Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 2nd May 2024, commencing at 9:00am
Lecture Theatre 4, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY - Brilliant Pupil Voice Programme (9:00am-9:15am)							
BOARD PHOTOGRAPH (9:15am-9:20am)							
1.	**24/25/36**	**9:20 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/37**	**9:21 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/38**	**9:22 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **11th April 2024.**	**D**	Read enclosure
4.	**24/25/39**	**9:24 (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.	**24/25/40**	**9:25 (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.	**24/25/41**	**9:35 (10 mins)**	**National Context for 2024/25.**	L. Shepherd	To receive an update on the national picture.	**N**	Verbal
7.	**24/25/42**	**9:45 (10 mins)**	**Vision 2030 Oversight.**	J. Grinnell	For information purposes.	**N**	Presentation
Collaborating in Communities							
8.	**24/25/43**	**9:55 (15 mins)**	**Collaborate for Children and Young People:**	D. Jones	To receive an update on the current position.	**N**	Read report

			• **Growing Great Partnerships Update.** **System Wide Update.**				
Operational Issues							
9.	**24/25/44**	**10:10 (40 mins)**	• **Integrated Performance Report Proposal.** • **M1 Flash Report/Operational Overview.** • **Integrated Performance Report for M12, 2023/24.** • **Digital, Data and Information Technology Update.**	K. Warriner A Bateman Executives/ Divisions K. Warriner	To receive and approve the Integrated Performance Report proposal. To receive an update on the current position. To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position.	**D** **A** **N** **A**	Read report Read enclosure Read report Read report
10.	**24/25/45**	**10:50 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Unrivalled Experience							
11.	**24/25/46**	**11:00 (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
12.	**24/25/47**	**11:05 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 24.4.24.** - **Approved minutes from the meeting held on the 20.3.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 21.2.24.	**A**	Read enclosure
Revolutionising Care							

13.	**24/25/48**	**11:10 (10 mins)**	**Gender Development Service (North Programme) Update.**	L. Cooper	To receive an update on the current position.	**A**	Read report
Pioneering Breakthroughs							
14.	**24/25/49**	**11:20 (5 mins)**	**Futures Committee:** - **Chair's verbal update from the meeting held on the 16.4.24.** - **Approved minutes from the Research and Innovation Committee held on the 18.1.24.**	S. Arora	To escalate any key risks, receive updates and note the approved minutes from the 18.1.24.	**N**	Read enclosure
Supporting our People							
15.	**24/25/50**	**11:25 (10 mins)**	**People Plan Highlight Report; including:** • **EDI update.**	M. Swindell M. Swindell	To receive an update on the current position. To provide an update on key areas and updates from the system on the workforce.	**A** **A**	Read report Read report
16.	**24/25/51**	**11:35 (15 mins)**	**Freedom To Speak Up Update; including:** • **Freedom to Speak Up Review Tool for Boards.**	K. Turner/ E. Saunders	To receive an update on the current position. For information and assurance.	**A** **N**	Read report Read report
Strong Foundations (Board Assurance)							
17.	**24/25/52**	**11:50 (10 mins)**	**Statement of Going Concern for the 2023/24 Annual Accounts.**	R. Lea	To receive a recommendation from the Audit and Risk Committee that the Board consider it appropriate for the Trust to prepare its 2023/24 financial statements on a going concern basis.	**D**	Read report
18.	**24/25/53**	**12:00 (5 mins)**	**Audit and Risk Committee:** - **Chair's highlight report from the meeting held on the 18.4.24.** - **Approved minutes**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 25.1.24.	**A**	Read enclosure

			from the meeting held on the 25.1.24.				
19.	**24/25/54**	**12:05 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 29.4.24.** - **Approved minutes from the meeting held on the 25.3.24.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 25.3.24.	**A**	Read enclosure
20.	**24/25/55**	**12:10 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Items for Information							
21.	**24/25/56**	**12:15 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
22.	**24/25/57**	**12:19 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Lunch (12:20pm-12:40pm)							
Date and Time of Next Meeting: Thursday, 6th of June 2024, 9:00am, Lecture Theatre 2, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was not used after the 4th of April 2024

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M12, 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 11th April 2024 at 11:00am**
Lecture Theatre 2, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. G. Meehan	Non-Executive Director (GM)	
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Communications	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Observing	Ms. M. Ashe	Policy Lead/Advisor to the CEO at Alder Hey	(MA)
Patient Story	Mr. R. Walton	Orthopaedic Consultant	(RW)
	Ms. Z. Mawdsley	4A Ward Manager	(ZM)
	Ms. R. Williams	Physiotherapist	(RW)
Item 24/25/06	Ms. N. Palin	Director of Transformation and Change	(NP)
Apologies	Mr. M. Flannagan	Director of Marketing and Communications	(MF)

Patient Story

The Chair welcomed Ash who had been invited to April's Trust Board to share her story and explain how staff at Alder Hey advocated for her which built Ash's confidence, made her feel safe and helped her progress to the next phase of her life. Members of Ash's Medical team; Roger Walton, Zoe Mawdsley, Rebecca Williams, and key workers; Alicia and Lisa, accompanied Ash to support her.

Ash explained that she came to Alder Hey to have a foot reconstruction operation which changed her life in many ways. Ash remained with Alder Hey for three months and during this period of time was eventually able to open up to members of her medical team about her situation at home. Ash explained that previously nobody had listened about what was happening to her and this caused her mental health to deteriorate from a very young age. Ash

advised that she gave up trying to tell people about her situation as she thought nobody believed her but staff at Alder Hey listened to what Ash had to say and did everything possible to protect her. Ash explained that for the first time in her life she finally felt safe and protected knowing that she wouldn't have to return to her old environment.

Ash drew attention to the kindness of staff at Alder Hey that made her feel as though she was part of a family who never gave up on her, especially Steph who brought her own decorations in at Christmas time to make Ash's room feel Christmassy and make her smile. The staff on Ward 4A also made sure Ash had the best Christmas ever and received presents. Ash explained that Steph set time aside to have a chat with her regularly and wrote positive quotes on post-it notes and put them up around her room. This gave Ash hope that things would be different in the future.

As a result of staff advocating for Ash, since being discharged she has moved into a new home which is a semi-independent environment where she is supported by key workers. Ash now feels that she is able express herself without feeling supressed and she feels like her inner child is healing as she gets to do things she has never done before. Ash now looks after a kitten called Skunk.

The Chair thanked Ash for being so brave and sharing her story with the Board and wished her well for the future. The Chair asked Ash if there was anything that Alder Hey could have done better during her stay in hospital. Ash explained that when she was struggling to eat, she was unable to find anything that appealed to her outside of the regular menu and this was a challenge. The Chair agreed that this would be fed back to the catering manager.
Action: AB

Roger Walton thanked Ash for taking a leap of faith to share her circumstances with the team which gave Alder Hey the chance to advocate and protect a vulnerable young person. Zoe Mawdsley advised that advocate arrangements were in place for Ash prior to discharge. This enabled Ash to meet with her advocate and ensure she was comfortable with the plans that were being made for her. Attention was drawn to the importance of promoting advocacy for teenage patients to enable them to understand their rights.

The Chair thanked the members of the medical team who have been part of Ash's journey.

24/25/01 Welcome and Apologies

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

24/25/02 Declarations of Interest

Non-Executive Director (NED), Gerald Meehan, declared that he is a NED at Wirral Community Health and Care NHS Foundation Trust, and the Independent Chair of Liverpool's Children's Services Improvement Board.

24/25/03 Minutes of the previous meeting held on Thursday 7th March 2024
Resolved:
The minutes from the meeting held on the 7th March were agreed as an accurate record of the meeting.

24/25/04 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 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)* – The initial meeting that was scheduled has been deferred to the 24.4.24. An update will be provided in May. **ACTION TO REMAIN OPEN**

24/25/05 Chair's and CEO's Update

An update was provided on the external meetings that the Chair has attended recently.

C&M Health and Care Partnership – There is a resource of £12m intended for distribution across Cheshire and Merseyside (C&M). It has been proposed that there will be nine Places across C&M with the distribution of resources going to the most deprived areas.

It was reported that the NHSE Regional Director, Richard Barker, is retiring. The Board was advised of the £460m deficit across the North and the forthcoming reduction of the workforce across C&M.

NHS Confederation Chairs' Forum – A discussion took place regarding the NHS Confederation's General Election Strategy and it was highlighted that whichever party is elected it is imperative that they recognise the need for efficiency across the NHS. It was pointed out that there is still a high level of support for the founding principles of the NHS but the public are unhappy with what they perceive as 'waste' in the NHS.

The Chair reflected on 2023/24 and felt that the Trust has had an amazing twelve months. As the organisation heads into the new financial year it will face immeasurable challenges as a result of the financial issues that the NHS as a whole is experiencing. Adopting a different terminology when talking about money and people will give staff a sense of forward thinking and hope which is important as the organisation values what they do.

The Chair acknowledged that the Board is effective as a team and recognised the challenges that Executive Directors face on a daily basis. Thanks were offered to all for their work and dedication throughout the year.

Louise Shepherd thanked Dame Jo for recognising the challenges that the Executive team face and the achievements that have been delivered in what has been a very challenging environment. It was pointed out that the Trust has made immense progress in 2023/24 and has been on a huge trajectory since the pandemic. It was felt that Alder Hey is in a positive place ahead of the coming year.

Reference was made to the interview that Hilary Cass gave following publication of the final recommendations of the Cass Review. It was felt that the interview set the right tone for the country, and a letter was sent to Hilary Cass to thank her for the support she has provided to the Trust in respect to the new Gender Service.

Local update

Liverpool Strategic Partnership (LSP) – The LSP signed off the Prototype proposal for North Liverpool that has been agreed with the Government. This will be used as a vehicle for other areas of work.

Liverpool Women's Hospital (LWH) Services in Liverpool Programme Board – The Programme Board has met on three occasions. The main focus of the work that is taking place is to raise awareness of the risks relating to care and the action that needs to be taken to address the issues. Discussions on the neonatal element of the agenda will be introduced in the next six months, and a Clinical Summit is scheduled for the 3.5.24 which will be attended by staff from LWH and Alder Hey.

National update

In terms of the new financial year the picture across the NHS as a whole is a challenging one. Positive discussions have taken place with NHSE about CYP, and the Department of Health has established a Children's Unit. A presentation was submitted to NHSE about the big ticket items going forward and NHSE are thinking about a policy offer for the next Government. It has been realised that there isn't a strategy for CYP therefore it is important to work more closely with the department.

Out of Hospital – There is a need for a solid wrap around community service. Alternative models are being discussed and it is imperative that the £3.5b resource is used wisely in order to make a difference. Innovation will be a big part of the new model and issues relating to the commissioning of children's services need to be resolved.

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

24/25/06 Strategic Update

Vision 2030 Strategy Update

Work is ongoing to progress the 'Bring me the Future' area of need, and the Trust is challenging itself to ensure it keeps the thread of the Vision 2030 Strategy in the Integrated Annual Plan.

Draft Annual Plan, 2024/25

The Board was provided with the latest draft copy of the 2024/25 Integrated Annual Plan. As a result of the national planning guidance only recently being published, further work is required to finalise the plan ensuring that all national targets are reflected. It is proposed that the final version is shared with Resources and Business Development (RABD) Committee at the end of April for final approval, ahead of submission to NHSE at the beginning of May.

It was reported that the 2024/25 plan is the most integrated plan that the Trust has developed. It incorporates four areas of need; Personalise My Care, Get Me Well, Bring me the Future and Improve My Life Chances. The Transformation Plan is also incorporated in the Annual Plan along with People, Access, Finance and Performance.

Attention was drawn to some of the risk elements in the plan; performance, access, stretch target ahead of plan, risk in resource due to ambition.

The Board was provided with an overview of the key elements of the financial section in the report (4.4). The following points were highlighted:

- To meet the organisation's commitment to the ICB system, and enable investment to deliver the Trust's strategic ambition Alder Hey will deliver on its obligations to ensure financial sustainability, including:
  - Achieving a financial balance turnover of just over £401m.
  - Setting activity targets to deliver above the mandated level *(stretch target).*
  - Capital spend of £12.7m in 2024/25 will continue to be managed through the ICS at system level with allocation of spend distributed to each provider. Attention was drawn to the urgent care incentive that will increase the Trust's capital spend if successful.
  - Continue investment in the Trust's campus and estate, with schemes including Neonatal Unit, Same Day Emergency Care (SDEC), Outpatient/Fracture Clinic, Alder Park site. The Board was advised of the investment that will be required for the renewal of medical equipment and the restrictions that are in place in terms of providers making their own decisions on capital spend investment.
- Further focus/emphasis will be required throughout the year on capital and the setting of divisional plans in order to understand costs and priorities for 2024/25. Time will also need to be set aside to discuss engagement with the organisation on the efficiency programme.

A discussion took place about the achievability of the stretch target and it was queried as to whether the Trust is stretching Outpatients enough. It was agreed that there is an opportunity in Outpatients and it was felt that the patient portal will be game-changing to managing Outpatients.

The Board was advised that what the Trust is trying to achieve will drive the organisation's sustainability. In terms of ambition, the plan feels appropriate but challenging in terms of delivery.

The Chair asked about the extent of the organisation's engagement with primary care and queried as to whether more needs to be done. It was reported that the Trust has appointed a Place Transformation Lead/Partners Lead who will develop this area of work. The difficult element will be the translation of the Trust's offer to GPs and mobilising it. A suggestion was made about setting time aside to enable Alder Hey clinicians to spend time with primary care clinicians.

Resolved:
The Board received and noted the content of the 2024/25 Integrated Annual Plan.

Mobilisation Plan 2030, Y2

The Board received an outline the mobilisation plan for launching years 2/3 of the Vision 2030 Strategy. It was advised that this approach marks a significant shift and aims to deliver an integrated annual plan for 2024/25 and an aligned portfolio of programmes directly connected to realising Vision 2030. The following points were highlighted:

- The Transformation report outlines a very successful year in the Trust's journey to realising its 2030 Vision but Alder Hey remains ambitious to further advancement as it enters year 2/3. It was reported that the Mobilisation Plan was approved by RABD during March's meeting and is fully integrated with the 2024/25 Annual Plan.
- The Trust is bringing on line a portfolio of strategic transformational programmes aimed at realising its vision whilst having a clear focus on the benefit realisation.
- The work that has taken place to establish a Benefits Case Framework with the support of the Chair of RABD, John Kelly, has put the Trust in a favourable position as it transitions into the 2024/25 period, having established a programme that outlines clear benefits.
- The primary benefit of a single integrated plan is to make it easier to ensure resources are aligned to areas that have the biggest impact and are working collectively to deliver.
- *Communications and Engagement Plan* - The Communications Strategy to support the Vision 2030 Strategy will involve the majority of Alder Hey's communications being realigned and delivered under the 2030 'brand'. This will mainstream Vision 2030 as integral to everything the organisation does and will provide alternative ways in which to keep everyone informed and share success.
- The Board was advised that the Trust received Substantial Assurance from MIAA in terms of how it is delivering its programmes.

The Chief Digital and Transformation Officer, Kate Warriner, drew attention to the criticality of the Development Management Office (DMO) in terms of the progress that has been made. Thanks were offered to the team.

Resolved:
The Board:

- Noted the significant progress made to date.
- Approved the outlined Mobilisation Plan and Benefit Plan.
- Agreed that a priority focus should take place on the portfolio of programmes under Acute Medical Model, Productivity and GIRFT, Home First with the support of the enabling strategic goals.
- Noted the revisions to the governance arrangements for 2024/25 and beyond.

24/25/07 Year-end Position 2023/24; including:

End of year achievements

An overview of the Trust's key achievements in 2023/24 was presented to the Board by the Executive leads, as detailed in the report.

The Chair drew attention to the headline analysis summary in the Integrated Performance Report (IPR) and asked as to whether time should be set aside to understand why the Trust isn't achieving the target for 18.2% of its metrics. It was reported that there are a number of targets that have been set which are unachievable therefore it has been agreed to undertake a refresh of the IPR. A new IPR proposal will be submitted to the Board in May.

Reference was made to some of the achievements that come under the 'Revolutionising Care' strategic goal; treated over 81% of patients within 4 hours of arrival to ED, one of the best ranked Trusts in England, virtually eliminated CYP waiting over 65 weeks for treatment in consultant-led care pathways, investment in Community teams and the go live of the Gender Service. It was pointed out that these achievements have helped Alder Hey gain recognition for the work that it is doing. On behalf of the Board, the Chair thanked everybody for their hard work.

Resolved:
The Board received and noted the 2023/24 end of year achievements.

Integrated Performance Report for M11, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 11. An update was provided on the following areas of the IPR:

Community and Mental Health Division
There was nothing to raise in addition to what was in the IPR.

Division of Medicine
There was nothing to raise in addition to what was in the IPR.

Division of Surgery
- Work is taking place to ensure the division doesn't get to a point where patients are waiting 65 weeks for treatment.
- Progress is being made with recruitment in surgical services that are vulnerable.

Resolved:
The Board received and noted the content of the IPR for Month 11.

24/25/08 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:

- *Catkin and Sunflower House Building;*
  - Work is progressing on the sprinkler system in the Under-Croft car park.
- *Alder Park (Phase 1: Eating Disorder Young People Service (EDYS) and Therapies);*
  - It was confirmed that the EDYS scheme is progressing well.
- *Park Reinstatement;*
  - The playground has been signed off by Liverpool City Council (LCC) and is now in use.
  - The programme is currently being assessed to develop potential options for bringing forward work package handovers where possible.
- *Former Police Station Refurbishment;*
  - Work on the former police station is on the verge of completion.

Resolved:
The Board noted the update on the Campus development.

24/25/09 Learning from Patient Safety Incidents

The Board was provided with a summary of activity following the transition to the Patient Safety Incident Response Framework (PSIRF), including oversight of those incidents that have been reviewed in line with the Trust's Patient Safety Incident Response Plan (PSRIP), highlighting any identified areas of patient safety learning and improvement for the reporting timeframe the 1.3.24 to the 31.3.23. The following points were highlighted:

- There was a low level of incidents reported in March 2024.
- Updates and learning from previous incidents have been included in March's report.
- It has been agreed that a monthly meeting will be established to share learning and ensure consistency of implementing PSIRF across divisions.
- Monitoring of the Serious Incident legacy action plans will continue to be undertaken.
- Bespoke training for all staff involved in learning responses and acting in Family Liaison roles (FLOs) has been commissioned and will be delivered by Consequence UK between May and June 2024.

Resolved:
The Board noted the update.

24/25/10 Fuller Public Inquiry - Phase 1 and 2.

A briefing paper was submitted to the Board to provide an overview of the Independent Inquiry into the issues raised by the David Fuller case, the recommendations outlined in Phase 1 Report which was published in November 2023, the subsequent self-assessment work undertaken within Alder Hey in response to this, the actions required to achieve full assurance, and Phase 2 of the Inquiry. The following points were highlighted:

- Following Phase 1 of the Fuller Inquiry, the Trust reviewed the 17 recommendations that were made and conducted a self-assessment of the organisation's mortuary arrangements.
- In February 2024 (Phase 2) the Fuller Inquiry conducted a short survey of trusts via a questionnaire. NHS England (NHSE) has advised that the quantitative data from the questionnaire may be used in the Inquiry's report to secure the best learning outcomes for the future.
- Reference was made to the Trust's self-assessment document that is included in the report. The Board was informed that a number of the recommendations have been RAG rated as green as a result of the actions that have taken place but it was pointed out that there is an opportunity to strengthen current arrangements. Recommendation 10 has been RAG rated as red and relates to the installation of CCTV cameras in the mortuary, including the post-mortem room.
- It was reported that a working group will be established to take progress this work and develop an action plan to fully address all areas highlighted within the self-assessment against Phase 1 recommendations.

The Chair asked as to who will be involved in the working group that is to be established. It was confirmed that the Associate Director of Safeguarding and Statutory Services, Nichola Osbourne, will Chair the working group and there will be participation from members of the Mortuary team and the Security team. The

Chair highlighted the importance of being rigorous and transparent when addressing this area of work.

Resolved:
The Board noted the content of the report and supported the proposal for future work to be reported into the Safety and Quality Assurance Committee (SQAC).

24/25/11 Mortality Report, Q3.

The Board received the Mortality Report for Q3. The following points were highlighted:

- The Medical Examiner process went live on the 1.4.24. All deaths at Alder Hey are reviewed by the coroner (80%) and the Medical Examiner process (20%). The Child Death Overview Process (CDOP) Panel also conduct a review.
- Attention was drawn to the lack of admin support for the Hospital Mortality Review Group (HMRG) process due to staff leaving. This is impacting on the process and has been identified on the risk register. Going forward it has been agreed to create a full-time administrative role which will support both the HMRG and CDOP.
- *Risk-adjusted Resetting Probability Ratio Test (RSPRT)* - The subsequent resetting of the graph in 2024 (P9) has triggered a further checking and review process to feedback to PICAnet. Factors currently unaccounted for in the PIM3 score, such as significant co-morbidities, resulted in a lower mortality risk adjustment for these cases than would be clinically expected. The Trust has provided a response to the query which has been accepted.

A question was asked about whether there is anything that can be done to help the further development of the PIM3 score. It was confirmed that work is taking place on the software programme.

Reference was made to the change to the requirement to report the deaths of children and young people (CYP) age 4 and over with a learning disability and/or Autism to the Learning Disabilities Mortality Review (LeDeR) programme. It was pointed out that the Trust will continue to review the death of all patients who had a learning disability/autism but it was queried as to how the Trust will benchmark itself going forward. It was agreed to look into this matter and provide an update.

24/25/11.1 Action: ABASS

Resolved:
The Board noted the content of the Mortality Report for Q3.

24/25/12 Safety and Quality Assurance Committee (SQAC)

The approved minutes from the meeting held on the 21.2.24 were submitted to the Board for information and assurance purposes.

The Committee is continuing to review the timeliness of clinicians acknowledging diagnostic notifications/reports. It was confirmed that this area of work is progressing and a further update will be provided in June 2024. During March's meeting the Committee welcomed the new Paediatric Public Health Medicine Consultant, Rachel Isba, and received the Health Inequalities and Prevention Steering Group (HIPSG) update report. Going forward the Committee will receive

updates on future plans relating to health inequalities and the public health agenda. The importance of pursuing the inequalities agenda via other aspects of SQACs assurance work was noted by the Committee.

Resolved:
The Board noted the approved minutes from the meeting held on the 21.2.24.

24/25/13 Alder Care Lessons Learnt Report

The Board was provided with an overview of the findings from NHSEs independent assurance review on the Trust's transition to a new version of the Electronic Patient Record (EPR) – Alder Care. Attention was drawn to the following points:

- The Trust sought independent assurance via NHSE which resulted in an exercise being commissioned to provide the Trust with a view on the adoption and safety of the new EPR solution, which is in live use.
- The external assurance exercise identified a number of positives associated with the transition to Alder Care including additional assurance on its safety. This is coupled with the identification of some improvement areas. The review has outlined two recommendations for the Trust to implement in the future.
- As part of the exercise, NHSE's Digital Support System team spoke to a range of stakeholders across the Trust who use Meditech Expanse on a daily basis. The staff that were interviewed were from a cross section of professions and divisions in the Trust, and thanks were offered for their participation. Staff commended the support that was arranged by the Trust during implementation.
- It was reported that the outcome of the review was favourable for the Trust and NHSE commended the multidisciplinary approach to implementation and support during the go-live phase.
- The Board was advised that the Alder Care Lessons Learnt Report was submitted to RABD on the 25.3.24 and will be shared with the Audit and Risk Committee (ARC) on the 18.4.24.

A question was raised about whether the external team reviewed the benefits of the new system. It was explained that the DSS team looked at benefits realisation pre go live, considered whether the Trust was achieving its anticipated objectives, and gained an informed view from user experience of the system.

It was felt that the outcome of the external assurance exercise was really positive taking into account the size of the project and there only being two recommendations to be actioned by the Trust.

Resolved:
The Board noted the Alder Care Lessons Report.

24/25/14 Gender Service (North) Update

The Board received an update on progress with the nationally commissioned Children and Young People's Gender Service (North). Attention was drawn to the following key areas of the programme:

- The new Gender Service commenced on the 1.4.24 and went operational on the 2.4.24. Referrals from the national waiting list will not commence

until the service leadership team are assured that sufficient capacity is available.

- *Estates* – The project is on track for the service to take occupation from mid-May 2024. Until then the service will operate from Alder Hey and Manchester sites until the move to Warrington.
- *Recruitment* – To date the service has appointed 31wte staff with an additional 15 wte equivalent scheduled to be interviewed in April/May 2024. It was reported that the Children's Focus Group has participated in the interview process.
- *Open Case Load* – A total of 109 CYP have been transferred to the North service. All records have been reviewed and triaged by the North clinical team and welcome letters/information have been sent to CYP who are on the open caseload. The booking of appointments has commenced, with the first appointments being undertaken w/c 8.4.24. The Board was advised that the feedback from patients to date is overwhelmingly positive.
- *Contracting* – The contract is in place and a side letter has been agreed by NHSE.
- *Regulation* - Alder Hey has submitted documentation to the CQC to ensure that the premises in Warrington are sufficiently registered. There are currently no known risks in relation to this.

Reference was made to the Cass Report which was published on the 10.4.24. It was reported that all of the recommendations in the report have been applied to the new Gender Service, and there are a number of areas highlighted in the report that the programme team are giving thought to.

A conversation ensued about the commencement of other Gender Services across the region, having a flavour in future reports with regard to how staff are feeling about being part of the new service, and a query was raised about the content of the side letter in terms of the protection that it gives the Trust. Following discussion, it was agreed to share the side letter with the Non-Executive Directors (NEDs).

24/25/14.1 Action: LC

Resolved:
The Board noted the update and acknowledged the commencement of Phase 1 of the CYP's Gender Service (North).

24/25/15 Liverpool Neonatal Partnership Governance Review

The Board was provided with a report that **1**. Outlined the present governance and assurance arrangements that exist for the Liverpool Neonatal Partnership (LNP). **2.** Proposed a review of the assurance report to ensure robust oversight at both Trust Boards. **3.** Proposed an enhancement to the reporting structure that will strengthen assurance across the partnership. The following points were highlighted:

- Following a number of reviews on maternity/neonatal services and the introduction of PSIRF, it was felt that it is appropriate and timely to review the content of the reporting/governance structure of the partnership to ensure it provides both boards with equal oversight of the totality of activity and safety issues involving the delivery of neonatal services in Liverpool. It was recommended that a lead Non-Executive Director should oversee the LNP for additional assurance and oversight. The Board was advised that

Non-Executive Director, Kerry Byrne, has agreed to take on this oversight role.

- A workshop took place in January 2024 to reset the workstreams where it was proposed that the development of a single integrated governance report should be undertaken for alignment purposes. The report will incorporate data on sepsis and total neonatal mortality.

A query was raised about whether the report will capture the development of a single team from a governance perspective using a safety lens. It was reported that there is a workforce and governance workstream that has an Executive Senior Responsible Officer (SRO). Time will be set aside going forward to address the workforce, leadership and culture.

Resolved:
The Board noted the content of the report and supported the planned review of the governance report/associated reporting structure. It was agreed that the Board will receive an update on a quarterly basis.

24/25/16 Children's Hospital Alliance End-year Report, 2023/24 and Workstreams for 2024/25

The Board received the Children's Hospital Alliance end-year report for 2024/24 and the workstreams for 2024/25. A number of points were highlighted:

- A lot of learning takes place via the Children's Hospital Alliance (CHA) as a result of organisations coming together, and over the last twelve months the CHA has supported a larger number of work strands than ever before.
- It was reported that Alder Hey plays an important role in terms of hosting activities and contributing towards programmes.
- The CHA has expanded its community, welcoming new members and having open discussions with more.
- In 2024/25 there might be an opportunity/potential to integrate some services in alternative ways.

For noting
The Board agreed that the Trust will continue to support the Children's Health Alliance and receive updates throughout the year.

Resolved:
The Board received and noted the Children's Hospital Alliance end-year report for 2024/24 and the workstreams for 2024/25.

24/25/17 Futures Committee

The Board was informed that the inaugural meeting of the Futures Committee is scheduled for the 16.4.24. An overview was provided of the areas of work that the Committee will focus on during forthcoming meetings; Futures Strategy including the delivery of the four pillars, the financial strategy, addressing the operational elements of research and innovation via alternative routes to enable the Futures Committee to progress the work that sits behind the Futures Strategy, etc. It was pointed out that clarity will be required to determine which elements of the Global Strategy will report into the Committee.

A discussion took place about the positioning of the Global Strategy in terms of it having its own autonomy and the Committee route that it will report into. It was agreed to discuss this matter further outside of the meeting.

24/25/17.1 Action: JG

Resolved:
The Board noted the update.

24/25/18 People Plan Highlight Report

The Board was provided with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during February/March 2024. The following points were highlighted:

- It was reported that consultants have agreed a new pay offer that was negotiated between the Government and the British Medical Association (BMA) Consultant Committee.
- The Board was advised that whilst no further strike dates from Junior Doctors have been announced, further strike action is expected.
- The Department of Health (DoH) separate pay spine for nursing consultation has closed. This consultation has been published to explore and understand the benefits and challenges of introducing a separate nursing pay spine, as a way of addressing issues identified in the 2023 pay negotiations by the Royal College of Nursing.

EDI Update

The Board was provided with a high-level overview of the strategic and operational activity regarding Equality, Diversity, and Inclusion (EDI) during February/March 2024. The following points were highlighted:

- There has been a real focus on training, with staff networks providing insight and feedback into the limitations of the current EDI training offer. This has enabled collaborative working with the Learning and Development team and the organisation's staff networks to develop a more robust, comprehensive training offer which will be delivered to managers, providing them with information and tools to enhance the support they provide to staff. Online training resources have also been acquired which will complement existing programmes.
- The LGBTQIA+ staff network has developed an Allyship training programme which has been delivered to the Finance team. The programme is aimed at providing staff with an understanding of Allyship and how they can actively support the staff network by becoming an Ally. The network members are also supporting the Learning and Development team to create lived experience videos which will support and complement manager training.
- The REACH staff network continues to make positive changes. It was reported that the network Chair, Anne Marie Davies, has recently left the Trust to take on a new role. The network has asked for expressions of interest from staff who are interested in taking on the role of the REACH Network Chair. Garth Dallas offered thanks to Anne Marie Davies for her hard work and commitment whilst in post.

Resolved:
The Board noted the EDI update.

24/25/19 People and Wellbeing Committee

The approved minutes from the meeting held on the 24.1.24 were submitted to the Board for information and assurance purposes.

During March's meeting five policies were ratified and there was a focus on the nurse retention project, the next steps to address the outcome of the Staff Survey, the accreditation programme, and an update was provided on EDI activity. The Committee received a presentation on SALS/PALS and two deep dives into BAF risk 2.1 and 2.2 were undertaken.

Resolved:
The Board noted the approved minutes from the meeting held on the 26.2.24.

24/25/20 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 26.2.24 were submitted to the Board for information and assurance purposes.

During March's meeting there was a focus on the 2024/25 draft plan, optimisation, step change in the divisions in terms of looking at performance in connection with finance, and innovation and commercial activity. The Committee also received an update on Alder Care.

Resolved:
The Board noted the approved minutes from the meeting held on the 26.2.24.

24/25/21 Board Assurance Framework Report (BAF)

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

- It was reported that nearly 50% of the Trust's BAF risks are ranked at 15 and above. Following a review of the risks it was confirmed that this is appropriate.
- The Assurance Committees have conducted in depth work throughout the year and work on risk appetite has commenced.
- The Board was informed that the BAF will be updated to reflect the Vision 2030 strategic objectives and language going forward.

Resolved:
The Board received and noted the contents of the Board Assurance Framework report for February 2024.

24/25/22 Directors' Register of Interests
Resolved:
The Board received and noted the Directors' Register of Interests.

24/25/23 Any Other Business

There was none to discuss.

24/25/24 Review of the Meeting

The Chair pointed out that whilst 2023/24 has been a challenging year it has also been a positive one for the Trust. Thanks were offered to all those who have helped Alder Hey achieve its end of year position as a result of their hard work and dedication.

Reference was made to the fantastic Strategy Board session that took place prior to Board on the 11.4.24 and it was felt that the message that should be shared with teams is that there is a lot of optimism for the future of Alder Hey but there will also be testing times ahead in 2024/25.

Date and Time of Next Meeting: Thursday 2nd May 2024, 9:00am, LT2, Institute in the Park

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2024- March 2025)

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for May 2024							
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	May-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. 11.4.24 - The initial meeting that was scheduled has been deferred to the 24.4.24. An update will be provided in May. **ACTION TO REMAIN OPEN**
7.3.24	23/24/296.1	Integrated Performance Report (M10)	*Green Plan* - Review the strategic element of the Green Plan to ensure this area is still being advanced.	J. Grinnell	2.5.24	On-track May-24	
Actions for June 2024							
8.2.24	23/24/260.1	System Wide Update	Liaise with the Chairs of CMAST to discuss as to whether transition will be dealt with under mental health via CMAST.	Dame Jo Williams	6.6.24	On track June-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	6.6.24	June-24	**26.4.24** - This action is in progress. An update will be provided in June. **ACTION TO REMAIN OPEN**
8.2.24	23/24/266.1	Gender Development Service (North) Update	Submit an initial draft risk register for the new Gender Development Service to the Audit and Risk Committee in April.	L. Cooper	6.6.24	June-24	**1.3.24** - The draft Risk Register for the new Gender Development Service was submitted to SQAC on the 20.3.24. It will also be submitted to ARC in July 2024. **ACTION TO REMAIN OPEN**
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.
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	6.6.24	June-24	11.4.24 - A meeting is in the process of being arranged. An update will be provided in June 2024. **ACTION TO REMAIN OPEN**
7.3.24	23/24/307.1	Futures Committee – Terms of Reference	Conversation to take place to decide as to whether investment decisions will be deferred to RABD or whether the Futures Committee will have autonomy to approve financial decisions.	S. Arora/ J. Chester/ J. Kelly	6.6.24	June-24	**26.4.24** - This action is in progress. An update will be provided in June. **ACTION TO REMAIN OPEN**
11.4.24		Patient Story	Liaise with the Catering Manager to see if arrangements can be made for patients who find eating a challenge, in terms of having an alternative choice of food outside of the regular menu.	A. Bateman	6.6.24	On-track June-24	
11.4.24	24/25/11.1	Mortality Report, Q3.	Look at how the Trust can benchmark itself following the change to the requirement for reporting deaths of CYP age 4 and above with a learning disability and/or Autism to the LeDeR programme.		6.6.24	On-track June-24	

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2024- March 2025)

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
11.4.24	24/25/17.1	Futures Committee	Discuss the positioning of the Global Strategy in terms of it having its own autonomy and the Committee route that it will report into.	J. Grinnell	6.6.24	On-track June-24	
Status							
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
7.3.24	23/24/296.1	Integrated Performance Report (M10)	*Electronic Roster KPI report* - Deep dive to take place during SQAC in April/May to gain an understanding of the data that is included in the Electronic Roster KPI report.	K. Byrne/ N. Askew	2.5.24	Closed	11.4.24 - A deep dive of the data included in the E-Roster KPI report will take place at SQAC during May's meeting. **ACTION CLOSED**
11.4.24	24/25/14.1	Gender Service (North) Update	Share a copy of the side letter that was approved by NHSE, with Non-Executive Directors.	L. Cooper	2.5.24	Closed	**26.4.24** - This action has been addressed. **ACTION CLOSED**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

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

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

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

Introduction

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

The purpose of this paper is to provide the Board with quarterly assurance and information on the core relationships and system partnerships in which the Trust are engaged. These system relationships and partnership arrangements are core enablers to the delivery of Vision 2030. They provide our health and care system with the architecture, connections and communities required to meet the needs of CYP and families.

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

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

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

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

The partnerships and partner programmes described below are important vehicles to enable setting and achievement of joint objectives across one system with the needs of CYP at the heart. They aim to address the key issues facing CYP's health and care today, influence strategic decision making and allocation of resources, share knowledge and expertise, bring together the networked CYP workforce and share innovations to revolutionise care delivery. This is necessary to improve CYP outcomes, experience, and to make system efficiencies.

Q4 23/24 has seen continued momentum in establishing key aspects of the collaborative CYP system in C&M; a macro view of the core CYP functions of the C&M system is included as **Appendix 1**. This paper highlights progress within key functions. There is sustained focus on building and simplifying the CYP system architecture and workplans.

There is an increasing ask from the system for Alder Hey (and all partners) to contribute to system working and system resource across multiple work programmes, alliances, and strategies. The C&M system is particularly focused on finance/productivity currently; the impact on limited capacity in this rapidly changing system environment is being continually monitored through the Chief Strategy and Partnerships Officer.

1.1 The C&M Health and Care Partnership

CYP remain a key priority area for the HCP. March 24's HCP meeting focused on opportunities for system-wide agreement for utilisation of the ICB's health inequalities budget, prevention strategies such as All Together Active and an update on the system's All Together Fairer / HCP Strategy. Alder Hey are linked clearly with the system strategy and plans (described further below) and are considering the potential impact of All Together Active and links with current Trust prevention plans. Alder Hey's Chair is a member at the HCP Board.

1.2 C&M ICB Children and Young People Committee

C&M ICB have CYP as a strategic priority and have established the CYP Committee to place the needs and voices of CYP, parents and carers at the heart of system decisions, whilst ensuring a system wide approach to better outcomes for CYP.

Strategic priorities for the CYP Committee include a focus on major cross-cutting issues for CYP such as **Neurodiversity, Mental Health / Appropriate Places of Care, Oral Health and CYP Edging Towards Care**.

The February & April 24 CYP Committee meetings included updates on:

- **C&M Health Equity Champions (HEC)** – Two HEC Young leaders presented an excellent update on what matters to Children and Young People in C&M – tasking the Committee to reflect on how it can support CYP in relation to themes such as connection with others, fear of knife and gun crime, positive emotional health, safety (psychological, community, physical) and transition to adult services.
- **Appropriate Places of Care** – meeting the needs of CYP with complex needs
- **Neurodiversity** – the C&M approach, with the emphasis on how the system can better meet the needs of CYP – regardless of diagnosis.
- **Parent/Carer voice**; a highly impactful parent/carer shared her grandson's story on the impact of trauma, neuro-developmental issues, and mental health. She highlighted gaps in care, issues of diagnostic over-shadowing when children present with complex, multi-causal issues and how this can lead to further delays in offers of support / intervention.
- **C&M's Joint Forward Plan and CYP Planning Priorities** (more below)
- **High Risk, High-Cost Placements**: linked to Appropriate Places of care – opportunities were discussed on the ability to improve experience and outcomes while working in ways that reduced costs to the system;
- **Place Update (Wirral):** Their approach to CYP and cross-Place working;
- **Data into Action:** Inclusion of CYP as a priority area in the C&M-wide data programme;
- **Oral Health:** A major investment (c. £2m over a 3yr programme) into CYP oral health prevention from the ICB is being mobilised by Beyond into 24/25; the initial procurement phase is completed with Q4 spend, and recruitment is underway to deliver the work programme.

The CYP Committee is committed to overseeing the development and delivery of the C&M CYP Strategy and an effective system focus on CYP as a population cohort. The Committee is responsible for oversight of the delivery of the CYP ambitions and priorities within the C&M Joint Forward Plan – specifically the role of the Committee is to;

- Keep Children, Young People & Family voices at the heart;
- Demonstrate ICB commitment to integrated CYP approach with CYP & Family; voices, Places, DCS Forum / Local Authority, NHS Trusts/Collaboratives, Voluntary/Community sector partners and more;
- Lock in a small number of CYP Committee level priorities for 24/25;

- Hold the whole system to account for addressing the needs of the CYP population; Hold the NHS to account for delivery of NHSE Long Term Plan.

The CYP 'plan on a page' of the ICB's Joint Forward Plan is in draft, and under development with widespread system partner engagement – see **Appendix 2**.

The CYP plan on a page incorporates key integrated system priorities, aligned with NHS Long Term Plan priorities and those of Directors of Children's services (DCS), and demonstrates the connected delivery vehicles owning each element of the plan.

Trust Board will be appraised of the final plan once agreed and Alder Hey's responsibilities within – relating to both Alder Hey's service delivery, and our delivery of the Beyond Programme and CYP Alliance.

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

Beyond continues to deliver the large-scale CYP transformation plan across C&M focused on early intervention / prevention to address the impact of health inequalities. Beyond presented a deep dive to Trust Board March 24.

Alongside delivering all expected workstreams, Beyond continues to support C&M work regarding system governance, for example lending significant support to the ICB CYP Committee, and leading the system in developing the CYP plan on a page Joint Forward Plan (described above). Key updates include;

- **Finance remains a risk to delivery**: ICB funding was confirmed as recurrent in 2023/2024. NHSE funding has been confirmed but this is yet to transfer to Beyond. Formal escalation with ICB is underway.
- **Data maturity is developing**, links are being made with ICS Data into Action to reflect children and young people's needs.
- Children's **voice and influence** has continued to grow with young people's voices being shared at the Children's Committee, the Beyond Board, within the Health Equity Collaborative and throughout the programme's Annual Conference: Beyond #24: What Matters to Children and Young People.
- During Q4 2024/25, Beyond was identified by the ICS as the delivery partner for **the 3-year Oral Health programme to delivery Supervised Toothbrushing** and the provision of toothbrush / toothpaste packs. Recruitment is underway for Programme Management roles for delivery.
- Programme Management resource was identified to support the **Neuro-Diversity Pathway developments** across the region.
- **Appropriate Places of Care** work is progressing, and outline business case models are being finalised for review at Place – a stakeholder event to review progress was held in April to shape.
- **Three** programmes of work **concluded** within year, a further **18** are being delivered **within expected timeframes**. **Eleven** projects are **experiencing delays; recovery plans** are in place and will be monitored in Q1 2024/25 with oversight from the Programme leadership.
- Evaluation is ongoing and outcomes are being tracked.

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

The C&M CMAST CYP Alliance has made great progress in the last quarter and continues to bring together senior clinical and operational colleagues from across the region. Membership has now expanded to also include key system leaders delivering adjacent programmes of work (Diagnostics, Elective Recovery, MHLDC, Mental Health Transformation Programme). This signals a growing reputation for the Alliance and increasing system connectivity.

The Alliance remains committed to its four key priorities: **Elective Recovery, Urgent Care, Diagnostics and Workforce.**

- The Elective Recovery workstream has been mobilised, with a key focus on developing a surgical hub for the region. Work will continue throughout 24/25 to formalise key operational targets.
- The Urgent Care workstream has been mobilised and will develop a proposal for a paediatric virtual urgent care model. Work will continue throughout 24/25 to formalise key operational targets.
- The Diagnostics workstream is pending the final socialisation of the C&M Diagnostics strategy, due imminently, after which a workstream can be mobilised.
- The workforce workstream will be onboarded in Q3 24/25.

The Alliance is currently considering how and where it formally connects to existing programmes of work, including the MHLDC provider collaborative, where there is opportunity for more streamlined working on shared priorities and workplans. There is a consensus to bring together the appropriate elements of the system to ensure our strategy for CYP services is joined up.

Key risks for the Alliance include:

Risk	Mitigation	RAG
Sustained PMO and administration capacity	• The Alliance has secured 0.7 WTE PMO support, plus administration support for our Board meetings	Yellow
Continued engagement in the Alliance and workstreams	• The Alliance continues to engage key system leaders and CEOs through a monthly 'hot summary'. • A proposal will go to CMAST COOs for workstream support in May. • Ask of Alliance members to nominate trust leads for workstreams.	Amber

1.5 MHLDC Provider Collaborative – CYP programme

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

The MHLDC Provider Collaborative is working with the C&M Mental Health Transformation Programme, and the CMAST CYP Alliance on their joint agendas, and considering how best to work together for our CYP population.

2. Place – Collaborating with our Local Communities

2.1 Liverpool

All partners in the City recognise the growing issues for children and young people both today and into the future, and the need to grow our shared understanding of their issues and the opportunities available to us in the emerging CYP system. Together there is an agreement to shape our city's vision and strategy for CYP ensuring shared priorities and activities to meet these needs. Through the Liverpool Strategic Partnership (LSP) we will collaboratively position Liverpool as a CYP leader in the local system and nationally, focusing initially in areas of the highest need in the North of the city.

This work will align Alder Hey's Vision 2030, the Beyond agenda, and the recently published (January 2024) Liverpool City Council document "State of Health in the City 2040[1]" - an independent report written by the Director of Public Health – which outlines how health in the city has evolved since 1984, the current state of health, and for the first time a projection of health and wellbeing in the city in 2040 based on current trends. It highlights the key health issues facing children and young people within the next two decades which are predicted to be **mental health, obesity, and child poverty,** along with a clear focus on **lung health** through prevention and wider system efforts on clean air and tobacco/vape control. Addressing these issues requires continued partnership working across health, social care, education, public health and the local VCSE network.

Alder Hey are active members of the refreshed Liverpool Strategic Partnership (LSP) - responsible for overseeing the public service reform work emanating from the Strategic Futures Panel and the review of the City Plan – which has a strong CYP theme within. Alder Hey's Chief Strategy and Partnerships Officer is assigned as the Trust's Executive lead for the City Plan refresh, the One Liverpool Plan refresh, and the associated development of the Children's partnership approach, which will also include key Alder Hey Executive and Divisional colleagues as it shapes.

Meanwhile, the **Healthy Children and Families Segment**, part of the One Liverpool Population Health Programme, continues to drive its agreed priorities of –

Starting Well	Lung Health	Emotional Health & Wellbeing
• Family hubs • Improving parent infant mental health • Increasing and sustaining breastfeeding • Supporting income maximisation • Literacy support programme • Transformed Healthy Children Programme • Pregnant women - support for healthy weight, smoking and develop holistic support via Women's Health Hubs/ Children centres	• Smoking and vaping • Implementation of the Asthma Bundle • Healthy homes	• Families / Adverse childhood experiences (ACE) • Early years 0-5 • 16-25 Transition • Whole school approach • Vulnerable groups and complex needs • Workforce

Alder Hey's leadership, engagement and operational implementation of health inequalities work continues with widespread partnership engagement -

Health Inequalities and Prevention Steering Group (HIPSG) - Whilst health inequalities and prevention can (and should) cut across everything we do at Alder Hey, the 2030 strategic initiative "4.1 Collaborating in communities" formally houses the "Health inequalities and prevention" workstream. In January 2024 Alder Hey appointed to a new Consultant in Public

[1] State of Health in the City: Liverpool 2040 - Liverpool City Council

Health medicine role – in partnership and linked formally with Liverpool City Council's Public Health team - who will take up this post on 1 May 2024. This appointment will increase capacity and leadership in this field, enabling more rapid delivery of key elements of Vision 2030. The HIPSG reports to Safety Quality Assurance Committee (SQAC).

Wellbeing Hub - £322,729 awarded by the Charity (over two years) for the creation of an Alder Hey 'Wellbeing Hub' that co-locates health and wellbeing services which will support and assist children, young people, families, and carers in promoting equality in access to health care and tackling health inequalities in services across the Trust. The delivery model is a partnership approach with voluntary/community sector partners working within the Wellbeing Hub.

Mini Mouthcare Matters – Launched across the Trust on 5/2/24 on a ward-by-ward basis. A communications plan accompanies this with staff training videos and patient and parent videos. As part of the initiative, mouth care packs containing toothbrushes and toothpastes will be available for all children and young adults admitted to Alder Hey for more than 24 hours. The Trust is also a member of the Liverpool Oral Health Group coordinated by LCC and involving multiple partners including VCSE (Voluntary, Community and Social Enterprises) to coordinate best efforts and resources across the city.

Healthy Weight Mini Grant Scheme – Whilst funding has now ceased for these projects, a full evaluation of impact is underway. The Trust is also engaged in the launch of the new specification of a Tier 1 / 2 Healthy Weight Service for the City; the plan to refresh this during 2024/25 and to state further intent that action is needed around the wider food environment including, access to healthy food, advertising exposure, vending, schools and more, is welcomed by the Trust. There is also an ambitious 'Good Food' Plan that aims to ensure everyone has access to healthy, nutritious food across the city.

2.1 Sefton

Sefton Place is proposing changes to its Children and Young People's Plan, led through a refreshed CYP Partnership Board of which Alder Hey are a partner member, from 'Heard, Happy, Healthy and Achieving' to 'Safe, Heard, Happy, Healthy and Achieving' -

- Ensuring all children are safe and that we protect those at risk of harm;
- Strengthen families and building resilient communities;
- Place children and young people at the core of the decisions we make about them;
- Getting the most out of life through play, leisure, culture and sporting activities;
- Protect children and young people from discrimination and advance equality for all;
- Reduce health inequalities and support families to live healthy lifestyles;
- High aspirations, opportunities and achievements for all children and young people

Alder Hey has shared Vision 2030 with the Sefton Place leadership team, and the Trust continues to support the development and mobilisation of the Sefton Plan including the Sefton Healthy Lung Programme, aligned to Beyond and Core20PLUS5CYP, and the Sefton Poverty Strategy to improve the life chances of children in poverty by acting early and focusing on the needs of parents to create the best possible support for children's learning and development at home and narrowing the educational attainment gap between children from low-income families and their better-off peers.

2.2 Knowsley

Alder Hey has shared Vision 2030 with the Knowsley Place Leadership Team and a further session is scheduled to discuss opportunities for collaboration, alongside regular interaction as members of the Knowsley Healthier Together Partnership Board. Their 2024/2025 plan is emerging and from a paediatric perspective will include healthy weight, oral health and a continued focus on their Northwood Neighbourhood Model; a targeted approach to population health in Knowsley - rolling out a model of healthcare across the borough, starting in areas with the greatest need and highest levels of health inequalities.

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

3.1 CYP Specialist Services – Delegation to Integrated Care Systems

As of 1st April 2024, 59 specialised services were formally delegated to ICBs in the North West region. The impact in 24/25 is still expected to be minimal, as the arrangements are in shadow format, with no intended change to funding allocations or service delivery. As further information is made available from NHSE during 24/25, Alder Hey will ensure individual services and divisions are fully assessing the impact of any changes and will continue to work with regional colleagues on the necessary and appropriate CYP strategy for the region, noting that most delegated paediatric services will be commissioned on a multi-ICB footprint.

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

Full development of the North West Specialist Commissioning Women and Children's 'case for change' is currently delayed until December 2024 (Gateway 2). Key updates include:

- Working groups, including Workforce, Estates, Financial Principles and Methodology are progressing assigned agendas. Notably various provider site visits are scheduled; service model fixed points and hurdle criteria are being developed; a PPV strategy is underway.
- Several clinical engagement events took place in February 24; Alder Hey were represented well. NHSE are currently considering the feedback.
- All relevant hosted and jointly hosted Operational Delivery Networks (ODNs) (by Alder Hey and RMCH) are engaged and supporting mobilisation of the programme of work.

Alder Hey continue to be actively engaged in this programme of work to support the development of the content of the case for change. Appropriate representation from Alder Hey will play into the Programme Board and relevant work streams as they develop, and we will be kept informed on progress, influencing the strategic direction as appropriate.

Further work will take place throughout 24/25, to understand the impact, risks and engagement needed from Alder Hey, and the Board will be kept updated as this evolves.

3.3 Operational Delivery Networks (ODN)

The Neonatal ODN, Paediatric Critical Care, Surgery in Children and Long-Term Ventilation (PIC/SIC/LTV) ODN and Cancer ODN continue to work with NHSE on the National Women's and Childrens Transformation Review (described above). ODNs remain concerned about their clinical capacity to fully deliver the objectives of this work and continue to raise this risk with NHSE.

The new NHSE ODN Service Specifications[2] have now been implemented from April 24. There are no significant changes to flag to Board, and the ODNs are currently assessing their compliance and taking the necessary actions to meet relevant criteria.

4. Collaborating Nationally for Children and Young People

4.1 Children's Hospital Alliance (CHA) – collaborating nationally with our CYP Hospital Partners

Alder Hey continues to play an active role in leading and supporting the workstreams of the Childrens Hospital Alliance (CHA) as the host trust for the partnership. Priorities and programmes of work are currently centred on:

- **Research and Innovation** - Research – new research collaboration among CHA members has been set up to support joint research bids for NIHR's Child Health Programme Development Grant; supporting Alder Hey with two bids under mental health. Innovation - AI Was Not Brought programme has completed, and Trusts are successfully using CHA business cases to obtain ICB funding for paediatric virtual wards.
- **Transforming services** - Shared responses to clinical challenges including high-cost drugs, Martha's Rule, and NHS England mutual aid tools.
- **Health inequalities** - Sophie's Legacy and Children's Hospitals Inequalities Research Project (CHIRP)
- **Insights and metrics** - Analysis to understand risks, expertise, and advocacy on changes to Specialised Commissioning in ICBs.
- **Policy & advocacy** - Meetings with Secretary of State, Leader of the Opposition, NHS England CEO to promote shared messages with strategic partners. Meeting with Minister of State for Employment at the DWP regarding support for families with children facing long stays in hospital.
- **Comms & member engagement** - Sharing regular intelligence across the CHA and expanding the community (welcoming Nottingham and Cardiff).

Future work of the CHA includes i) a position on a credible digital offer for children following £3.4b funding made available from the Spring Budget ii) feedback to GOSH CEO on Martha's Rule implementation to inform future work of Patient Safety Commissioner iii) further best practice from health inequalities programmes.

4.2 Policy Update and Horizon Scanning

UK House of Lords Preterm Birth Committee : A parliamentary select committee has been appointed to conduct an inquiry into preterm birth in England, particularly its prevention and consequences. The acting Director for the North West Neonatal ODN gave evidence, and the committee will be considering the evidence received until the end of April before reporting their findings.

Children in Care in the North of England : Health Equity North on behalf of the Child of the North All Party Parliamentary Group published a report showing the disproportionate rates of children in care in the North compared to southern counterparts. If the North had experienced

[2] NHS England » Specialised services clinical network specifications

the same care entry rates as the South between 2019 and 2023, it would have saved at least £25 billion in lifetime social costs of children in care. Policy recommendations include the immediate need to tackle child poverty, offer better material support to families and build sustainable prevention strategies. These align closely with the findings of Liverpool's State of Health 2040 report (aforementioned).

