BOARD OF DIRECTORS PUBLIC MEETING
Thursday 9th January 2025, commencing at 9:00am
Lecture Theatre 3, 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/PATIENT STORY (9:00pm-9:15pm)							
1.	**24/25/265**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/266**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/267**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **5th December 2024.**	**D**	Read enclosure
4.	**24/25/268**	**9:19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**24/25/269**	**9:20 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**24/25/270**	**9:30 (15 mins)**	**Emerging Government Guidance and Policies.**	M. Ashe/ E. Saunders	To provide an overview of the emerging government guidance and policies and what it means for Alder Hey.	**N**	Presentation
7.	**24/25/271**	**9:45 (10 mins)**	**Cheshire and Merseyside Financial Position Update.**	R. Lea	To receive an update on the current position.	**A**	Read report
8.	**24/25/272**	**9:55 (10 mins)**	**Collaborate for Children and Young People: Partnerships Update.**	D. Jones	To receive an update on the current position and key areas.	**A**	Presentation
Operational Issues							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**24/25/273**	**10:05 (40 mins)**	**Evidence of Our Performance:** • **Flash Report, M9.** • **Integrated Performance Report for M8, 2023/24:** - **Experience and Safety.** - **Update on Martha's Rule.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions**	A. Bateman N. Askew N. Askew A. Bateman A. Bateman M. Swindell D. Jones R. Lea Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A**	Read report
10.	**24/25/274**	**10:45 (10 mins)**	**Tuberculosis Positive Case Update.**	M. Swindell	To receive an update on the current position.	**A**	Read report
Unrivalled Experience							
11.	**24/25/275**	**10:55 (10 mins)**	**Organ Donation Annual Report.**	A. Bass	To receive the Organ Donation Annual Report, 2023/24.	**A**	Read report
12.	**24/25/276**	**11:05 (5 mins)**	**Mortality Report, Q2.**	A. Bass	To receive the mortality report for Q2.	**A**	Read report
13.	**24/25/277**	**11:10 (5 mins)**	**Learning from Patient Safety Incidents.**	N. Askew	To receive an update on the current position.	**A**	Read report
14.	**24/25/278**	**11:15 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 18.12.24.** - **Approved minutes from the meeting held on the 20.11.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 20.11.24	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Collaborating in Communities							
15.	**24/25/279**	**11:20 (5 mins)**	**Liverpool Neonatal Partnership Board:** - **Chair's Highlight Report from the meeting held on the 25.11.24.**	A. Bass/ K. Byrne	To receive an update on the LNP Board meeting that took place on the 25.11.24.	**A**	Read report
Supporting our People							
16.	**24/25/280**	**11:25 (10 mins)**	**People Plan Highlight Report, including:** • **EDI update.**	M. Swindell	To receive an update on KPIs and actions.	**A**	Read report
Strong Foundations (Board Assurance)							
17.	**24/25/281**	**11:35 (10 mins)**	**EAO Inquest 9th/10th December - Summary of Coroner's Findings and Residual Actions for the Trust.**	A. Bass/ E. Saunders	To provide a briefing on the outcome of the inquest that took place on the 9th and 10th of December 2024.	**N**	Read report
18.	**24/25/282**	**11:45 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's Highlight Report from the meeting held on the 16.12.24.** - **Approved minutes from the meeting held on the 2.12.24.** - **2024/25 Top Key Risks, (M8).**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 2.12.24, and to receive an update on the top key risks for 2024/25.	**A**	Read enclosures
19.	**24/25/283**	**11:50 (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							
20.	**24/25/284**	**11:55**	**Any Other Business.**	All	To discuss any further business before the close	**N**	Verbal

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(4 mins)			of the meeting.		
21.	**24/25/285**	**11:59 (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 (12:00pm-12:30pm)							
Date and Time of Next Meeting: Thursday, 6th February 2025, 9:00am, LT4, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was not used in December 2024

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M8, 2024/25	R. Lea

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 5th December 2024 at 13:00**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	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)
	Ms. C. Lee	ACOO for Division of Surgery	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. R. Murphy	Senior Communications Manager	(RM)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Observing	Mr. G. Barker-Begley	Head of Nursing for ED and Urgent Care	(GBB)
Apologies:	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. B. Pettorini	Director of Surgery	(BP)

Patient Story

The Chair welcomed Paul and his dad, who had been invited to December's Board meeting to share their journey with Alder Hey. Hari Parekh, Clinical Psychologist, also attended the meeting to offer support to the family.

The Board was informed that Paul arrived at Liverpool Fresh CAMHS in December 2023 for an initial assessment which was a crucial step in understanding and addressing his ongoing struggles with tics, sleep difficulties, and potential ADHD traits. The assessment also highlighted Paul's difficulty managing his feelings, which led to verbal outbursts when frustrated. During the assessment Hari was struck by how excited Paul was when he talked about music. Hari worked with two members of staff in the Dreamers Programme at the Charity to see if the Trust could positively support Paul's interest in music and channel his feelings. They introduced Paul to a Congolese and British rapper called Blue Saint and helped to organise ten individual sessions for Paul. During their work, Paul appeared in a music video, and credited the music as a way to channel his feelings at the time. At the end of his ten sessions, Paul had made arrangements to perform in front of his class with Blue Saint. The week after, they produced and recorded his song.

Paul's dad explained about their home circumstances and advised that as a result of the support received from family, friends, school, and social services they have braved the storm, and things are starting to get better.

The Chair asked as to whether the Trust could have done anything different/better in terms of Paul's care. Dad advised that he was really happy with the care that was provided, and Paul suggested having more time with the artist would be good.

The Chair thanked Paul and his dad for attending December's Board and wished both of them well for the future.

24/25/238 Declarations of Interest

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

24/25/239 Minutes of the previous meeting held on 7th November 2024.
Resolved:
The minutes from the meeting held on the 7.11.24 were agreed as an accurate record of the meeting.

24/25/240 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 24/25/189.1: *Liverpool Neonatal Partnership Governance (Meeting to take place between the Chair and CEO of Alder Hey and LWH to discuss the barriers being experienced in terms of interpreting data i.e. mortality and having access to reports for joint meetings e.g. LNP Board. Kerry Byrne agreed to attend this meeting in her capacity as lead NED for the LNP)* – An initial meeting has taken place, and discussions are ongoing. A further meeting has been scheduled for the 16.12.24. **ACTION CLOSED**

Action 24/25/214.1: *Evidence of our Performance (Write to the Secretary of State to request financial support for the purchase of a second CTC scanner)* – The Trust is in the process of compiling a letter to the Secretary of State with the support of the Trust's Policy Lead/Advisor to the CEO. **ACTION CLOSED**

Action 24/25/214.4: *Integrated Performance Report (Neurology Service - Advise as to whether Manchester has accepted the proposed plan to help alleviate some of the issues being experienced by the Trust's Neurology service)* – Work is ongoing with the team on the transformation programme. The issue relating to the stabilisation of the rota has been escalated to the Integrated Care Board (ICB) who have helped to facilitate this matter. Also, colleagues in Manchester have approached Great Ormand Street Hospital (GOSH) to see if they can offer support. **ACTION CLOSED**

24/25/241 Chair's and CEO's Update

The Chair opened the meeting by formally welcoming John Grinnell as the new Chief Executive Officer (CEO) of Alder Hey and offered congratulations on behalf of the Board.

The Board was informed that the new Regional Director of NHS North West, Louise Shepherd, had held an inaugural meeting with provider Chairs and CEOs. During the meeting the performance of providers was acknowledged in a positive way. There are plans to establish a mechanism to jointly address the challenges for the three ICBs, commencing with a workshop in December which will enable organisations to share their experiences and learn from others.

The Chair advised that the CEO of the Cheshire and Merseyside (C&M) Integrated Care Board (ICB), Graham Urwin, has confirmed that he will be retiring in June 2025. Reference was made to the critical financial situation that the C&M ICB are in, which remains very challenging.

It was reported that new Vice Chancellor of Hope University visited the Trust for a tour of the Innovation Hub. The visit was successful, and the Vice Chancellor has shown an interest in looking at ways of working on areas of mutual interest.

The Trust will also be receiving a visit in the near future from the CEO of Brathay Trust. Brathay deliver experiential residential programmes to young people across the UK at their dedicated Centre in the Lake District. They are also able to breakdown financial barriers via the use of bursaries to ensure young people have the opportunity to have life-changing experiences.

John Grinnell made reference to December's agenda and felt that it captured relevant items for discussion during the meeting. It was pointed out that Alder Hey's front door is the busiest it has ever been. The Trust launched its Anti-Racism Statement w/c 2.12.24.

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

24/25/242 Vision 2030 Strategy Update

The Board was provided with an overview of the outcome of the Strategy Board Workshop that took place on the 5.12.24. There was some important learning and reflection during the session that will support the ongoing deployment of the strategy as the organisation moves into the next stage. It was reported that a 5-year plan and multi-year programme has commenced and the current Transformation Programme will be formally closed at the end of the 2024/25 financial year. The Board was advised that the feedback provided during the session will be reflected in plans going forward.

Resolved:
The Board noted the update from December's Strategy Board Workshop.

24/25/243 Cheshire and Merseyside System Wide Issues Update

The Board received a C&M System update. A number of slides were shared that provided information on the following areas:

- What does the new 10-Year Plan mean to Alder Hey?
  - *Vision 2030:* The Trust's strategy is in full alignment with the direction of the 10-year plan and work is progressing from an Alder Hey perspective with an emphasis on analogue to digital (Bring me the Future), sickness to prevention (Improve my Life Chances), and hospital to community (Get Me Well and Personalise my Care).
  - *National Influence:* Alder Hey is working with partners in the Children's Hospital Alliance to formally feedback key areas of focus for children and young people (CYP) including; reducing the time CYP are waiting for elective care nationwide, building capacity and capability for CYP outside of hospitals, developing a prevention-led health service.
- NHS 10-Year Plan – Alder Hey's contributions;
  - Alder Hey has crafted three aligned approaches to formally feedback into the Government's 10-year plan engagement; direct response as a Trust, response as a partner in CHA, via Beyond, and working with the ICB re the voice of CYP.
- NHS 10-Year Plan – Alder Hey's response;
  - Alder Hey has ensured that CYP are heard within the Trust's response, taken on board the voice of clinicians, colleagues, and the Youth Forum, aligned with the CHA and wider CYP sector, charities, and professional bodies in order to provide recommendations.
- CYP System and Partnerships: Key objectives for Q4.

A question was raised and responded to about the assurances in place with regard to the digital work being undertaken with Palantir. It was confirmed that a memorandum of Understanding is in place and legal advice was taken before pressing ahead with the project.

Resolved:
The Board noted the C&M System wide update.

24/25/244 Evidence of Our Performance

Flash Report, M8

The Board received the Flash Report for November 2024. The following points were highlighted:

- Diagnostics achieved 95% performance.
- M8 is the fifth consecutive month with a reduction for referral to treatment (RTT) >52 weeks; there are now 364 patients waiting over 52 weeks for treatment or care.
- *Challenges;*
  - Never Event reported in M8.
  - Elective recovery YTD is under 90%.
  - ED performance is at 73.5%. This is the first time in 12 months that the Trust hasn't achieved the 77% national target.

A slide was shared that provided a summary of winter demand and performance. Attention was drawn to the following points:

- *ED Attendances* - There were 360 additional attendances to ED in comparison to the same period in 2023 - (October-November).
- *Type 1 ED Ranking* – The Trust's Emergency Department has been ranked as the 2nd best nationally. It was noted that ranking is determined by Trust Type 1 ED performance from the 1.4.24 to the 31.10.24.
- RSV admissions have reduced in comparison to the same period in 2023 - (October – November). It was reported that the RSV surge commenced earlier in 2024 and there may be further presentations in the next 2 to 3 weeks.
- The demand in Critical Care is higher compared to the same period in 2023 - (October-November).
- Theatres have delivered 66 more sessions compared to the same period in 2023 - (October-November).

Integrated Performance Report for M7, 2023/24

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

Outstanding Care and Experience – Safe and Caring

- There has been a decrease in key metrics relating to sepsis and Friends and Family Test (FFT) due to increased occupancy.
- 94% of PALS concerns have been responded to within 5 working days and 92% of formal complaints have been responded to within 25 working days.
- *Out Patient Department* - There was 1 Never Event reported in November. This incident related to an injection taking place on the wrong limb as a result of the patient turning over during the preparation procedure. Learning has been taken from this incident and it has been agreed going forward that the area to be injected should be marked ahead of the procedure.

Support our People

- Whole time equivalents (WTE) remain a challenge and the plan was exceeded for the first time in October 2024 due to an increase in temporary workforce usage, substantive workforce which includes the bulk nurse recruitment, and a reduction in the overall plan due to the impact of CIP. A meeting took place w/c 2.12.24 to explore the underlying aspects of this matter.
- There has been an increase in sickness absence due to seasonal ailments. Actions are in place to address this issue.

LC queried as to whether there is a breakdown of vaccine data available by division that can be shared. It was confirmed that there is.

24/25/244.1 Action: NA

Pioneering Breakthroughs

- The Mobile Research Unit is now on site and ready for use to extend the Trust's research into the community. The plan is to use the unit for all outreach activities rather than just research related activities.
- The 3rd MRI scanner is now operational.
- Lyrebird Ambient AI pilot is now live and being tested in ED given the pressures. The Trust will evaluate the technology ahead of a six-month stock take with the company.

Financial Sustainability: Well Led

- The latest position as at M7 is a £1.6m deficit, which is off plan by £0.7m YTD due to the impact of the pay award.
- The Trust is forecasting to achieve a £3.3m surplus, however, the Trust is carrying a £1.2m pay award risk that the organisation will endeavour to mitigate via an internal stretch.
- CIP was above plan in M7, £14.7m CIP has been transacted in year, with £5.2m in progress and opportunity.
- Cash remains high, although slightly lower than plan due to high levels of accrued income as awaiting payment of YTD ERF.
- Capital is broadly on plan YTD however the forecast has been updated to £1.5m favourable to plan, following movement of the Neonatal expenditure to 2025/26 with the agreement with the ICB.

Community and Mental Health Division

- *ADHD Medication Shortages* – The Trust has been advised that the shortage of ADHD medication will be resolved by January 2025.

Non-Executive Director, Gerald Meehan, advised of his recent visit to the Trust's Gender Service based in Warrington. It was reported that the facilities are very good with a balance between feeling professional yet homely. The team is preparing for a lot of referrals in January, and attention was drawn to the importance of bringing the service together nationally and having a model that includes research. A discussion took place, and it was agreed to provide a briefing on the network approach that is being taken to wrap around the service nationally.

24/25/244.2 Action: LC

Division of Medicine

The Board was advised that UKAS conducted an inspection of the Trust's laboratories on the 4.12.24. Due to a number of staffing and workforce issues (sickness/recruitment), it is likely that the accreditation will be suspended for a three-month period. This does not relate to any safety or technical issues, but UKAS have advised that the department needs to be fully staffed and have asked to see some of the service's plans in relation to this. The Board was informed that the department is expecting to be in a better position by March; with one member of staff returning from sick leave in January, and recruitment taking place in February and March for two Band 6 posts. The service is also expecting to have a locum in place by January.

Division of Surgery

- The Division has launched a referral performers pilot with primary care colleagues and is starting to track the benefits.

Resolved:
The Board:

- Noted the Flash Report for M8.
- Noted the content of the IPR for Month 7.

24/25/245 ED Waiting Room

The Board was advised that as part of the wider NICU/SDEC new build, the current ED waiting area is required to be handed over to Morgan Sindall Construction (MSC) to enable key works activities to proceed. The commencement

of this change will take place on the 7th of January 2025 and will continue until MSC are able to hand the building back for occupation which is expected to be early in December 2025.

The identified changes are as follows:

- The current ED waiting area is to be closed.
- The current Radiology waiting area will be moved to the performance space within the atrium.
- An ED waiting area is to be created within the existing Radiology waiting area space and adjacent corridor space.
- ED reception to share a joint reception desk with Radiology within the atrium.
- ED Nurse streaming to be co-located with the new reception area.

An overview of the implications due to the changes was provided along with the financial impact, as detailed in the report. The Board was informed that work is being undertaken to look at ways of informing families of the impending adjustments to the ED waiting area.

The Chair drew attention to the importance of preparing communications to explain the reason for these alterations, and a suggestion was made about liaising with the Children and Young People's Forum on this matter. It was also pointed out that attention will need to be given to the sensory issues that this change will create for a number of patients.

Resolved:
The Board noted the impending alterations that will impact the organisation and acknowledged the operational, clinical, security and financial implications of the proposed changes.

24/25/246 Alder Hey in the Park Campus Development Update

The Board was provided with an update on progress, budget controls, risks and actions on capital projects. The following points were highlighted:

- *Catkin and Sunflower House* – A conclusion is yet to be reached in terms of a commercial settlement with the contractor.
- *Neonatal Unit* – Progress is being made with the construction of the building.
- *Springfield Park* - Approval of the planning application for the swale is expected by the end of January 2025.
- *Social Prescribing Base Camp* – It was reported that the installation of the base camp is underway.
- *Master Site Planning* – A workshop is to take place during the first quarter of 2025 to discuss the opportunities of the Campus from a strategic perspective.

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

24/25/247 Digital, Data and Information Technology Update

The Board received an update on progress relating to Digital and Data and its contribution to Vision 2030. An overview of the work that has been undertaken was shared in respect to the overall service, key areas of transformation and operational performance. The following additional points were highlighted:

- The Trust hosted NHS England's Chief Data Officer on the 27.11.24. It was confirmed that the visit was very successful.
- Work is underway to review the recent cyber incident.

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

24/25/248 PALS and Complaints, Q2

The Board received an update on the performance against complaints and PALS targets in Q2 2024/25 and a thematic analysis of the top reasons for complaints and PALS. The following points were highlighted:

- The format of the new report continues to be refined by the Safety and Quality Assurance Committee (SQAC).
- 85% of formal complaints were responded to within 25 working days with excellent compliance in the Divisions of Medicine and Surgery. ADT is the primary category of complaints that are linked to medication shortages.
- Corporate services are consistently failing to achieve 100% compliance in responding to the concerns of families in a timely manner. A review is underway to improve oversight and ownership under the auspices of the Corporate Services Collaborative.

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

24/25/249 Mid-Year Nurse Staffing Report

The Board received the mid-year Nurse Staffing report in order to receive assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing. Attention was drawn to the following points:

- The Trust has trialled an NHSE pilot to support the implementation of the CYP safe nursing care tools (SNCT). It was reported that the collection of data will be beneficial to the Trust, but it has to be collected a minimum of three times before it can be used to set establishments, therefore the senior team have used the data during the 2024 round of establishment reviews in shadow form. All establishment reviews, with the exception of the Out Patients Department, have been conducted in 2024 between August and October. Sunflower House and ED will undertake their first data collection in January 2025.
- The Senior Nurse/AHP team have increased the oversight and scrutiny of bank shifts through the Trust's daily Safer Staffing meeting. The Board was advised that there is a decreasing trend of temporary staffing usage, but further work is still required on temporary payments.
- There has been a reduction in leavers in the reporting period, April to August 2024.

- A meeting has taken place between the Trust, NHSE and the Regional team regarding the organisation's workforce. The action that arose as a result of discussions has been shared as part of Alder Hey's best practice.

The Chair asked as to whether work has been undertaken to quantify the retention of the Trust's nurses. It was reported that figures have been determined for leavers and it was agreed to share this information with the Board.

24/25/249.1 Action: NA

Resolved:
The Board received and noted the mid-year Nurse Staffing Report.

24/25/250 DIPC Report, Q2

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

- It was reported that the Trust is seeing cases of respiratory viral infections (RSV) despite the ongoing vaccination programme. The IPC team continues to perform daily "isolation walks" among all areas of the Trust to communicate to staff the appropriate IPC precautions and has developed visual graphics to identify contagious patients. The IPC team sends out monthly newsletters with key messages and updates and provides bespoke education sessions for areas.
- IPC Committee governance has been strengthened with oversight and approval of updated IPC policies and relevant workplans for the operational groups reporting into the IPC Committee.
- The Sharps Safety Group is now under the leadership and supervision of the Health and Safety team.
- The Hand Hygiene Improvement Group are looking at innovative ways to encourage people to maintain hand hygiene. The Innovation team have arranged for a pilot to take place in association with an external company. The technology that is to be used will enable the Trust to undertake an audit.
- All band 6 staff are in post and receiving training, but it was reported that the Trust was unsuccessful in appointing a Deputy Director of Infection, Prevention and Control.

It was suggested that water safety be included in the IPC reporting process, and a question was raised about whether the Trust has thought about promoting hand hygiene via the use of different languages as families are key to driving this area of work forward.

Resolved:
The Board noted the Infection, Prevention and Control update for Q2.

24/25/251 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 23.10.24 were submitted to the Board for information and assurance purposes.

The Board was advised that the Trust now has a Named Doctor for Safeguarding in post therefore the Committee has agreed that risk 2748 can be removed from the Corporate Risk Register.

Resolved:
The Board noted the approved minutes from the meeting held on the 23.10.24.

24/25/252 Futures Committee Assurance Report

The approved minutes from the meeting held on the 30.9.24 were submitted to the Board for information and assurance purposes. An update was provided on the following areas of work:

- It was reported that Alder Hey is awaiting a decision on the Paediatric Open Innovation Zone Programme bid which is part of the Liverpool City Region Investment Zone.
- Attention was drawn to the Memorandum of Understanding that has been signed between Alder Hey and Vietnam.
- *Alder Hey Anywhere* – Following approval of a preferred supplier the patient portal is to be launched in March 2025.
- The new Alder Hey Mobile Research Unit has been delivered and is ready to use to build connections in the community/expand outreach activity.
- The Futures Committee received a presentation during November's meeting on risk appetite and tolerances for clinical innovation. It was reported that a further session is to take place with the Non-Executive members of the Committee.

It was felt that a lot of change has been facilitated via the Futures Committee and the Trust is now in a position to reach out externally to partners.

Resolved:
The Board noted the approved minutes from the meeting held on the 30.9.24

24/25/253 People Plan Highlight Report

The Board received a detailed report on the progress that has been made against the core workstreams of the People Programme. It was pointed out that together they include the key elements of the Trust's culture evolution, creating the right conditions for people to thrive, learn and work differently to deliver a healthier, happier fairer future for children and young people. Attention was drawn to the following points:

- A positive meeting took place between the Chairs of the staff networks and the Freedom to Speak Up Guardian (FTSUG) about linking FTSU with the role of the Chairs of the staff networks. It was confirmed that the Chairs are in agreement for the FTSUG to attend future network meetings.
- Work has commenced on avoidable employee harm with a session having taken place with staff side and unions to create a positive working environment and adopting best people practises. An Avoidable Employee Harm workshop has also been held with the senior HR team to reflect on the current state and assess the work needed to embed restorative just and learning approaches into all people practices.

- The Aspiring Chief Medical Officer programme was announced at the Clinical Leaders' summit with a call for expressions of interest from medical colleagues.
- Discussions have taken place with regard to the diversified and accessible recruitment workstream. Some immediate interventions have been identified in terms of removing barriers and taking positive action to promote more inclusive practises. The Equality, Diversity and Inclusion (EDI) Steering Group and staff networks have been identified as key stakeholders and 'critical friends' to the diversified and accessible recruitment workstream. Regular meetings into 2025 are currently being scheduled to support this wider programme of work

Resolved:
The Board received the People Plan Highlight Report which included an update on One Alder Hey and Thriving, Professional Hub, and the Future Workforce.

24/25/254 People Committee

The approved minutes from the meeting held on the 19.9.24 were submitted to the Board for information and assurance purposes.

During November's meeting there was a focus on the positive outcome of the 2024 staff awards with suggestions made about acquiring sponsorship for next year's awards ceremony. A conversation took place on PDRs and the importance of having a structure in place across the Divisions to ensure PDRs are done in a timely manner, especially as some managers have more staff than others. It was reported that this item will be discussed further at a future meeting. The Committee also received assurance in other areas and approved a number of policies.

The Chair of the People Committee informed the Board of her recent attendance at a Schwartz Round. This session was the first one to be held in person since the pandemic and it provided an opportunity for staff from all backgrounds to come together in a safe space to share their experiences and thoughts after hearing from a key speaker. The Board was advised of the impact of these meetings and a suggestion was made about having a Schwartz Round specifically for Board members.

