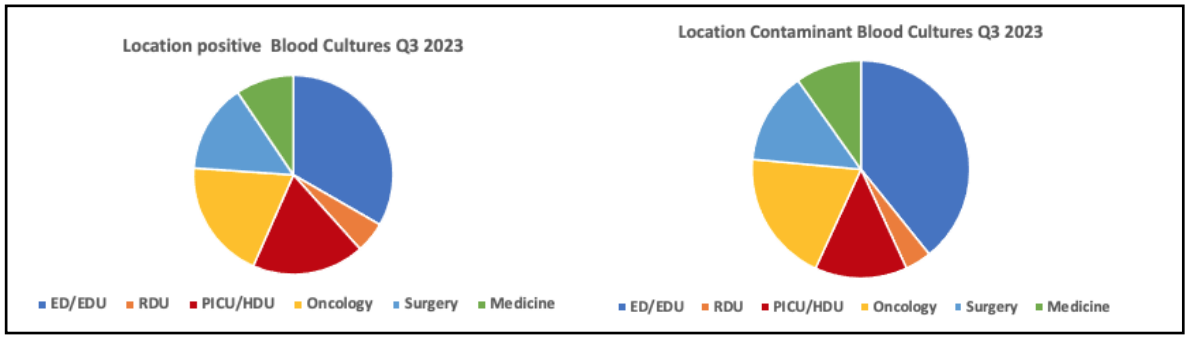


During Q3, 3 patients had healthcare associated MSSA blood stream infections: 1 was admitted in the cardiac ward, 1 in the neurosurgical ward and 1 in oncology. The PIR in the latter case did not identify any lapse in care.

3.1.3 Review of all bloodstream infections across the Trust

To develop a common CLABSI prevention bundle across the Trust, IPC has started reviewing all significant blood stream infections cases across the Trust (not just those subject to UKHSA mandatory surveillance). During this review we have identified that:

- A significant proportion of our positive blood culture results are due to skin contamination (64%). Out of the blood culture results that represents "true infections" the majority (78%) are obtained from central vascular catheters (*i.e.,* CLABSIs). This happens all across the Trust as the departments were most blood cultures are obtained, mirrors the distribution of blood cultures contamination.



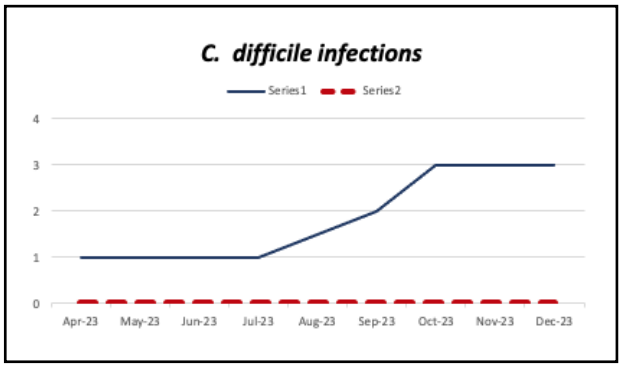
RDU: Renal Dialysis Unit.

Action: the rate of blood culture contamination will be reported to each ward as a proxy of good ANTT practices and hand hygiene. Reducing the rates of skin contamination has been associated in research studies with overall better care of central line catheters which directly impacts CALSBI rates.

- The majority of the CLABSIs cases (N=43) occurred in the Trust in Q3 were due to other pathogens than *E. coli, klebsiella, Pseudomonas* or MSSA. For example, 4 patients had *Enterococcus*, 4 patients had *Enterobacter* and 3 patients had *Candida*.

  Action: PIR are now conducted for all significant blood stream infections to engage with all stakeholders to agree on a CLABSI preventive bundle across the Trust.

3.1.4 *C. difficile* Infection



3.2 Healthcare acquired viral infections.

3.2.1 Respiratory viral infections

During Q3, out of the 1437 positive respiratory viral tests analyzed in the microbiology laboratory, 225 (16%) were obtained on patients admitted for longer than 3 days (*i.e.*, viral healthcare acquired infection).

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.

3.2.2 Gastrointestinal viral infections

During Q3, a Norovirus outbreak occurred in 4B ward with 3 patients and 11 staff members affected. Daily meetings were held between clinical team, domestics, patient flow, and IPC to ensure appropriate measures were put in place.

3.3 Other Notable Infections

3.3.1 Group A *Streptococcus*

No case of healthcare associated Group A *Streptococcus* was identified during Q3 23/24.

3.3.2 Measles

No positive measles cases reported during Q2 23/24.

4. Infection Prevention & Control Associated Risks

See Appendix 1 at the end of report.

5. Discussion and next steps

During Q3, the Infection Prevention & Control team has increased its visibility across the Trust with daily isolation rounds and monthly steering group meetings to advance the core competences of IPC across the Trust and ensure a multidisciplinary engagement with IPC interventions. This has been achieved despite significant staff abscesses within the team.

IPC Committee governance of has been strengthened with oversight and approval of updated IPC policies and relevant workplans for the operational groups reporting into IPC Committee. The DIPC attends the monthly subdivision IPC committees, which now also reports to IPC Committee.

The IPC department actively participated in the External Strategic Review conducted by Prof Holmes and Dr Jon Otter and have continued to incorporate the recommendations made in the feedback session to become a center of excellence in the prevention of healthcare acquired infections and antimicrobial resistance in children and young people.

6. Recommendations

The Trust Board is asked to note the content of this report, the actions being taken to ensure the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice and note that the IPC service continues to struggle to perform as a data-driven programme due to the lack of implementation of an electronic surveillance system and significant rates of staff absences.

Alder Hey Children's NHS
NHS Foundation Trust

Appendix 1: Infection Prevention & Control associated Risks

Risk Number Inphase ID	Ulysses ID	Risk Description	Initial Risk score	Target risk score	Risk score Q3 23/24	Risk movement	Mitigations in place Q1
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 who is booked on the accreditation course in March 2024. Additional night / weekend sessions held to increase compliance.
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	⟷	Cleaning Policy awaiting final ratification at SQAC. Screens on 4C to replace bay privacy curtains agreed by Kwikscreen – final feedback due in early Q4. Business case continues to be prepared for presentation.
00002714	2748	IPC Policies are not up to date and not reflective of current IPC practice	9	4	6	↓	Significant number of outstanding policies ratified at Dec 23 SQAC and submitted for ratification at Jan 24 SQAC. Recovery plan remains in place and on track.
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 and Director of Finance to discuss ICNET solution.
00002710	2744	Non delivery of IPC standards due to insufficient IPC staffing levels	12	6	9	↓	Score reduced in October 2023 under close scrutiny as Lead Nurse started

							period of long-term absence in November 2023. Clinical oversight of remaining staff and processes by DIPC ensures safe service. Prioritisation of work and streamlining of processes by DIPC and DD of AHPs.
00002682	2716	Confidential information could be accessed and used inappropriately – patient letters stored on the K drive and not in medisec	12	3	3	CLOSED	All letters in secure location and required 3 months post migration prior to deletion of letters from the K drive has taken place. All actions completed and risks mitigated. Risk closed in December 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 21st February 2024, along with the approved minutes from the 17th January 2024 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

0144 **1. Executive Summary**

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

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

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

- SQAC received an update on Sepsis training and noted the good ongoing discussions which had taken place to address this issue. SQAC noted the importance of all the divisions continuing to pursue improved compliance levels. SQAC gained a clearer understanding of the data and noted the ongoing process to ensure that all staff mandatory training requirements are correct.
- SQAC received a positive Patient Safety Strategy update, and noted the first workstream closure report which was welcomed by SQAC.
- SQAC received the ED monthly report and noted the improved report which enabled SQAC to have a good understanding of challenges and progress in those areas. SQAC expressed thanks to colleagues for the improved data reporting, whilst noting the potential to further enhance future reports.
- SQAC received the Safeguarding Quarterly Report (1st October 2023-31st December 2023). This included a detailed update on the investment into Safeguarding and the improved capacity of the Safeguarding team. SQAC noted the challenges in relation to the recruitment for the Safeguarding named nurse and the Safeguarding named doctor, with assurance received that colleagues are aware of the issues and are working hard to address.
- SQAC received the 2022-23 Safeguarding Children and Adults at Risk Annual Report
- SQAC received the NatSSIPs report, noted its contents, and considered where this activity will sit within the new architecture. (In future this will be within the patient safety programmes, reporting in to SQAC through that route).
- SQAC received the Safe Waiting List report and noted the extremely good progress made against the original piece of work. SQAC were supportive of the Safe Waiting List management becoming business as usual, and agreed to cease receiving the quarterly Safe Waiting list update to SQAC. SQAC agreed that for awareness that they would receive an evaluation of the follow up work in six months.
- SQAC received the Board Assurance Framework, with discussion held regarding the experience risk and understanding the intersection of the different risks and the various parts of BAF, and how colleagues fully understand and manage the intersections.
- SQAC were delighted to receive the Children & Young People Engagement Leads report which detailed positive action.
- SQAC received the Clinical Effectiveness & Outcomes Group – Chair's Highlight Report.
- SQAC received the Divisional updates and a deep dive review of ED Mental Health Presentations, including referrals to crisis care with a postcode analysis of end users and what the Divisions are doing to address. SQAC also received a Deep dive on the impact of PAU.

0145
- SQAC received the Clinical Ethics Committee Annual Report. SQAC expressed thanks to JR for her great work to embed and activate the new clinical ethics framework for the benefit of patients and staff.
- SQAC received Quarter 3 2023/24 Complaints, PALS & Compliments Report
- SQAC received a Deep dive of complaints themes over the last 5 years
- SQAC received the Patient and Family Feedback Quarterly Report
- SQAC received the Patient Experience Framework and EDS2022

Good discussion was held during SQAC meeting, with strong assurance evident from right across the organisation that teams are extremely focused on quality and safety.

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 17th January 2024
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)
	Bea Larru	Director, Infection Prevention & Control	(BL)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RH)
	Jacqui Pointon	Associate Chief Nurse–Community & Mental Health Division	(JP)
	Laura Rad	Head of Nursing-Research	(LR)
	Jo Revill	Non-Executive Director	(JRe)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Paul Sanderson	Interim Chief Pharmacist	(PS)
	Melissa Swindell	Chief People Office	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)
In Attendance:			
23/24/173	Will Weston	Medical Services Director	(WW)
23/24/175	David Porter	Consultant Infection & Immunology, Infectious Diseases	(DP)
	Peter White	Chief Nursing Information Officer	(PW)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Natalie Palin	Director of Transformation and Change	(NP)
	Jill Preece	Governance Manager	(JPr)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)
Apologies:	Pauline Brown	Director of Nursing	(PB)

23/24/169 Welcome and Apologies

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

23/24/170 Declarations of Interest

None

23/24/171 Minutes of the Previous Meeting

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

23/24/172 Matters Arising & Action log

Quality Assurance Rounds update

JR advised that a Revised Quality Assurance Round position statement is due to be presented at the Executive Team meeting on 18.1.24, the position statement proposes a hybrid Quality Assurance model commencing from April 2024 which would be a mixture of face to face Quality Assurance Round Visits and some Quality Assurance Rounds visits held by microsoft teams. Room 20 in the Institute in the Park had been secured for face to face Quality Assurance Round visits for Thursday afternoon following Trust Board to enable Executive colleagues and Non Executives to hopefully transition from Trust Board to the Quality Assurance Round. There would be a pre Quality Assurance Round pack that is circulated to the relevant service that would then be circulated to Executive Directors, Non

Executive Directors and to members of the governance team for review, prior to team presenting a much smaller slide set to allow for further discussion.

NA stated that providing that the Executive Team were supportive of the revised Quality Assurance Review statement that NA requested whether FB could share this with Non Executive Directors for any further discussion if required.

JoR thanked JR for ongoing work regarding the model and the hybrid approach which appeared to be an extremely sensible solution.

JR stated that this would be a work in progress and that once the draft pre reading pack is finalised that JR would welcome FB and Non-Executive Directors insight as to whether the draft pack includes relevant information for Non-Executive Directors.

FB stated that it is important to consider the timing of receipt of the slide deck being shared with Executive Team and Non-Executive Directors to enable sufficient time for colleagues to review in advance of the Quality Assurance Rounds.

Update regarding possibility of a Divisional Safeguarding Accountable Officer
NO was not present at the meeting and unable to provide an update, update would be obtained offline.

Update regarding PALS & Complaints - timeframe for resolution of reports whereby date does not currently exist in PALS & Complaints Report
PW advised that the data analytics team are collaborating with relevant teams to address any gaps. PW advised that the Divisional Integrated Performance Reports had been shared with relevant colleagues on 5.1.24, with the data analytics team scheduling calls to review this. PW stated that there may be some other data that may be missing, however this was dependent on colleagues retrieving some of the data, PW stated that there were a number of ongoing queries, however this was ongoing and had been actioned.
Resolved: SQAC agreed this action could be closed and removed from the action log.

ED Deep dive MH presentations (Including referral to crisis care) including postcode analysis of end users – SQAC **NOTED** that this item was deferred from January 2024 meeting due to the lack of data available. FB and NA clarified the level of detail required for the deep dive for the February 2024 meeting.
Resolved :SQAC to receive Deep Dive information for February 2024 meeting.