5. Partnership Governance and Partnership Quality Assurance Rounds

Following Executive approval of the Quality Assurance Round (QAR) Pack, and implementation from April 24, we are now able to progress this is agenda for our partnerships. The QAR has been purposely developed to be inclusive of partnerships/collaborations, eliminating the need to have multiple templates. We have reached out to RMCH to arrange the first Partnership QAR with the joint Cleft Lip and Palette Service.

Appendix 3 provides an assurance summary of the key joint services and strategic partnerships, demonstrating named executive leads, purpose, partners, governance/reporting arrangements, summary progress and any risks for escalation to Trust Board.

6. Risks and Issues to Highlight

The Board is asked to note the following issues;

1. The increasing requirement for strategy / system resource across multiple work programmes, alliances, and strategies;
2. Whilst the funding is confirmed, the NHSE CYP Transformation funding has not yet transferred from ICB to the Beyond programme (at time of writing). This has been formally escalated.
3. The increasing transformation priorities being placed on ODNs, at present, without sufficient resource from NHSE. This has been formally escalated.

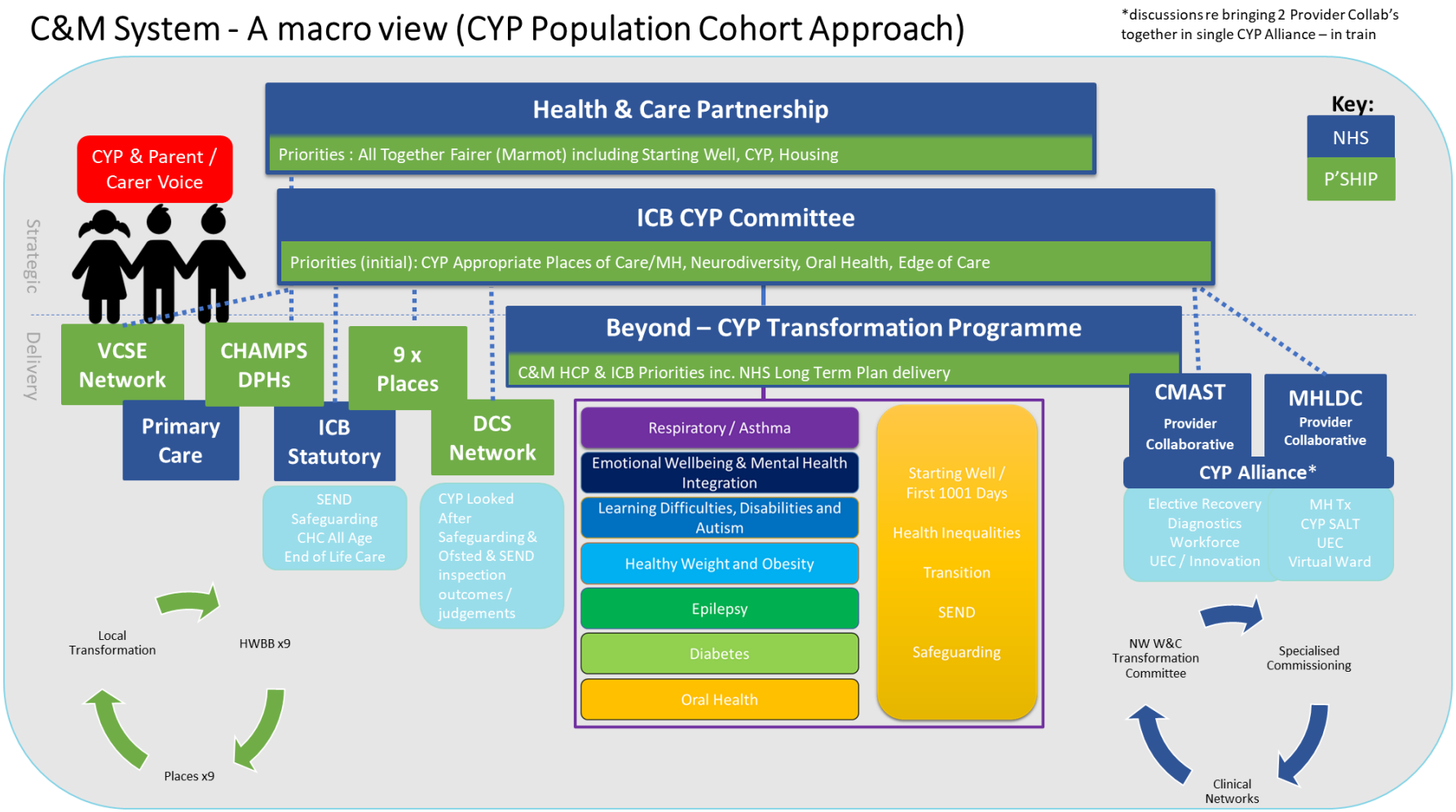
There is also an emerging risk that the significant system pressures facing C&M ICB in terms of finance and productivity have a knock-on effect on system transformation capacity; plans are too emergent currently to assess full impact, but this will be kept under review through the Chief Strategy and Partnerships Officer; Trust Board will be kept appraised.

7. Recommendations

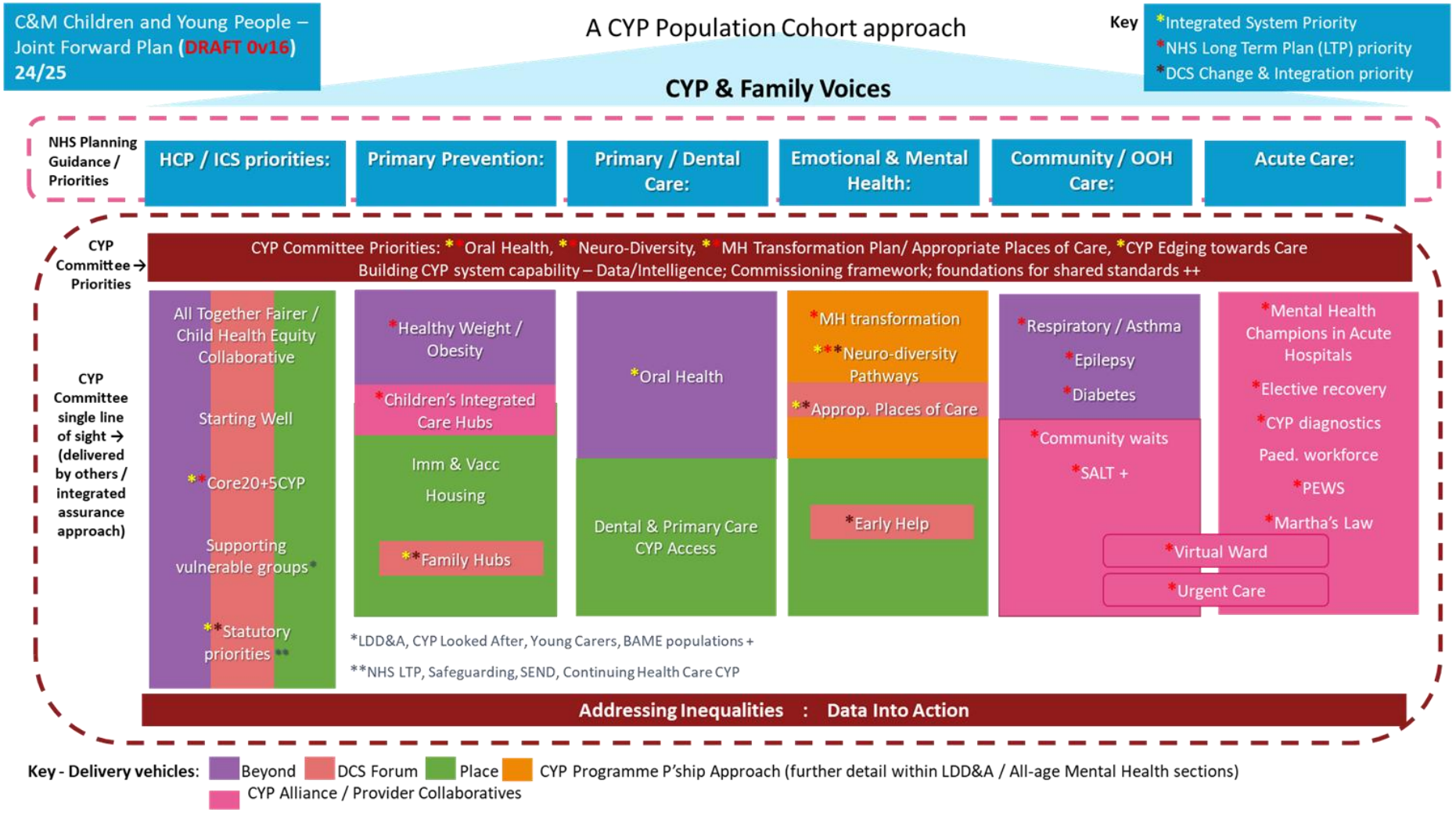
Trust Board are recommended to:

- Receive and note the content of this report and progress made.
- Take assurance that strategic partnerships are appropriately managed and governed.
- Acknowledge the issues and emergent risk summarised.

Appendix 1:


C&M System - A macro view (CYP Population Cohort Approach)
*discussions re bringing 2 Provider Collab's together in single CYP Alliance – in train
Key:
NHS
P'SHIP
Health & Care Partnership
Priorities : All Together Fairer (Marmot) including Starting Well, CYP, Housing
CYP & Parent / Carer Voice
ICB CYP Committee
Priorities (initial): CYP Appropriate Places of Care/MH, Neurodiversity, Oral Health, Edge of Care
Strategic
Delivery
Beyond – CYP Transformation Programme
C&M HCP & ICB Priorities inc. NHS Long Term Plan delivery
VCSE Network
CHAMPS DPHs
9 x Places
Primary Care
ICB Statutory
DCS Network
SEND
Safeguarding
CHC All Age
End of Life Care
CYP Looked After
Safeguarding &
Ofsted & SEND
inspection
outcomes /
judgements
Respiratory / Asthma
Emotional Wellbeing & Mental Health Integration
Learning Difficulties, Disabilities and Autism
Healthy Weight and Obesity
Epilepsy
Diabetes
Oral Health
Starting Well / First 1001 Days
Health Inequalities
Transition
SEND
Safeguarding
CMAST
Provider Collaborative
MHLDC
Provider Collaborative
CYP Alliance*
Elective Recovery
Diagnostics
Workforce
UEC / Innovation
MH Tx
CYP SALT
UEC
Virtual Ward
Local Transformation
HWBB x9
Places x9
NW W&C Transformation Committee
Specialised Commissioning
Clinical Networks

Appendix 2: C&M Joint Forward Plan – CYP Plan on a Page (DRAFT)



Appendix 3: Joint Services / Partnership Assurance Summary

Purpose	Partners	Established	Governance/ Reporting Arrangements	Summary Progress 23/34	Risks / Issues for Escalation to Trust Board
Liverpool Neonatal Partnership Executive Lead: Adam Bateman					
Joint delivery of Level 3 neonatal service	Liverpool Women's FT (LWH)	2020	Liverpool Neonatal Partnership (LNP) Governance structure LNP Board (monthly) provides assurance to Trust Boards at LWH & Alder Hey LNP Integrated Governance (monthly) – assurance to Surgical Critical Care Board (Alder Hey) and Family Health Board (LWH) Internal – Division of Surgery	LNP governance structure is in the process of being reviewed and will be presented at Board in Jan 2024. LNP Board has moved to bi-monthly with leadership team meeting MD's between boards. Monthly risk and integrated governance meetings continue with feedback into Family Health Divisional Board and Surgical risk meeting. New programme board has been established with programme plan and this will be supported by both divisional teams, and report in to both divisional boards. Positive recruitment of nursing staff with good retention. ANNP recruitment has been difficult, however, fellow recruitment has supported this. Consultant recruitment continues. Build progressing in line with expected timeframes.	Managing the capacity and flow during the build period and the supporting of neonatal care outside the 1C environment. Recruitment of tier 1&2 medial team (inclusive of ANNP's). Procurement of equipment and increasing costs. Ensuring safe and effective governance across both sites.
Liverpool Adult Congenital Heart Disease (CHD) Partnership Executive Lead: Alf Bass					
Joint delivery of Level 1 adult CHD service	Liverpool Heart & Chest FT; Liverpool University Hospitals FT; LWH	2018 – revised Memorandum of Understanding (MOU) Sept 2020	External – Liverpool ACHD Partnership Board (quarterly) – now merged in joint governance with CHD ODN Board Internal – Division of Surgery	-North West wide delivery of seamless all-age CHD service in partnership -Joint governance with CHD ODN to remove duplication in the system fully embedded -Previous plans for a single patient treatment list have been superseded by the development of a CHD database	None for escalation.

				which will have this functionality built in – database go live anticipated in Summer 2024	
NorCESS - North West Epilepsy Surgery Executive Lead: Benedetta Pettorini					
Joint delivery of Northern Epilepsy surgical service - aim to improve the uptake and access to epilepsy surgery in those children for whom surgical control or amelioration for their epilepsy is a possibility	Royal Manchester Children's Hospital (RMCH)	2012	External – North West Paediatric Partnership Board (NWPPB - Alder Hey & RMCH) Internal – Division of Surgery	-NorCESS is a long-standing specialist commissioned service by NHS England, receiving regular funding and serving CYP across the North West - the multidisciplinary team (MDT) review children with epilepsy who meet the criteria for evaluation for surgical intervention, provide a comprehensive pre-surgical evaluation and co-ordinate epilepsy surgical procedures for children for whom it is identified as appropriate.	Ongoing risks re: persistent problems with specialist recruitment (e.g., neurology and neurophysiology). These are logged within the joint service and escalated via an agreed escalation plan to NWPPB.
North West Obesity Tier 3 service Executive Lead: Urmi Das					
Joint delivery of level 3 obesity hub & spoke model	RMCH	Nov 21	External - NHSE monitoring & C&M CYP Programme Board (quarterly) Internal - Division of Medicine	-Service running across 2 hubs (AH & RMCH) and spoke in Preston. -Inequalities uplift in funding for 23/24 -Led for Alder Hey by Dr Senthil Senniappan. -Monitored through divisional routes and NWPPB as a joint service	Service remains in pilot phase with capped funding. Challenges with demand and issues are region wide and escalated to NHSE regarding adult transition and tier 2 obesity services.
Alder Hey & Public Health Liverpool Executive Lead: Dani Jones					
Delivery of a shared work plan via collaborative resource	Liverpool City Council Public Health	May 21	Internal – Health Inequalities & Prevention Steering group à Safety & Quality Committee	-Collaborative funding with LCC for public health consultant identified and recruitment progressing -Health Inequalities and Prevention Steering Group continues - coalescing the -Trust's Health Inequalities activity – chaired by Public Health professional -Prevention Pledge commitments – in partnership with the ICS. Priority project work includes: -Prevention in pathways: supporting long waiters with access to preventative support e.g., Mental health, food insecurity etc	None for escalation.

				-Dental / Oral Health -Smoking Cessation (CYP, families and staff) -Healthy Weight & Obesity – community/VCSE local delivery - Appointment of Alder Hey Consultant in Public Health Medicine, partnering with Liverpool City Council PH team – due to commence 1st May 24	
North West Paediatric Partnership (NWPPB) **Executive Leads: Dani Jones / Alf Bass**					
Joint oversight of NW ODNs & commitment to collaborative delivery of specific specialist / tertiary paediatric services as mutually agreed.	RMCH	2019	External – North West Paediatric Partnership Board NWPPB – biannually) Internal – Resource and Business Development – ODN assurance paper (biannually)	-Joint development and oversight of NW ODNs and joint services -MOU's/partnership agreements described on a case-by-case basis at a service/network level, following the principles set out in the NWPPB MOU approved by Trust Board in 2019. -Scoping future NW service models e.g., cardiology, neurology -Aligned models for NW delivery across e.g., Long Covid	None for escalation.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	**Integrated Performance Report – 2024-25 Proposal**
Report of:	Kate Warriner, Chief Digital and Information Officer Adam Bateman, Chief Operating Officer
Paper Prepared by:	Ellen Mathews, Head of Service Development & Performance Andrew McColl, Deputy Director of Finance

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The Trust Board is asked to approve the proposed changes to the IPR for 2024-25, with implementation in May and new report available for Trust Board on 6 June.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☑ Game-changing **research and innovation** ☑ **Strong Foundations** ☑
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

1. Executive Summary

As part of Annual Planning and the implementation of the new 2030 Vision strategy the Integrated Performance Report (IPR) requires a refresh to reflect the objectives and priorities for the 2024/25 financial year.
This report details the following changes:

- Amend the format of the IPR to show greater alignment to the five Strategic Goals (whilst still annotating CQC domains for assurance and transparency).
- Incorporate headline Strategic metrics, alongside core operational performance, into a single IPR.
- Updates to current suite of metrics,
- All agreed metrics and narrative will be included in the IPR on a monthly basis (not quarterly) to ensure consistency of reporting to Trust Board

The proposed changes were approved at Operational Delivery Board on 25 April. The Trust Board is asked to approve these proposed changes, with implementation in May and new report available for Trust Board on 6 June.

2. Background and current state

The current format of the Integrated Performance Report (IPR) was introduced in 2022-23 and is reviewed annually in line with national planning guidance and the Trust Integrated Annual Plan.

The IPR is consistent with national recommendations from “Making Data Count” and has been recognised nationally as one of a handful of Trusts which meets all the best practice criteria.

It is important therefore to maintain the quality of this report, but also apply principles of continuous improvement to ensure it remains fully up to date and meeting the needs of the Trust Board, for assurance, to inform decision making, and to support Quality Improvement for Children, Young People and Families.

3. Proposed changes for 2024-25

The most significant change to the 2024-45 IPR is the incorporation of headline strategic metrics, alongside core operational performance, creating a single IPR.

The Trust continues to develop a range of metrics to monitor the success of the strategy deployment, and it is proposed that headline strategic metrics are incorporated into the IPR, alongside the established core operational performance metrics.

For the first half of 2024-25, it is proposed that the SRO for each strategic goal agrees 1 headline metric for inclusion in the IPR, with expectation that other metrics may be added (with appropriate governance and approval processes) in the second half of 2024-25 and in 2025-26 as the strategic programmes continue to develop.

Strategic Goal	Proposed headline metric for IPR – pending agreement from SROs
Outstanding Care and Experience	Overall experience of Children, Young People and Families
Support Our People	Staff Thriving Index
Pioneering Breakthroughs	Number of patients benefitting from Futures solutions or products deployed to care
Revolutionise Care	Improving Clinical Outcomes
Collaborate for CYP	Social Value Generated

The following table shows the "mapping" from current section headings in the IPR, to the proposed new section headings which show greater alignment to the five Strategic Goals:

Section Headings 2023/24 IPR	Proposed Section Headings 2024/25 IPR
Unrivalled Experience Safe	**Outstanding Care and Experience** (combine CQC Safe and Caring into one section)
Unrivalled Experience Caring	
Smartest Ways of Working – Accessible Services Effective	**Revolutionise Care** (combine CQC Effective and Responsive into one section)
Smartest Ways of Working – Accessible Services Responsive	
Collaborating for CYP – Reducing Health Inequalities	**Collaborate for Children and Young People**
Collaborating for CYP – Green Plan	
Smartest Ways of Working – Digital – AlderC@re	**Pioneering Breakthroughs**
Pioneering Breakthroughs – Research and Innovation	
Supporting our People Well Led	**Supporting our People** (CQC Well Led)
Financial Sustainability Well Led	**Financial Sustainability** (CQC Well Led)
Risk Management Well Led	**Risk Management** (CQC Well Led)

The full suite of metrics for 2024-25 can be seen at Appendix one. In addition, Divisional Summaries will be continue to be included for:

- Community & Mental Health
- Medicine
- Surgery
- Clinical Research Division
- Corporate Services Collaborative

4. Summary and Conclusion

The IPR requires a refresh to reflect the objectives and priorities for the 2024-25 financial year.
This report has detailed the following changes:

- Changes to the format of the IPR to show greater alignment to the five Strategic Goals (whilst still annotating CQC domains for assurance and transparency).
- Incorporate headline Strategic metrics, alongside core operational performance, into a single IPR.
- Updates to current suite of metrics
- All agreed metrics and narrative will be included in the IPR on a monthly basis (not quarterly) to ensure consistency of reporting to Trust Board

The Trust Board is asked to approve these proposed changes, with implementation in May and new report available for Trust Board on 6 June.

Appendix One: Proposal from IPR Design team regarding which metrics to include in 2024/25 IPR

Strategic Goal (SRO)	Core Operational Performance (SRO)	CQC Domains	IPR Metrics 2023/24	Proposed IPR Metrics 2024/25
Outstanding Care and Experience (Chief Nursing Officer and AHP/HCP Lead)	**Patient Safety** (Chief Nursing Officer and AHP/HCP Lead and Chief Medical Officer)	Safe	***DRIVER METRIC*** Incidents of harm per 1,000 bed days (rated Minor harm and above)	***DRIVE*** Incidents of harm per 1,000 bed days (rated Minor harm and above)
			DRIVER METRIC Number of Incidents rated No Harm and Near Miss per 1,000 bed days	***DRIVE*** Number of Incidents rated No Harm and Near Miss per 1,000 bed days
				Patient Safety Incidents (All)
				Severe or Fatal Incidents – Physical only
				Severe or Fatal Incidents – Physical & Psychological
			Number of Serious Incidents (Steis reported)	Number of PSIIs (Patient safety incident investigation) undertaken
			Number of Never Events	Number of Never Events
			Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients	Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients
			Sepsis: % Patients receiving antibiotic within 60 mins for ED	Sepsis: % Patients receiving antibiotic within 60 mins for ED
			Medication Errors resulting in harm	Medication Errors resulting in harm
			Pressure Ulcers G2-4	Pressure Ulcers Category 3 and 4
				Pressure Ulcers Category 2
			Recording of Restrictive Interventions	Recording of Restrictive Interventions
			Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)	Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)
			Hospital Acquired Organisms - MRSA (BSI)	Hospital Acquired Organisms - MRSA (BSI)
			Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - C.difficile
			Hospital Acquired Organisms – MSSA	Hospital Acquired Organisms – MSSA
			Number of employees trained in new Level 1 of Patient Safety	Number of employees trained in new Level 1 of Patient Safety
		Caring	***DRIVER METRIC*** F&F Test - % Recommend the Trust	***STRATEGIC HEADLINE METRIC*** F&F Test - % Recommend the Trust
			DRIVER METRIC % Complaints Responded to within 25 working days	% Complaints Responded to within 25 working days
			% PALS Resolved within 5 Days	% PALS Resolved within 5 Days
			Number of formal complaints received	Number of formal complaints received
			Number of PALS contacts	Number of PALS contacts

			F&F ED - % Recommend the Trust	F&F ED - % Recommend the Trust

** Safer Staffing report will continue to be included as an Appendix to the IPR*

Strategic Goal (SRO)	Core Operational Performance (SRO)	CQC Domains	IPR Metrics 2023/24	Proposed IPR Metrics 2024/25
Revolutionise Care (Chief Transformation and Digital Officer and Chief Medical Officer)	**Access to Care** (Chief Operating Officer)	Effective		***STRATEGIC HEADLINE METRIC*** Improving Clinical Outcomes Metric to be developed
			DRIVER METRIC ED: % treated within 4 Hours	***DRIVER METRIC*** ED: % treated within 4 Hours
			DRIVER METRIC % Was Not Brought Rate (All OP: New and FU)	% Was Not Brought Rate (All OP: New and FU)
			Number of Cancelled Operations	Report at R&BD only
			Number of Super Stranded Patients (21 days)	Report at R&BD only
			% Clinical Letters completed <10 Days	Report at R&BD only
			Theatre Utilisation (Capped Touch Time)	Theatre Utilisation (Capped Touch Time)
			Virtual Ward Bed Days	Report at R&BD only
		Responsive	***DRIVER METRIC*** % Recovery for DC & Elec Activity Volume	Replaced by productivity metrics below
			DRIVER METRIC Number of RTT Patients waiting >65weeks (Incomplete pathways, OP&IP)	***DRIVER METRIC*** Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)
			DRIVER METRIC Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis	***DRIVER METRIC*** % of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks
				ASD and ADHD referral to triage within 12 weeks
			Diagnostics: % Completed Within 6 Weeks of referral	Diagnostics: % Completed Within 6 Weeks of referral
			Waiting List Size	Report at R&BD only
			CAMHS: Number of children & young people waiting >52week	CAMHS: Number of children & young people waiting >52week
				Number of Paediatric Community Patients waiting >52 weeks
			% Individual Health Assessments completed within 20 days of referral	% Individual Health Assessments completed within 20 days of referral
			Cancer: 2 week wait from referral	
				Cancer: 62 day referral to treatment
			31 day wait from decision to treatment	Cancer: 31 day wait from decision to treatment

			31 day wait until subsequent treatments	
			31 days from urgent referral for suspected cancer to first treatment	
			Cancer: Faster Diagnosis within 28 days	Cancer: Faster Diagnosis within 28 days
			% Recovery for OP New & OPPROC Activity Volume	Replaced by productivity metrics below
				Elective admissions (IP &DC) per clinical WTE
				Outpatient attendances per Consultant WTE
				A&E Attendances per ED Consultant WTE
				Inpatient Discharges per working day
				Day Cases per working day
				Outpatient New & OPPROC per working day
				Reduce overdue Outpatient Follow Up Waits

Strategic Goal (SRO)	Core Operational Performance (SRO)	CQC Domains	IPR Metrics 2023/24	Proposed IPR Metrics 2024/25
Supporting Our People (Chief People Officer)	**Our People** (Chief People Officer)	Well Led	***DRIVER METRIC*** Staff Turnover	***DRIVER METRIC*** Staff Turnover
			DRIVER METRIC Sickness Absence (Total)	***DRIVER METRIC*** Sickness Absence (Total)
			DRIVER METRIC Colleague Satisfaction – Thriving Index	***STRATEGIC HEADLINE METRIC*** Staff Thriving Index
			Short Term Sickness	Short Term Sickness
			Long Term Sickness	Long Term Sickness
			Mandatory Training	Mandatory Training
			% PDRs completed since April	% PDRs completed within rolling 12 months
			Medical Appraisal	Medical Appraisal
			Churn Rate	Workforce Stability

Strategic Goal (SRO)	Core Operational Performance (SRO)	CQC Domains	IPR Metrics 2023/24	Proposed IPR Metrics 2024/25
Pioneering Breakthroughs (Chief Operating Officer and Director of Research & Innovation)			*Research & Innovation:* Number of Chief Investigator led studies	
			Research & Innovation: Number of innovation solutions deployed with real-world impact	
			Research & Innovation: Number of Patients Recruited into Research Studies	
			Digital - Alder Care: Divisional Critical Criteria	
			Digital - Alder Care: % System Build Completion	
			Digital - Alder Care: % Specialty Documentation Build	
				STRATEGIC HEADLINE METRIC Number of patients benefitting from Futures solutions or products deployed to care
				Clinical Capacity created (hours per week)
				Professionals who have accessed learning through the International Academy
				Number of patients accessing digital healthcare solutions delivered through Futures

Strategic Goal (SRO)	Core Operational Performance (SRO)	CQC Domains	IPR Metrics 2023/24	Proposed IPR Metrics 2024/25
Collaborate for CYP (Director of Strategy and Partnerships)				***STRATEGIC HEADLINE METRIC*** Social Value Generated
			Health Inequalities Difference in Median Waiting time for patients with LD on the waiting list	*Health Inequalities* Difference in Median Waiting time for patients with LD on the waiting list
			Health Inequalities: Oral Health: Number of children <10 years old waiting >52wks for tooth extraction	*Health Inequalities:* Oral Health: Number of children <10 years old waiting >52wks for tooth extraction
			Health Inequalities: Alder Hey Community Mental Health Services: Number of CYP of BAME background referred	*Health Inequalities:* Alder Hey Community Mental Health Services: Number of CYP of BAME background referred

			Green Plan: Reduce Carbon Footprint	*Green Plan:* Reduce Carbon Footprint
			Green Plan: Reduce Energy Usage	*Green Plan:* Reduce Energy Usage
			Green Plan: Reduce Waste – target £50k cost saving	*Green Plan:* Reduction in Waste

Strategic Goal (SRO)	Core Operational Performance (SRO)	CQC Domains	IPR Metrics 2023/24	Proposed IPR Metrics 2024/25
	Financial Sustainability (Director of Finance and Development)	Well Led	***DRIVER METRIC*** Revenue Position (Year End Forecast)	***DRIVER METRIC*** I&E Year End Forecast
			DRIVER METRIC CIP Position (Recurrent FYE)	***DRIVER METRIC*** Recurrent Efficiency Plans Delivered (Forecast)
			DRIVER METRIC % ERF Value (Income)	***DRIVER METRIC*** % ERF Value (Income)
			Revenue Position (Variance to date)	I&E distance from target (cumulative YTD)
			CIP Position (In Year, Delivered to date)	
			Liquidity	Liquidity
				Cash in Bank
				Capital Expenditure

Strategic Goal (SRO)	Core Operational Performance (SRO)	CQC Domains	IPR Metrics 2023/24	Proposed IPR Metrics 2024/25
	Risk Management (Director of Corporate Affairs)	Well Led	Number of High Risks (scored 15 and above)	Number of High Risks (scored 15 and above)
			% of High Risk within review date	% of High Risk within review date

April 2024 Performance – Subject to change

***Denotes performance as latest position in-month**

Strategic Goals	Key Metrics	Target	Actual for April
Outstanding Care and Experience	Number of Severe or Fatal Incidents – Physical & Psychological	0 (zero)	0*
	Number of PSIIs (Patient safety incident investigation) undertaken	0 (zero)	0*
	Number of Never Events	0 (zero)	0*
	Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	1- C diff, 1- MRSA	x2 C Diff*
	FFT - % Recommending Trust	> 95%	92%*
Supporting our People	Staff Turnover	*<10%*	9.8%
Revolutionise Care	ED: % treated within 4 Hours	> 77%	88.5%*
	Number of RTT Patients waiting >52weeks	0 (zero)	793*
	% of children and young people who receive an outcome of their ASD and ADHD pathway within 65 weeks	>90%	% to have outcome within 65 weeks metric in development and number waiting is 2,328
	Elective Recovery	> 107%	107%
	Diagnostic Performance	> 95%	87.8%*
Collaborate for Children and Young People	Return Springfield Park to Liverpool City Council	Nov-23	July 2024

Operational Plan Progress Summary

Published May 2024

Strategic Goals	Progress in April 2024	Areas of challenge
Outstanding Care and Experience	• Continued improvement in ED sepsis • Selected as a national pilot site for Martha's rule • Launch of partnership with Chester Zoo and our young people • Support gained form the Charity to mobilise the family hub	• Responsiveness to PALS and complaints • Sepsis compliance in in patient areas
Supporting our People	• Sickness absence figures and turnover rates continue to show good progress and are both within target • PDR compliance showing marked improvements	• Responsiveness to the Staff Survey Team data – will require monitoring
Pioneering Breakthroughs	• 8 developments were prioritised through Clinical Digital Design Authority for April, and 7 developments were completed in the month. • Alderc@re highlights include Epilepsy national requirements to document valproate discussions, new risk assessment order change for mental health crisis patients and migration of the acuity scoring to the Safer Nursing Tool • Two new research funding awards granted. • Patient portal gate review and re-alignment with 2030 strategy and governance. • Additional automation processes identified for 24/25 to support Finance, Community and Transcription services • AsOne C&M Beyond roll-out. Workshops planned with Merseycare and C&W Partnership	• Number of priority development requests outstanding with Meditech

BRILLIANT BASICS

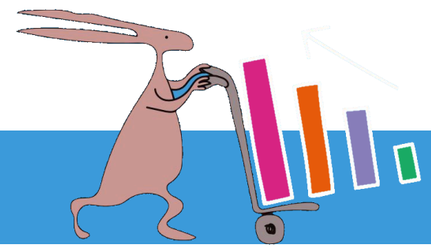
Strategic Goals	Progress in April 2024	• Areas of challenge
Revolutionise Care	• A strong end to 2023/24 with high performance against cancer & ED metrics, as well as only one patient waiting over 65 weeks for treatment. • 87% of patients treated in ED within 4 hours. • 87.8% of diagnostic tests performed within six weeks. • Productivity sprint group work ongoing to produce dashboard triangulating workforce, activity and financial metrics. • First look suggests 104% of activity against plan achieved in M1.	• Number of patients waiting over 52 weeks currently at 793, with a forecast of 11 patients waiting over 65 weeks • Medical scope and sleep studies remain areas of challenge for diagnostic performance. • Number of patients waiting for ASD or ADHD diagnosis is now over 2,300. • ASD/ADHD Transformation Board commencing 3rd May 2024 including a workstream on capacity/demand in addition to digital, workforce and clinical model/pathways. This includes review of all reporting metrics. • Impact of ADHD medication shortage continues to affect available diagnostic capacity – working group in place to safely manage risk. • Continued engagement and sign off of ROI by Process Owners
Collaborate for Children and Young People	• Completion and hand over of new play park • Site clearance of old play park • Areas have been planted, seeded and turfed and are now establishing.	• Residual infrastructure works that are now completed • Exceptional weather conditions • Extended sign off process with Liverpool City Council.

BRILLIANT BASICS

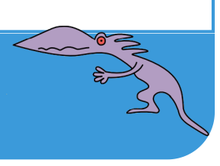
NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: April 2024



Contents



Icon Definitions

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

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

XmR chart

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

Process limits

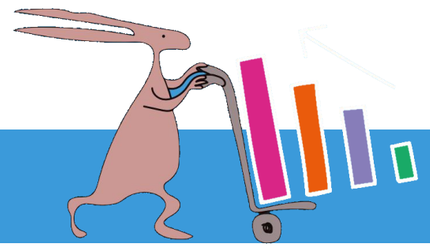
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

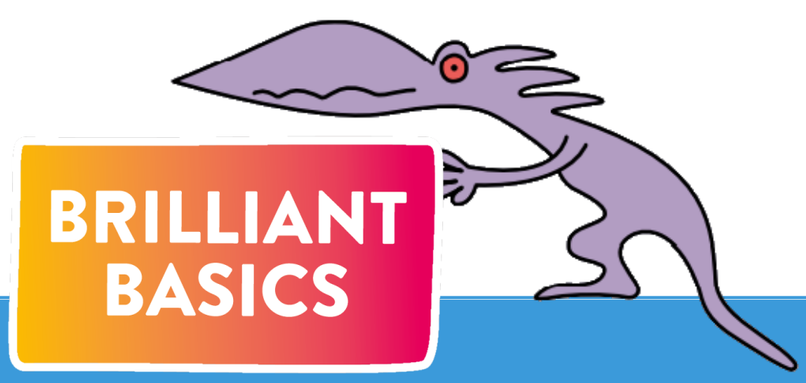
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Cancer 2-week referrals is consistently achieving target with an improving trend	Cancelled Operations, Stranded Patients, Staff Turnover, Deteriorating inpatients, Level 1 patient safety training are inconsistently achieving target with an improving trend	RTT 65wk breaches, Oral Health & CAMHS 52wk breaches, Theatre Utilisation & Diagnostics, are not achieving targets but demonstrating improvement
	Common Cause	Mandatory Training, Cancer and MRSA metrics are achieving targets	Virtual Ward, F&F Trust & ED, Complaints, Sepsis, EL/DC Recovery, WNB, Sickness, ED 4hr, & ERF are inconsistently achieving target and are yet to evidence statistical improvement	Clinic Letters completed, F&F All & ED PDRs Completed & Long-Term Sickness are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern		PALSs resolved within 5 days, Medical Appraisal are inconsistently achieving target with a declining trend along C.Difficile showing increased volume.	>65 Wk waits ASD/ADHD are not achieving targets with a declining trend

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

- We are consistently passing 15.9% of our metrics.
- We are achieving 61.4% of our metrics inconsistently.
- We are not achieving the target for 22.7% of our metrics but experiencing improvement in 5 of these metrics.

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



Unrivalled Experience - Safety

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

Highlights:

Decrease for the third consecutive in the number of unplanned admissions from inpatient beds to Critical Care. 97% of patients requiring antibiotics for sepsis in ED received within 60 minutes; this is the highest compliance in 18 months and continues the improving trend over the last 4 months

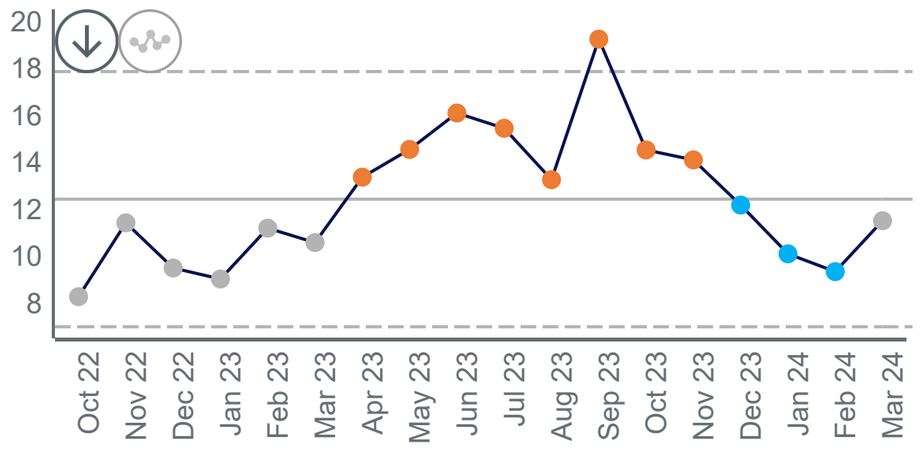
Areas of Concern:

83% of patients on inpatient wards requiring antibiotics for sepsis; review undertaken by the ACNs as second consecutive month of reduced performance. All missed sepsis cases are reviewed daily by the Divisional Senior Nurse / AHP of the day and the governance team, and immediate review and actions are taken; actions are overseen by the Sepsis Nurse. The learning is shared at the weekly Divisional incident review meetings and at monthly Divisional Governance meetings.
There were 2 cases of C difficile reported one of which is understood to be hospital acquired and a Post Infection Reviews has been undertaken

Forward Look (with actions)

Improvement in antibiotic administration on inpatient wards

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



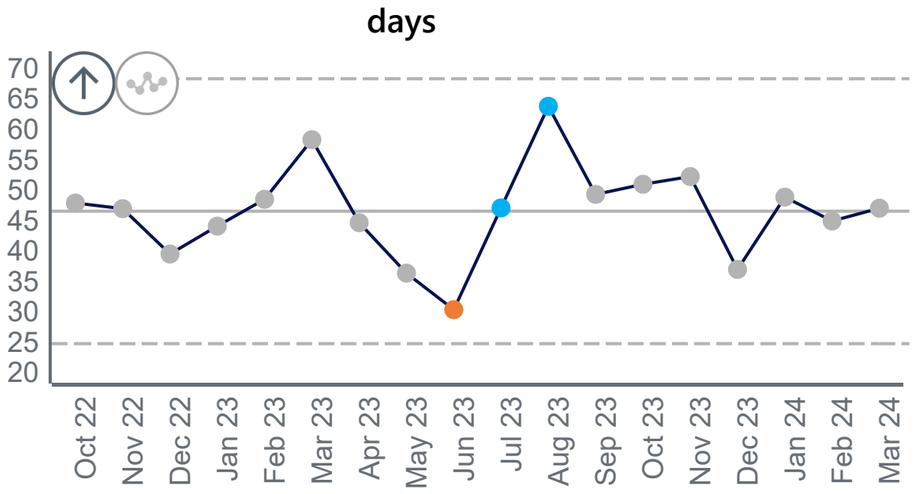
Technical Analysis:

Common cause variation has been observed with performance of 12 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 that are reported as moderate harm are reviewed at the weekly PSIRI panel meeting

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 47 incidents of no harm per 1000 bed days. With a monthly average of 47 during the period. Of the 486 patient safety incidents resulting in no harm in March 2024, this includes 45 who have no harm assigned as not involving a patient directly.
Rates currently assessed on Physical Harm only

Actions:

Trust staff consistently report incidents of 'no harm' and 'near misses' enabling learning from incidents

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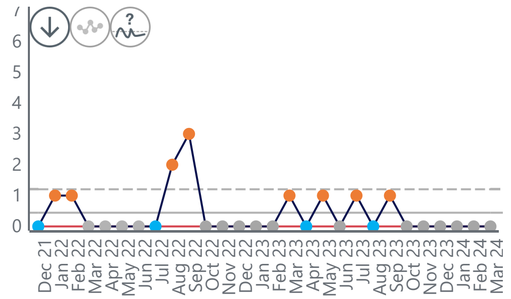
Integrated Performance Report | April 2024

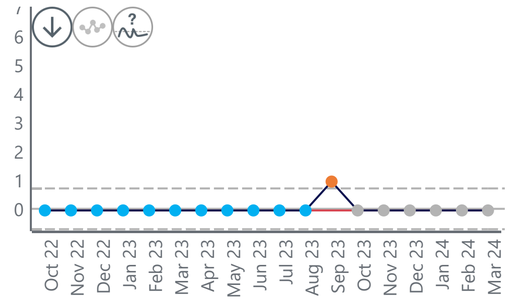
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

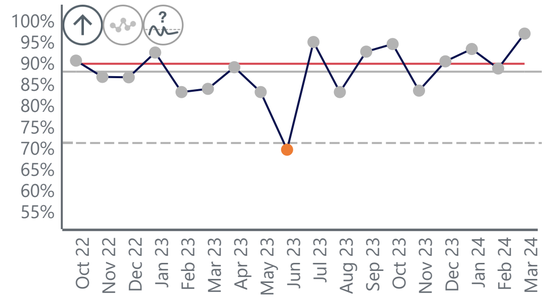
Number of Serious Incidents (Steis reported)



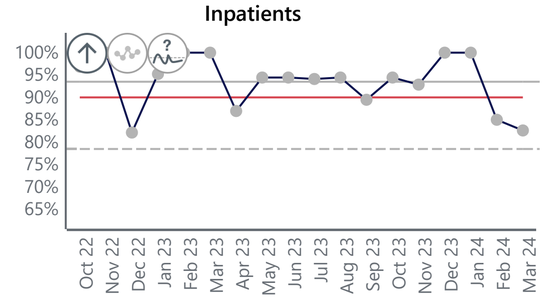
Number of Never Events



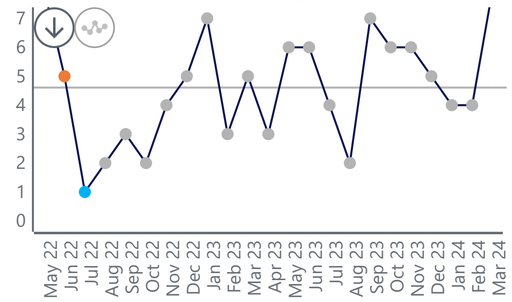
Sepsis % Patients receiving antibiotic within 60 mins for ED



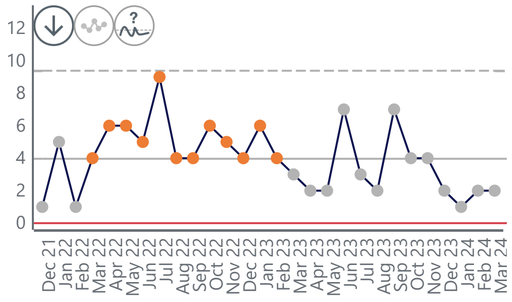
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



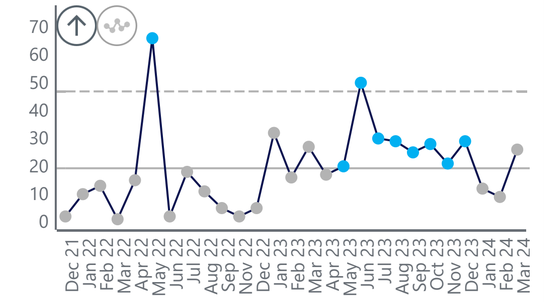
Medication Errors resulting in Harm



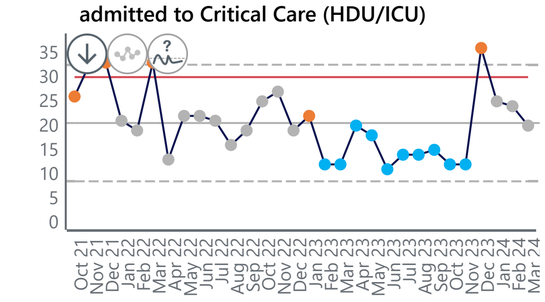
Pressure Ulcers Category 2-4



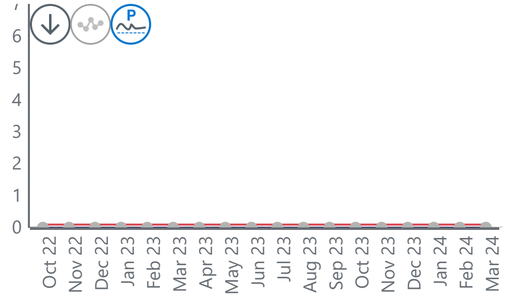
Recording of restrictive interventions



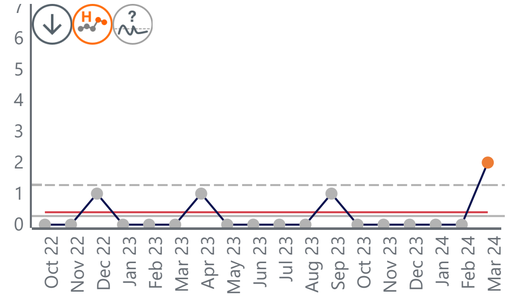
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



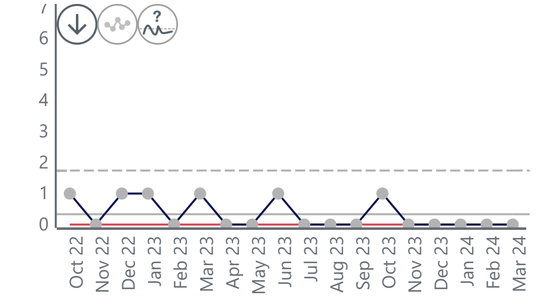
Hospital Acquired Organisms - MRSA (BSI)



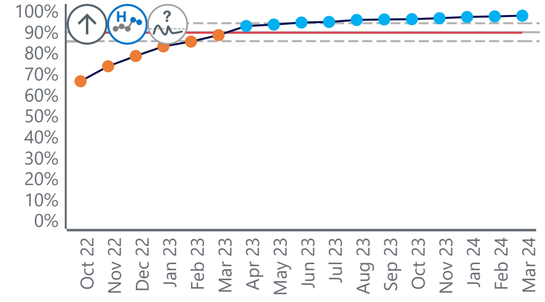
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Integrated Performance Report | April 2024

Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring

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

Highlights:

BI team have worked with Divisions to review and put in place singular methodology to calculate compliance with KPIs

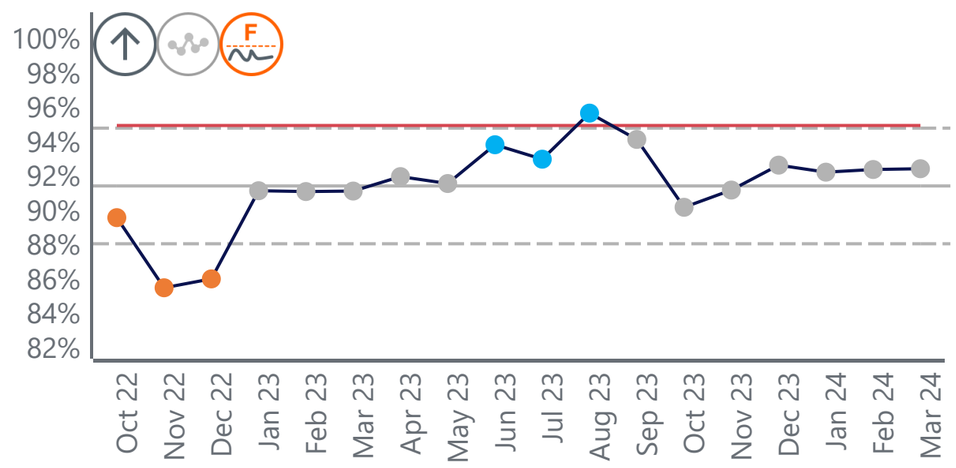
Areas of Concern:

Continued increasing trend in the number of PALS concerns however static number of formal complaints

Forward Look (with actions)

Focused drive on local and first contact resolution principle. Review of PALS office functionality underway with plan to utilise the space in front of the office; whilst this may increase the number of contacts this will be a positive increase as it would demonstrate the improved accessibility to the team and will facilitate early triage and resolution

F&F Test - % Recommend the Trust



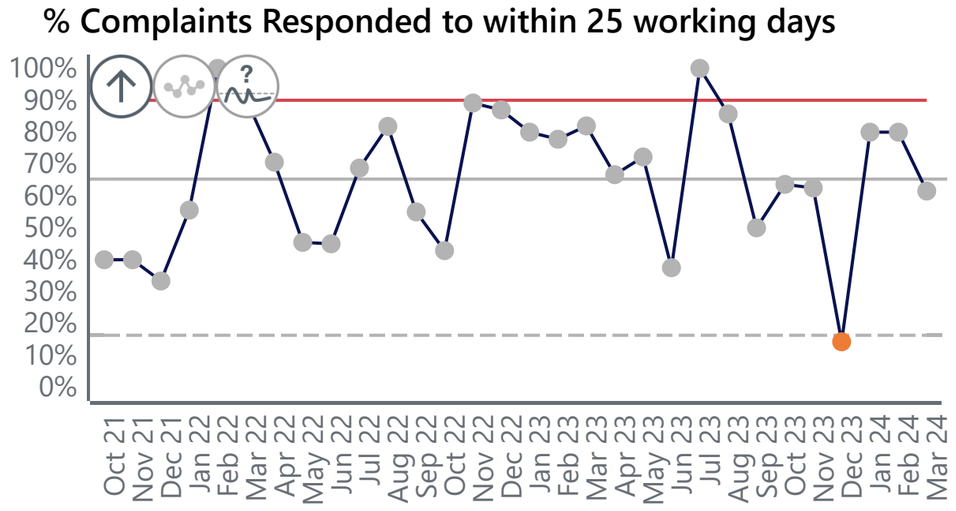
Technical Analysis:

Consistently not achieving the 95% target. March performance of 92.5% represents slight increase from February performance of 92.4%. However this is improvement from March 2022 with performance of 91% and represents fourth consecutive month above average of 91%.

Actions:

Patient Experience Strategy Group undertaking a comprehensive review of the FFT process to facilitate meaningful feedback from CYPF

% Complaints Responded to within 25 working days



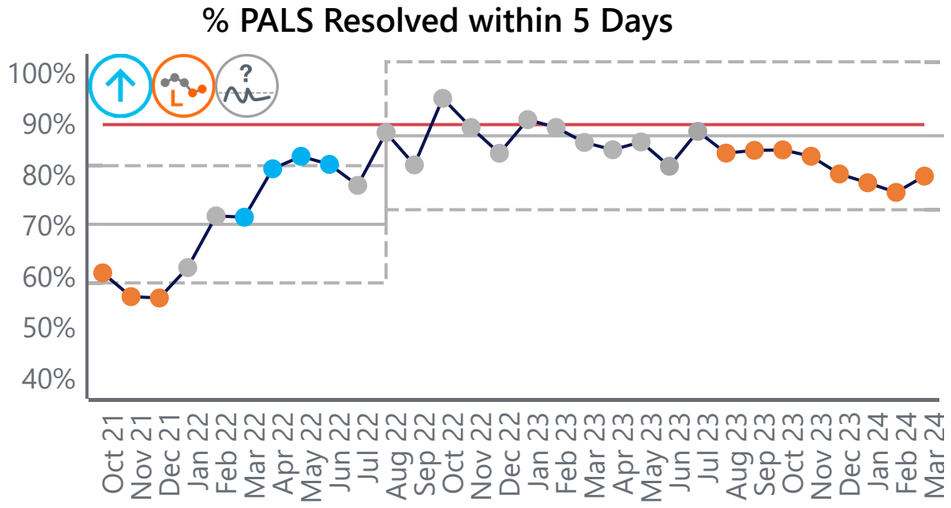
Technical Analysis:

Inconsistently achieving the 90% target with an average of 65% which shows significant fluctuation from month to month. Performance in March 2024 was 62% which represents 5 breaches out of 13 complaints due in the month.