Resolved:
The Board noted the approved minutes from the meeting held on the 19.9.24

24/25/255 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 28.10.24 were submitted to the Board for information and assurance purposes.

2024/25 Top Key Risks (M7)

The Board was advised of the latest position of the 2024/25 Finance, Transformation and Performance Committee's key risks.

Resolved:
The Board noted the approved minutes from the meeting held on the 28.10.24 and the update on the Committee's top key risks in M7.

24/25/256 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:

- BAF risk 3.1 *(failure to fully realise the Trust's Vision for the Park and Alder Hey Campus)* – Two of the Campus risks have a reduced risk score.
- BAF risk 1.2 *(Children and young people waiting beyond the national standard to access planned care and urgent care)* - Reference has been made in the BAF to the work on follow-ups that has taken place in respect to improving access.
- *BAF risk 4.2 (failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families*) – This risk has been reviewed following the recent cyber-attack.
- The next iteration of the BAF will include further updates on finance and the emergence of risks that have been discussed by the Assurance Committees.

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

24/25/257 Any Other Business

There was none to discuss.

24/25/258 Review of the Meeting

The Chair thanked everyone for their contributions during the meeting. It was felt that the Board had had a productive session and attention was drawn to the ongoing focus that will be required on Finance and People as the organisation heads into 2025.

Date and Time of Next Meeting: Thursday 9.1.24 at 9:00, LT4, Institute in the Park.

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for February 2025							
6.6.24	24/25/76.2	Integrated Performance Report (M1)	*Division of Surgery* - Discussion on the high risk relating to overdue outpatient/follow-up appointments to take place at a future RMF.	E. Saunders	9.1.25	Feb-25	**27.8.24** - A request has been made for this item to be included on September's RMF agenda. **27.9.24 -** A request has been made for this item to be included on December's RMF agenda. **3.1.25** - An update will be provided in February. **ACTION TO REMAIN OPEN**
5.9.24	24/25/142.1	Alder Hey in the Park Campus Development Update	Provide an update on the resolution for the sprinkler system in the Under-Croft car park.	D. Powell	5.12.24	Feb-25	**27.9.24** - This item will be included on November's Board agenda. **3.10.24** - This action has been deferred to December as further work is required before an update can be submitted to the Board. **28.11.24** - This action has been deferred to January. **3.12.24** - A report on the resolution of the sprinkler system in the Under-Croft car park will be submitted to the Board in February following approval of the proposal by the FTPC. **ACTION TO REMAIN OPEN**
3.10.24	24/25/181.2	Alder Hey – Autumn and Winter Emergency Response Plan, 2024/25	*National debate on the Healthier Together App* - Set time aside to think about whether the Trust should continue with its established symptom checker which is to be promoted and further developed this winter, or whether Alder Hey should link in with the national initiative 'Healthier Together' and the options available.	A. Bateman	6.2.25	On track Feb-25	
3.10.24	24/25/183.1	Alder Hey in the Park Campus Development Update	Board discussion to take place on a partnership strategy for the Campus and the options available.	D. Powell	9.1.25	Feb-25	**3.12.24** - A workshop is taking place at the end of January to discuss site planning opportunities. An update will be provided in February. **ACTION TO REMAIN OPEN**
7.11.24	24/25/214.2	Integrated Performance Report	Invite the family of a patient who were supported by the Wellbeing Hub, to a future Board meeting to share their story.	D. Jones/ K. McKeown	6.2.24	On track Feb-25	
7.11.24	24/25/219.1	Staff Story (EDI)/ Equality Act	Discuss the recommendations made by the Chairs of the staff networks and provide feedback on the outcome following discussion by the Exec team - (It was suggested that the big items be discussed; recruitment, promotion, management training, but in terms of the smaller asks it was felt that these should be responded to point by point with a mini action plan underpinning this work. A request was made to include reciprocal mentorship in the items to be discussed with a view to establishing a Reciprocal Mentorship Programme).	M. Swindell	9.1.25	Feb-25	**7.1.25** - Work is taking place with the network leads to support the recommendations made by the Chairs of the staff networks. An update on progress will be provided in February 2025. **ACTION TO REMAIN OPEN**
5.12.24	24/25/244.1	Integrated Performance Report for M7, 2023/24	Submit a briefing to the Board on the network approach for the Gender Service.	L. Cooper	6.2.24	On track Feb-25	
Actions for June 2025							

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
6.6.24	24/25/83.1	2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement	Covering report sheet to be more specific to identify actions that are important versus business as usual.	A. Bass	Jun-25	On track Jun-25	
Actions for September 2025							
5.9.24	24/25/149.1	Wellbeing Guardian Dashboard	Integrate Freedom To Speak Up in the next iteration of the Wellbeing Guardian Report.	J. Revill	Sep-25	On track Sep-25	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
5.9.24	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	7.11.24	Closed	**5.6.24 -** This action is being progressed. An update will be provided during September's meeting. **5.9.24** - There hasn't been an opportunity to address this action therefore the action is to remain open. **7.11.24** - It was confirmed that there is nothing formal to report. **ACTION CLOSED**
2.5.24	24/25/51.1	FTSU Update	In order to show the meaning of culture from an FTSU perspective, it was agreed to include more detail in the FTSU report to provide anonymised examples of culture once the Trust has agreed its definition of culture.	K. Turner	9.1.25	Closed	**22.8.24** - This action cannot be completed until the Trust has agreed its definition of culture. **3.10.24** - This action will be reviewed following December's Trust Strategy Board. **3.1.25** - The FTSUG with the support of the Assoc. Director of Organisational Development will keep this action under review and will include more detail in the FTSU report to provide anonymised examples of culture once the Trust has agreed its definition of culture. **ACTION CLOSED**
4.7.24	24/25/111.1	LUFT/LWH/Alder Hey – Partnership Update	Liaise with LUFT/LWH to organise a Board to Board meeting in September 2024.	E. Saunders/ K. Mckeown	9.1.25	Closed	**22.8.24** - Following discussion with LUFT/LWH it has been agreed to arrange for this meeting to take place at a later date. **27.9.24** - An initial meeting is taking place between Erica Saunders and Daniel Scheffer ahead of arranging a Board to Board meeting. **6.11.24** - A further meeting has taken place in November. Arrangements are yet to be made for a Board to Board meeting. **28.11.24** - Arrangements are yet to be made for a Board to Board meeting. **3.1.25** - An Exec to Exec meeting took place in December and the actions agreed during the meeting have superseded Action 24/25/111.1. **ACTION CLOSED**
5.9.24	24/25/140.1	Vision 2030 Strategy Deployment Update	Agenda item to be included on November's Strategy Board to discuss the outcome of the stock take exercise of the Trust's strategic goals to look at what is/isn't working in order to adapt the organisation's plans.	K. Warriner	5.12.24	Closed	**3.10.24** - The Trust Strategy Board has been deferred to the 5.12.24. **28.11.24** - This item has been included on December's Strategy Board agenda. **ACTION CLOSED**
3.10.24	24/25/182.1	Integrated Performance Report for M5, 2023/24	Review the attendance list of risk meetings co-ordinated by the Governance team to ensure there is appropriate representation.	E. Saunders	5.12.24	Closed	**3.1.25** - This action is being monitored on an ongoing basis. **ACTION CLOSED**

3.10.24	24/25/189.1	Liverpool Neonatal Partnership Governance	Meeting to take place between the Chair and CEO of Alder Hey and LWH to discuss the barriers being experienced in terms of interpreting data i.e. mortality and having access to reports for joint meetings e.g. LNP Board. Kerry Byrne agreed to attend this meeting in her capacity as lead NED for the LNP.	Dame Jo Williams/ J. Grinnell/ K. Byrne	5.12.24	Closed	**5.12.24** - An initial meeting has taken place, and discussions are ongoing. A further meeting has been scheduled for the 16.12.24. **ACTION CLOSED**
7.11.24	24/25/214.1	Evidence of our Performance	Write to the Secretary of State to request financial support for the purchase of a second CTC scanner.	Dame Jo Williams	5.12.24	Closed	**5.12.24** - The Trust is in the process of compiling a letter to the Secretary of State with the support of the Trust's Policy Lead/Advisor to the CEO. **ACTION CLOSED**
7.11.24	24/25/214.4	Integrated Performance Report	*Neurology Service* - Advise as to whether Manchester has accepted the proposed plan to help alleviate some of the issues being experienced by the Trust's Neurology service.	U. Das	5.12.24	Closed	**5.12.24** - Work is ongoing with the team on the transformation programme. The issue relating to the stabilisation of the rota has been escalated to the Integrated Care Board (ICB) who have helped to facilitate this matter. Also, colleagues in Manchester have approached Great Ormand Street Hospital (GOSH) to see if they can offer support. **ACTION CLOSED**
7.11.24	24/25/214.5	Integrated Performance Report	Discussion to take place to look at whether the Trust is in a position to request funding from the Government for something that may create a transformational change for Alder Hey and the NHS, for example, no patients waiting for treatment over 39 weeks.	Execs	9.1.25	Closed	**7.1.25** - The Trust has reached out to NHSE in terms of requesting support for Alder Hey's transformation approach. This request will also be incorporated in the letter that is being compiled to the Secretary of State for Health and Social Care, Wes Streeting. **ACTION CLOSED**
5.12.24	24/25/244.1	Integrated Performance Report for M7, 2023/24	Share a breakdown of the vaccine data by Division with Lisa Cooper.	N. Askew	5.12.24	Closed	**7.1.25** - A breakdown of the vaccine data by Division has been shared with Lisa Cooper. **ACTION CLOSED**
5.12.24	24/25/249.1	Mid-Year Nurse Staffing Report	*Nurse Retention* - Share the analysis with the Board on the figures that have been determined for leavers.	N. Askew	5.12.24	Closed	**7.1.25** - Information was shared with the Board on Alder Hey's leavers and hires along with cost savings. **ACTION CLOSED**

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**Cheshire and Merseyside Financial Update**
Report of:	**Chief Finance Officer**
Paper Prepared by:	Chief Finance 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:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **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

C&M Financial Update
Trust Board Part 1
9th January 2025

Executive Summary

The purpose of this paper is to update the Board on the latest C&M financial position as at the end of November, including system efficiency plans and workforce and also an update on the forecast for the full financial year. The information contained in this paper has been collated from reports shared by ICB.

The key points to note from this paper are:

- C&M system is reporting a deficit of £229.4m at the end of November which is £67.3m adverse to the plan as agreed at the start of the year and also £18.9m worse than the recovery trajectory submitted at the end of August.
- CIP plans are behind plan by £22.4m at Month 8, with only 53% of the full year plan delivered to date.
- Forecast for the year highlights a further deterioration in the risk adjusted forecast to £222m deficit largely due to the residual gap in funding for the pay award, overall, a £72m variance to the £150m deficit plan set.
- Workforce numbers have increased over the last 3 months at nearly 1000 WTE over plan YTD with a significant reduction of 1468 required to hit the workforce plan by the end of March 25.

The Trust Board are asked to note the contents of this paper.

1. Year to date System Financial Position

The financial plan for the ICB in 24/25 as agreed with NHSE is to achieve a combined £150m deficit (£62.3m surplus for the ICB and £212.3m for providers) by end of March 25.

As of 30th November 2024 (Month 8), the system is reporting a YTD deficit of £229.4m against a planned YTD deficit of £162.1m resulting in an adverse YTD variance of £67.3m, with £40.7m in the ICB and the remaining £26m within provider positions.

YTD Actual Run Rate	M1 YTD £m	M2 YTD £m	M3 YTD £m	M4 YTD £m	M5 YTD £m	M6 YTD £m	M7 YTD £m	M8 YTD £m	FY Plan £m	M8 as a % of Plan %
ICB	3.4	1.7	6.9	(0.4)	**(0.7)**	**1.1**	**6.2**	**0.8**	62.3	1%
Providers	(30.9)	(70.5)	(107.9)	(137.9)	**(166.2)**	**(185.4)**	**(206.7)**	**(230.2)**	(212.3)	108%
TOTAL ICS	(27.5)	(68.8)	(101.0)	(138.3)	(166.9)	(184.3)	(200.5)	(229.4)	(150.0)	153%

The ICB variance largely relates to overspend in Continuing Health Care (CHC) and Mental Health care packages and continued increase in prescribing spend. Places within the ICB have been challenged to deliver additional mitigations to offset these areas of significant overspending.

The drivers of the provider variance include £5m residual industrial action costs, £7m residual pay award gap along with £16m undelivered CIP and c£30m of operational pressures which are partly mitigated by non-recurrent benefits, underspends, vacancies across a range of providers.

2. Financial Position by Organisation

The table below shows the position reported by all organisations at the end of November compared to the plan submitted and compared to the recovery trajectory submitted at the end of August.

Org	Month 8 YTD (Excluding 8/12ths of deficit funding)			Mth 8 YTD vs YTD Recovery Trajectory			explanation of variance to trajectory	
	Plan	Actual	Variance	Trajectory	Variance to Trajectory	Variance	pay award related	other non pay award
	£m	£m	£m	£m	£m	£m	£m	£m
Alder Hey Children's	0.1	(0.5)	(0.6)	0.1	(0.6)	Worse	(0.6)	0.0
Bridgewater Community	0.7	(1.7)	(2.4)	(1.6)	(0.2)	Worse	0.0	(0.2)
Cheshire & Wirral Partnership	0.5	0.8	0.2	0.4	0.3	Better	0.0	0.3
Countess of Chester Hospitals	(17.5)	(24.2)	(6.7)	(23.2)	(0.9)	Worse	(1.1)	0.2
East Cheshire Trust	(11.8)	(12.1)	(0.3)	(12.0)	(0.1)	Worse	(0.6)	0.4
Liverpool Heart & Chest	8.8	8.4	(0.4)	8.4	0.0	No change	0.0	0.0
Liverpool University Hospitals	(91.2)	(97.0)	(5.7)	(97.5)	0.5	Better	(2.3)	2.9
Liverpool Women's	(19.7)	(19.0)	0.6	(19.1)	0.0	No change	0.0	0.0
Mersey Care	3.8	3.8	0.0	3.8	0.0	No change	(0.6)	0.6
Mid Cheshire Hospitals	(22.0)	(24.2)	(2.1)	(25.1)	0.9	Better	(0.5)	1.4
Mersey & West Lancs	(25.5)	(22.5)	2.9	(22.6)	0.1	Better	(0.4)	0.5
The Clatterbridge Centre	0.4	0.4	0.0	0.3	0.1	Better	0.0	0.1
The Walton Centre	3.5	4.0	0.5	3.9	0.1	Better	0.0	0.1
Warrington & Halton Hospitals	(22.8)	(24.3)	(1.5)	(24.0)	(0.3)	Worse	(0.5)	0.2
Wirral Community	1.3	1.3	0.0	1.3	(0.0)	No change	0.0	(0.0)
Wirral University Hospitals	(12.4)	(23.3)	(11.0)	(19.4)	(4.0)	Worse	(0.6)	(3.4)
TOTAL (C&M Providers)	**(203.7)**	**(230.2)**	**(26.6)**	**(226.1)**	**(4.1)**	Worse	**(7.3)**	**3.2**
C&M ICB	41.5	0.8	(40.7)	15.6	(14.8)	Worse	0.0	(14.8)
TOTAL C&M ICS	**(162.1)**	**(229.4)**	**(67.3)**	**(210.5)**	**(18.9)**	Worse	**(7.3)**	**(11.7)**

There are 4 trusts reporting an adverse variance to the risk adjusted August trajectory relating entirely to the impact of the pay award funding, without this issue the provider run rate would have been c£6m better than the trajectory.

3. System Efficiency (CIP)

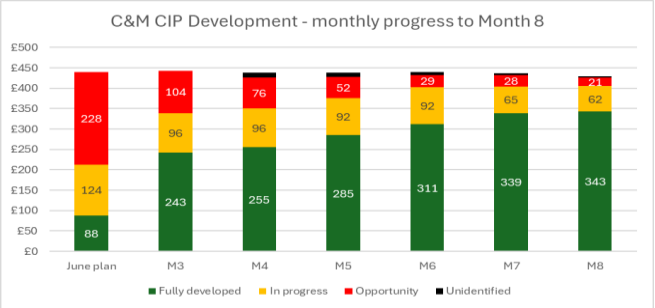
The plan for the year assumed an aggregate system efficiency plan of £440m (6.1%).

At Month 8 there is currently a shortfall on planned CIP delivery of £22.4m against the YTD plan, with £15.1m attributable against providers and £22.4m against the ICB. The £235.3m efficiencies delivered YTD represent 4.5% of provider and ICS expenditure/allocation against the annual plan of 6.1%. Only 65% of the YTD CIP plan has been delivered recurrently which will result in a risk for 25/26 planning and overall exit run rate.

Org	CIP Efficiency - YTD Delivery												CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M8 YTD Plan	M8 YTD Actual	M8 YTD Variance	M8 YTD % Variance	M2 CIP actual as a % of Op Ex	M3 CIP actual as a % of Op Ex	M4 CIP actual as a % of Op Ex	M5 CIP actual as a % of Op Ex	M6 CIP actual as a % of Op Ex	M7 CIP actual as a % of Op Ex	M8 CIP actual as a % of Op Ex	FY CIP Plan % of Op Ex	Actual Recurrent	Actual Non Recurrent	Actual Recurrent as a % of YTD plan	full year CIP (new plan)	YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	%	%	%	%	%	%	£,000	£,000	%	£,000	%
Alder Hey Children's	11,269	11,804	535	5%	2.3%	2.4%	2.8%	3.2%	3.7%	3.7%	3.9%	4.8%	7,805	3,999	69%	19,950	59%
Bridgewater Community	2,952	1,894	(1,058)	-36%	1.2%	1.6%	1.7%	1.9%	2.7%	2.6%	2.6%	6.9%	504	1,390	17%	6,939	27%
Cheshire & Wirral Partnership	8,806	7,971	(835)	-9%	2.7%	2.9%	3.1%	2.8%	3.4%	3.4%	4.0%	5.0%	2,907	5,064	33%	13,913	57%
Countess of Chester Hospitals	11,431	6,574	(4,857)	-42%	0.1%	0.7%	1.4%	1.6%	1.8%	1.9%	2.4%	5.3%	6,574	0	58%	19,822	33%
East Cheshire Trust	6,025	6,033	8	0%	2.0%	2.0%	2.5%	2.8%	3.0%	3.4%	3.8%	5.0%	2,823	3,211	47%	11,225	54%
Liverpool Heart & Chest	6,781	5,013	(1,768)	-26%	1.9%	2.3%	2.5%	2.6%	2.9%	2.9%	3.0%	4.6%	3,830	1,183	56%	10,644	47%
Liverpool University Hospitals	60,486	52,804	(7,682)	-13%	4.3%	4.4%	4.6%	5.0%	5.3%	5.2%	5.5%	8.5%	30,387	22,417	50%	114,600	46%
Liverpool Women's	3,397	4,384	987	29%	1.2%	1.6%	2.5%	3.8%	3.8%	3.5%	3.5%	3.3%	1,688	2,696	50%	5,904	74%
Mersey Care	17,311	17,311	0	0%	3.5%	3.4%	3.4%	3.4%	3.4%	3.3%	3.3%	3.5%	16,060	1,251	93%	25,967	67%
Mid Cheshire Hospitals	14,039	11,153	(2,886)	-21%	2.3%	2.5%	2.7%	3.0%	3.2%	3.3%	3.7%	5.2%	7,174	3,979	51%	22,437	50%
Mersey & West Lancs	26,670	28,537	1,867	7%	2.9%	3.2%	3.6%	3.8%	4.0%	4.2%	4.4%	4.8%	20,670	7,867	78%	45,165	63%
The Clatterbridge Centre	6,667	6,667	0	0%	3.3%	3.4%	3.3%	3.3%	3.3%	3.2%	3.2%	3.4%	3,586	3,081	54%	10,000	67%
The Walton Centre	5,666	5,666	0	0%	4.1%	4.3%	4.3%	4.3%	4.3%	4.2%	4.1%	4.5%	5,086	580	90%	8,558	66%
Warrington & Halton Hospitals	9,540	9,716	176	2%	1.7%	2.0%	2.5%	2.8%	3.0%	3.3%	3.6%	5.1%	7,249	2,467	76%	19,433	50%
Wirral Community	3,674	4,066	392	11%	2.4%	4.0%	4.1%	3.8%	3.9%	4.6%	5.5%	5.4%	928	3,138	25%	6,275	65%
Wirral University Hospitals	16,724	16,724	0	0%	3.1%	3.1%	2.7%	2.4%	4.3%	4.4%	4.5%	5.2%	11,677	5,047	70%	26,878	62%
TOTAL Providers	**211,438**	**196,318**	**(15,120)**	**-7%**	**3.0%**	**3.3%**	**3.4%**	**3.6%**	**3.5%**	**3.5%**	**4.3%**	**5.5%**	**128,948**	**67,370**	**61%**	**367,710**	**53%**
C&M ICB	46,357	38,993	(7,364)	-16%	0.6%	0.6%	0.6%	0.8%	0.6%	0.8%	0.8%	1.0%	38,993	0	84%	72,236	54%
TOTAL ICS	**257,795**	**235,311**	**(22,484)**	**-9%**	**3.7%**	**3.8%**	**3.9%**	**4.1%**	**4.2%**	**4.3%**	**4.5%**	**6.1%**	**167,941**	**67,370**	**65%**	**439,946**	**53%**

The following table sets out the current risk and development status of efficiency schemes across all organisations with overall 10% of CIP schemes, currently deemed high risk which has significantly reduced in the last quarter as can be seen from the monthly CIP development progress chart.

	CIP RISK				% of CIP
	Low	Medium	High	Total	High Risk
	£m	£m	£m	£m	%
Alder Hey Children's	16.3	1.7	1.9	20.0	10%
Bridgewater Community	2.8	2.1	2.0	6.9	28%
Cheshire & Wirral Partnership	10.8	1.1	2.0	13.9	15%
Countess of Chester Hospitals	9.0	2.7	8.1	19.8	41%
East Cheshire Trust	6.8	1.4	3.0	11.2	27%
Liverpool Heart & Chest	5.6	3.3	1.8	10.6	17%
Liverpool University Hospitals	89.4	18.1	7.1	114.6	6%
Liverpool Women's	3.7	2.2	0.0	5.9	0%
Mersey Care	12.2	13.8	0.0	26.0	0%
Mid Cheshire Hospitals	19.1	1.0	2.3	22.4	10%
Mersey & West Lancs	40.8	6.6	0.6	48.0	1%
The Clatterbridge Centre	10.0	0.0	0.0	10.0	0%
The Walton Centre	6.4	2.2	0.0	8.6	0%
Warrington & Halton Hospitals	15.6	3.6	0.3	19.4	2%
Wirral Community	5.5	0.3	0.5	6.3	7%
Wirral University Hospitals	16.3	1.7	1.9	20.0	10%
C&M ICB	20.6	34.0	11.6	66.2	17%
Total	290.9	95.7	43.2	429.8	10%

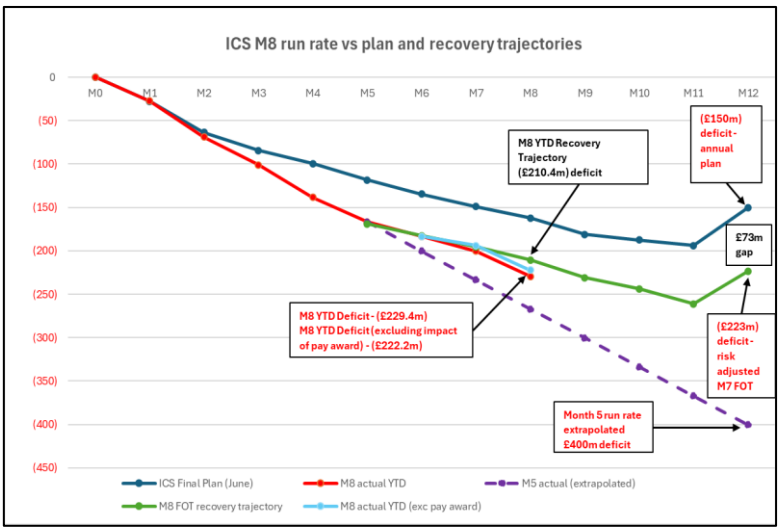


4. Financial Forecast for Year

At the end of August, the system submitted a risk adjusted forecast for the year of £220m deficit against the plan of £150m deficit. This was not formally approved by NHSE, and the expectation is that the system will achieve the £150m deficit by March 25 and all actions required to achieve this will be put in place by all providers and the ICB.