Assurance on Key Risks
23/24/173 *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 1,13,16,17 and 21.
- Workstream 1 had demonstrated a downward trend in relation to the number of incidents rated as minor harm and above, and an upward trend for the number of incidents rated as no harm and near miss, whilst noting that the trend is not statistically significant.
- The Neonatal New-born Screening programme is due to move to BAU in the next couple of months. Patient Safety Strategy colleagues had recently received the first report back from NHSE and as anticipated there had not been compliance with national targets, as Trust neonates on the whole are extremely sick patients and are not fit the majority of the time for the nationally designated investigations and screening, and the only target that the Trust can consistently comply with is the blood spot test, further discussions are taking place with NHSE to ensure that the targets are more appropriate for the Trust in the future as part of the learning from this pilot work.
- Patient Safety Strategy Board received a positive update from the Learning Disabilities workstream which continues to meet its target in relation of 90% of appropriate referral's. There had been good uptake with regards to the Oliver McGowan eLearning training with 25% of staff currently trained to

date since the roll out in October 2023.An additional Health and Inequalities workstream had been discussed which may be able to be introduced in the near future where the waiting list for the cohort of patients with learning disabilities are disproportionately high.

- The Antimicrobial resistance workstream reported that they are currently meeting 2023/24 CQUIN, the team also reported that they are behind on AMR prescribing targets, where the Trust had seen an increase in antibiotic use, and this related to a funding request for the ICNET software package to support with data collection and analysis.
- Patient Safety Strategy had a comprehensive discussion regarding the Hospital optimisation with regards to further work planned over the coming weeks involving thematic reviews, with focus on leadership, communication, escalation and recognition.
- The metrics benefit tracker had increased with 22 metrics being tracked, however there are still some metrics and baselines to be established which Patient Safety Strategy Board colleagues are working on with respective leads, with further ongoing discussions planned with DMO colleagues and A McColl to agree how high level metrics could be generated.
- Patient Safety Strategy Board had maintained good levels of governance, resulting in a green overall rating for the programme.
- WW highlighted that colleagues are likely to struggle in the short term as the Patient Safety Strategy Project Manager is due to commence maternity leave on 18.1.24.
- PSIRF went live on 1.1.2024, PSIRF plan and policy are available on the external website.
- The Trust had since had two Patient Safety incident response investigation panel meetings which had been chaired by J Rooney, these would continually to be held on a weekly basis.

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

NA advised that he was not able to attend the previous Patient Safety Strategy Board meeting and alluded to the Deteriorating Patients Workstream and stated that on review of the Patient Strategy Strategy Programme slides he felt that the information contained on the slides did not fully capture all of the ongoing work, NA referred to Marthas rule as an example. NA welcomed a review and refresh of this particular workstream. WW was in agreement with NA comment and stated that the discussion held related to resetting, and identifying what the goals and benefits should be.

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 ongoing support and for the comprehensive update and the supporting materials which really impact the workstreams. FB stated that she hoped that the Project Manager support could be resolved, given the upcoming maternity leave of the project manager.

23/24/174 ED MH attendance & ED @ its best update report

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

- 6,328 children had been seen in ED in December 2023. 85% of children had been seen in ED within 4 hours, this is an improvement of 7% from the last couple of months and a 12% improvement since December 2023.
- UD advised that the areas requiring further improvement related to 10 children and young people who had waited for more than 10 hours, these patients were socially complex patients who required support from the police and social services, with the division reviewing this area to determine how improvements could be made in the future.
- The Division of Medicine are focussing on time to triage, which is 3 minutes more than the national standard, and the time to clinical assessment, which is slightly higher, with continued focus from the Division of Medicine.
- There are 252 appointments available via UTC, key improvements areas are supporting the virtual offer. UD stated that she is hopeful that the data would be available for PAU pilot this month. The Division of Medicine are updating the handover Standard Operating Procedures for ambulance transfers. The UTC utilisation is in the process of being reviewed.

- UD alluded to the Mental Health data which was from August 2023, and that colleagues are envisaging an upward trend of improvement, however unfortunately the division do not have any data currently due to the change in meditech/expanse and once the data is received the division would be in a position to update further.
- The Division of Medicine had made specific pledges in 2022, and all of the pledges were on a downward trend. Nursing and consultant spend had decreased, staff burnout seemed static, and as a triumvirate the Division of Medicine would need to regroup and review this further.

JoR thanked UD for the thorough report and sought clarity regarding how the division are going to address staff burnout. UD stated that the Division of Medicine had previously extensively collaborated with Jo Pottier, Organisational Psychologist, following COVID pandemic with external support with regards to listening events to enable a forum for staff to communicate with colleagues who were acting as Champions. UD, CW and SC are meeting on 18.1.24 and this is this is an area to review further working alongside J Pottier and the SALS teams to provide support for staff. UD stated that she is happy to keep JoR updated if required. JoR thanked UD for her update.

ABa referred to the numbers within the table regarding the increased risk in staff burnout which details the headcount relating to sickness, and that in 2022/23 this was 18 with a % of 39.2 and that it had been 8, 6 and 8 and the % increases. AB sought clarity whether the data is correct.

FB echoed ABa comments and queried if the % is coming from somewhere else, or whether it is just about absence and stress related sickness. UD advised that she would need to review the data further.

NP stated that as she understands it this is not based on the total staff denominator, and it is based on the number of staff sickness and that the % is based on the overall number of staff who are away sick at any one time, and it may be that the overall denominator is required regarding the total number of staff who are away sick to provide a sense in terms of the total.

ABa stated that this is not really a reflective number as the division may be doing really well in some aspects of sickness and the stress is remaining the same but would be recorded as a higher % as the overall level of sickness had decreased. CW advised that the Division of Medicine would further review and interrogate the data to enable an update to be provided at February 2024 SQAC meeting.

FB queried whether there is a process to supplement this data with more qualitative data. UD advised that there is room to be more proactive, UD stated that there were days during December 2023 when the Division of Medicine did not meet the 4 hour targets and that this had impacted staff.

FB referred to those patients who had left before being seen and requested an update on these young people with regards to follow up. UD alluded to the UTC numbers of 250 and above and stated that colleagues aim to provide all of these patients with an appointment, UD stated that an update would be shared at the February SQAC meeting.

FB stated that she had assumed that these patients were not going to UTC, UD confirmed that she would obtain clarity regarding this and would share an update at the February SQAC meeting.

Resolved: SQAC received and **NOTED** the ED MH attendance & ED @ its best update report and welcomed a comprehensive update at the February 2024 meeting.

23/24/175 Sepsis Quarterly Report

DP presented the Sepsis Quarterly Report which provided an overview of the current position.

- SQAC noted that there had been ongoing challenges undertaking the longer term tasks due to issues regarding data and also due to sickness on the inpatient element. Following ongoing work with the BI team, the Sepsis dashboard reporting is now reporting which should substantially change the amount of time that is being spent on data analysis by the 2 nurses involved in collecting data. DP is currently awaiting meetings with the BI team regarding the sepsis dashboard with ongoing work required to correct errors and improvements in display.
- Recruitment–ED sepsis nurse had been in post since October 2023, DP is hopeful that this postholder would soon be in a position to provide cross cover during periods of staff sickness of inpatient nurse.
- Inpatient receiving antibiotics<60 min target by quarter – quarter 3 data is not included in the report as it had been delayed as the inpatient nurse has been away on sick leave for the last 3 week period. DP advised that he not anticipate a major change, and advised that the Trust had been above 90% over the last 18 months.
- DP advised that he envisaged that the November & December 2023 figures for Inpatients receiving antibiotics <60 minutes by month would be available over the coming weeks.

- Inpatient receiving antibiotics<90 mins by month, which is a Trust target, information had been extracted by DP as it had not been incorporated into the Integrated Performance Report, DP is in discussion with BI team to incorporate this within the Integrated Performance Report – the Trust had maintained >90 consistently since data reporting resumed in June 2022.
- ED patients receiving antibiotics<60 mins, DP shared quarter 3 data, and advised that this is the first 2 quarters that the Trust had been around or above 90% compliant with the 60 minute target and this is is currently 89.9% for the last quarter. With a month by month usual variation which is not statistically significant due to the relatively small numbers.
- ED patients receiving antibiotics <90 minutes is above 90% consistently since June 2022.
- Training – DP stated that it is a similar position following previous SQAC updates, and that mandatory training compliance remained below 90%. DP alluded to a downward trajectory regarding medical and dental staff. DP referred to the extensive work undertaken during the last quarter to review training roles and reassigning sepsis mandatory training across all other roles in the Trust, this is now completed, and the next steps are to liaise with the Learning & Development Team for implementing onto staff matrices which is envisaged to take some time. DP stated that he does not envisage that this would have a significant impact on these figures as in most cases the team had added training onto people who did not have it before, who should have had mandatory training, with relatively few people that should not have had the training applied to them and may not have undertaken the mandatory training as they do not feel it appropriate to them. DP stated that this is still an issue that there needs a solution to improving increased mandatory training compliance.
- DP provided an overview of focus for the next 6 months with focus on ED Antibiotics, 60 minute data – and data accuracy, training, sepsis dashboard – with continued work on correcting errors, improvements in display, colleagues are currently awaiting BI input, ED/Inpatient working – harmonisation of data collection and analysis and cross cover arrangements, Analysis of antibiotic delays, resumption of normal data analysis - this is to be shared at the March 2024 Patient Safety Strategy Board meeting and would be presented to SQAC at the April 2024 meeting and resumption of normal data analysis.

FB alluded to the training slide and referred to the number in () underneath each of the % which FB assumed is the denominator and that this has been increasing across a number of staff groups.
FB stated that she is assuming that this was the additional numbers of staff who had been added in who had been identified as needing to be trained and requested DP to review this offline.
FB stated that how SQAC interpret the headline figure is significant, as progress is being made within nursing staff - if managed to get to 86.8% of that much higher number of people required, increasing number of people with training.

DP confirmed that those numbers are not included and stated that the increase in numbers on the report that Learning and Development provides must be of staff coming into post, and that colleagues are reliant on what Learning and Development share with colleagues.
FB alluded to the ongoing improvements required for those additional staff who had been identified as in need of training.
FB requested DP to further review this and confirm to FB offline exactly what is in the data.

KB referred to the theme regarding training given that there had been ongoing work to encourage people to undertake training, however this is not evident in the mandatory training compliance figures. KB queried whether the divisions have an understanding regarding what the barriers are, and whether there are underlying reasons why compliance had not significantly improved. CW stated that she envisaged that some of the figures are the new staff who had been identified, and that within the Division of Medicine for those new staff the Division had been pushing for these staff to undertake the training as soon as they had been identified. DP stated that there is a need to draw a distinction between new staff, and that any new staff who had come into post that are included on the matrix would be included within the figures. DP advised that Sepsis colleagues had not yet informed Learning & Development Team regarding the changes to the roles that had been agreed as a Sepsis Steering Group and therefore those changes would not be in that data. CW advised that from a nursing point of view these were notified individually to be included.
FB requested an update at February 2024 SQAC meeting to fully understand the current position and to confirm the current position regarding what is included in those denominators within the training

table. DP stated that if changes are being made to the Sepsis mandatory training without involvement of the Sepsis Steering Group this makes it slightly difficult to interpret. DP and CW would discuss this offline.
Resolved: Offline discussion to be held with DP & CW.

JG highlighted the importance of the data and access/availability being rapidly addressed given the need for BI support. JG confirmed that he would ensure that this is raised and discussed at Executive Team meeting to address these issues as a priority.

NA stated that there are two elements - sepsis that has been ongoing for a protracted length of time which required some help and support regarding the dashboard and visualization and that a theme from today's meeting related to a lack of availability of data post Alderc@re/Expanse go live and queried whether this is an additional conversation that is required at the Executive Team meeting on 18.1.24.

DP highlighted the importance of ensuring that the data makes sense, and is accurate to ensure that there is a clear understanding for colleagues and the BI team.

Resolved SQAC to receive a Training data update report at the February 2024 meeting
Resolved: Executive Team to address the dashboard and BI issues regarding the sepsis data
Resolved: Executive Team to provide support regarding how the training is correctly recorded and how the system could be improved.
FB thanked all for robust discussion and stated that SQAC would welcome some improvement in this area, given the longevity of the issues raised.

Resolved: SQAC received and **NOTED** the Sepsis Quarterly report and welcomed update at February 2024 meeting.

23/24/176 Drugs & Therapeutics Quarterly Report

PS presented the Drugs & Therapeutics Quarterly Report for Quarter 2
PS advised that moving forward he would like to ensure that the Drugs & Therapeutics Quarterly reporting are reporting more promptly, PS advised that the report would evolve over time and report does require amending in the future. PS stated that he would like the Medicine Safety Committee information to be more obvious within he report, with further work required to enhance future reports.

- Risks are being managed as appropriate.
- Chief Pharmacist post is anticipated to resolve over the coming weeks - Chief Pharmacist interviews are scheduled to take place on 29th January 2024.
- PS advised that he is continuing to work on the finance report. A deep dive had been presented to Patient Safety Board regarding Medication incidents; colleagues are also picking up TPN as a workstream.