Actions:

Divisions to respond to complaints within 25 working days and apply for an extension if required in line with the policy

% PALS Resolved within 5 Days



Technical Analysis:

Special cause variation has been observed whilst Inconsistently achieving the 90% target. March 2024 performance was 80% and is an increase from 77% in February 2024 following four consecutive months with declining performance

Actions:

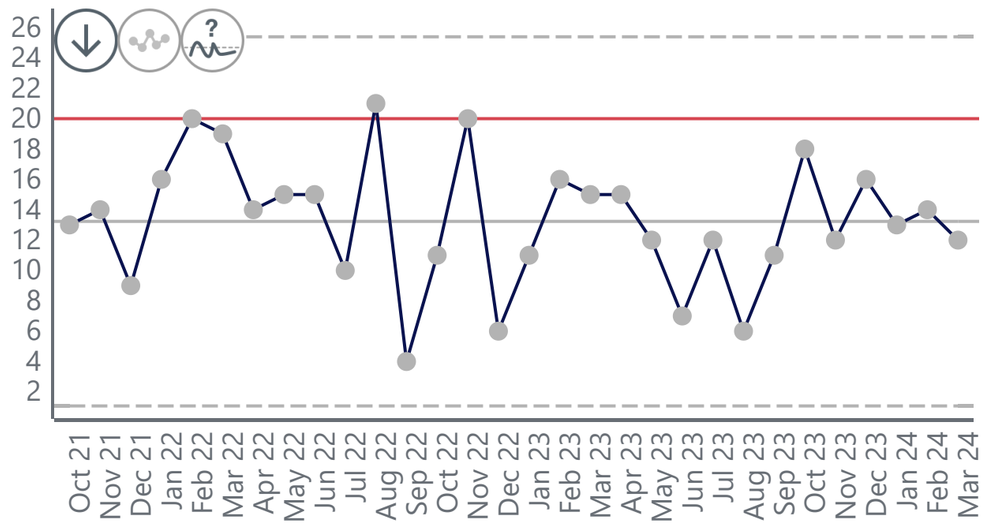
All services to respond within 5 working days

Integrated Performance Report | April 2024

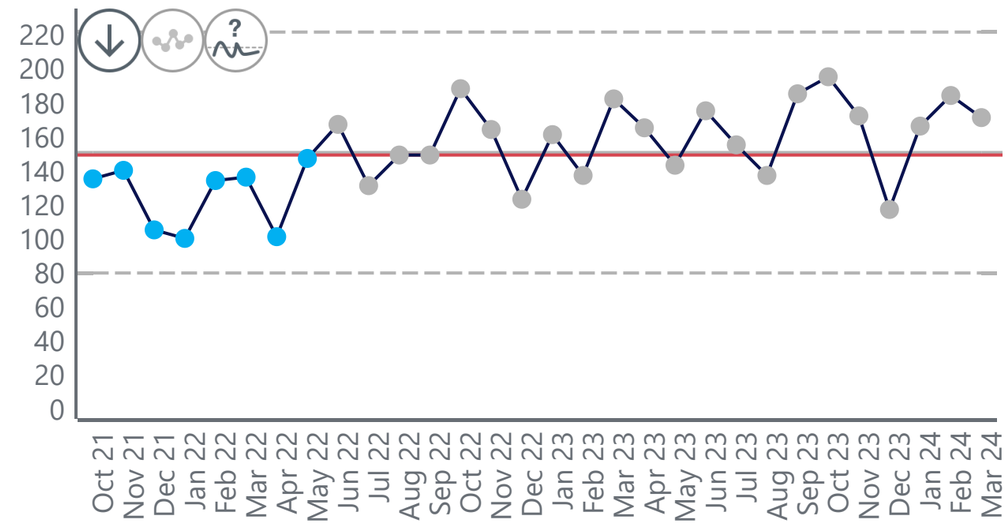
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

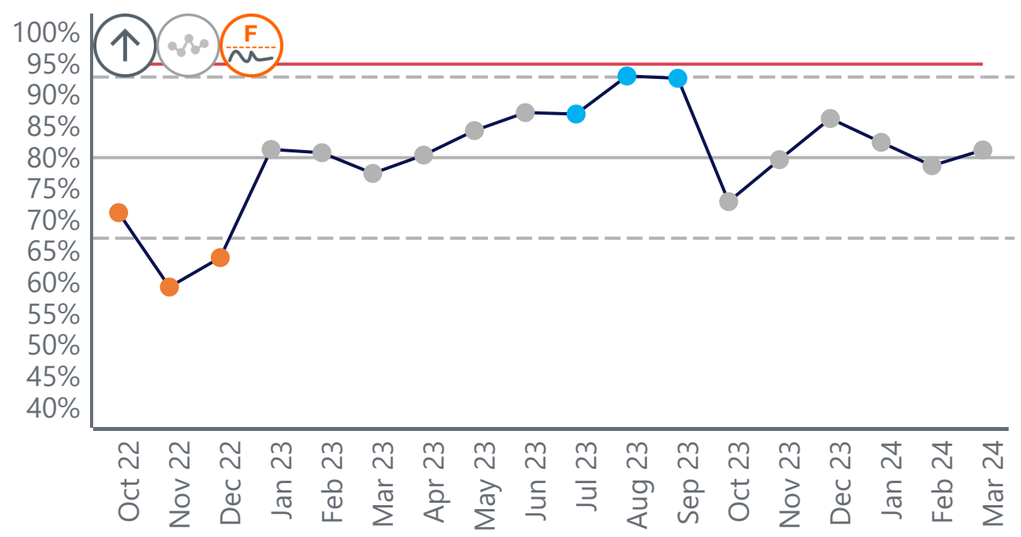
Number of formal complaints received



Number of PALs contacts



F&F ED - % Recommend the Trust



Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

- ED performance achieved 84%, exceeding the national target of 76%.
- WNB rate is showing a third consecutive reduction in month, achieving target of <10%
- Overall trend for virtual ward bed days is showing continuous improvement

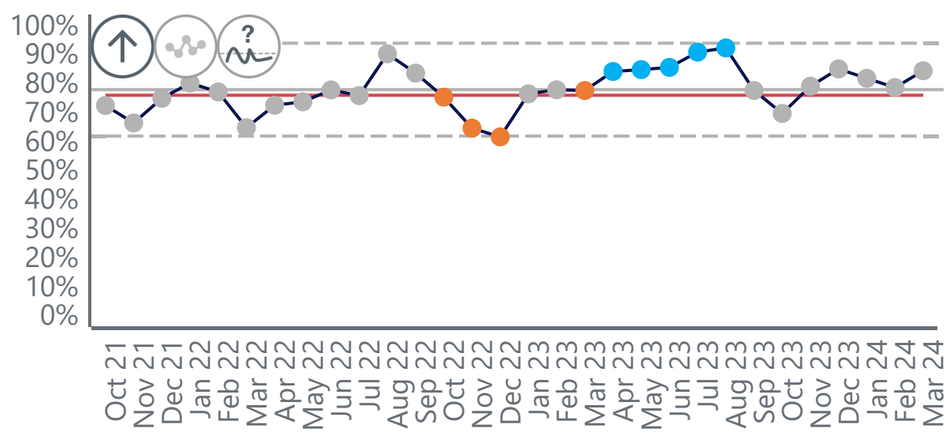
Areas of Concern:

- % of Clinic letters completed within 10 days performance remains static
- Although showing a sustained improvement, theatre utilisation remains below the national target of 85%

Forward Look (with actions)

- Theatre utilisation will be a priority for 2024/25 and will be monitored via the Revolutionising Care Programme
- WNB will continue to be monitored and striving for a sustained performance of <8%

ED: % treated within 4 Hours



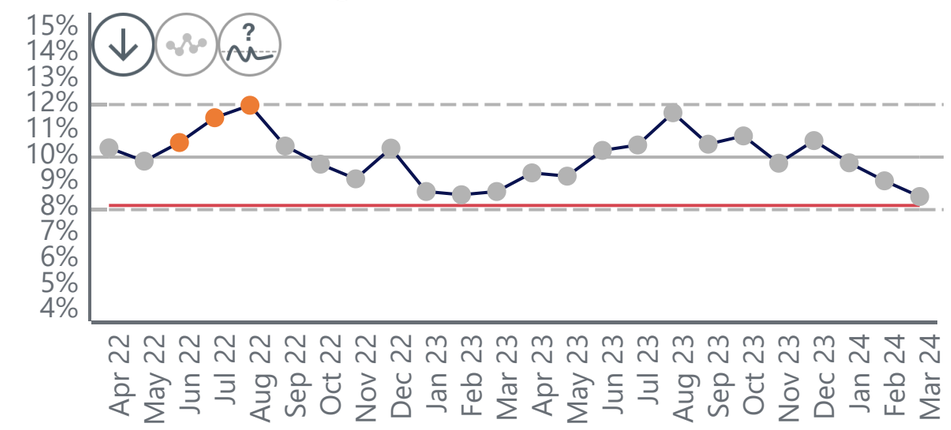
Technical Analysis:

Trust achieving the national target (>76%) in Mar-24. Common cause variation has been observed with performance of 84.4%. Improvement from Feb-24 of 78.6%. Mar-24 performance is +6.8% compared to Mar-23 (77.6%) whilst also having +850 extra attendances in Mar-24. 11/12 months achieving the national target in 23/24 with annual performance of 82.5%.

Actions:

- ED have a stretch target of 85% for 2024/25.
- A review of the acute medical model is underway and a priority for the Division of Medicine for 2024.25.
- Embed PAU pathways.

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



Technical Analysis:

WNB rates demonstrates common cause variation. Performance in February 2024 of 8.2% which is reduction when compared to February 2024 (8.9%). 3rd consecutive month showing a reduction although a number of bookings are still be actioned for the month which could alter March 2024 position.

Actions:

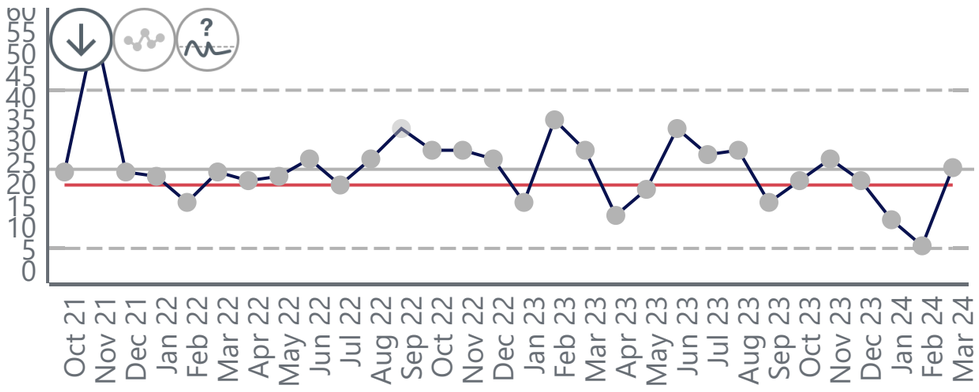
- Priority remains on those specialties where WNB is greater than 10%
- WNB reminder calls include ADHD and mental health services
- ENT are continuing a piece of work regarding opt in/opt out

Integrated Performance Report | April 2024

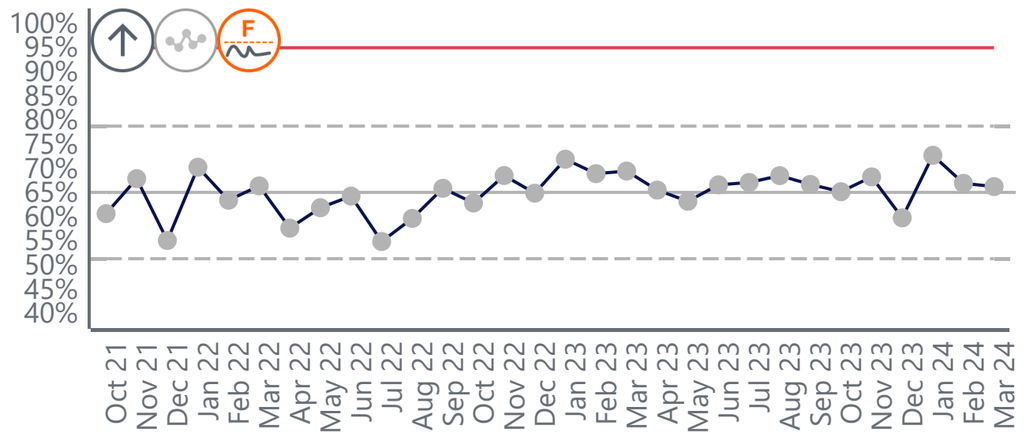
Alder Hey Children's NHS Foundation Trust

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

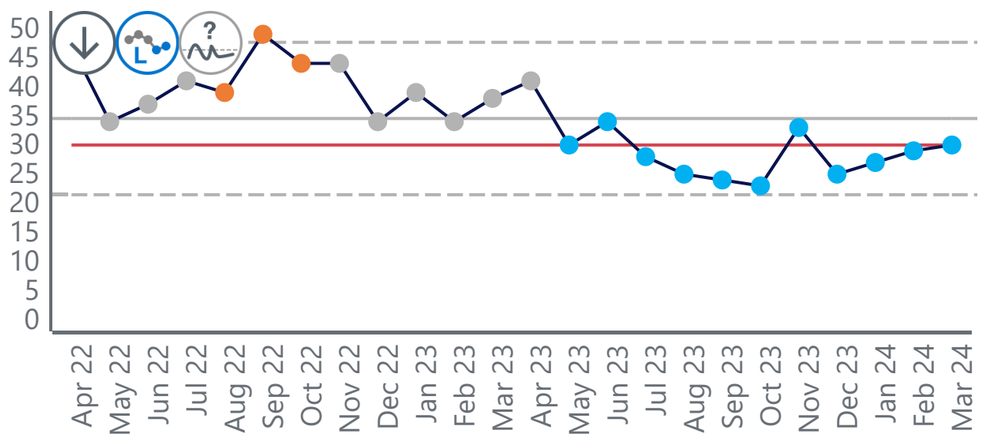
Number of Cancelled Operations (on day of admission for a non-clinical reason)



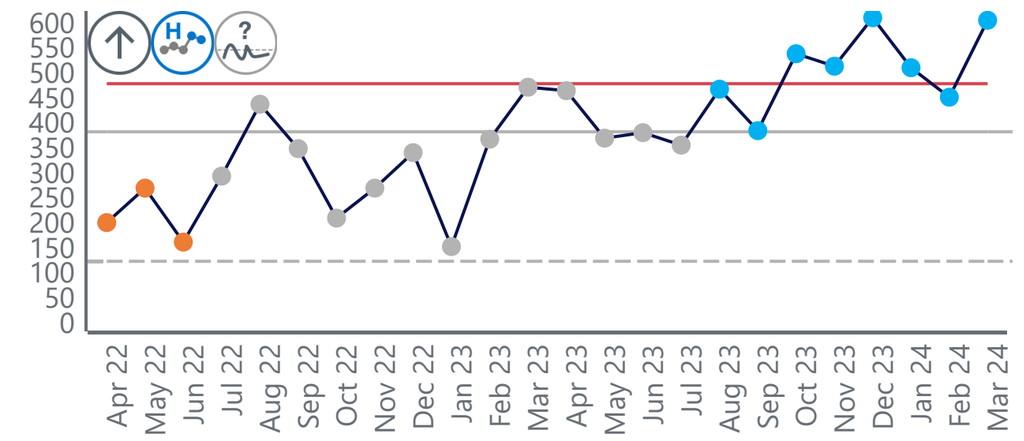
% of Clinical Letters completed within 10 Days



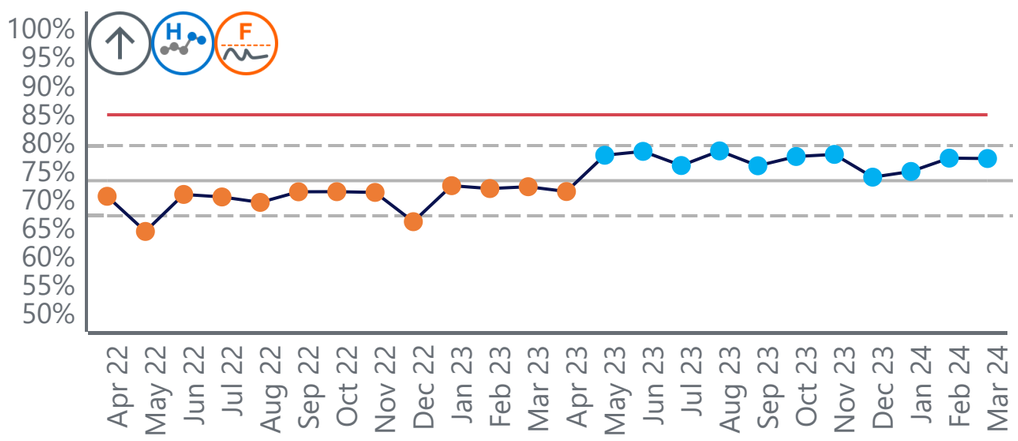
Number of Super Stranded Patients (21 days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

- Only one patient waited over 65 weeks from referral to treatment in March 2024.
- 100% compliance for access to cancer services, exceeding national standards
- Strong Activity Recovery (volume) in March with 129% for OP

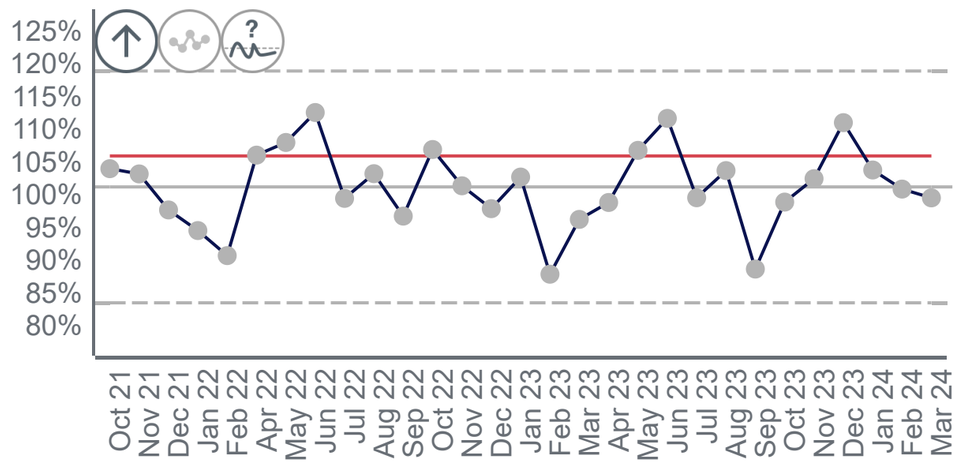
Areas of Concern:

- ASD and ADHD long waits continue to grow with now 2,100 children and young people >65 weeks waiting for diagnosis
- IHA within 20 days fallen to 27% in March (was 64% in July)
- Diagnostic 6 week waits (DM01) achieved 85% in March, failing to reach the expected of 90% target in Q4

Forward Look (with actions)

- Capacity & Demand modelling being carried out in surgery division to identify the capacity gaps for achieving zero 52+ weeks by March 2025.
- Productivity programme implemented focusing on theatres and throughout through the surgical division.
- Implement improvement plans with ASD/ADHD and IHA service

% Recovery for DC & Elec Activity Volume



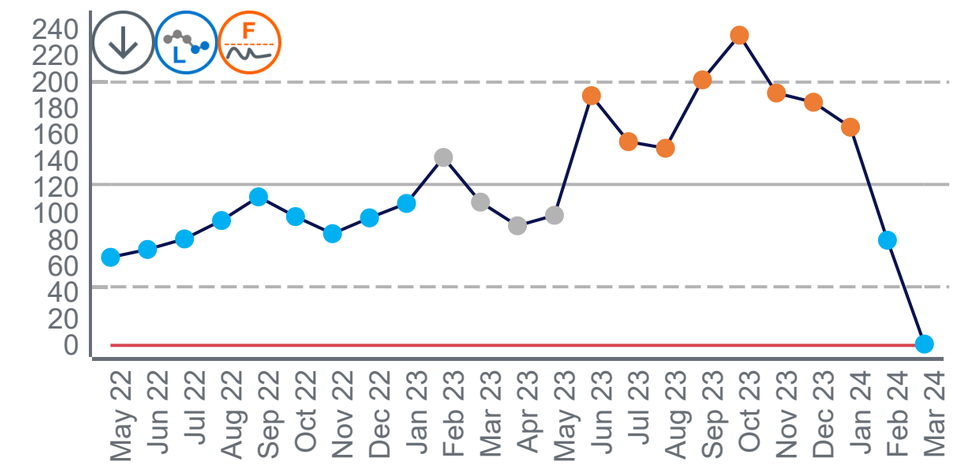
Technical Analysis:

February performance of 100% is below target of 106% for 2019/2020 baseline. February 2024 experienced industrial action 24th-28th however the month is 12% higher than February 2023 (88%) performance. The data series continues to demonstrate common cause variation.

Actions:

- Review of theatre schedule to ensure appropriate reallocation of sessions to the areas with high patient demand • Modelling of surgical specialities to be finalised by end of April 2024 • Increased catheter lab operating from 36 weeks to 42 weeks, signed off as of 1st April

Number of RTT Patients waiting >65 weeks



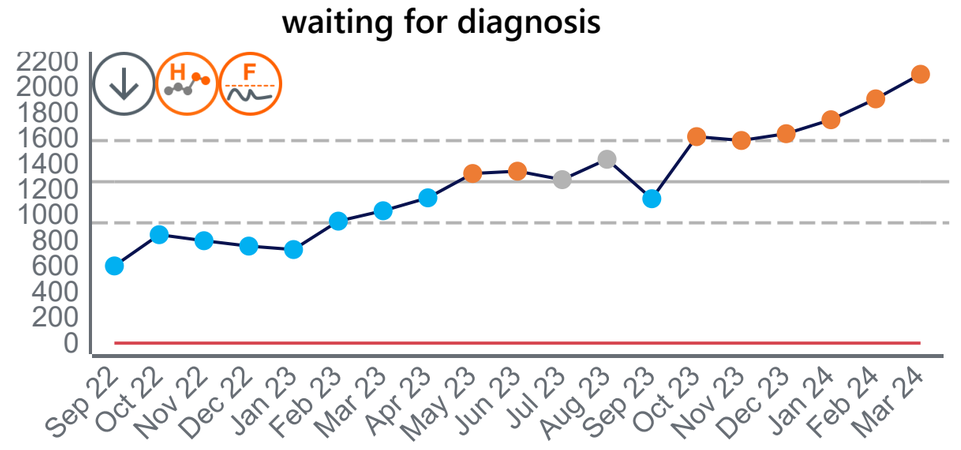
Technical Analysis:

Now demonstrating common cause variation with number of patients waiting > 65 weeks significantly decreasing to 1 in March 2024 (80 in February).

Actions:

- Modelling of surgical specialities to be finalised by end of April 2024, striving for zero 58 week patients by September 2024, exceeding the national target of zero 65+ week

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



Technical Analysis:

March 2024 shows 2,100 patients which is above the outer control limits, now showing special cause variation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

Actions:

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

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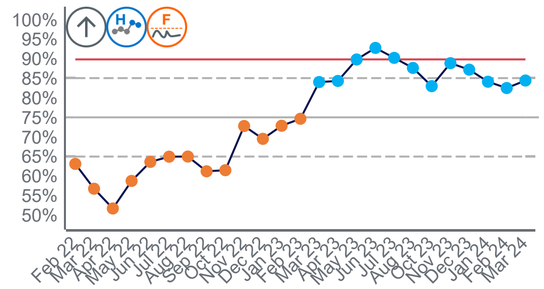
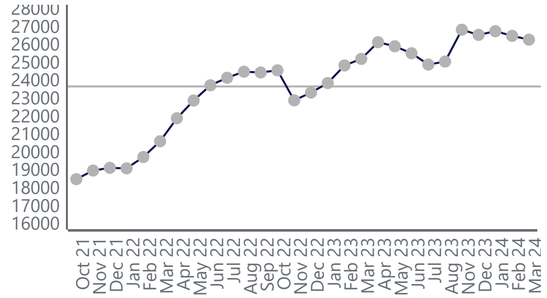
Alder Hey Children's NHS Foundation Trust

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

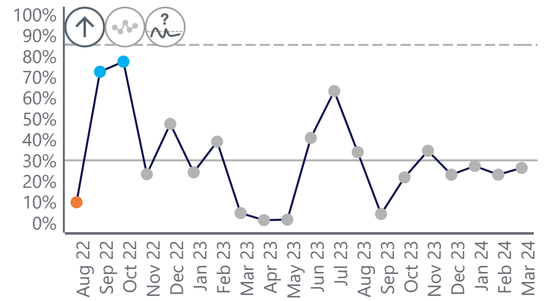
Diagnostics: % Completed Within 6 Weeks of referral



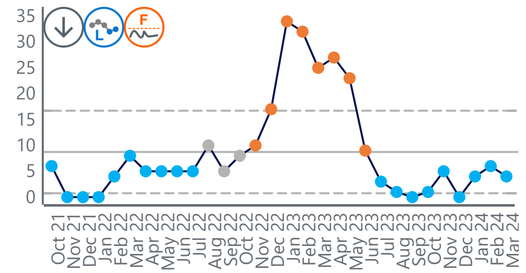
Waiting List Size



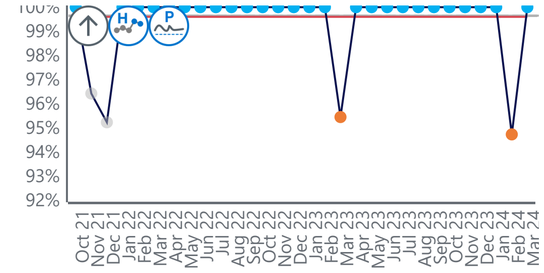
IHA: % complete within 20 days of referral to Alder Hey



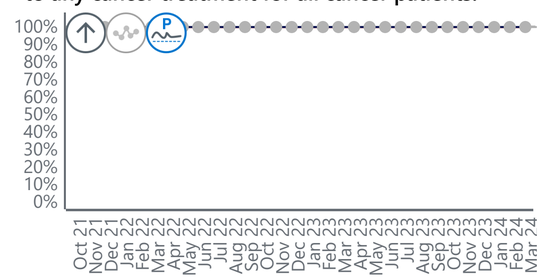
CAMHS: Number of children & young people waiting >52weeks



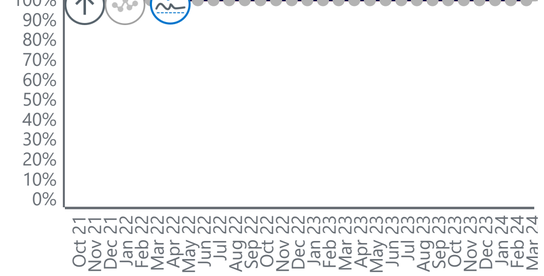
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



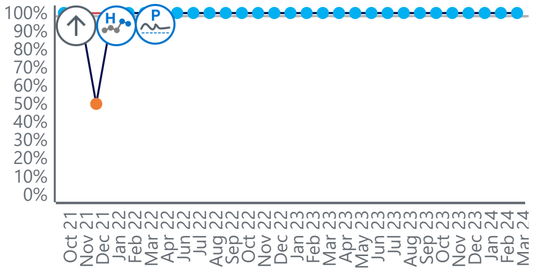
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



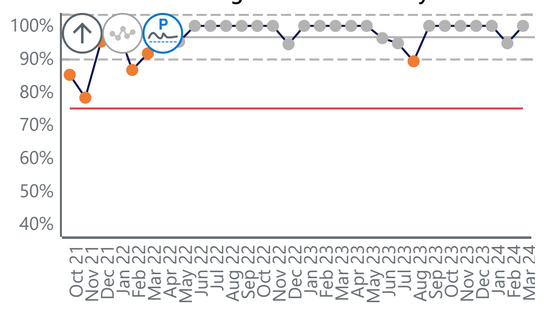
All Cancers: 31 day wait until subsequent treatments



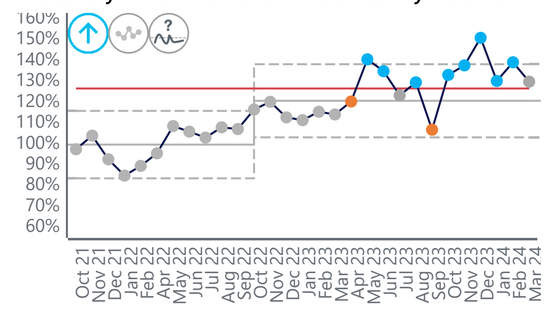
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Collaborating for CYP - Reducing Health Inequalities: Responsive

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

Highlights:

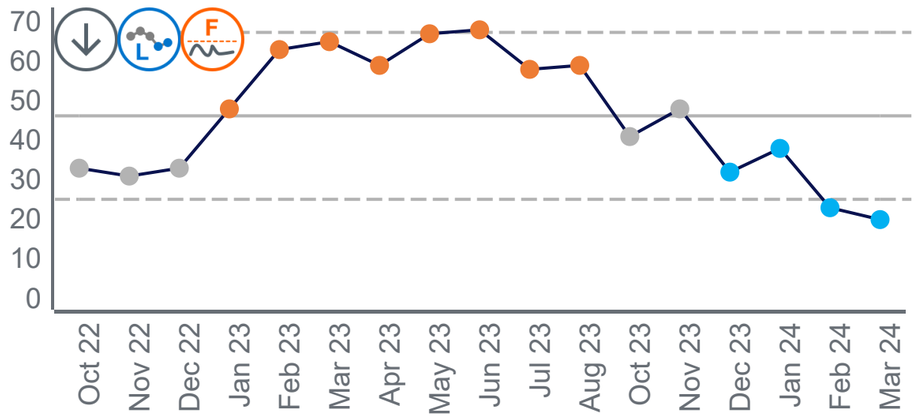
Beyond continues to focus on "shift-left" via integrated early intervention and prevention that addresses the wider determinates of health and social outcomes. The programme is linked to the "All Together Fairer" Marmot programme in relation to the wider determinants of health inequalities and is involved in the CHEC. They work with the ICB regarding delivery of the CORE20+5 deliverables, some of which are directly delivered via Beyond, and some more broadly through system delivery.
A Professor of Public Health reporting to the Medical Director has been appointed to the Trust and will lead the health inequalities and prevention agenda through the Health Improvement Steering Group (HIPSG).

Areas of Concern:

Forward Look (with actions)

A Professor of Public Health reporting to the Medical Director has been appointed to the Trust and will lead the health inequalities and prevention agenda through the Health Improvement Steering Group (HIPSG).
This appointment will support the interrogation of the data below and enable us to build a meaningful plan of action.

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



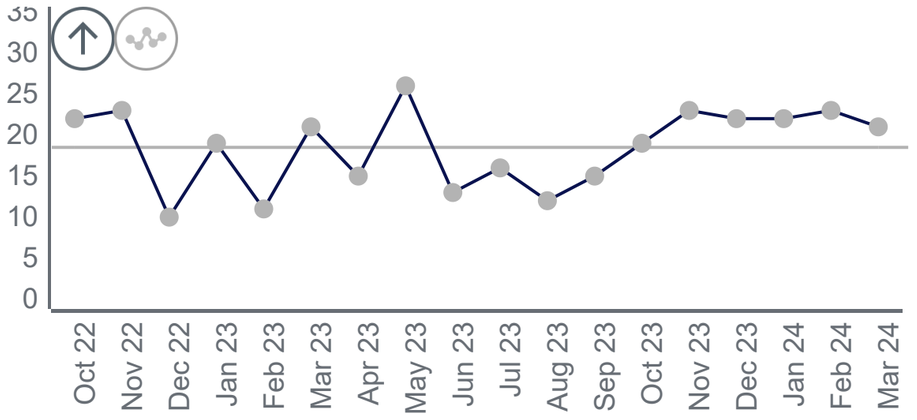
Technical Analysis:

Now demonstrating special cause variation with number of patients waiting > 52 weeks decreasing to 20 children. 2nd consecutive month with a reduction. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Weekly Planning Meetings – This ensures that all capacity is full utilised and longest waiting patients are dated first. This process also allows collaborative working with Nursing to understand where additional OP capacity can be included

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



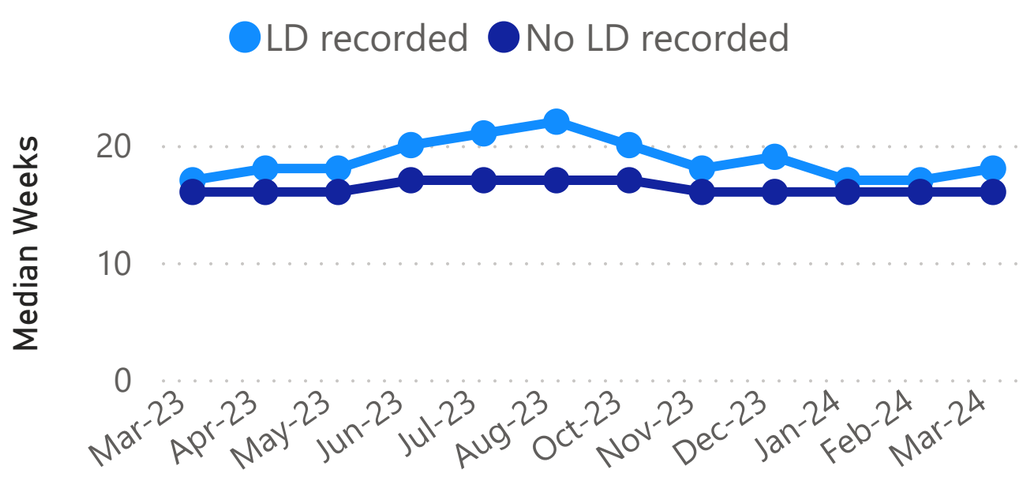
Technical Analysis:

New Metric which shows on average 19 referrals of BAME background are accepted per month. March 2024 shows 21 patients. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

This metric will support our understanding of BAME representation and meeting their needs within the CAMHS cohort.

Median Waiting Time (RTT) for LD Waiters



Technical Analysis:

Median wait of Learning and Disability (LD) patients on a RTT open pathway was 18 weeks end of March 2024 for LD recorded waiters compared to median wait of 16 weeks for non-LD recorded patients waiting.

Actions:

This metric will support our understanding of waiting times for this cohort and the actions we need to take

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Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

• There has been a continued reduction in staff turnover.
• Sickness absence is reporting below the target, with improvement seen in both the percentage of short term and long term sickness. Ongoing and improved activities within Divisions to effectively reduce long Term sickness with focus on increased qualitative return to work meetings and reduced Occupational health DNA'S to improve sickness absence.
• Mandatory training remains above the target with improvements in sickness absence, PDRs and mandatory training also seen.

Areas of Concern:

PDR compliance remains an area of concern. Positively, improvement has been seen from February to March, with plans continuing to support completion by the end of April 2024. The medical appraisal completion recovery is also slow than following the previous drop in performance in 2023.

Forward Look (with actions)

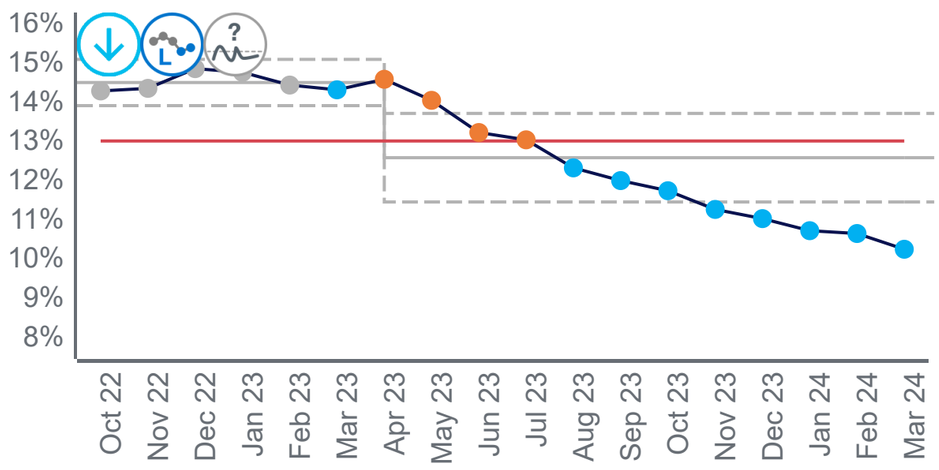
PDR completion has increased to 76% (+7% from February), with the deadline to complete PDRs extended to the end of April 2024, and an improving position through April. Weekly reporting and completion plans are in place.

Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

Staff Turnover



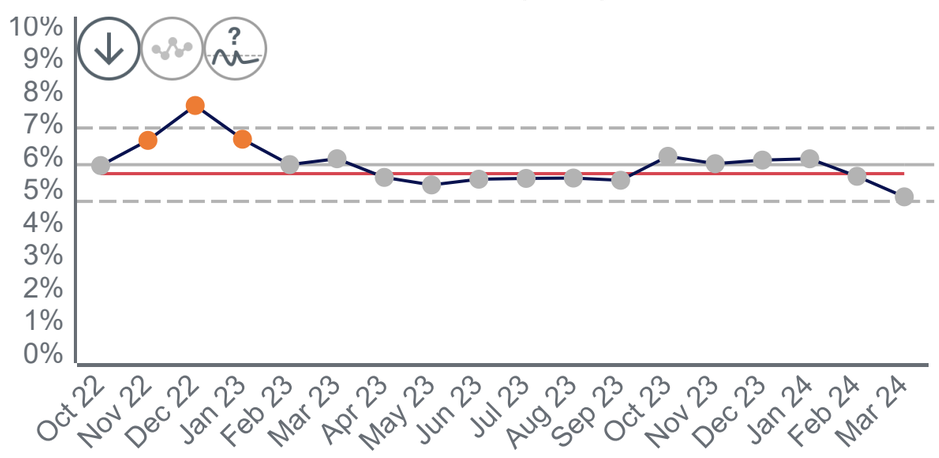
Technical Analysis:

Staff Turnover continues to demonstrate special cause variation, 10.2% is the 11th consecutive month with a reduction and 8th consecutive month within target.

Actions:

There is a continued reduction in turnover, this is and has been reporting under the target (13%) since August 2023. The target will reduce to 10% from April 2024 for 2024/25. 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 March 2024 is 4.74% which is below the 5.5% target. A decrease from February 2024 at 5.40%. March 2024 performance comprises STS at 1.64% and LTS at 3.10%. Still demonstrating common cause variation. 2nd month below target since September 2023.

Actions:

4.74% in March 2024, with long term sickness still the larger portion of the sickness absence percentage. The following remain in place: • Discussions at Divisional Boards • Management meetings • Divisional wellbeing activities • Focus on Stage 3 long term sickness • Return to Work discussions are being reinforced. The sickness absence target has been reviewed and will

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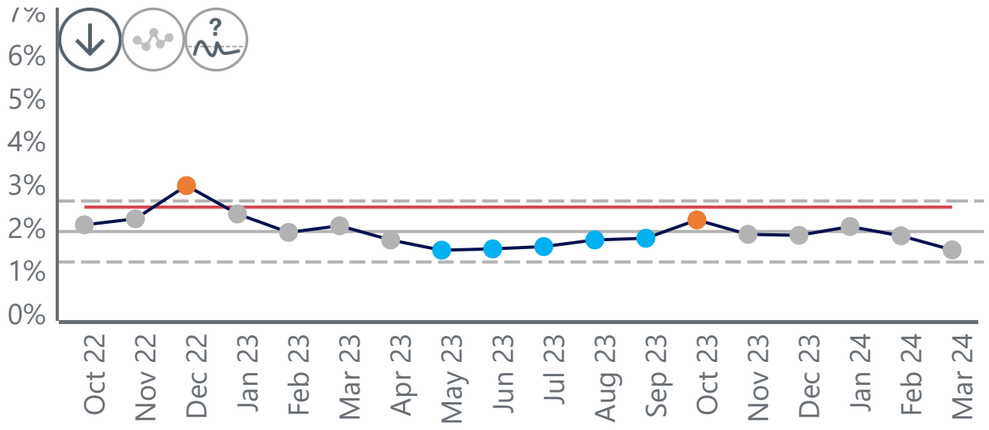
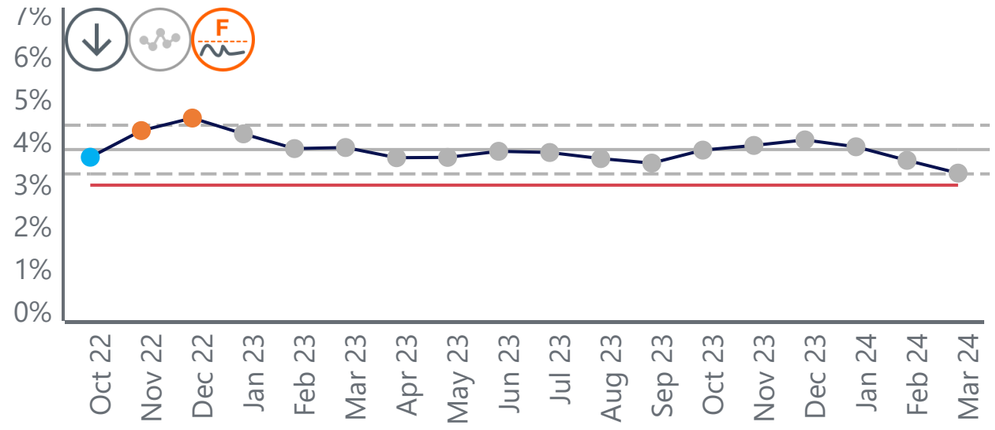
Well Led - Supporting Our People - Watch Metrics

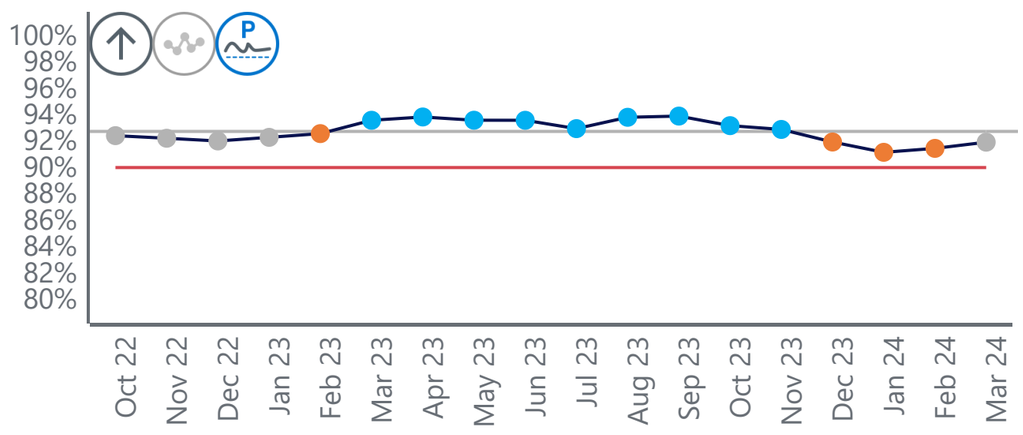
Short Term Sickness



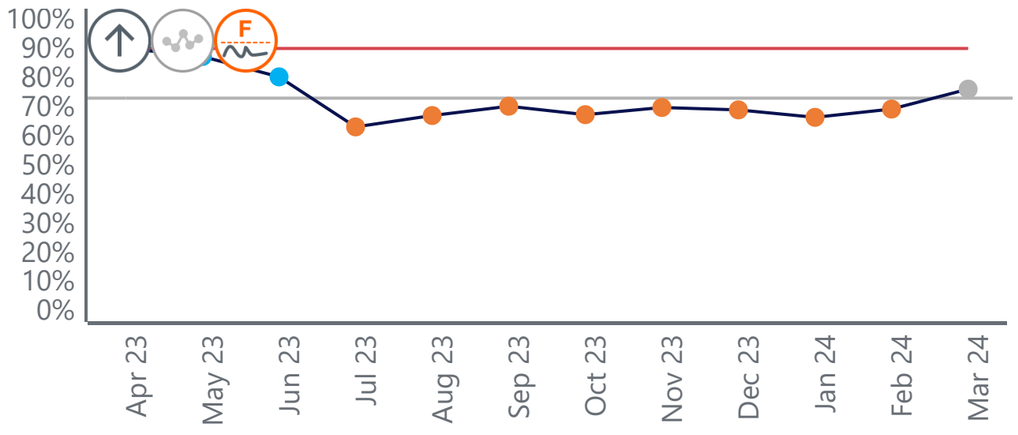
Long Term Sickness



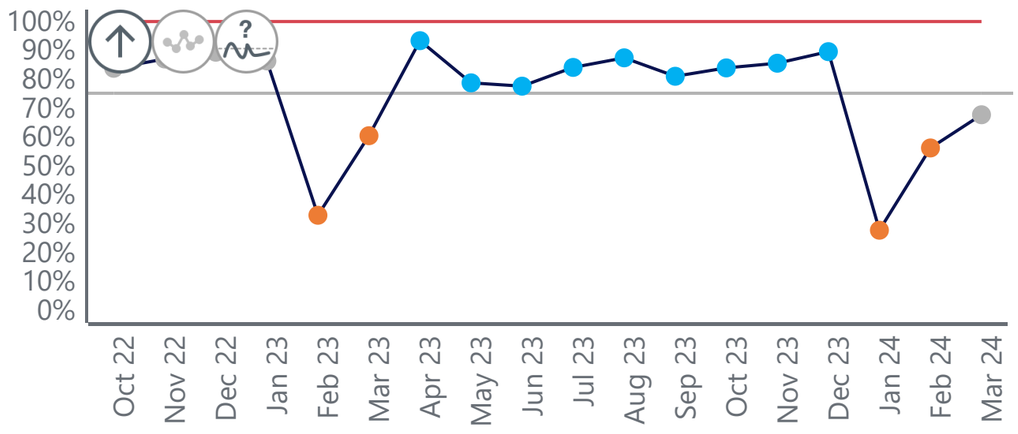
Mandatory Training



% PDRs Completed (Rolling 12 Months)



Medical Appraisal



Staff movement / Churn rate - In Development

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Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

The Trust is reporting a £10.3m surplus position for 23/24. This is £2m away from the plan set at the start of the year. The deterioration from plan/forecast is due to a reduction in ERF income compared to forecast, mirroring ICB/Spec Comm notification of expected ERF income. Outturn was £2.7m away from the revised forecast submitted in November due to industrial action in addition to the ERF income reduction noted above. The full £17.7m CIP has now been achieved in year, with £10.2m identified as recurrent savings and the remaining £7.4m gap carried forward into 24/25. Cash has remained high in line with plan & capital in line with expectations.

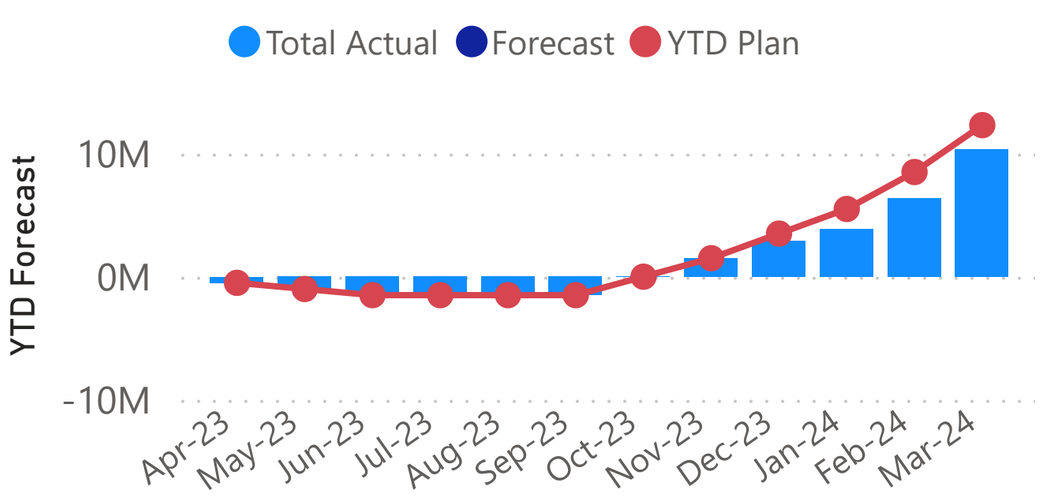
Areas of Concern:

CIP gap is closed in year. CIP carried forward remains an area of concern given the gap recurrently is £7.4m which will be carried forward into 24/25. However, significant progress has already been made to support the delivery of CIP targets in 24/25 including the work on benefits from the strategic initiatives.

Forward Look (with actions)

Continued cost control as we go into 24/25. Continued focus required on recurrent efficiency. Work also continues with divisions on transformation schemes to identify recurrent savings and benefits in 24/25.

Revenue Position (Year End Forecast)



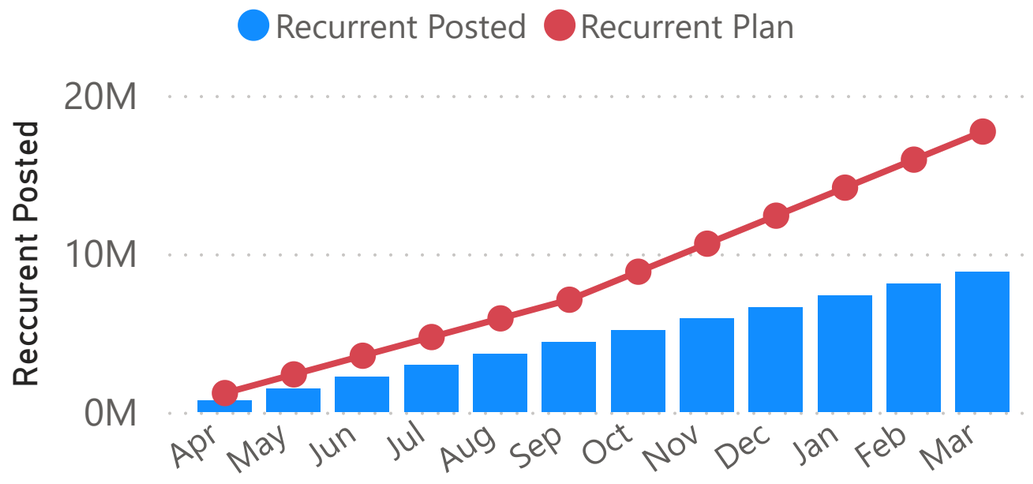
Technical Analysis:

The trust is reporting a £10.3m surplus position.

Actions:

Plan set at the start of the year has not been achieved due to taking a more prudent approach on ERF income.

CIP Position (Recurrent Full Year Effect)



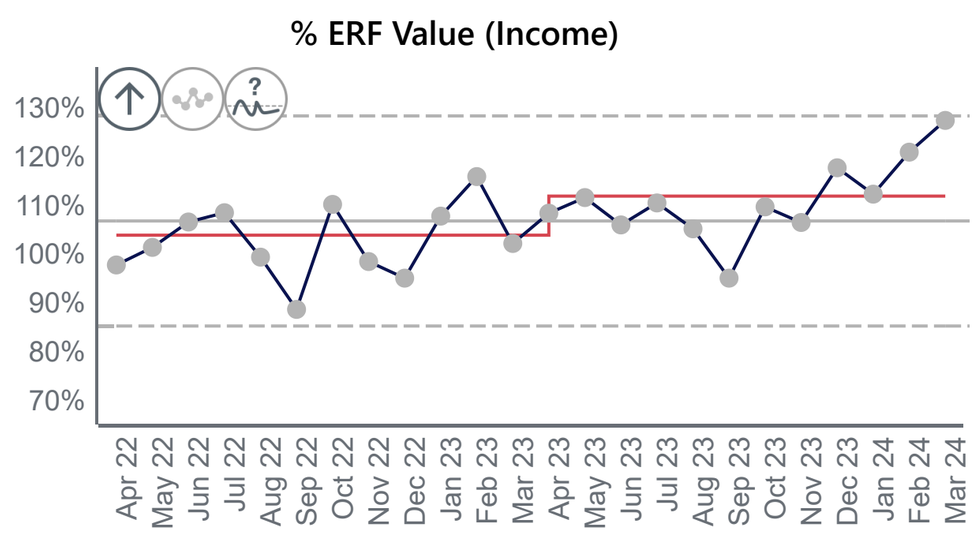
Technical Analysis:

In year CIP identified is £17.7m so achieved in full. Of this, £10.2m is recurrent.

Actions:

Significant progress has been made to support the delivery of CIP targets going into 24/25 including the work on benefits from the strategic initiatives.

% ERF Value (Income)



Technical Analysis:

Full year achievement is estimated at 110.8% which is below the internal target set, but above the revised external target of 102.7%.

Actions:

Continue to monitor those areas (at POD and speciality level) that are under performing versus plan going into 24/25.