Over the recent months, external support has been in place for those providers most at risk of non-delivery alongside a weekly Financial Incident Command Centre (FIIC) chaired by the ICB, which all providers are expected to submit weekly returns containing extensive data requests.

Prior to the submission of the risk adjusted forecast, the extrapolated M5 run rate and unmitigated position would have equated to £400m deficit, however the current risk adjusted trajectory including the M8 position is a £223m deficit, a £73m gap to the £150m deficit required to be achieved by March.



The system continues to develop mitigation plans to deliver the £150m deficit plan however they remain high risk given the remaining time to deliver plans in year.

5. Workforce

During November, the total WTE across C&M was 79,822 which is a reduction from the WTE number in March 24, however, is c1000 over the plan set for November and c1500 more than what is required for the end of March 25. Greater workforce controls are expected from the ICB to all providers with a focus on recruitment and variable pay which will support delivery of this reduction. The workforce run

rate and key workforce metrics (starters/leavers, vacancy panel outcomes, and NHS jobs data) are also being monitored weekly through the weekly FICC.

Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Plan	M6 Actual	M7 Actual	M8 Actual	M1 to M7 Trend	M7 Variance from plan trajectory favourable / (adverse)		M12 Plan (March 25)	Futher change expected M8-12 increase / (decrease)
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE		WTE	%	WTE	WTE
Alder Hey Children's	**4,368**	4,333	4,347	4,326	4,334	4,292	4,345	4,310	4,400	4,418		(112)	-2.6%	4,273	(144)
Bridgewater Community	**1,434**	1,453	1,462	1,447	1,454	1,445	1,471	1,459	1,476	1,471		12	0.8%	1,479	8
Cheshire & Wirral Partner	**4,072**	4,061	4,024	4,017	4,000	3,967	4,032	4,032	4,041	4,014		14	0.4%	4,028	14
Countess of Chester Hosp	**4,886**	4,849	4,783	4,809	4,829	4,829	4,896	4,848	4,841	4,842		(20)	-0.4%	4,764	(78)
East Cheshire Trust	**2,675**	2,691	2,633	2,633	2,656	2,697	2,653	2,660	2,668	2,641		31	1.2%	2,625	(16)
Liverpool Heart & Chest	**1,912**	1,874	1,880	1,898	1,886	1,889	1,900	1,887	1,915	1,904		(8)	-0.4%	1,880	(23)
Liverpool University Hospi	**15,448**	15,261	15,163	15,041	15,228	15,170	14,900	15,128	15,153	15,119		(362)	-2.5%	14,601	(518)
Liverpool Women's	**1,687**	1,703	1,718	1,717	1,715	1,748	1,756	1,760	1,783	1,784		(24)	-1.3%	1,764	(19)
Mersey Care	**11,623**	11,344	11,224	11,091	11,244	11,286	11,263	11,475	11,419	11,474		(211)	-1.9%	11,263	(211)
Mid Cheshire Hospitals	**5,687**	5,445	5,425	5,398	5,429	5,428	5,373	5,380	5,455	5,455		(102)	-1.9%	5,350	(105)
Mersey & West Lancs	**10,614**	10,458	10,538	10,478	10,556	10,551	10,648	10,547	10,694	10,621		26	0.2%	10,564	(57)
The Clatterbridge Centre	**1,893**	1,890	1,919	1,920	1,896	1,906	1,887	1,930	1,921	1,926		(27)	-1.4%	1,907	(18)
The Walton Centre	**1,562**	1,554	1,522	1,570	1,552	1,600	1,573	1,608	1,608	1,614		(56)	-3.6%	1,559	(56)
Warrington & Halton Hosp	**4,786**	4,626	4,646	4,637	4,657	4,615	4,708	4,707	4,699	4,658		(68)	-1.5%	4,559	(100)
Wirral Community	**1,560**	1,587	1,579	1,567	1,566	1,564	1,566	1,568	1,570	1,581		(63)	-4.2%	1,512	(69)
Wirral University Hospitals	**6,258**	6,389	6,499	6,300	6,350	6,315	6,326	6,344	6,358	6,301		(30)	-0.5%	6,227	(74)
C&M Providers Total	**80,465**	**79,607**	**79,361**	**78,849**	**79,352**	**79,303**	**79,297**	**79,645**	**80,002**	**79,822**		**(999)**	**-1.3%**	**78,354**	**(1,468)**
by Sector															
Acute	50,353	49,719	49,687	49,296	49,704	49,604	49,503	49,616	49,868	49,637		(525)	-1.3%	48,688	(949)
Specialist	11,423	11,353	11,386	11,431	11,382	11,436	11,461	11,495	11,628	11,645		(227)	-1.9%	11,384	(261)
Community / MH	18,689	18,444	18,289	18,123	18,265	18,263	18,332	18,534	18,506	18,539		(248)	-1.2%	18,282	(258)
TOTAL Providers	**80,465**	**79,516**	**79,361**	**78,849**	**79,352**	**79,303**	**79,297**	**79,645**	**80,002**	**79,822**		**(999)**	**-1.3%**	**78,354**	**(1,468)**

6. Alder Hey Response

At the end of November, Alder Hey is reporting in line with its financial plan, except for the impact of the pay award funding gap (£0.6m). Delivery of efficiency savings is slightly ahead of plan, however 10% still categorised as high risk which is in line with the system average but continues to be monitored and challenged weekly to ensure schemes are delivered and does not create a risk to the overall financial forecast for the year.

Our workforce numbers are a challenge as we are currently reporting above plan by 112 WTE with c50% due to recent bulk nurse recruitment with expectation that the variance reduces over the coming months as staff complete induction. The remaining relates to recruitment into vacancies particularly in the Community and Mental Health division, increase in WTE for service developments in areas such as GDS and hosted networks and also a gap in workforce plans to reduce WTE in line with efficiency plans. The ICB are expecting our WTE to reduce by 144 from current numbers by March to achieve the plan set. Given the latest recruitment, further controls have now been introduced across both clinical and non-clinical roles including an affordability cap and a restriction on the amount of bank and agency usage to support with this expected reduction.

Following the risk adjusted trajectory submitted at the end of August, the ICB requested organisations achieving plan to deliver a further 0.5% to mitigate against the projected financial gap. A best endeavour approach was agreed by the Board to achieve a further £1m, taking our forecast for the year to £4.3m surplus, however this was caveated on the basis the pay award was fully funded which has not been the case, and therefore the latest forecast for Alder Hey is to achieve the £3.3m surplus as per the plan agreed at the start of the year. Financial forecasts are submitted and discussed at FTPC meetings on a monthly basis and an in depth review of all actions and mitigation taken. Weekly reports continue to be shared with the Executive Team tracking both WTE and financial performance. The workforce efficiency group continues to meet to oversee the implementation of the additional workforce controls and review the workforce metrics on a weekly basis.

7. Conclusion

The report outlines the latest position across the C&M system, highlighting the risks and challenges in delivering the plan for the year.

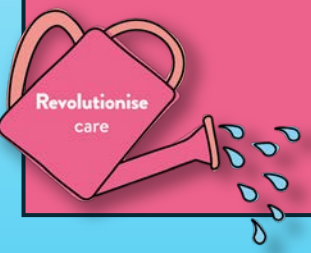
The board are asked to note the contents of this paper.

Flash Report December 2024

Alder Hey Children's NHS Foundation Trust

Performance is subject to change

1	0	90%	1
Severe/Fatal Incidents/Never Events	Number of Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections



81.1%	256	115%	95.8%
ED: % Treated within 4 Hours	Number of RTT Patients waiting >52 weeks	Elective Recovery Volume vs 19/20	Diagnostic Performance

TBC	10.6%	81.6%	6.95%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

VISION 2030

HIGHLIGHT

- 0 Patent Safety Incident Investigations
- Diagnostics achieved 95% performance
- 6th consecutive month with a reduction for RTT >52 weeks

UPDATE

Financial Sustainability

Position to be updated verbally in meeting given extended close for M9 reporting

CHALLENGES

- Severe Incident
- Sickness above target and WTE anticipated to be above plan, although position to follow once determined.

NHS
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NHS Foundation Trust

Integrated Performance Report

Published: December 2024

VISION 2030

A Healthier, Happier and Fairer Future for Children and Young People

OUR ASPIRATION
To be world-leading

Our Journey
To 2030

Get me well

Personalise my care

The Needs of Children, Young People and Families

Improve my life chances

Bring me the future

Outstanding care and experience

Collaborate for children & young people

Revolutionise care

Support our people

Pioneering breakthroughs

respect

excellence

innovation

together

openness

Contents

VISION 2030

Our Journey To 2030

IPR Summary

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

Variation	Assurance: Achieving Target	Assurance: Inconsistently Achieving Target	Assurance: Not Achieving Target
Special Cause - Improvement	Mandatory Training, MSSA and Level 1 patient safety training are consistently achieving target with an improving trend	Incidents of harm, Severe/Fatal incidents, Complaints resolved, RTT 52 weeks, Elective admissions per WTE, DC Recovery, MSSA are inconsistently achieving target with an improving trend	Diagnostics, Staff Turnover, PDRs completed and IHAs are not consistently achieving target but demonstrating an improving trend
Common Cause	Category 3 & 4 Pressure Ulcers, Cancer, MRSA metric and Liquidity are achieving targets	Incidents no harm, F&F, Sepsis, PALS resolved, ED 4hr, WNB Rate, ERF, C.Diff, Sickness (All) and risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation, Long Term Sickness and Medical Appraisal are not achieving targets and currently not demonstrating statistical improvement
Special Cause - Concern		F&F Emergency Department are inconsistently achieving target but demonstrating declining trend .	

From an overall perspective the headline analysis summary based on all metrics:

- 50% of measured metrics have achieved target in the month of November 2024.

From an SPC perspective the headline analysis summary based on attributed metrics:

- We are consistently passing 20.8%* of our metrics.
- We are achieving 64.6% of our metrics inconsistently.
- We are not achieving the target for 14.6% of our metrics, 0 are showing special cause of concern.

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

* *Consistently passing adjusted to include YTD and those with 24/25 targets set only*

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

• 87% of formal complaints responded to within 25 working days • Zero Category 3 or 4 pressure ulcers and very low rate of Category 2 pressure ulcers • Improved compliance with administration of antibiotics for sepsis in ED and inpatients although below 90% • Very low reporting / requirement for restrictive interventions

Areas of Concern:

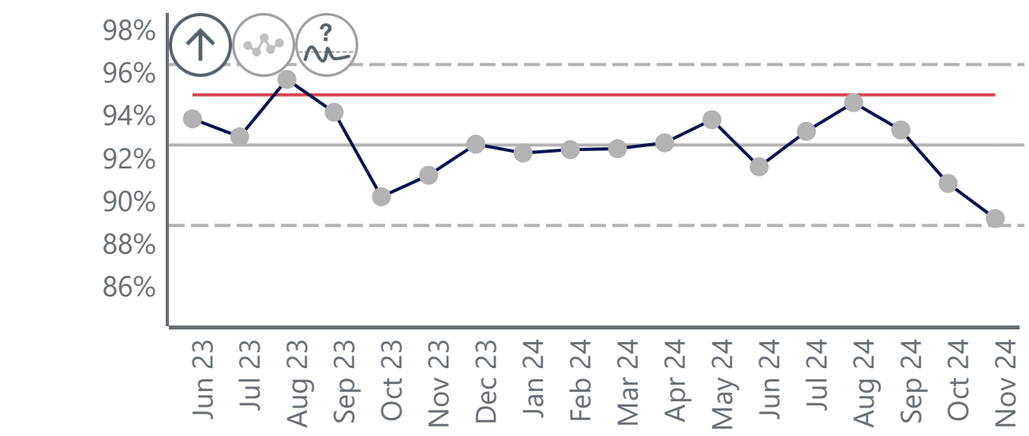
• Number of families responding to the ED FFT who would recommend the Trust has fallen to 71% associated with increased waiting times • Overall compliance responding to PALS concerns has decreased to 80%; Medicine and Surgery continue to have high compliance. Corporate Collaborative to review and support corporate leads to respond going forward • Static position in regards to patients being admitted to Critical Care unexpectedly from wards; increase in the number of patients being admitted to PICU from HDU • 1 case of C-diff reported; under review • Improved compliance with administration of antibiotics for sepsis in ED and inpatients although below 90% • 1 never event recorded which will be investigated through a PSII

Forward Look (with actions)

• Need to maintain oversight and scrutiny of antibiotic compliance for sepsis and learning from individual case reviews; include as a Key Message from the Patient Safety Meeting in the New Year

F&F Test - % Recommend the Trust

Target: Statutory



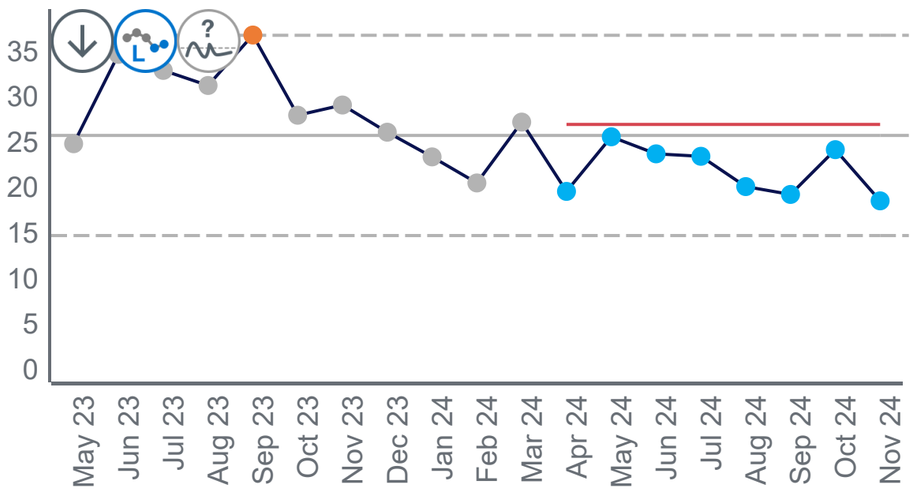
Technical Analysis:

89% of families would recommend the Trust from those who completed the FFT; review of the changes made in the FFT process in the New Year and impact of changes

Actions:

89% of families would recommend the Trust from those who completed the FFT; review of the changes made in the FFT process in the New Year and impact of changes

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



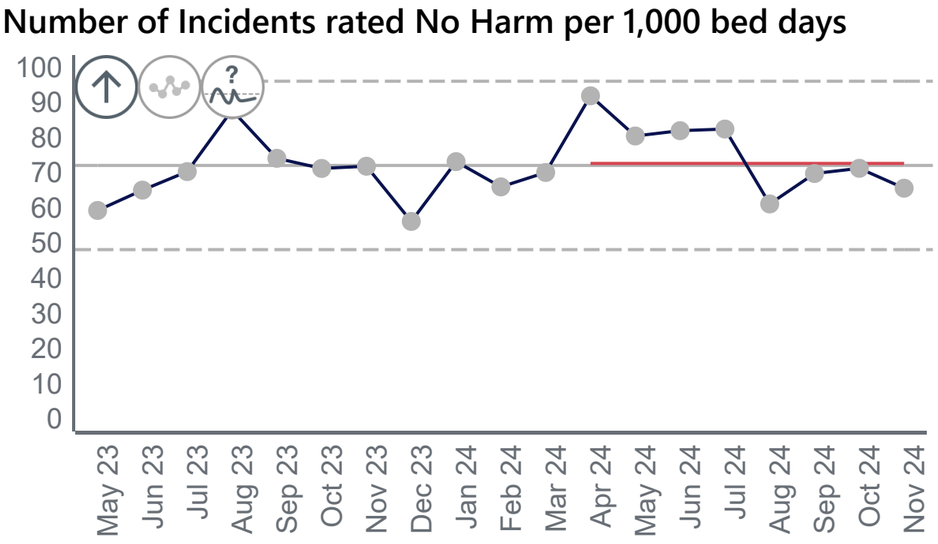
Technical Analysis:

Common cause variation has been observed with performance of 112 incidents of harm per 1,000 bed days, with a monthly average of 18.6 incidents during the period. Incidents are assessed on Physical and Psychological Harms. The target is set on a 5% reduction of 23/24, with a monthly target of 27.

Actions:

Continue to promote a culture of reporting, learning, and restorative practice

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



Technical Analysis:

Common cause variation observed with 396 incidents of no harm per 1000 bed days, with a monthly average of 65.76. This includes 38 incidents with no harm assigned due to not involving a patient directly. Incidents are now assessed on Physical and Psychological Harms and target is set against a 5% improvement on 23/24 with monthly target 71.

Actions:

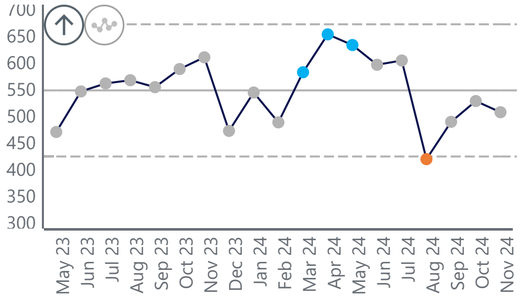
Continue to promote a culture of reporting, learning, and restorative practice

Integrated Performance Report | December 2024

NHS
Alder Hey Children's
NHS Foundation Trust

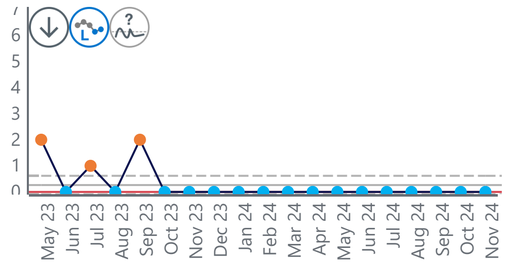
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



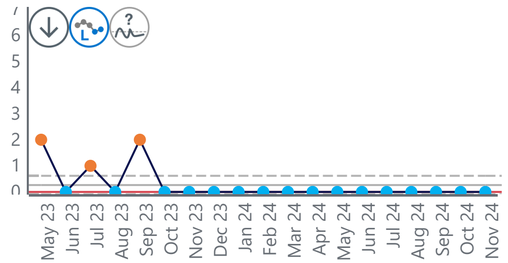
Severe or Fatal Incidents – Physical only

Target: Internal

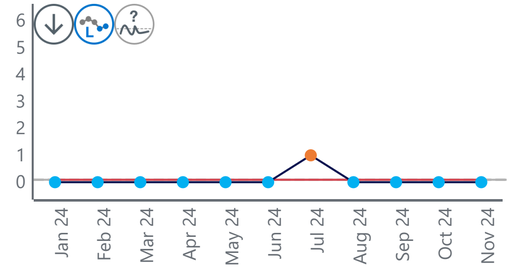


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

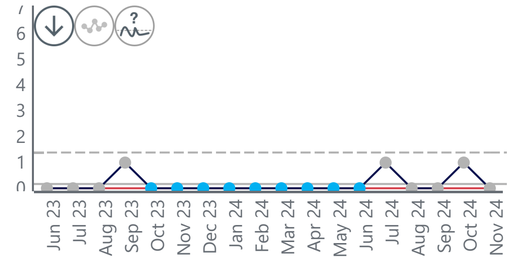


Number of PSIIs (Patient safety incident investigation) undertaken



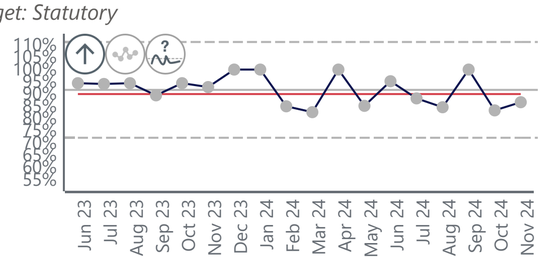
Number of Never Events

Target: Internal



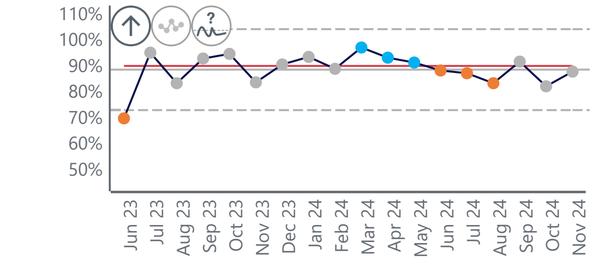
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

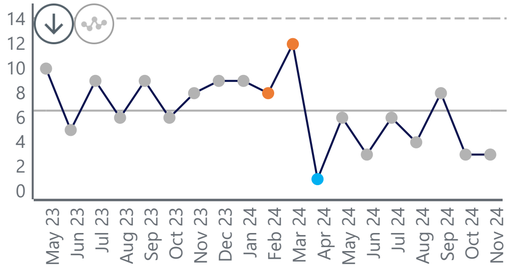


Sepsis % Patients receiving antibiotic within 60 mins for ED

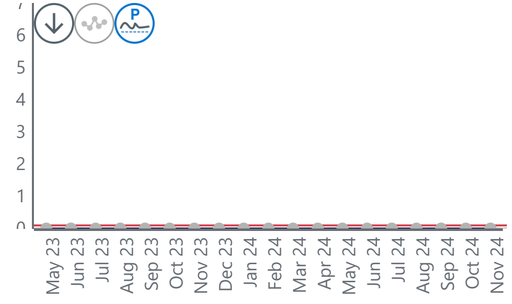
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

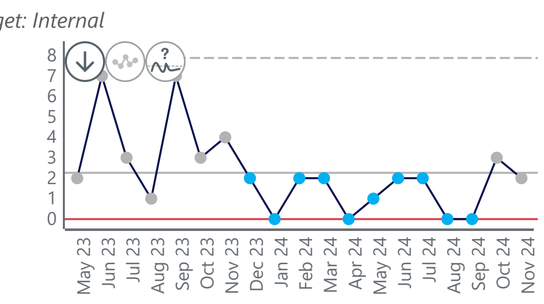


Pressure Ulcers Category 3 and 4

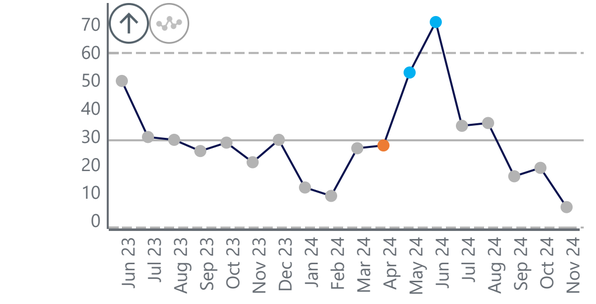


Pressure Ulcers Category 2

Target: Internal

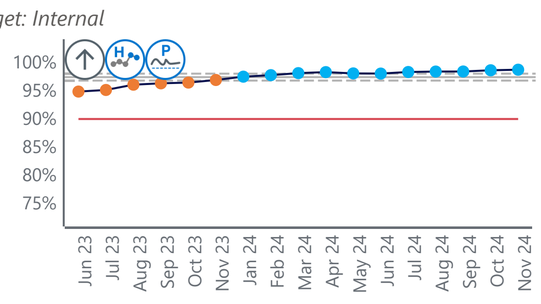


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



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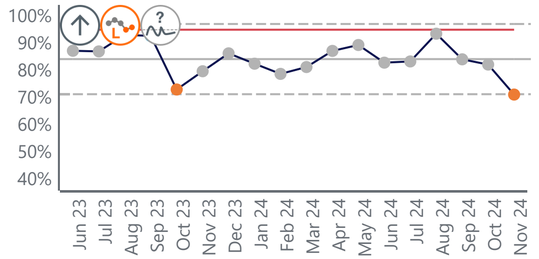
Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

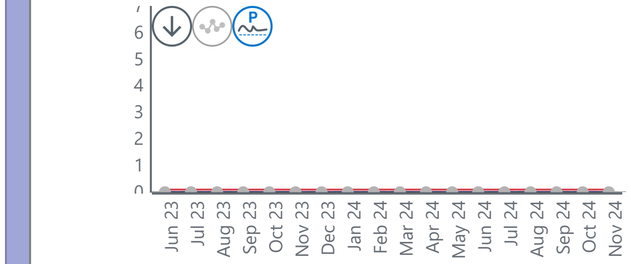
F&F ED - % Recommend the Trust

Target: Internal



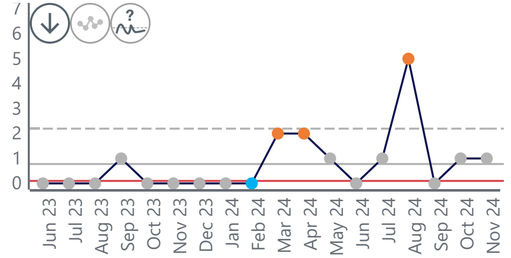
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