FB stated that she would welcome updates in future reports on updates when working with a particular team to help teams make improvements and to highlight good practice and success relating to improvement programmes and highlighting this from a pharmacy viewpoint.
PS advised that the Pharmacy quality team had produced pharmacy quality dashboard in Inphase, and that it would be beneficial to include a screen shot of this in future reports to share this work.
FB stated that it is good to see these reports and confirmed that the sequencing of future Drugs & Therapeutics Quarterly Reports would be reviewed offline to ensure timely reporting.

Resolved: Drugs & Therapeutics reporting scheduling to be reviewed to ensure timeliness of future Drugs & Therapeutics Quarterly reports

FB expressed thanks to PS for Drugs & Therapeutics Quarterly Report.
Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Quarterly Report

Caring
Effective

23/24/177 Board Assurance Framework

ES presented the Board Assurance Framework

ES alluded to process and advised that colleagues are now starting to see an Inphase generated report presented through all of the assurance committees.

There are no significant changes to the way in which SQAC risks and framed and that in due course colleagues would be discussing the reinstatement of deep dives which is good practice.

ES referred to a theme regarding coding across the organisation, which had been heavily referenced at RABD meeting on 16.1.24. ES advised that this warrants a review, as colleagues had been informed that there are insufficient coders. ES had suggested the insertion as a gap in control in the financial risks, and may impact 1.1, 1,2 and possibly 1.4.

SQAC **NOTED** the move within the Board Assurance Framework to focus more on the strategic risks and to incorporate in the future a risk regarding Experience, actions would be addressed offline.

FB stated that the layout of the Board Assurance Framework report and the work being recorded on the risks is extremely good. FB requested an offline discussion with ES & KB to discuss reviewing the list of highly scored list pertaining to SQAC - FB, ES and KB were supportive of an offline discussion to ensure assurance for SQAC where these are being scrutinised.

Resolved: Offline discussion to be held with FB, KB & ES.

KB alluded to Section 5 regarding the corporate risks which had recently been added in a slightly different format. KB referred to if reviewing Risk 1.1. currently scoring 9 and stated that there are 12 corporate risks above 15 which sit below this. KB referred to Risk 1.2 which is scored at 20 there are only four risks. KB requested whether NA could review all 3 risks relevant to SQAC to undertake a sense check. NA advised that both he and ES had previously agreed to review the BAF. NA confirmed that this would be reviewed as appropriate.

Resolved: NA to review 3 risks relevant to SQAC.

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

23/24/178 Confidential Enquiries/National Guidance Assurance Report

JR presented the Confidential/Enquiries/National Guidance Assurance Report for Quarter 3

- The Trust participated in 5 Confidential Enquiries during the reporting period.
- Since the last update at SQAC, for Quarter 3 the Trust had submitted 7 out of 9 cases for the Juvenile Idiopathic Arthritis submissions, 2 of those were not applicable for the Trust, the organisational questionnaire had also been completed and submitted ahead of the February deadline; the publication of this report is scheduled for November 2024.
- MBRRACE- 5 deaths were identified as being eligible for submission and were submitted in Quarter 3 within the 30 day submission timeframe.
- The Perinatal Review Tool 5th Annual Report was only released at the end of December 2023, once this had been fully reviewed this would be presented within the next Confidential Enquiries/National Guidance Assurance report, together with any relevant learning and recommendations as relevant to the Trust.
- Suicide in Children and Young People for the National Confidential Enquiry into suicide and safety, the Trust received a request from the national team in December 2023 as the Trust had a suicide of a young male in April 2023, within the community, to determine whether any of the information should be included in the national report, the Trust submitted the information as requested, and feedback from the national team was that there is no further information or details required.
- Feedback from Community & Mental Health Division had provided assurance that the Trust Self-Harm Reduction and Suicide Prevention policy remains safe and current, there is further input required from the Emergency Department, Hospital Wards and Security team before this is fully up to date, with the timeframe for completion extended to June 2024.
- Learning Disability deaths continue to be reviewed by the Child Death Overview Panel and through the Trust internal processes through the Hospital Mortality Review Group.
- Roll out of the Oliver McGowan training.
- As there are now 2 Clinical Effectiveness & Outcome Group leads in post they are offering support to clinical staff to ensure that the Trust continues to comply with submission of any requests for any National Confidential Enquiries.

- With the exception of the Perinatal Review tool report that had just been released, there had been no other national reports received in Quarter 3.

FB expressed thanks to JR for comprehensive report
Resolved: SQAC received and **NOTED** the Confidential/Enquiries/National Guidance Assurance Report and **NOTED** the progress and oversight of the Trust participation and compliance with the National Confidential Enquiry submissions.

23/24/179 Clinical Effectiveness & Outcomes Group – Chairs Highlight report

JR presented the Clinical Effectiveness & Outcome Group – Chairs Highlight report

- JR confirmed that the Clinical Effectiveness & Outcomes Group meeting did not meet in December 2023 due to personal circumstances. A Clinical Effectiveness & Outcomes Group meeting was held in January 2024 and was extremely positive, acknowledgement was made regarding the improvements made with NICE guidance and the continued improvement with oversight and learning from clinical audits.
- The corporate team and divisions now have a weekly audit and NICE compliance meeting which is proving beneficial to all.
- A report was presented regarding the consensus for a Trust wide document management system – JR had requested further feedback from stakeholders, with a potential discussion at Executive Team in the future regarding the forward plan.
- Record Keeping policy was presented, Clinical Effectiveness & Outcomes Group requested a Task & Finish group to be established to understand what the audit activity would be.
- There is an acknowledgement of staff pressures across the Trust and an understanding as to why some staff had not been able to complete some audits, there is ongoing work taking place regarding audits.
- JR referred to an areas for escalation regarding staff capacity impacting on the ability to submit case notes to the National mandated Epilepsy Audit, - Gavin Cleary, CEOG Lead had met with clinician on 16.1.24 to understand what the barriers were regarding submission. FB sought clarity whether support was required from SQAC or whether this is for SQAC awareness only. JR confirmed that it is for SQAC awareness only at the current time. JR advised that from feedback received from the clinicians stated that some of the requests for case notes submissions are extremely lengthy, colleagues are reviewing whether this needed to be the lead consultant who actions this, therefore colleagues are looking at different options within the team, so that the Trust is not in a position when reporting into Quality Accounts that the Trust had not submitted the required case note requests.
- JR stated that this is a new group which is consistently improving at each meeting.

FB stated that there is a sense that the Clinical Effectiveness & Outcomes Group are taking ownership of a set of issues. JR stated that the group is aided by the two clinical leads having the one on one clinical discussions to understand what the barriers are as opposed to finding out retrospectively that the information had not been submitted by the deadline.
FB thanked JR for comprehensive update

Resolved: SQAC received and **NOTED** the Clinical Effectiveness & Outcome Group – Chairs Highlight report.

23/24/180 Divisional Update and Deep Dive regarding:

Surgery Division – RP provided Divisional update:-

- Key successes related to two long term patients who had been with the Division for a year - both patients successfully went to GOSH for transplants, both patients are doing well, 2nd patient had previously been particularly unwell on PICU and colleagues were uncertain whether this patient would be well enough to undergo a transplant, Division of Surgery colleagues are extremely proud of the collaborative working to ensure the transplant occurred.
- Challenge within the division relating to medications management in HDU, with HDU undertaking a thematic review of all of the HDU incidents to understand issues regarding medication administration with HDU colleagues working collaboratively with pharmacy, it is envisaged that this thematic review would be completed by the end of January 2024, with some actions to be established to support.
- The division had 1 open SI, report had been sent and signed off and closed on 18.1.24.

- The division had seen a similar position to the Medicine Division with regards to PALS, and the division had consistently achieved 100% compliance for over 1 year, this is not reflected on the Integrated Performance Report, and this would be followed up with the BI team.
- RP advised that the division are currently undertaking an extensive review of the Risk Register as it had remained static for a period of time, 1 of the high risks had been downgraded, with the division now having 2 high risks – one of which had been redrafted and reconfigured to ensure the context is current and reflects the current position. Other risks had been closed and a number of risks had been consolidated, the division would continue to review over the coming months.

Community & MH Division – JP provided Divisional update

- Community & Mental Health Division had welcomed a visit from the Medical Director from primary care, the visit particularly focussed on neuro developmental disorders, ADHD, ASD. As a result of the visit members of the Community & Mental Health Division are now going to be part of a national group.
- Challenges within the division related to being prepared for PSIRF, there is a dedicated session planned in early February 2024. The Community & Mental Health Division had extended the weekly incident review meetings to accommodate any of the additional tasks in this regard.
- PSIRF information is available on the Community & Mental Health Division newly formed SharePoint page.
- 13 staff had completed the HSIB level 2 training.
- Medication incidents – with regards to new issues relating to duplicate prescriptions being issued, this was present on meditech 6 to prevent duplicate prescriptions being issued, that isn't presently available in Alderc@re, whilst a fix is being reviewed, the division are having to ensure that people are extremely focussed on the Standard Operating Procedure and are being extra vigilant through the admin and clinical staff.

FB requested whether JP could provide an update regarding the challenge regarding the lack of named doctor and named nurse and safeguarding children, and what those challenges are, and requested that JP explain the actions being taken to address.
JP stated that the Trust currently do not have these staff in post and that the division are trying to recruit to these posts. LC stated that both are statutory posts that this organisation is required to have. LC stated that the impact on Children & Young People is such that the Trust is not meeting the statutory requirements to provide these roles for Children & Young People, however PLACE had agreed that the Designated Doctors would act into these roles and provide support which is what they have been doing, however the Designated Doctors across Liverpool and Sefton PLACE are community paediatricians and safeguarding consultants within Alder Hey, which has placed additional stress on the work being undertaken by them.

Medicine – CW provided the Divisional update

- Success related to the divisional collective response and collaborative working across the division regarding the Industrial Action.
- CW stated that it had been challenging to ensure that the rota had been safely staffed during the period of Industrial Action, division are focussed on planning for further Industrial Action.
- There had been a decrease in the was not brought rate for the 2nd consecutive month the division had seen a reduction which is 1% away from the Trust target.
- CW referred to the low harm incidents and advised that the division review all incidents on a monthly basis. CW stated that there had not been many moderate incidents over the last 12 month period. The Division of Medicine are reviewing the low harm incidents and as a % they remain constant and do not reduce with the division ensuring a real focus in this area. By reviewing this information, it has shown that the patient accident category is surprisingly high within the ward areas, with work required with ward managers to reduce and understand the reasons for this.
- CW advised that the data for complaints and PALS is not accurate with ongoing work progressing regarding this. The Division of Medicine had been 100% compliant with PALS & Complaints in December 2023.

KB referred to all of the Divisional reports and stated that there is a significant increase in incidents between July and August 2023 for incidents overdue review. KB stated that for the Medicine Division

that this goes from 13 to 62 and is currently 104. KB sought clarity regarding what had impacted these figures during July and August and sought clarity on what actions are being taken to reduce these figures. CW stated that prior to transitioning to Inphase there was an extensive drive to ensure that all incidents were closed and that the Division of Medicine were successful in achieving this, however the Division of Medicine had seen an upward trend, the Division of Medicine have a real focus to decrease these figures to ensure incidents are reviewed and closed, this is also being highlighted at the weekly divisional incident meeting.

NA noted that there had been a reduction in performance of reviewing incidents and risks within the appropriate time frames. This would be followed up offline with a discussion with the ACNs
NA alluded to the challenged area of 3B as it is stark within the report regarding the challenges on 3B. NA stated that he is keen to understand what measures are in place to support 3B, CW would discuss offline with NA.

Resolved: Offline discussion with NA & CW.

JoR referred to patient accidents and stated that it is difficult to get a sense whether this is a high or small number, or whether this is historic information. CW advised that she has requested detailed work with ward managers to review this, and that this is ongoing.

Research Division - LR presented the Research Divisional update

- Division strategy is ready to be launched shortly, with wide engagement received across the organisation and with patient groups.
- LR referred to an Alder Hey led study reviewing mini tablets and acceptability with young children which had caused excited within CRF with good patient and family feedback received.
- Challenges continue regarding portfolio and commercial research, this continued to be managed as appropriate.
- The division had experienced a quiet month in December 2023 due to universities and sponsors taking a two week break.
- Patient experience had decreased due to reduced activity, this would be monitored by the division.

Deep Dive review of ENT cancellations

RP provided an overview regarding the on the day cancellations.

- The Division of Surgery had 25 ENT on the day cancellations during the reporting period. On review there had been 803 planned procedures during this time, 25 of which had been cancelled on the day. 9 cancellations were attributable to the patient being unwell or not needing the procedure any longer, represent 1% of total planned procedure.
- Division had given some consideration regarding the possibility of undertaking pre op phone calls 48 hours prior to admission, however this would involve allocating appropriate resource, and given the context of the volume of the ENT cancellations the division do not feel that this is required, the division would consider this in the future if the situation changes and would continue to monitor.

FB stated that the suggested approach sounds an extremely sensible conclusion and stated that it is good to hear that the division are reviewing.

FB expressed her thanks to Divisions for Divisional updates and for the Deep Dive review of ENT cancellations which had been extremely constructive.

Resolved SQAC received and **NOTED** the Divisional updates and the Deep Dive review on ENT cancellations.

23/23/181 *Well Led*
Responsive

Transition Report

JP presented the Transition Report and advised that initial progress had been put on hold due to Alderc@re roll out and the absence of an individual in the data team. No data reports available since August 2023.