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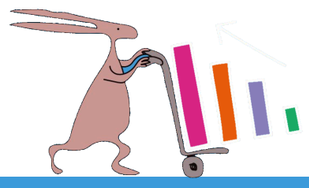
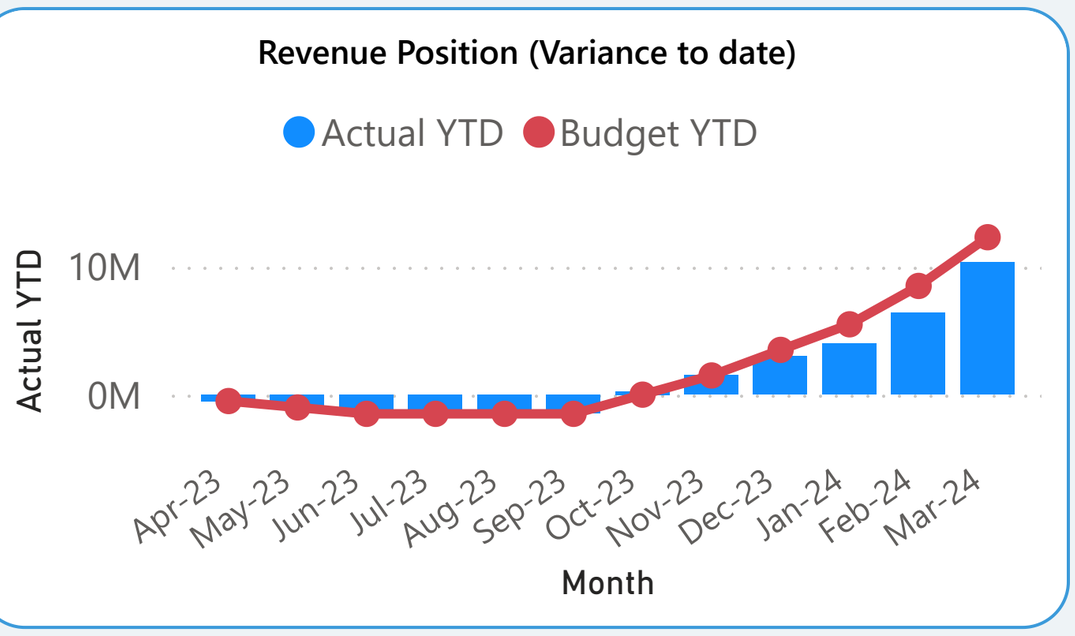
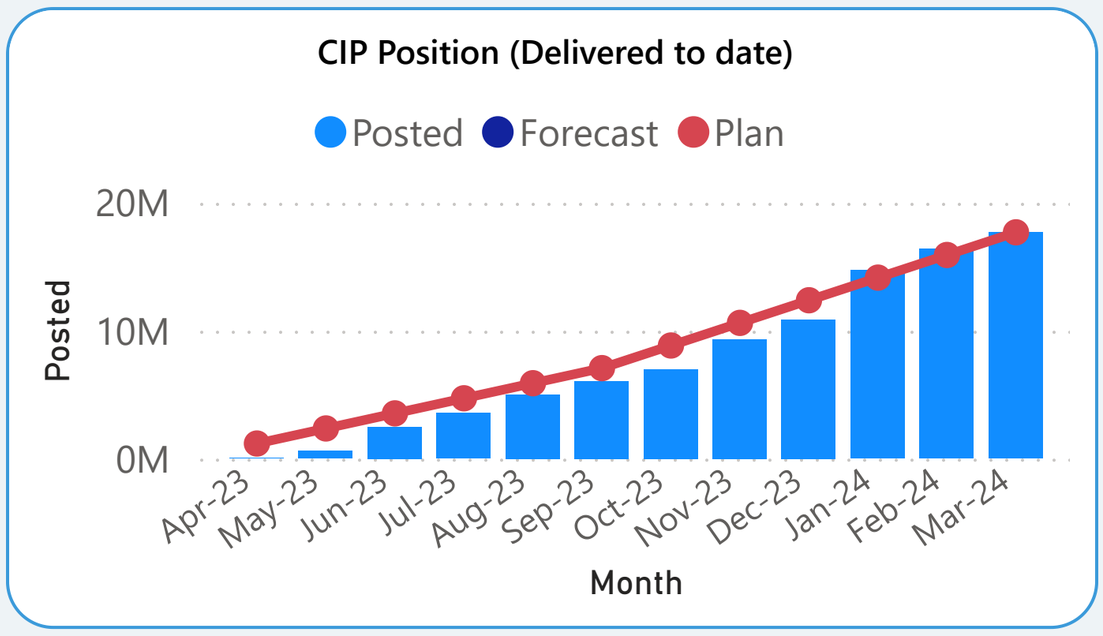
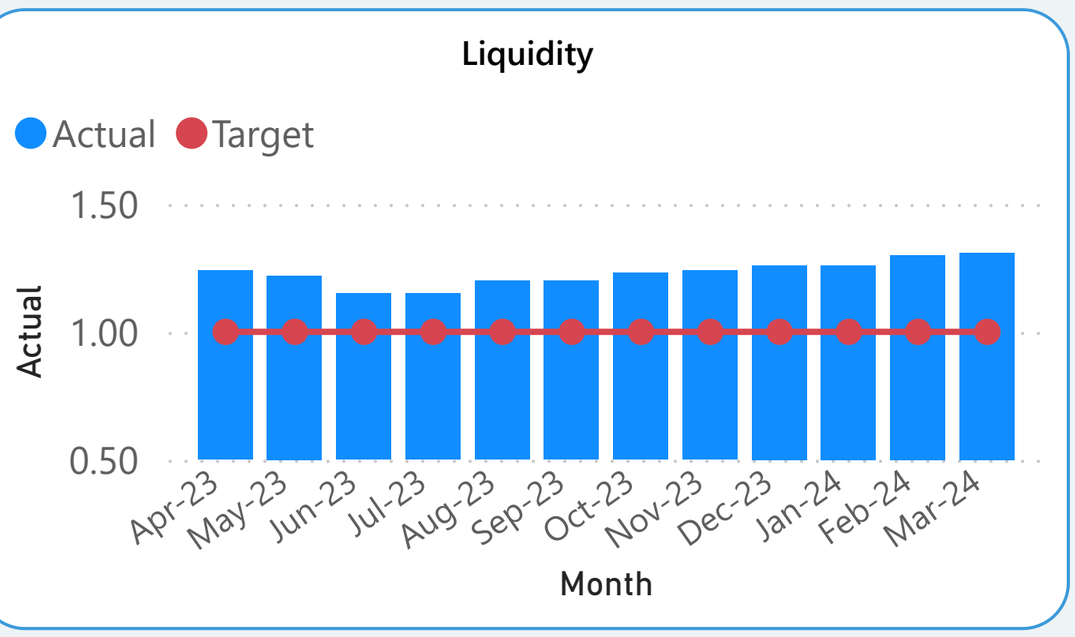


Alder Hey Children's NHS Foundation Trust

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 report functionality.
'Risk bullseye' visual now fully developed and reported in committee reports.
Improved compliance with review of risks noted this month.

Areas of Concern:

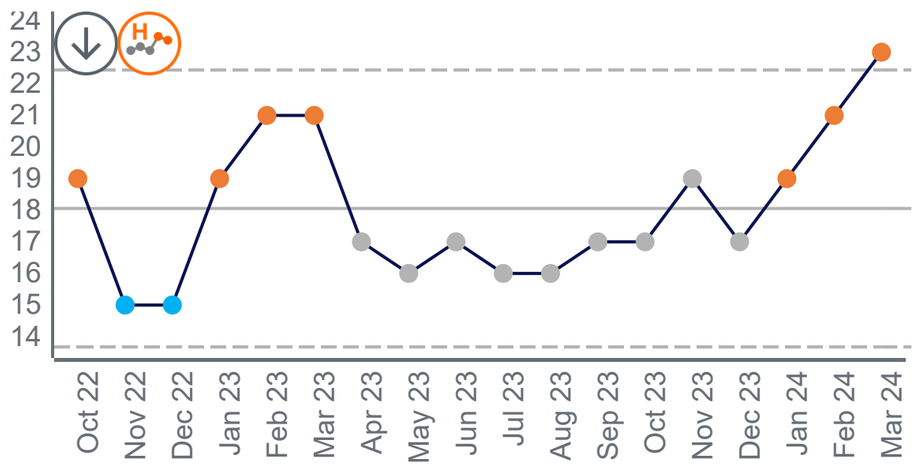
None at the time of reporting

Forward Look (with actions)

Continue to oversee and escalate any overdue high risks to relevant divisional director and risk lead for immediate review and action.

Overview of high risks continues at risk management forum

Number of High Risks (scored 15 and above)



Technical Analysis:

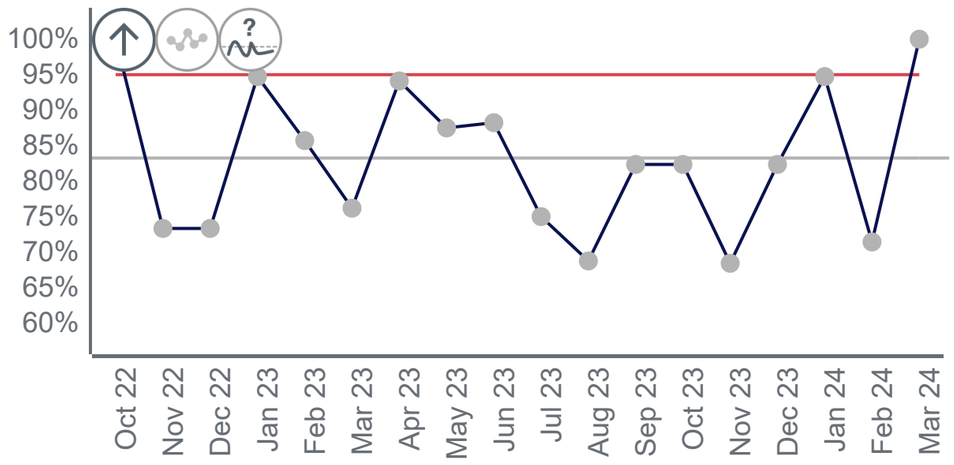
March 2024 position of 23 high risks open, demonstrating special cause variation with an average in the period of 18 a month.

Actions:

23 high risks reported in March 24 slightly increase up from 21 reported in February 24

High risks themed as follows: • Quality – Safety = 10 risks • Workforce = 6 risks • Compliance and Regulatory = 3 risks • Financial = 2 risks • Quality – Effectiveness = 1 risk • Reputation = 1 risk

% of High Risks within review date



Technical Analysis:

Demonstrating common cause variation and inconsistently achieving the 95% target with an average of 83% which shows significant fluctuation from month to month. March 2024 performance is 100% (23/23) of risks are within expected review date.

Actions:

100% of high risks within review date

Smartest Ways of Working - Safe Digital Systems- Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

- 12 significant developments were completed through AlderCare Optimisation Programme in March.
- Scoping work has commenced to review the options for integrating observation devices into the Trusts clinical systems.
- Two strategic workshops have been held with the aim to shape the future of the Alder Hey patient portal. Options to be shared for a decision to be made regarding the direction of the future of the platform

Areas of Concern:

Outstanding developments with Meditech.

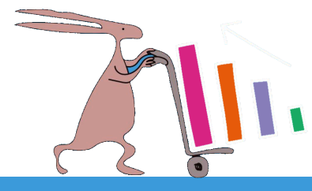
Forward Look (with actions)

- A paper aligning digital programmes to 2030 to be produced in April which will then be mobilised in May.
- Resource mode enhancements due to be tested in April and delivered in May through AlderCare optimisation.
- Plan for integration of observation devices to be finalised by May.

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:

Smart Gloves project approved by H&S – due to launch 07/05.

ICB energy group formed and making joint funding bid.

Areas of Concern:

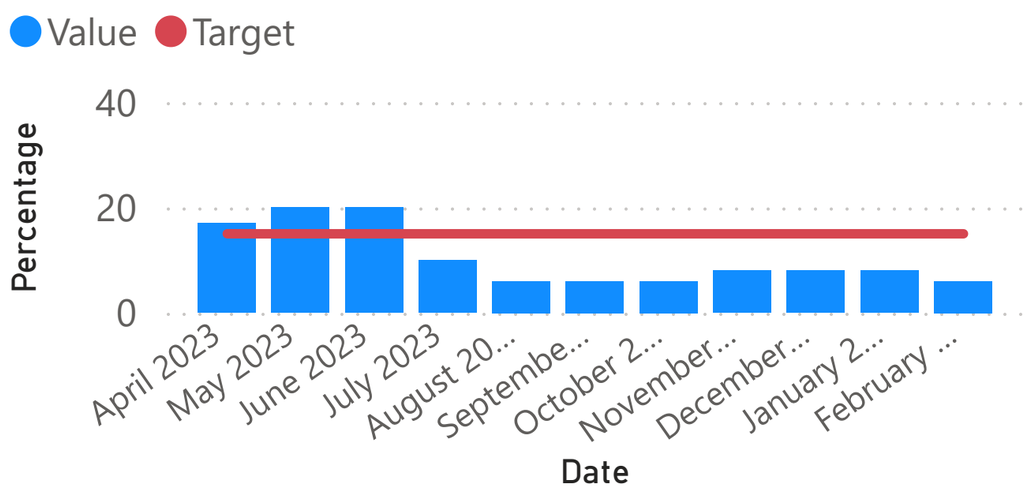
SPV performance. Slow resolution of issues.

Forward Look (with actions)

Developing "better bins" project – looks good on £ and CO2.

Working with SPV to resolve key issues e.g. CHP and heating.

Green Plan: Reduce Carbon Footprint



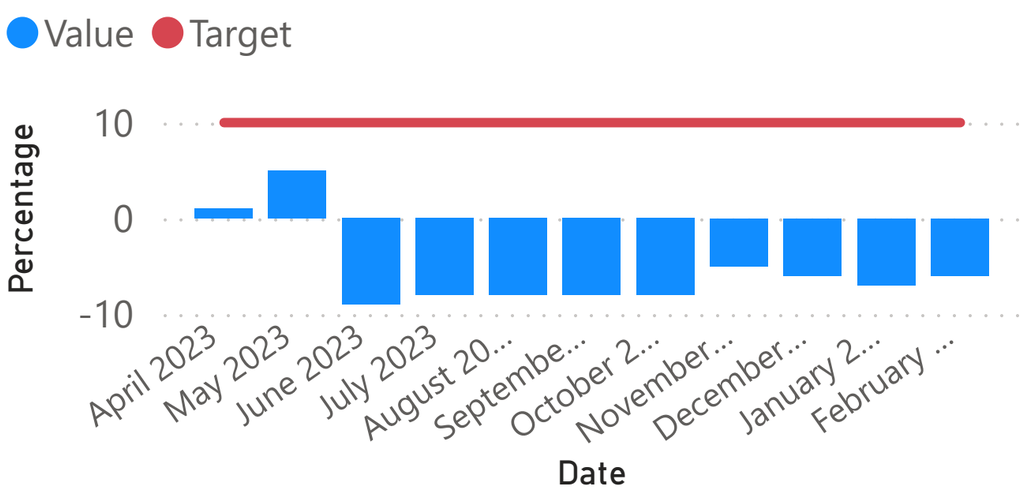
Technical Analysis:

Energy use now back to 2022 performance

Actions:

Joint SPV/MITIE/ Trust action plan on course to get us best ever performance in next Q.

Green Plan: Reduce Energy Usage

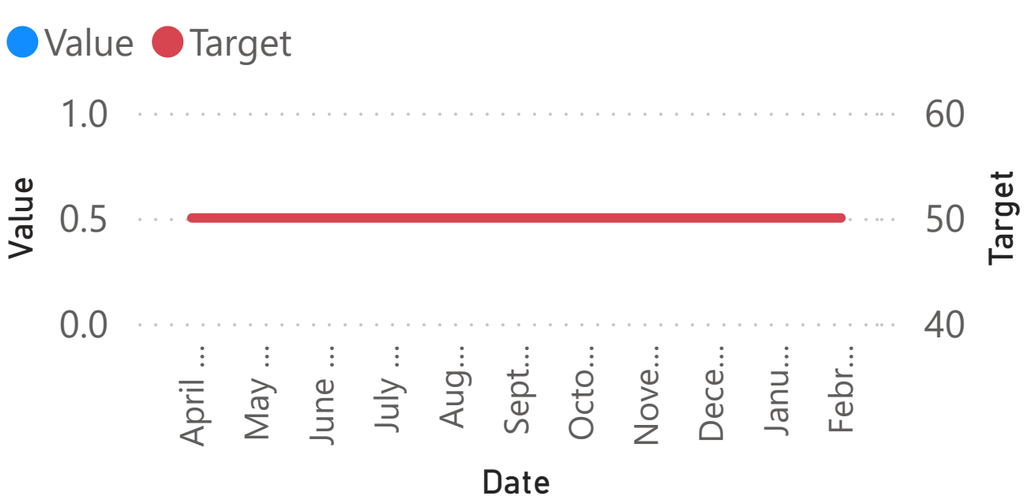


Technical Analysis:

Energy use now back to 2022 performance

Actions:

Green Plan: Reduce Waste



Technical Analysis:

No reduction

Actions:

Complete review of new compactors.

Develop "better bins" project and agree pilot area.

Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Reduction in number of formal complaints received (3)

• Reduction in number of PALS received, and improvement in number of PALS resolved within 5 days

• Lowest WNB rate in 2023/24 (11.5%)

• Introduction of SNOMED codes into Expanse to aid Mental Health reporting from 01 April 2024, and significant improvement in the number of data errors in MHSDS (<10)

• Improvement in RTT for CAMHS (64%)

• Improvement in ASD/ADHD referral triage time (100% within 12 weeks)

• Continued reduction in staff turnover (11%)

• Further reduction in sickness absence (4.5%) (mainly LTS)

• Improvement in community dietetics RTT (70%) with reduction in average longest waiter to access service

• Appointed to several vacancies within community paediatrics (4 staff grade, 2 MT fellows)

• Projector installed in 2.2 waiting area to improve experience for children and young people

• Go Live of NHS England Gender Service North West

Areas of Concern

• Waiting times to access SALT (Sefton) continue to remain high and RTT has reduced compared to previous month (57%)
• CAMHS: 4 young people waiting 52+ weeks (due to non-attendance)
• 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 shortage – 103% increase in waiting list size over previous year (1034 March 2023, 2100 March 2024).
• Challenges with waiting times to access GP phlebotomy service due to demand – actions underway to improve waiting time
• Continued risk relating to lack of a Named Doctor Safeguarding within safeguarding team (post in recruitment phase).

Forward Look (with actions)

• Virtual ward GP pathway due to commence in May 2024

• Refurbishment work on Police Station ongoing - planned move date of June 2024

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

• Review of Divisional letter and text reminders ongoing: – meetings held with all services, completion date 30 April 2024

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

• Room utilisation: Four months of room audit completed, with room reallocation work ongoing to improve capacity in challenged areas.

• Launch of Neurodiversity transformation programme across division

• Detailed review of SALT waiting times and improvement plans

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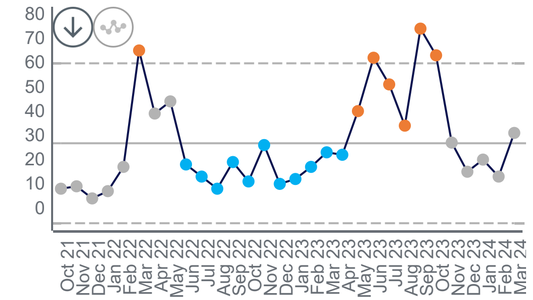
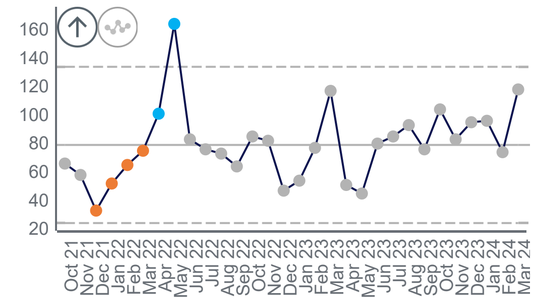
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

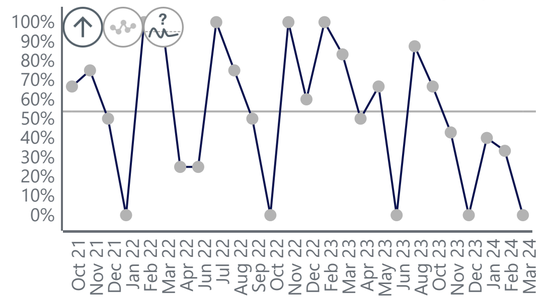
Number of Incidents rated Minor Harm and above



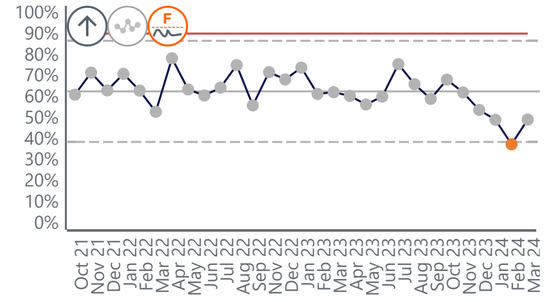
Number of Incidents rated No Harm and Near Miss



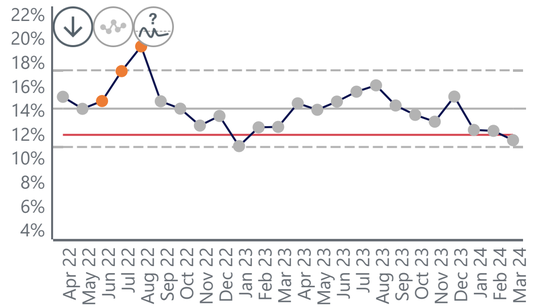
% Complaints Responded to within 25 working days



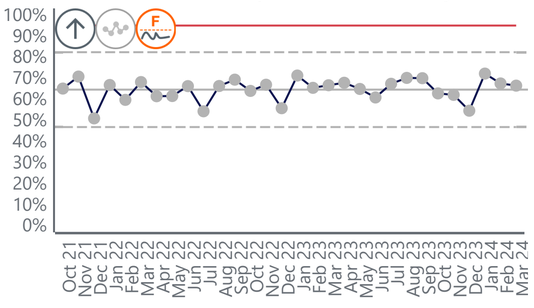
% PALS Resolved within 5 Days



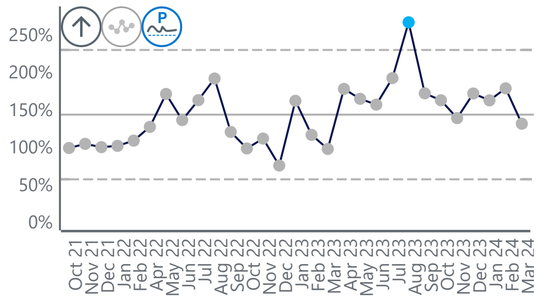
% Was Not Brought Rate (All OP: New and FU)



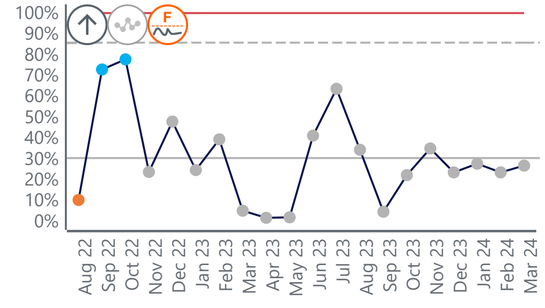
% of Clinical Letters completed within 10 Days



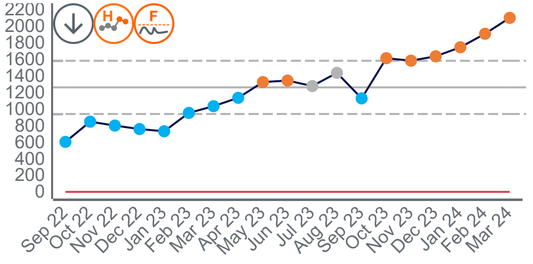
% Recovery for OP New & OPPROC Activity Volume



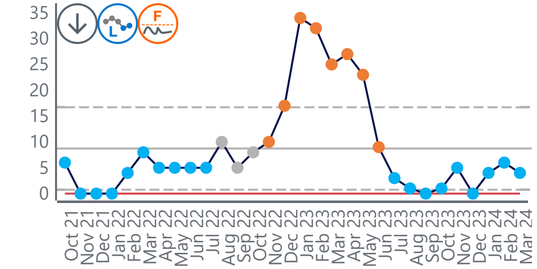
IHA: % complete within 20 days of referral to Alder Hey



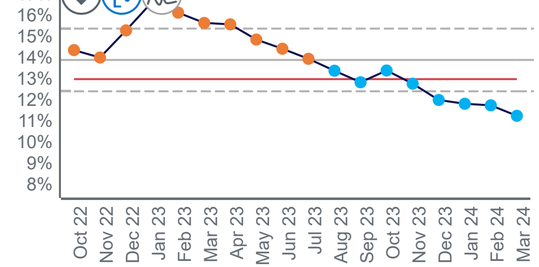
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



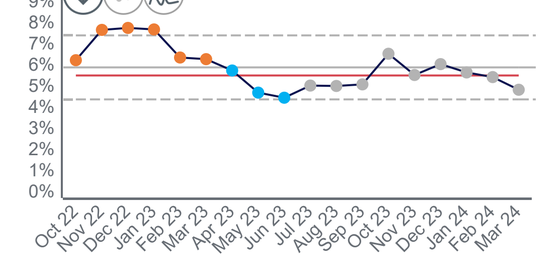
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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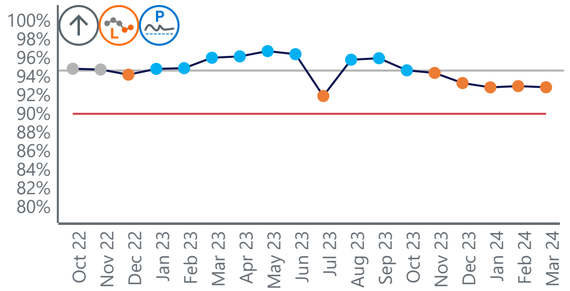
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

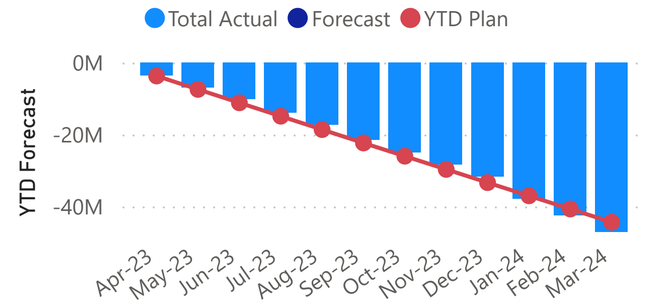
Mandatory Training



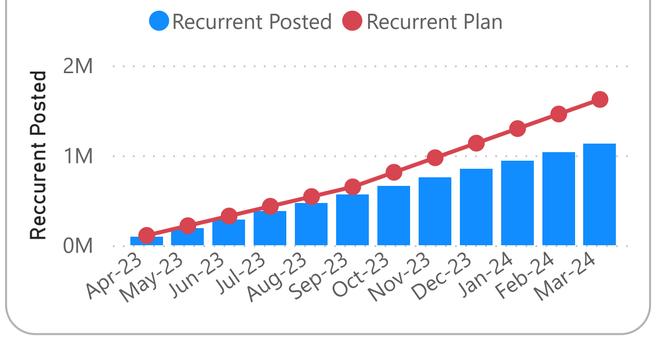
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

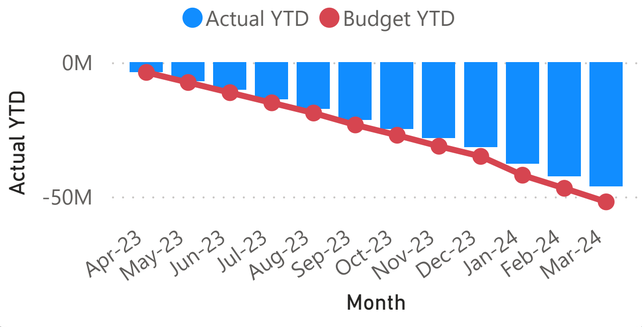
Revenue Position (Year End Forecast)



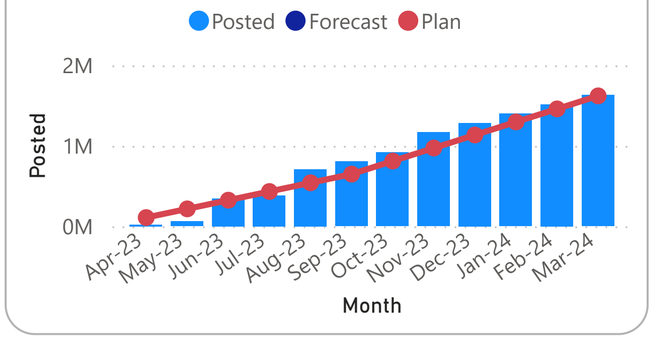
CIP Position (Recurrent Full Year Effect)

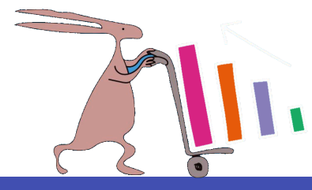


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Emergency department achieved all targets for quarter four achieving 81.4% against the 4hour target and 90% of ambulance handover were completed within 30mins

• Two clinical areas achieved gold accreditation in the quality assurance rounds- MDU and Radiology

• No child waited over 65 weeks for treatment by the end of March

• 97% sepsis patients received antibiotics within 60 mins

• 100% response rate for formal complaints for 4th consecutive month

• Reduction in C&YP who waited for 12 hours + within ED for treatment

• Reduction in medical time to clinical assessment, remains above national standard

• ED left before seen reduced to 3%

• Continue reduction in WNB rate for the division, below 6%

• Improvement in diagnostic performance to 85%

• Increase in PDR compliance within month

• Third consecutive month seeing a reduction in staff turnover

• Third consecutive month where a reduce sickness absences rates where seen

• Positive CIP position for the end of the year

Areas of Concern

• Reduction in ward sepsis patients who received antibiotics within 60 mins 87%, equating to 2 children

• ED F&F increased to 81% however we anticipated a greater increase with the reduction in waiting timers

• Deep dive required into the median time to triage following increase in waiting time for triage

Forward Look (with actions)

• Further focus on improving PDR compliance to ensure all staff receive a meaningful PDR- HR and divisional senior leaders supporting progress

• Focus on CYP waiting 52 weeks + ensuring all who have waited 65 weeks will receive treatment in March, escalated twice weekly check ins in place to monitor progress

• DOM1 trajectory in place to monitor performance and impact of improvement plans to ensure material difference seen month on month

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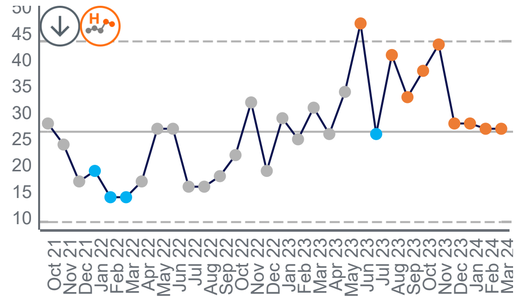
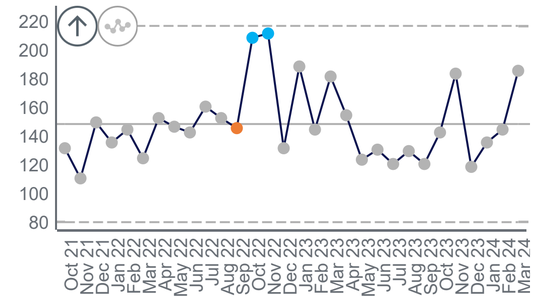
Divisional Performance Summary - Medicine

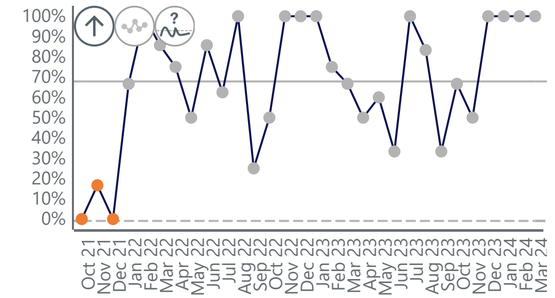
Number of Incidents rated Minor Harm and above



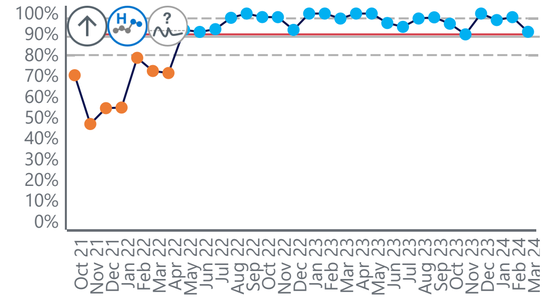
Number of Incidents rated No Harm and Near Miss



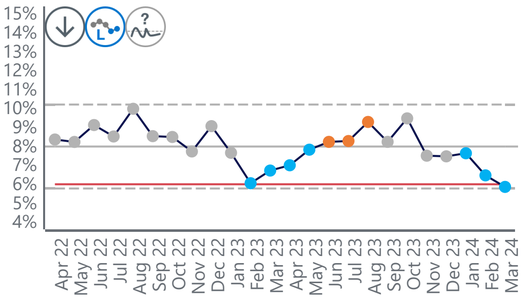
% Complaints Responded to within 25 working days



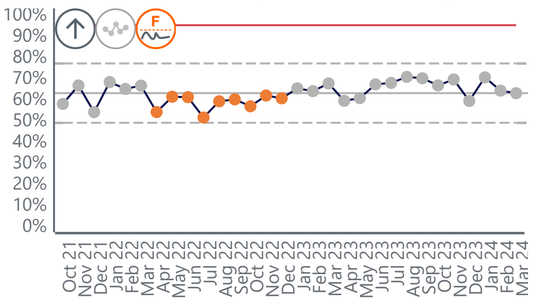
% PALS Resolved within 5 Days



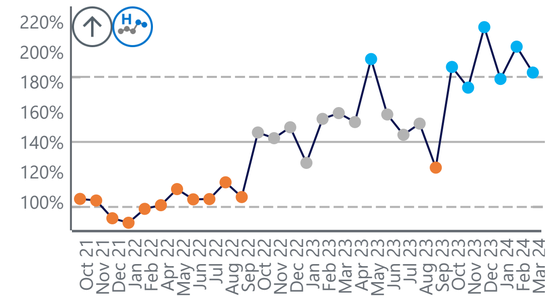
% Was Not Brought Rate (All OP: New and FU)



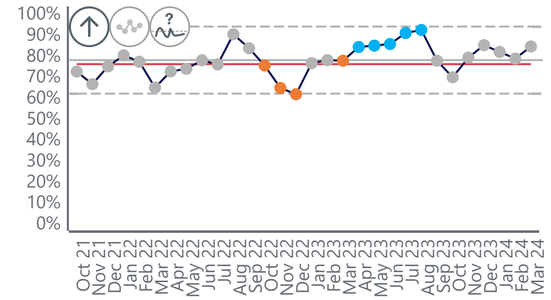
% of Clinical Letters completed within 10 Days



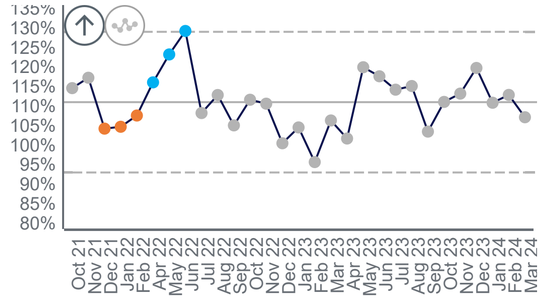
% Recovery for OP New & OPPROC Activity Volume



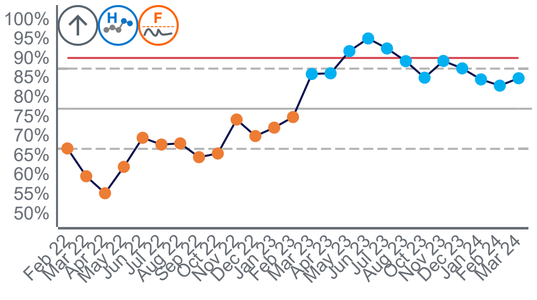
ED: % treated within 4 Hours



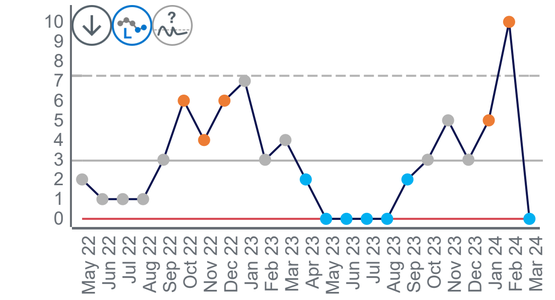
% Recovery for DC & Elec Activity Volume



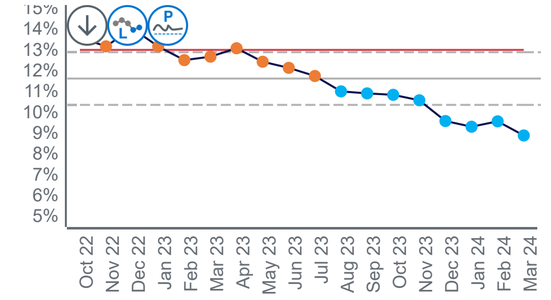
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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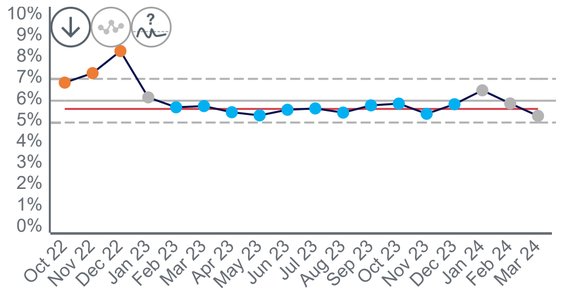
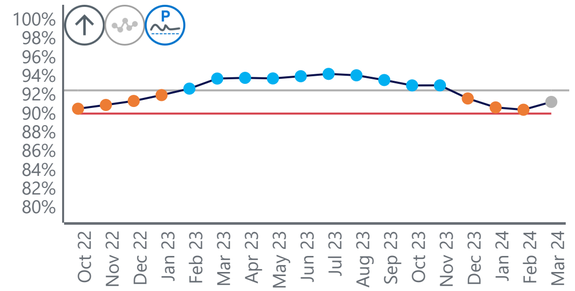
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

Sickness Absence (Total)



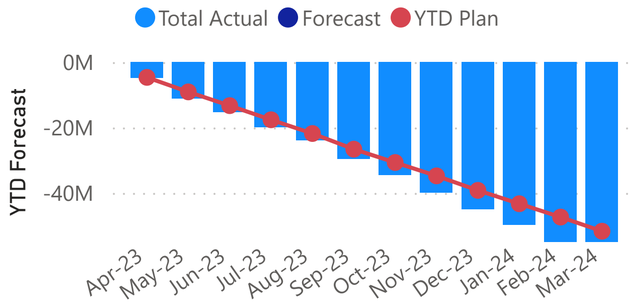
Mandatory Training



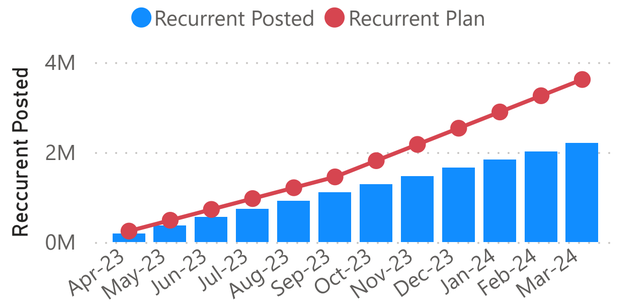
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

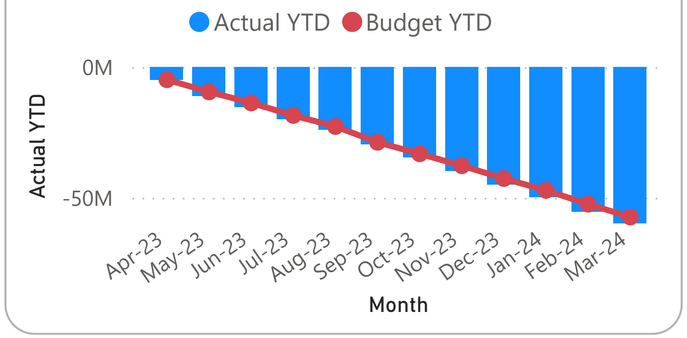
Revenue Position (Year End Forecast)



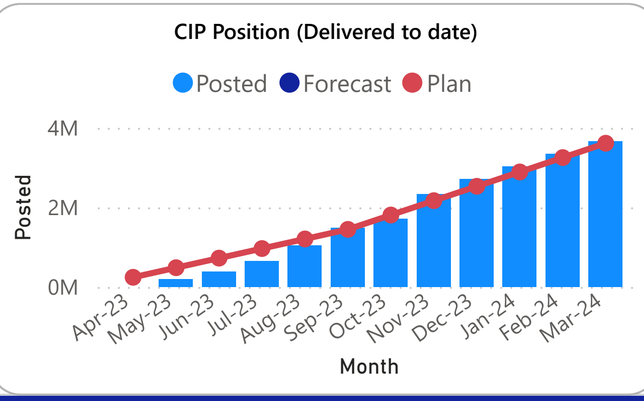
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Positive reduction in WNB rate for 4th consecutive month with evident improvement in Community Ophthalmology where a hybrid booking pilot is being ran.

• Continued to achieve 100% PALS and complaints response

• Sickness absence continues to decrease and is below trust average. Some key improvement seen in theatres.

• Staff turnover continues to be below target and again some key improvements seen in theatres.

• Significant reduction in patients waiting over 65 weeks for treatment with only 1 patient remaining at year end.

• Mandatory training remains above trust target and increased in month.

Areas of Concern

• Completion of clinic letter within 10 days remains static- requires targeted work and division will focus on this area once we see sustained improvement in other areas of key focus.

• Although DM01 compliance increased, remains fluid and requires sustained improvement.

Forward Look (with actions)

• Targeted review of outlying high WNB rates- Gynaecology, Orthotics & Oral Surgery

• Continued focus on completely clearing 65 weeks by the end of September.

• Key action plans in place for at risk specialities in terms of delivery of activity- volume and income.

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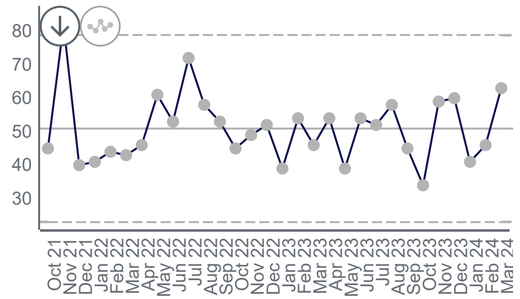
Divisional Performance Summary - Surgery

Number of Incidents rated Minor Harm and above



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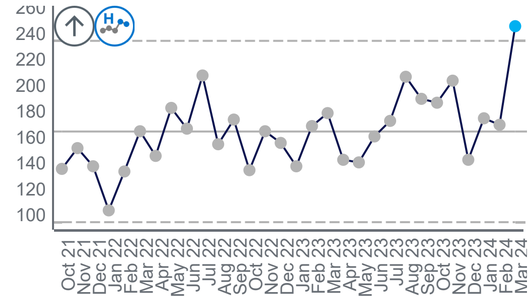

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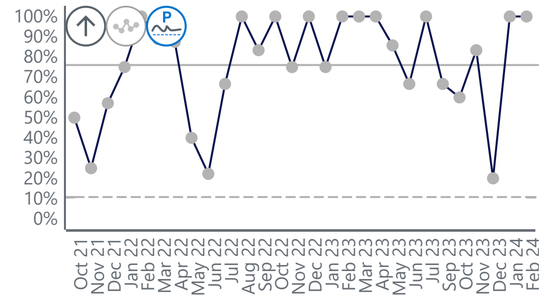
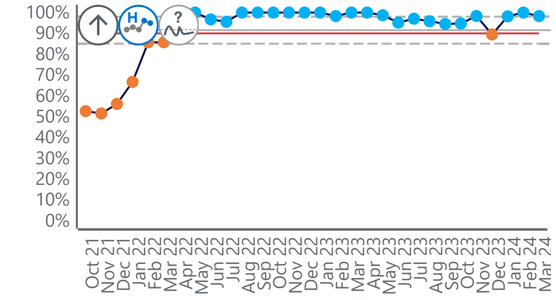


% PALS Resolved within 5 Days



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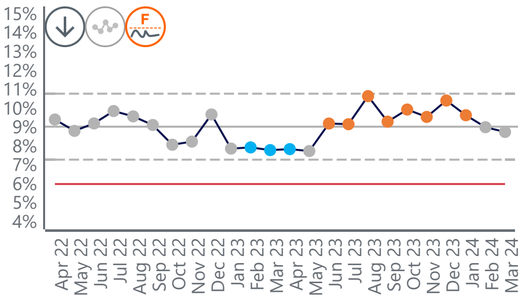

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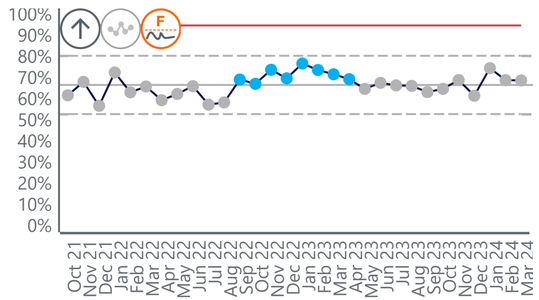
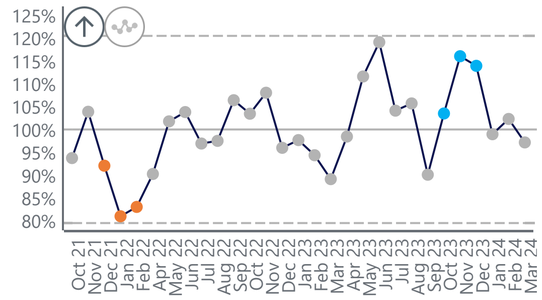


% Recovery for OP New & OPPROC Activity Volume



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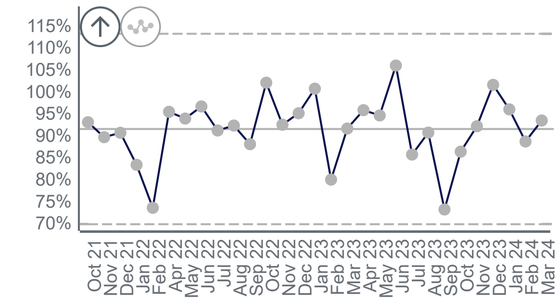

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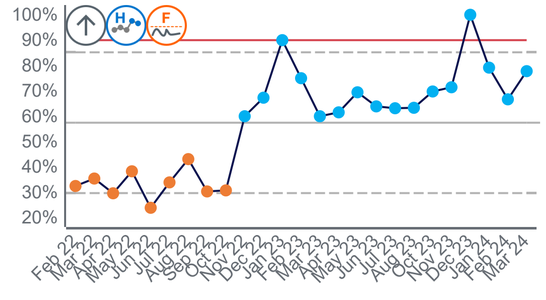

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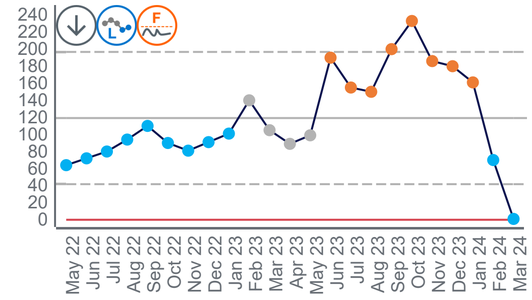
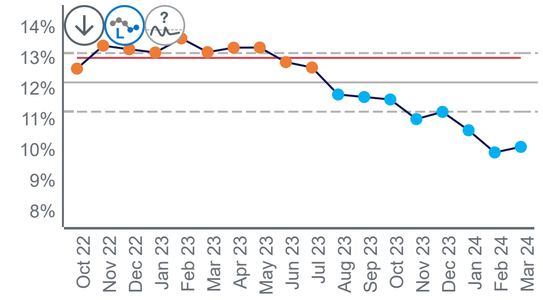


Staff Turnover



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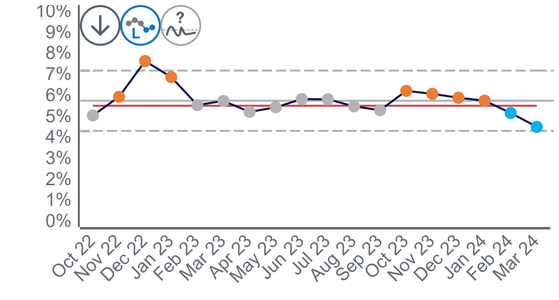

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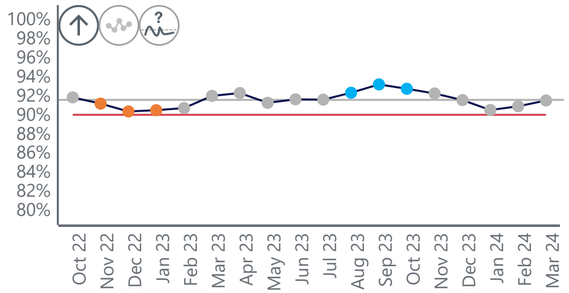
Divisional Performance Summary - Surgery

Mandatory Training



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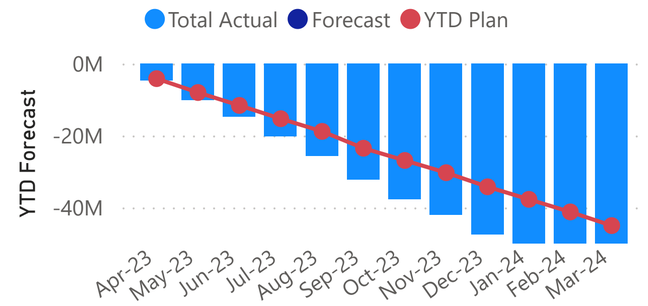
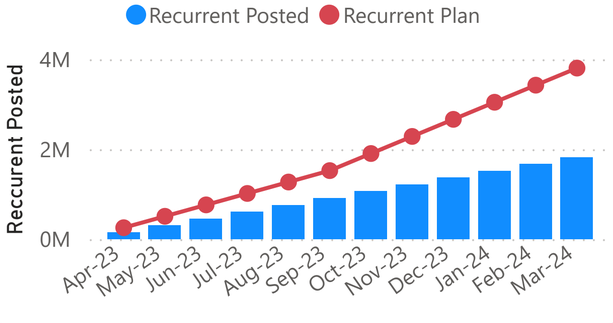
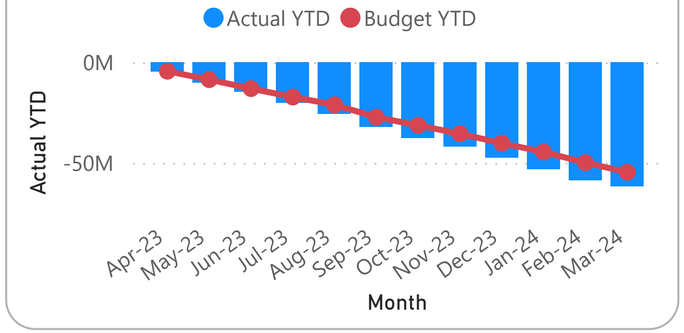


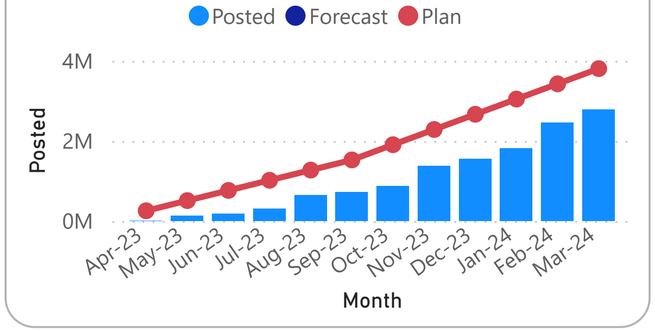
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

•Sickness, mandatory training and staff turnover are all ahead of target

•PDRs are complete however there are a couple of recording issues for staff who are shared between clinical services and research

•2 new DMD clinical trials have opened with the first participant recruited for the DYNE trial

•Recruited a new programme manager for the Neuroscience and Mental Health collaborative programme with the Walton Centre and Merseycare (starting in May)

•Overachievement against commercial income targets for research

•Paediatric Medicines Research Unit team collected their RCPCH PIER award at ceremony in Birmingham

•Successful collaborative meeting with GOSH as part of NIHR Biomedical Research Centre Paediatric Excellence Initiative

Areas of Concern

•Delays relating to AfC panels, consistency panels and vacancy panels leading to workforce gaps

Forward Look (with actions)

•Launch of membership of Northern Health Science Alliance and external lecture form Prof Sam Behjati (Wellcome Sanger Institute) both planned for April

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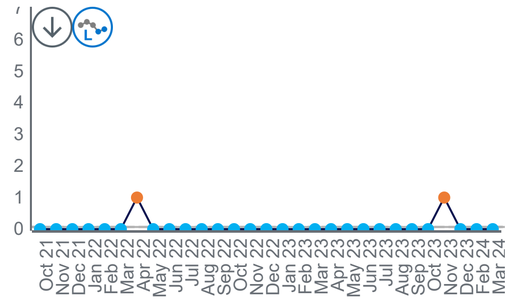
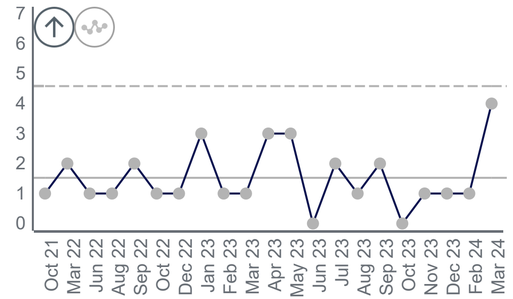
Divisional Performance Summary - Clinical Research

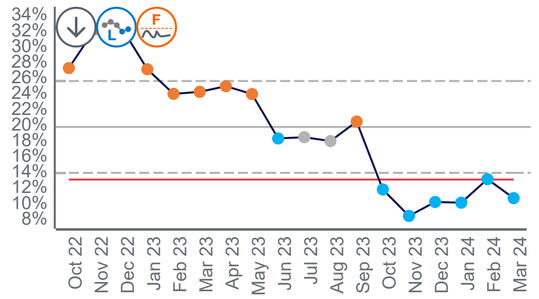
Number of Incidents rated Minor Harm and above



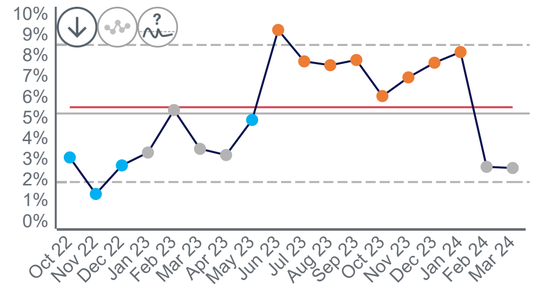
Number of Incidents rated No Harm and Near Miss



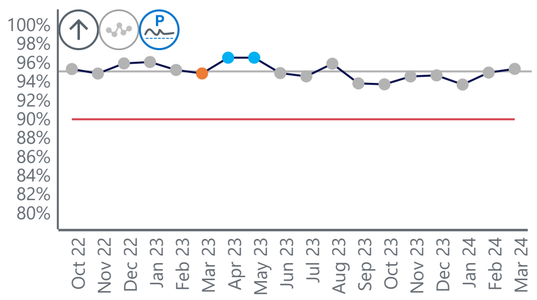
Staff Turnover



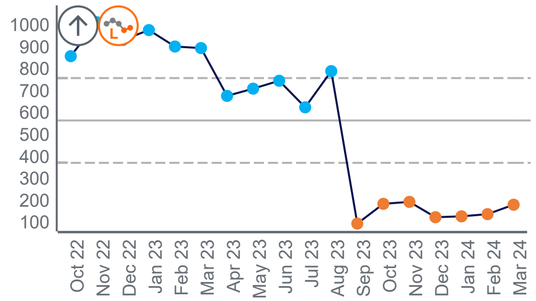
Sickness Absence (Total)



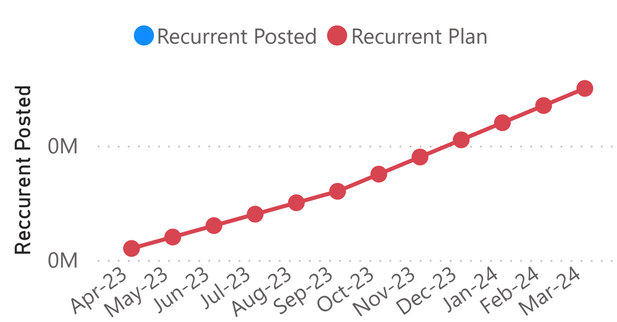
Mandatory Training



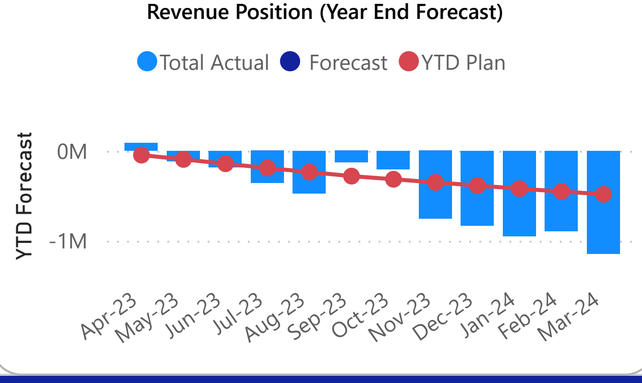
Number of Patients Recruited into Research Studies



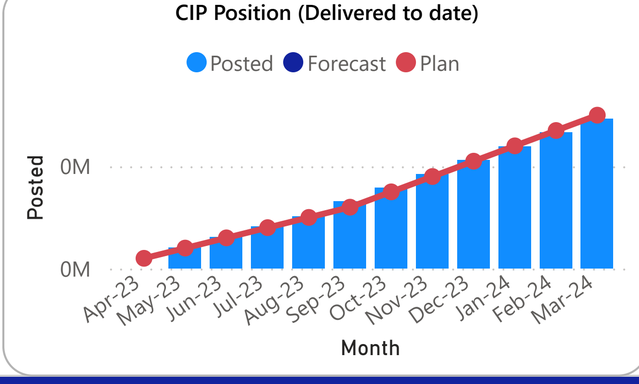
CIP Position (Recurrent Full Year Effect)



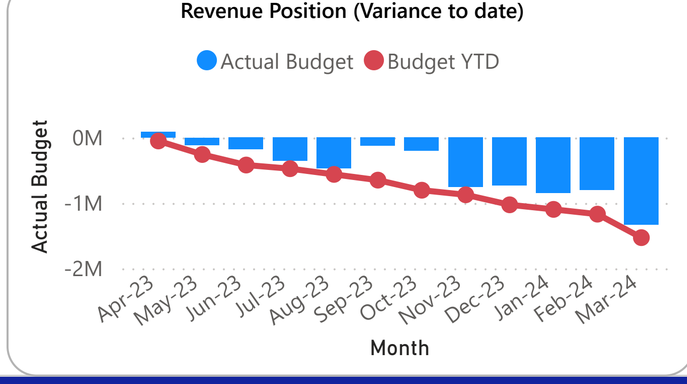
Revenue Position (Year End Forecast)



CIP Position (Delivered to date)



Revenue Position (Variance to date)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative continues to meet monthly. Highlights from the meeting held on 23rd April are:

- Mandatory training for Corporate Services remains above the 90% target at 93%.
- Short term sickness is currently sitting at 1% and continues to below Trust target (2.5%).
- Staff Turnover remains steady at 11% which is below Trust target.
- Positive engagement in all service areas in monthly review of risks and actions required regarding any overdue risks.
- 100% of CIP already identified and/or delivered at M12.