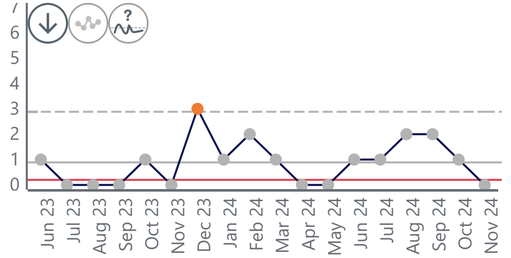
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



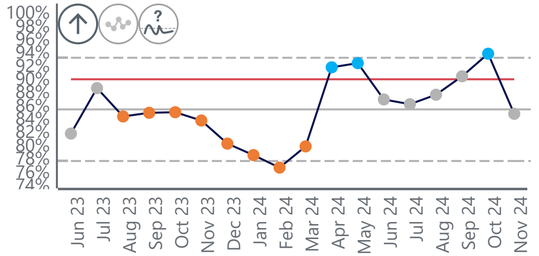
Hospital Acquired Organisms - MSSA

Target: Internal



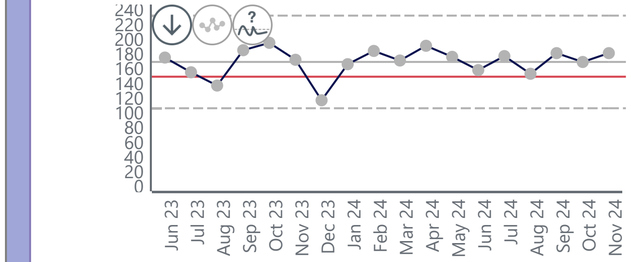
% PALS Resolved within 5 Days

Target: Internal



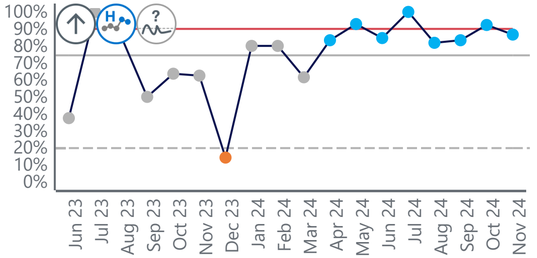
Number of PALs contacts

Target: Internal



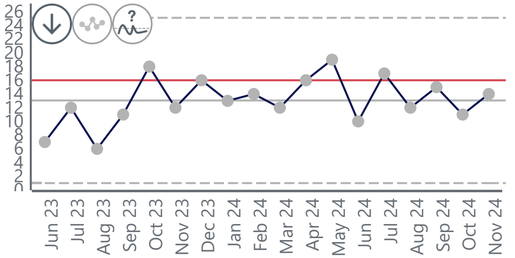
% Complaints Responded to within 25 working days

Target: Internal

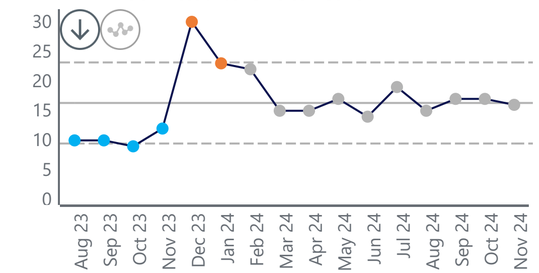


Number of formal complaints received

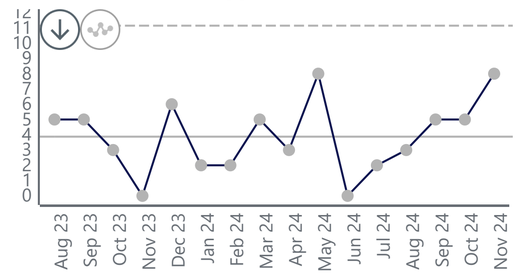
Target: Internal



Number of patients deteriorating from an inpatient bed admitted to Critical Care



Number of patients deteriorating from HDU admitted to PICU



Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

SRO: Operational: Adam Bateman, Chief Operating Officer and 2030 transformation programme: Kate Warriner, Chief Transformation and Digital Officer and Alf Bass, Chief Medical Officer

Highlights:

• The trust achieved 95% DM01 compliance in November • TT utilisation remained at 80% for the third consecutive month which is the highest performance YTD. Daycase TT utilisation was the highest YTD • Case mix continues to be a factor as we are converting a higher volume of patients to DC from IP. This is reflected in the YTD performance of DC (103%) and EL (94%). OP New & OPROCs consistently above activity plan with YTD performance at 103% • Further reduction in the number of overdue follow-ups by 31st March 2025. Plastic surgery has piloted sending a text message to overdue follow up patients via ISLA care. 31% have responded to say their symptoms have resolved and do not require an appointment. This functionality is being rolled out to other specialities.

Areas of Concern:

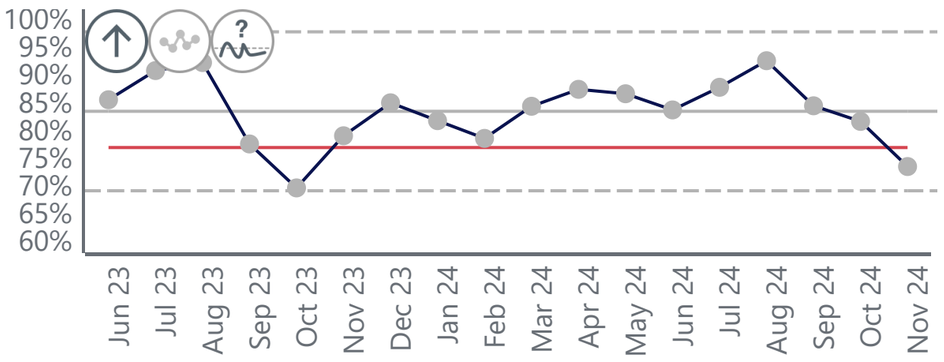
• WNB remains above the trust target • ASD & ADHD assessment waiting times are below the target of 95%

Forward Look (with actions)

WNB predictor tool feedback and actions will now feed into monthly access to care meeting with divisions. Main theme of WNB is due to families not being aware of the appointment. Patient demographic software is planned to go live in January and is expected to mitigate this issue.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

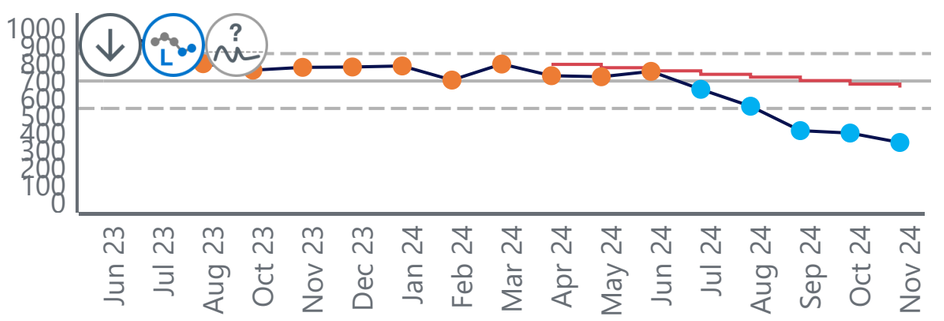
Trust is below the national target (>77%) in November-24. Common cause variation has been observed with performance of 73.6%, a decrease from Oct-24 (81.7%). Becoming first month below target since Oct-23. Nov-24 performance is -5.5% compared to Nov-23 (79.1%), although Nov-24 did see an additional +602 attendances compared to Nov-23. 2024/2025 performance to date is 84.2%

Actions:

Maximising streaming opportunities within the department. Recruiting to vacant and sickness absence senior gaps to ensure sufficient rota cover. Introducing clinically ready to proceed to ensure speciality delays are addressed.

Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)

Target: Internal 24/25



Technical Analysis:

Demonstrating special cause variation of improving nature with number of patients waiting > 52 weeks at 352 for Nov 2024 against a trajectory of 667. Further decrease from Oct 2024 position of 420 and the 5th consecutive month with a reduction. Top 3 services with waiters >52 weeks: Dentistry (n= 188), Neurology (n=50) & ENT (n=30). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

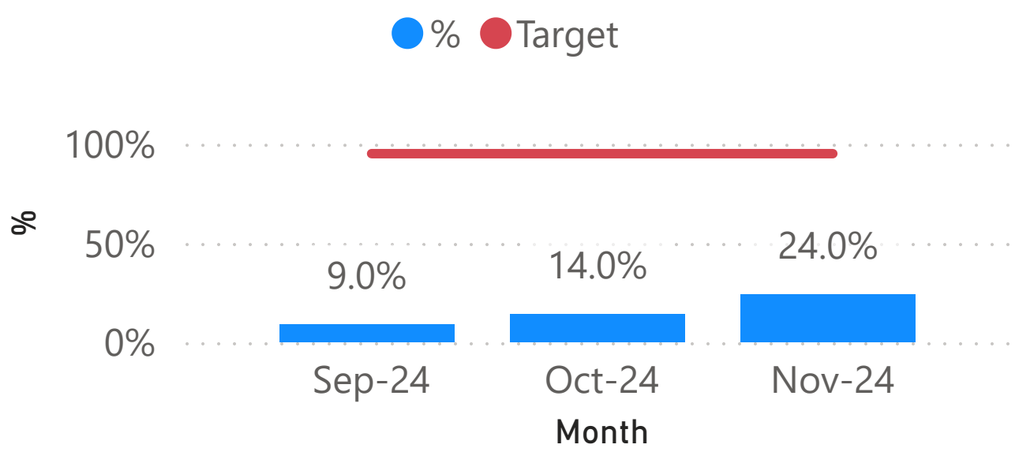
Actions:

The Trust is focused upon reducing the number of patients over 52 weeks by March 2025. It is expected that this will be achieved in all but 4 specialties across both Medicine and Surgical Divisions

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

% of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks



Technical Analysis:

Performance at the end of November is 24% which is 2nd consecutive month of improvement

Actions:

Focus remains on longest waiting children and young people therefore % of young people receiving an outcome within 65 weeks of assessment remains low as expected. Actions are in place for both ASD and ADHD to ensure available capacity is prioritised to the longest waiters and transformation programme is continuing with workstream focussing on capacity and demand.

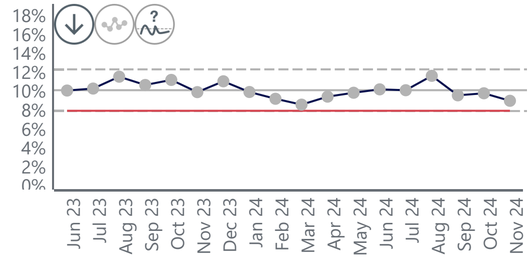
Integrated Performance Report | December 2024

Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

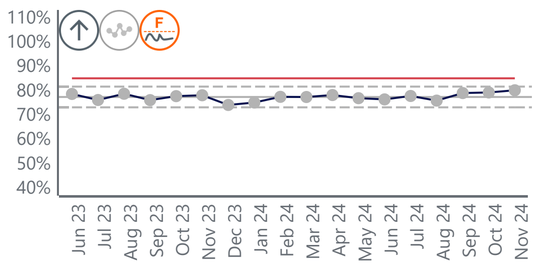
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

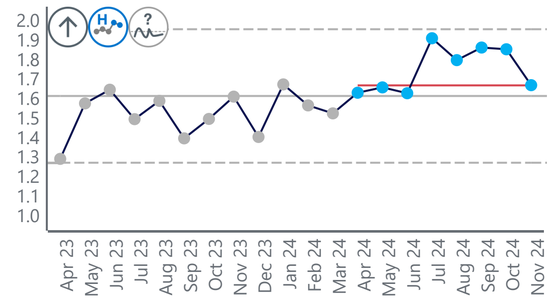


Theatre Utilisation (Capped Touch Time)

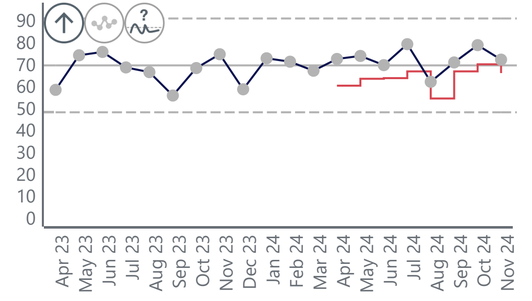
Target: Internal



Elective admissions (IP & DC) per clinical WTE

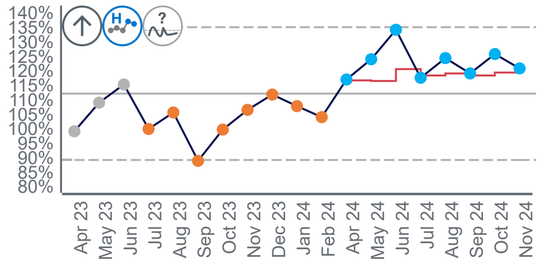


Outpatient attendances per Consultant WTE



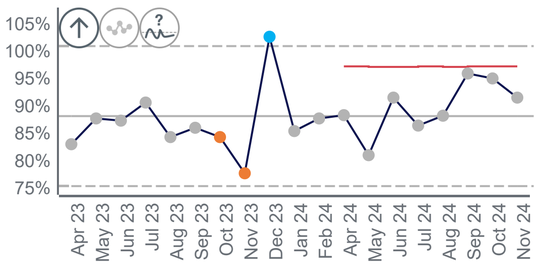
% Recovery for Daycase Discharges

Based on 19/20 baseline



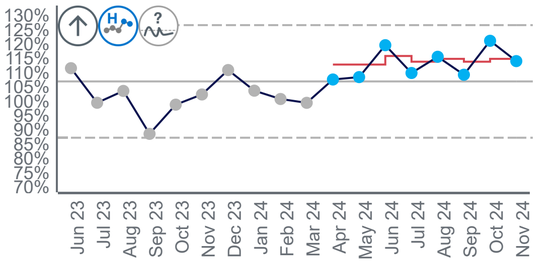
% Recovery for Elective Discharges

Based on 19/20 baseline



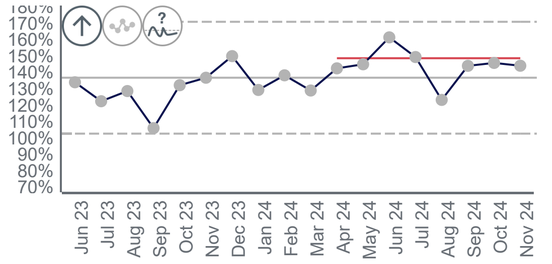
% Recovery for DC & Elec Activity Volume

Based on 19/20 baseline



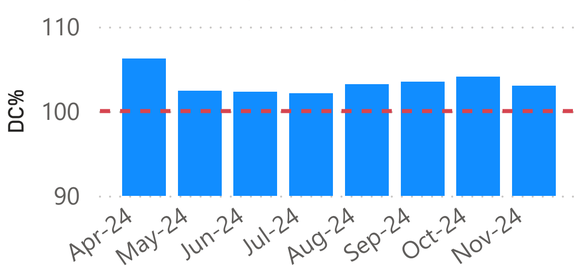
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline



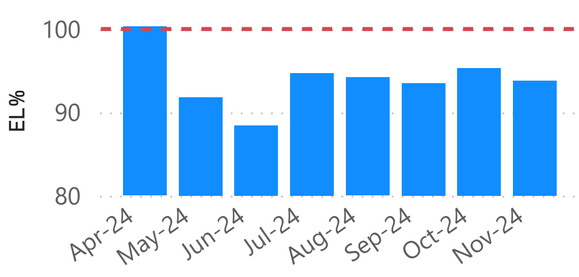
Daycase Activity vs Plan (YTD Position)

SLAM Performance (Volume)



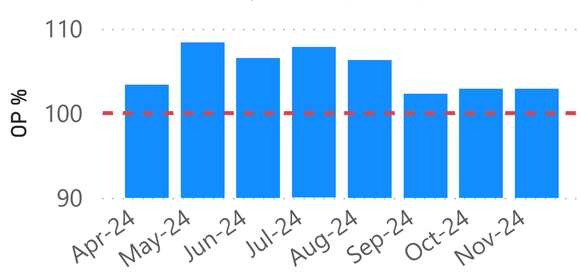
Elective Activity vs Plan (YTD Position)

SLAM Performance (Volume)

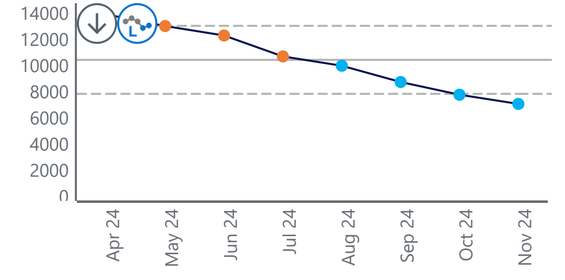


OP New & OPPROC Activity vs Plan (YTD Position)

SLAM Performance (Volume)



Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



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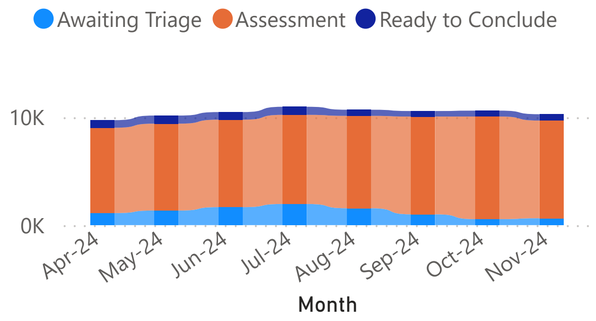
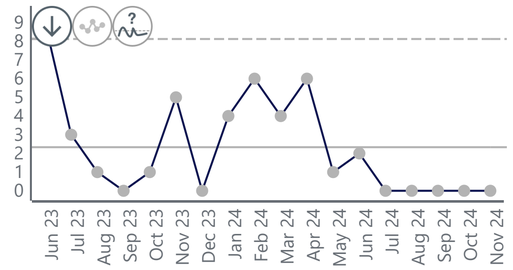
Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

ADHD/ASD Diagnosis Status

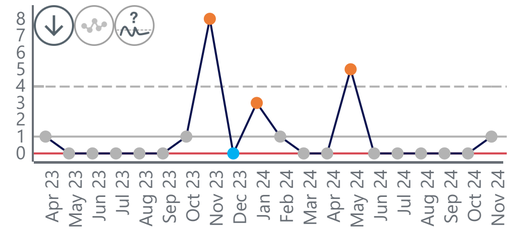


CAMHS: Number of children & young people waiting >52weeks



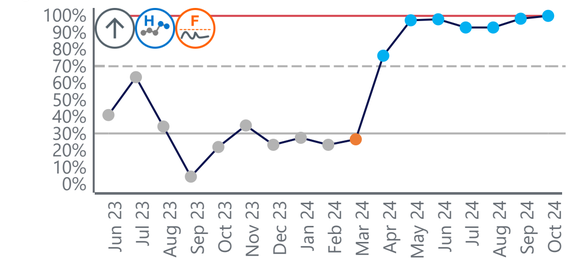
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



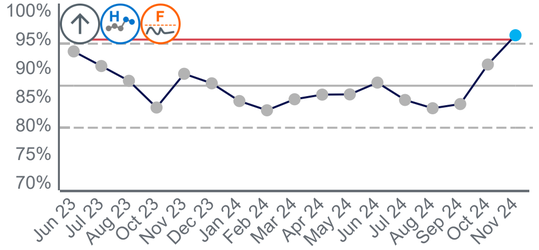
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



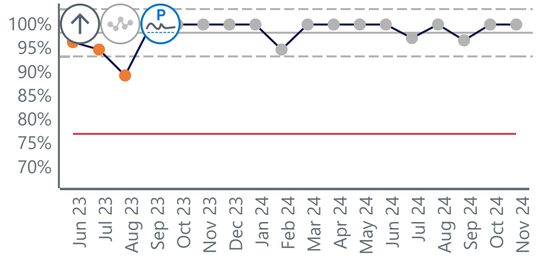
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



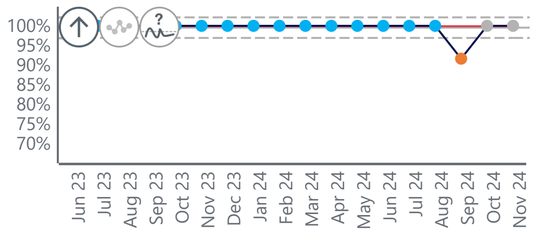
Cancer: Faster Diagnosis within 28 days

Target: Statutory



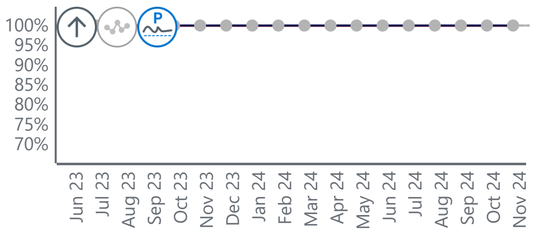
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

Target: Internal (Stretch)



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training completion remains over 90% and has increased slightly.

Areas of Concern:

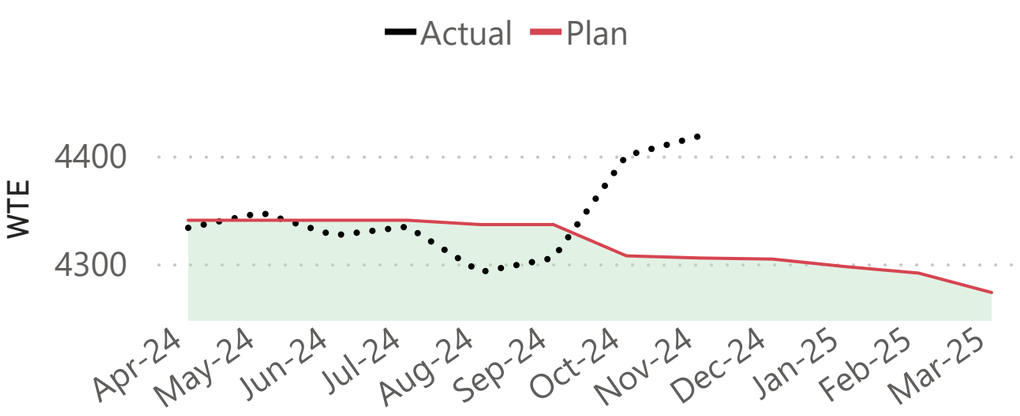
• PDR completion has remained below 90%, though is slowly increasing • Sickness absence has seen an increase, notably in short term sickness absence. Actions are in place • Total Workforce (WTE) remains a challenging plan, exceeded in both October and November 2024.

Forward Look (with actions)

• The WTE plan continues to be challenging, as the WTE plan reduces further to March 2025. Both long- and shorter-term actions to support a reduction in WTE are being reviewed.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

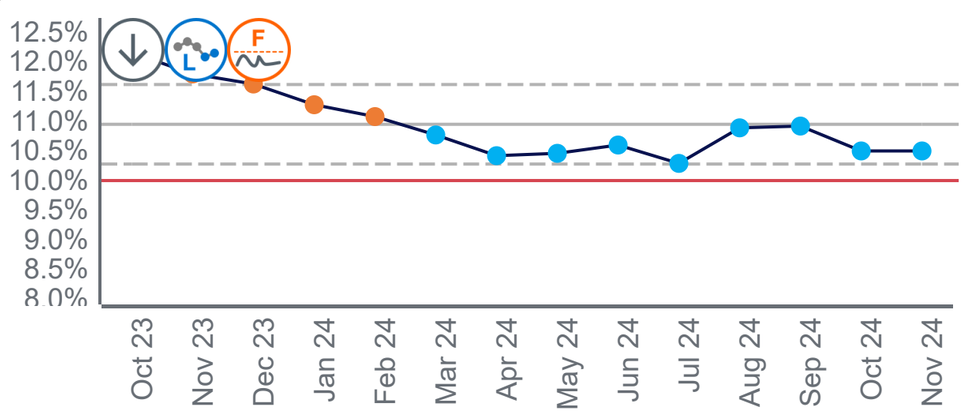
Total workforce for the end of November 2024 was 112.44 WTE above plan. Actual WTE was 4417.84 against a plan of 4305.4. 24/25 year end plan is set at 4273.4 WTE.