- Audit of transition coded appointment had commenced. Results are due to be presented in March 2024 prior to the auditor leaving the Trust in April. Sample from this code to look at content and length of appointment to also check whether NCEPOD standard regarding additional time to do transition in clinic appointments is being met.
- Ongoing work regarding Assurance baseline assessment and action plans for each specialty team, JR received support from the Heads of Nursing in the Divisions of Medicine and Surgery to complete this work.
- Quality standards were updated in December 2023 – one of the standards relate to meeting with a member of each adult service as part of transition, with one action for the Transition Steering group is to meet with Adult providers to refresh the work regarding any blockages for people who are transitioning from the specialisms from Children's care to adult care.
- Lack of data for community services that are using EMIS – awaiting ambulatory module for expanse to move over from EMIS, however Pro's and Con's work to be undertaken to determine whether this should happen sooner rather than later in the absence of a timescale for the ambulatory module.

FB thanked JP for the Transition Report and stated that SQAC are really beginning to understand the detail of the workstream.

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

23/24/182 RM49 Hospital Cleaning Policy

RP stated that the flow chart had been established, which was discussed at the cleanliness group who agreed with the process and advised that the clinical teams within the Division of Surgery are supportive of the process within the policy.

LR stated that she had not reviewed the policy in detail and sought clarity whether this included gene therapy waste. BL stated that the policy aligns with the national standards and that the policy was shared at the December 2023 SQAC meeting, and that this had been a long process.

Resolved: LR & BL to discuss gene therapy waste offline

Both Medicine and Community & Mental Health Divisions were supportive of RM49 Hospital Cleaning Policy.

Resolved SQAC received, **NOTED** and **RATIFIED** RM49 Hospital Cleaning Policy

FB expressed here thanks to BL for ongoing support

23/24/183 Any other business - None.

23/24/184 Review the key assurances and highlights to report to the Board.

- SQAC received an update regarding progress in relation to resetting the Quality Assurance Rounds, with some clear actions to be presented to Executive colleagues and to Non Executive Directors to approve, to enable a degree of face to face Quality Assurance Rounds throughout 2024.
- SQAC received a positive Patient Safety Strategy update, which provided good evidence of progress within the workstreams that had been detailed in the report, with good assurance that the Programme is progressing well, and is on trajectory.
- SQAC received the ED monthly report: MH attendances and ED @ its best update. SQAC noted the challenges regarding the data. SQAC clarified the additional deep dive information that had previously been requested at the 18th December 2023 meeting, and welcomed the deep dive information to be presented at the 21st February 2024 SQAC meeting.
- SQAC received the Sepsis Quarterly Report update, with a robust discussion held, focusing on two issues 1) The data issues and the need for these issues to be resolved - Executive Team colleagues agreed to review this offline to enable support in addressing the issues as a matter of some urgency. 2) SQAC agreed to receive clarification on what the training data is demonstrating– SQAC agreed they would receive this update at the 21st February 2024 meeting.

- SQAC received the Drugs & Therapeutics Quarterly Report. SQAC agreed that the cycle of reporting would be reviewed to ensure that the Drugs & Therapeutics reports are shared more promptly with SQAC.
- SQAC noted that there would be some quality improvements coming through via Inphase with further thought by Pharmacy colleagues on how the Drugs & Therapeutics Report could be further enhanced in the future.
- SQAC received the Board Assurance Framework, SQAC noted the move within the Board Assurance Framework to focus more on the strategic risks, and to incorporate in the future a risk regarding Experience. Actions would be addressed offline.
- SQAC noted the issues regarding coding issues. FB, ES and KB would discuss offline regarding reviewing the list of highly scored risks pertaining to SQAC.
- SQAC received the Confidential Enquiries/National Guidance Assurance Report and noted the good level of assurance within the report.
- SQAC received the Clinical Effectiveness & Outcomes Group – Chair's Highlight Report and noted the good level of assurance within the report.
- SQAC received the Divisional updates and the deep dive regarding ENT cancellations. SQAC noted that the Medicine Division had achieved a good compliance level regarding the 4-hour waiting time despite the challenges due to Industrial Action and the high levels of attendance. SQAC noted this was attributed by the Team to good collaborative working.
- SQAC received an overview of the ongoing work regarding low harm incidents and the potential to learn from them, particularly the low harm incidents that were linked to patients' accidents.
- Discussion was held regarding closing incidents and risks and the need to remain focused on this.
- SQAC received an update from the Community & Mental Health division regarding the national leadership in neurodevelopmental work and the ongoing work that is progressing within the division to ensure that the division are ready for PSIRF.
- SQAC received an update on detailed work regarding prescriptions.
- SQAC received the Transition Report, noting clear progress regarding the transition work.
- SQAC received, noted, and Ratified RM49 Hospital Cleaning Policy.

FB expressed thanks to all.

Date and Time of Next Meeting: 21st February 2024 9.30 -11.30 am via Microsoft teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	**Futures Committee Terms of Reference**
Report of:	**Director of Research & Innovation**
Paper Prepared by:	**Director of Research & Innovation**

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

1. Executive Summary

Pioneering breakthroughs are best achieved via partnership, internally or externally, as recognised in the Trust's new Vision 2030 strategy.

The accompanying document sets out proposed terms of reference for a new governance structure – the Futures Committee. The new Committee will oversee synergistic working between the various components of the Trust's new Futures strategic initiative, forming a stronger internal partnership which addresses the unmet need of Bring Me The Future.

The Board is asked to approve the creation of a Futures Committee, to be governed by the attached Terms of Reference.

2. Background and current state

Governance of the Trust's Research and Innovation activities was formally brought together by the Trust Board in late 2022 with the formation of the Research and Innovation (R&I) Committee – an expansion of the preceding Innovation Committee – which met first in April 2023.

Since the decision to form an R&I Committee, the Vision 2030 strategy has matured, including the development of the Futures strategic initiative, intended to deliver the strategic objective of achieving Pioneering Breakthroughs and thereby meet the desire of children and young people to 'Bring Me The Future'.

In adding a subset of the activities of the Trust's iDigital and Academy infrastructures to those of R&I, Futures requires a new approach to governance which ensures appropriate oversight and assurance which ensures the multi-disciplinary synergies needed to deliver the ambitions of the Trust's emerging Futures strategy.

3. Main body of report

See attached Terms of Reference document

4. Conclusion

A new and broader governance structure is required to oversee Futures, which incorporates and expands upon the duties of the current R&I Committee.

4. Recommendations & proposed next steps

That the Board approve the creation of a Futures Committee which will subsume the duties of the Research and Innovation Committee, as set out in the accompanying Terms of Reference.

John Chester
Director of Research and Innovation
March 2024

Alder Hey Children's NHS Foundation Trust

FUTURES COMMITTEE

TERMS OF REFERENCE

DRAFT for approval: in confidence

Constitution	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Futures Committee (the Committee). It will replace and subsume the responsibilities of the current Research and Innovation (R&I) Committee .
Background	'Futures' is a major strategic initiative within the Trust's 'Vision 2030' strategy refresh. It addresses the strategic objective of generating pioneering breakthroughs which address the area of need expressed by children and young people, 'Bring Me The Future'. The vision of Futures is to deliver pioneering breakthroughs which lead to healthier, happier, and fairer futures for children and young people. Its strategic approach is to develop ideas and solutions which address the unmet needs of patients, their families and communities. This will be achieved through the deployment of knowledge, training, devices, data, diagnostics, and therapeutics, in partnership with other appropriate world-leading experts and organisations. In some cases these solutions will have potential for commercialisation and net income generation. Futures incorporates many of the activities of the Clinical Research and Innovation teams, along with sub-sets of those from the Alder Hey Academy and iDigital teams. It is envisaged to underpin some, but not all, of the Trust's Commercial and Global endeavours.
Membership	Non-Executive Directors x 3 [one of whom shall be the Chair] Chief Executive Chief Scientific Officer Managing Director of Futures Managing Director of Innovation Clinical Director of Innovation Director of Research Director of Alder Hey Academy Chief Digital and Transformation Officer Managing Director of Trust Director of Finance and Development

	Chief Medical Officer Chief Nursing Officer Director of Corporate Affairs Director of Strategy and Partnerships
Attendance	In addition to members above, it is anticipated that the following will attend each meeting (but will not have voting rights): Head of Research Operations Deputy Managing Director of Innovation Deputy Director of Finance Director of Marketing and Communications The following would attend, on an occasional basis, as required by the agenda: Divisional Directors Lead Research Nurse Senior Innovation Consultants Other persons may attend specific meetings, by invitation, subject to Chair's approval An Executive Assistant will attend to take minutes of the meeting and give appropriate support to the Chair and Committee members, during and between meetings.
Quorum	Chair or nominated deputy, one other NED, Chief Scientific Officer and/or Managing Director of Futures, one other Executive Director. Virtual or remote participation in meetings shall count towards the quorum. Where a quorum is not met, meetings may still proceed, but any decisions or approvals required must be subsequently confirmed, out-of-Committee, by a simple majority of members via e-mail in order to provide appropriate oversight and assurance.
Frequency/ Duration	Meetings shall normally take place on a quarterly basis and the Committee will meet not less than three times a year. The Chair may, at any time, convene additional meetings of the Committee to consider business that requires urgent attention.
Authority	The Committee will operate under the broad aims of a) overseeing delivery and periodic reviews of the various activities undertaken within the Trust's 'Futures' strategic initiative and b) providing assurance to the Board that delivery in these areas supports the Trust's strategic priorities.

	The Committee has authority on behalf of the Board to: • Guide the development of a cohesive approach to the distinct but interlinked activities encompassed within Futures, ensuring that the Trust maximises the opportunities presented by its facilities, clinical expertise, partnerships and networks. • Make timely decisions to initiate, prioritise or de-prioritise specific projects and initiatives that fall within the duties set out below, ensuring that an agile, flexible and business-like approach is retained, particularly in connection with commercial opportunities. • Seek and commission appropriate external advice which aids successful delivery of these agendas.

Duties	• Provide robust assurance to the Board on the development and implementation of the Trust's Futures strategic initiative, the strategies of its various components and their key themes.
	
	• Provide high-level oversight of mechanisms for developing ideas, solutions and, where appropriate, their commercialisation.
	
	• Receive, review and provide feedback on high-level synopses of:
	
	  • portfolio, performance and financial data which have been scrutinized by Research Management Board and Innovation Management Board;
	
	  • external grant applications and awards, inward investment opportunities and strategic partnerships, particularly those which facilitate commercialisation and income generation;
	
	  • teaching and training offers aimed at national and international individuals, groups and organisations;
	
	  • opportunities for sharing of routine and specialized, 'raw' or processed data, arising in the Trust, with particular emphasis on integration with other data sources which enhances the benefits for children and young people, their families and communities.
	
	• Nurture and foster a culture in which Research, Innovation, Learning, Education, [Career] Opportunities and Digital Health are recognised by all staff as being essential components of improving the futures of children, young people and society

- Ensure the delivery of agreed outputs which align to the Trust's vision, including but not limited to:
    - A sustainable pipeline of innovative technologies, devices and processes
    - A balanced portfolio of clinical research studies, individually and collectively with the greatest potential for:
        - improving access of patients to new avenues in prevention, diagnosis and treatment;
        - translation into clinical practice with positive impact for patients, health services and society;
        - reducing the burden of physical and emotional harm
        - new, data-driven approaches which facilitate smarter, kinder treatments;
    - A unique sub-set of outreach and knowledge transfer tools in learning, education and opportunity aimed at external and international health and care professionals;
    - A collection of state-of-the-art digital and data platforms which underpin all aspects of Futures;
    - A sub-set of the Trust's commercial activities;
    - A subset of the Trust's international activities.

- Shape new and stronger clinical, academic and commercial partnerships which align with and promote the values and aims of the Trust,, where necessary undertaking due diligence to safeguard the reputation of the organisation.

- Understand and oversee the protection of intellectual property element of Futures activities, seeking appropriate advice where required

- Oversee development of 'Healthcare Anywhere' approach, which:
    - delivers diagnosis, treatment, care and monitoring in the most appropriate setting for patients and their families;
    - develops the next generation of world-class paediatric researchers and innovators;
    - teaches and trains the Trust's staff in the principles and practice of Research and Innovation, Education and Digital

  using the most efficient, user-oriented processes and pathways.

- Ensure appropriate commercial acumen and business skills are available to the Trust, wherever necessary.