Areas of Concern

- Long term sickness saw a slight increase in-month to 5.6% with assurance that current cases are being managed in line with Trust Policy.
- Overall PDR completion rate increased to 70% but is still below Trust target and for B7+ is 79%

Forward Look (with actions)

- Despite overall Mandatory training sitting at 93% the Collaborative continues to receive deep dive data on hotspot areas
- Ensuring all risks are reviewed within timescale.

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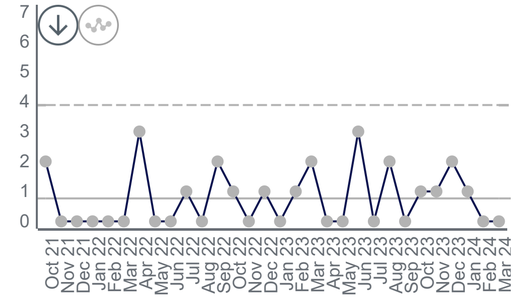
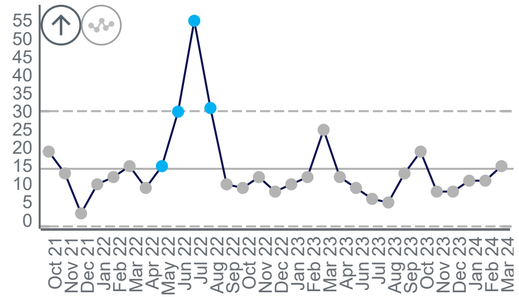
Divisional Performance Summary - Corporate

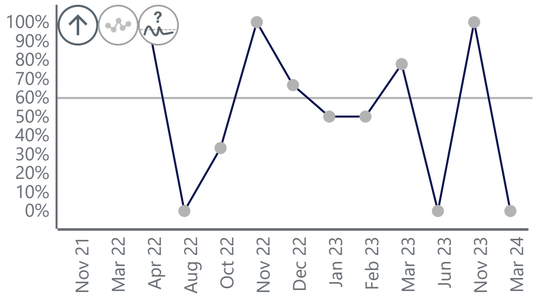
Number of Incidents rated Minor Harm and above



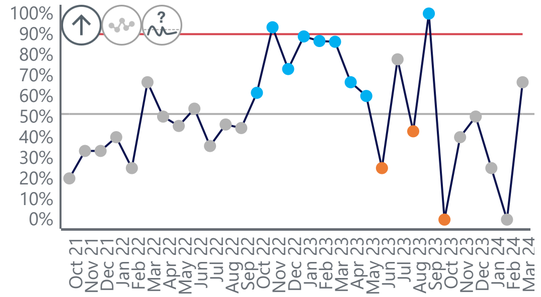
Number of Incidents rated No Harm and Near Miss



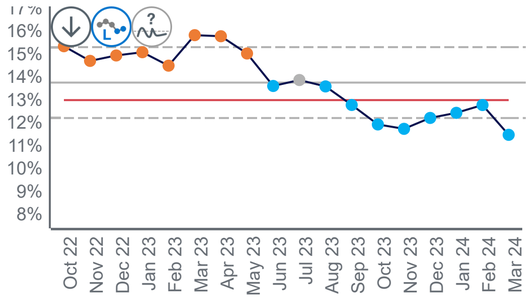
% Complaints Responded to within 25 working days



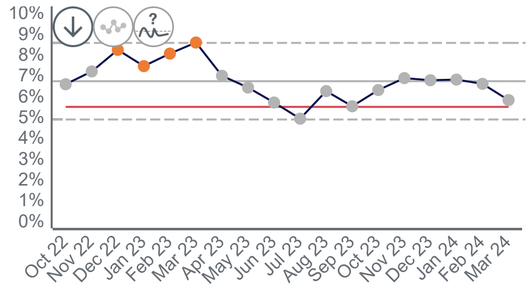
% PALS Resolved within 5 Days



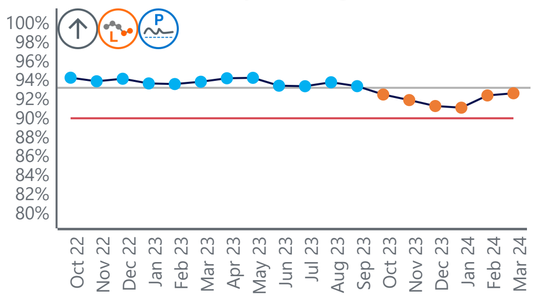
Staff Turnover



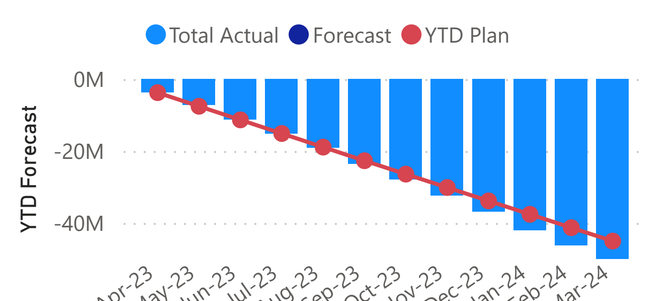
Sickness Absence (Total)



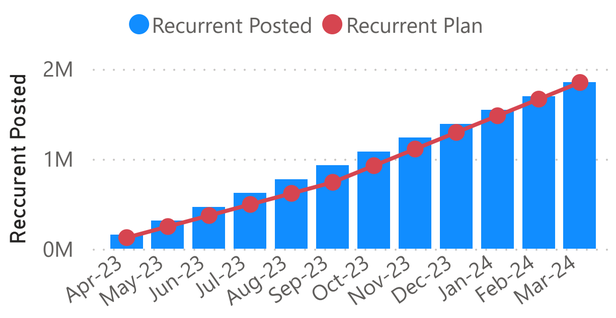
Mandatory Training



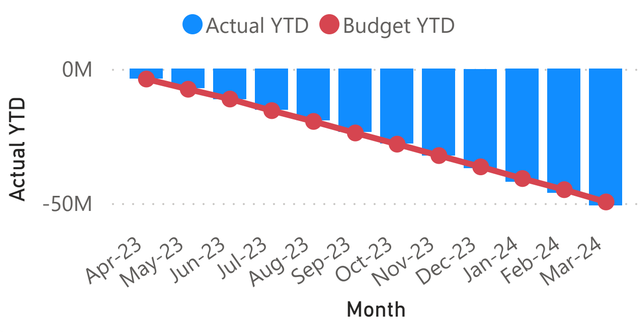
Revenue Position (Year End Forecast)



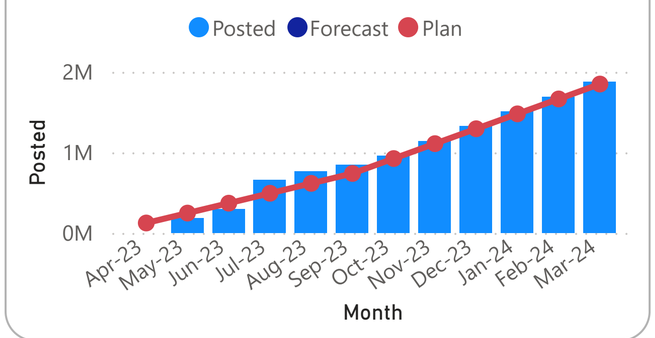
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



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

	Day		Night		Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate		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	93%	-	100%	-	112	17.1	12.69	-2.09	-13%	1	43%	0.00	0.00%	0.00	0.00%	18.13	3.52%	0.00	0.00%	2	35	0	1	4	100%	0	0
HDU	76%	60%	75%	56%	348	23.9	31.64	-6.17	-8%	2.72	59%	0.61	0.74%	0.00	0.00%	156.20	6.09%	3.68	2.84%	4	84	0	3	1	100%	0	0
ICU	89%	84%	86%	73%	496	36.4	31.64	2.32	1%	2.17	52%	2.92	1.88%	0.00	0.00%	235.85	4.91%	0.00	0.00%	5	149	0	1	1	100%	2	0
Ward 1cC	80%	63%	75%	95%	381	16.4	14.9	-4.68	-8%	-0.7	-13%	1.00	1.67%	0.00	0.00%	21.95	1.18%	33.75	12.06%	2	65	1	15	6	100%	2	0
Ward 1cN	62%	15%	72%	-	195	15.8	15.84	-0.32	-1%	1.43	59%	2.00	5.71%	0.00	0.00%	78.13	7.18%	5.00	16.13%	2	45	0	8	3	66.67%	0	0
Ward 3A	94%	86%	97%	132%	800	10.1	10.3	-8.49	-18%	1.27	8%	1.00	1.82%	0.00	0.00%	149.39	8.76%	73.41	14.38%	1	45	4	16	23	91.30%	0	0
Ward 3B	67%	174%	71%	-	423	13.7	13.67	3.03	7%	0.36	6%	0.00	0.00%	0.00	0.00%	92.37	7.43%	38.52	21.72%	2	66	0	6	1	100%	0	0
Ward 3C	95%	124%	78%	177%	694	13.6	11.12	-1.81	-3%	4.23	36%	0.00	0.00%	0.00	0.00%	99.88	5.04%	61.04	17.19%	2	93	0	6	11	90.91%	0	0
Ward 4A	70%	75%	74%	118%	707	10.6	10.39	-5.04	-7%	0.81	14%	0.00	0.00%	0.00	0.00%	193.21	9.18%	4.91	1.35%	4	53	0	4	20	90%	1	0
Ward 4B	59%	93%	60%	75%	538	14.4	11.98	2.53	5%	1.46	4%	0.00	0.00%	0.00	0.00%	115.81	9.59%	179.27	14.28%	9	78	1	5	10	60%	0	0
Ward 4C	98%	81%	99%	90%	819	9.9	11.63	-0.79	-1%	0.7	5%	4.00	7.33%	1.00	9.10%	104.49	6.10%	64.87	17.79%	9	190	0	4	12	91.67%	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 a combination of short-term sickness 7.43% and 3 WTE vacancy (these were recruited to with external candidates in January 2024). HCA fill rate includes CSWD and those who support clinic as not in the baseline establishment.

3C: Fill rate for both RN and HCA is similar to the previous month, falling slightly below 80% on night duty. This in part due to 7.43% sickness within the RN establishment. In addition the over establishment included 9 RN's who were supernumerary in this reporting period. The ward continues to support 3 x HCA 1:1 on a long-term basis. There was an increase in overall 1:1 for HCA's overnight. Risk assessments are reviewed to ensure correct supervision in place.

4B: RN sickness levels continued to be monitored as there was an increase in short term sickness within this period compared to the previous month. 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, this is not currently reflected within the Healthroster hence the apparent underfill within the RN staffing.

4C: Have seen a significant improvement in fill rate for December.

A weekly forward look meeting is established within the Division of Medicine to proactively move staff within the division to ensure safe staffing across all wards.

Surgery

Ward 1cNeo staffing is overseen by safer staffing and supported by the Liverpool Neonatal Partnership, with nurses being deployed from LWH if required. Staff rotate to 1C who work within the LNP and have had a number of new staff who are supernumerary and are therefore may not be reflected on rosters. All vacancies have now been recruited into, however there was some vacancy in December. Care hours per patient day are reflective of the care based on acuity of the patients.

1C Cardiac fill rate below 80%, however the ward activity was reduced in December which reflects this.

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 and will continue over the next few months.

Ward 4A : RN fill rate below 80% due to a combination of maternity leave and increased sickness rates.

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. 1.53 WTE supernumery RN's for this period. Activity increased with 61 admissions to HDU in December.

ICU: Supernumerary staff in post within the 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. Additional shifts were being creating in error which has impacted on fill rate reporting. This will be rectified in the February roster reports.

Summary

Alder Hey are above the National Benchmark in wards 4B, 3C, 1C cardiac and within critical care whilst the other areas are comparable. 4C general paediatrics is lower than the National benchmark for December despite the fill rate, this may be contributable to the increased patient count within that month.

There is a consistent difference from the National benchmark for Ward 4B. Ward 4B has been consistently higher over the last few months. Deep dive into capacity and staffing has been undertaken and as a result a full review of the nursing model has been completed with the aim to changing the nursing patient ratio from 1-4 to 1-6.This was a successfully piloted in August 2023 and has continued. 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. Changes to the Healthroster will not immediately be apparent, therefore the benchmark data will remain an outlier.
During this period reported, staff moves on NHSP were not recorded on E-Roster.

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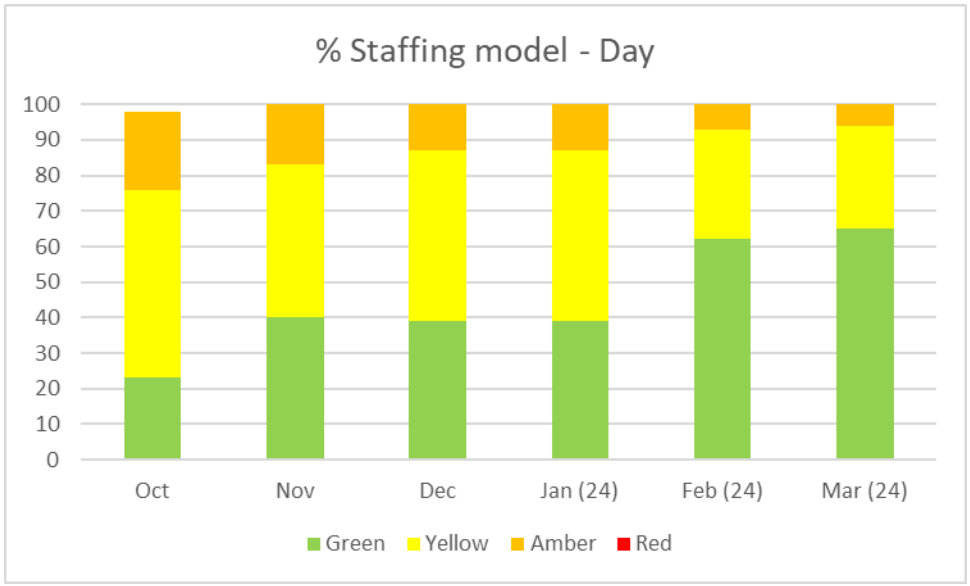
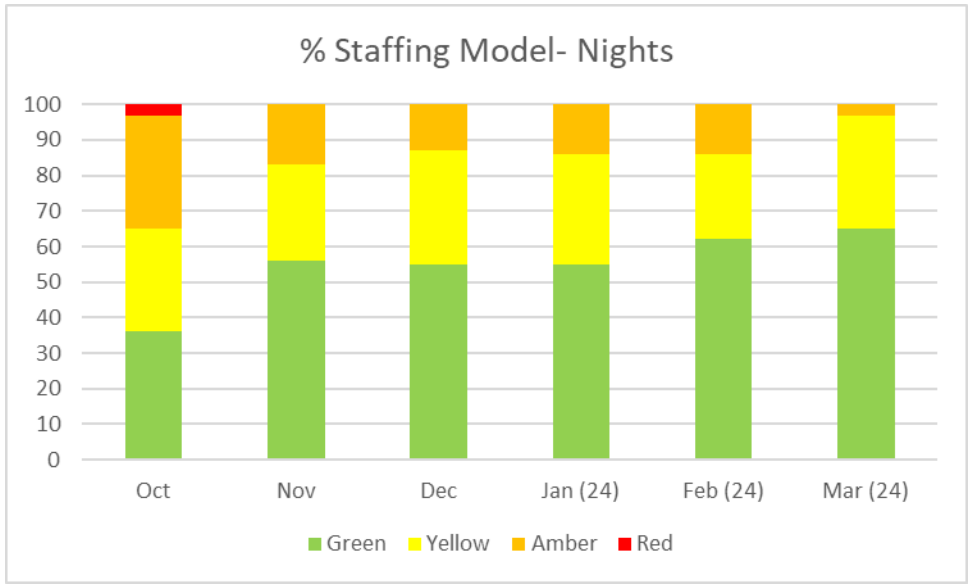
Summary of Staffing models October 2023 – March 2024

Staffing RAG data has been similar to previous months, however last red staffing model was reported in October 2023. To note the percentage of shifts both day and night that are staffed to a green nursing model has improved consistently from November and significantly from February onwards.





Electronic Roster KPI Report

Summary Narrative

This is our third E Roster KPI data set, and we are starting to see some impact of the work between the Roster team and the ward managers, with some more compliance across a range of metrics. The key elements that have been highlighted from the March KPI data are summarised below:

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 (4th March - 31st March)	% 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	22.13%	80.00	-453.79	0.00%	0.00	2	44.59%	24.14%	6.40%	6.19%	0.00%	0.00%	36.73%
Accident & Emergency - Nursing (912201)	32	42.46%	720.00	-53.73	19.45%	2327.50	7	10.22%	19.50%	1.63%	1.36%	8.63%	3.31%	34.59%
Burns Unit (915208)	45	25.00%	140.00	443.78	4.96%	111.00	4	5.02%	16.85%	2.40%	1.34%	3.98%	0.00%	25.37%
Critical Care Ward (913208)	66	35.07%	1200.00	3286.38	13.74%	3018.75	52	10.94%	12.54%	0.00%	0.28%	5.43%	5.27%	23.52%
High Dependancy Unit (HDU) (913210)	45	24.53%	640.00	266.61	8.44%	720.33	5	24.72%	15.60%	4.43%	1.59%	5.54%	10.24%	38.34%
Medical Daycase Unit (911314)	33	23.89%	50.00	59.37	10.73%	108.00	5	22.03%	23.47%	0.26%	0.00%	0.81%	0.00%	24.54%
Outpatients (916503)	37	47.63%	420.00	1242.04	18.53%	1064.08	5	44.85%	38.67%	0.81%	1.94%	21.85%	1.42%	44.49%
Sunflower House (912310)	18	57.29%	190.00	596.48	31.29%	1162.75	49	15.29%	24.06%	0.20%	2.24%	3.89%	12.19%	43.42%
Surgical Daycase Unit (915418)	26	39.95%	85.00	385.87	13.16%	398.50	1	27.44%	15.46%	1.38%	2.35%	12.17%	0.00%	31.36%
Theatres - Cardiac & Cardiology (915405)	44	28.85%	130.00	290.75	10.87%	196.50	0	8.44%	12.98%	2.24%	7.90%	7.09%	0.00%	37.29%
Theatres - Emergency (915420)	44	35.18%	230.00	-24.02	11.66%	236.25	0	4.88%	28.02%	1.96%	0.86%	0.45%	0.00%	36.97%
Theatres - IP Anaesthetics (915423)	45	18.58%	82.00	-509.75	5.55%	192.00	3	2.21%	20.77%	1.26%	1.84%	0.22%	6.03%	30.11%
Theatres - IP Porters (915435)	44	45.78%	101.00	-4.5	12.64%	195.50	2	3.05%	25.54%	0.00%	1.72%	0.00%	0.00%	27.26%
Theatres - IP Recovery (915422)	28	44.73%	103.00	-479.95	19.22%	334.00	0	8.96%	21.36%	4.79%	5.24%	5.13%	0.00%	36.57%
Theatres - IP Scrub (915424)	45	24.87%	128.00	17.57	25.57%	402.00	0	18.99%	17.46%	0.73%	1.56%	17.88%	0.00%	44.54%
Theatres - Ortho & Neuro Scrub (915436)	45	44.80%	37.80	189.1	27.86%	672.50	0	10.56%	21.64%	0.00%	0.52%	8.68%	4.20%	35.04%
Theatres - SDC Anaesthetics (915429)	45	48.35%	58.40	40.42	31.21%	250.00	0	27.00%	30.52%	0.00%	4.19%	5.24%	0.00%	39.96%
Theatres - SDC Recovery (915430)	44	60.78%	177.30	209.07	15.76%	213.42	0	11.68%	15.94%	6.38%	2.92%	9.46%	0.00%	34.71%
Theatres - SDC Scrub (915421)	45	54.27%	532.00	113	18.82%	475.75	0	16.40%	14.89%	0.27%	0.92%	25.89%	0.00%	42.06%
Ward 1C Cardiac (913307)	45	54.70%	361.00	2117.17	21.25%	1596.25	2	7.92%	19.04%	3.48%	2.55%	4.71%	7.33%	42.16%
Ward 1C Neonatal (913310)	42	31.01%	556.00	475.33	0.39%	19.00	0	35.75%	15.29%	3.86%	0.83%	5.86%	0.00%	28.55%
Ward 3A (915309)	44	33.38%	371.00	-31.25	19.10%	1519.00	58	7.89%	19.88%	2.44%	0.76%	9.66%	4.16%	36.10%
Ward 3B - Oncology (911208)	32	38.15%	555.00	3553.18	15.78%	788.75	16	14.65%	20.14%	3.02%	0.58%	4.28%	5.63%	37.46%
Ward 3C (911313)	33	38.18%	607.00	1940.88	25.92%	2257.00	79	25.77%	21.78%	4.23%	0.41%	9.25%	3.94%	41.59%
Ward 4A (914210)	45	31.19%	634.00	1178.47	13.47%	1148.00	18	17.13%	24.66%	2.97%	0.49%	4.83%	4.55%	40.10%
Ward 4B (914211)	30	35.82%	533.00	-30.53	15.52%	1186.75	8	28.05%	21.79%	3.60%	1.96%	9.88%	5.61%	46.64%
Ward 4C (912207)	41	39.69%	280.00	84.88	20.27%	1598.42	32	16.88%	18.24%	3.38%	0.32%	9.95%	0.00%	32.56%
Mar-24	**40**	**37.95%**	**9001.50**	**15714.49**	**15.80%**	**20593.58**	**325**	**17.47%**	**20.08%**	**2.26%**	**2.02%**	**7.34%**	**2.84%**	**36.23%**
Feb-24	**38**	**38.09%**	**9001.50**	**25961.77**	**15.30%**	**20805.07**	**261**	**19.43%**	**16.96%**	**2.67%**	**2.00%**	**7.33%**	**3.35%**	**34.64%**
Jan-24	**31**	**35.00%**	**9001.00**	**29114**	**13.60%**	**20742**	**409**	**21.22%**	**15.84%**	**2.08%**	**2.17%**	**8.89%**	**3.48%**	**34.06%**

Lead time has improved by from 38 days to 40 days from February to March (target is 42 days) - Staff are receiving on average 38 days' notice of shifts to be worked. This is a continued improvement over the last few months and helps staff with their work life balance as well as assuring managers well in advance that they have the correct skill mix and staffing numbers to provide safe and effective care to their children and young people. Surgery, for the second month running, have achieved the KPI of 42 days: an excellent achievement. 60% of rosters are now going out with more than 6 weeks' notice. Community have improved from 20 days to 28 with further improvement anticipated. A new template went live in Sunflower which delayed this month's roster and the next going out sooner. The Roster team continue to work with the Ward and Divisional leads to improve these lead times and achieve our target of 42 days right across the Trust.

Roster changes since approval (target is <25%) – we have seen a very slight improvement in month.This mainly relates to rosters now going out a week earlier. The Roster team plan to work with Managers to improve the initial roster. This work will commence in April with improvements expected by Q2.

Net hours reduced again to 15714 from 25961 – Continued significant improvement has been made in this area. These are hours in the roster that are unaccounted for. The E Roster team are working with the departmental managers to correct any administrative errors so there is full assurance that the data is correct, and a true reflection of what colleagues owe or are owed. These hours can be used in place of booking temporary staffing via NHSP when managers are confident that they are correct.

Bank/Agency use has fallen in March in terms of hours from 20,805 to 20,593, albeit the percentage of shifts filled by temporary staff is up to 16% from 15% (target is <10%) - This figure relates to the fact that 15.8% of all shifts are identified through NHSP. Fill rate has increased in line with this, and Managers have fed back that they generally utilise their own staff so helping with patient continuity. The monthly figure reflects staff using any outstanding annual leave before the end of March.

Additional duties have increased from 261 to 325 (target is 0) – This month has seen a deterioration in position. The main factor relates to the 2 hot spot areas as 79 shifts have come from 3C and 49 from Sunflower House. Again, this may be reflective of additional leave allocation and the need to cover it. These hours reflect staff booked over the funded establishment.

Unfilled roster reduced from 19.43% - 17.47% (target is <15%) Another further improvement in this area. This could be in part due to some roster template reviews and an increase in bank fill rates. The E Roster team continue to work with Managers to review templates.

Annual leave, other leave, and parenting leave - Annual leave up from 17 to 20 %. Reflective of additional leave allocation for staff with outstanding leave before end of Q4. However, maternity and paternity down further from 3.35 to 2.84% which is becoming a consistent theme.

Sickness is 7.34% so stable (target <5%) - continues to be above target but definite consistent improvements in most areas. The figure is greatly affected by Theatres, where there are smaller staffing departments identified, so percentages are affected by small numbers of staff absence. Also, OPD where staff absence is very high at 22%.

Study leave has seen a slight improvement from 2.67% to 2.26% (target is <2%). It was noted that allocations were significantly higher in Surgical Day Case Recovery and the Advanced Practice element of AED.

Total unavailability is 36.23% from 34.64% (target is <30%) – A slight deterioration in month. 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, hence is reflective of the over allocation of staff to annual leave in Month 12.

Progress and Challenges

Some really good progress again this month in most areas including maternity leave, bank hours and study leave, but again significantly in the areas of net hours and really importantly lead times. The importance of getting rosters out well in advance and impact this has cannot be understated. Surgery significantly achieved the target of 42 days for the second month running. Lots of green in the leave areas as well, and again of note is the continued reduction in the % age of staff on parenting leave matrix.

Roster sign off meetings are live in Surgery and the Medical Division and now in the Community Division.

Some areas of challenge this month that may be an anomaly of the end of Q4, with many relating to additional leave and subsequent impact on shift unavailability. Some hot spot areas for sickness and again areas of over allocation of study leave.

Meetings are already in place with the E Roster team and Ward and Divisional Managers, to look at the quality of rosters and make changes as necessary, that will have a direct positive impact on the KPIs. From this months' data it is apparent progress is being made consistently, with Managers developing an understanding of what the data is telling them and working towards rosters playing a key role in their workforce planning.

This report is shared with the Divisional leads to use with their managers to further performance manage and improve these key workforce markers.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

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

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

Does this relate to a risk? Yes ☐ No ☐

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

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

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

Alder Hey Digital, Data and Information Technology Update

1. Executive Summary

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

Key headlines include:

- Digital Maturity Assessment 2024
- Good progress with Digital and Data Futures/2030 strategy
- Good Operational performance
- Improvements to Information Governance service and KPIs

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

2. National and Regional Updates

2.1 Digital Maturity Assessment 2024

In 2023, NHS England published national Digital Maturity Assessment. The assessment aims to helps Trusts gain a clearer view of their digital capabilities a single repository of information. This will enable the tracking of the development of digital capabilities year to year. Alder Hey were partnered with Liverpool Women's as their assigned peer to review each-others results prior to them being submitted regionally and nationally.

The assessment for 2024 has recently been launched with a few enhancements from the previous year and it has been confirmed Liverpool Women's will remain as the peer for Alder Hey. The team will ensure they meet the deadline in May for submission and it is envisaged results will be available by the end of June.

2.2 Liverpool digital collaboration

Alder Hey continue to work with the ICB around joined up digital programme opportunities across Liverpool. A weekly meeting has been established which is attended regularly by the Alder Hey CDIO and any progress will be reported back to the Trust through the relevant committees.

3. Digital and Data Futures Progress

Digital capabilities and resource will be required to deliver the programmes and projects that sit within the 2030 Strategy. There is currently a piece of work underway to align digital resources into the following 3 areas:

- Digital Transformation
- Futures
- Business as Usual

The proposed alignment of programmes and resources will be collated and ratified through the relevant committees.

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

Two strategic workshops have been held with a multidisciplinary group with the aim to shape the future of the Alder Hey Patient Portal. The consensus from the workshops is that there is a need for realignment of the vision and objectives with Trust 2030 strategy, and a review of the requirements to refresh the specifications. Options to be shared for a decision to be made regarding the direction of the future of the platform and a clear way forward agreed by May.

3.2 Outstanding Records and Safe Systems

Phase 1 of the implementation of InPhase is nearing close to completion. There have been several lessons learned which have been documented and reported through the relevant committees. It has been noted that the learning must be applied to future phases. Phase 2, which sees the introduction of Nursing Audits, is currently being scoped out and will need a proposal approving prior to mobilisation.

Good progress has been made with AlderCare Optimisation. There have been over 20 key developments delivered through the programme since January. Meditech have progressed some issues but there are still a few outstanding developments to be completed by the supplier.

Electronic, Blood Transfusion consent forms went live on 1st April. Usage will continue be monitored and focused support provided to any areas that are struggling. Finally, options are being gathered on how the Trust manages its Patients Observations across the wards and in critical areas. An options appraisal will be presented to the relevant committees in April, followed by the development of an action plan once a way forward is agreed.

3.3 Healthier Populations through Digital, Data and Analytics

The team have been heavily involved in developing a new ‘Productivity Dashboard’ for the organization, which has been a joint effort between Operational, Financial and Human Resource colleagues. Data will be brough together from these 3 areas to show productivity levels against a baseline of data from 2019/2020. The first draft of the dashboard is now available and will be reviewed with the aim to finalise in May.

Work is well underway to redesign the Mental Health and Emergency Department Data Sets which are required for a revised national submission in May and June respectively.

Progress has been made in refreshing the Trusts – Integrated Performance Report and the team have also been contributing to the Annual Planning process. Finally, The Data Teams continue to work through a number of requests which are due to be reprioritized during April.

3.4 Technical roadmap and Operational Service Excellence

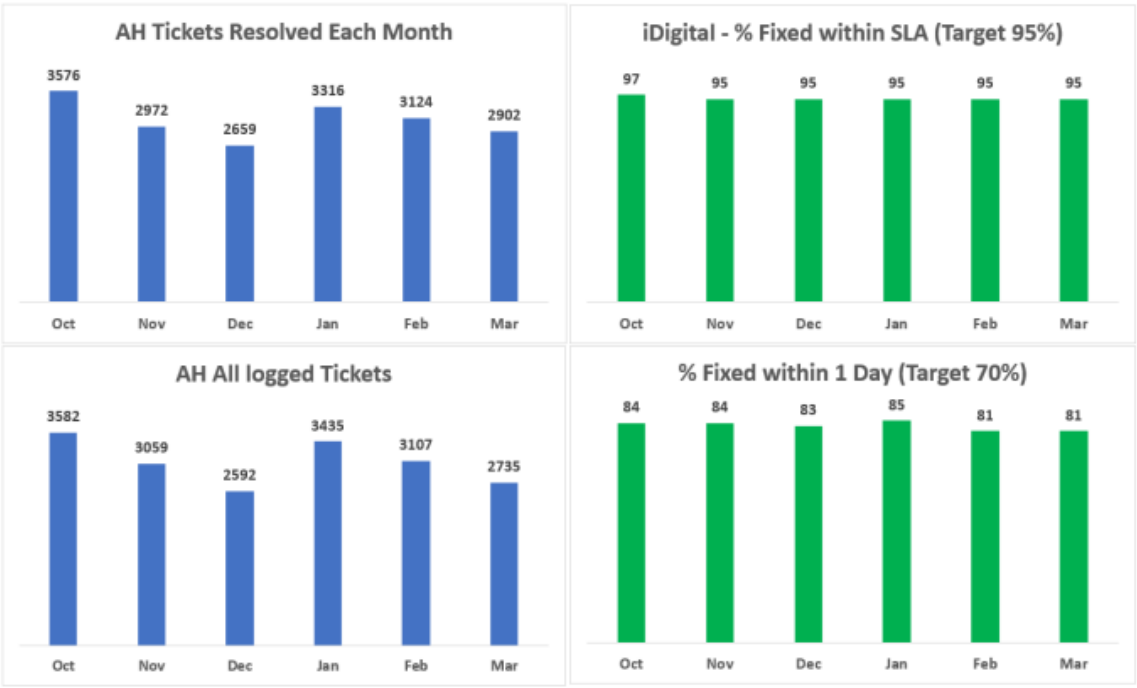
Replacement firewalls and a transition to a new Internet circuit is scheduled to be completed in April. This will provide greater resilience and consistency across the various Wi-Fi channels in the hospital.

As per national policy, the Trust is looking to introduce Multi Factor Authentication, across all users accessing the network remotely, by June. A pilot has been successfully completed with no issues raised during the process. Communication and a plan for further roll out has now been developed and will be launched in May.

3.4.1 Operational Performance

The graphs below provide performance from March 2024. Key highlights include:

- Key Performance Indicators met consistently for previous 6 months.
- Tech Bar resolved 226 tickets.
- 81% of tickets resolved in 1 day



4. Information Governance

There have been significant improvements made across a range of areas within Information Governance, since the successful collaboration of the service with Liverpool Heart and Chest via iDigital. Key headlines in 23/24 include:

- 93% compliance with FOI requests in comparison to 71% in 22/23
- 98% compliant Trust wide for mandatory training
- Substantial assurance received on Subject Access service following external audit.
- 33% reduction in reported Data protection incidents
- IG Team were shortlisted as finalists in the NHS Health and Social Care National Strategic Information Governance Awards

5. Summary and Recommendations

In summary, progress with digital and data developments and delivery at Alder Hey remain positive and the mobilisation and delivery of the new strategy continues well.

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

Alder Hey Children's NHS Foundation Trust

Board of Directors

Thursday, 2nd May 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

May 2024

1. Executive Summary

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

Good progress has continued to be made to deliver projects:

2024/25 Q1 & Q2:

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

2024/25 Q3 & Q4:

- Elective Surgical Hub
- Phase 1 Alder Park
- Fracture/Dermatology Outpatients

2. Key Risks

The tables below show the number and rating of key/high project risks managed locally. A quarterly review of the full risk register has been undertaken by the Development Team.

Project	Manager	Open Risks	Low	Med	High (15+)
Park	KO	6	3	3	
Eaton Road Frontage	KO	3	2	1	
Fracture/ Dermatology OPD	KO	7	0	7	
Police Station Refurb	TJ	15	11	4	
Neonatal & UCC	JOB	19	3	16	
Gender Development Services (GDS)	JVH/JG	4	1	3	
Alder Park Phase 1: EDYS	TJ/Day PM	To be developed			
Elective Surgical Hub	JVH/JG	Scope of project TBD			

In addition to the risks above, a number of projects are affected by external resource issues which we are reliant on in order to meet delivery milestones. In particular Mitie project management resources and groundworks (Lorne Stewart). The groundworks impacting on the critical path activities have now been completed, allowing the projects affected to progress. Regular escalation meetings remain in place to check, challenge and manage any implications.

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Park	Failure to deliver long term vision for park	BAF 3.1	12	Programme continually assessed for mitigations/improvement.
Neonatal & UCC	Affordability	Not assigned	12	Development team to identify mitigation plan for SPV/other costs. An update paper was presented to RABD members 15.04.24.
SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Trust has responded to CEs and associated correspondence received. A further update was shared with RABD members 15.04.24.

3. Construction 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 Enabling (scope TBD)																									
	Phase 2+ Site Plans (scope TBD)																									

4. Construction 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	Phase 1 (EDYS & Therapies)																									
	Construction Phase 2 TBD (Sefton CAMHS)																									
Elective Surgical Hub	Refurbishment																									
Fracture/ Dermatology OPD	Refurb Construction																									
North-East Plot Alder Park	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: • Delay 3 weeks due to completion of infrastructure works and removal of asbestos is being managed within the programme. • Main construction works commenced 22.04.24. • Service diversion works due to conclude 02.05.24. • Hoarding installation commenced, to complete 10.05.24.		Completion of service diversion works. Impact on budget. Management of noise and site access routes during peak works.	Monitor via monthly Construction Progress meeting. On-going site management plan, including enhanced communications to patients & families.
Full final phase of construction contract signed 21.12.23: • An update report re: increased SPV / other costs was shared 15.04.24 with RABD members. • 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.	Agree EDU design and decant plan. Review of shell space bids TBC.
Equipment Specification & Procurement: • Proposals for monitor selection and options & recommendations paper for incubators presented at 09.04.24 Neo Natal/SDEC Programme Board.		Coordination of technologies and flow of patient data between component systems: incubator, monitoring, alarms and line of sight elements. Costs TBC.	Finalise equipment requirements.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Trust meetings with contractor held 06.03.24 and 09.04.24. An update report was shared 15.04.24 with RABD members.		Possible contract claim.	Follow up meeting with contractor end May '24, date TBC.
Sprinkler System Under-Croft Car Park: • Principal contractor to be appointed to undertake works and installation.		Fire compliance. Budget TBC.	Finalise scope of works and costs April '24.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Immediate priorities are being progressed: • Permanent solutions for those staff currently accommodated on a 'temporary' basis. • Alternative accommodation for teams/services currently based in the Histopathology building, to allow demolition of the building. • Potential increased scope: meeting rooms and storage.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for works/kit.	Space pressure plan being developed for Executive Director support & approval May '24. Budget and scope of works to be finalised.
Former Police Station Refurbishment: • Main contract in place, works progressing.		Operational date currently assessed as July 2024.	On-going bi-weekly senior Principals' meeting & pre-move planning with service senior leadership team.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: • FOSP site walkabout with Trust 09.04.24. Main discussion points: ➢ Swale – size & design. ➢ Sensory Garden – FOSP funded bid with LCC. ➢ Park Concession – potential funding sources to be explored. ➢ Park Completion Programme. ➢ Communications. ➢ New Playground security.		Inconsistent communications.	Continued and maintained input & communications from all key stakeholders. Quarterly newsletters and regular website updates.
Completion Works: • New playground opened for use 28.03.24. • Drainage works and final seeding to the football pitches expected to commence April 2024. • Existing infrastructure works completed 14.04.24. • Lighting, planting, street furniture & signage, path works completion Q2 2024.		Delays in completion football pitches.	Programme continually assessed inc 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
Work ongoing in line with programme. • Appoint Construction Contractor: Spring 2024. • Start on Site: 06.06.24. • Construction Completion: 16.12.24.		Timely appointment of a construction contractor. Delay to completion, impact on operational running of the services. Mitie PM resources.	Regular meetings. Close monitoring of critical risks. Capacity management plan to accommodate 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: • Planning consent approval granted 11.04.24 to carry out improvements to Eaton Road Frontage and associated works. • Phase 1 scope of works to be agreed. • 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.		Trust has identified a mitigation to satisfy 278 (traffic calming) requirements. Budget TBC.	Site Master Planning proposals will be shared with Executive Design Review Group May '24, and with Trust Board June '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 to be concluded, date TBC.		Programme, available budget. Mitie PM resources.	Regular meetings established between Trust and SPV to agree priority scope of works & timeline.

Gender Development Services (GDS) – Estates Solution

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Contract executed. Construction works progressing in line with programme and furniture in place.		Programme, available budget. Suppliers lead in times.	Delivery schedule and move plan to drafted for final agreement.

Alder Park – Refurbishment of Lyndhurst Building (former Dewi Jones Unit) Phase 1: EDYS & Therapies

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Contractor appointed, and works currently being reviewed with specialist suppliers/advisors.		Programme, available budget.	Develop Phase 2 business case. Develop wider site master planning.

6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 2 May 2024.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd February 2024

Paper Title:	Learning from Patient Safety Incidents 1st-30th April 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 system wide learning following the transition to PSIRF and next steps, noting that this is an iterative process as we continue to transition and embed 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	☐	**Not Assured** Evidence indicates poor

		applied and effective in practice		to improve their effectiveness		effectiveness of controls

1. Purpose

The purpose of this paper is to provide the Trust Board with 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 system wide learning and improvement for the reporting timeframe 1st – 30th April 2024.

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 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

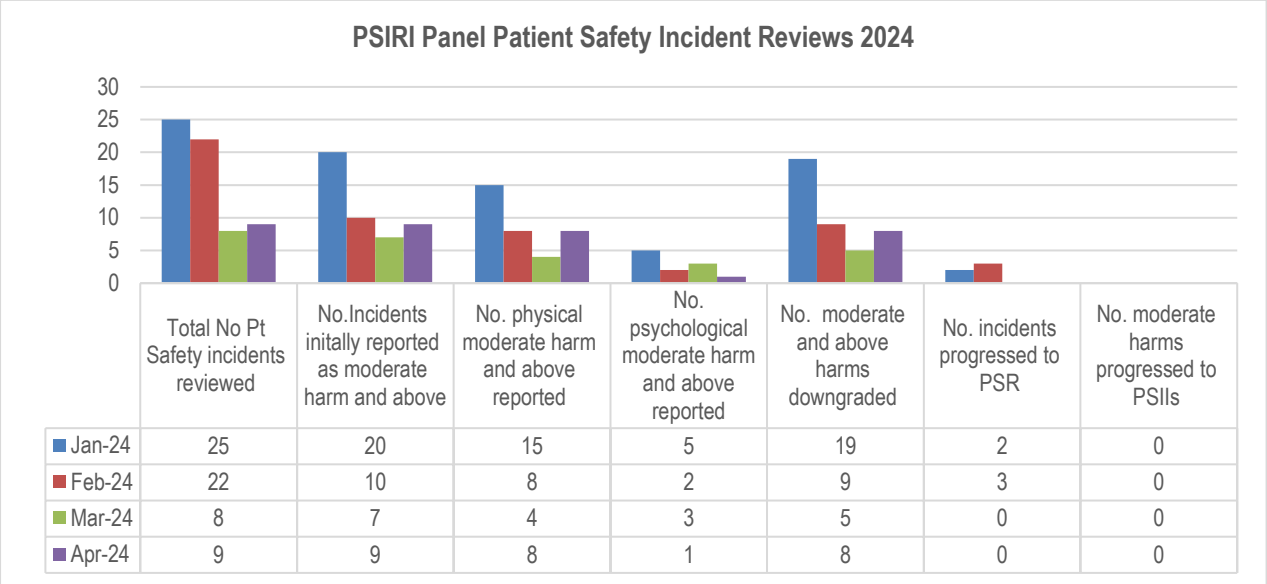
PSIRF replaces the methodology of root cause analysis with a systems-based patient safety incident investigation (PSII) approach or more locally a Patient Safety Response (PSR).

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.

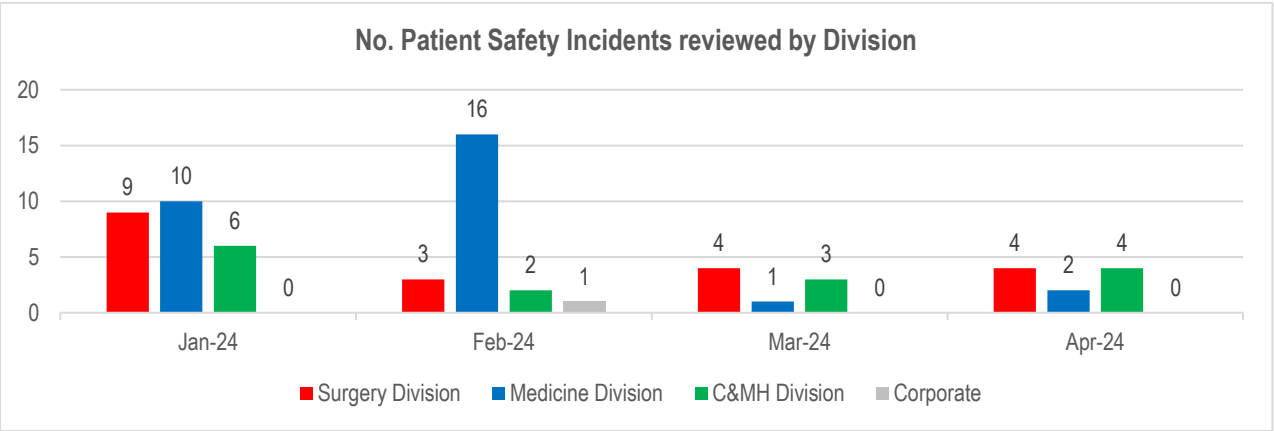
Table 1 below notes the number of patient safety incidents reviewed at PSIRI panel throughout April 2024. Table 2 notes the number of patient safety incidents presented and reviewed by division.

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. incidents progressed to PSR	No. moderate harms progressed to PSIIs
Jan-24	25	20	15	5	19	2	0
Feb-24	22	10	8	2	9	3	0
Mar-24	8	7	4	3	5	0	0
Apr-24	9	9	8	1	8	0	0

Table 2



A total of 9 new reported incidents were reviewed at the weekly PSIRI panel during the reporting period 1st -30th April 2024, of which all 9 incidents had been initially reported as either moderate and above physical or psychological harm. A further 2 incidents were also re-reviewed following a request in month for further information.

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 8 incidents based on incident findings and use of the NHS England harm grading criteria .

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. 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)

1 PSR was commissioned in April 24 to investigate the reported incidents as outlined below:

3.3.1

- # **9232 Moderate physical harm (Medicine Division)** *Patient developed an extravasation injury from cannula sited in left foot. Patient had been on an IV infusion for antibiotics and mum had alerted to staff nurse who alerted nurse in charge of concern around swelling to toes.*

- *Patient had bandage in situ to protect cannula instead of tubigrip - which is what hospital policy states. Cannula removed. Extravasation injury evident on removal. 4cm area of redness, whole foot swollen.*

- *Large 4cm area of purple bruising from infiltration, entry point of cannula evident. Reviewed by medical team and tissue viability referral completed.*

- *Tissue viability referral received regarding extravasation injury to left foot.*

PSIRI panel discussion: SBAR presented and discussed on 18.4.24. Panel agreed incident remains moderate physical harm. Formal duty of candour to be undertaken. Formal complaint has been also made regarding this incident. Medicine division to nominate a family liaison and work with family to discuss their needs / concerns and respond to family – incorporating these into the ongoing review as currently initial review is not sufficient. Tissue viability input ongoing. Dressing to be changed on alternate days by community nursing team and reviewed by TVN.

2 incidents were requested to be re-presented back to the PSIRI panel for discussion, oversight and assurance as outlined below:

3.3.2

- **#8077 Moderate physical harm (Surgery Division)** *Baby transferred from St Marys to PICU. Positive Staph aureius on arterial line. Positive chest swab reported 15/3/24. Patient colonised with staphylococcus aureus umbilical area on 25/2/24 and underwent cardiac surgery 29/1/24. Positive throat swab for staphylococcus aureus 29/1/24 on PICU post-surgery. Patient deteriorated 9/2/24 and had subsequent chest swabs and blood cultures 9/2/24 for staphylococcus aureus. Patient has had wound debridement and multiple intravenous antibiotics.*

Learning noted: Missed opportunities to communicate swab results to surgical team. Lack of documentation. WHO checklist ticked without swabs being checked by bedside nurse transferring to theatre. WHO list wording currently notes 'known infections'. Microbiology to be added to form. Theatre team to check microbiology when setting up for patient. undertake by ward manager and matron without involvement of IPC.PSIRI panel requested further post infection review (PIR) of incident with IPC team involvement and use of correct PIR documentation.

PSIRI panel decision: - Previously presented at PSIRI panel in March 24 as post infection review undertake by ward manager and matron without involvement of IPC.PSIRI panel requested further post infection review (PIR) of incident with IPC team involvement and use of correct PIR documentation. Meeting with IPC planned for 2nd May 24. Learning review to be presented at PSIRI panel May 24.

3.3.3- #7991 Moderate physical harm (Surgery Division)*: Patient was prescribed IV paracetamol following second surgery for inguinal hernia repair as nil by mouth due to coffee ground vomiting. IV paracetamol prescribed on downtime paper MAR as IT systems down for Meditech downtime.*

Learning noted: Pharmacists supported prescribing and administering of Parva Lex as very rarely used on ward. Mum present and made aware immediately and informed of next steps as advised by pharmacy. Standardise the storage of IV paracetamol across the Trust. Review the Trust guidelines for the treatment of IV paracetamol overdose. Discuss at the Bedside verification group the ability to scan IV paracetamol. Investigate the use of guard rails for intermittent infusions.

PSIRI panel discussion: Previously presented at PSIRI panel in March 24 and SBAR presented and discussed. Panel agreed incident remains moderate physical harm and division progressing with MDT review. Formal duty of candour to be undertaken. PSIRI panel requested further update, assurance, and any further learning post MDT discussion. MDT panel held and draft learning response out for review. Learning review to be presented at PSIRI panel May 24.

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 April 24 that would benefit from linking into an existing quality improvement workstream to inform system learning as outlined in table 3 below:

Table 3

Brief incident description	PSIRI Panel findings /Learning	PSIRI Panel Recommendations
Surgery Division		
#7487 Potential delay of escalation to PICU of	Patient had an underlying cardiac defect with poor prognosis. The patient's cause of death	Incident and learning to be shared as part of the

deteriorating patient for cardiac surgery Discussion at QAQI and discuss of rapid deterioration pathway of cardiac patient.	as agreed with the coroner was: 1a congenital cardiac defect and 1b multi-organ failure. Incident downgraded to no harm. Lessons for improvement - Deteriorating Patient Pathway for Cardiac Patients to be updated with PICU to include blood gas information and points of escalation. This will give staff standardised guidance regarding when to escalate blood gas result	deteriorating patient workstream.
Medicine Division		
#8227- Patient attended ED 2/3/24 and streamed to UTC- and discharged. Parents brought child back to ED later same day as still concerned and admitted to PAU. Patient had PEW overnight between 1-3. The next day patient started to become more unwell with increased PEW. Parents raised concern. Patient admitted to PICU.	Documentation from nursing team records parental and nursing concerns. This was not recorded on PEW. Panel agreed this was a rare presentation that is not fully understood and although there is learning in relation to escalation, the clinical team were investigating and liaising with other clinical teams. PEW should not be used in isolation and other clinical factors should be considered to determine deterioration. Response team should be contacted should nursing team feel their escalation is not being responded to in a timely manner. Nurse concern and parental concern should be recorded on PEW.	Incident and learning to be shared as part of the deteriorating patient workstream.

6. Training and Education

6.1 Patient Safety E-Learning

The table below demonstrates the Trusts 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)	**98.23%**
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 (Appendix 1). Oversight of the action plans are being monitored by the Divisions.

8 Next Steps

Areas of focus include the following:

- **Bespoke Training:** Bespoke training for all staff involved in learning responses and acting in Family Liaison roles (FLOs) has been commissioned and will be delivered by Consequence UK between May-June 24

- **Patient Safety Investigators**-Shortlist and interview to the 2 Patient Safety Investigator vacancies

- **Delivery of comprehensive MDT learning reviews** for 2 incidents: Ward 4c safeguarding incident and SI 2023/18692 (Death of a patient on PICU following elective craniofacial surgery). Learning review outputs will be shared with Baord once concluded.

- **Non-documentation of parental and nursing concerns on PEW:** Emerging theme of non-documentation of parental and nursing concerns on patients PEW noted by PSIRI panel. Escalate to Patient Safety Board for consideration for deteriorating patient workstream to report back into Patient Safety Programme board.

9.Recommendations

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

Appendix 1

Legacy SI action plans: During the reporting period (1st – 30th April 2024), **2** legacy SI action plans remained open. Both remain within their expected date of completion.