Actions:

Total workforce has increased by just over 17 WTE between October and November, predominantly due to an increase in bank and agency spend. Actions and measures to support a reduction in WTE are being reviewed.

Staff Turnover

Target: Internal



Technical Analysis:

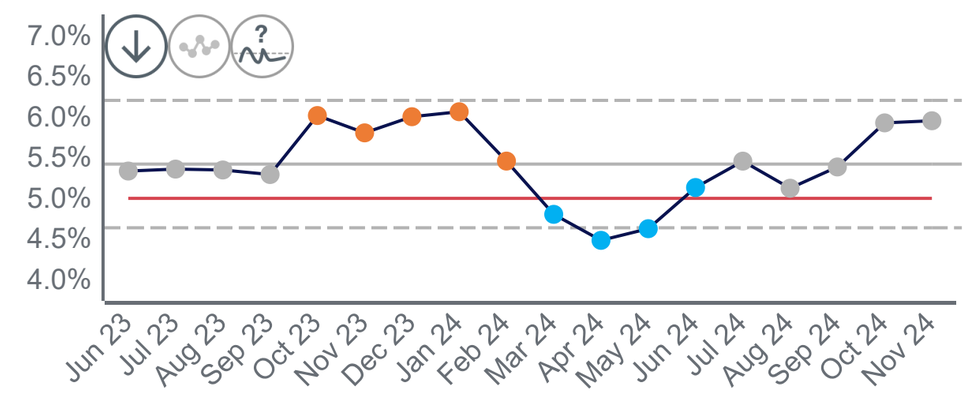
Staff Turnover is demonstrating special cause variation of improving nature with performance of 10.5% in November 2024

Actions:

While staff turnover is reporting above the 10% target, it has reduced in month and retains the significant improvement seen across the previous 18 months.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in November 2024 is 5.94% which is above the 5% target. An increase from October 2024 at 5.92%. November 2024 performance comprises STS at 2.11% and LTS at 3.83%. Still demonstrating common cause variation, 5th consecutive month above the target in 24/25.

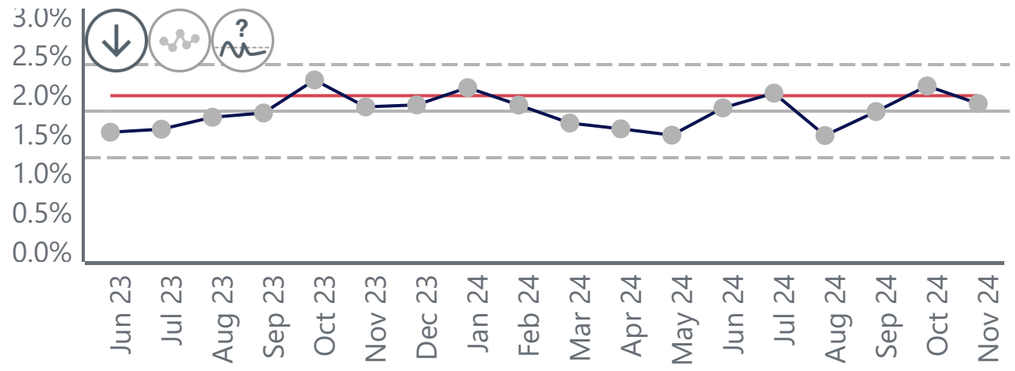
Actions:

Sickness absence has remained high and are similar to absence levels during this period last year. Considering high absence levels, additional case and trend reviews are being held with the Deputy CPO.

Supporting Our People - Watch Metrics

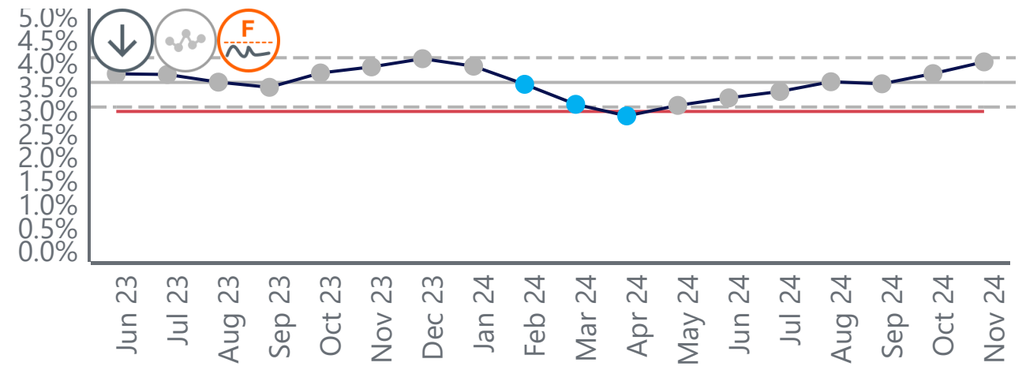
Short Term Sickness

Target: Internal



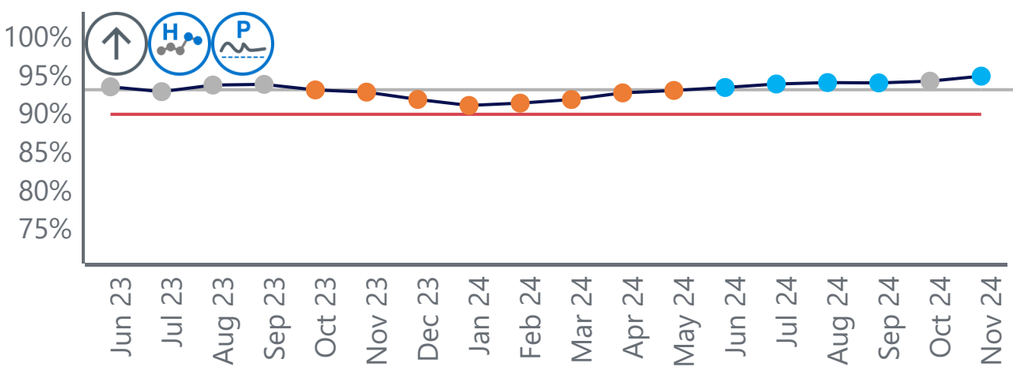
Long Term Sickness

Target: Internal



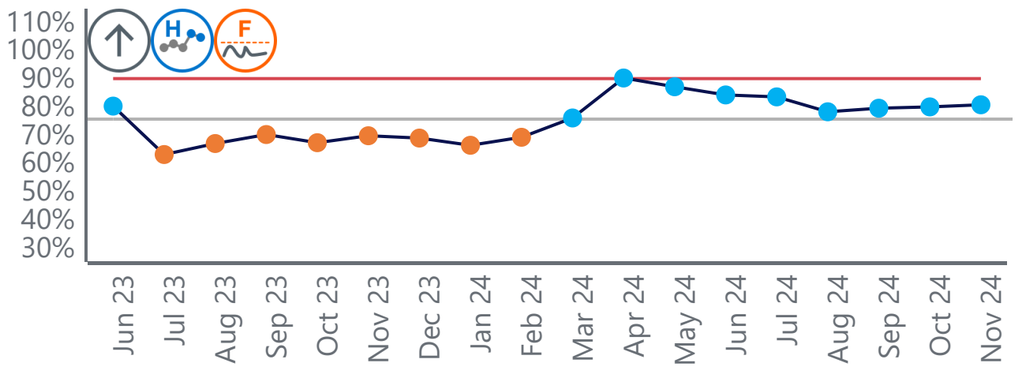
Mandatory Training

Target: Internal



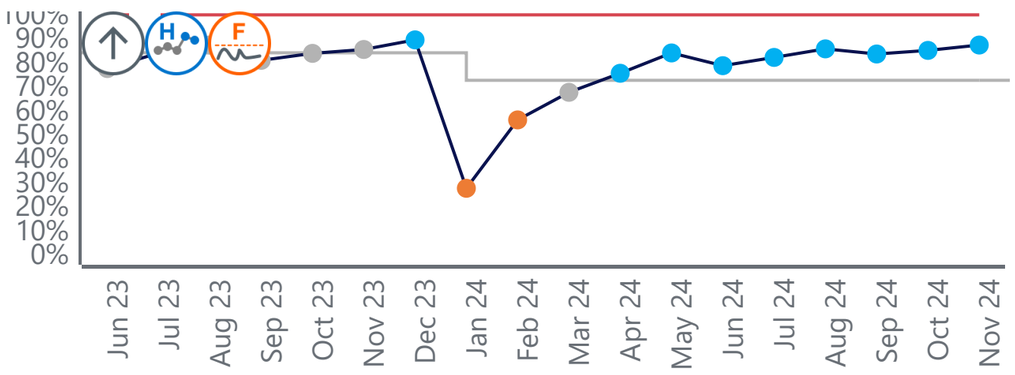
% PDRs Completed (Rolling 12 Months)

Target: Internal

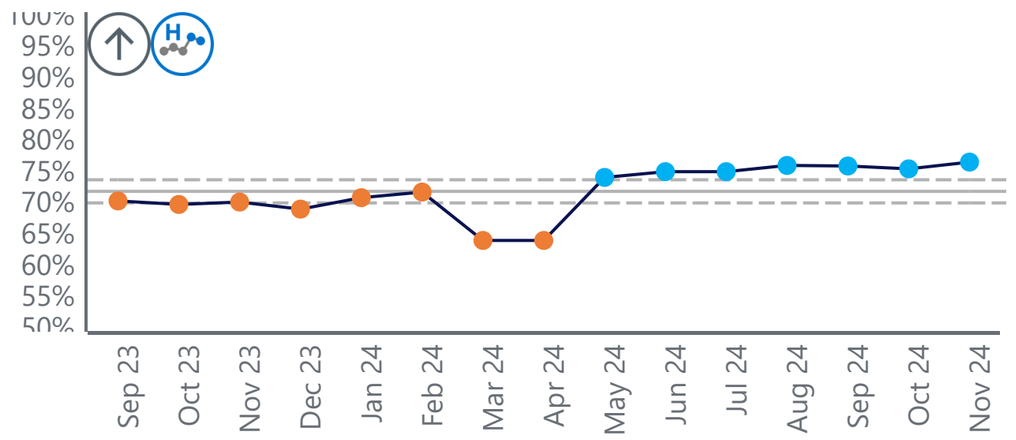


Medical Appraisal

Target: Internal



Workforce Stability



Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

SRO: Adam Bateman, Chief Operating Officer and Managing Director Alder Hey Futures and John Chester, Director of Research & Innovation

Highlights:

• Press coverage of NIHR capital awards - Alder Hey Children's Hospital awarded £1.1 million for research | ITV News Granada • Continued overachievement against commercial research income target • Submission of Investment Zone business case to Combined Authority external panel • Continued pilot of Lyrebird ambient AI tool • Collaborative meetings with UCLan, Liverpool John Moores and Liverpool Hope Universities took place with partnership opportunities identified • Mobile Research Unit on site with live call for use cases.

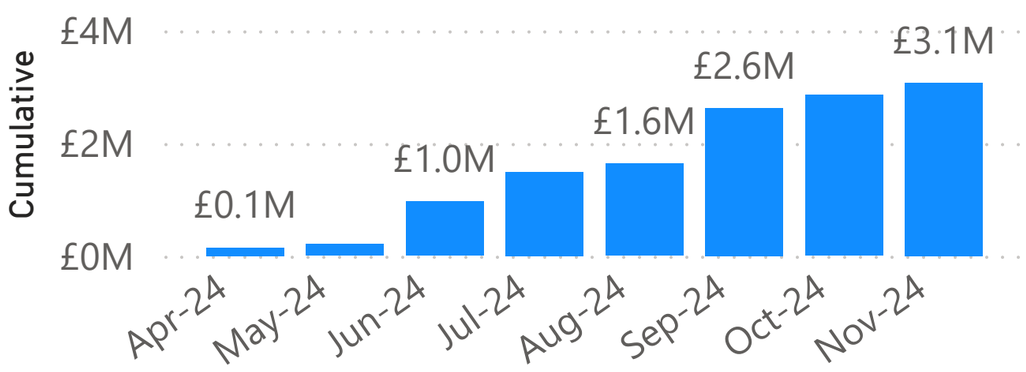
Areas of Concern:

• Underachievement against innovation income target• Data capture issues for research metrics due to staffing changes and system issues • Delivery against research targets in 3rd MRI scanner business case behind target – pipeline under review.

Forward Look (with actions)

• External panel review of Investment Zone business case on Thursday 12th Dec • Internal funding call to support research discovery and capacity building to go live in Dec • Protocols for rapid evaluation of innovative technology under development for submission to Health Research Authority.

Commercial and Non-commercial Income to Research and Innovation - Cumulative



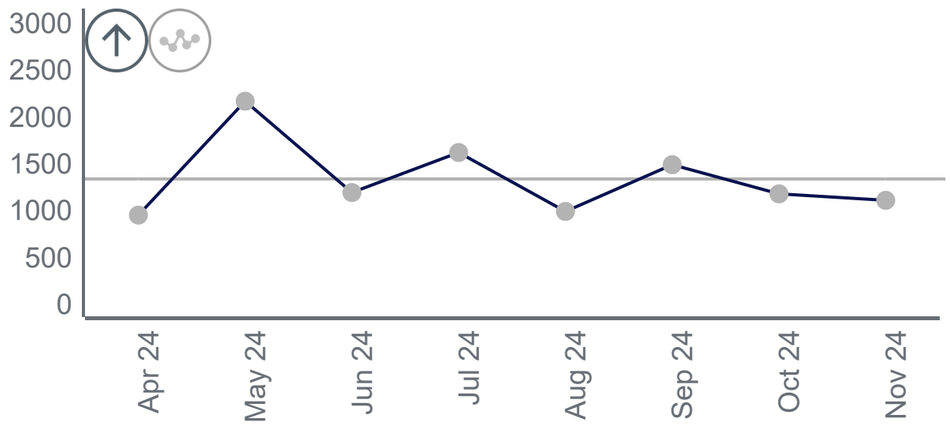
Technical Analysis:

This includes commercial and non-commercial income to research and innovation (cumulative total).

Actions:

Research income is ahead of target at M8. Innovation income is behind target – opportunities are under review.

Manual hours saved through automation solutions - Monthly

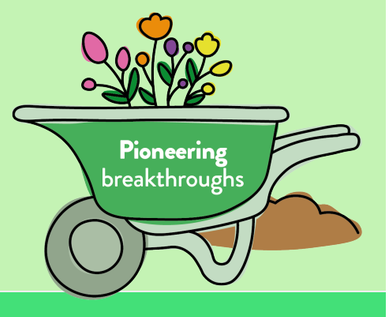


Technical Analysis:

This relates to fully implemented RPA solutions.

Actions:

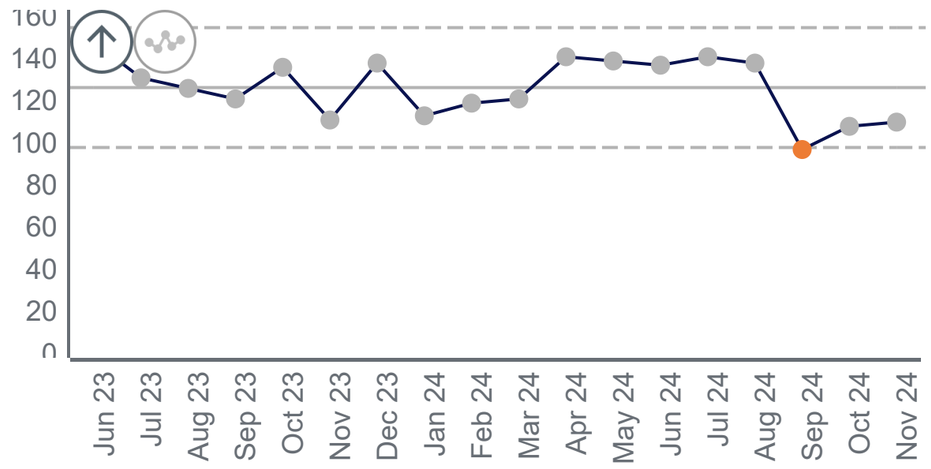
Monthly RPA prioritisation meetings and reports implemented for corporate and clinical teams using RPA.



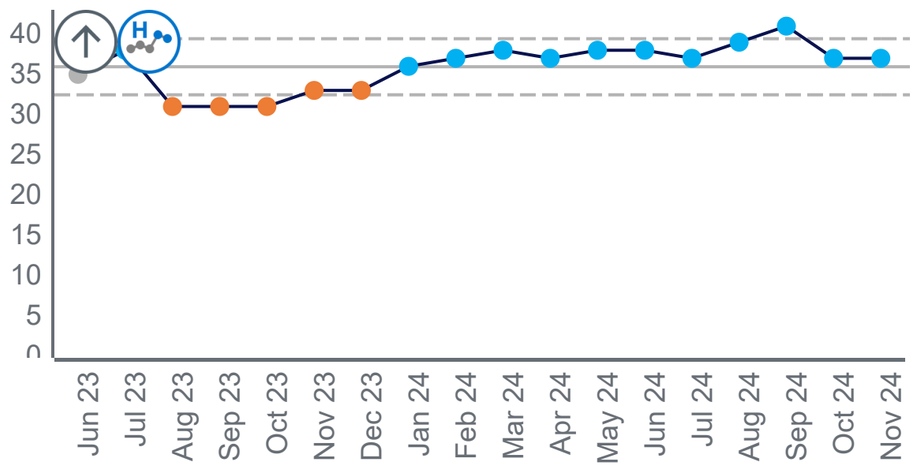
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

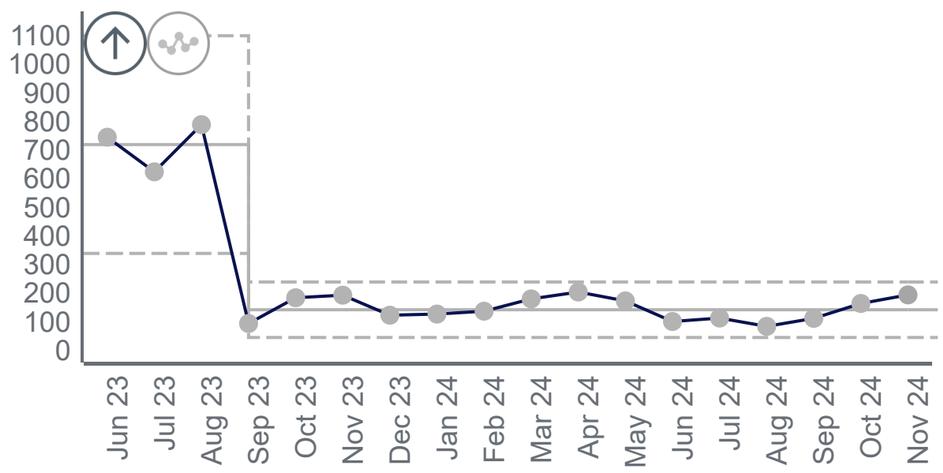
Number of Active (Open) Studies - Academic



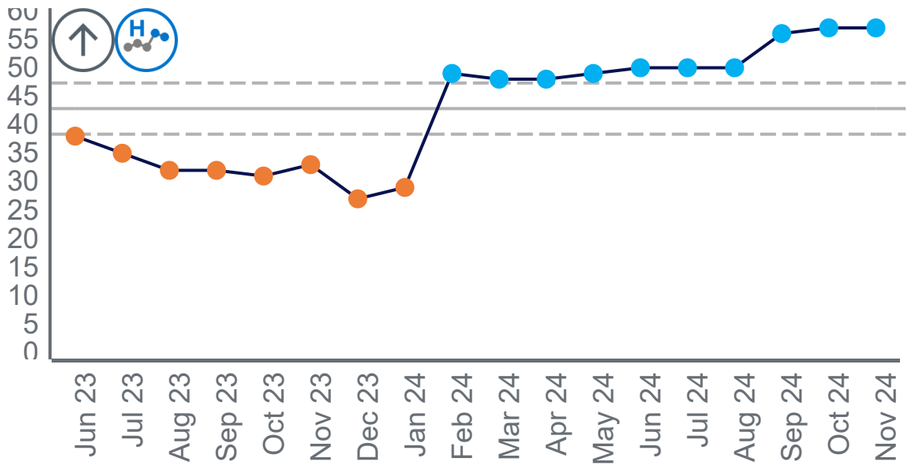
Number of Active (Open) Studies - Commercial

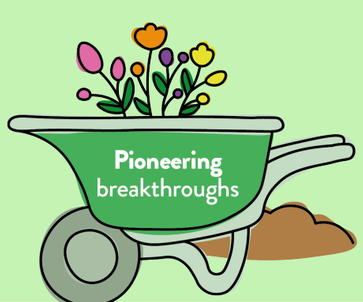


Number of Patients Recruited into Research Studies



Number of Chief Investigator led studies





Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

SRO: For collaborating in communities – Dani Jones, Chief Strategy and Partnerships Officer & Exec Lead for Health Inequalities – Alfie Bass, Chief Medical Officer

Highlights:

• Wellbeing Hub mobilised 11/11/24. 30 referrals received at 13/12/24. • Vaccinations & Immunisations - 600 CYP screened to date with input into 100 management plans for vaccination and vaccinated 20 children. Vaccination has been contraindicated in 5 children. • AH reporting progress against Schedule 2N (NHS Standard Contract, specific actions to reduce health inequalities) to CQRM on 20/12/24

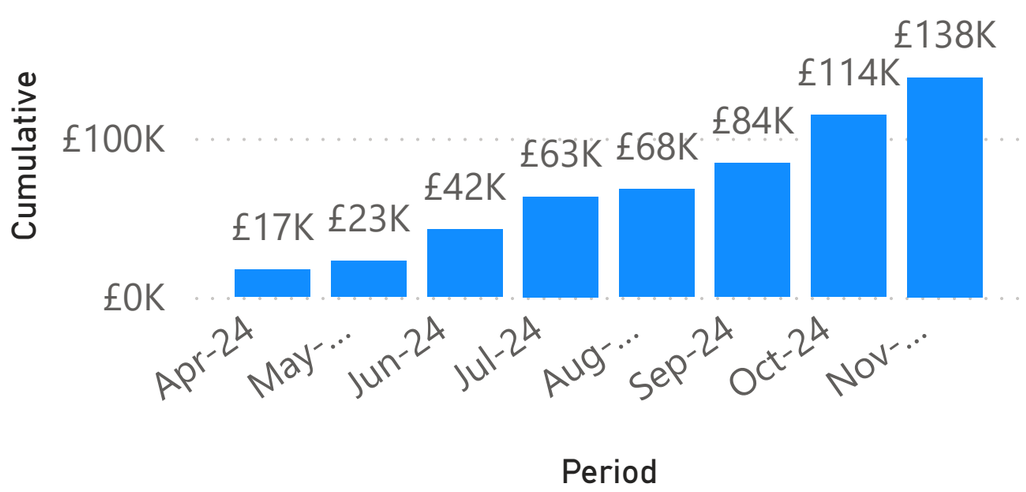
Areas of Concern:

None

Forward Look (with actions)

• Improve my Life Chances Summit scheduled for 7/3/25

Social Value Generated - Cumulative



Technical Analysis:

The SV reported links to 2 outcomes within national framework: 1. Supporting the Local Economy: Developing education, skills and training opportunities. 2. Supporting the Local Economy: Employment Opportunities for Local People. Activity typically higher during term time.