- Ensure effective communications and marketing of Futures activities and achievements, both internally and externally

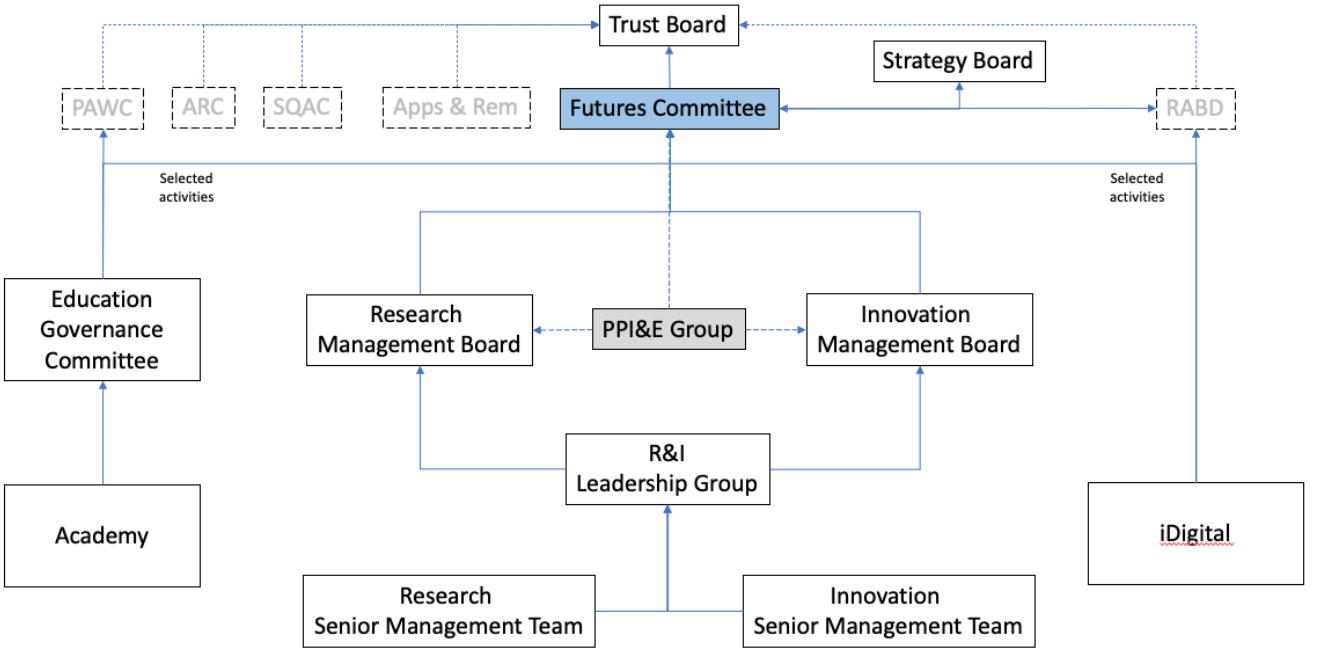
	• Ensure leverage of the Trust's position and optimise clinical, academic and commercial opportunities locally, regionally, nationally and internationally • Provide assurance to the Board on the scientific, technological and financial sustainability of Futures activities and their potential impact on clinical practice and services. • Maintain oversight of the register of relevant company interests, ensuring it is in line with relevant legislation and policy. • Provide assurance to the Board that the company structure and approach to subsidiary and joint ventures is efficient and compliant with relevant standards and legislation. • Approve investment decisions and ensure due diligence in line with the Trust's Scheme of Delegation. • Identify, monitor and control risks relating to the delivery of high-quality activities which align with Vision 2030, the Futures strategy and other relevant strategies within the Trust. • Ensure that key risks are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate • Receive, review and provide feedback on o minutes from subsidiary groups (as in schematic below) o independent external advice from Research Advisory Panel and Innovation Advisory Panel
Reporting	Minutes of meetings will generally be circulated to members for comment and approval, within 10 working days after Committee meetings. The Committee will ensure that confirmed minutes of its meetings are formally recorded and submitted promptly to the Trust's Board of Directors and Strategy Board (as in schematic below), along with a Chair's report, identifying key areas. Any items of specific concern or which require approval from the Board of Directors will be the subject of a separate report.

	The Committee will prepare and submit an annual report on its activities to the Board of Directors in June, via Audit Committee in May.
Conduct	The Committee will develop a work plan with specific objectives which will be reviewed formally on an annual basis. The Committee will also review its performance against these Terms of Reference and its objectives. These will provide the basis for reports to the Trust Board of Directors, describing how the Committee has discharged its responsibilities, after six months and thereafter on an annual basis. Agenda and papers for Committee meetings will be distributed not less than 4 working days prior to meetings. Additional papers to be tabled after that only in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance. The Chair will seek to achieve consensus in reaching decisions. Where this is not possible, there will be a show of hands, requiring a simple majority. In case of a tie, the Chair will have the casting vote.
Other Matters	These Terms of Reference will be reviewed following 6 months of operation and thereafter on an annual basis.

Date approved: March 2024

Review date: September 2024

Proposed new governance structure for Futures



To be confirmed: relationships with Commercial & International/Global

Alder Hey Children's NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Tuesday 16th January 2024 at 13:00, Innovation Hub,
Alder Hey Children's NHS Foundation Trust

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	(JG)
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nurse	
	Sian Calderwood	ACCO, Medicine	
	Audrey Chindiya	Associate Finance Director – Operational Finance	
	Esme Evans	Accountant, CAMHS	
	Rachel Greer	ACCO, CAMHS	
	Hannah Grierson	Interim Accountant, Medicine	
	Dani Jones	Director of Strategy and Partnerships	
	Emily Kirkpatrick	Deputy Director of Finance	
	Jane Halloran	Acting Deputy Development Director	
	Graeme Montgomery	Accountant, Surgery	
	Andy McColl	Deputy Director of Finance	
	Natalie Palin	Associate Director Transformation	
	Melissa Swindell	Director of HR & OD	
	Gary Wadeson	Associate Director Income, Costing & Commissioning	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
	Erica Saunders	Director of Corporate Affairs	(ES)

23/24/160 **Apologies:**

Emma Hughes	Acting Manging Director for Innovation
Fiona Marston	Non-Executive Director

23/24/161 **Minutes from the meeting held 20th December 2023**
The above minutes were approved as a true and accurate record.

23/24/162 **Matters Arising and Action log**
Action reference no. 115 in relation to: To provide further details on high and low income areas, deficit and plans. As the SLR report Q3 would be presented in March due to availability of data this action would be deferred until 25th March 2024.

23/24/163 **Declarations of Interest**
There were no declarations of interest.

23/24/164 **Finance Report**
Month 9 Financial Position
£1.5m surplus was reported for M9 as well as £3m year to date, this is off plan by £0.5m.

RABD noted the current position in relation to Industrial Action and across the divisions.

Whilst talks continue around national reimbursement for IA there is no confirmation.

The level of CIP posted to date is behind plan by £1.5m. It is anticipated that the full £17.7m CIP will be met in year subject to the delivery of schemes still in red and amber. Recurrent CIP has improved significantly in M9, with the gap as yet identified recurrently dropping from £11.9m to £5.9m between M8 and M9.

KW updated RABD on the coding position advising that vacancies have been bank filled and permanent recruitment plans are in place. As the team are currently working through the back log a review will take place in 4 weeks.

Resolved:
RABD received and noted the M9 Finance report.

23/24/165 **Month 9 Integrated Performance Report**

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

Long stays reduced.

Focussed work in community CAMHS, ADHD and community ophthalmology in Q4 is planned to support continued improvements in rates to attendance.

Ear Nose, Throat and Dental continue to be the services with longest waits.
Resolved:
M9 IPR report was received.

23/24/166 **Surgery Division**

CL highlighted:
200 patients in December are to be coded, 50 have been noted as high income and are being prioritised.
Reduction in on call costs will continue to reduce in April due to job plan review.
Overspend in M8 included £0.3m nursing, Critical Care.
Top 12 schemes to hold forecast position was discussed.

Following discussion on Surgery position it was agreed a further updated would be presented at the February RABD on the underlying position.
Action: Surgery/Finance Team

23/24/167 **Medicine Division**

SC highlighted:
Overall ERF activity is overperforming YTD (£1.0m) mainly driven by overperformance in ED, Nephrology, and Neurology.
37 high value cases to be coded.
Deep Dive into oncology coding and capturing underway, possible code change to reduce average 250 follow ups per month.
Reduction in WNB rate for the second consecutive month now at 7%.
Consultant premium costs related to maternity leave, restricted duties & sickness (13 WTE) in core medical specialties, (£1.0m) and the impact of Industrial Action (£0.4m).
HCA 121 and sickness, which continue to be an area of significant challenge within the core Medical wards (£0.7m); escalated response initiated
The full £3.6m CIP target has been fully delivered in year through various schemes including non rec vacancy slippage.

A discussion was held on the tariff associated with costs in relation to general paediatrics and whether this should be challenged nationally. Further work to be carried out on understanding reasons and if any scope to challenge nationally. GW agreed to take forward.
Action: GW

The Chair asked for an update to be provided at the next divisional update on the top 10 loss making services.
Action: SC

23/24/168 Community Division

RG highlighted:
ERF activity is ahead of plan year to date.
Vacancies within CAMHS directorate £1,436k, this is expected to reduce over the coming months as vacancies are filled.
Industrial Action costs are £41k.
Drugs Overspend within Community Medicine as a result of increased activity (£90k), these costs are offset by Income
Currently no slide for CIP, this will be included going forward.

Nathan said CAMHS/Surgery still have high level of agency staff spend. RG commented that we continue to try to recruit into vacant post with aim of reducing agency costs in line with recruitment to posts.

We are currently reviewing SLR with costing accountant to ensure we are reporting against the correct service lines, this will be developed over the coming months.'

23/24/169 Corporate Collaborative

Resolved:
As ES had been required to leave the meeting RL highlighted the successful CIP meeting £1.9 target.

23/24/170 Campus Update

JH highlighted:

- Gender Development Service is on target.
- Catkin and Sunflower House sprinkler system is back out to tender with additional information to attract a greater response.
- Fracture and Dermatology outpatients revised programme in place following October 2023 SPV meeting.

Resolved:
RABD noted progress to date of the Campus projects.

23/24/171 PFI

Pipework Report
AB went through the above report that was requested in relation to the defect.

Whilst there has been a reduction in the number of leaks resulting from corroded pipework, there is still a future risk of continued leaks.

Next steps include:

- Board to Board meeting between Alder Hey Children's and Alder Hey SPV to review the risk, the immediate replacement programme and the long-term maintenance and replacement programme
- To request the SPV surveys the areas of the pipework system that have yet to be inspected
- Further water chemistry works are planned until June 2024.

The Chair queried when the outstanding actions would be completed, AB advised that as the investigatory work is still being completed a end date was not yet available

Resolved:
RABD received and noted the current position.

23/24/172 **Board Assurance Framework**

Resolved:
RABD received and noted the Strategic Risks.

23/24/173 **Patient Access Policy**

RABD noted the three changes as per request of the NHS Commissioning Structure and approval through the Safe Waiting List Management Oversight Group, October 2023.

Resolved:
RABD ratified the Patient Access Policy.

23/24/174 **Any Other Business**

No other business was reported.

23/24/175 **Review of Meeting**

RABD noted the good divisional presentations and to continue reviewing areas requiring support.

Date and Time of Next Meeting: Monday 26th February 2024 at 1pm, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	**Board Assurance Framework Report 2023/24 (January)**
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 January 2024.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2023/24

1. Purpose

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

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

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

2. Review of the BAF

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

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

3. Summary of BAF at 5th February 2024

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

4. Summary of January 2024 updates:

- ***Strategy Deployment (DJ).***
  Risk reviewed; no change to score. Vision 2030 progressing as per agreed timeframes.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; Current risk evidence, actions and controls assessed and no change to score in month. Specific updates include:
  1. ICS commitment to CYP is progressing through the new CYP Committee, which will meet again mid-February.
  2. Formal engagement and socialization of Vision 2030 with partners continues. Feedback continues to be positive, and there is much system alignment on the priorities for CYP.
  4. Place level capability and capacity within the strategy team remains a risk.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed; work continues to update in line with the 2030 Vision and improvements made. Additional resource has been agreed to support EDI and anticipated reduction on risk score once in post. No change to risk rating currently.

- ***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.

  Project Co have issued the Jan pipework update. Project co. confirmed flushing on ground source heating is now complete and flushing on the cooling system began on 22nd Jan.
  - Rectification programme has resulted in a 72% decrease in leaks between 2021 and 2022.
  - To date in 2023, leaks have decreased by 53% compared to 2022.
  - In overall terms the leaks in 2023 amount to 4% of the total leaks between 2017 to 2023.

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

  Joint water safety workshop to discuss water issues took place on 22nd Jan; an action plan has been developed and agreed. Key take away proceed at pace to install dosing system safely.

  Chiller commissioning works have re-commenced in Jan Project Co expect to provide an update early Feb to the Trust.

  Works on the skylights will recommence April 2024.

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

  Overall, diagnostic waits decreased slightly in January due to decrease in sleep capacity (sickness). This should now be resolved due to an increase of 1 additional sleep study session available per week 12th February 2024.

  Capacity to reduce long waits (RTT) continues to remain a challenge. There are still a number of 78 week waits which are being managed closely by the services (Dental & ENT) due to both patient and hospital cancellations. However, we continue to meet the agreed trajectory with Cheshire & Merseyside to have zero 65 weeks by 31st March 2024. Division of Surgery continue to actively manage this with focus on ENT, Dental and Spinal (all of which have protected theatre sessions). There is an ongoing risk regarding the potential for further Industrial Action which is a threat to elimination of 65ww by March 2024.

- ***Inability to deliver safe and high-quality services (NA).***
  This risk remains as currently articulated pending a further review of the risks relating to CYP experience. These are currently partially articulated within the gaps in assurance and a discussion will be held in February as to potentially articulating these either more fully in risk 1.1 or considering an additional specific risk on the BAF. A meeting is planned with ES, KB and NA to further discuss this and the outcome will be reflected in future BAF reviews and updates. The risk continues to be monitored through SQAC.