StEIS reference	Date incident reported	Date StEIS reported	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Number of extensions
Surgery Division							
2023/12980	02/07/2023	05/07/2023	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	9 7 actions completed.	31/01/2024	31/05/2024	3
2023/17791	15/09/2023	21/09/2023	Never Event – Wrong implant / prosthesis used.	9 7 actions completed.	01/05/2024		0

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 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 24th April 2024, along with the approved minutes from the 20th March 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. 1.2. 1.4.	Inability to delivery safe and high-quality services Children and young people waiting beyond the national standard to access planned care and urgent care Access to children & Young People's Mental Health	9 20 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

0111 **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 the positive Patient Safety Strategy update. SQAC was pleased to note the clear progress and good documentation on the workstreams scrutinised in month.
- SQAC received the ED monthly report, ED@ its best update in the new format, SQAC agreed that the improved format strengthened oversight regarding ED, and created a good base to enhance future reports. SQAC noted the strong performance in ED against national targets.
- SQAC received the Sepsis update which highlighted improved performance across a multi-annual timeframe. SQAC noted the intersection between Sepsis responses and Martha's rule and the planned introduction of the Alder Hey response to Martha's rule.
- SQAC received the Drugs & Therapeutics Quarterly report, which was presented in an improved format with good data which enabled SQAC to understand what the major workstreams are and what improvements are being made. SQAC noted the improvement in governance around Drugs and Therapeutics. SQAC made a plea for key messages in the report to be highlighted for ease of access.
- SQAC received the Board Assurance Framework. SQAC are awaiting review of key risks that SQAC have responsibility for and anticipate an update on this very soon.
- SQAC received the new Patient Experience Group Terms of Reference and the workplan. SQAC provided conditional approval.
- SQAC received the Clinical Effectiveness and Outcomes Group Chairs Highlight report which clearly highlighted current issues of concern which were escalated to SQAC. The report clearly detailed what actions are in place to address those issues of concern, providing clear evidence that there are plans in place to address issues.
- SQAC received the Transition Report and noted a number of caveats regarding the data and potential further work in the future to clarify the data. SQAC noted the good progress overall.
- SQAC received the Confidential Enquiries/national guidance assurance report, the contents of which were extremely clear and provided SQAC with assurance.
- SQAC received the Divisional updates with good engagement across all divisions, and reports better aligned in terms of what is reported and the format. The reports indicate clearly that the Divisions are sighted on highly-scored risks, that these are being kept under review, that risks are being added/removed and the risk scoring is regularly being reviewed.
  SQAC noted the concern expressed regarding the CT scanner issue and the ongoing discussions which are taking place regarding this.

0112
- SQAC received a deep dive regarding E Roster, SQAC received a good understanding of the E Roster and had a clear understanding of the challenges.
- SQAC received, and noted the SQAC Annual Workplan and SQAC Terms of Reference, which SQAC approved, subject to one minor amendment within the Terms of Reference.
- SQAC received and approved the SQAC Annual Report, subject to the addition of narrative within the final assurance section to include some assurance regarding the National Confidential Enquiries/National Guidance and to include assurance regarding NICE compliance issues.
- SQAC received the Research Annual Report, with some focus on SQAC related issues. SQAC welcomed the report in the new format, and acknowledged that there is a new team forming and stronger engagement of research Division across the Trust. SQAC welcomed further developments in due course.
- SQAC received the External Visits/Accreditation Report, ES made a plea to SQAC to ensure that the External Visits/Accreditation report is fully reviewed to ensure that all of the necessary information had been included. Divisions to raise this internally through the divisional internal governance meetings.
- SQAC received, Noted and Ratified the Decontamination of Reusable Medical Devices Policy.
- SQAC received, Noted and Ratified C33–Prevention and Control of Creutzfeldt – Jakob (CJD) Disease Policy.
- SQAC received, Noted and Ratified Autologous Stem Cell and Bone Marrow Transplant Policy.

4. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 20th March 2024
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	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)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RH)
	Jacqui Pointon	Associate Chief Nurse–Community & Mental Health Division	(JP)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Office	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)
In Attendance:			
23/24/212	Dr. Matthew Neame	Chief Clinical Information Officer, Division of Medicine	(MN)
	Ian Gilbertson	Deputy Chief Digital and Information Officer	(IG)
23/24/218	Julie Grice	ED Consultant, Mortality Lead	(JG)
	Veronica Greenwood	Deputy Director of Allied Health Professionals (AHPs)	(VG)
23/24/221	Rachel Isba	Consultant in Paediatric Public Health Medicine	(RI)
	Peter White	Chief Nursing Information Officer, IDigital/Nursing	(PW)
	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:	Nathan Askew	Chief Nursing Officer	(NA)
	Pauline Brown	Director of Nursing	(PB)
	Dani Jones	Director of Strategy	(DJ)
	Laura Rad	Head of Nursing - Research	(LR)
	Paul Sanderson	Chief Pharmacist	(PS)

23/24/206 Welcome and Apologies
The Chair welcomed everyone to the meeting and noted the apologies received.

23/24/207 Declarations of Interest
None

23/24/208 Minutes of the Previous Meeting
The Committee members were content to APPROVE the notes of the meeting held on 21st February 2024.

23/24/209 Matters Arising/Review of Action log
The action log was reviewed and updated.

Assurance on Key Risks

23/24/210 *Delivery of Outstanding Care*
Safe

ABa presented the Patient Safety update

- Patient Safety data metrics highlighted an increase in patients deteriorating in the intensive care unit in December 2023, a deep dive had been undertaken, with the report due to be presented to 28th March 2024 Patient Safety Strategy Board, with an update to be shared at April SQAC meeting.

- Patient Safety Strategy Board received the major trauma peer review, which was performed this year, this reported good practice. The Trust is 78% completely compliant with the national standards and 22% partially compliant with the national standards. Good practice was noted with regards to excellent governance and learning, and a senior leadership team who are engaged with the wider trust, with good psychology and dietetics support into the service. The peer review team were extremely impressed with the trauma 'app' which allows recording of real time data during a trauma call and enables integration into an electronic patient record. The Trust is not fully compliant as the Trust does not currently have an appointed trauma rehabilitation Consultant. This role is being performed by the lead consultant for major trauma.
- Patient Safety Strategy Board received an excellent presentation from the Medical Services Director regarding a new way of reviewing patient safety metrics and triangulating that data from various different areas and presenting that information in a different way to identify hotspots.
- Under the antimicrobial stewardship work the ICNET software package had now been agreed.
- Patient Safety Strategy Board agreed to move the hospital optimisation deteriorating patient pathway which is moving into its own area and will overlap with the hospital strategy and the get me well workstreams. Martha's rule is likely to move into the Patient Safety Strategy Board workstream.

FB alluded to an update on learning disabilities which is Amber on the dashboard.
ABa stated that this is predominantly regarding the Oliver McGovern training, and that the Trust is able to roll out the online requirements. However the face to face element is proving challenging regarding the technicalities of the face to face training.
KB referred to the vision and goals section and stated that a significant number of the deadlines had passed. KB requested that when goals have a time defined deadline that they should have a position statement against them. ABa agreed that he would ensure this feedback is relayed to ensure that this is actioned as appropriate.

Resolved: ABa to provide feedback to Patient Safety Strategy colleagues to ensure that position statements are included for those goals that have a time defined deadline.

FB alluded to the work regarding the different data sets to identify where issues may be increasing and which issues are going to present risks in relation to safety which SQAC would welcome receiving further information on in due course, whilst also acknowledging the complexities.

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

23/24/211 ED MH monthly report: MH attendances and ED@its Best

UD presented the ED MH attendances and ED@its Best update

- During the month of February 2024 there had been higher than average daily attendances-1233 more children and young people, compared to February 2023.
- February 2024 performance was 79%, the national standard is 76%, the division are hoping to achieve 80%.
- Year to date performance was 82% which is 6% above the national standard.
- February 2024 was a busy month given the measles outbreak nationally, ED was extremely focussed on contingency plans and in addition to this there was 5 days of Industrial Action requiring the Division to deliver an alternative workforce rota.
- 14 children had waited more than 12 hours, all of these children had socially complex situations. Medicine divisional colleagues are trying to work closely with social services, police and with external partners, with the aim of streamlining such complex cases.
- Triage time was 80 minutes; Medicine Divisional colleagues are aiming to optimise this to 15 minutes which is a national standard.
- Year to date attendance and breaches from 2022/2023; ED had performed well despite the increased number of attendances.
- There was an 8% improvement in year to date compared to 2023, of patients being seen or discharged.
- Urgent treatment centre utilisation is currently 83%, Medicine divisional colleagues are reviewing this to optimise to full capacity.

- Key improvement areas under review are flow and analysis of PAU, the division are aiming to streamline 80% of performance and above for Quarter 4.
- Sepsis compliance is 89%, there had been 6 patients who had been given antibiotics just over the 60-minute target. There is a deep dive and learning in relation to these patients.
- Friends and family test continue to be at 79%, this is a decrease from 83%.
- There were a total of 89 Mental Health attendances in January and February 2024; 82 children and young people - (92%) were referred to crisis care, 20% of these children and young patients were admitted, there were 4 patients who fell outside of this, 2 of these children and young people had health issues and medical issues, and unfortunately there is no data for the other 2 children and young people which the division are currently reviewing.

FB thanked UD for update and stated that it is clear that the division remain extremely focussed on waiting times and patient flow, whilst working with external partners to address issues. FB stated it is really important to think about how the division can manage the ongoing increasing attendances.
NP referred to the national target of 85% 4 hourly target and stated that when reviewing the performance data, it is rated as Amber at 78%. NP alluded to the importance of ensuring the correct messages are conveyed to the appropriate team, given that colleagues had sustained performance despite seeing 1,000 additional children, as this is a really positive message. NP alluded to the nuance regarding the productivity and the ratio of attendances per individual, and that the attendances are making a significant impact in terms of the workload for the team.
FB stated that the largest difference was that in previous when there had been significant increases in ED attendances, the performance figures had significantly decreased, and that this year the performance is more robust which the data also suggests this.
CW advised that colleagues had previously met NA to discuss how this report could be enhanced further and how this is communicated to SQAC and to relevant teams.
FB alluded to the Friends and Family test and stated that colleagues assume that Children & Young People who experience longer wait times are likely to be those Patient and Family test responses that are less positive. FB requested whether these responses could be tracked for 1 month to determine whether there is a direct correlation of feedback for these patients and families who had long waits in ED.
Resolved: Friends & Family test information to be tracked for 1 month to determine whether there is a direct corelation of negative response for those families who had long waits in ED.
Resolved: SQAC received and **NOTED** the ED monthly update report: MH attendances and ED@its Best update

23/24/212 Quarterly Diagnostic Notifications Update

MN presented the Quarterly Diagnostic Notifications Update:-

- The Trust currently have around 5,000 unacknowledged notifications in the system that had breached the 28 day standard, this is an increase of 2,000 since the previous update provided in December 2023.
- Continued excellent performance is noted within Community & Mental Health Division, stable performance (1,200) unacknowledged notifications within the Division of Medicine and an increase in the Division of Surgery since the previous update in December of approximately 3,000.
- The unacknowledged notifications are being monitored on a monthly basis by MN and Senior clinical leads. To address those trends the surgical governance leads, provide monthly progress data. Additional technical support had been provided to PICU with the aim to mirror the process used really successfully in ED team to manage as a department. MN and colleagues are engaging with the clinical leads and the service manager for the spinal team, as this team work slightly differently to other colleagues, additional support is also provided to this team.
- There is additional work ongoing to manage the notifications received from externally ordered investigations, with good progress made.
- There is a Meditech development request which is pending which is being tracked through AlderC@are Board to provide the system with greater configurability.
- There is ongoing evidence of good practice across a range of departments, there is clear focus on departments within the Surgical Division, with plans in place to support colleagues, with ongoing monitoring.

FB requested that in future reports it would be helpful to receive the total number of notices, to enable the committee to have oversight of the % as opposed to just a raw number, to understand what is going well and what is outstanding. FB acknowledged that this is work in progress and welcomed further progress in those areas where the unacknowledged notifications are increasing.
KB sought clarity regarding what is the balance between top down directions trust wide regarding how to deal with the notifications, versus asking the teams to deal with them in their best way.
MT is supportive of teams should they need to manage the unacknowledged notifications slightly differently.

FB alluded to spreading of good practice, and ensuring visibility for all teams, and whether a standardised approach would be easier in terms of communication and expectation. FB alluded to the fact that some teams are really different and need a bespoke solution in such cases.
RP stated that this is an area of focus for the Division of Surgery. RP requested to meet with MN offline to understand the volume of notifications versus the volume breach, to enable RP to understand whether clinicians within the Division of Surgery are requesting significantly more tests and to understand why some notifications are being acknowledged and other notices are not. RP stated following the offline discussion with MN a comprehensive update for the Division of Surgery would be provided to SQAC at the April meeting.

JG sought clarity from MN whether MN and colleagues have sufficient technical support, and queried whether there is any artificial intelligence support available. JG stated that this feels like a risk which is exponential and escalating and queried whether there is any support required.

ABa stated that he does not accept JG's interpretation and stated that he would have accepted this interpretation 3-4 months ago, however the Community & Mental Health Division have a relatively low volume of unacknowledged notifications compared with other Divisions. ABa stated that the Division of Medicine are in a steady state, and that there is a 28-day period that you are allowed before it breaches. However, the Trust does not know what the steady state is for the Division of Surgery at present, however colleagues feel that this should be lower than those figures currently. Division of Medicine had reached what may be there steady state of 1,200 unacknowledged notifications. This is not an accumulation per month, this is the unacknowledged notifications within the 28 days. ABa advised that there may be reasons for this and is comfortable with this number. ABa stated that the Division of Surgery do have some hotspots e.g. spinal surgeons have accumulated almost 500 unacknowledged notifications and support is required for this team to resolve this within their working practice, this team would also reach a steady state, although at present the steady state number is unknown and it could be similar to medicine or it could be higher as surgery run some very high volume clinics such as fracture clinics with 70 patients in that clinic per day, with almost all of the patients requiring an x-ray. PICU is not addressed, and they will reach a steady state. ABA does not feel this is as negative as it appears.
ABa stated that he would like to see a steady state per month with regards to around the same number per month of unacknowledged notices within the Division of Medicine and the Division of Surgery and at present it is unclear what that number would be, ABa suspected it may potentially be between 1,000 -2,000 and that providing that there is not an ongoing increase on a monthly basis ABa would be content with this. ABa sought clarity from MN whether MN would be comfortable with this projection.
MN stated that unacknowledged notifications would never reach zero and there are good reasons why clinicians have unacknowledged notifications in their list i.e., they know the result is there, however they need to have a discussion with a colleague before they complete and action it. MN stated that there are 5 clinicians across the whole trust with over 100 unacknowledged notices, most people can decrease these within a day or two of review. MN stated that it feels that some focus and attention is required however MN is hopeful that this situation is recoverable with the right work over the coming months.
FB expressed her thanks to MN for the insightful report and welcomed the next quarterly report at the June 2024 SQAC meeting, together with progress on those areas requiring focus and progress regarding the data. FB stated that SQAC are extremely supportive of the ongoing work undertaken by MT and colleagues and advised that should MT require any support from the Divisional leads for MN to request support.

Resolved: SQAC received and **NOTED** the Quarterly Diagnostic Notifications Update

23/24/213 Quarter 3 Infection Prevention & Control Quarterly Report 1st October 2023– 31st December 2023

BL presented Quarter 3 IPC Report

- BL advised that the IPC Team review all significant blood stream infections cases across the Trust, and not just those subject to UKHSA mandatory surveillance.
- BL alluded to the work of the CLABSI working group with regards to bacteraemia's, to reduce the number of skin contaminants.
- BL stated that there had not been a significant increase in C Difficile cases, however local adults Trusts are reporting an increase of more than 400 cases.
- ICNET had been approved, which would ensure a more data driven programme.

AB sought clarity from BL whether the IPC report should include a summary of water safety.
BL stated that this is reported through the Water Safety Committee within the Trust. BL stated that she is happy to include a summary within future IPC reports.

AB requested BL's view with regards to central line infections, as often this is reported as per thousand-line days and sought clarity regarding comparison of PICU against global best practice and wards and also regarding any trends or international and national best practice basis.
BL referred to CLABSI's and stated that internationally the Trust is moving to a process of rather than reporting CLABSI's that the Trust reports hospital onset bacteraemia's. BL advised that some of the lines that the Trust have are not technically a central line, particularly in neonates as they have a midline, and in many countries the CLABSI rates though prevention had decreased, and other hospital findings had shown that focussing on CLABI'S makes the quality improvement really difficult as going from one event to Zero involves significant work. Other hospital feedback related to whilst not having CLABSI's that they are seeing patients in hospital for more than 3 days that these patients would get a hospital acquired bacteraemia. BL stated that she has been trying to promote this issue within the IPC community within the UK, as colleagues can document and trend the hospital acquired bacteraemia's. BL stated that she meets monthly with the PICU team as the CLABSIs are patients that have a blood stream infection and a line, and doesn't have a secondary focus of that infection and requires clinical support to agree which patients meet the definition. BL stated it would be much easier to report hospital acquired bacteraemia's and stated that Bristol had started to report in this way.

FB expressed thanks to BL for ongoing work and support and acknowledged the continuous improvement of the format of the report and welcomed the short summaries of the actions.

Resolved: SQAC received and **NOTED** the Quarterly IPC Report.

23/24/214 Inphase update and lessons learned Report

PW presented the Inphase update, and the lessons learned report
PW had consulted with members of the development teams and colleagues from Alder Hey and Liverpool Heart and Chest. Following discussions there were particular themes, including the Trust relationship with the supplier which had been challenging at times, elements of training provided, the ongoing support and the significant challenges regarding reporting. PW formally expressed apologies to SQAC and to other committees for the challenges in terms of reporting and the difficulties that teams have experienced when obtaining data from the system, and having to present incomplete data and recognising the stress and concern that this has caused those individuals.

PW referred to the sustainability of the system as the Trust transfers to business as usual as there are still a number of outstanding items which are detailed within the report. PW advised that as the Trust had transitioned, the Trust is currently in a much more stable situation, the reporting is more effective, and the deployment of the data analytical team creating dashboards and visualising the data in addition to the downloads had been extremely effective. The collaboration between Alder Hey and Liverpool Heart & Chest has been extremely effective.

PW referred to the Working Group who had been meeting on a weekly basis for over 12 months, with significant progress made with all governance leads had fully engaged and had shared best practice.
KB stated that if colleagues had taken more time at the start of the project to get this right then the Trust would not have experienced some of the challenges it had. It feels like it was driven by not

wanting to extend Ulysses. KB stated that in reality the Trust should have extended the Ulysses contract and the cost of extending this would have been less than the pain that the teams had experienced over the previous months, together with challenges and dissatisfaction for colleagues. KB stated that the response from the team at Alder Hey to resolve issues over the last 9 months had been outstanding. KB alluded to the timing and stated that she is of the opinion that the Trust accelerated too quickly.
PW agreed with KB feedback and stated that this is a fair assessment. PW stated that there had been a substantial EPR deployment in between and large whole Trust digital implementations and to undertake two large fundamental shifts of workflow for the whole hospital was ambitious.
IG stated that KB comments are a fair assessment of the position. IG stated that he is of the opinion that the Trust made some incorrect assumptions when embarking on this, IG advised on the complexities and issues regarding extraction of the data.
FB stated that there are wider ramifications as systems are not updated or no longer maintained by their producers with difficult choices. FB alluded to ownership and sought clarity whether it is clear on who owns each of the systems.
IG stated that there is currently an exercise being undertaken, resulting in a closure report detailing roles, responsibilities and clarity which would be formally agreed between I.T and the Governance team prior to sign off. IG stated that he envisaged that the closure report would be signed off ahead of the next SQAC meeting.
FB sought clarity regarding where this would be agreed.
JG stated that this would initially be shared at Executive Team meeting for review to determine which Sub Committee this should be presented to.
NP highlighted the importance of ensuring the shared learning is shared beyond the Digital programme managers, given the importance of understanding capacity, time and scope of the programme.
FB alluded to the training points and stated that if colleagues do not have the opportunity to train users up prior to go live, people need to be really aware what this means once Go live occurs.
Resolved: Closure report to be shared with Executive Team for review and determine which Sub Committee this should be presented to.
Resolved: Shared learning to be cascaded to appropriate colleagues

FB thanked PW for comprehensive update.
Resolved: SQAC received and **NOTED** the Inphase update, and lessons learned report.

23/24/215 Craniofacial learning slides

RP presented the learning slides and provided an overview of an unexpected death which tragically occurred post operatively of a 19 month old patient who was admitted in 2023 for elective craniofacial surgery.

Oversight of this case is via the Division of Surgery and through the Trust Divisional Action plan.

A coroner's inquest is scheduled for 11th April 2024.

Resolved: SQAC received and **NOTED** the craniofacial learning slides

23/24/216 Neonatal Sepsis RCAs

RP presented the Neonatal Sepsis RCA and provided an overview of an infant who presented with a high temperature and some tachycardia, the patient was born with biliary atresia which was resolved and had stomas in place and was having refeeding through her stomas.

FB stated that it is really useful to receive the shared learning and to receive the themes which are common to the two incidents, together with the actions and the update on the ongoing work to address themes.

KB sought clarity whether these cases were classed as avoidable deaths, and what this means for the relationship with the families and sought clarity how the Trust had supported staff. KB queried the impact of the planned inquest.

RP stated that both families had family liaison officers. RP advised that the parents of the patient with sepsis had attended two meetings, to understand their child's care/gaps in care, family had been extremely engaged and had wanted to aid learning in the future.

RP stated that the parents of the craniofacial patient that ongoing discussions had taken place, RP stated that the Trust had answered queries openly and honestly.

ABa referred to staff support and provided assurance that whilst support had been offered as the Trust has now transitioned to PSIRF a new just and restorative learning approach had been developed and would be piloted with the staff involved in the craniofacial case

JR provided the background detail regarding the Patient & Engagement expert who had experienced the loss of a child to surgery in former years at GOSH, this Patient & Engagement Expert had been commissioned to provide external support. JR confirmed that the restorative learning review is planned for 25th April 2024.

ABA alluded to the inquest and stated that the most important issue is that the Trust accepts what has happened and that the Trust is open and honest, and highlighted the importance of ensuring that lessons are learned and are embedded across the organisation. ABa stated that the Trust had to do the right thing for the family, staff and future patients.

FB stated that the Trust needed to ensure there is appropriate communication at the time of the upcoming inquest.

FB reminded all regarding the psychological support which is in place for staff as routine, and that following such incidents, this need may be evident for staff involved.

JG referred to the regulatory element, ES confirmed that these aspects had been addressed.

FB referred to the context of the shift to PSIRF and stated that these cases are profound tests, and that it would be helpful to keep such cases under review, retrospectively look back and consider whether cases as 'setting good lessons' or any shared learning with regards to PSIRF approach.

Resolved: SQAC received and **NOTED** the Neonatal Sepsis RCA's.

23/24/217 *Caring*
Effective
Board Assurance Framework

ES presented the Board Assurance Framework and advised that there are no significant updates.
ES stated that the risk appetite discussions are commencing and advised that it is timely to refine and nuance some of the thresholds descriptions categories that pertain to safety.
ES alluded to 1.4 and how this aligns with GDS go live, as the GDS risk is currently described in the reputation, however ES envisaged this would be moving to a place to commence describing in other terms.

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

23/24/218 **Quarter 3 Mortality Report**

JG presented the Quarter 3 Mortality Report

- JG stated that she had raised with SQAC during 2023 that the number of deaths were higher, however at the end of 2023 the figures had remained exactly the same as previous years.
- HMRG group are performing well, despite no admin support since the beginning of the year, however approval had recently been received for admin support.
- ME examiners pilot commenced on 4th March, which is a legal requirement from 1st April.
- There had been ongoing issues with community deaths, SUDI protocol, this is being worked though
- No concerning themes (this report does not include the 2 deaths discussed at this SQAC meeting as these deaths would be included in the next Mortality report-although these cases had been discussed

the coding had not been finalised, in depth discussions took place, with further information required, whilst also awaiting feedback from the family).

- Postmortem cases are taking longer due to a national shortage of paediatric pathologists.
- PICU deaths had triggered the reset of the RSPRT which enables analysing of PICU deaths, based on the paediatric index of mortality the PIM3 which is a worldwide validated PICU score which tries to predict the observed versus the expected mortality, it is however recognised that PIM3 which is currently being used is outdated and has limitations especially with complex children with a number of co morbidities. The Trust had undertaken an in depth review and have submitted this to PICANET who monitor this, and they have no concerns at present, however this may trigger in the future given the complexities of the children who the Trust care for. JG advised that an update would be provided within the end of year report with the Learning Disabilities
- SQAC received an update on learning and future plans.

FB thanked JG for comprehensive and informative Quarter 3 Mortality Report update and noted the areas of focus.

Resolved: SQAC received and **NOTED** the Quarter 3 Mortality Report

23/24/219 Clinical Audit & Effectiveness Annual Plan

JR presented the Clinical Audit & Effectiveness Annual Plan
The Clinical Audit & Effectiveness Group commenced in September 2023, once CPSG had disbanded, with an interim chair until December 2023, Appointed chair commenced in January 2024, the group continues to mature.

SQAC received the Clinical Audit & Effectiveness Annual Workplan for 24/25 together with the Terms of Reference, both the Annual workplan and the Terms of Reference had been reviewed and approved at CEOG on 8th March 2024.

JR referred to the outcomes of the workstreams and advised of ongoing discussions with the Chair of CEOG and the Divisional Director for Surgery regarding upcoming work regarding outcomes.

KB alluded to Audit & Risk Committee and stated that it is helpful to receive minutes of the meeting to understand the level of the discussion and queried whether this is appropriate for SQAC to receive the notes of the CEOG meetings.
FB stated that from the other Sub Committee meetings there are Chairs highlight report which FB finds more useful rather than a full set of minutes, FB stated that this could be considered offline with FB, KB and ES. KB stated that the CEOG notes could be shared with KB offline.

Resolved: SQAC received, **NOTED** and APPROVED the Clinical Audit & Effectiveness Annual Plan

23/24/220 Clinical Effectiveness and Outcomes Group Chairs Highlight report and the Clinical Audit Plan.

JR presented the Clinical Effectiveness and Outcomes Group Chairs Highlight report and the Clinical Audit Plan.

- The last meeting of the Clinical Effectiveness and Outcome Group meeting was held on 8th March 2024.
- Clinical Effectiveness & Outcome Group acknowledged the continuous improved compliance with NICE guidance. There is a weekly meeting with Divisions to review compliance for audit and NICE, and also to improve compliance of policies and Standard Operating Procedures.
- CEOG are working with divisions to enable a divisional reporting template to provide further written assurance regarding progress regarding divisional level audits which is ongoing.
- Record keeping policy pilot is being rolled out to nursing staff from April 2024.
- The Trust is on trajectory to undertake the Clinical Audit masterclass in June 2024.
- The Transition group continue to make good progress against NICE guidance.
- CEOG Annual workplan and CEOG Terms of Reference were approved at the 8th March 2024 CEOG meeting.
- G Cleary, the CEOG co-chair had resigned as he had been appointed to a national post, with the CEOG co-chair post to be advertised, resulting in a capacity issue within CEOG team at present.

- Trust wide Audit plan 24/25 shared with SQAC for oversight. The Trust have 15 national mandated audit for 24/25. There are no regional mandated audits at present.
- There are 24 local Trusts audits, within Appendix 2 which is an interim position at present.
- The Quality contract for 24/25 had been published, however there is no agreement at present regarding which details are required to be included within the Trust plan.
- The interim Trust wide Audit plan was approved at CEOG on 8th March 2024, with plans to be resubmitted to CEOG for further refinement. Audit Plan is also due to be presented at the next Audit and Risk Committee meeting.

KB stated that when the plan is being established next year whether there should be a process whereby JR undertakes a discussion with key members of SQAC to determine whether there are any audits that may need to be included in the plan, based on the reports received during the year and concerns discussed, similarly with the Audit Committee. FB stated it would be helpful to receive divisional input regarding divisional risks.
FB thanked JR for comprehensive update.

Resolved: SQAC received, **NOTED** and approved the interim Clinical Effectiveness and Outcomes Group Chairs Highlight report.

23/23/221 Health Inequalities & Prevention Steering Group (HIPSG) update – April 2023/24

R Isba presented the Health Inequalities & Prevention Steering Group (HIPSG) update Report
RI provided the committee with details regarding her background and confirmed that she will take up post of Consultant Paediatric in Public Health Medicine on 1st May 2024 in a substantive role, this appointment would increase capacity and leadership regarding health inequalities and prevention work.
RI advised that progress had been made against plan and stated that given that RI is due to commence in her role in 1st May 2024 that it is a good opportunity to have a pause regarding plans to consider requirements for the coming year and beyond, with emphasis regarding data. RI stated that the report is continually being refined and would evolve over time.
RI alluded to waiting times for Children & Young People with a formally recorded learning disability on their notes, as these children are waiting longer, and have varying different needs, and thinking about issues in a data driven public healthy way and is very clinically focussed. RI understanding is that the recommendations from the paper are now being operationalised through colleagues working within Learning Disability team and complex needs.
RI stated that future reports may be displayed in a slightly different format.
FB stated that in a number of other reports submitted to SQAC, the reports do not break down the data to enable the identification of patient outcomes or patient experience are equal for different cohorts for the different group of patients that the Trust treats, and stated that one of the challenges for 24/25 would be a move to routinely identifying the different cohorts within Trust data by protected characteristics and by other available data, which would be an incremental process and to think about other reports and how the Trust better thinks about some of those inequalities of outcome as part of the general assurance process.

FB thanked RI for update and welcome future Health Inequalities & Prevention Steering Group updates

Resolved: SQAC received and **NOTED** the Health Inequalities & Prevention Steering Group (HIPSG) update Report – April 2023 - February 2024.

23/24/222 Divisional Update and Deep Dive regarding:

Surgery Division – RP presented the Surgery Divisional update

- The Division of Surgery had appointed 2 locum consultants for burns and plastics.
- There is an acute staffing gap currently in domestic supervisors which is impacting the cleanliness audit processes, this is on the risk register, with oversight and mitigation in place currently.
- SQAC raised a query at the February 2024 meeting regarding the open incidents and the associated actions. The Division of Surgery had reviewed the overdue incidents and there are currently 121 incidents in the month, the Division of Surgery are reporting on and working to a 21 day closure, as opposed to the Trust standard 28 day, with targeted work to reduce open incidents.
- The Division of Surgery had 3 moderate harms, which had all been overseen through the PSIRF panel and have actions in place. 1 of the MDT reviews aligned to this had already taken place with

immediate actionable learning which is being shared at the March 2024 Patient Safety Strategy Board.

- Sepsis compliance continues to improve and is almost at 90% target, with some data match issues this is being addressed through the team, with targeted work in various areas.
- There is continual oversight regarding compliance with Sepsis pathways, 9 in target, and 2 out of target with deep dives undertaken.
- RP stated that SQAC raised a query at the February 2024 meeting regarding Grade 1 and Grade 2 pressure ulcers and stated that the issues relating to Grade 1 and Grade 2 pressure ulcers mainly related to orthotics, plaster cast and devices for children who have had fractures orthopaedic conditions. The Tissue viability nurse is working closely with this team to ensure targeted work, RP is hoping to see a marked improvement in the future.
- There had been no PALS breaches in February 2024, despite receiving 58 PALS.
- There is 1 risk over 16 which is being presented to Risk management forum on 26.3.24 which relates to a Trust wide Capital Replacement Programme.
- There had been targeted action on the risk register to manage the overdue actions, currently 3.

Community & MH Division – JP provided Community & MH Divisional update

- The Community & Mental Health Division have targeted work with regards to open incidents and closing PALS within 5 days with targeted work to ensure improvements, reason related to capacity and volume.
- A significant challenge for the division related to interpreting incidents as the numbers had increased, which is impacting speech and language therapy and safeguarding which impacts both in terms of accessibility, experience and safety this had been escalated to the Patient Experience Group.
- ADHD service had been nominated for a National SEND partnership award, which they had won alongside Woolton High School.

FB welcomed update in due course regarding interpreting challenges.

Medicine – CW provided the Medicine Divisional update

- There had been a reduction in the was not brought rate which is 6% which is extremely positive, actions had included immediate response to short notice cancellations, cancellation rescheduling with appropriate patients who could be moved, increased validation pre booking to ensure appropriate allocation of appointments, and further reminder messages to all patients.
- Challenges regarding patients waiting 65 weeks for treatment within neurology service, there is a plan for all patients to commence treatment by the end of March 2024, with daily oversight by the general manager and service manager.
- Division of Medicine were involved in a sickle cell peer review for non-malignant haematology, colleagues are awaiting the formal outcome, however informal feedback had been extremely positive.
- The Division of Medicine continue to manage incidents with excellent oversight from the governance team and senior nurses. With continued focus on reducing low harm incidents, resulting in the reduction of low harm incidents and are gradually stabilising, with high reporting.
- There had been no moderate or above harm in February 2024.
- Incidents open more than 30 days continue to reduce with focussed work in the division – currently 30. Highest incident reporting is medication, a deep dive had been undertaken on the wards, CW confirmed that all incidents had no harm.
- The Division of Medicine had no hospital acquired infections in February 2024
- The Division of Medicine achieved 100% compliance regarding complaints which had been sustained for 3 month period.
- 100% compliance regarding PALS, with 1 breach which was outside of the Division of Medicine.
- Friends and Family responses rate had increased resulting in highest reported response rate for the last 12 month period, with focused work ongoing to continually improve
- Risks continue to be well managed, with good oversight and no overdue reviews, there is a slight increase of overdue actions, however the division are confident that there is good control in place to manage this.
- The Division have had a slight decrease in sepsis compliance, CW stated that this reduction is not significant and currently is at just under 90% in both ED and Inpatients. All sepsis cases had been reviewed and any learning and actions had been communicated, all actions had been undertaken.

- Sepsis training compliance had been an ongoing focussed work over the last few months, the Division of Medicine had increased compliance by 5% from 82% to over 87% with continued focus from the division.

KB stated that the number of clinical audits is extensive and that there are 68 ongoing and sought clarity whether this is the right level and whether this is sustainable for the team. UD stated that within medical appraisals every 3 years a clinician has to undertake an audit or be part of a team audit and that the Division of Medicine may not be able to restrict the number of audits completed, given the need for colleagues to revalidate. CW stated that there are some nursing audits, and that CW would review these given KB comments.
FB alluded to whether the audits could be better organised into larger deeper audits that colleagues may be really concerned about.

KB alluded to the restriction of capital funding for the replacement of medical equipment and alluded to whether there is a requirement for a discussion with the ICB, as replacing medical equipment suggests patient safety ramifications if the trust is not able to purchase equipment in line with manufacturers requirements.
JG stated that there is a planned deep dive at the next Risk Committee regarding equipment replacement requirements. JG stated that this would not be framed as the ICB are restricting what the Trust can purchase, and it is regarding broader capital limits within the system, and what this means when experiencing peaks for replacement of equipment. JG stated it is worth updating the committee on this once the risk profile had been reviewed, JG stated that the team are exploring managed service contracts given the scale of kit and that RL is working with the charity. JG stated it would be helpful for SQAC to keep this under review with regards to patient safety. FB stated that if the Trust is reaching a point when equipment requires repair and is not available when it is required there is a distinct quality and safety risk regarding which SQAC would remain sighted on.
RP stated that she chairs the Capital Subgroup meetings, and that she works closely with the Medical Engineering Manager, both of whom have oversight regarding replacement of medical equipment. RP advised that discussion had taken place with R Lea this week regarding charity rules, charity spending and whether there could be any challenge regarding the core equipment rule in place, RP advised that there is ongoing work continuing, and there is assurance with regards to the equipment that the Trust has in terms of safety. RP highlighted how the Trust address the upcoming challenges over the next 18-24 months.

Research Division - CW presented the Research Divisional update

- Positive engagement with staff and patients
- Division of Research are celebrating receiving Gold standard ward accreditation for the 3rd year
- Division of Research continue to have a delay in opening studies that require lab support whilst waiting for the post holder to commence in post in April 2024.
- Division of Research continue to have staff missing and incorrect profiles in mandatory training reports, with plans in place to address, issues had been escalated to the learning and development team.
- The Research Committee is changing to the Futures Committee from April 2024 and therefore proposing a wider range of research quality metrics to be reported into SQAC. A new plan is in the process of being shared with NA in April 2024 for review.

JG alluded to the inconsistency of around incidents and SQAC noted that there is a meeting scheduled to take place on 2nd April 2024 to review this. JG highlighted the importance of ensuring that the level of detail is correct. FB stated that this is correct and that there is also confidentiality and privacy concerns, and that this would be discussed at the planned meeting scheduled on 2nd April with NA. FB stated that it is a balance of a flavour regarding what the issues have been, and that it is important not to identify patients and staff unless unavoidable.

Resolved SQAC received and **NOTED** the Divisional updates

23/24/223 *Well Led*
Responsive

Commissioning for Quality & Innovation (CQUIN) Programme 2023/2024

POC presented the Commissioning for Quality & Innovation (CQUIN) Programme 2023/24 report.

- The Trust has 10 CQUIN's, of which 5 are specialised commissioning CQUIN's, and 5 are from the ICB. The Trust would not receive any financial penalties from ICB for non achievement, however this should not prevent the Trust from achieving the CQUIN's.
- Staff flu vaccination CQUIN was Amber at Quarter 3, - 49% in December 2023, there has been significant ongoing work in the interim months, with ongoing improvements, aiming to reach 80% for Quarter 3/4.
- Dream CQUIN - supporting patients to drink, eat and mobilise following surgery, discussions had taken place with Specialist Commissions and requests had been made for information to be extracted from patient records retrospectively for Quarter 3 and Quarter 4.
  RP stated that this is a data extraction issue, colleagues are working with the data analytical team to address the level of data analysis required.

CW alluded to the shared decision making CQUIN which both CW & RP had been involved in. CW stated that a Quality Assurance round was held in January 2024 and that there had been really good discussions, with good evidence of decision making around the hospital, with good outcomes.

Resolved: SQAC received and **NOTED** the Commissioning for Quality & Innovation (CQUIN) Programme 2023/24 Report

23/24/224 Quality Assurance Rounds – Themes & Risks Biannual update and Quality Assurance Round Annual Report

JR presented the Quality Assurance Round – Themes & Risk Biannual update and Quality Assurance Round Annual report which provided SQAC

- Biannual findings - During September 2023 and February 2024 14 Quality Assurance rounds were held, 10 Quality Assurance Rounds were cancelled or rescheduled, all cancelled Quality Assurance Rounds had been rescheduled.
- Main challenges identified during this time impacting on delivery of key line enquiries relate to recruitment and workforce issues, the top 3 categories relate to recruitment and workforce due to national staff shortages, staff retention, turnover and skill mix and recruitment and workforce.
- Service delivery issues colleagues are still being challenged regarding the waiting list backlog and the increasing number of referrals and acuity of patients that are greater than the service capacity, with some discussions held regarding the shortage of clinic space room.
- A further category related to a national shortage of drugs
- Successes continue to demonstrate the positive feedback received from patients through family and friends and the delivery of services.
- The Trust is noted to have a proactive approach to research and improved reporting of incidents, themes and trends.
- Staff had reported the positive impact of them being supported to access training and development opportunities.
- JR had been requested to review the delivery of Risk module training, there is a now a module in place which would be offered from April 2024 for all staff, risk appetite discussions had also recommended at Sub Board level.
- Governance Team continue to provide support and Risk Management Training once highlighted and once the Quality Assurance Rounds have concluded.

Annual Quality Assurance Round findings

- 34 Quality Assurance Rounds were undertaken, the recurrent challenges identified relate to recruitment and workforce issues, service delivery concerns, the increasing number of new referrals, specifically in relation to CAMHS, ASD and ADHD against commissioned activity.
- Further detail of key actions to address the challenges are detailed within the report and they are aligned with the current risks and mitigations outlined, these mirrors' themes, risks and trends outlined in the Biannual Quality Assurance Round report.
- Successes identified over the last 12 months continue to demonstrate excellent feedback received and service delivery with improved reporting of incidents themes and staff feeling supported in training and development opportunities.

Next steps

- From March 2024 CQC have moved to a single assessment framework. The current Quality Assurance Round template and process had been revised. SQAC approved this change earlier this year. In January 2024 SQAC approved the transition from the current framework to a hybrid approach from April 2024 with an opportunity for all stakeholders to be supported in a more dynamic Quality Assurance Rounds process. This revised hybrid approach had been aligned to the new CQC single assessment framework and is due to commence from March 2024. Oversight and assurance of risks would continue to be identified and monitored through the Risk Management Forum.

FB stated that the hybrid approach would entail some face-to-face Quality Assurance Rounds and that NED's welcome the visits to various departments and having the face to face interactions.
FB alluded to the previous challenges when making arranging for Quality Assurance Rounds and highlighted the importance to adhere to the agreed timetable. FB stated that the Quality Assurance dates are not tentative dates and that they are confirmed dates. FB highlighted the importance of NED's receiving the Quality Assurance Round pack which is required to be submitted 1 week prior to the Quality Assurance round.

NP alluded to those thematic areas in terms of different teams and progress that is being made corporately. NP stated that there is a Clinical Summit planned for April 2024 and this is real robust intelligence and referred to how the Trust demonstrates that it is listening to colleagues on an organisational level. JR stated that she is not aware of the clinical summit, JP stated that she is happy to work with colleagues in the brilliant basics team to address NP comments.

Resolved SQAC received and **NOTED** the Quality Assurance Round report and Annual Report

23/24/225 Ward Accreditation report and Annual Report

POC presented the Ward accreditation report Biannual report

- A total of 66 assessments had taken place since recommencement of Ward Accreditation assessments which recommenced from May 2021.
- Since the last report 16 accreditation assessments were planned, 4 were cancelled on the day due to not having a full team available, 12 accreditation assessment had been completed.
- 24 wards are now in the Ward Accreditation scheme, as ED and EDU/PAU although assessed on the same day the outcomes have now been reported separately.
- The overall position for the Trust indicates that 7 wards/departments had achieved Gold awards, and 17 wards/department had achieved Silver awards. There are no Bronze awards and no White awards.

POC alluded to the progress regarding the review of the accreditation process with regards to aligning the assessment framework criteria to reflect the new quality statements issued by CQC and advised that this identified good overall.
POC stated that since applying the new scoring framework that 3A, 4A, 1C, Cardiac, 3B, Clinical Research Facility and the EDU/EDU assessment unit were all identified as good overall. Within this assessment framework there were a couple of areas that were identified as outstanding, and a couple of areas that required improvement within the Well Led element on 3B, and EDU/PAU under the effective framework. This is a new process which would be applied to all of the Ward Accreditation Assessments in the future.

Ward Accreditation Annual report

- 24 ward and departments are now included in the Ward Accreditation scheme. Within the last year Dental, Outpatients, Renal unit, Children's community nursing team, have had their first Ward Accreditation Assessments.
- 7 wards/departments achieved Gold awards and 17 wards/department achieved Silver Awards
- No White awards
- Surgical Day Case had achieved and maintained a Gold Award on 4 consecutive occasions, Burns unit had maintained a Gold award on 3 consecutive occasions, Clinical Research Facility had achieved and maintained a Gold award on 3 consecutive occasions & Neonatal had maintained a Gold award on 2 consecutive occasions.
- Sunflower House had its first Ward Accreditation assessment and had received a Gold award.
- The Renal Unit are new to the Accreditation process and had received a Gold award.

- The Childrens Community Nursing Team had received a Gold award
- This last year has seen a decrease in the number of areas identified as White on the day of assessment. All wards and departments had been compliant against the mandatory safety check, there had also been significant improvements in the checking of emergency and resus equipment across the organisation. There had also been significant improvements in medicine management practices in relation to safe storage of medication.

POC advised that the Ward accreditation programme had been driven by J Allen and advised that JA is due to retire on 28.3.24 following 44 years' service at Alder Hey. SQAC acknowledged the ongoing work and support received by JA and requested that POC conveyed SQAC gratitude to JA for ongoing support ahead of JA upcoming retirement.

FB acknowledged the significant improvement with regards to visibility and stated that it is extremely important that SQAC receive this information. FB stated that she was delighted to see the significant improvement regarding the White outcomes and acknowledged the good progress to align the Ward Accreditation Framework to meet the CQC framework. FB welcomed the good practice, with regards to the significant number of Gold and Silver awards.
JP alluded to the strong leadership provided by JA and sought clarity on future Ward Accreditation plans given JA imminent departure. POC advised that he has had a discussion with NA with further ongoing discussions required to ensure that JA's legacy around the ward accreditation programme is given the due credit it deserves to ensure ongoing assurance for the Trust

KB sought clarity on what is preventing those Wards/Departments who are awarded Silver achieving Gold awards. POC stated that there is no specific issue in each individual areas and issues are pretty generic and advised that JA provided immediate feedback to wards/teams together with an associated action plan.

FB alluded to whether colleagues are making really good use of data intelligence in relation to other parts of the Trust's operation and asked colleagues to think about this in the future.

Resolved: SQAC received and **NOTED** the Ward accreditation report and Annual Report

23/24/226 Mobilisation of the Children and Young Peoples Gender Service (North)

LC presented the Mobilisation of the Children & Young Peoples Gender Service (North)

- The Children & Young People Gender Service North would form part of the Community & Mental Health Division from 1st April 2024.
- The Clinical lead and senior leadership team within the service will form part of the divisional governance groups, subgroups and the Divisional Board.
- Risk and governance training would also be delivered to the gender north services from April 2024, with a staggered approach to recruitment.
- There is a good governance structure in place. Service is now live on Inphase, the risks and risk register have been reviewed.
- The service will form part of the bimonthly risk review meetings, in addition to all of the divisional governance meetings. There would be a twice yearly assurance reports (quarter 1 and quarter 2) with delivery in late October.
- Trust Board had agreed an interim arrangement regarding Freedom of Information requests, Subject access requests, complaints and PALS this would be provided by Arden and GEM CSU who currently provide this service for NHSE with oversight and monitoring to understand the demand that this may place internally on the governance structure at Alder He to ensure in the future that the right calibre and the right number of staff are recruited to. There is a discrepancy between the information from Tavistock and Portman as the current provider with regards to what they say that they receive, to what they report externally.
- The North Programme had commissioned a telephone helpline which would be staffed, this is currently provided for Children & Young People who are on the national waiting list.
- LC referred to Freedom of Information Requests and data transfer agreement and confirmed that sign off would be the responsibility of Alder Hey to ensure direct oversight
- Recruitment to internal governance structures would commence in the next 6 months to ensure the correct skill mix.

KB alluded to FTSU and queried whether this is within Arden and GEM or whether this would be for the Trust, LC stated that this would be for the Trust. KB stated that she would not expect high levels of FTSU to be submitted initially and that future FTSU concerns may be more complex and challenging. LC stated that the Trust could look to ensure a champion within the service.

KB alluded to the risk register and stated that she had envisaged more risks, and requested whether KB and LC could undertake an offline discussion. LC stated that the largest risk related to the open case load, and on review of this the level of risk had been decreased. LC stated it would be helpful for LC, KB and L Neil to meet offline.

FB thanked LC for comprehensive update
Resolved: SQAC received and **NOTED** the Mobilisation of the Children and Young Peoples Gender Service (North)

23/24/227 Record Keeping policy

PW presented the Record Keeping policy
PW alluded to the challenges to ensure the correct wording and ensuring that the policy complies with national standards. Policy would continue to evolve.
RP alluded to the audit section regarding the audit process and that this would be completely new, and stated that 10 per month, per specialty, per department, per ward relates to 40 areas for the Division of Medicine and sought clarity on the logistics of who would action this, given ongoing pressures, and sought clarity whether there is a digital solution to this audit, if records are entered electronically, and whether there is a digital solution to extract this information digitally.
PW stated that there is a solution for meditech, however given the scale of records that would need to be included Badger for critical care, EMIS for community and some legacy paper documentation. PW agreed with RP that this is a heavy demand and PW would discuss this further offline with ACNs.
FB sought clarity whether there is a communications and dissemination plan in place.
PW advised that this had been shared at CEOG who were supportive and Ratified this to be presented to SQAC. PW advised that he plans to liaise with teams to disseminating the policy as appropriate.
JP stated it is important to acknowledge that this is work in progress and that the Policy and implementation should have a shorter review date of 6 months.
PW advised that he is content to set a shorter 6 month review of the policy and advised that the workgroup would continue
Resolved: SQAC received and RATIFIED the Record Keeping Policy, with the caveat that this is work in progress and that the Policy would be reviewed in 6 months' time, SQAC to receive an update at September 2024 meeting regarding any successes, challenges or barriers encountered.

23/24/228 High Consequences Infectious Diseases (Airborne) Policy

BL presented the High Consequences Infectious Diseases (Airborne) Policy

Resolved: SQAC received and RATIFIED the High Consequences Infectious Diseases (Airborne) Policy

23/24/229 Management & Prevention of Clostridioides Difficile (C.difficile) Policy

BL presented the Management & Prevention of Clostridioides Difficile (C.difficile) Policy

Resolved: SQAC received and RATIFIED the Management & Prevention of Clostridioides Difficile (C.difficile) Policy

23/24/230 Any other business - None.

23/24/231 Review the key assurances and highlights to report to the Board.

- SQAC received the positive Patient Safety Strategy update, and was pleased to note progress on the workstreams scrutinised in month.
- SQAC received the ED monthly report and recognised the continuing high volumes of patients compared to same time last year, and a level of performance which was remarkable given this

challenge. SQAC was pleased to note the continued focus on managing patient flows and achieving targets in this area.

- SQAC received the Quarterly Diagnostics Notification update, with comprehensive discussion held regarding the current position. A further report is requested in three months, which it is hoped will demonstrate progress in teams where the numbers of unacknowledged reports is mounting month on month.
- SQAC received the Quarterly IPC Report
- SQAC received the Inphase update, and lessons learned report: the learnings are relevant across the Trust and will be shared at Audit and Risk Committee.
- SQAC received the Baby E learning slides, with good discussion held; and
- SQAC received the Neonatal sepsis RCA's, with good discussion held. Common themes around escalation and communications are identified in both reports and subject to action plans. As early incidents utilizing the PSIRF methodology, retrospective review of the process will be useful in due course: meanwhile the Committee explored engagement with families, staff and CQC, and the progress of action plans.
- SQAC received the Board Assurance Framework
- SQAC received the Quarter 3 Mortality Report, noting that the incidents discussed above were not yet reflected in data; however, MRG had reviewed both incidents thoroughly and engaged with families.
- SQAC received the Clinical Audit & Effectiveness Annual Plan, highlighted the high level of activity and the need to seek to align activity to strategic priorities as far as possible, and to ensure loops are closed.
- SQAC received the Clinical Effectiveness and Outcomes Group Chairs Highlight report
- SQAC welcomed Rachel Isba and received the Health Inequalities & Prevention Steering Group (HIPSG) update 2023-February 2024. SQAC welcomed future update regarding future plans regarding health inequalities and the public health agenda and noted the need to pursue this inequalities agenda through other aspects of the Committees assurance work.
- SQAC received the Divisional updates with good engagement across all divisions.
- SQAC received the Commissioning for Quality & Innovation (CQUIN) Programme 2023/24
- SQAC received the Quality Assurance Rounds – Themes & Risks Biannual update and Quality Assurance Round Annual Report 2023/24
- SQAC received the Ward accreditation report and Annual Report, and noted the good work being undertaken here.
- SQAC received the Mobilisation of the Children and Young Peoples Gender Service (North) Report
- SQAC received, noted and APPROVED the Record keeping policy, and agreed that this would be further reviewed in 6 months' time.
- SQAC received, noted and APPROVED the High Consequences Infectious Diseases (Airborne) Policy
- SQAC received, noted and APPROVED the Management & Prevention of Clostridioides Difficile (C.difficile) Policy

23/24/230 **Date and Time of Next Meeting:** 24th April 2024 9.30 – 11.30 am via Microsoft teams

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	Children and Young People's Gender Service (North): Programme Update
Report of:	Lisa Cooper, SRO Children and Young People's Gender Service (North)
Paper Prepared By:	Emily Gardner, Programme Director Children and Young People's Gender 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
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
167	There is a risk that the new location for the Gender Service will not be ready by the agreed date of July 2024 to start seeing patients in, following the use of interim space from April 2024.	10
168	There is a risk that the research proposed to support the Children and Young People's Gender Service is not on track, and the scope and eligibility for research is not clear	12

1. Purpose of report

The purpose of this report is to provide an update to Trust Board regarding progress with the nationally commissioned Children and Young People's Gender Service (North).

2. Background

The Gender Identity Development Service (GIDS) was 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. The service closed on 31 March 2024.

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.

The final report of the Cass Review was released on 10 April 2024 and further updates are awaited from NHS England regarding next steps, it is expected that a final service specification will now be developed.

3. Summary of progress

The service commenced on the 01 April 2024 and as part of Phase 1 go live, is focusing on ensuring the safe transfer and support of the children and young people on the open caseload, who transferred from the previous provider. Referrals from the national waiting list will not commence until the service leadership team are assured that sufficient capacity is available. Receiving referrals from the national waiting list will be referred to as Phase 2 go live.

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

- Service update and feedback from young people
- Estates
- Workforce and recruitment
- Service risk register

4. Service update and feedback from young people

All children and young people transferred in the open caseload have been triaged by the North clinical team to ensure appointments are booked appropriately. The final transfer of all remaining data and records was completed by the previous service provider on 25 April 2024, with the final number of children and young people transferred to the new service being 109. An additional 2 files were received incorrectly which have been closed.

Welcome letters and information have been sent to all children and young people on the open caseload and appointments have commenced booking, with the first appointments being

undertaken w/c 08 April 2024. The service is currently on track to meet the agreed target with NHS England, to provide an assessment for the 109 children and young people by 31 June 2024.