Actions:

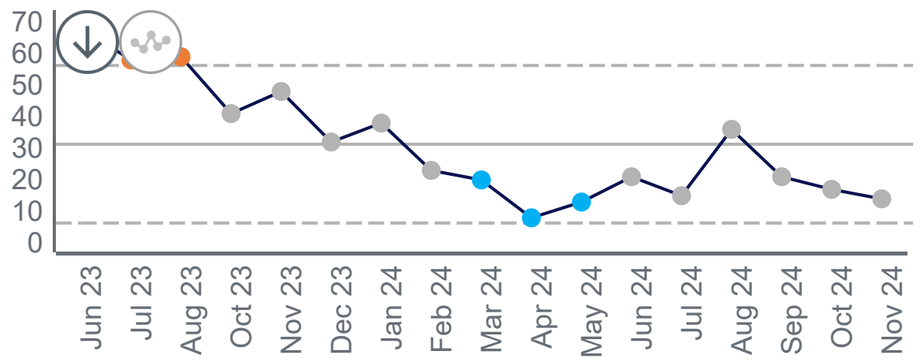
November consisted of a range of activities in schools across the Liverpool City Region and the team developed and undertook a number of specialised events for NEET young people. Outcomes are positive including young people being offered university placements and securing employment. The team continue to reach out and explore potential partnership opportunities with other

Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

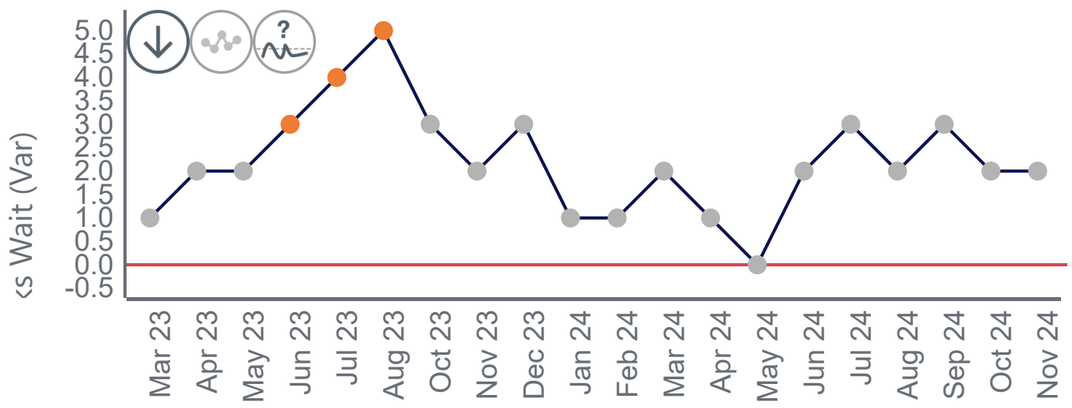
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

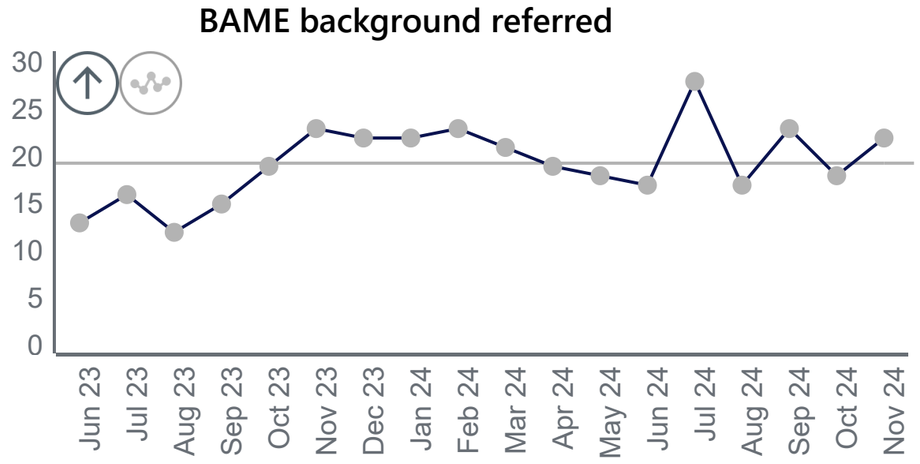


Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD

Sept-23 Unavailable



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



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

£0.5m deficit, which is off plan by £0.6m YTD, due to pay award impact. M8 has been a challenging month both activity and costs. This has been mitigated by bringing forward the release of future benefits into the position. Forecasting to achieve £3.3m surplus, however, the Trust are carrying £1.2m pay award risk and further risks to delivery linked to management of in year pressures. Divisional forecasts continue to highlight challenges and risk but despite a challenging M8 the overall forecast position has remained largely in line with M7 as deterioration in Surgery is offset by improvement in Corporate. The financial improvement plan has resulted in some significant savings, primarily through technical workstreams, which has given the trust assurance to continue to forecast to plan albeit with the known stretch target of £1.2m as set out above. CIP was above plan in M8, £16.3m CIP has been transacted in year, with £3.6m in progress and opportunity. Cash remains high, although slightly lower than plan due to high levels of accrued income as awaiting payment of YTD ERF. Capital broadly on plan YTD however forecast has been updated to £1.5m favourable to plan,

Areas of Concern:

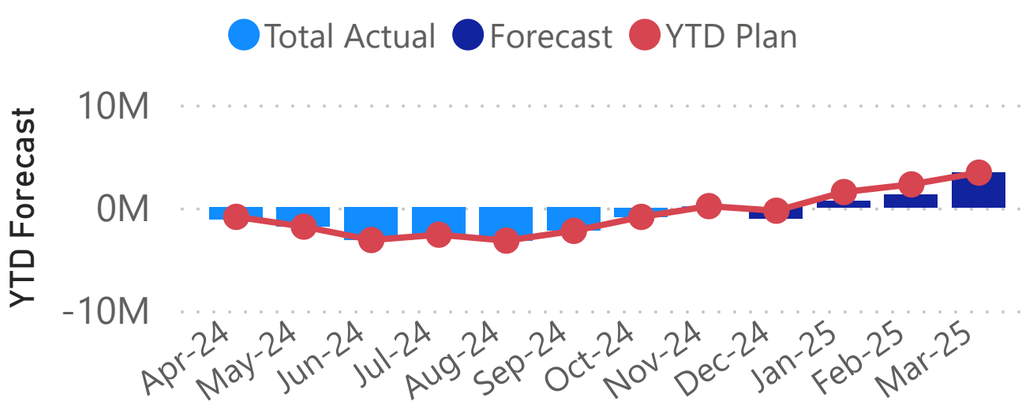
Work is ongoing to deliver full savings of £19.9m and whilst significant progress has been made to date resulting in £12.5m of savings recurrently posted in M8, this does leave a recurrent pressure of £7.4m still to find. Divisional forecasts continue to highlight significant financial and operational challenges with Medicines forecast deteriorating by £2.7m since Q1. SDG meetings continue to focus on 4 key priorities (Workforce, Drugs, Coding and Activity) with a view to deliver savings to support the position. The capital allocation in year remains tight, however following a re-prioritisation exercise it is believed that this risk has been mitigated in year, but that future year capital allocation remains a challenge. Given risk of slippage and potential for new national funding streams, the risk of potential underspend of CDEL in year is now being actively management, with a paper going to Executive to look to mitigate this risk of both under and overspend of CDEL with a view to carefully manage the position

Forward Look (with actions)

Continued focus on cost control to reach the year end position, with finance improvements in place being monitored through SDG. Continued focus required on achievement of £19.9m efficiency target. Continued prioritisation of capital programme. ICB are now requiring all Trusts to hold gold command meetings with an intense focus on finance and improving run rate which is being managed through Executive weekly meetings

I&E Year End Forecast

Target: Statutory



Technical Analysis:

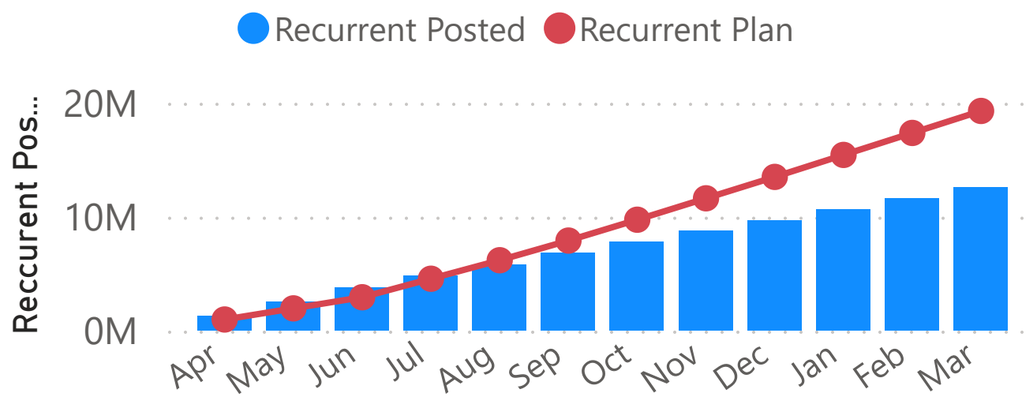
Current plan is £3.3m surplus (£1.2m pay award risk) however, initial forecast continues to highlight significant challenge. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through SDG meeting and divisional deep dives. SDG meetings continue to focus on 4 key priorities (Workforce, Drugs, Coding and Activity) with a view to deliver savings and achieve the full year forecast. Executive considering any additional controls required

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

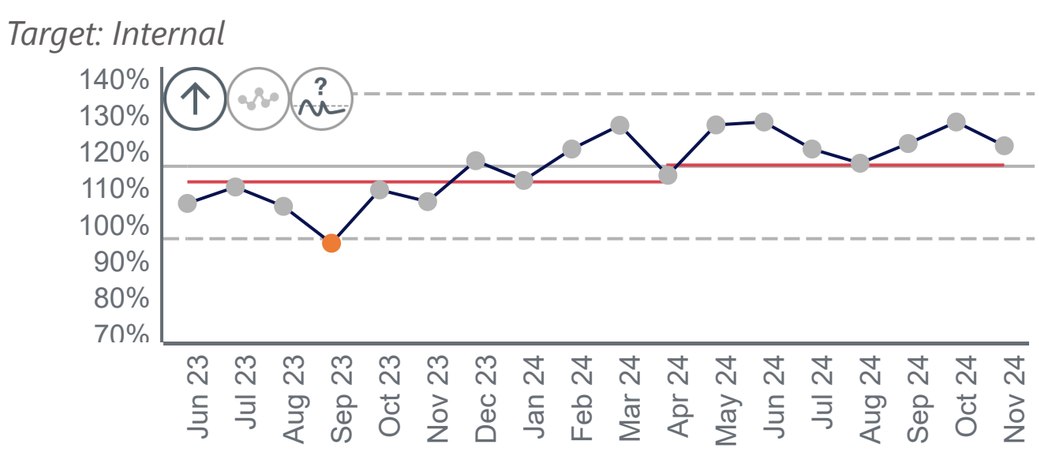
In year CIP identified and in progress is £18m whilst recurrent CIP is £12.9m

Actions:

Significant work is ongoing to support the delivery of efficiency targets across the Trust, including the work on benefits from the strategic initiatives.

% ERF Value (Income)

Target: Internal



Technical Analysis:

November performance estimated at 121.9%.

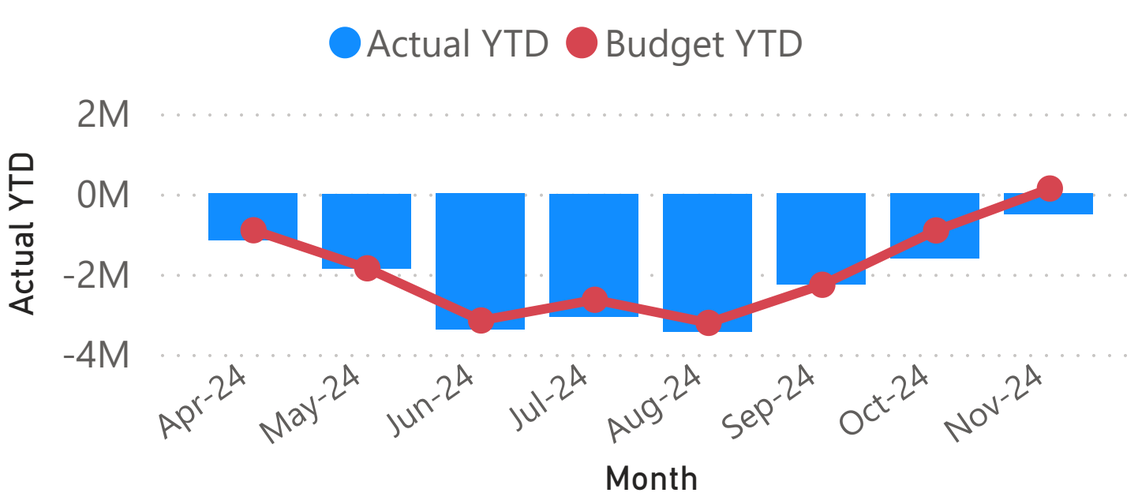
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

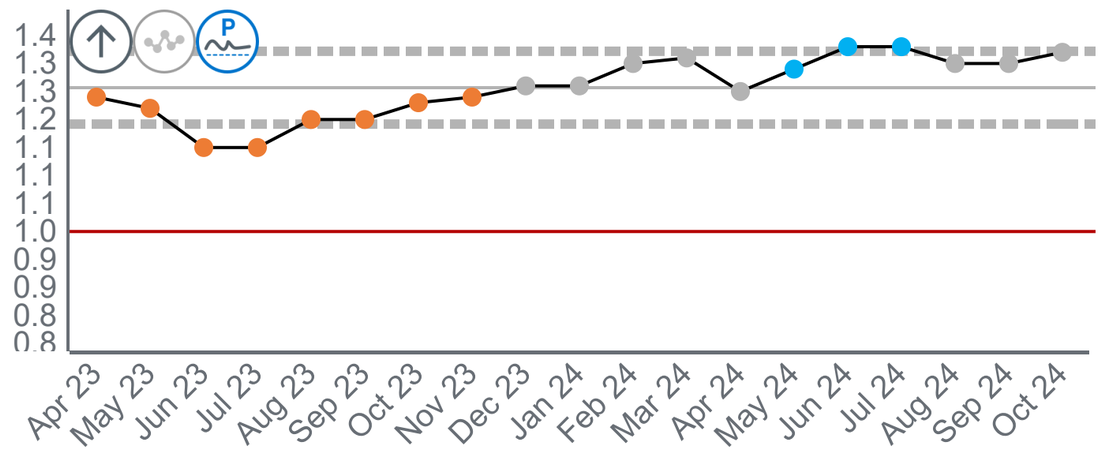
I&E distance from target (cumulative YTD)

Target: Internal

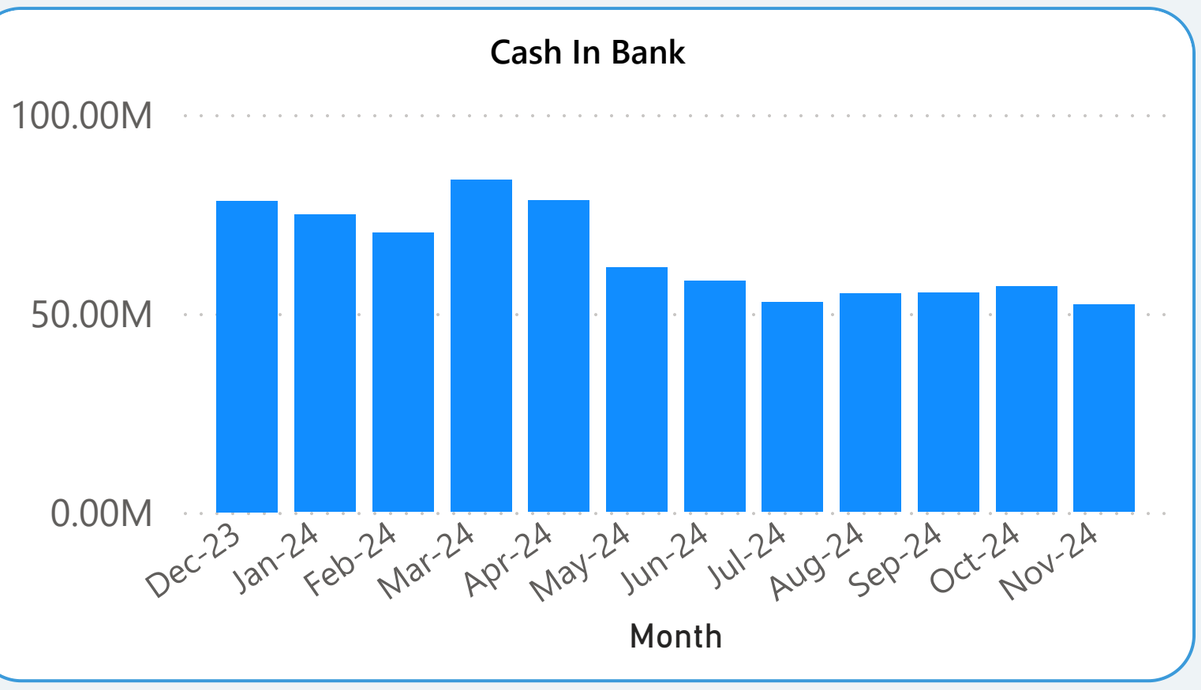


Liquidity

Target: Internal



Cash In Bank



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Risk oversight meetings continue with positive discussions with teams regarding risk descriptions and tolerances. Risk management training with Community and Mental health managers undertaken. Deep dive into all long standing high moderate risks undertaken at Decembers RMF.

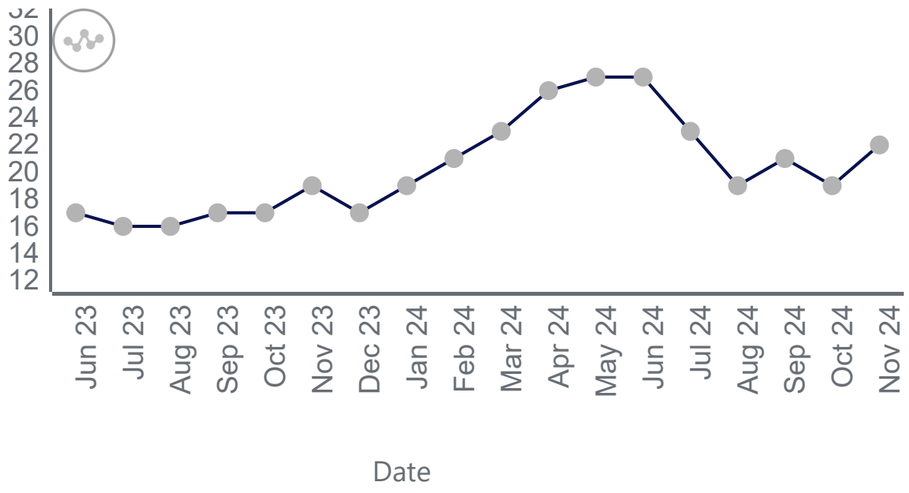
Areas of Concern:

No concerns of note.

Forward Look (with actions)

Roll out and testing of application of risk appetite framework with community and mental health divisions

Number of High Risks (scored 15 and above)



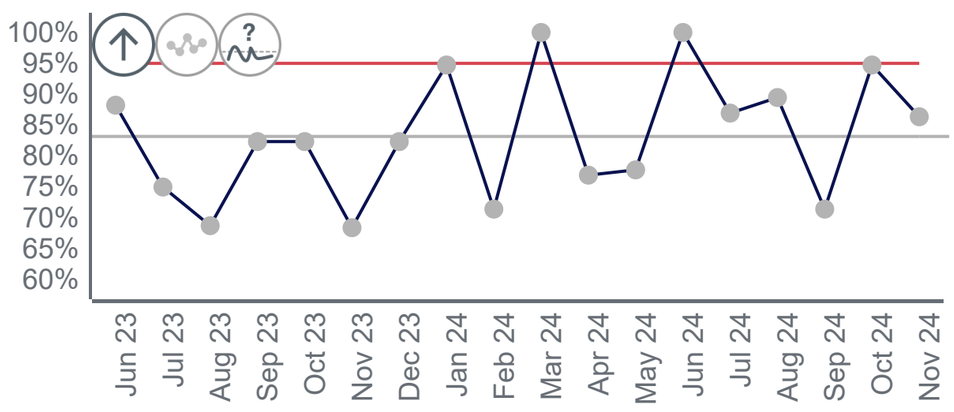
Technical Analysis:

22 high risks on risk register as of end of November 24: a slight increase from the previous reporting period

Actions:

% of High Risks within review date

Target: Internal



Technical Analysis:

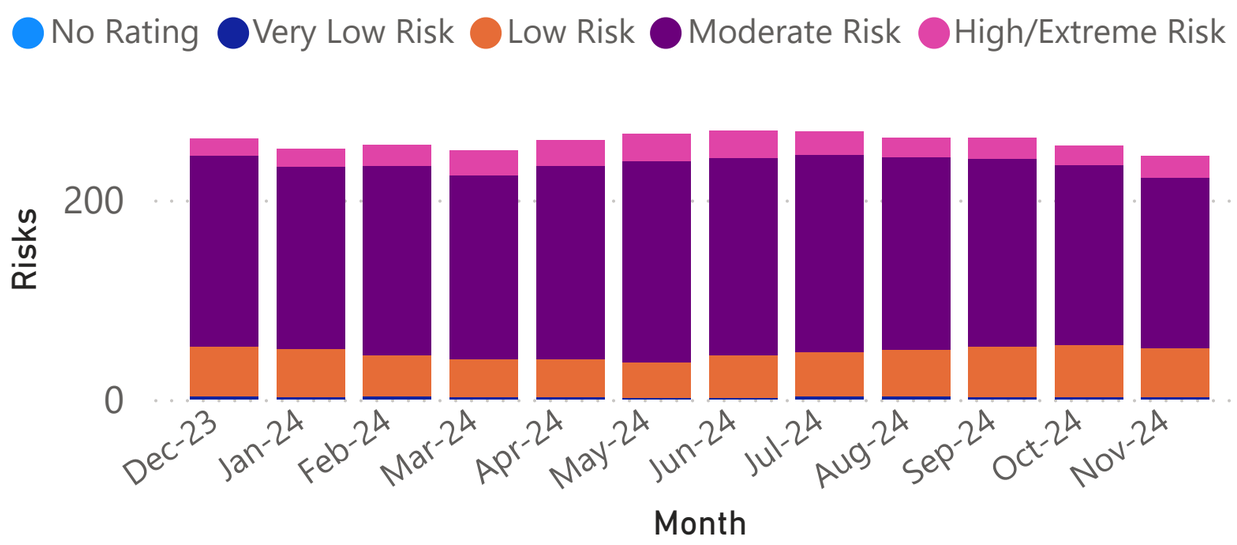
91% (20/22) risks within expected review date

Actions:

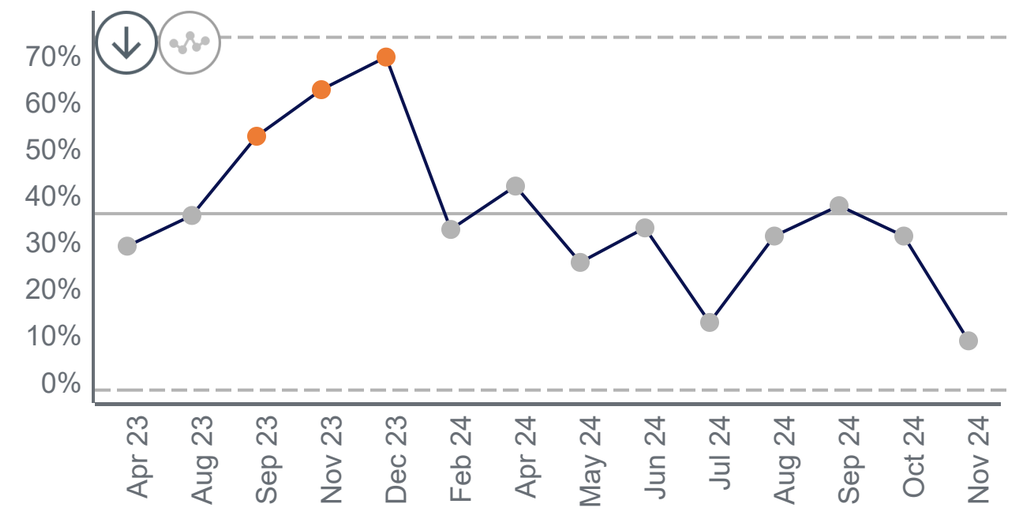
Overdue risks have been escalated to risk owner/manager for immediate review and update

Well Led - Risk Management

Trust Risk Profile



% of high risks with actions past expected date of completion



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

- WNB rate is 10% which is the lowest since June 2023 (10%) with Sefton CAMHS being 9%
- 100% Initial Health Assessments completed within 20 days of receiving referral
- Mandatory training compliance has improved, and remains above Trust target (97%)
- No children and young people waiting over 52 weeks for CAMHS, community paediatrics and therapies.
- Continued reduction in number of children and young people waiting 2+ years for a follow up (reduced from 1325 to 29)
- Improvement in % of friends and families recommending outpatients and community services (94%)
- RTT for SALT has continued to improve (80% Liverpool, 97% Sefton)
- RTT for Dietetics remains high (92% Liverpool, 83% Sefton)
- Ave wait for treatment reduced for CAMHS (18w Liverpool, 14w Sefton)
- CAMHS PIFU discharge pathway commenced November 2024

Areas of Concern

- Increase in urgent Eating Disorder referrals – with decrease in RTT (33%) (recovered target in December)
- Increase in number of complaints received (3) and PALS contacts (57)
- Sickness absence has increased (8%) – improvement in short term sickness (2%) but increase in long term sickness (5.5%)
- Outpatient Fracture / Dermatology work has commenced. Delays with redevelopment work which is impacting on ability to reduce clinic room waiting list.
- Work continued regarding data reporting for Mental Health Services via MHSDS due to data quality issues impacting on submissions. Data engineering rewrite commenced in November 2024 – with first MHSDS Improvement Steering Group completed November 2024.
- Continued challenges with ADHD medication shortage – unable to initiate medication for ADHD in line with ICB guidance

Forward Look (with actions)

- Procurement and tender process ongoing for independent sector capacity for ADHD assessments – evaluation process underway with expected start date January 2025
- Sunflower House Meditech development work completed, testing and training ongoing throughout November and December – Go live date January 2025
- CAMHS documentation changes accepted for Meditech development sprint Dec 2024 which will aid with Mental Health data reporting.
- Continued work ongoing to improve Mental Health data reporting. Annual data re-submitted for 2023/24, awaiting feedback.
- ASD / ADHD transformation programme continuing with good engagement from teams and external colleagues. Clinical model development ongoing with planned sign off March 2025
- Launch of digital H&W scales in December 2024
- First OPD team away day planned for January 2025
- Work ongoing with Victim Support to provide psychological support to children impacted by the Southport critical incident.