- ***Access to Children and Young People's Mental Health (LC)***
  Review of risk and actions undertaken. All actions up to date.

- ***Financial Environment (JG).***
  Risk has been reviewed and updated to include the issue of divisional budget position not being achieved due to emerging cost pressures and industrial action. This was previously identified as a stand alone risk in the divisions however we have incorporated into the BAF to be managed through the controls identified. Overall risk score remains at 16. 24/25 initial financial plan us due to be submitted end of February and once allocations are known the score will be reviewed and updated accordingly.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed in month - all actions remain on track. No change to score.

- ***Digital and Data Strategic Development and Delivery (KW).***
  Risk reviewed, score static. Aldercare Optimisation programme in delivery with early priorities delivered. Monthly change cycle in place with divisional input and oversight with CXIOs.

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

- ***Failure to deliver the best experience for Staff, Children and Young People and their Families (MS).***
  Risk reviewed. Actions updated and a new control added. Risk to be fully reviewed with CPO to ensure that the controls and actions reflect the changed risk descriptor and broader focus on organisational culture.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  Risk reviewed. No change to score in month. Actions under review as part of annual planning and Futures engine room discussions.

5. Corporate risks (15+) linked to BAF Risks (as at 1st February 2024)

There are currently 19 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked
STRATEGIC OBJECTIVE: The best people doing their best work *(Outstanding care and experience)*				
1.1 Inability to deliver safe and high-quality services (3x3=9)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.4
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval	5x3	Surgery	
2657	As there is no consistent method for recording and communicating resuscitation decisions across the trust there is a child may be resuscitated inappropriately and receive inappropriate and potentially harmful treatment. A child may not receive resuscitation when it is in their best interests to do so.	5x3	Medicine	
67	NatPSA/2023/010/MHRA - Risk of death from entrapment or falls	5x3	Business Support	
91	Junior doctor staffing in general paediatrics	5x3	Medicine	2.1
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	2.2
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	2.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	2.1 & 2.2
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	2.1 & 2.2
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	2.1
132	Gender Service	4x4	Community	2.1
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	3x5	Community	
120	Current urgent provision of Bypass machines within Alder Hey	5x3	Surgery	

Risk	Risk Title	Score (IxL)	Division	Linked
111	Anaesthetic cover out of hours	5x3	Medicine	
120	Current urgent provision of Bypass machines within Alder Hey	5x3	Surgery	
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)				
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2
2019	Delay in treatment for Speech and Language Therapy	3x5	Community	1.2
2360	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18 week referral to treatment target for routine).	3x5	Community	1.2
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)				
	None			
1.4 Access to Children and Young People's Mental Health (3x5=15)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.1
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.1
STRATEGIC OBJECTIVE: Delivery of Outstanding Care *(Support our people)*				
2.1 Workforce Sustainability and Development (3x5=15)				
91	Junior doctor staffing in general paediatrics	5x3	Medicine	1.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.2
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.2
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	1.1
132	Gender Service	4x4	Community	1.1

Risk	Risk Title	Score (IxL)	Division	Linked
2.2 Failure to deliver the best experience for Staff, Children and Young People and their Families (3x3=9)				
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.1
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.1
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1
2.3 Workforce Equality, Diversity and Inclusion (3x5=15)				
	None			
STRATEGIC OBJECTIVE: Sustainability through external partnerships *(Collaborate for children and young people)*				
3.1 Failure to fully realise the Trust's vision for the park and Alder Hey campus (3x4=12)				
	None			
3.2 Strategy Deployment (3x4=12)				
	None			
3.4 Financial Environment (4x4=16)				
2579	Risk of failure to achieve financial balance due to existing and emerging cost pressures, impact of Industrial Action on the delivery and recovery of NHS services, reduced effectiveness of services, inability to invest and innovate and potential of increased workforce pressures	3x5	Medicine	
3.5 System working to deliver 2030 Strategy (4x4=16)				
	None			
STRATEGIC OBJECTIVE: Game-changing research and innovation *(Pioneering Breakthroughs)*				
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)				
	None			
STRATEGIC OBJECTIVE: Game-changing research and innovation *(Revolutionise Care)*				

Risk	Risk Title	Score (IxL)	Division	Linked
4.2 Digital and Data Strategic Development and Delivery (3x4=12)				
	None			

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

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.

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

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

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

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

CQC Domains	Linked Risks	Owner
■ Effective ■ Responsive		Adam Bateman

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

Description

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

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

Gaps in Controls / Assurance

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

Action	Description	February 2024	
		Due Date	Action Update
Reduce the long-wait backlog for planned care	Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	31/03/2024	All services working towards zero 65 week waiters by 31st March 2024. Particular concern in ENT, Dental and Spine where additional investment continues in insourcing and theatre time protection for services.
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

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

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

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

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

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

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

Description

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

Feb 2024

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

Gaps in Controls / Assurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Action	Description	February 2024	
		Due Date	Action Update
Management essentials training	Develop a Thriving Leaders Framework for the organisation beginning with a management essentials training programme for all new managers to cover core HR and management knowledge and skills and to complement Strong Foundations leadership programme already running	29/03/2024	Majority of Management Essentials training now developed with delivery dates set and materials developed. Outstanding is training in Stress Risk Assessments which was escalated in Thriving Ops meeting today and actions taken forward by Head of L&D.
Stress risk assessments	Skills and capacity gap to conduct good quality stress risk assessments for staff affected by work-related stress	29/03/2024	Stress Risk assessments training discussed in Thriving Operational group on 31st January 2024. Highlighted as an outstanding training as not yet sourced and no delivery plan. Head of L&D agreed to progress with external training provider and update Thriving ops group next week.
Suicide Postvention planning and process	Suicide Postvention guidance and team to be developed and establised to provide effective and compassionate response in the event of the death by suicide of a staff member.	29/03/2024	Deputy CPO and Associate Director of Organisational Development met on 30.1.24 to start drafting organisational postvention guidance and strategy. Agreed to draft guidance and then consult key stakeholders before finalising and communicating.

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.

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

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

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

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

CQC Domains	Linked Risks	Owner
		Rachel Lea

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

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

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

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

Action	Description	February 2024	
		Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	31/03/2024	
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2024	Regular updates continue to be provided to RABD and Trust Board as appropriate
Infrastructure works	Weekly coordination meetings, site walkarounds, RAMS, mitigation measures identified	31/03/2024	
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	31/03/2024	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves	30/06/2024	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell

Strategy Deployment	
Risk Number	Strategic Objectives
3.2	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

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

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

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

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

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

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.

Feb 2024

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

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations and overall financial position of Trust.
2. Long Term tariff arrangements for complex children shows underfunding of c£3m for Alder Hey
3. Devolved specialised commissioning and uncertainty impact to specialist trusts
4. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
5. Long Term Plan shows £3-5m shortfall against breakeven
6. Deliverability of high risk recurrent CIP programme
7. Increasing inflationary pressures outside of AH control
8. Divisional budget positions are not acheived due to emerging cost pressures and impact of Industrial Action.

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

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

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

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

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

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

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

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

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

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

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

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

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

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

CQC Domains	Linked Risks	Owner
		Kate Warriner

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

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

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

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

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	Corporate Risk Register Report (CRR) 1st – 31st December 2023
Report of:	Associate Director of Nursing and Governance
Paper Prepared by:	Associate Director of Nursing and Governance Trust Risk Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ■
Summary / supporting information:	This paper provides the Trust Board with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR) for the reporting period 1st – 31st December 2023. This paper was presented at both ARC (25.1.24) and RMF (6.2.24) for individual risk in-depth discussion and assurance of mitigation and progress. In addition, all 'long standing high risks' (greater than 12 months since identification as a high risk) were subject to deep dive in Februarys RMF. Since reporting to ARC and RMF the following risks have reduced in score: • Risk # 2442 reduced from 15 down to 10. • Risk # 57 reduced from 16 down to 12. • Risk # 2753 reduced from 16 down to 8. • Risk #22 reduced from 12 down to 9 Full details outlined in the paper. Supporting documents include: Risk Strategy & Risk Management Policy & Procedure and supporting policy documents. Board Assurance Framework

0195	CQC standards
Action/Decision Required:	To note ■ To approve ☐
Strategic Context: ➢ **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 Implications:	Supports resource identification.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
*22	*'There is a risk to monitoring and management of risks and incidents and providing up to date and accurate assurance reports to Trust board, sub board committees and divisions following the roll out and implementation of InPhase caused by several limitations to the current functionality of the incident and risk modules post implementation, leading to staff dissatisfaction and potential reputational damage'.* Mitigations include: - Joint InPhase visualisation reporting dashboards workshop for priority reports held with Alder Hey and LHCH 30.11.23. - Visualisation workshop with King's College to review their dashboards held Feb 24 - Overdue risk notifications now being received. - Work ongoing with BI to generate board papers automatically through SQL Server Reporting Services plus further development of the Heatmap visualisation - completion due 29.2.24. - Formal board papers drafted by Data Analytics Team to reduce administrative tasks to manually create graphs and tables. - Ongoing support available from the analytics team for changes and future requests. - InPhase portals and dashboards to support day-to-day working being developed when requested. Enhancements will be ongoing as skills are developed internally. - InPhase position paper presented by CNIO at ARC January 24 RMF February 24. Based on the above and mitigation in place risk score reduced from 12 to 9. (Feb 24)					9 (L3XC3)
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

0196

1. Purpose

This paper provides the Trust Baord with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR) for the reporting period 1st – 31st December 2023.

2. Summary CRR:

Total number of open high risks = **17** (excluding BAF, Cheshire & Merseyside Children's & Young People's Partnership and network risks).

Risk Register High risks	**Current reporting period** 1st – 31st December 2023	**Previous reporting period** 16th September – 30th November 2023	**Previous reporting period** 16th August – 15th September 2023	**Previous reporting period** 1st May – 15th August 2023
Number of new high risks reported	**0**	**2**	**0**	**2**
Number of high risks closed or removed	**1**	**1**	**0**	**0**
Number of high risks with increased risk score	**0**	**2**	**1**	**3**
Number of high risks with decreased risk score	**1**	**2**	**0**	**4**
Number of high risks overdue review	**3**	**6**	**4**	**2**
Number of high risks with no agreed action plan	**0**	**2** (Ref: 68, 91)	**2** (Ref: 25, 39)	**2** (Ref: 25, 39)
Number of high risks with actions past expected date of completion	**12** (Ref: 2753, 2441, 2719, 2579, 2657, 2463, 2589, 57, 2019, 2360, 2627, 2100)	**12** (Ref: 2746, 2441, 2753, 2463, 57, 2019, 2360, 2627, 2719, 2579, 2657, 2100)	**9** (Ref: 1524, 2463, 2767, 2779, 2360, 2627, 2753, 2441, 2746)	**9** (Ref: 1524, 2100, 2463, 2767, 2779, 2360, 2627, 2579, 2073)
Number of high risks with static risk scores	**17**	**14**	**16**	**11**

0197

Table 1 – Closed high risks
Table 2 – Risks with decreased scores
Table 3 – Long-standing high risks (greater than 12 months since identification as a high risk)

3. Themes

There are currently seven themes identified on the CRR: Quality – Safety (5 risks), Workforce / Staffing & HR (5 risks), Compliance and Regulatory (3 risks), Financial (1 risk), Operational (1 risk), Quality - Effectiveness (1 risk) and Reputation (1 risk).

Quality – Safety

Risk 2463 (4x4 = 16) ***"Risk that children and young people will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard)"*** **caused by significant increase in referrals to ASD continuing from 2020 (start of covid) and capacity within current pathway is funded to set level by Commissioners.** Controls include regular meetings with commissioners and divisional senior management team. Strategic planning meetings are underway and digital platform for referrals to ASD pathway to be developed. Reviewed risk and remains the same.

Risk 2360 (3x5 = 15) ***"Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgent and 18-week referral to treatment target for routine)"*** **due to demand on the service outweighing commissioned capacity in the team**. Mitigations include Crisis Care Team are available 24/7 to ensure urgent clinical need is met for patients waiting for specialist CAMHS and agency staff are in post to provide clinical cover where there are staffing gaps. Further actions being taken include PCO and Operational Manager to monitor choice breaches and ensure calls are being made. Discussion regarding the current risk score - remains as 15 despite an improving picture due to it being almost certain that young people will still breach.

Risk 2719 (4x4 = 16) ***"Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS" due to insufficient Consultant Neurologists.*** Mitigations include a locum consultant in post (0.6WTE) and a weekly improvement meeting to develop an alternative Neurology model to support retention. Ongoing actions include Neurology on-call to move from 24/7 service to 5 days 9-5 cover with 4 hours telephone advice service on Saturdays and Sundays and an in-depth service review to assess demand against current capacity. Risk Manager is liaising with Leeds to look at their model of working which they have been doing for the last 3 years. This is a work in progress and in Neurology cover as usual till the 15th.

Risk 91 (3x5 = 15) ***"Junior doctor staffing in General Paediatrics - The middle grade tier of the junior doctor workforce is underfilled. This poses a risk for both the on call medical rota and day to day ward cover for general paediatric inpatients" caused by positions offered at the recent interviews have not been taken up by the successful candidates".*** Ongoing action includes clinical fellow recruitment. Risk reviewed, clinical fellow recruitment underway.