To date 28 children and young people have been seen for a full face to face assessment. For the assessments completed, feedback has been requested from children, young people and families and it is clear the new service is providing reassurance to children, young people and families following an uncertain and turbulent time whilst the previous service provider was preparing to close. Some examples of feedback are provided below:

"I feel really reassured after today's meeting. I was anxious and worried before I came, and now I feel so much better. I feel like we will get the support we need. The ladies listened to us and understood us."

"Welcoming and friendly. Had a great rapport. Felt like we were listened to and that we were genuinely cared about".

"Open, friendly, honest".

"They were very funny, kind, sweet and understanding".

"Put at ease straight away. Friendly, informative and kind".

"Good to meet in person, and for them to meet [my child]".

"I felt very comfortable talking about ourselves, support we have had and support we would like. Our voices were listened to, and questions answered, that could be".

"Thank you for seeing us face to face!"

"I felt that the appointment went very well, and I was impressed with the level of care received".

"The café and the staff were amazing and really helpful".

5. Estates

Staff working within the service continue to use interim space across Alder Hey and Manchester sites whilst renovation work continues at the premises at Warrington. Staff space is due to be available to use from 20 May 2024, with all work remaining on track for early July 2024.

6. Workforce and Recruitment

Recruitment has continued with a focus on clinical roles which has been successful and there is a robust plan in place to support the induction of all staff into the service and Alder Hey. Staff will be commencing employment throughout April – June and to date the service has appointed 32.2 wte staff. Recruitment to clinical roles in the service has impacted on Alder Hey mental health services with currently 12 wte securing roles in the service.

7. Service Risk Register

Following the commencement of the service on 01 April 2024, risks have been developed and managed on InPhase as per Alder Hey governance processes.

To identify appropriate risks, CQC reports relating to the previous service provider and the Cass Review have been reviewed to ensure lessons learned are identified. Whilst the service risks focus on those which the service can impact or control, the external landscape relating to this

service continues to be high profile, complex and sensitive with many challenges. Therefore, additional risks which may impact on the wider Alder Hey will continue to be identified and included in the corporate risk register as required.

8. Recommendation

It is recommended that Trust Board note the service progress including the positive feedback received in relation to the assessments provided to date.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	**Futures Committee**
Report of:	**Shalni Arora, Non-Executive Director**
Paper Prepared by:	**Shalni Arora, Non-Executive Director**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information:	This paper provides a summary from the recent Futures Committee meeting held on 16th April 2024, along with the approved minutes from the meeting of the Research & Innovation Committee held on 18th January 2024.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☑ **Strong Foundations** ☐
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐					
Risk Number	Risk Description				Score
	Insert BAF risks relevant to Futures				
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

Introduction

To provide an update to the Trust Board on the previous Futures Committee meeting held on 16th April 2024.

1. Agenda items received, discussed / approved at the meeting:

- Draft Research and Innovation Committee Annual Report, 2023/24
- Futures Committee Purpose and Ways of Working
- Current Status of Futures Disciplines
- Presentation on collaboration with Wavelength
- Progress Update on Futures Strategy Document and Implementation Plan
- Updates on the four Pillars of the Futures Strategy
- Investment Zone Update
- Strasys Partnership Update
- Overview of Risk Registers
- Board Assurance Framework and Risk Appetite

2. Key risks/matters of concern to escalate to the Board (include mitigations)

None reported; however, following discussions the risk level and appetite will be refined and discussed at the next meeting.

3. Positive highlights of note

This is a new Committee with a great deal of work ahead in implementing the Futures Strategy. The Futures Committee meeting was held soon after the Strategy Board meeting at which the Futures strategy was presented to Board.

4. Issues for other committees

None reported.

5. Recommendations

The Board is asked to note the Committee's regular report and the approved minutes from the final meeting of the Research & Innovation Committee held on 18th January 2024.

Alder Hey Children's NHS Foundation Trust

Research and Innovation Committee

Confirmed Minutes of the meeting held on **Thursday the 18th January 2024**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. J. Grinnell	Managing Director/Chief Finance Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Dr. F Marston	Non-Executive Director	(FM)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. D. Cole	Senior Project Adviser	(DC)
	Mr. D. Hawcutt	Clinical Director of Research	(DH)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Ms. S. Leo	Head of Research	(SL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. L. Rad	Lead Research Nurse	(LR)
Observing:	Ms. F. Ashcroft	CEO of the Charity	(FA)
Item 23/24/56	Dr. L. Oni	Senior Lecturer in Paediatric Nephrology/ Honorary Consultant Paediatric Nephrologist	(LO)
Apologies:	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Ms. K. Birch	Academy Director	(KB)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)

23/24/52 Apologies

The Chair noted the apologies that were received.

23/24/53 Declarations of Interest

There were none to declare.

23/24/54 Minutes of the previous Meeting

The minutes from the meeting held on the 6.11.23 were agreed as an accurate record of the meeting.

23/24/55 Matter Arising and Action Log

Matters Arising

There were none to discuss.

It was confirmed that the actions on the log will be addressed during specific items on the agenda.

23/24/56 Progress and Prospects: Proposed LifeArc Funded UK Centre for Rare Kidney Diseases

The Committee received a presentation on the proposed LifeArc funded UK centre for rare kidney diseases. The funding will enable the design of a UK wide multicentre platform for kidney research which is also an exemplar for all rare disease specialities. A number of slides were shared that provide the following information:

- Overarching view of the of the UK Kidney Ecosystem *(a community united to stop kidney failure).*
- Rare kidney diseases;
  - Childhood kidney failure is due to rare diseases which are devastating and very expensive.
  - For rare diseases treatments need to reach children at scale.
  - There is an urgent need to transform rare disease research.
- Systemic exclusion of children;
  - A summary of the UN convention on the rights of the child (Article 6, 12 and 24).
- Inequalities;
  - Socioeconomic barriers preventing CYP living with long-term health conditions form achieving optimal outcomes.
- Time for change.
- Transformation.
- Highly collaborative community.
- A rare disease ecosystem;
  - Ecosystem proof of concept.
- Barriers to success.
- UK Kidney ecosystem will commence in Liverpool therefore it is imperative that Alder Hey becomes a trial ready hospital.

It was pointed out that the work that has taken place to develop a rare disease ecosystem feels very much like Vision 2030 in action in terms of cutting across communities and health inequalities. The Committee was advised that it has taken a huge team effort to reach this point and the project has been extensively scoped out in order to align systems and unite people. It was reported that the Trust's research structure aligns with this work and Alder Hey and therefore is able to support the UK Kidney Ecosystem.

It was queried as to whether there will be opportunities for other rare diseases to come to the fore so that an ecosystem can be created to support drugs and therapeutic interventions. It was reported that screening is expanding significantly, and generation studies are due to commence in April 2024 to look at providing a diagnosis during childhood rather than when the patient presents in early adulthood. There will be a boom in medicines that will treat genetic diseases and when this happens children will want to be treated locally therefore it is imperative that they are able to access treatment in their local environment. It was agreed to discuss this matter further outside of the meeting and invite members of the Children's Alliance to join the discussion.

23/24/56.1 Action: LS/LO

The Chair queried as to how this work will be captured as deliverables against the Research strategy. It was felt that this should be mapped out against the research

road map and included in the Futures Strategy to monitor the Trust's performance in terms of its role as a centre to help others scale up practice.

0137

Resolved:
The Committee noted the progress and the prospects of the proposed LifeArc funded UK centre for rare kidney diseases.

23/24/57 Research Strategy Update

The Committee received the final version of the Alder Hey Research Strategy, 2024-2030. An overview of the strategy was provided which included information on the following areas:

- Strategy development.
- Children and Young People's priorities.
- The Strategy and its strategic aims *(transforming children's futures, through cutting-edge research).*
- The themes;
  - Drivers of theme development.
  - Socio-economic inequalities and health.
  - Neuroscience, child development, and mental health and wellbeing.
  - Infection and inflammation.
  - Healthcare interventions.
  - Healthcare design and delivery.
  - Fundamentals.

It was reported that the development of the strategy was undertaken in association with CYP and has been socialised internally and externally to provide clarity on what it is that the Trust is trying to achieve. The Trust is committed to reporting on progress towards its objectives on an annual basis to the same groups of stakeholders whom it engaged with in order to develop the strategy. Objectives will be refreshed taking into account stakeholder feedback and changes to the health research landscape.

The Committee was asked to review and approve the Alder Hey Research Strategy (2024-2030) with the understanding that finalising the implementation and financial plans are key prerequisites for its successful delivery.

Thanks were offered to the team for the outstanding work that has taken place to produce the strategy and feedback on the document was provided by Committee members, as follows:

- Give thought to how the strategy is socialised with Alder Hey's partners ahead of the launch.
- A suggestion was made about including a number of case studies in the strategy to bring it to life.
- Look at the possibility of developing a Communications Strategy with the view to making the strategy accessible for all ages and groups.
- Include narrative early on in the strategy to describe what success looks like.
- Have an understanding of benefits in order to understand the return and impact.
- *Clinical Trials* - Look at having a fast fail process as this will save money.

Following discussion, the Committee approved the strategy on the understanding that a Communications Plan will be progressed, and a case study will be included in the document.

The Chair pointed out that the Research Strategy needs to be approved initially to enable work to commence on the Implementation Plan and the Financial Sustainability Plan. The Committee approved the Research Strategy and agreed

that the Implementation Plan and the Financial Sustainability Plan will be submitted to the Committee in April for approval.

23/24/57.1 Action: DH

Resolved:
The Research and Innovation Committee approved the Alder Hey Research Strategy; 2024-2030 on the understanding that the Communications Plan is progressed, and a case study is included in the strategy.

23/24/58 Futures Strategy Update

The Committee received an update on the current position of the Futures Strategy. A number of slides were shared that provided information on the following areas:

- What is Alder Hey Futures?
  - Our mission.
  - Inspired by.
  - Disciplines collaborating.
  - Core principles.
  - Priority programmes of work.
  - Breakthroughs with impact.
- Four big programmes for multi-disciplinary collaboration.
- Case study of what Futures can do.
- Northern Institute for Child Health and Well-being.
- What we've been doing.
- Engagement in Q2/Q3 .
- Investment, solutions, and pipelines in Q2/Q3.
- Critical success factors.

John Chester responded to questions that were raised about artificial intelligence (AI) in relation to the Trust's vision, the leverage of a potential partner's work that could be applied to CYP, and how AI will fit into countrywide systems and processes that are being developed. A discussion took place, and a number of examples were provided of where AI could be used to align with the Trust's agendas. Attention was drawn to the importance of being specific on what it is the Trust wants to use AI for and having the support of a large technology partner to enable this area of work to be progressed.

Suggestions were made about conducting a piece of leadership work on AI and having a strategic place holder to review new AI opportunities as they arise. It was pointed out that AI is integral to the success of Futures, and it was felt that it would be beneficial to focus on this area of work at an upcoming Strategy Board in order to bring it to life.

Resolved:
The Research and Innovation Committee noted the update on the Futures Strategy.

23/24/59 Potential Futures Committee

The Committee received the proposed Terms of Reference (ToR) for a new governance structure in the form of the Futures Committee. A discussion took place on the evolution of the Research and Innovation Committee into a Futures Committee with a broader remit. Committee members were asked to provide comments on the draft ToR. The following points were raised:

- *iDigital* – It is important to be clear on what is in/out of scope to ensure the Committee doesn't get caught up in the operational elements of iDigital.
- It was suggested that financial decisions/investment opportunities should be submitted to RABD for approval rather than the Futures Committee.

- Attention was drawn to the importance of determining the areas of assurance that need to be reported into the Audit and Risk Committee and RABD.
- It was felt that the Futures Committee needs to be a place where ideas can be brought together to address central problems, have a shared capability and bring the power of the Executive team into this space.
- Review the membership to ensure that the right people are sitting on the new Futures Committee.
- Consider including research studies in the governance reporting framework to ensure this element of assurance doesn't get lost in the system.
- Describe in greater detail the role and purpose of the Committee.
- Look at addressing the operational elements of research and innovation via another route to enable the Futures Committee to focus on the work that sits behind the Futures Strategy.

Committee members agreed to provide John Chester with any further comments that they may have on the draft ToR.

23.24.59.1 Action: All

Resolved:
The Research and innovation Committee approved the draft Terms of Reference pending amendments as per the feedback received from committee members. It was agreed that the inaugural meeting of the Futures Committee will take place on the 16.4.24.

23/24/60 Strasys Partnership Update

The Committee was provided with a high-level summary of the status of the Strasys partnership and the progress that has been made to date.

An overview of the work programme was shared with the Committee, and it was reported that in order to manage and test the collaborative process the Strategic Partnership Board has identified two distinct groups of potential products for initial focus, designated as wave 1 and wave 2.

Wave 1 has been agreed and the five products in this group are ready to be qualified and commercialised. This work has already begun and subject to Partnership Board approval, the Strategic Partnership will look to take some of these to market in Q1 of 2024. A discussion took place around the financial element of the partnership and Adam Bateman responded to a question raised by the Chair regarding income.

Resolved:
The Research and Innovation Committee noted the update on the Strasys partnership.

23/24/61 Innovation Strategic Inward Investment Update/Investment Zone Update

The Committee was provided with an update on the investment zone funding opportunity within the Liverpool City Region Combined Authority (LCRCA).

The LCRCA has advised of the annual spend profile and reported that a prioritisation exercise will need to take place to determine the order in which projects will progress through the process. To support this, further information about all projects has been requested. Priority will be given to those LCR projects demonstrating an urgent requirement to draw down funding across 2024/2025.

The Committee discussed this area of work in detail, and it was agreed to compile a report that includes financials to respond to the request made by LCRCA. The

report will initially be submitted to RABD and the Executive team for scrutiny ahead of submission on the 29.1.24, and an update will be shared with the new Futures Committee in April.

0140

23/24/61.1 Action: JC/AB/RL

Resolved:
The Research and Innovation Committee noted the innovation strategic inward investment update/Investment Zone update.

23/24/62 Innovation Finance - Management Accounts, Q3

The Committee received a Q3 finance update for the Innovation department. A number of slides were shared that provided information on the following areas:

- Total innovation position for 2023/24 by spend type.
- Total innovation position for 2023/24 split by capital/revenue/other.
- Total innovation position for 2023/24 – Funding streams analysis.

It was queried as to why details of the pipeline hadn't been included in the update. It was confirmed that this was an oversight and that information on grants would be circulated to Committee members outside of the meeting.

23/24/62.1 Action: EK

Resolved:
The Research and Innovation Committee noted the Q3 finance update for innovation.

23/24/63 Research Finance - Management Accounts, Q3.

The Committee received a Q3 finance update for research. A number of slides were shared that provided information on the following areas:

- Total research position for 2023/24 by spend type.
- Total research forecast position for 2023/24 split by activity.
- Total research position for 2023/24 – Funding streams analysis.

Reference was made to commercial income, and it was queried as to whether this item could be addressed in detail during a future meeting to gain greater understanding of the data and to look at the landscape in terms of how it fits with the Trust's aspirations. It was pointed out that the Trust will have to be radical in terms of finding additional resources, but it was confirmed that commercial data can be presented during a future meeting.

23/24/63.1 Action: DH

A discussion took place about the LifeArc grant from a benefits perspective and an overview was provided of the process for awarding the grant.

Resolved:
The Research and Innovation Committee noted the Q3 finance update for research.

23/24/64 Research Performance Report for Q3

The Committee was provided with a summary of the performance of the Clinical Research Division in Q3 (Oct-Dec 2023) across key workstreams including research support, research delivery, strategic programmes and partnerships and the Clinical Research Facility. An overview of the following areas was provided:

- Highlights and successes; including the strategic partnership workstream within the division for the MRI scanner,
- Strategic research programmes and partnerships.
- Progress toward 2023/24 improvement priorities.
- Staff engagement.

A discussion took place about the closure of the DETECT study and what it means for the distribution of funding.

The Chair drew attention to the importance of setting time aside to discuss which operational performance reports will be submitted to the new Futures Committee.

Resolved:
The Research and Innovation Committee received and noted the Innovation Performance Report for Q3, 2023/24

23/24/65 Innovation Performance Report for Q3.

The Committee received the Innovation Performance Report for Q3, 2023/24. An overview of the following areas was provided:

- 2023/24 operational plan KPIs.
- HR metrics.
- Risk summary.
- New to pipeline for 2023/24.
- Pipeline performance data.
- Priority, active and deployed project updates – forward look.
- Commercial summary.
- Brand and marketing.

Resolved:
The Research and Innovation Committee received and noted the Innovation Performance Report for Q3, 2023/24

23/24/66 Commercial and Partnership Monitoring Update

The Committee received the innovation commercial monitoring report and was provided with an update as at the 11.1.23 on the following areas:

- Highlights for the period.
- Commercial product opportunities solution.
- Co-creation/partnership agreements.
- Partnerships.
- Looking ahead in 2023/24.

A discussion took place regarding Palantir and it was agreed to keep the Committee updated on negotiations.

23//24/66.1 Action: DC

A query was raised about the progress of the mask agreement. An update was provided, and an action was taken to discuss this area of work with the Innovation Board with the intention of formally closing the partnership.

23/24/66.2 Action: DC

Resolved:
The Research and Innovation Committee noted the commercial and partnership monitoring update.

23/24/67 Acorn Partnership Update

0142 The Committee received an update on the progress that has been made in terms of the two companies that Alder Hey is trying to exit. It was confirmed that a meeting is taking place w/c 22.1.24 with the Trust's lawyers to make sure there are no underlying issues that could affect the exiting of the agreement.

Resolved:
The Research and Innovation Committee noted the Acorn Partnership update.

23/24/68 Board Assurance Framework (BAF) Report

The Committee received the Board Assurance Framework Report (BAF) for December 2023. It was reported that the Research and Innovation risk has been re-written.

Resolved:
The Research and Innovation Committee noted the contents of the BAF report for December 2023.

23/24/69 Any Other Business

For noting
Reference was made to the expression of interest to host a mobile research unit. Committee members were asked to liaise with John Chester if they would like to use the mobile unit for any projects that they may be involved with.

23/24/70 Review of the meeting

The Chair felt that the meeting was very productive and thanked everyone for their feedback on the various agenda items discussed during the meeting. It was felt that the presentation that was shared with the Committee by Dr. Louise Oni was very interesting and helped bring the Vision 2030 Strategy to life. It was confirmed that there was nothing to raise with other Assurance Committees.

Date and Time of the Next Meeting: Tuesday, 16th April 2024, 9:30am-12:30pm, VEC Meeting Room, Innovation Hub, Alder Hey.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	People Plan highlight Report.
Report of:	Chief People Officer
Paper Prepared by:	Sharon Owen, Deputy Chief People Officer

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during February/March 2024.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
#2664 #16 (2.1 BAF)	Industrial strike action impacting staff availability. Workforce sustainability and Development	12 15

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

1. Executive Summary

The purpose of this paper is to provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during March/April 2024.

2. Current Position

2.1 Workforce Metrics

The monthly workforce metrics are provided in the monthly Integrated Performance Report (IPR). Complete sickness figures for April 2024 are not available at the date of this report writing, information is based on March 2024 data.

Key highlights from the workforce metric data:

Sickness at 4.74% is below the Trust target of 5.5% and has decreased since January 2024. Sickness absence is largely driven by long term sickness absence at 3.10% with 1.64% Short Term sickness absence. Divisional HR Business Partners are supporting divisions to ensure that there are action plans in place to support all staff on long term sickness.

Turnover at 10.2% has reduced month on month consecutively for 11 months and below the Trust's annual target of 13%. Retention initiatives are proving successful in reducing high levels of turnover.

Personal Development Reviews (PDR's) PDR compliance as of March 2024 was 76% albeit this figure has significantly increased throughout April, with considerable focus on improving this position. It is anticipated that the organisation will reach 90% target by 30th April 2024.

2.2 Industrial Action

BMA **consultant** members have **voted to accept** the new pay offer negotiated between the Government and BMA Consultant Committee has been accepted by BMA Consultant colleagues. Eligible BMA consultant members voted 83% (turnout 62%) to accept the offer. The effective date for the new pay structure will be 1st March 2024 (backdated; confirmation of date this will reach pay is pending). This draws BMA consultant industrial action to a close.

Following the rejection of the offer for **SAS** doctor colleagues, the BMA SAS committee have indicated that they will enter discussions with the Government about another pay offer ahead of calling for strike action (which they have a mandate for).

The BMA **successfully re-balloted junior doctor** members in England (ballot closed 20th March 2024); 61.86% of those eligible voted in the ballot, with 97.97% voting in favour of strike action, and 97.08% voting in favour of action short of strike. No further strike dates have been released for junior doctors in England or Wales.

2.3 Organisational Health and Wellbeing

The Health and Wellbeing Steering Group continues to meet 6 weekly to focus on Organisational HWB, as outlined by NHSE and to provide assurance against the 9 WB Guardian principles.

Following a baseline assessment against the NICE Wellbeing at Work guidance in 2023, Physical HWB was identified as a priority area and a task and finish group was set up. Addressing staff wellbeing following traumatic incidents has also been an area of focus leading to the development of a Debriefing Guidance and pathway, in collaboration with the EPRR lead to ensure that all staff know and have access to the opportunity for a group psychological debrief following a traumatic incident. There is also work underway as part of the new patient safety strategy to ensure that staff wellbeing is considered routinely when incidents are raised. Postvention support in the event of a suicide in the organisation, is a programme of work being led by the SALS Clinical Lead and Deputy Chief People Officer who are developing local guidance.

3 Conclusion and next steps

- A detailed review of areas of high sickness, identifying correlations with low levels of Return-to-work compliance and Occupational Health DNAs to explore bespoke interventions to improve the position.
- Review data on PDR completions per division with targeted action plans

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	**Highlight report- Equality, Diversity, and Inclusion**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Angela Ditchfield, Head of Equality, Diversity, and Inclusion

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	This report provides the board with an overview of the recent equality, diversity, and inclusion activity undertaken in the trust during April 2024 including updates from our staff networks
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Implications:	

1. Introduction

This paper aims to give the Board a high-level overview of the critical strategic and operational activity regarding Equality, Diversity, and Inclusion (EDI) during April 2024.

2. Quality Round

The Equality, Diversity, and Inclusion team were invited to present at a Quality Ward Round supported by the Youth Forum and Patient Experience Team. Chris Browne from the EDI team developed a survey for our children, young people, and their families. The aim was to gather information regarding how inclusive their experiences have been whilst visiting Alder Hey and to discover how we could better support them. The Youth Forum supported the team to gather this information from patients and staff on the wards, outpatients, and the emergency department. The initial feedback was encouraging, and we will continue to share with all divisions and departments to ensure that we have a good understanding of how we can better support our staff, children, young people, and their families. Once all the data has been collected and analysed, we will use this to identify any key themes and areas for development.

3. Staff Networks

Our fantastic developing staff networks continue to grow from strength to strength and staff have found them to be a positive support.

- **LGBTQIA+ staff network**: The network has been approached by other departments regarding the delivery of the Allyship training programme following the successful launch to the Finance team. The network will continue to deliver the training providing staff with an understanding of how they can actively support the staff network by becoming an Ally. Planning for PRIDE 2024 continues and our staff network have been working collaboratively with other local trusts. The plan will be to match together with other Liverpool NHS trusts.
- **REACH staff network:** We recently invited staff to submit an Expression of Interest to take on the role of REACH staff network chair role. The closing date is the 23rd of April, and we are hoping that there will be lots of interest and we

can appoint a new chair to continue to drive forward the staff network objectives.

- **Armed Forces staff network:** The staff network is organising a social meeting to encourage armed forces children, young people, and their families to come together and spend some time in a safe space with others from armed forces backgrounds. They continue to promote the group within Alder Hey, providing support to staff, children and young people and their families.
- **ACE Disabilities and Long-Term Conditions staff network** continues to be a positive influence, supporting staff and driving forward positive change that impacts both on our staff and our children and young people. The last meeting saw the launch of the new hidden disabilities signs which will be displayed across the trust to highlight that not all disabilities are visible, and we all need be kind to each other. The network is also supporting the development of the Strong Foundations, Management Essentials EDI training course and will be filming their lived experiences which will support the training programme.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
April 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 2nd May 2024

Report of:	FTSU Guardian
Paper Prepared by:	FTSU Guardian
Subject/Title:	Freedom to Speak Up – Progress Update Report
Background Papers:	FTSU Board reports from September 2016 onwards NGO Guidance Staff Survey
Purpose of Paper:	To provide the Board with a summary of progress to date to improve and enhance mechanisms for staff to raise concerns and describe the actions planned for the coming period
Action/Decision Required:	The Board is asked to note the progress made to date and to support the further actions outlined
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Best people doing their Best Work**
Resource Impact:	To be identified

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP ANNUAL PROGRESS REPORT

1. Purpose

The purpose of this paper is to provide the Board with a summary of the activities of the FTSU team for 2023/2024 including the Q4 data and to outline the actions planned for the coming period.

2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed.

3. FTSU annual Activity

The tables below are taken from the National Guardians Office portal, for submitted data (the only exception being Q4 data 2024 as this has only recently been submitted however the data is correct), the data demonstrates an increase in staff using FTSU to raise concerns, between 2022-2023 and 2023-2024.

The Freedom to Speak Up Guardians hours were increased in March 2023, following this increase, and the FTSU visibility programme, there has been an escalation in prominence of the FTSUG across the organisations, thus allowing staff greater access to the FTSUG and their ability to raise concerns via this route.

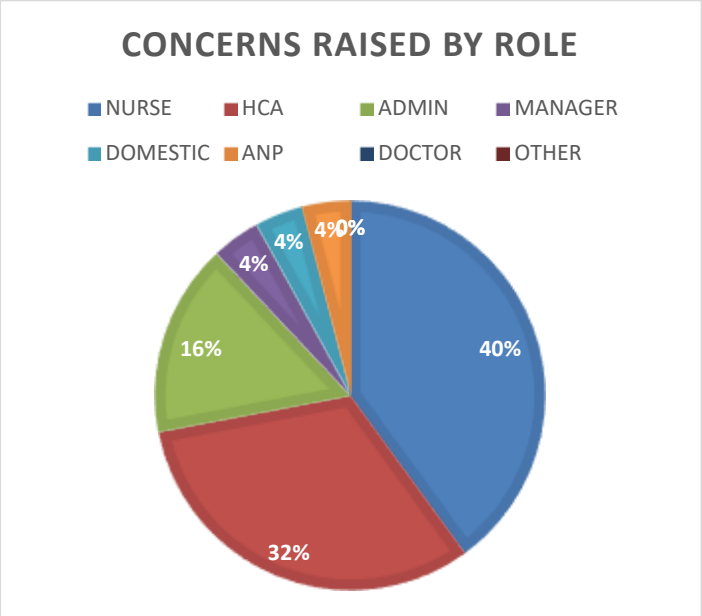
2022/2023

Alder Hey Children's NHS Foundation Trust	Q1 2022/2023	North West	8
Alder Hey Children's NHS Foundation Trust	Q2 2022/2023	North West	18
Alder Hey Children's NHS Foundation Trust	Q3 2022/2023	North West	16
Alder Hey Children's NHS Foundation Trust	Q4 2022/2023	North West	20

2023/2024

Alder Hey Children's NHS Foundation Trust	Q1 2023/2024	North West	28
Alder Hey Children's NHS Foundation Trust	Q2 2023/2024	North West	27
Alder Hey Children's NHS Foundation Trust	Q3 2023/2024	North West	32
Alder Hey Children's NHS Foundation Trust	Q4 2023/2024	North West	25#

4. Q4/ Data



Contacts by Professional Groups

There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a range of worker/professional groups and levels of seniority.
A comprehensive definition for professional groups forms part of the updated guidance.

Recording Cases and Reporting Data (nationalguardian.org.uk)

Themes highlighted in bold are reported as part of the mandated quarterly data collection and returned to the National Guardian's Office.

Theme	Open	Closed	Total

Patent Safety and Quality	0	0	0
Worker Safety and Wellbeing	0	0	0
Inappropriate Attitudes and Behaviours	6	3	9
Policies, Processes, Procedures, Systems	7	0	7
Infrastructure/Environment	1	1	2
Cultural	6	1	7
Leadership			0
Senior Management Issue			0
Middle Management Issue			0
Total	20	5	25

*Speak Up cases often contain multiple themes; therefore, data sets do not always equate together. Issues are recorded under the workers own description.

Of the 20 cases that remain open in Q4:

- 7 are awaiting an outcome from managers,
- 4 are open, relating to one area, where an action plan is being created to address the issues raised,
- 3 are paused as the members of staff wanted to take some time before they progressed/or not,
- 2 are due to close however the closure meeting has not taken place
- 2 are pending decision as to whether their concerns follows a formal route of investigation
- 1 remains open due to no contact but will close within the month if this remains the same
- 1 is open as the escalation meeting with senior leads has not yet taken place

Inappropriate Attitudes and Behaviours

There were 9 issues raised in Q4 in this category these were related to the breakdown in relationships between staff members, poor behaviours not being challenged and addressed by leadership teams, poor team culture and a lack of good communications strategies. Staff continue to be supported throughout this process by the FTSUG, being provided with options that they may wish to explore and are always encouraged to seek the support of their managers.

Policies, Processes, Procedures, Systems

There were 7 issues or concerns raised in this category in Q4. These relate to policy and process and the approach that has been taken by managers as a result of their interpretation of the policy, which has had, in some cases, a negative impact on the individual. There continues to be ongoing support from HR and OD, in providing training to managers regarding our employment policies, which will hopefully see a decline in these types of concerns.

Infrastructure/Environment

The 2 issues raised in relation to infrastructure, were centred on the availability of resource, in terms of staffing, equipment and structure. The 1 case that remains open does have an agreed action plan to address the concerns raised, however these have not yet been implemented therefore the case remains open.

Culture

The 7 cases relating to culture are focused in one area, there have been a number of meetings with senior leads to raise these concerns and recently an agreement that a clear action plan would be created to address all concerns raised, plus a focus on the development of a communication strategy that would aid relationships within the area and improve engagement

Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again scoring the process highly in terms of satisfaction. Previously staff, when responding to the question '*when people speak up in this organisation, things change'* were indicating by 33%, that this was not the case, however recently this has decreased to 16.7%, demonstrating an improvement.

To view results from the questionnaire post closure please click on the link below:
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=OVmEMfpVb8x8dRhYPVxLZDFdyaHIx6lu&id=G888R1c5sE6Cur6KaqH2Sri2S89zA4NJtHQSSVjh0UBUQktJNk5OWUNCN01YUVNOWjlSTkVQSFBDMC4u

5. Staff Survey results 2023

Question	Response 2022	Response 2023	National Best	Average results	Worst results
Q20a I would feel secure raising concerns about unsafe clinical practice.	76.81%	77.51%	77.96%	70.24%	63.19%
Q20b I am confident that my organisation would address my concern.	65.68%	66.91%	69.29%	55.90%	43.62%
Q25e I feel safe to speak up about anything that concerns me in this organisation	68.02%	70.19%	73.98%	60.89%	50.32%
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	57.55%	60.17%	66.13%	48.65%	35.26%

The responses to these 4 questions have positively increased, as have the number of responses and whilst slightly below the national best, we are significantly above the average results. These responses are encouraging however it does still demonstrate that 26.02 % of our organisation do not feel safe in raising anything that concerns them and 33.87% are not confident that their concern would be addressed, therefore there is still work required to ensure that we are creating the correct conditions for staff to raise concerns and to feel that they are then acted upon.

6. FTSUG Visibility Programme

This program continues and to date the FTSUG has visited 23 of the 30 wards/departments identified and expressing an interest in a FTSU visit. The response from staff has been encouraging and the aim to increase visibility and promote the principle of FTSU has been successful, which may well be demonstrated in the increase of staff numbers through the FTSU service.

The visits are planned, and time is spent with the department/ward manager so that a greater understanding of the area can be established and any challenges they may be experiencing, this is rich intelligence and helps provide context to the FTSUG should any concerns arise from that area in the future.

There is no planned end date to this programme, and this will become business as usual for the FTSUG in the year ahead.

7. MIAA Audit

As previously indicated, the FTSU service has recently been subjected to an MIAA audit, with an overall assessment of 'substantial assurance', there are 5 recommendations outstanding, below is a summary of the current position regarding these recommendations:

- Recommendation – The Trust should ensure all staff members complete their Freedom to Speak Up E-learning. April 2024 compliance is currently 89.72%, please note that this training was only mandated in August 2023, therefore this uptake should be considered with that in mind.
- Recommendation – The Trust should implement and embedded the new Risk Management system 'InPhase' for the logging of Concerns. April 2024 Currently it has not been possible to use the InPhase system to report and capture FTSU concerns, as this does not comply with the guidance indicated by the National Guardians Office in terms of staff confidentiality, this has been raised with the CNIO for this system and we are currently Awaiting system upgrade.
- Recommendation – The Trust should identify individuals with the skills and competencies required to be a Deputy Freedom to Speak up Guardian and who can make a positive impact. April 2024 The Business case is due for submission, once this process is completed, the role will be advertised as per our trust process.
- Recommendation – The Trust should share Lessons learnt through the Trust to prevent the same issues being repeated. September 2024 This is still in development but should deliver by the implementation date of September 2024.
- Recommendation – The Trust should provide a Freedom to Speak Up Annual Report. April 2024 This paper forms part of the annual report however further development is underway.

8. FTSU Champions

FTSU Champions remain an important element of the FTSU service, their promotion of the FTSU service, the FTSU training modules, Speak Up, Listen Up and Follow Up and their signposting of staff to the FTSUG, is a valuable form of communication and engagement that benefits staff and the organisation. We continue to recruit into this role, to ensure it is reflective of our organisation's diverse population, recently we have recruited from our consultant body and hope to expand this further.

Recently the FTSUG and the lead for the SALs Pals, met to look at creating a model that would see the SALs Pals and the FTSU Champions working collaboratively. We are aiming to have a standardised approach for both groups, which is in development but will include how we recruit our champions so that managers are very much part of this process, we will also look at how the intelligence gained, can be shared with ward/departmental leads and how this relationship can be built upon and to also look to develop a FTSU Champion guidance document that will mirror that of the SALs Pals guidance. The plan is to share the progress of this work with the triumvirate for each division, for their review.

As this work progresses the Board will be provided with regular updates.

9. FTSU APP Development

The FTSU app has now progressed to the developer stage, with a timeframe for the first draft to be approximately 2-3 weeks, discussions between the FTSUG and the assigned developer continue, this is to ensure that the app provides all aspects of a case journey and beyond, which would include regular reviews post closure to monitor detriment.

Kerry Turner
Freedom to Speak Up Guardian
April 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	**Freedom To Speak Up Review Tool for Boards**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Director of Corporate Affairs

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The report provides a snapshot of Alder Hey's FTSU arrangements against the various parameters set out in the National Guardian's Office review and planning tool, together with suggested areas for improvement.
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:	Funding for Deputy FTSUG

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
BAF 2.2	Organisational culture	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		

0155

National Guardian
Freedom to Speak Up

NHS
Alder Hey Children's
NHS Foundation Trust

Freedom to Speak up

A reflection and planning tool

0156

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

Enter summarised commentary to support your score.

The FTSU Guardian is a full time post directly line managed by the Executive lead. The NED lead meets with the FTSUG and myself as Exec lead as a triumvirate on a monthly basis to ensure line of sight of all key issues of concern. In addition the FTSUG also has monthly one to one meetings with the Chief Nurse and Managing Director. Quarterly formal reports to the Board have been in place for a number of years and have continued to develop.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Implement actions from MIAA audit including recruitment of Deputy Guardian
2 Continue to ensure Alder Hey's speaking up arrangements reflect best practice and guidance from the NGO

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I am confident that the board displays behaviours that help, rather than hinder, speaking up	Yes
I effectively monitor progress in board-level engagement with the speaking-up agenda	Yes
I challenge the board to develop and improve its speaking-up arrangements	Yes
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am involved in overseeing investigations that relate to the board	N/A to date
I provide effective support to our guardian(s)	Yes

Enter summarised evidence to support your score.

The NED lead meets on a monthly basis with the FTSUG and Executive lead in order to receive updates on concerns raised, any trends, national or local developments and future plans. The NED lead has continued to focus on information provided to the board on a quarterly basis to improve transparency in terms of process whilst maintaining confidentiality. The NED lead has been proactive in raising the profile of her role through communication mechanisms such as 'Ask the Execs' and this has resulted in some members of staff seeking direct access to her as the NED lead. She has had direct oversight of one investigation (not relating to the board) and has been satisfied with the process surrounding this.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 As chair of the Audit Committee, ensure that the actions from the MIAA audit are tracked.
2 Continue to champion speaking up at board level and attend any relevant national or system level events

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	Yes
We regularly and clearly articulate our vision for speaking up	Yes
We can evidence how we demonstrate that we welcome speaking up	Yes
We can evidence how we have communicated that we will not accept detriment	Yes
We are confident that we have clear processes for identifying and addressing detriment	Yes
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	Yes
We regularly discuss speaking-up matters in detail	Yes

Enter summarised evidence to support your score.

In 2023/24 the Board approved an FTSU strategy position statement in support of the Trust's Vision 2030 and underpinning People Strategy. The Board also approved the FTSUG's proposal to include the national Speaking Up training module as mandatory training for all staff. The Trust has had in place an annual Speaking Up week for a number of years and the Guardian has a well-publicised programme of visibility visits to all areas of the organisation including community locations. The Guardian uses these occasions to communicate key messages with regard to speaking up principles at Alder Hey including unacceptable behaviours that should not be tolerated by staff. The Guardian was an influential figure in the development of the Trust's Respect at Work policy and signposts staff to this and other routes as appropriate. Our most recent staff survey results demonstrate the Trust's continued progress in this area.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1 Invite FTSU Champion team to a Board meeting at least annually to broaden collective knowledge and understanding and invite feedback

2

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes

Enter summarised evidence to support your score.

A central pillar of the Trust's People Strategy is to ensure we foster a culture and environment in which all of our staff can thrive and develop. The adoption of a Just and Restorative culture is part of that development and is woven through key aspects of our work including the Patient Safety strategy, delivered via the Patient Safety board. FTSU is a recognised tool in the patient safety strategy and the Guardian regularly spends time with teams in order to support individuals who have experienced safety incidents and need support through the learning process. The Guardian has developed strong relationships with the chairs of the staff networks and has worked in partnership with them on specific cases.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Continue to develop the FTSU data set and triangulation with other information sources such as SALS, incidents and concerns raised through other routes.

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Yes
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	No
Enter summarised evidence to support your score. The Board took the decision to create a full time Guardian role in 2023. A business case for the creation of a formal part time Deputy role is yet to be approved. This is necessary as the NGO is clear that Champions cannot hold their own case load so the current position is not sustainable	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Finalise business case for FTSU Deputy in accordance with MIAA recommendation.	
2 Consider succession plan for Guardian role over the next 12 months.	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	Yes

Enter summarised evidence to support your score.

The national Speaking Up policy was adopted by Alder Hey in September 2022 which was in advance of the mandated deadline. Alder Hey has a centralised Document Management System which contains all policies, accessible on the Trust intranet. In addition, a managers' guide to handling concerns raised by staff was developed as a companion to the policy which contained a variety of helpful examples and scenarios.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Ensure the policy is referenced routinely in FTSU communications plans.

2 FTSUG to signpost to policy at induction sessions.

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	Yes
We tell positive stories about speaking up and the changes it can bring	Yes
We measure the effectiveness of our communications strategy for Freedom to Speak Up	No

Enter summarised evidence to support your score.

The Trust's internal communications manager has worked closely with the Guardian from the beginning of her tenure and they have developed a rolling comms plan that has included the development of visual collateral such as banners and lanyards, through to the annual Speaking Up Week in October which over time has used mechanisms such as pledges by senior leaders in relation to speaking up. The Guardian has also supported colleagues to bring their experiences to board meetings through the 'Staff Story' slot.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider a methodology for measuring the impact of FTSU comms other than the annual staff survey metrics.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes
Our HR and OD teams measure the impact of speaking-up training	No
Enter summarised evidence to support your score. The board approved the proposal to include the NGO training as mandatory for all staff during 2023. The Guardian has a specific session with new starters at each corporate induction.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 The Guardian to engage with the Head of Learning and Development to consider how the Speaking Up training module can be evaluated.	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	Yes
We have enabled managers to respond to speaking-up matters in a timely way	Yes
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes
Enter summarised evidence to support your score. The Guardian works with managers as required when issues are raised in their area. There have been notable examples of positive and productive joint working in recent months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Guardian to consider specific learning sessions for managers following visibility activities.	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes

Enter summarised evidence to support your score.

The Guardian is a key member of all organisational forums that focus on staff wellbeing, enabling her to undertake horizon scanning for potential hotspots as issues arise in particular services for example. One key source of data (anonymised) is the SALS service. The Guardian has developed a close working relationship with the SALS team since it was put in place in 2020; the lead for SALS is also leading the development of the Trust's cultural programme.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Continue to refine data sources, analysis and triangulation as part of board assurance and learning.

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	Yes
We share the good practice we have generated both internally and externally to enable others to learn	Yes

Enter summarised evidence to support your score.

The FTSUG analyses the case studies published by the NGO to ensure that any learning that can be derived for Alder Hey is assimilated. During 2023 a report was compiled for the board by the Guardian and a member of the HR team to summarise this. The Guardian also draws learning from network events that can be adopted by the Trust and similarly has regularly offered her time to guardians on other organisations who have expressed an interest in the Alder Hey approach.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider formalising the dissemination of learning from elsewhere through an annual report eg to the PAWC.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes
Enter summarised evidence to support your score. The Guardian has been in post since 2018 having been recruited through an open internal process. She subsequently undertook NGO training and remains registered as Alder Hey's Guardian.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 N/A	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	No
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes

Enter summarised evidence to support your score.

There is a long-standing robust management support structure in place the FTSUG. She reports to the Executive lead, including monthly one to one meetings and ad hoc as required to discuss specific cases. She also meets on a monthly basis with the Chief Nurse, who is her professional lead as well as with the Managing Director. She has standing open access to meet with the Trust Chair on request. The Guardian has an annual PDR with the Executive lead with agreed performance objectives and development opportunities identified. She is able to access emotional support/clinical supervision from the Associate Director of Organisational Development. The FTSUG routinely reports the Trust's data to the NGO in accordance with stipulated requirements.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 As above the formal Deputy arrangements need to be finalised.

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes

Enter summarised evidence to support your score.

The FTSUG keeps a detailed confidential database on which she documents each case. As part of the closure process of each case, individuals are asked about their experience and whether they would use the service again. This information is summarised for the quarterly board assurance report in addition to the number of open cases and the length of time they have been open; any delays in closing cases are documented with the reason for the delay.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider more proactive board endorsement of FTSU activities through Speaking Up week.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	Yes
We know who isn't speaking up and why	No
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	No

Enter summarised evidence to support your score.

Whilst the Trust scores well on staff survey metrics relating to raising concerns, it is understood that there is scope for improvement and a better insight into the factors that enable and disable staff from speaking up. Work has been done to identify barriers such as professional boundaries, geographical location, confidentiality etc. and the development of the team of Champions has aimed to address these by actively recruiting Champions from all parts of the organisation both in terms of service and structure but also in terms of characteristics and background. The FTSUG regularly spends time with the Champions and ensures they are well supported.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider targeted work to identify groups or individuals who may be reluctant to use speaking up mechanisms.

2 Develop a methodology to assess changes in appetite to raise concerns among staff groups identified and contributing factors.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	Yes
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	Yes
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes
Enter summarised evidence to support your score. The FTSUG considers the issue of detriment specifically with each member of staff who raises a concern. This is reflected in the board report which is overseen by the Executive and NED leads.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Review the questions in relation to detriment and consider supplementary information as appropriate.	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	No
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	No
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	No
Our improvement plan is up to date and on track	No
Enter summarised evidence to support your score. We do not currently have a standalone FTSU strategy, having taken the view that speaking up must rather be an integral part of our overarching People Strategy. We developed a position statement in support of the People Strategy which can be developed into an improvement plan but again this must align to the work that is currently underway in relation to the Trust's Just and Restorative culture approach.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider the development of an FTSU improvement plan	
2 Consider appropriate metrics to evaluate improvement	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	No
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	No
Our speaking-up arrangements have been evaluated within the last two years	Yes
Enter summarised evidence to support your score. As above our speaking up arrangements were formally audited during 2013/24 by MIAA. The scope of the review included policies and procedures, staff and training, actions taken as a result of concerns and lesson learning. The outcome of the audit was ‘substantial assurance’ with five recommendations for further development which were classified as low risk, other than the planned move to Inphase from the current bespoke database.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider structured evaluation of staff attitudes to speaking up out with of the annual staff survey.	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes

Enter summarised evidence to support your score.
The quarterly board assurance report has developed significantly over time and has recently undergone some structural changes suggested by the NED lead when she took over the role last year. Periodically the standard report has been supplemented by case studies and self-assessments which can be built into the workplan at intervals during the year.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Continue to refine the quarterly report to include the areas identified in this assessment with oversight from the NED lead.
2 Implement the MIAA recommendation with regard to a formal annual report on FTSU activity.

Erica Saunders
Director of Corporate Affairs/Executive lead for FTSU
April 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	Discussion Paper to support the assessment of Going Concern for 2023/24 Annual accounts
Report of:	Finance
Paper Prepared by:	Emily Kirkpatrick

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	Nil
Associated risk (s)	Minimal

1. Purpose

This paper is intended to provide the key reasons as to why the Audit & Risk Committee supports and recommends to the Trust Board that the 2023/24 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2023/24 financial statements on this basis.

2. Background

The Trust is compliant with the Department of Health and Social Care (DHSC) guidelines preparing the 2023/24 financial accounts on a going concern basis. Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption, a Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. A key consideration of going concern is that the Trust has the cash resources to meet its obligations as they fall due for the foreseeable future. For these purposes, 'foreseeable future' is considered to be twelve months from the date of signing of the annual accounts.

International Accounting Standard 1 – presentation of financial statements (IAS 1) requires the Trust directors to assess and satisfy themselves that it is appropriate to prepare financial statements on a going concern basis. The 2023/24 DHSC Group Accounting Manual (GAM) sets out the interpretation of going concern in the public sector context.

<u>Directors' assessment of going concern</u>
The specific factors that the Directors should consider in respect of their assessment of going concern are:

- Financial conditions
- Operating conditions
- Other conditions such as serious non-compliance with regulatory or statutory requirements

Having considered the above the Trust directors have a reasonable expectation that the Trust will remain in operation for the foreseeable future. The Trust has a proven track record of consistently meeting the performance and control totals set by the regulator and over the last 5 years has delivered within these targets often making significant surpluses to support the sustainability of the Trust.

As a specialist provider of children's services, the Trust is commissioned to provide services across the North West Region and nationally for highly specialised services and it is expected that NHS funding will flow from commissioners, at similar levels to that previously provided for all of these specialist services. There remains a firm requirement to still provide the services.

The Trust currently has a significant level of its own cash resource available demonstrating strong liquidity (£78.3m as at 31st March 2024).

In 24/25 there will be a 'blended' approach to funding in England. Some elements will be 'variable': elective points of delivery will be funded based on actual activity undertaken. Drugs & devices will be pass-through. All other areas will remain block funded. Outside of England our contracts will likely be full PBR, though that is yet to be fully agreed. Based on the updated funding arrangements, and planned activity for 2024/25, initial draft plans have been submitted to the ICS and NHSE with a planned control total with a breakeven position.

Whilst these are still yet to be approved, it is expected this will be achieved prior to the anticipated sign-off of the 2023/24 financial statements in June.

As such the Trust board can take assurance that it is reasonable to expect that the 2024/25 funding levels will be maintained based upon these plans as the actual income streams are not expected to be materially different. Arrangements beyond 2024/25 are yet to be confirmed and the Trust assumes similar arrangements to those in place for 2024/25 will be adopted.

The Trust has calculated a number of liquidity ratios based upon its forecasted closing Statement of Financial Position as at 31st March 2024 as follows;

Quick Ratio	Cash & Receivables Current Liabilities	96,696	/	(73,039)	1.32
Current Ratio	Current Assets Current Liabilities	101,049	/	(73,039)	1.38

Generally the higher the ratios are the greater the margin of safety
An ideal ratio is considered to be between 1 & 1.5

The Trust has also completed a scenario analysis to assess operational liquidity for the next 18 months to September 2025 and consider what level of cash the Trust could close H2 25/26 with, expressed as a percentage of current levels and this is shown in Appendix A.

The outcome of this analysis demonstrates that in all scenarios, the level of cash available at the end of next financial year is likely to remain significant therefore all examples fully support the Directors assessment that a Going Concern basis should be adopted.

3. Conclusion

The Trust Directors have a reasonable expectation that Alder Hey Children's NHS Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements. **On this basis the Board is asked to agree that the 2023/24 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2023/24 financial statements on this basis.**

Appendix A – Liquidity Scenario Analysis

Going Concern Liquidity Scenario Testing for 24/25 & H1 25/26 - 30th September 2025						
	Base Case		Upside Case - Capital Restraint		Downside Case - CIP not delivered	
	£'000	£'000	£'000	£'000	£'000	£'000
Bank & cash balance per 31st March (Draft Close)		78,269		78,269		78,269
Trust Operations 24/25 :						
Draft Planned Income (exc non cash)	408,508		408,508		408,508	
Draft Planned Expenditure (exc non cash)	(413,859)		(413,859)		(413,859)	
Draft CIP Target	19,300		19,300		19,300	
Draft Plan Capital Expenditure April - March 23	(15,414)		(15,414)		(15,414)	
		(1,465)		(1,465)		(1,465)
Downsides:						
CIP Not delivered @ 50%						(9,650)
Mitigations:						
Capital restraint 24/25 - uncommitted capital spend				2,500		
Projected Cash Balance 31/3/25		**76,804**		**79,304**		**67,154**
Trust Operations H1 25/26:						
Projected Planned Income (3% Growth)	210,382		210,382		210,382	
Projected Planned Expenditure (Incl Inflation)	(213,137)		(213,137)		(213,137)	
CIP Target - H1	9,940		9,940		9,940	
Indicative Capital Expenditure April - September 25	(4,894)		(4,894)		(4,894)	
		2,290		2,290		2,290
Downsides:						
CIP Not delivered						(4,970)
Mitigations:						
Capital restraint 25/26 - 1/3rd of indicative capital spend				1,615		
Projected Cash Balance 30/9/25		**79,094**		**83,209**		**64,474**
% of current cash balance		**101%**		**106%**		**82%**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	**Chair's Report from ARC meeting on 18 April 2024**
Report of:	**ARC Chair**
Paper Prepared by:	ARC Chair

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This meeting focussed on reviewing the year end reports and assurances for 23/24 and the forward plans for 24/25 from Risk Management, Internal Audit, Anti-Fraud Service, Programme Assurance, EPRR, Data Quality, Data Protection, Cyber Security and Freedom of Information plus the plan for the external audit of the 23/24 annual accounts. We also: • reviewed the positive outcome from the review of Internal Audit effectiveness • approved an increase in days from 190 to 225 for the Internal Audit Plan following a benchmarking exercise to similar Trusts in C&M • had a detailed discussion on the forward plan for the implementation of the remaining modules in InPhase and completion of the outstanding issues within the risk and incident modules. ARC has asked that a detailed project plan for Phase 2 be brought to the June meeting and ARC will continue to receive update reports until the Committee is assured as to the effectiveness of the project management controls • received the draft Annual Governance Statement, subject to minor amendments to be made following the meeting

0182

Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	None

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

0183 **1. Introduction**

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board and provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

- Update on retrospective sourcing of missing key documents from the recruitment process of existing staff
- Presentation from Surgery on risk management processes within the Division
- Presentation from the Director of Corporate Affairs and Associate Director of Nursing & Governance on risk management oversight provided by the Corporate Services Collaborative
- Board Assurance Framework
- Update from the Risk Management Forum including the Corporate Risk Register
- Trust Risk Management Report
- Annual Report on Risk Management for 2023/24
- Outcome of the review of Internal Audit effectiveness
- Review of resources for the Internal Audit Plan
- Draft Director of Internal Audit Opinion and Internal Audit Annual Report for 2023/24
- Internal Audit Plan 24/25
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Internal Audit Charter
- Anti-Fraud Services Annual Report for 23/24
- Anti-Fraud Services Annual Plan for 24/25
- Statement of Going Concern for the 23/24 annual accounts
- External Audit Plan for 23/24 annual accounts
- Trust-wide Clinical Audit Plan for 24/25
- Annual Assurance Report for 23/24 and Forward Plan for 24/24 for:
    - Emergency Preparedness Resilience and Response (EPRR)
    - Project Assurance
    - Data Quality
    - Cyber Security
    - Data Protection
    - Freedom of Information
- Lessons learned report from the InPhase and Aldercare implementations
- Annual Governance Statement
- Fraud, Bribery & Corruption Policy
- Approach to the regular effectiveness review of ARC, Internal Audit, External Audit and the Anti-Fraud Service
- ARC Terms of Reference and Work Plan
- Private meeting with Internal & External Audit

3. Key risks / matters of concern to escalate to the Board (include mitigations)

The Committee received the lessons learned report on the implementation of some of the modules within InPhase (risk, incidents, complaints / PALs). The system was implemented to a very tight timescale due to the contract expiry of the Ullysses system and the introduction of PSIRF. A number of issues were experienced during the implementation – principally relating to staff training, availability of expected reports and communication – as a result of the system specification being insufficiently detailed. Thes issues were present for an extended period of time which impacted on user experience and (initially) confidence in the system.

InPhase was purchased to enable read-across of various information sources across the Trust to support improved patient safety. There are still modules relating to legal claims, NICE guidance, central alert system, FTSU and volunteering to bring fully into use to enable this. Given the importance of achieving this, and the issues experienced with the implementation to date, ARC has asked that an Executive be identified as the system owner and for a detailed Phase 2 project plan to be presented to the June ARC meeting describing how the remaining modules will be implemented along with completion of any actions currently outstanding.

4. Positive highlights of note

Following the identification of a staff member fraudulently obtaining employment at the Trust in 2019 (subsequently dismissed in 2021) a review of a sample of staff records for recruitments in a similar time period identified gaps in key employment documents held on file or updated to ESR. A significant exercise was launched to review the HR files of all current employees to identify any gaps in key documents and to source them retrospectively from employees as required, or update the information to ESR if the documents were held but ESR was not up to date. The Committee received assurance of the significant improvements made as a result of the exercise and asked for a final report to the June 24 meeting following the resolution of a small number of remaining gaps.

The Committee received the outcome from the detailed review of Internal Audit effectiveness. Whilst there were no significant or adverse findings, the review identified some enhancements which require response from both MIAA and the Trust to ensure continuous improvement.

In recent years the Committee has recognised that the days available within the Internal Audit Plan for management and the Committee to direct resources to areas of Trust priority was becoming increasingly “tight” due to the number of externally mandated or expected audits. As a result, the Committee used some benchmarking information made available by Health Procurement Liverpool to compare the size of our Plan to other similar trusts in C&M. This showed that we had the smallest Plan (at 190 days) in our peer group and the data suggested that we should instead be around 235 days. Recognising this is a significant increase in days in one year the Committee agreed to increase to

0185 225 days for 24/25 with a review at the end of the year to consider a further increase to 235 for 25/26.

The Trust received substantial assurance from MIIA on our internal control system – the second highest opinion available and is an excellent outcome given that we direct some audits to areas of known issues. The Trust has a history of receiving this level of assurance but it is worth noting that there were no limited opinion audit reports in the year and, at the year-end, there were no critical or high recommendations overdue.

The Committee was pleased to receive assurances on key risk areas for the Trust from EPRR[1], Data Protection, Freedom of Information, Cyber Security, Data Quality and Programme Assurance. The Committee approved an updated Programme Assurance approach for 24/25.

5. Issues for other committees

None.

6. Recommendations

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

[1] Recognising that whilst the Trust has recently submitted a non-compliant return for EPPR that, in practice, systems are safe as demonstrated by EPPR exercises and responses throughout the year.

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 25th January 2024**
Meeting Room 7, Alder Hey Children's Hospital

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
In Attendance:	Mr A Bateman	Chief Operating Officer	(AB)
	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Ms. E. Kirkpatrick	Assoc. Director of Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRO)
	Mr. D. Spiller	Manager, External Audit	(DS)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Item 23/24/68	Mrs. S. Owen	Deputy Chief People Officer	(SO)
Item 23/24/95	Mr. P. White	Chief Nursing Information Officer	(PW)
Apologies:	Ms. J. Revill	Non-Executive Director	(JR)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mr J. Wilcox	Financial Accountant	(JW)

23/24/89 Introductions and Apologies

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

23/24/90 Declarations of Interest

There were none to declare.

23/24/91 Minutes from the Meeting held on 12th October 2023
Resolved:
The minutes from the meeting held on the 12th of October were agreed as an accurate record of the meeting, subject to a minor amendment which the Chair will address outside of the meeting.

23/24/92 Matters Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

Action 22/23/81.2: *Internal Audit Follow-up Report (Post Project Assessments/Benefits Realisation Exercises on Projects - Conduct a post project assessment/benefits realisation exercise on the new Sunflower and Catkin buildings during Q4 2022/23 or Q1 2023/24 using the developed process. MIAA to review implementation of the assessment and report to ARC as to whether the recommendation can be closed)* – MIAA to include a post project assessment/benefits realisation in the current Project Management audit for non-building projects. Work is on-going and an update will be provided in April 2024.
ACTION TO REMAIN OPEN

Action 23/24/04.2: *MIAA Follow-up Report (Include the outcome of the IT Assets Hardware follow up review conducted by MIAA in October's Follow-up Report)* – A discussion regarding this action will take place outside of the meeting between MIAA and the Chair.
ACTION TO REMAIN OPEN

Action 23/24/34.3: *Internal Audit Progress Report (HPL Review - Incorporate an update on the HPL actions in October's Internal Audit Progress Report)* – An update on HPL was included in January's Progress Report. **ACTION TO BE CLOSED**

Action 23/24/51.1: *NHS Employment Check Standard Audit (HR department to develop a proposal, using a risk-based approach, to identify whether key documents were obtained for recruitments over a period of time and report back to October)* – Further assurance was requested by the Chair of the Committee which was presented during January's meeting.
ACTION CLOSED

Action 23/24/52.1: *Terms of Reference for the Revised Key Financial Controls Audit (Liaise with E&Y to ensure that there is nothing else that needs to be included in the audit from their perspective)* – MIAA have liaised with E&Y and can confirm that there is nothing else that needs to be included in the audit from E&Y's perspective. **ACTION CLOSED**

Action 23/24/54.1: *Corporate Report (Conduct a review of the 'People Risks' to determine whether they are people risks or clinical risks, for example, for some of the risk the impact is appears to be clinical but the "cause" is people)* – Work is taking place to progress this action. **ACTION TO REMAIN OPEN**

Action 23/24/54.2: *Corporate Report (Create four to five codes for longstanding risks to provide rationale as to why a risk is still outstanding)* – Work is taking place to progress this action. **ACTION TO REMAIN OPEN**

Action 23/24/67.1: *Expenditure Controls Assurance (1. Submit the action plan for this piece of work to ARC on a regular basis until it has been signed off. 2. Circulate the 2022/23 National Cost Collection report that was submitted to RABD in August 2023. 3. Submit a position paper to ARC in January 2024)* – This item has been included on January's agenda.
ACTION CLOSED

Action 23/24/68.1: *NHS Employment Check Standard Audit (Recruitment and Selection Process Audit - Look at the possibility of having a more explicit risk on the risk register appertaining to residual risks)* – This action has been addressed. **ACTION CLOSED**

Action 23/24/68.2: *NHS Employment Check Standard Audit* (*Recruitment and Selection Process Audit - Liaise with the Governance Team to see whether the audit needs to be registered as a priority audit for the Trust)* – This action has been addressed.
ACTION CLOSED

Action 23/24/72.1: *Corporate Risk Register (Risk 2441: Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval. Review risk 2441 to see if the likelihood has gone down based on the progress that has been made)* – It was agreed to leave the likelihood score as it is until an agreement has been reached on the non-neonatal transfer. **ACTION CLOSED**

Action 23/24/72.2: *Corporate Risk Register (Risk 25 (defective ventilators) - Check that risk 25 has been closed on the InPhase system)* – This action has been addressed. **ACTION CLOSED**

Action 23/24/72.3: *Corporate Risk Register (Deep Dive of Adoption related Risks - It is a legal requirement when a child or young person is adopted that their medical record is closed and a new adoption record is created. Erica Saunders agreed to liaise with Lisa Cooper to ensure all mitigations are in place for this risk from a historical perspective and to see whether it would be beneficial to conduct an audit on this area of work)* – A meeting has been scheduled between Erica Saunders and Lisa Cooper to discuss this matter.
ACTION TO REMAIN OPEN

Action 23/24/76.1: *Internal Audit Progress Report (Data Security and Protection Toolkit Audit - Discuss the findings of the audit as narrative is not included in the report to support the substantial opinion. Look at an alternative approach for sharing the supporting detail with Committee members going forward)* – Going forward, the DSPT report will include findings of the audit to support the opinion. Findings from this year's audit to be circulated.
ACTION CLOSED

Action 23/24/76.2: *Internal Audit Progress Report (MIAA liaise with E&Y to make them aware of the change to the score following an audit of the Trust's Key Financial Controls and acquire their agreement to of this amendment)* – MIAA have liaised with E&Y to confirm their agreement of this change. **ACTION CLOSED**

Action 23/24/77.1: *Internal Audit Follow Up Report (Consent Review - Request be submitted to CEOG asking that auditing of consent processes feature in all Divisions clinical audit plans)* – This request was due to be submitted to CEOG in December but due to unforeseen circumstances the meeting was cancelled. The auditing of the consent process has been reviewed with all of the divisions and all but medicine have consent audits on their plan. A discussion will take place with the Director of Medicine regarding this matter and an update will be provided in April 2024. **ACTION TO REMAIN OPEN**

Action 23/24/78.1: *Consultant Job Planning Position Update (Consolidated update to be included in January's Internal Audit Follow-up Report on the Consultant Job Planning position/recommendations)* – A full summary of the Consultant Job Planning recommendations has been included in January's Internal Audit Progress Report.
ACTION CLOSED

Action 23/24/83.1: *Review of External Audit - Effectiveness Survey (Pre-meet to take place ahead of the wash-up session to discuss the outcome of the survey)* – This action has been addressed. **ACTION CLOSED**

Action 23/23/67.2: *2022/23 National Cost Collection (Discussion to take place regarding the cost collection assurance that the Trust Board is being asked to provide assurance on) –* Discussions have taken place with ARC/Executive Directors and it has been agreed to include the National Cost Collection on the 2024/25 draft Internal Audit Plan.
ACTION CLOSED

23/24/93 NHS Employment Check Standard Audit.

The Committee was provided with an update on the pre-employment checks audit undertaken by the Recruitment and Employment Services Team, which commenced in October 2023. A 12-week programme of work was undertaken to review and audit all historic personnel files against the NHS Pre-employment Check Standards, as earlier audits identified some gaps in assurance against these standards. The following points were highlighted:

- A total of 3,300 files were checked and the information that was held on file but not uploaded to ESR has now been updated on ESR.
- 5,000 data points have been added to ESR records. It was reported that every candidate is required to be checked against the 6 NHS Employment Check Standards before being cleared to commence employment. The Committee was advised that the majority of the information had been obtained but hadn't been input to ESR. This has since been rectified.
- Going forward compliance will increase as a result of the implementation of the Trac system, and the new structure within the Recruitment and Employment Services team which has provided enhanced organisational assurance on current pre-employment recruitment practices.
- It will be beneficial to conduct a regular audit going forward therefore it has been proposed that an annual audit on pre-employment checks be undertaken by MIAA to ensure ongoing and future checks remain compliant against the Standards.
- The Committee was advised that the audit concluded in January but further analysis is required before the final outcome of the audit can be shared. It was agreed to submit a final report on the audit in April 2024.

23/24/93.1 Action: SO

It was queried as to whether the audit covered the review of every file going back to 2015 other than those on the system, and if so, what was the outcome? It was reported that the final report will provide this level of detail.

GD referred to the item in the report relating to DBS checks and queried as to whether 93% compliance is acceptable. It was explained that the Trust's target is 100% compliance. The organisation undertakes three yearly checks and the element of non-compliance may be due to long term leave, maternity, etc. It was confirmed that there is a process in place to address this area of work.

The Chair drew attention to the identified gaps in references on a number of records and pointed out that a risk judgement will have to be made regarding this matter once the overall analysis of the audit is available. It was queried as to whether there is a risk relating to this issue on the Corporate Risk Register. It was confirmed that there is.

The Chair thanked the Deputy Chief People Officer, Sharon Owen, and the team for the work that has taken place on the audit.

Resolved:
The Audit and Risk Committee (ARC) noted the update relating to the NHS Pre-employment Checks Audit.

23/24/94 National Cost Collection - Briefing

The Committee was provided with an outline of what the National Cost Collection is, and the steps that the Trust needs to take to assure itself that the information submitted is accurate. It was reported that a review of the National Cost Collection processes had been included on the draft Internal Audit Plan for 2024/25, which, if approved will aim to provide further assurances around this process.

The Committee was advised that the organisation submits costs on an annual basis to NHS England as a requirement of the Trust's Provider License. Given the financial scrutiny across the NHS, this return is becoming increasingly high profile as a means of determining whether trusts are using their resources effectively; therefore, it is imperative that the data the Trust provides is correct. Alder Hey is also using the national costing data internally to help drive efficiencies.

The Chair queried as to whether checks on the accuracy of Patient Level Costings (PLICs) are conducted when preparing the submission. It was confirmed that checks are carried out via discussions with the Divisions, quarterly reports and engagement thus ensuring the data is as informative as possible to drive the cost section.

Resolved:
The Audit and Risk Committee noted the briefing on the National Cost Collection.

23/24/95 InPhase Update

ARC was provided with a current summary position of the reporting functionality of the Risk and Incident Management system (InPhase) and the action plan for the resolution of outstanding challenges and actions. It was reported that several developments have been deployed with close collaboration between the Data and Analytics team, Alder Hey and Liverpool Heart and Chest governance teams. Improved visualisations and Structured Query Language Server Reporting Services functionality to automatically build reports has been welcomed. The following points were raised:

- The Committee was advised that the day to day inputting of data onto the system has been successful.
- There has been a sustained reporting of incidents which has increased since the implementation of InPhase.
- The Trust has regular use of the risk system.
- The issue relating to reporting has been addressed, and the organisation is now in a position where it is developing templates for reports that will be populated directly from a database.
- The challenge relating to the duplication of risks/risks not saving has been fully resolved. The Trust will continue to monitor this area of the system.

The Chief Nursing Information Officer, PW, shared the current Pharmacy Dashboard, along with a number of slides that provided an overview of the developments that have been undertaken and are now live. PW responded to questions that were raised about what was done differently to produce a successful medication dashboard for Pharmacy, how the organisation will embed the system/dashboards across the Trust to help prevent risks, anticipate near misses and change the mindset/culture of the organisation.

The Chair queried as to whether there's a formal process for the optimisation phase of InPhase, including appropriate resources. It was reported that investment will be required from a people perspective to enable the tool to be developed to its full potential. A discussion took place about the possibility of the optimisation phase being included in the benefits realisation work that is taking place for projects to see if it fits, or whether it would be more suited to being framed in the context of a strategic initiative.

For noting
The Chair felt that the detail in the presentation was beneficial and asked that an update on InPhase be submitted to ARC on an ongoing basis for the present time.

PW advised the Committee that the implementation of InPhase has been really challenging but drew attention to the system's potential. PW thanked all those who supported the team through the initial stage of the project.

Resolved:
ARC noted the update and acknowledged the mitigations that are in place to address the outstanding issues.

23/24/96 Update on the Risk Management Process within Division of Medicine (DoM) and Division of Surgery (DoS)

The Committee received an overview of the risk management process within the DoM. A number of slides were shared that provided information on the following areas:

- Theme category of current risks.
- New risk process.
- Process for approving risks.
- Follow up process for risks that remain overdue/risks with no actions recorded against them.
- Priorities;
  - Further education to be provided to risk managers to ensure risks are managed effectively.
  - Identify clinical teams with no or a low number of risks to enable discussion to be held as to the accuracy of this.
  - A DoM governance SharePoint is in the process of being developed to allow ease of sharing guidance and training resources for risk management.
  - DoM aims to improve the compliance of risk review due dates and action due dates to ensure risk management is robust and provides assurance.
- Challenges;
  - Engagement and timely action from risk managers and owners.
  - Ensuring InPhase is as user friendly as possible.
  - Ensuring that the extraction of reports/data from InPhase is as straight forward as possible.

The Director of Medicine, UD, responded to questions that were raised about whether all staff in the Division are risk aware, having appropriate attendees at risk validation meetings, and a suggestion was made about implementing Divisional action plans to ensure areas that require targeting are addressed.

A discussion took place about the benefits of conducting a cross cutting piece of work in the near future to acquire intelligence on how staff feel about risk management in the organisation and whether they see it as being helpful. The Committee was informed that the message on risk is starting to filter across the organisation; for example, Ward 3C have compiled a newsletter advising of their risks and providing details of where their risk register can be found, and work is in progress in terms of holding Corporate Services to account on their risks via the Corporate Services Collaborative.

The Chair referred to the interim action tracker portal that was implemented whilst the issues with InPhase were being rectified and asked whether staff are aware of the portal. The Chair pointed out that there will be a focus on long overdue risks now that the position with InPhase is more settled.

The Chair enquired as to whether the DoM is in the process of incorporating consent in their Divisional Audit Plan. It was reported that a meeting is scheduled to take place in February to discuss this matter.

Thanks were offered to UD for sharing the presentation with the Committee.

As a presentation from the DoS was not made to this meeting, the presentation was deferred to the April 24 meeting.

Resolved:
ARC noted the update on the risk management process within the DoM.

23/24/97 Risk Appetite and Tolerance

The Committee received an update on the current situation regarding the risk appetite and tolerance work that was paused due to the challenges that were experienced with the reporting functionality on the new InPhase system. Reference was made to the filtering issues that were detailed in the report and it was confirmed that this matter has since been resolved, therefore arrangements will be made to revisit the risk appetite work with the Assurance Committees.

The Chair reported that a discussion took place recently at Board around advocacy and the need for a risk appetite discussion on this area of work. The Chair asked as to whether forthcoming risk appetite discussions with the Committee Chairs should include advocacy. It was agreed to widen the meetings to incorporate this area of work and invite JG to meetings.

23/24/97.1 Action: JP

Resolved:
ARC noted the position paper regarding risk appetite and proposed risk tolerances.

23/24/98 Board Assurance Framework

The Committee received the Board Assurance Framework (BAF) report for December 2023.

The Chair drew attention to the gaps in assurance and minimal actions in BAF risks **2.1** *(Workforce Sustainability and Development),* **2.2** (*Failure to deliver the best experience for Staff, Children and Young People and their Families*) and **2.3** (*Workforce Equality, Diversity & Inclusion*) and asked that this matter be brought to the attention of the Chief People Officer.

23/24/98.1 Action: JP

Garth Dallas referred to BAF risk 2.3 and asked as to why it still has a risk rank of 15 but doesn't seem to have any mitigating actions in place. The Chair advised that the only action present (relating to a business case for EDI) has a due date of March 2023, and asked for a formal
request to be submitted to the People and Wellbeing Committee for a deep dive into BAF risk 2.3.

23/24/98.2 Action: GD

The Chair thanked JP for the amount of work that has taken place to populate and improve the BAF.

Resolved:
The Audit and Risk Committee noted the content of the BAF report for December 2023.

23/24/99 Risk Management Forum (RMF) Update including the Corporate Risk Register and minutes from the last meeting.

The Committee was provided with an overview of the key points and areas of concern that were discussed during the RMF meetings that took place on the 24.11.24 and the 15.12.24. It was reported that November's meeting was well attended and the deep dives undertaken were productive.

The Chair reflected upon attendance at October's RMF and felt that there was a lack of representation from a number of services, in particular HR. It was pointed out that this may have been due to the half-term school holiday, therefore it was agreed to undertake a six month review of attendance and provide an update during April's meeting.

23/24/99.1 Action: JR

Corporate Risk Register (CRR)

The Committee received the CRR for the reporting period from the 1.12.23 to the 31.12.23.

Attention was drawn to risk 91 *(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).* It was queried as to whether there is any intelligence to explain why successful candidates are not accepting the positions offered to them. The Committee was advised that a deep dive of risks will take place in February of which risk 91 will be included. In addition to the deep dive, JR agreed to raise a question to see if there are any underlying issue.

23/24/99.2 Action: JR

The Chair referred to risk 2746 *(The risk of patient harm due to a lack of clear guidance and a training structure in relation to chest drains)* and asked as to whether it should remain at 15 until the new system has been purchased, rolled out and is working effectively. It was reported that the business case has been approved, the chest drains have been delivered and a representative is scheduled to visit the Trust to discuss the development of training needs for staff. The DoS reviewed the risk and were of the opinion that there was enough mitigation in place to reduce this risk to a 12. The Chair felt that this risk was downgraded ahead of time therefore JR agreed to discuss this matter further with the DoS.

23/24/99.3 Action: JR

The Committee was advised that work is going to take place to look at temporary and longstanding risks via a separate lens to determine the major barriers to mitigation For example, risk 2100 *(Risk of inability to provide safe staffing levels caused by staff ill health and absence higher than the Trust absence target of 5%)* is a long standing risk about the workforce being impacted by industrial action therefore it's categorised under people but the risk of not having staff is a risk to service and patient safety. It was concurred that there is a duality to some risks which should be captured but it is important not to skew the profile and provide false assurance. Following discussion it was agreed to have a conversation outside of the meeting about impact versus cause and the wording of some of the risks.

23/24/99.4 Action: KB/JR

Resolved:
ARC noted the RMF update, CRR and the approved RMF minutes from the meeting held on the 24.11.24 and the 15.12.24.

23/24/100 Trust Risk Management Report.

The Trust Risk Management report was submitted to provide the Committee with the opportunity to scrutinise the effectiveness of risk management in the Trust. The assurance presented in the report is a direct reflection of the evidence available on InPhase at the time of reporting. The following points were highlighted:

- The Committee was asked to note that there are 261 risks on the Trust Risk Register for the reporting period; 1.12.23 to the 31.12.23. This is a slight increase compared to the previous reporting period (258).
- The highest number of risks remain in the moderate category (191) accounting for 73.18% of the total number of risks. This is a slight increase compared to 184 reported in the previous reporting period. This area of risk will be subject to a deep dive during the next RMF.
- 4 new risks have been identified in the reporting period, 16 have been closed, 55 are overdue a review and there are 0 with no current risk rating assigned
- Attention was drawn to an InPhase technical issue that resulted in a delay to risks being reviewed. This matter was escalated to the Chief Executive of InPhase and a temporary portal was implemented. This issue will be addressed fully once a countrywide system upgrade of the next version is undertaken at the end of February.
- It was reported that risks without an ongoing action plan are increasing as staff aren't au fait with the new InPhase system yet. The Governance Team have taken the opportunity during risk oversight meetings to log on to the system and update action plans, etc. in person with risk holders. It was confirmed that the InPhase notification issue has been resolved.

- *Risk *22* - The lack of functionality for risk reporting remains on the risk register with a current risk score of 12.
- The number of long-standing high-moderate risks has increased slightly to 33 despite challenge to risk owners to reduce risk scores given controls are in place.

The Chair queried as to whether it would be beneficial for Divisions/Service leads to receive communication from the Chair of ARC highlighting the progress that has been made with the InPhase system, advising of the help that is available in terms of action trackers/reports, and explaining about the importance of focusing on overdue risks and actions in order to reduce them. It was confirmed that this would be really helpful.

23/24/100.1 Action: KB

Resolved:
ARC noted;

- The content and the level of assurance provided in the report.
- The areas of escalation to the Chief Executive of InPhase.

For noting
AB left the meeting as the risk element of the session had come to a close.

23/24/101 Draft Internal Audit Plan 2024/25

The Committee received a briefing note that set out the context for the production of the Trust's draft Internal Audit Plan for 2024/25. It was reported that discussions have taken place with the Trust's Executive Team to discuss potential reviews for the Plan. Reviews include mandated/core reviews, audits that have to be undertaken on a cyclical basis and reviews from the areas of discussion from the 2023/24 Internal Audit Plan. It was pointed out that Fit and Proper Persons and Conflicts of Interest reviews haven't been done for three years and there is an ask from NHS England that these audits take place.

Reference was made to Conflicts of Interest and it was reported that a review was undertaken in 2021/22. Taking this into account it was queried as to whether a further audit should be undertaken in Q1 of 2025. MIAA agreed to review this and provide an update.

23/24/101.1 Action: KS

The Chair explained that there are six mandated/core reviews on the plan that the Trust has no influence over thus leaving availability for only three reviews of the Trust's choice which doesn't feel appropriate. It was pointed out that a review of PSIRF implementation needs to be undertaken but currently there isn't room on the plan to do this. Clinical governance structure is another area that may need to be addressed as a result of Virtual Ward, new models of care and remote working. It was confirmed that a review of clinical governance will be considered for 2025/26. Reference was made to other areas of review that have been requested/usually take place that aren't included on the plan, for example, Consultant Job Planning and Data Quality to look at the KPIs from the Integrated Performance Report. A request was also put forward for a review of e-Rosters.

It was felt that there is a lot more demand than space in the plan therefore it was agreed that MIAA will undertake an anonymised piece of benchmarking work across Cheshire and Merseyside based on turnover/number of staff and provide feedback on the findings.

23/24/101.2 Action: GB

MIAA provided an overview of the mandated/core reviews and explained as to why they have to be undertaken in 2024/25. It was pointed out that a review of the core financial systems has been increased to full scoping coverage but it was felt that this could be reduced to core controls which will free space on the plan for one review. Following discussion, it was agreed to approve the Internal Audit Plan subject to the inclusion of a review of PSIRF implementation and feedback being received on the outcome of the benchmarking work.

The Chair suggested that MIAA contact the audit leads for Safeguarding and mandatory reviews to agree a date for field work. A request was made about avoiding a review of the National Cost Collection when costings are being taken.

The Chair referred to the commercial sensitivity of information relating to the cost of audit days and asked that a meeting take place to discuss a way forward in terms of ensuring that the Committee receives the data that it requires without compromising MIAA from a competitive perspective.

23/24/101.3 Action: KB/KS/GB/ES

The Chair advised that going forward the Committee will receive the findings of the DSPT audit. It was requested that the findings from the previous year be shared with members of the Committee.

23/24/101.4 Action: KS

Resolved:
ARC received and approved the Internal Audit Plan for 2024/25 subject to a review of PSIRF implementation being included and receiving the outcome of the benchmarking work.

23/24/102 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the 2023/24 Internal Audit Plan during the period; October 2023 to December 2023. The following points were highlighted:

- Three reports were finalised in the reporting period;
  - Key Financial Controls (*overall 'Substantial Assurance'*):
    - General Ledger – RAG rated 'Green'
    - Accounts Payable – RAG rated 'Green'
    - Accounts Receivable – RAG rated 'Green'
    - Treasury Management – RAG rated 'Amber'
  - On Call Payments – Moderate Assurance
  - Freedom to Speak Up – Substantial Assurance
- There are three reviews currently in progress;
  - Project Management Non-Building Projects – fieldwork
  - Cyber Assessment Framework – fieldwork
  - Assurance Framework – fieldwork

It was confirmed that the three reviews currently in progress will be completed by April 2024. MIAA advised that they are almost in a position to provide an audit opinion and it was felt that this has been helped by agreeing dates with the lead for each audit early in the year. The Chair pointed out that the Trust now has a history of being in a good position by January which is really positive.

Reference was made to the review that was undertaken following a specific request from the Trust due to on call payments for the Digital service being significantly higher than expected. Following testing, MIAA recommended that the Trust conduct an investigation as it was found that on call payments had been made to a member of the Digital Team without any justification. It was reported that this recommendation has been actioned and will be checked as part of MIAAs follow-up work.

A discussion took place regarding the learning from the on-call payments audit and it was felt that thought should be given to undertaking a review of areas where high on call payments are made to look at trends and verify that the additional authorisation process has been implemented.

23/24/102.1: ACTION: RL

The Chair queried as to whether an interim measure is required until FTSU data is transferred onto the InPhase system as presently it is stored on the FTSU Guardian's laptop. It was reported that a meeting is taking place between the FTSU Guardian and J R to discuss this matter and an update will be provided to the April meeting.

23/24/102.2: ACTION: JR

Resolved:
ARC received and noted the content of the Internal Audit Progress Report.

23/24/103 Internal Audit Follow Up Report

The Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been between October 2023 to December 2023. The following points were highlighted:

- Of the 11 recommendations which have fallen due in the reporting period, seven have been confirmed as implemented and four recommendations relating to the Junior Doctors/Non-Consultant Spend and Payroll reviews remain partially implemented with approval requested from ARC for extensions.

The Chair drew attention to the Junior Doctors/Consultant spend review and queried as to whether the budget had been compiled realistically. It was reported that a lot of work has taken place but the response to the recommendation doesn't reflect this. The Committee was advised that as part of the annual planning process each budget is being reviewed to ensure that rotas and budgets are aligned and budgets are refreshed in preparation for the new financial year.

The Chair referred to the partially implemented recommendations relating to the three payroll reviews and pointed out that the Committee is unable to approve the request for an extension based on the current information. It was felt that if the Committee was provided with detail on the interim actions it may be in a position to approve the request. A suggestion was made about trialling a template that will allow action owners to advise of the work that has taken place, why the recommendation hasn't been completed on time and the reason why an extension is required. This will help provide the Committee with assurance and the action owner from having to attend the meeting. It was agreed to use this template for the three payroll recommendations and if successful implement it as a process going forward.

23/24/103.1 Action: KS/SO

The Chair thanked MIAA for sharing the final position of the Consultant Job Planning

recommendations and incorporating all of the actions together in one document, which detailed the huge amount of work that has taken place to address the recommendations.

Resolved:
ARC received and noted the content of the Internal Audit Follow Up Report**.**

23/24/104 Anti-Fraud Progress Report

The Committee received the MIAA Anti-Fraud Progress Report that sets out the work undertaken during the period from the 3.10.23 to the 17.1.24. Attention was drawn to the following key points:

- The new 'Failure to Prevent Fraud' offence will come into force during 2024 and will cover several offences within the Fraud Act 2006, the Companies Act 2006, the Theft Act 1968 and the common law offence of "cheating the public revenue". As a result of existing counter fraud arrangements NHS organisations are already well placed to respond to any requirements once they are made known.
- In October 2023, the NHS Counter Fraud Authority issued a 'Learning Report' on the lessons identified following the successful prosecution of a major fraud, theft and bribery investigation. The Learning Report was shared with senior members of Finance and Procurement to enable a review to be conducted to determine the controls/assurance in place at the Trust in relation to the recommendations in the report. It was confirmed that Counter Fraud Service will follow this up with a self-assessment questionnaire. A further update on the exercise will be included in the next quarterly report.
- *Counter Fraud Activities;*
  - The latest compliance figures for staff completion of the fraud module is 98.07%.
  - Attention was drawn to the detail in the report on the circulation of a variety of fraud materials and activities that have taken place in the reporting period.
- A review is underway of the processes in place for ID validation and vetting of agency, bank staff and non-substantive staff on the bank; including sample testing. An update on the outcome of the review will be provided in the next quarterly report.
- *National Fraud Initiative Exercise;*
  - The Trust has completed its part of the exercise with no issues identified.
  - MIAA are in progress with the payroll exercise data matches with no issues identified.

The Chair queried as to whether the focus of the local proactive exercise should be approved by the Committee from a governance perspective. It was agreed to include the proposed proactive exercises in the next quarterly report for approval.

23/24/104.1 Action: VM

The Chair referred to Appendix C in the report and asked that the information relating to the nature of the allegations be reinstated in the report.

23/24/104.2 Action: VM

Resolved:
ARC received and noted the Anti-Fraud Progress Report.

23/24/105 E&Y General Update

It was reported that E&Y will commence interim work w/c 22.1.24. There will be a focus on two areas; Property, Plant and Equipment (PPE) findings and IFRS16. Reference was made to IFRS16, and it was reported that in the event the Trust acquires outside expertise, E&Y will need to undertake a review of the expert advice provided. It was confirmed that the Trust plans to obtain external expertise due to the organisation's expert person being absent from work.

Resolved:
ARC noted the update provided by E&Y.

23/24/106 CIO Quarterly Update

Resolved:
ARC noted the content of the:

- Data Protection quarterly report.
- Freedom of Information quarterly report.

23/24/107 Accounts Policies: External Audit Strategy and Accounting Issues.

The Committee was informed of the key accounting issues which may arise during the preparation of the Trust's Annual Accounts and were advised of the accounting policies that will be adopted in the preparation of the annual accounts. The following points were highlighted:

- The contractual claim against the Trust in relation to the Sunflower/Catkin building is ongoing and will remain as a provision in the year-end accounts.
- It is expected that the 2023/24 accounts we will have a balance remaining in the provision for the final costs associated with park reinstatement that are likely to occur post 31st March. The value of the remaining provision is expected to reduce but there will be an element in the accounts which will be adjusted for RPI inflation as appropriate.
- *Equity Investments* – The Trust is continuing to progress with the exiting/closure of five agreements. This work is ongoing and will remain as a note in the accounts. It was reported that the equity investments do not hold any value in the Trust's accounts, and therefore any closures will have no impact on the overall financial statements.
- *Valuation of PPE* – The last time the Trust had a full valuation of the estate was on 31st of March 2023 via its professional valuers. The Trust plans to apply indices provided by its professional valuers to update these valuations for the 2023/24 accounts, as per the Trust's policy.
- *IRFS16 for PFIs* – It was reported that the Trust's PFI doesn't fit with the national model therefore Alder Hey has commissioned external expertise to support in updating its current PFI accounting model with the impact of the IFRS16 changes.

The Chair asked as to whether there is anything novel on the horizon that the Trust will be tied in with at the end of the year. It was confirmed that there isn't.

Resolved:
ARC agreed the proposed accounting treatments to be followed in the 2023/24 annual accounts.

23/24/108 Audit and Risk Committee Effectiveness Review, 2023/24

The Committee was advised that it's almost two years since a self-assessment has been undertaken and whilst the remit of the Committee hasn't changed significantly in that time, the ARC membership has changed and therefore new views are available. It is proposed that a self-assessment be completed across 2023/24 and 2024/25 via a desk top exercise and a questionnaire for attendees and members of ARC. It was confirmed that the desk top exercise has been completed and the outcome of the questionnaire will be shared in October 2024.

23/24/108.1 Action: KB

There are two major actions outstanding from the 2021/22 self-assessment; clinical audit and risk appetite. These two actions are important developments which have required significant time from executives, senior managers and the ARC Chair and remain ongoing.

Resolved:
ARC considered the actions laid out in section 1 of the report and approved their inclusion to the existing ARC Self-assessment Action Plan.

23/24/109 Effectiveness Review of Internal Audit

The Committee was advised that various questionnaires to evaluate Internal Audit were obtained from other NHS Audit Committees whilst others were obtained on-line from reputable sources. It is proposed that all members and regular attendees of ARC be asked to complete the questionnaire as well as other key stakeholders who regularly interact with Internal Audit and receive reports within their area. In addition to this, it was suggested that MIAA submit a short report to advise of the outcome of their client satisfaction questionnaire.

It is recognised that ARC undertakes numerous assessments and self-assessment questionnaires (for example, those for Internal Audit, External Audit and ARC itself) and therefore, it was felt that it would be beneficial to stagger these over a period of time. It was confirmed that a proposed approach and timetable for undertaking these assessments will be prepared for the ARC meeting scheduled for April 2024.

23/24/109.1 Action: KB

Resolved:
ARC noted the proposal for the effectiveness review of Internal Audit and approved the recommendations detailed in the report.

23/24/110 Any Other Business

It was reported that the Chairs of the Assurance Committees were asked as to whether the timings of January's Committee meetings were appropriate. It was confirmed that a January meeting works well for ARC.

23/24/111 Meeting Review

The Chair referred to the action log and asked that a reminder be shared with the respective people who have actions for April's meeting to enable them to prepare in advance.

Date and Time of the Next Meeting: Thursday 18th April 2024, 2:00pm-5:00pm, LT2, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Minutes of the meeting held on Monday 25th March 2024 at 13:00, via teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	
	Fiona Marston	Non-Executive Director	
	Dame Jo Williams	Non-Executive Director	
	Gerald Meehan	Non-Executive Director Observing)	
	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)
	Melissa Swindell	Director of HR & OD	
In attendance:	Nathan Askew	Chief Nurse	
	Audrey Chindiya	Associate Finance Director – Operational Finance	
	Jenny Dalzell	Associate Director of Strategy and Partnerships	
	Emily Kirkpatrick	Deputy Director of Finance	
	Jane Halloran	Acting Deputy Development Director	
	Emma Hughes	Acting Manging Director for Innovation	
	Chris McNally	Deputy Costing Accountant	
	Andy McColl	Deputy Director of Finance	
	Natalie Palin	Associate Director Transformation	
	Jill Preece	Governance Manager	
	Gary Wadeson	Associate Director Income, Costing & Commissioning	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item: 204	Paul Sanderson	Pharmacy Manager	
207	Katie Tootill	Chief Procurement Officer	
207	Richard Jolley	Procurement and Contract Manager	

23/24/197 **Apologies:**

Dani Jones	Director of Strategy and Partnerships	
Erica Saunders	Director of Corporate Affairs	(ES)

23/24/198 **Minutes from the meeting held 26th February 2024**
Subject to two minor admin errors the minutes were approved as a true and accurate record.

23/24/199 **Matters Arising and Action log**
The Chair welcomed Dame Jo Williams to RABD who would be taking over the NED role from Fiona Marston next month. The Chair also welcomed new NED Gerald Meehan who was observing his first RABD meeting as part of his induction.

Neonatal Project update: It was noted an additional RABD is to be arranged for after Easter to go through a number of items including the Year End position and Neonatal update.

23/24/200 **Declarations of Interest**
There were no declarations of interest.

23/24/201 **Finance Report**
Month 11 Financial Position

The Trust has reported a £2.4m surplus in February (M11), and £6.4m year to date which is off plan by £2.1m (£0.6m in month).

Year end plans are going as predicted and a further updated will be presented at the Extraordinary RABD mid April.

Resolved:
RABD received and noted the M11 Finance report.

Q3 Service Line Report
GW and CMc presented the above report highlighting the income approach.

RABD discussed the best way to use the collected data within the report. Suggestions were made: Top 5 loss making services, reviewing areas that can be nurse lead instead of Consultant. FM highlighted patient needs would be prioritised first.

Resolved:
RABD received and noted quarter 3 Service Line Report.

23/24/202 Month 11 Integrated Performance Report
AB highlighted:
Sharp reduction in the number of patients waiting over 65 weeks for treatment and expect this to be zero by the end of Quarter 4 (with some possible exceptions relating to WNB and patient choice)

Resolved:
M11 IPR report was received.

23/24/203 24/25 Draft Financial Plan
AMc presented the annual plan summary for 2024/25. The plan will be presented to Trust Board on 11th April 2024 for approval, submission to ICB is due 24th April 2024 with the final plan submitted to NHSE on 3rd May 2024.

Resolved:
RABD noted the current position on the 24/25 Draft Financial plan.

23/24/204 Drugs Deep Dive
AC presented the above paper, at Month 11 the Trust are £0.9m away from plan, compared to £2.3m deficit at this same point last year (M11 2022/23). The three factors for this improvement are additional funding from the annual planning process at the beginning of the year. The second factor is due to the significant changes in the way commissioners fund drugs. The final factor is recurrent CIP drug savings of £1.4m for 23/24. Pharmacy continue to review where savings can be made and possible commercial options.

£0.9m deficit cost pressure in Medicine is largely driven by inflation. Medicine division, activity continues to be relatively high, and, in some specialties, actual activity has outstripped funded activity resulting in an associated cost pressure on the drugs budget.

AC noted a patient who was receiving high value medication is now in remission and has been discharged.

Resolved:
RABD noted the detailed deep dive on Drugs.

23/24/205 AlderCare

KW went through the review of the EPR system that was implemented in September 2023. The external assurance exercise has identified a number of positives associated with the transition to AlderCare at Alder Hey and provided assurance that the system is safe. In particular, the speed of the new platform, the multidisciplinary approach to implementation and support during the go-live were highly commended.

In terms of areas for improvement, better technical planning around migration, reporting and flex buttons were highlighted. DSS Team have provided two clear recommendations to be reviewed and actioned by the Trust.

Resolved:
RABD noted the outcome of the AlderCare review.

23/24/206 Innovation and Commercial Activity

Going forward the above item would be presented to Futures Committee.

There continues to be a wealth of interest in Was Not Brought from other Trusts and ICB's. However, at present we are unable to continue conversations until we have agreement on which platform WNB and other AI solutions will be hosted on. A review is due to take place in April 2024.

KW noted concerns that have been raised nationally with a potential partner for Was Not Brought in relation to data security.

Midwave have secured a second CYP as One platform sale to *Hertfordshire NHS Foundation Trust*.

AB gave an update on progress to date with the Strasys Partnership.

Resolved:
RABD noted the Innovation and Commercial Active report.

23/24/207 Procurement

RJ gave an overview of the report noting progress against the workplan for 23/24, any areas highlighted as behind track continue to be focused on with implementation due to start.

The 24-25 workplan has been developed in collaboration with divisions, department leads and our category procurement groups. Across the 116 projects there is a CIP opportunity of £482k. Challenges continue to be inflation and increase support across ICB.

KT gave an update on the review of Procure to Pay (P2P) services that has taken place over the last 12 weeks.

September 2023 HPL were asked to consider the migration of Procurement services for Liverpool University Hospitals and Liverpool Women's NHS Foundation

Trust. The Business Case will be presented at the Trust Board in April 2024 for approval or decline.

Vacancy changes included Steve Doran Head of Procurement leaving the post on 31st March 2024. Richard Jolley has successfully been recruited to the role, RABD noted their congratulations.

RJ went through income received for hosting the procure partnerships.

JG highlighted the need for the Procurement service to challenge ourselves with higher income returns and savings. The Chair asked for procurement to include this as an action for an update at the July RABD.
Action: KT/RJ

AB asked going forward for details on benchmarking, digital management as well as highlighting areas of opportunity and how they can be taken forward.

NA queried if the HPL services expands would there be a negative impact on Children's services. KT responded advising that part of the Business Case was to show that current services would not be negatively impacted.

Resolved:
RABD received and noted the quarterly Procurement report.

23/24/208 Benefit Realisation

Following the update received last month, NP presented plans to launch years 2 and 3 of vision 2030.

DJW asked for communication to be clear when sharing across the Trust, i.e what does productivity mean for my area?

KW noted the change in the programme now as it goes into delivery mode.

Resolved:
RABD APPROVED:
- The outlined mobilisation plan and proceed for approval to Trust Board (April 24).
- A priority focus on the portfolio of programmes under Acute Medical Model, Productivity and GIRFT, Home First with the support of the enabling strategic goals
- Note: The revisions to the governance arrangements for 24/25 and beyond.

23/24/209 Operational Delivery Network

Jenny Dalzell presented the above report highlighting the ODN drive for safety across the patient pathway, this is to ensure safe delivery from all services.

Alder Hey and Royal Manchester Children's Hospital have jointly submitted intentions to NHSE to obtain a 3% hosting fee for the provision of support services from the host organisation.

The ODN will be excluded from Alder Hey's CIP plans in 24/25, this is to enable budgets to be ringfenced as per 23/24 MOU with NHSE.

Resolved:
RABD received the bi annual Operational Delivery Network report.

23/24/210 Campus Update

JH highlighted:

- The playground is now completed, confirmation from Liverpool City Council is awaited on when this will be open. Commitment has been given that it be open before Easter.
- Regular assurance meetings continue with Mite and positive progress is being seen.
- Contract has now been signed for the Gender Development Service.
- Nursery is on schedule for completion in January/February 2025.

Resolved:
RABD noted progress to date of the Campus projects.

23/24/211 Board Assurance Framework

JG went through a meeting held earlier this morning reviewing RABD's risks for 2024/25. Further update will be presented next month.

Resolved:
RABD received and noted the Strategic Risks.

23/24/212 PFI

Resolved:
RABD received and noted the current position.

23/24/213 Communications and Marketing Paper

RABD took the report as read. DJW noted feedback from the last Council of Governor meetings around clear messages to staff and what it means for different areas. CB agreed to pick this up with Staff Governors.

FM referred to the Non-Executive Director Jo Revill highlighting her experience in communications and would be keen to support. CB advised that he had met with Jo Revill last week with a further meeting to take place.

Resolved:
RABD received and noted the communications report.

As there were a number of changes to be made to the two items below it was agreed they would be deferred until the April RABD. FM noted that the current TOR include workforce and clarity to be included on this item being around ensuring we have the right resources.

23/24/214 Terms of Reference
23/24/215 Workplan

23/24/216 Any Other Business

Fiona Marston

On behalf of RABD the Chair thanked Fiona Marston for her contribution and wished her well in the future.

23/24/217 **Review of Meeting**
RABD noted the good discussion and paper on Drugs Deep Dive and Service Line Review.

Date and Time of Next Meeting: Monday 29th April 2024 at 1pm, Lecture Theatre 4, Institute in the Park, Alder Hey Children's NHS Foundation Trust.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 2nd May 2024

Paper Title:	**Board Assurance Framework Report 2023/24 (March)**
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 March 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 develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and 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	Resources and Business Development Committee
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 11 March 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	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	PAWC	3x4	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	PAWC	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	PAWC	4x3	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 KW	Strategy Deployment	RABD	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 March 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  The BAF continues to be reviewed in Line with the 2030 vision. The current gaps in control have been reviewed and remain in place. The risk is regularly reviewed at each meeting and updated as appropriate.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in March significantly increased above the national standard of 76%, achieving 84.3% This in turn enabled Alder Hey to achieve a Q4 position of 81.4% (meeting the requirement of 80%).

  Continued improvement plans are in place for Sleep Studies (sickness) and Gastro (availability of theatres) to improve the Overall DMO1 compliance.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. The trust achieved zero 78 weeks at end of March 2024. The number of patients waiting over 65 weeks at end of March was 1. The requirement for zero 65 weeks set by NHS England has been extended to 30th September 2024. Focus on most challenged areas (Dental, ENT & Spine) will continue to meet this target with the internal aim to reach 60 weeks by end August 2024.

  Risk remains for achieving 65-week cohort regarding cancellation of agreed appointments, potential doctors strikes but these patients are being closely monitored by services.

- ***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 February pipework update, we are awaiting the March update.
  To date leaks have decreased by 47% compared to 2022.
  In overall terms the leaks in 2023 amount to 4.5% 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. AB has developed and shared action plan to work to. Key take away proceed at pace to install dosing system safely.

  Chiller commissioning works continue positively Project Co expect to provide an update early April to the Trust. A further Lift is required for

additional cooling coil replacements date and time TBC.

Works on the skylights will recommence on the 15th April 2024 with all lights completed and compound struck down with landscapes re-instated by December 2024.

- ***Access to Children and Young People's Mental Health (LC)***
  Review of actions undertaken and remain on track for completion.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (MS).***
  Risk continues to evolve to reflect Vision 2030. All actions updated.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS)***
  Risk reviewed and actions updated and closed where appropriate. New actions added to address change in risk focus. No change to risk rating

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risk reviewed and deep dive risk assessment undertaken at March People and Wellbeing Committee. Risk rating updated and all actions reviewed.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed, no change to score in month. New playground completed and handed over to LCC. Infrastructure works being progressed (1 out of 3) to allow further handover of land to the contractor to complete path and mound works. Other Campus activities on target for completion.

- ***Strategy Deployment (KW).***
  Risk reviewed, score remains static however will be continually reviewed in light of financial climate and planned transformation benefits progress. Transformation programme aligned to annual plan and an integrated transformation programme is in progress from April 2024. Clinical capacity for involvement has been highlighted as a potential risk to delivery against multiple priority areas.

- ***Financial Environment (JG).***
  No change to risk score, remains at 16 due to challenges within the overall system and risk of delivery of the 24/25 efficiency programme. As we move forward in the 24/25 financial year a review of controls and actions that can be taken to mitigate the risk.

- ***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. System commitment to CYP continues through the new ICS CYP Committee, and new provider collaborative Alliances (CMAST and MHLDC) which are gaining system buy in.
  2. Annual planning guidance was issued 28th March. As the impact of this is assessed at individual provider, and system level, this risk and associated score may change. This risk will closely align to BAF risk 3.4 (Financial Environment) and it will be necessary to keep abreast of emerging changes collectively.

- ***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).***
  No change to risk score in month. Emerging strategy for Futures being developed for Futures Committee on 16/04/24, AH Research Strategy finalised, annual planning complete including budget setting.

- ***Digital and Data Strategic Development and Delivery (KW).***
  Risk reviewed, score remains as previous. Good progress made with regards to Aldercare optimisation progressing. Feedback received from NHSE lessons learnt review.

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

There are currently 25 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
2623	When the CT breaks, this causes disruption to other services who rely heavily on CT and patients receiving their treatment.	4x4	Medicine	
174	We are unable to carry out our planned outpatient activity due to lack of rooms available. Sometimes rooms are booked, but upon arrival no room is allocated. Other times we are unable to book clinics as told rooms unavailable.	3x5	Medicine	
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.	4x4	Community	
169	There is a risk that Child Protection (CP) Medical Examinations completed by Physician Associates (PAs) may not result in successful prosecution due PAs not being recognised as 'Professional Witnesses'.	4x4	Community	
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	4x4	Medicine	1.2
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	3.4
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support	1.2, 2.1 & 2.2
117	Safe follow up care	4x4	Business Support	1.2, 2.1 & 2.2
2677	We are now in Year 7 since the Alder Hey in the park building became operational. Most of the Trusts Medical Devices were purchased or replaced at this time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 years. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital equipment. This year (22/23) we had planned to replace £6.3m of this capital equipment. However, external capital expenditure restrictions have been placed upon the Trust by the ICS which means we only	4x4	Surgery	3.4

Risk	Risk Title	Score (IxL)	Division	Linked
	have £2.3m allocated for device replacements. the remaining £4m is "at risk" and will roll over into next year's replacement budget which will then stand at £9.5m			
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2
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	
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	
111	Anaesthetic cover out of hours	5x3	Medicine	1.2, 2.1 & 2.2
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	1.4
2019	Delay in treatment for Speech and Language Therapy	3x5	Community	1.2

Risk	Risk Title	Score (IxL)	Division	Linked
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
117	Safe follow up care	4x4	Business Support	1.1, 2.1 & 2.2
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)				
	None			
1.4 Access to Children and Young People's Mental Health (3x5=15)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.1
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2
STRATEGIC OBJECTIVE: Delivery of Outstanding Care *(Support our people)*				
2.1 Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (3x4=12)				
91	Junior doctor staffing in general paediatrics	5x3	Medicine	1.1
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	4x4	Medicine	1.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.2
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Risk	Risk Title	Score (IxL)	Division	Linked
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.2
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.2
2.2 Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (3x3=9)				
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.1
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support	
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
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.1
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.1
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)				
	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			

Risk	Risk Title	Score (IxL)	Division	Linked
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	
2677	We are now in Year 7 since the Alder Hey in the park building became operational. Most of the Trusts Medical Devices were purchased or replaced at this time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 years. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital equipment. This year (22/23) we had planned to replace £6.3m of this capital equipment. However, external capital expenditure restrictions have been placed upon the Trust by the ICS which means we only have £2.3m allocated for device replacements. the remaining £4m is "at risk" and will roll over into next year's replacement budget which will then stand at £9.5m	4x4	Surgery	
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	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)*				
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.

Apr 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	April 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.

Apr 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	April 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

Apr 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	April 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.

Apr 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	April 2024	
		Due Date	Action Update
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	30/09/2024	
Data / BI - case load monitoring	Case load size reporting and monitoring to be improved including: - BI dashboard to be created - validation of data	31/05/2024	Validation ongoing - improvements to accuracy since meeting in February just need some consistency and feedback from ACLs at 1:1s and MDT that caseload is accurate.
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/05/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	03/04/2024	email sent to Will Calvert re. implementation phase. original request to start implementation was sent on the 19.02.24 - was advised that implementation takes around 28 days - I've emailed to chase where things are up to and will update BAF once I receive a response
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	31/05/2024	
Review of KPIs and Reporting Measures	Review of KPIs and reporting measures for Sefton & Liverpool place	31/05/2024	

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	
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
12	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. 3. Not developing inclusive recruitment and talent management practices to improve workforce diversity

Apr 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. Lack of robust 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	April 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 develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and 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	4	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.

Apr 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthyl reporting to PAWC
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 Trust Intranet and accessible for staff
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)	2023 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 Programme	Strategy implementation as part of the People Plan
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at People and Wellbeing 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
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 bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PAWC
Alignment of staff safety and patient safety work via developing safety culture training and developing Restorative Just & Learning culture strategy	Patient Safety Board minutes
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
- lack of embedded safety culture across the organisation - lack of understanding about a just and restorative culture approach - lack of consistent compassionate leadership - Inconsistent application of Trust values and behavioural framework - insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas - insufficient OD resource available to fully address all culture tensions and challenges when they arise

Action	Description	April 2024	
		Due Date	Action Update
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards.	30/09/2024	Staff survey data deep-dive planned with OD team to establish areas of excellence and challenge Staff Thriving Index in pilot stage Thriving Teams MDT operational and feeding into OD, QI, Transformation, HR, FTSU and Divisional Leadership meetings.
Leadership competencies	NHSE Board level leadership competencies published with full appraisal process to follow in autumn 2024. All leader competencies to be developed based on same principles with reference to NHSE line manager competencies and other published leadership competencies.	31/10/2024	
Leadership programme review and update	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focussed review and development	09/09/2024	
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/07/2024	Meeting with Director of Transformation on 4th April to discuss @its Best MDT model and underpinning resource. Output to be reviewed with Head of OD. Consider next stepts in terms of building capability across HR and other supportive People functions.
Review of governance framework supporting culture work	Review of governance framework and reporting processes for culture work including via Patient Safety Strategy Board and People and Wellbeing Committee.	30/03/2024	Culture risk deep dive discussed in PAWC with agreement to review risk with CPO and Director of Corporate Affairs and agree governance framework to support this work. Meeting date to be set.
Safety culture training	Safety culture training to be developed and implemented with teams to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	31/05/2024	Safety culture and human factors training pilot delivered with all PICU staff (completed March 2024). Pilot review to be arranged with Patient Safety training and leadership team to determine feasibility of and agree next steps for roll out across the organisation.
Values and behavioural framework review, update and implementation	Current values and associated behavioural framework to be reviewed in dialogue with segmented groups of staff to develop updated values and underpinning framework. Both to be embedded across the organisation with support from Brilliant Basics.	15/07/2024	

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	
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
12	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. - Non-compliance with the public sector equality duties

Apr 2024	
Control Description	Control Assurance Internal
Establishment of 4 x Staff Networks	All networks have appointed chairs, supported by Head of EDI. members of EDI Steering Group and report bi-monthly
Education and Training in EDI	Mandaotry EDI Training for all staff. current compl;iance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
PAWC Committee ToR includes duties around equality, 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 Head of EDI	monitored through PAWC
People Policies	People 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.
NHS England Improvement Plan supported by Trust Board, and associated actions into action plan	NHSE EDI Improvement 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	Programme in year 3 of delivery, continues to include a focus on inclusive leadership
EDI Steering Group established - Chaired by NED	Minutes reported into PAWC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People and Wellbeing Committee

Gaps in Controls / Assurance
Multi-factoral issues spanning training and education, sufficient EDI resources to support the agenda, cultural awareness and understanding

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

Apr 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	April 2024	
		Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	31/05/2024	Meetings will continue with LCC until full legal agreement of transfer of Park to the Council.
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2024	Regular updates continue to be provided to RABD and Trust Board as appropriate
Infrastructure works	Weekly coordination meetings, site walkarounds, RAMS, mitigation measures identified	31/05/2024	
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		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Resources and Business Development Committee

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.

Apr 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

Action	Description	April 2024	
		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.

Apr 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	April 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.

Apr 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	April 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.

Apr 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	April 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.

Apr 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	April 2024	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2025	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/06/2023	Programme to commence Nov 2023