Risk 2441 (5x3 = 15) ***"Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval"*** **caused by Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work**, this includes on call and out of hours. Mitigations include Northwest & North Wales Paediatric Transport Service (NWTS) have an additional transport team which has been created to respond to the surge and Connect Northwest have an additional ambulance which can transport neonates. Ongoing actions include a meeting is to be hosted with paediatric transport providers and representatives from UHNM and Alder Hey Children's Hospital (AHCH) regarding paediatric transfers. Additional actions taken on the neonatal pathway:

1. Requested final approved neonatal SOP from KIDS-NTS transport (KIDS NTS is a combined Neonatal and Critical Care advice and transport service).
2. Contacted Connect Northwest to confirm they have disseminated SOP.
3. Neonatal transport SOP cascaded to Neurosurgery.

Additional actions taken to reduce paediatric transport pathway:
1. Contacted Midlands and Northwest commissioners on the 4 and 5 December requesting a commissioner update on mitigating this risk.
2. Meeting scheduled in January 2024 to finalise new pathway.
NOTE: February 24 update: Risk score now reduced to 10 (5x2) (**Likelihood of risk reduced following agreement to formalise KIDS NTS as the responsible transport provider for neonatal transfers. Further work required for paediatric transfers to be protocolised and escalation plan to be documented if KIDS team are unable to transfer).**

Workforce / Staffing Levels & HR

Risk 1524 (4x4 = 16) ***"Delayed initiation and review of ADHD medication"*** **due to a lack of capacity in ADHD Nurse Led Service, specifically medical supervision of ADHD medication initiation and completing prescribing**. Mitigations include nurse prescribers in place for ADHD service, SOPs to support safe prescribing. Contracts with ICB to be reviewed to reduce the gap between capacity and demand and to train new nursing team in ADHD and band 6 staff to complete a prescribing course. Recruited 8 x new nursing staff to the ADHD team however there is a period of induction and development required before these staff can really make a positive impact on the waiting times. Four staff currently completing the NMP course (completion April 24). No reduction in risk score due to the national shortage of ADHD medications.

Risk 2073 (4x4 = 16) "*Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service due to insufficient workforce (wte) within Clinical Health Psychology to respond to the demand of the service".* Mitigations in place include weekly waiting list management, offering brief interventions, group interventions and self-help resources and a daily duty team is in place Monday – Friday to triage referrals and offer urgent intervention if required. Ongoing actions include recruiting to the skill mix of the workforce to trial brief intervention options. Controls reviewed and no specific updates to actions. No change to risk score.

Risk 2589 (4x4 = 16) ***"Inability to safely Catkin and Community Clinics" due to reduced support to the clinical teams due to workforce vacancy, sickness within the team and historical working patterns***. Mitigations include nurse rotas, NHSP and an E-Roster system is in place. Ongoing actions consist of ensuring staffing business continuity plan is complete and up to date. Risk reviewed - No change to score at present, however alternative recruitment strategy now employed (gone out to advert) for Community based staff. Care Support Worker Development/Trainees (CSWD) now allocated to OPD. Weekly operational meetings and daily staffing reviews/skill-mixing being optimised.

Risk 2019 (3x5 = 15) ***"Delay in treatment for Speech and Language Therapy" caused by an increased waiting list for access to assessment and for treatment by the Community Speech and Language Team (across Liverpool and Sefton).*** Controls include additional staff are doing additional hours to support reducing the waiting list, recruitment, permanent vacancies have been backfilled and the core offer has been reviewed. Ongoing actions include recruitment request to backfill secondments and validation of the treatment waiting list and of the longest waiters. A project is to be established to redesign the flow of patients into and following the first appointment. Risk increased in November 2023 from 12 to 15- the wait to access to the service for assessment is steadily reducing, however the wait to receive follow up has increased, exacerbated further by long-term sickness, new vacancies, and inability to recruit.

Risk 2100 (4x4=16) "*Risk of inability to provide safe staffing levels"* caused by staff ill health and

absence higher than the Trust absence target of 5%. Controls include, sickness and absence policy, corporate report monitoring, Occupational Health Service, early intervention service. Ongoing actions include training and e-learning tool to be rolled out for managers. Risk reviewed - actions on track and risk score remains unchanged.

Compliance and Regulatory

Risk 57 (4x4 = 16) ***"Risk of not meeting Statutory Guidance in relation to adoptions, which impacts on the adoption process for children and families" due to the current capacity and demand pressures within the Adoption Medical Advisor role.*** Senior management is to look at the current internal pool of clinicians for expressions of interest for the role and meetings with the Local Authority and Adoption in Merseyside colleagues. Risk reviewed; progress being made on the recruitment to Adoption Medical Advisor. Clinician commencing into post on 6PA job plan from Jan 2024. Ongoing long-term sickness of 1x Medical Advisor is still a factor.

NOTE: February 24 update: Risk score now reduced to 12 (4x3) New recruited Adoption Medical Advisor commenced in post Jan 24 on 6PA job plan. Induction underway,

Risk 2627 (3x5 = 15) ***"Not compliant with national guidance with transferring and transcribing patient records following adoption"*** **due to pre-adoption records not being routinely closed post adoption** and therefore previous medical records including safeguarding history are attached to the new NHS number. Named Nurse for Children in Care in place to oversee the process running up to adoption. Ongoing actions include review, update, and formalise an interim process for closing the previous medical record when a new NHS number is assigned to a newly adopted child or young person. Risk reviewed - action plan associated to Adoption record processes included in a monthly internal meeting.

Risk 67 (3x5 = 15) ***"NatPSA/2023/010/MHRA - Risk of death from entrapment or falls - Our current fleet of beds (178) are classed as adult beds and thus are not designed in accordance with the relevant standard for paediatric beds" due to*** The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails, trolleys, bariatric beds, lateral turning devices and bed grab handles. Controls include the current bed rail assessment on Meditech provides some assurance. Further actions being taken consist of updating the bed rail assessment, Trust policy and user training. No update from supplier.

Financial

Risk 2579 (3x5 = 15) ***"Risk of failure to achieve financial balance due to existing and emerging cost pressures, impact of Industrial Action on the delivery and recovery of NHS services, reduced effectiveness of services, inability to invest and innovate and potential of increased workforce pressures" due to CIP delivery risks, junior doctors and HCA and Bank spend.*** Controls include vacancy approval and divisional scrutiny via Divisional Group. Further actions consist of a review of all current sickness and cover arrangements to embed an increasingly financially sustainable plan. Reviewed and discussed, although discussion of merging with corporate risk, to date it was felt the division should recognise the risk in addition. Risk reviewed and considering M8 financial position risks remain, further controls to be added pending discussion at SLT.

Operational

Risk 2753 (4x4 = 16) ***"There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome"*** **due to children and young people are waiting beyond the national standard to access planned care post Covid 19 pandemic due to a prolonged loss of capacity.** Mitigations in place include a clinical review has been undertaken of patients who have waited 52 weeks with no clinical intervention e.g., outpatient appointment and weekly reviews of referral to treatment waiting times for each specialty to monitor progress towards reducing waiting times in line with national / internal targets. Further actions being taken consist of trajectory plans for ENT, dental and spine. Risk score remains the same. Dentistry have increased daycase activity. ENT have

temporarily increased outpatient activity. Spine activity remains at current rate but have been impacted by industrial action. Weekly monitoring remains.
NOTE: February 24 update: Risk score now reduced to 8 (4X2) Risk reviewed and downgraded as being monitored and no harm identified in the specialities.

Quality – Effectiveness

Risk 2657 (5x3 = 15) ***"As there is no consistent method for recording and communicating resuscitation decisions across the trust there is a child may be resuscitated inappropriately and receive inappropriate and potentially harmful treatment"*** **caused by no consistent method for recording and communicating resuscitation decisions across the Trust.** Mitigation includes the Trust's Resuscitation Policy. Ongoing actions include implementation of ReSPECT across the Trust. Solution developed within Expanse. Currently out to test with Palliative Team to ensure it matches clinical workflow. Once accepted will be pushed to live system.

Reputation

Risk 2779 (4x4 = 16) "*There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff" caused by the current provider of a service that supports children and young people with gender incongruence or gender dysphoria receiving significant scrutiny from media outlets.* Controls include a supporting governance structure, a national communications group and Gateway review process in place. Ongoing actions include a report to be shared with Trust Board regarding an update on service planning. No change to risk. Some recruitment has taken place, with more recruitment planned. This will remain under review.

0201

Table 1: CLOSED HIGH RISKS

DIVISION	Ref	Risk	Date Closed	Reason for closure
Medicine (Gastroenterology)	68	Gastroenterology Operating Capacity	11/12/2023	Risk closed as now being managed by Surgical Division through another risk.

Table 2: RISKS WITH DECREASED SCORES

DIVISION	Ref	Risk	Prior Score / New Score	Reason for decrease
Surgery (Paediatric Surgery)	2746	The risk of patient harm due to a lack of clear guidance and a training structure in relation to chest drains. There are two different chest drain systems used within the trust and conflicting guidelines to manage them safely. There is a lack of a robust training program and competency framework in relation to each of these drainage systems.	5x3 = 15 4x3 = 12	Business case has now been approved. Plans for procurement and roll out of the system have been formed.

Table 3: LONG-STANDING HIGH RISKS (greater than 12 months since identification as a high risk)

Division/ Service	Ref	Risk Owner	Risk Score (CxL)	Risk	Date identified
DIVISION OF COMMUNITY & MENTAL HEALTH:					
ASD / ADHD	1524	Lisa Cooper, Divisional Director	4x4 = 16	Delayed initiation and review of ADHD medication. **Summary** Risk score remains static.	**December 2017**
ASD / ADHD	2463	Lisa Cooper, Divisional Director	4x4 = 16	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard). **Summary:** Risk remains static.	**July 2021**
Rainbow – Children In Care	2627	Lisa Cooper, Divisional Director	3x5 = 15	Not compliant with national guidance with transferring and transcribing patient records following adoption. **Summary:** Risk remains static.	**May 2022**
CAMHS - Sefton	2360	Lisa Cooper, Divisional Director	3x5 = 15	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgent and 18-week referral to treatment target for routine). **Summary:** Risk remains static.	**February 2021**
DIVISION OF SURGERY:					
Neurosurgery	2441	Adam Bateman, Chief Operating Officer	5x3 = 15	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval. **Summary:** Risk remains static.	**June 2021**
DIVISION OF MEDICINE:					
Palliative Care Team	2657	Susannah Holt, Consultant Palliative Care	5x3 = 15	As there is no consistent method for recording and communicating resuscitation decisions across the trust there is a child may be resuscitated inappropriately and receive inappropriate and potentially harmful treatment. **Summary:** Risk remains static.	**July 2022**
CORPORATE SERVICES:					
HR	2100	Melissa Swindell, Chief People Officer	4x4 = 16	Inability to provide safe staffing levels. **Summary:** Risk remains static.	**January 2020**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th March 2024

Paper Title:	NHS leadership competency framework for board members
Report of:	Director of Corporate Affairs
Paper Prepared by:	NHS England

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Board members are asked to note the new framework published on 28th February as part of the response to the 2019 Kark review and the expectation of NHS board to incorporate the competencies in to PDR processes going forward. Further papers will be brought in due course to facilitate a more detailed discussion.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	n/a

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
2.1	Workforce Sustainability and Development	3x5=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

Date published: 28 February, 2024
Date last updated: 28 February, 2024

NHS leadership competency framework for board members

Publication (https://www.england.nhs.uk/publication)

Content

1. Introduction

1.1 Context

Leaders in the NHS help deliver better health and care for patients by setting the tone for their organisation, team culture and performance.

We have worked with a wide range of leaders from across the NHS to help describe what we do when we operate at our best. We have engaged with stakeholders including NHS Providers, NHS Employers and NHS Confederation, and built in best practice from other industries. We have used the feedback to design the 6 competency domains in the Leadership Competency Framework (the framework) to support board members to perform at their best.

The competency domains reflect the NHS values (https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#nhs-values) and the following diagram shows how they are aligned:

Working together for patients*	**Compassion**
Building a trusted relationship with partners and communities	Creating a compassionate, just and positive culture
Respect and dignity	**Improving lives**
Promoting equality and inclusion and reducing health and workforce inequalities	Setting strategy and delivering long term transformation Driving high quality sustainable outcomes
Commitment to quality of care	**Everyone counts**

Driving high quality and sustainable outcomes Setting strategy and delivering long term transformation	Promoting equality and inclusion and reducing health and workforce inequalities Creating a compassionate, just and positive culture
Providing robust governance and assurance	

*Wherever the word “patient” is used in this document, this refers to patients, service users and carers.

The competency domains are aligned to Our NHS People Promise (https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/), Our Leadership Way (https://www.leadershipacademy.nhs.uk/organisational-resources/our-leadership-way/) and the Seven Principles of Public Life (https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2) (Nolan Principles). A high-level summary of the values and concepts from these documents is in Appendix 1.

1.2 Background

In 2019, the Tom Kark KC review of the fit and proper person test was published. This included a recommendation for ‘the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed’. This framework responds to that recommendation and forms part of the NHS England Fit and Proper Person Test Framework (https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/) for board members (FPPT).

The framework takes account of other NHS England frameworks and strategies including:

- NHS England Operating Framework (https://www.england.nhs.uk/publication/operating-framework/)
- NHS National Patient Safety Strategy (https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/)
- NHS Long Term Workforce Plan (https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/)

(./NHS England » NHS leadership competency framework for board members_files/leadership-competency-framework.png)

- NHS Equality, Diversity and Inclusion Improvement Plan (https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/#high-impact-action-1)
- National Quality Board Shared Commitment to Quality (https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/)
- NHS Well Led Framework (https://www.england.nhs.uk/well-led-framework/)
- The statutory framework of the Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted)

1.3 Purpose

Being an NHS board member means holding an extremely demanding yet rewarding leadership responsibility. NHS board members have both an individual and collective role in shaping the vision, strategy and culture of a system or organisation, and supporting high-quality, personalised and equitable care for all now and into the future.

This framework is for chairs, chief executives and all board members in NHS systems and providers, as well as serving as a guide for aspiring leaders of the future. It is designed to:

- support the appointment of diverse, skilled and proficient leaders
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- help organisations to develop and appraise all board members
- support individual board members to self-assess against the six competency domains and identify development needs.

People taking on first-time director roles, in particular, are unlikely to be able to demonstrate all the competency examples. However, this framework should provide a guide by which, over time, directors can measure themselves and develop proficiency in all areas. Where development areas are identified, commitment to working on these will be important.

As non-executive directors have different roles and responsibilities to those of executive directors, and there are differences between executive director roles, the framework supports the assessment of board members in their role as part of a unitary board. All six competency domains should be considered for all board members, taking account of any specific role related responsibilities and nuances.

Achievement against the competency domains supports the Fit and Proper Person assessment for individual board members.

2 The six leadership competency domains

2.1 Driving high-quality and sustainable outcomes

The skills, knowledge and behaviours needed to deliver and bring about high quality and safe care and lasting change and improvement – from ensuring all staff are trained and well led, to fostering improvement and innovation which leads to better health and care outcomes.

2.2 Setting strategy and delivering long-term transformation

The skills that need to be employed in strategy development and planning, and ensuring a system wide view, along with using intelligence from quality, performance, finance and workforce measures to feed into strategy development.

2.3 Promoting equality and inclusion, and reducing health and workforce inequalities

The importance of continually reviewing plans and strategies to ensure their delivery leads to improved services and outcomes for all communities, narrows health and workforce inequalities, and promotes inclusion.

2.4 Providing robust governance and assurance

The system of leadership accountability and the behaviours, values and standards that underpin our work as leaders. This domain also covers the principles of evaluation, the significance of evidence and assurance in decision making and ensuring patient safety, and the vital importance of collaboration on the board to drive delivery and improvement.

2.5 Creating a compassionate, just and positive culture

The skills and behaviours needed to develop great team and organisation cultures. This includes ensuring all staff and service users are listened to and heard, being respectful and challenging inappropriate behaviours.

2.6 Building a trusted relationship with partners and communities

The need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities, and our workforce. Strengthening relationships and developing collaborative behaviours are key to the integrated care environment.

3 Using the framework

3.1 Recruitment

The competency domains should be incorporated into all NHS board member* job/role descriptions and recruitment processes. They can be used to help evaluate applications and design questions to explore skills and behaviours in interviews, presentations and other aspects of the recruitment and assessment process.

* ‘Board member’ refers to all board members – executive and non-executive.

3.2 Appraisal

The competency domains in section 5 should form a core part of board member appraisals and the ongoing development of individuals and the board as a whole. The framework should be applied as follows – a new Board Member Appraisal Framework incorporating the competencies will be published to support this:

Chairs should:

- Carry out individual appraisals for the chief executive and non-executive directors, based on the framework and other objectives
- Assure themselves that individual board members can demonstrate broad competence across all 6 domains and that they have the requisite skills, knowledge and behaviours to undertake their roles
- Assure themselves there is strong, in-depth evidence of achievement against the competency domains collectively across the board, and ensure that appropriate development takes place where this is not the case
- Ensure the findings feed into the personal development plans of non-executive directors
- As and when required, include relevant information in the Board Member Reference (https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2023%2F08%2FPRN00238-ii-appendix-2-the-board-member-reference-template.docx&wdOrigin=BROWSELINK) when a board member leaves

Chief executives should:

- Carry out individual appraisals for the executive directors based on the framework and other objectives
- Ensure the findings feed into the personal development plans of the executive directors

The senior independent director (or deputy chair) should:

- Carry out the appraisal for the chair based on the framework and other objectives
- Ensure the findings feed into the personal development plan of the chair

Board members should:

- Self-assess against the six competency domains as preparation for annual appraisal
- Identify and plan development activity as part of ongoing continuous professional development (CPD), taking into account any professional standards that are also applicable for specific board member roles
- Review the self-assessment with their line manager and obtain feedback

All board members will have more detailed individual, team and organisational objectives. The 6 domains identify competency areas and provide examples of leadership practice and behaviours which will support delivery against objectives.

3.3 Development

Even the most talented and experienced individuals are unlikely to be able to demonstrate how they meet all the competencies in this framework all of the time. However, it should provide a means by which, over time, individuals can measure themselves and develop proficiency in all areas.

The competency domains will be built into national leadership programmes and support offers for board directors and aspiring board directors. All board members should actively engage in ongoing development to enable continued and greater achievement across the competency domains over time, and should be supported to do so.

Board members should refer to the directory of board level learning and development opportunities (https://www.england.nhs.uk/long-read/directory-of-board-level-learning-and-development-opportunities/) for existing development offers.

3.4 Scoring guide

Appendix 2 is an optional scoring guide for individual board members to use when self-assessing against the competency domains.

4 Next steps

The Board Member Appraisal Framework will be published by autumn 2024. It will reflect the competency domains in this framework, as well as other performance objectives. It will also provide guidance on how to assess performance against the 6 competency domains, including for experienced board members and those who have been in post less than 12 months.

The LCF will continue to be kept under review, and may be updated periodically to reflect changes in the NHS operating environment, as well as feedback received from users. Feedback can be sent to england.karkimplementationteam@nhs.net (mailto:england.karkimplementationteam@nhs.net).

5 Detailed leadership competency domains

The individual competencies are expressed as ‘I’ statements. This is to indicate personal actions and behaviours that board members will demonstrate in undertaking their roles. However, it is recognised that, including in the context of a unitary board, high performance and delivery against objectives is also achieved through effective team working and collaboration.

1. Driving high-quality and sustainable outcomes

What does good look like?

I am a member of a unitary board which is committed to ensuring excellence in the delivery (and / or the commissioning) of high quality and safe care within our limited resources, including our workforce. I seek to ensure that my organisation* demonstrates continual improvement and that we strive to meet the standards expected by our patients and communities, as well as by our commissioners and regulators, by increasing productivity and bringing about better health and care outcomes with lasting change and improvement.

* All references to “organisation” also refer to systems for board members of integrated care boards.

Competencies

1. I contribute as a leader:

a. to ensure that my organisation delivers the best possible care for patients

b. to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation

2. I assess and understand:

a. the performance of my organisation and ensure that, where required, actions are taken to improve
b. the importance of efficient use of limited resources and seek to maximise:

i. productivity and value for money

ii. delivery of high quality and safe services at population level

c. the need for a balanced and evidence-based approach in the context of the board’s risk appetite when considering innovative solutions and improvements

3. I recognise and champion the importance of:

a. attracting, developing and retaining an excellent and motivated workforce
b. building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles
c. retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate

4. I personally:

a. seek out and act on performance feedback and review, and continually build my own skills and capability
b. model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training

2. Setting strategy and delivering long-term transformation

What does good look like?

I am a member of a unitary board leading the development of strategies which deliver against the needs of people using our services, as well as statutory duties and national and local system priorities. We set strategies for long term transformation that benefits the whole system and reflects best practice, including maximising the opportunities offered by digital technology. We use relevant data and take quality, performance, finance, workforce intelligence and proven innovation and improvement processes into account when setting strategy.

Competencies

1. I contribute as a leader to:

a. the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities
b. ensure there is a long-term strategic focus while delivering short-term objectives
c. ensure that our strategies are informed by the political, economic,

social and technological environment in which the organisation operates
d. ensure effective prioritisation within the resources available when setting strategy and help others to do the same

2. I assess and understand:

a. the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments
b. the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy
c. clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans

3. I recognise and champion the importance of long-term transformation that:

a. benefits the whole system
b. promotes workforce reform
c. incorporates the adoption of proven improvement and safety approaches
d. takes data and digital innovation and other technology developments into account

4. I personally:

a. listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same
b. seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies

3. Promoting equality and inclusion, and reducing health and workforce inequalities

What does good look like?

I am a member of a unitary board which identifies, understands and addresses variation and inequalities in the quality of care and outcomes to ensure there are improved services and outcomes for all patients and communities, including our workforce, and continued improvements to health and workforce inequalities.

Competencies

1. I contribute as a leader to:

a. improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care
b. ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes
c. reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups

2. I assess and understand:

a. the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6)

3. I recognise and champion:

a. the need for the board to consider population health risks as well as organisational and system risks

4. I personally:

a. demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds
b. encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities.

4. Providing robust governance and assurance

What does good look like?

I understand my responsibilities as a board member and how we work together as a unitary board to reach collective agreement on our approach and decisions. We use a variety of information sources and data to assure our financial performance, quality and safety frameworks, workforce arrangements and operational delivery. We are visible throughout the organisation and our leadership is underpinned by the organisation's behaviours, values and standards. We are seen as a Well Led organisation and we understand the vital importance of working collaboratively.

Competencies

1. I contribute as a leader by:

a. working collaboratively on the implementation of agreed strategies
b. participating in robust and respectful debate and constructive challenge to other board members
c. being bound by collective decisions based on objective evaluation of research, evidence, risks and options
d. contributing to effective governance and risk management arrangements
e. contributing to evaluation and development of board effectiveness

2. I understand board member responsibilities and my individual contribution in relation to:

a. financial performance
b. establishing and maintaining arrangements to meet statutory duties, national and local system priorities
c. delivery of high quality and safe care
d. continuous, measurable improvement

3. I assess and understand:

a. the level and quality of assurance from the board's committees and other sources
b. where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making
c. how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements
d. the use of intelligence and data from a variety of sources to recognise

and identify early warning signals and risks – including, for example, incident data; surveys; external reviews; regulatory intelligence; understanding variation and inequalities.

4. I recognise and champion:

a. the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders
b. working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement

5. I personally:

a. understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same

5. Creating a compassionate, just and positive culture

What does good look like?

As a board member I contribute to the development and ongoing maintenance of a compassionate and just learning culture, where staff are empowered to be involved in decision making and work effectively for their patients, communities and colleagues. As a member of the board, we are each committed to continually improving our approach to quality improvement, including taking a proactive approach and culture.

Competencies

1. I contribute as a leader:

a. to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues
b. to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement
c. to improve staff engagement, experience and wellbeing in line with

our NHS People Promise (for example, with reference to equality, diversity and inclusion; freedom to speak up; personal and professional development; holding difficult conversations respectfully and addressing conflict)
d. to ensure there is a safe culture of speaking up for our workforce

2. I assess and understand:

a. my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture

3. I recognise and champion:

a. being respectful and I promote diversity and inclusion in my work
b. the ability to respond effectively in times of crisis or uncertainty

4. I personally:

a. demonstrate visible, compassionate and inclusive leadership
b. speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice
c. challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe, or staff or people being excluded in any way or treated unfairly
d. promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention

6. Building trusted relationships with partners and communities

What does good look like?

I am part of a board that recognises the need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities and our workforce. We

are seen as leading an organisation that proactively works to strengthen relationships and develop collaborative behaviours to support working together effectively in an integrated care environment.

Competencies

1. I contribute as a leader by:

a. fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners
b. identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest

2. I assess and understand:

a. the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems
b. the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners

3. I recognise and champion:

a. management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues
b. open and constructive communication with all system partners to share a common purpose, vision and strategy

Appendix 1: Values and concepts from key documents which form an anchor for this framework

Our people promise

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly

- We are a team

NHS values

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

Our leadership way

We are compassionate

- We are inclusive, promote equality and diversity, and challenge discrimination
- We are kind and treat people with compassion, courtesy and respect.

We are curious

- We aim for the highest standards and seek to continually improve, harnessing our ingenuity
- We can be trusted to do what we promise

We are collaborative

- We collaborate, forming effective partnerships to achieve our common goals
- We celebrate success and support our people to be the best they can be

Health and Care Act 2022

- Collaborate with partners to address our shared priorities and have the core aim and duty to improve the health and wellbeing of the people of England.
- Improve the quality, including safety, of services provided.
- Ensure the sustainable, efficient use of resources for the wider system and communities

Seven principles of public life

- Selflessness
- Integrity
- Objectivity
- Accountability

- Openness
- Honesty
- Leadership

Appendix 2: Optional scoring guide for individual self-assessment against the competencies

Download a word copy of this scoring guide (https://www.england.nhs.uk/wp-content/uploads/2024/02/B0496i-app-2-optional-scoring-guide-for-individual-self-assessment-against-the-competencies.docx).

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