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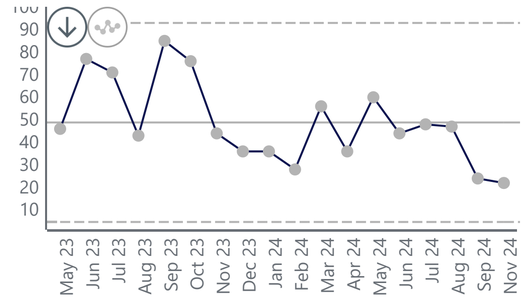
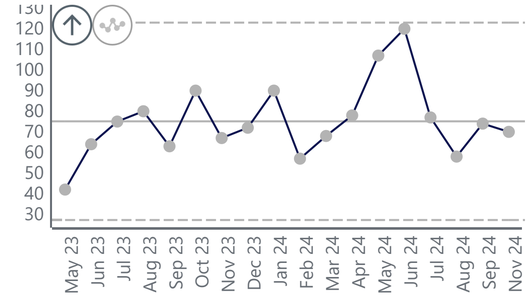
Divisional Performance Summary - Community & Mental Health

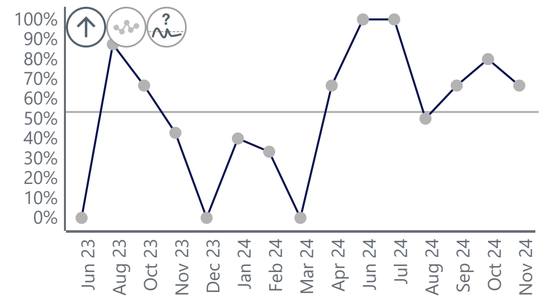
Patient Safety Incidents rated Low Harm & Above



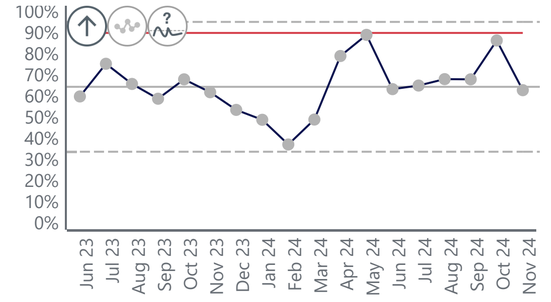
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

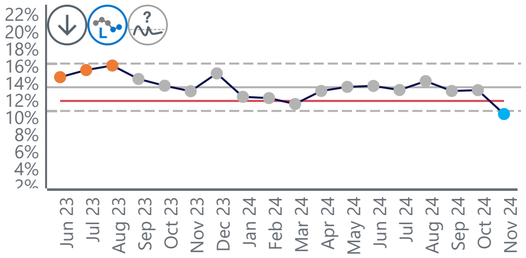


% PALS Resolved within 5 Days

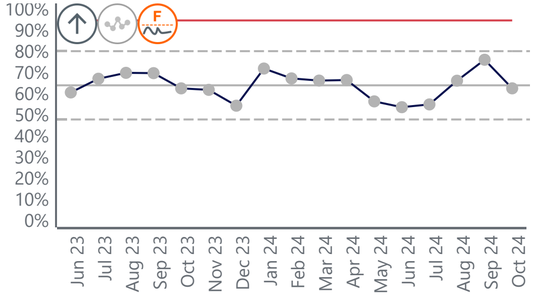


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

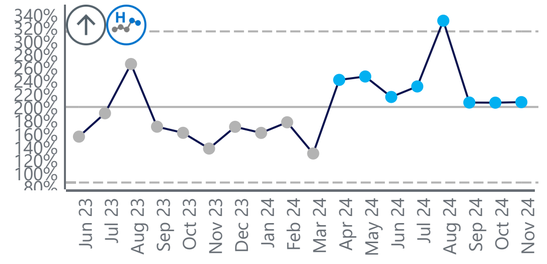


% of Clinical Letters completed within 10 Days

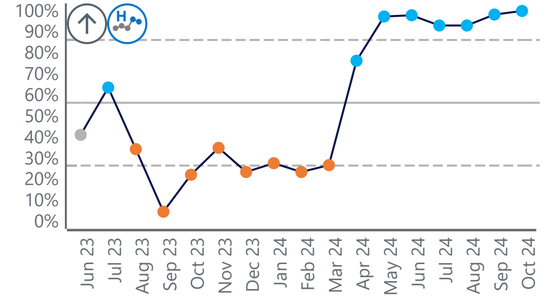


% Recovery for OP New & OPPROC Activity Volume

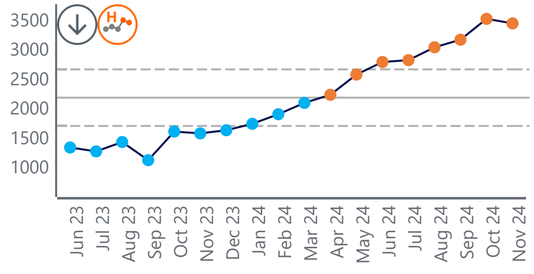
Based on 19/20 baseline



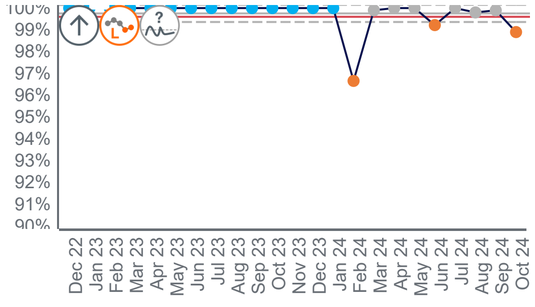
IHA: % complete within 20 days of referral to Alder Hey



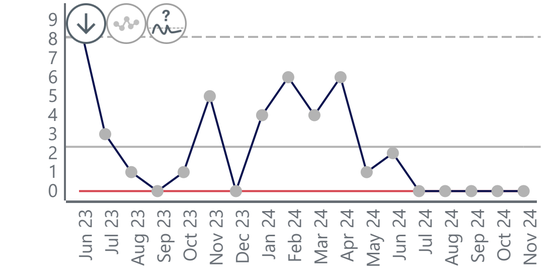
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



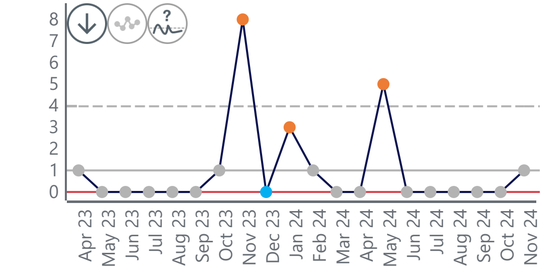
ADHD & ASD: % Referral to triage within 12 weeks



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



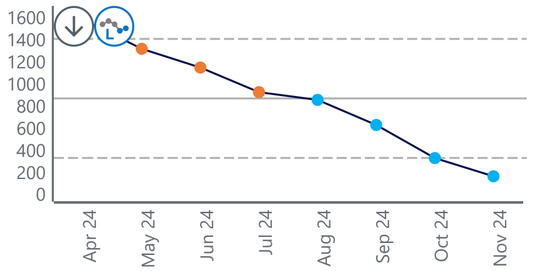
Number of Paediatric Community Patients waiting >52 weeks



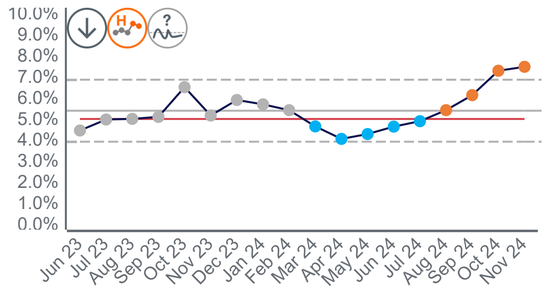
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

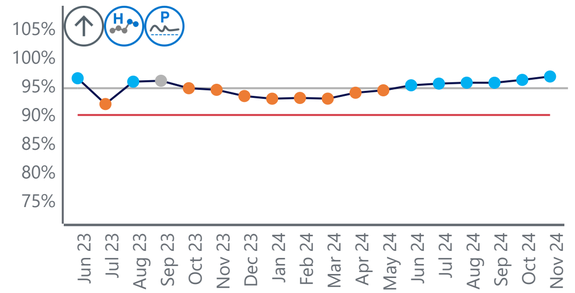
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



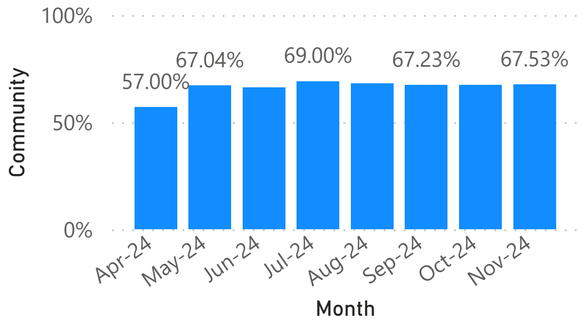
Sickness Absence (Total)



Mandatory Training

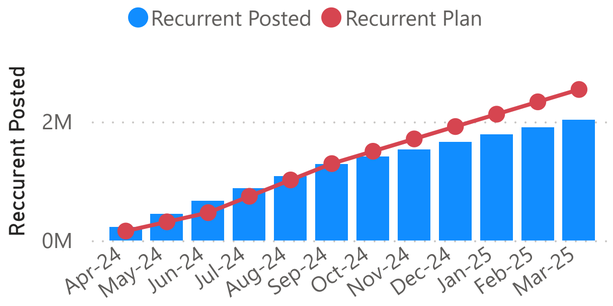


Workforce Stability

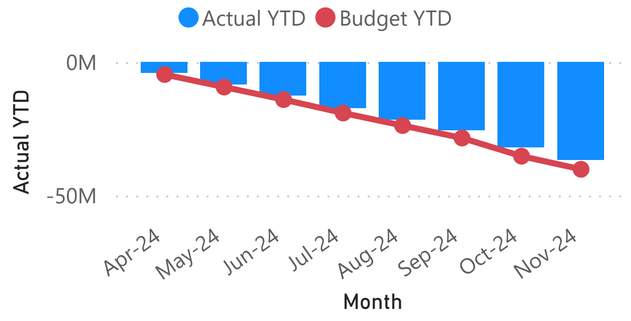


Staff Turnover

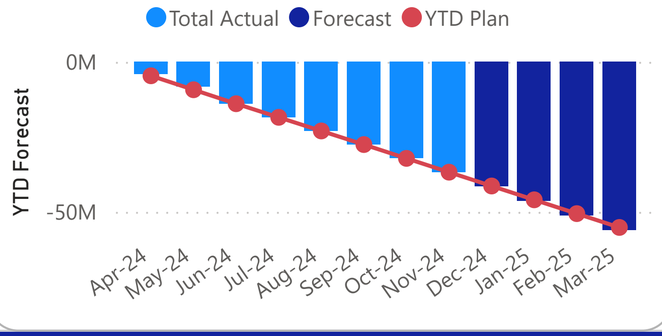
Recurrent Efficiency Plans Delivered (Forecast)



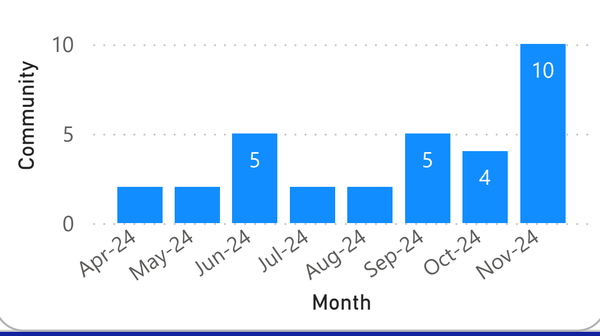
I&E distance from target (cumulative YTD)



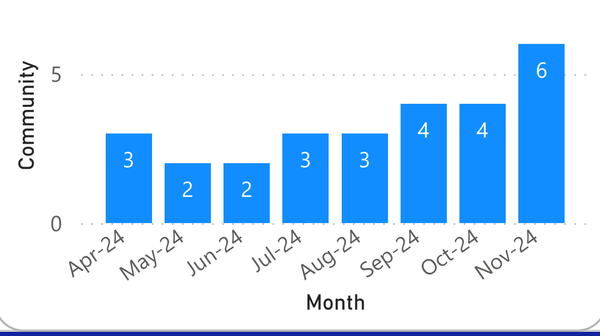
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

- 100% response rate for formal complaints for 12 consecutive month
- 98% compliance in PALS for the month
- DM01 target achieved for the first time in over a year
- Continued reduction in children waiting over 2 years for follow up care
- Slight reduction in OP new and OPROCs however offset by increase in Day Case per day
- Maintained high performance in mandatory training compliance
- Research number of research participants per clinical division
- Sickness rates maintained below 5%

Areas of Concern

- Challenges ED performance not achieving national standard for the first time since October '23. Associated with increase attendances, 10% increase compared to November 2023
- Challenges month for all ED measures including increased in medium time to triage and increase number of children waiting over 12 hours within the department
- Significant acute bed capacity challenges over periods during the month, associated with increase demand and peak RSV surge
- Reducing in F&F from ED associated with increase waiting time
- Continued reduction in children waiting over 52 weeks for treatment; however, primary area of concern being neurology for March 2025 target
- Challenging financial position, owing to reduction in forecast income anticipated and increase in non-pay spend, resulted in worsening end of year forecast position
- Although all CIP schemes have been identified a challenge remains regarding delivery and transaction of the CIP target

Forward Look (with actions)

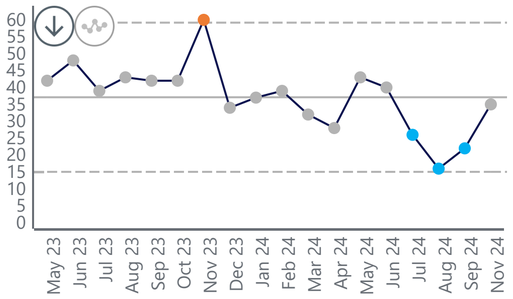
- Continued heightened monitoring and actions associated with DM01 recovery plan
- High impact actions in place to improve waiting times and metrics within ED to ensure all children and young people are seen as promptly as possible. Improvement already seen in December MTD
- Maintained monitoring surrounding winter plan and actions associated to decompress hospital bed based
- Plans to ensure no child is over due their follow up appointment by over two years by the end of March 2024
- Divisional health and wellbeing occurring in November to support staff during one of the busiest times of the year within the division
- Action plan in place for Haematology and Transfusion laboratory services with plans in place to increase rota resilience again from January 2025

Integrated Performance Report | December 2024

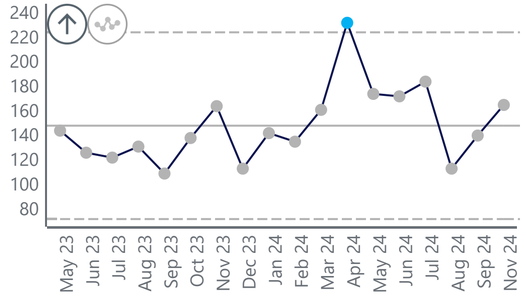
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

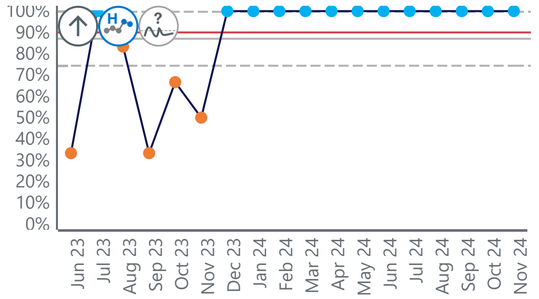
Patient Safety Incidents rated Low Harm & Above



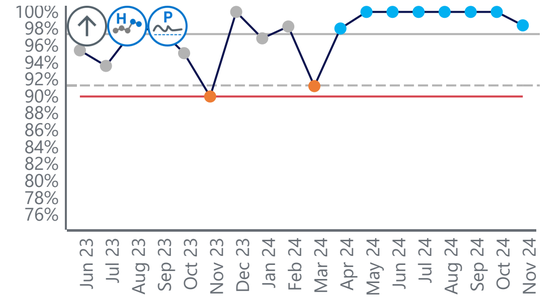
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

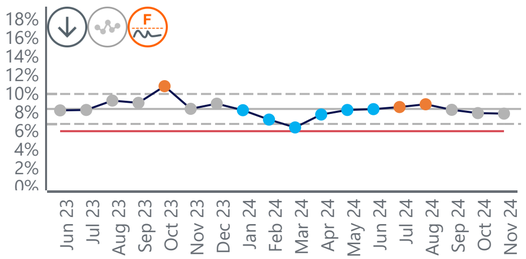


% PALS Resolved within 5 Days

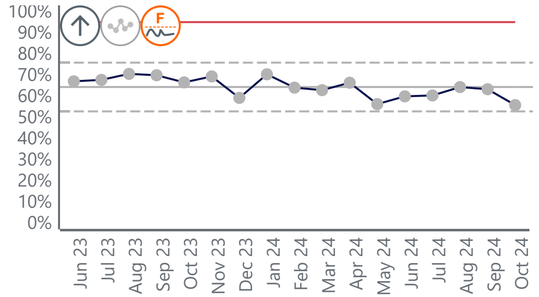


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

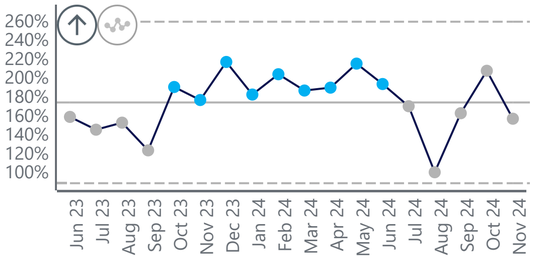


% of Clinical Letters completed within 10 Days

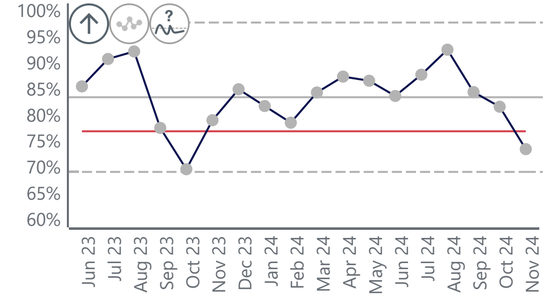


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

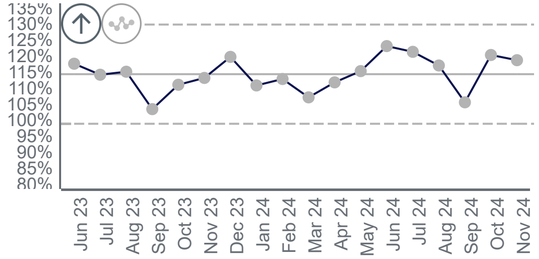


ED: % treated within 4 Hours

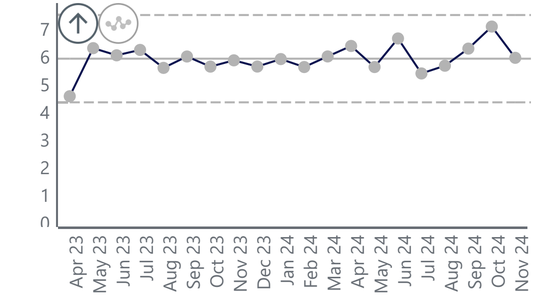


% Recovery for DC & Elec Activity Volume

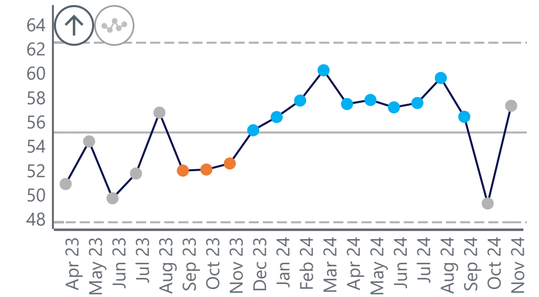
Based on 19/20 baseline



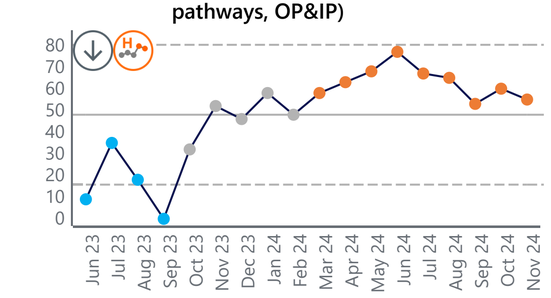
Inpatient Discharges per working day



Day Cases per working day



Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



Integrated Performance Report | December 2024

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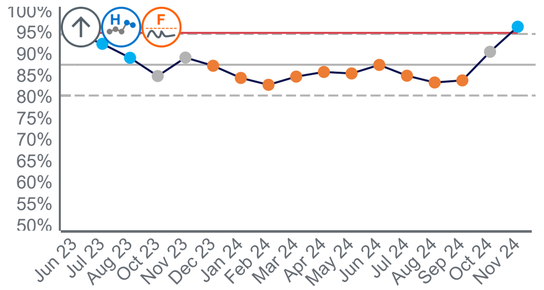
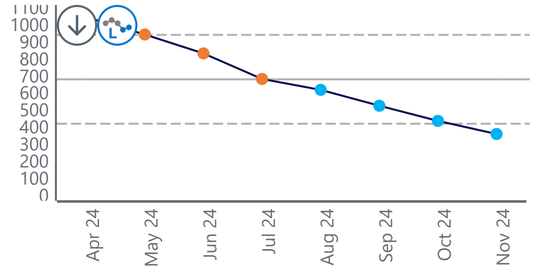
Divisional Performance Summary - Medicine

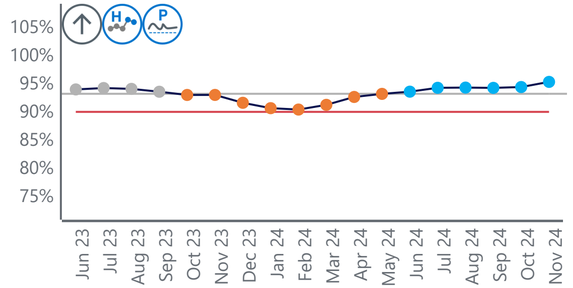
Diagnostics: % Completed Within 6 Weeks of referral



Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025

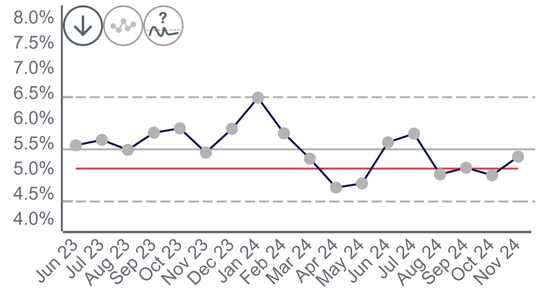


Mandatory Training

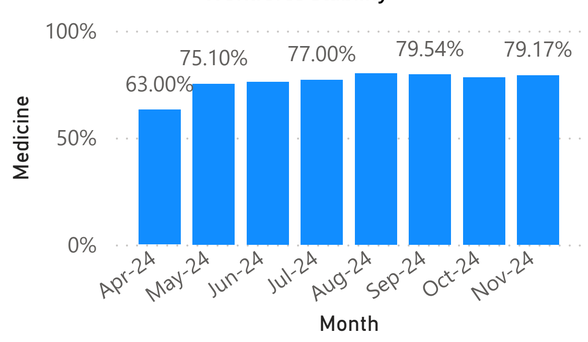


Staff Turnover

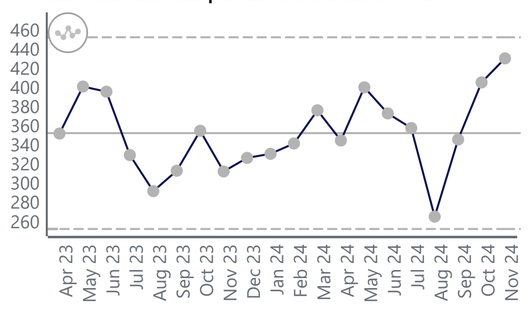
Sickness Absence (Total)



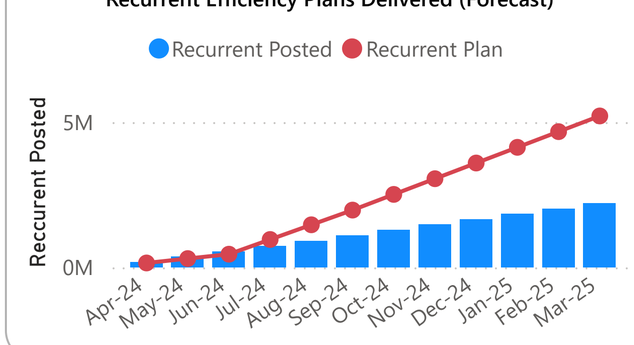
Workforce Stability



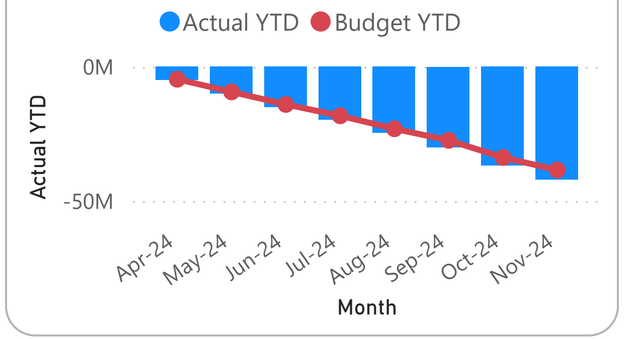
A&E Attendances per ED Consultant WTE



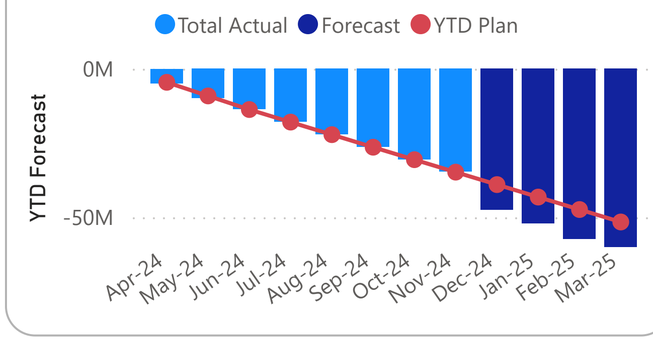
Recurrent Efficiency Plans Delivered (Forecast)



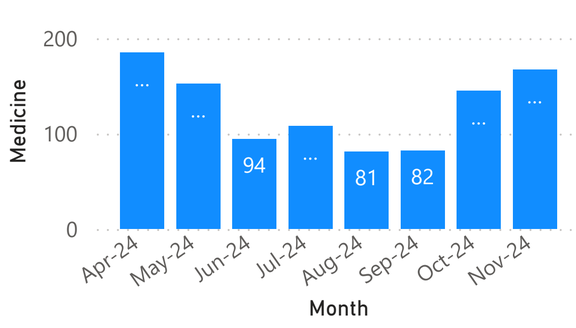
I&E distance from target (cumulative YTD)



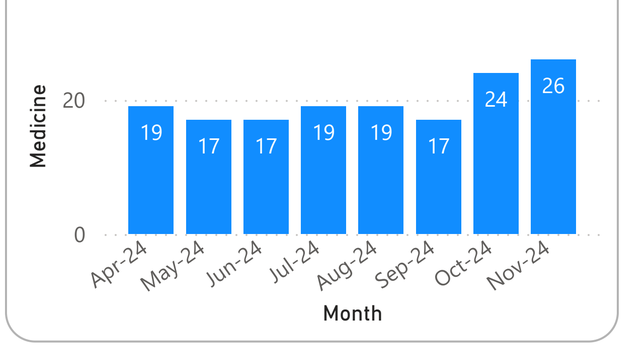
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

- Compliance with formal complaints remained at 100% and PALS above target
- Volume of CYP waiting over 52 weeks for treatment reduced for 6th consecutive month
- Day cases per working day remain high which reflects on the positive work within productive theatres programme
- % recovery for Outpatient NEW and Procedures continued to perform above 19/20 levels of activity volume (131%)
- % recovery for DC/Elective continued to perform above 19/20 levels of activity (110%)
- Mandatory training continued to be above trust target and improving.
- Workforce stability increased for 8th consecutive month.

Areas of Concern

- Diagnostics compliance dropped in month which was due to Cystoscopy compliance
- % clinical letters completed within 10 days dropped in compliance and remains under compliance.
- Sickness absence increased in month at 5.9% due to short term illness and is in line with historical trends through winter.
- Forecast position worsened due to key variances in ERF and pay in month 8. Key plans in place to improve ERF position based on uncoded activity and forecast increase in volume in some areas. Pay pressure predominantly relates to national critical care pressures and therefore an increase in bank spend to fully staff/open surge capacity.

Forward Look (with actions)

- New management process going live to ensure weekly diagnostic compliance is reviewed and appropriate validation takes place to ensure future compliance. Target compliance to be achieved by mid-December.
- Immediate actions planned to support transcription of clinical letters and documentation in clinic by engagement with new Lyrebird technology in high volume areas- rollout through December and January.
- Division focused on wellbeing support for staff to support to include check ins, review of hybrid working and wellbeing walkarounds.

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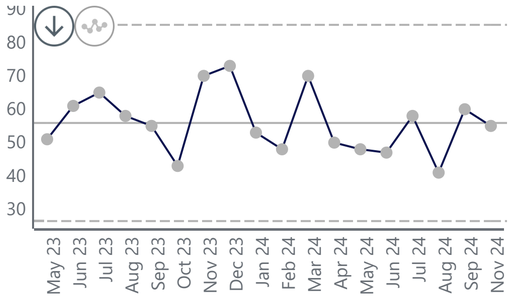
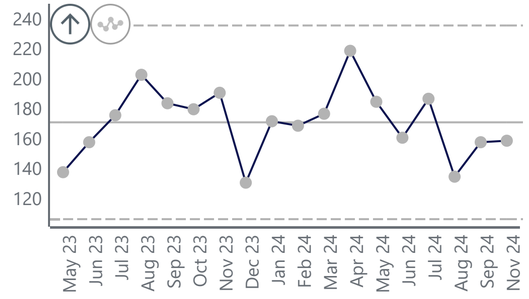
Divisional Performance Summary - Surgery

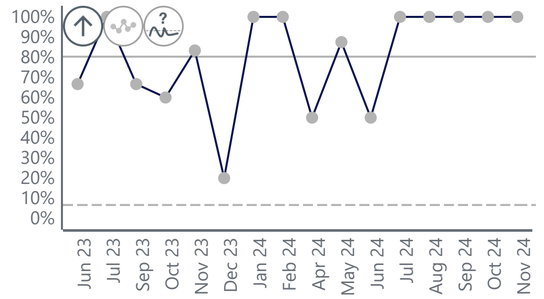
Patient Safety Incidents rated Low Harm & Above



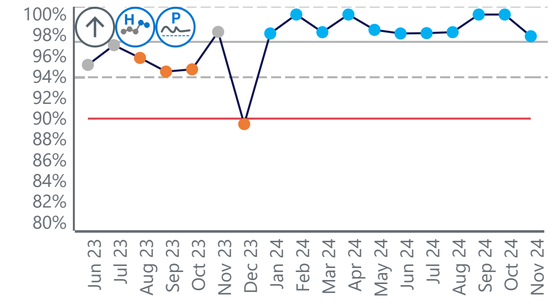
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

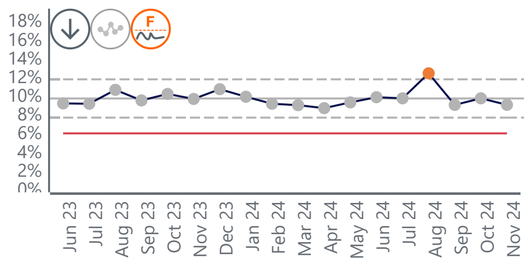


% PALS Resolved within 5 Days

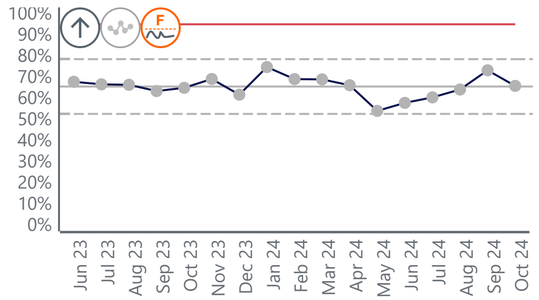


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

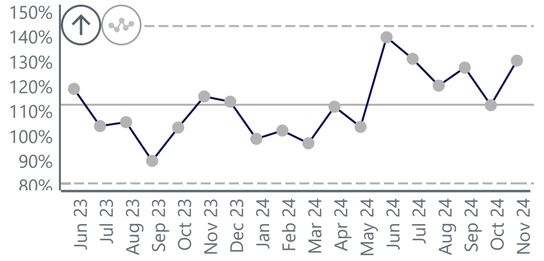


% of Clinical Letters completed within 10 Days



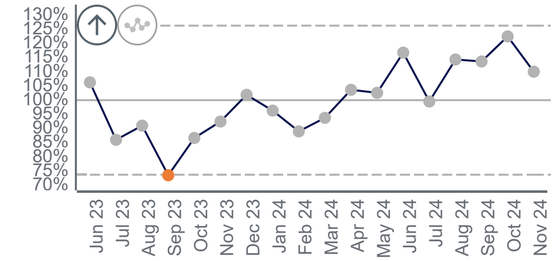
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

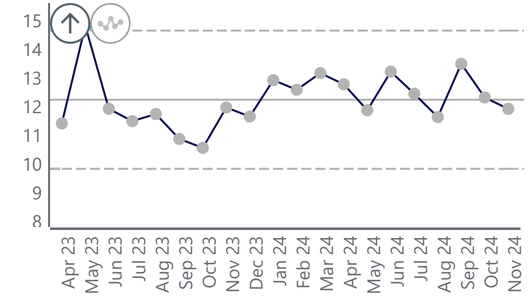


% Recovery for DC & Elec Activity Volume

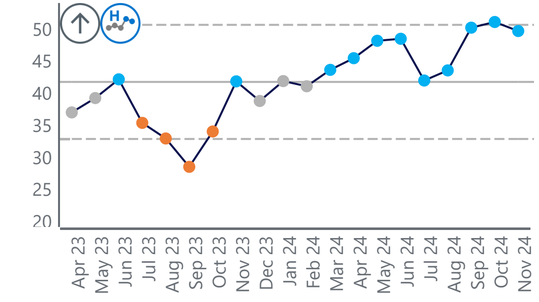
Based on 19/20 baseline



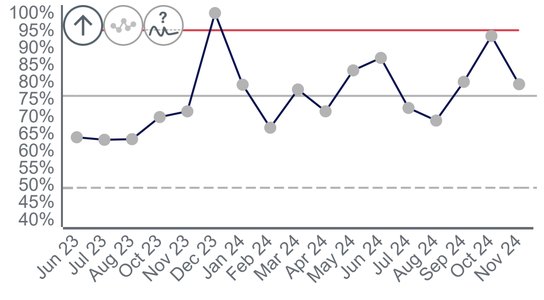
Inpatient Discharges per working day



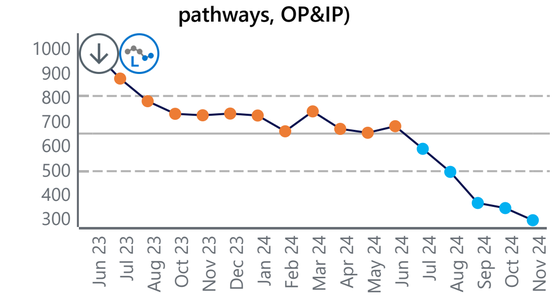
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



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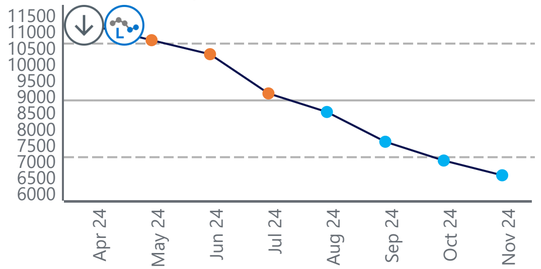
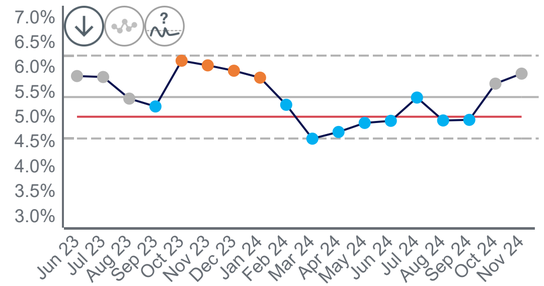
Divisional Performance Summary - Surgery

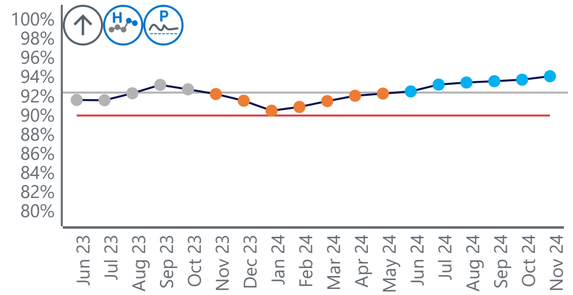
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



Sickness Absence (Total)

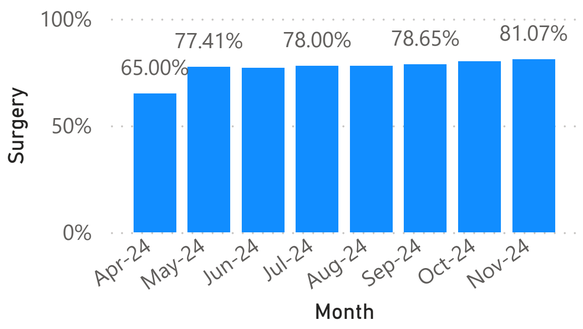


Mandatory Training

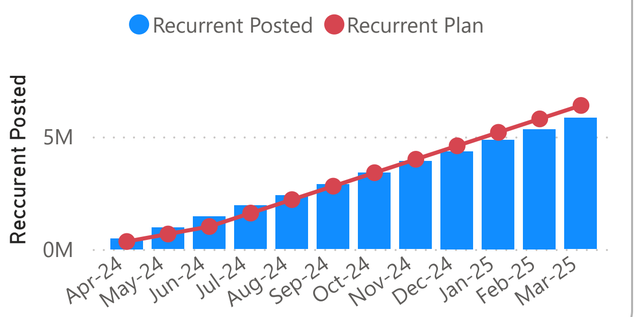


Staff Turnover

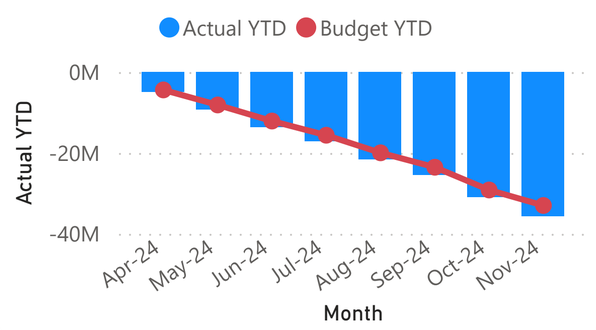
Workforce Stability



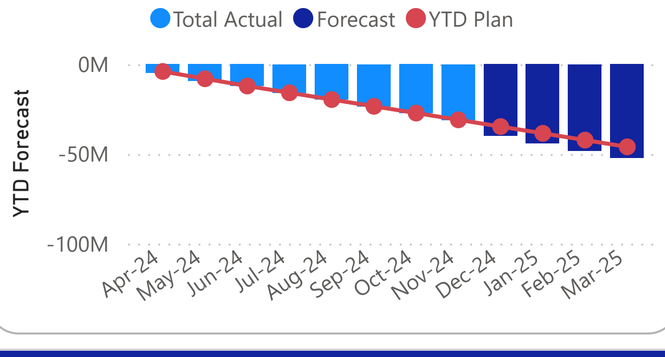
Recurrent Efficiency Plans Delivered (Forecast)



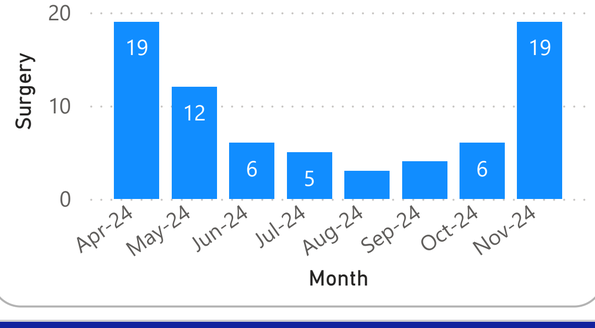
I&E distance from target (cumulative YTD)



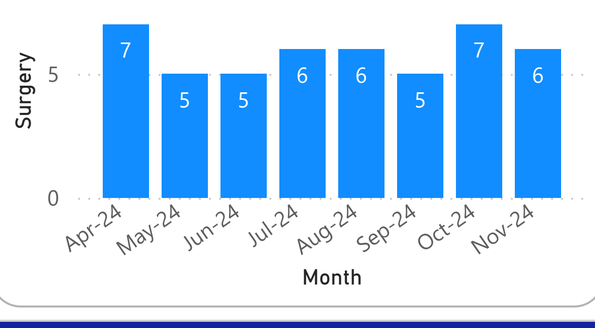
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• Research Management Board and Innovation Management Board working together with a shared section of Board meetings implemented from November
• Press coverage of NIHR capital awards - Alder Hey Children's Hospital awarded £1.1 million for research | ITV News Granada
• Continued overachievement against commercial research income targets at M8
• Mobile Research Unit call for use cases remains live
• Sickness absence has dropped to 1% with staff on long term sickness absence returning to work
• Mandatory training remains on track and all B7+ PDRs completed
• CRD staff wellbeing week took place w/c 25th November with a mixture of lunchtime sessions and bitesize mindfulness activities – feedback under review

Areas of Concern

• Research pipeline for 3rd MRI scanner behind schedule – review underway.

Forward Look (with actions)

• Internal funding call to support research discovery to be launched in December.

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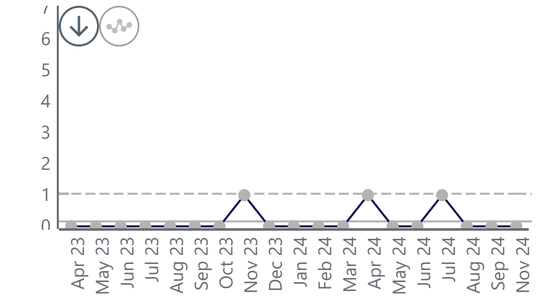
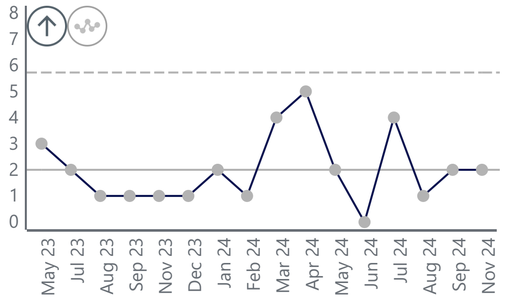
Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

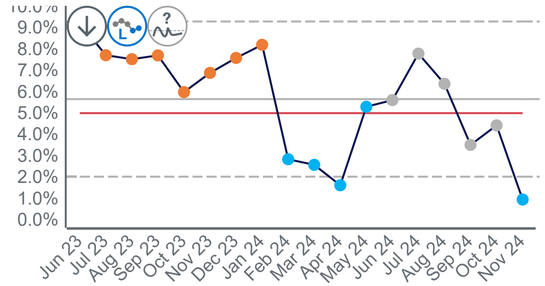


Patient Safety Incidents rated No Harm

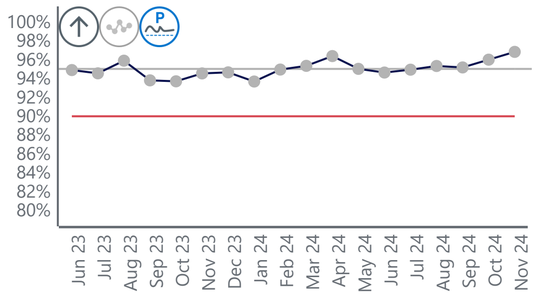


Staff Turnover

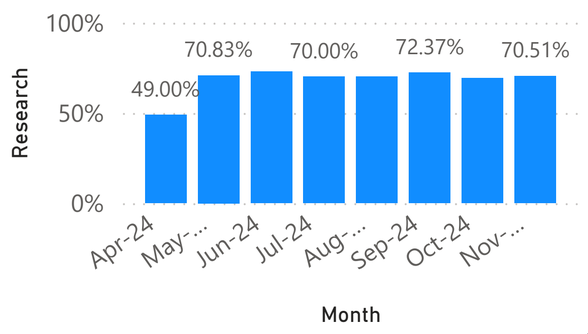
Sickness Absence (Total)



Mandatory Training



Workforce Stability



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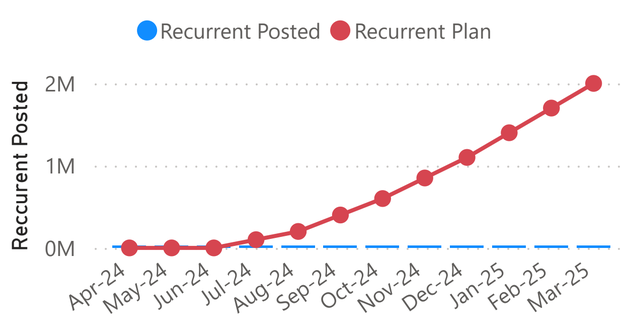
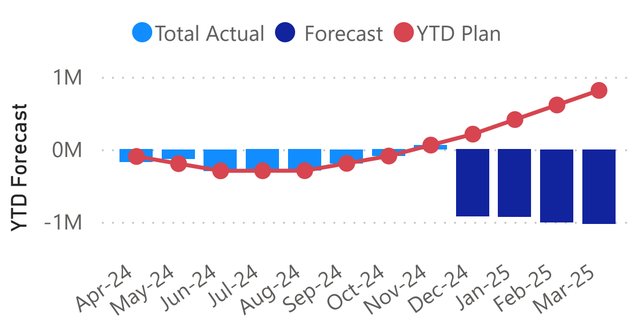
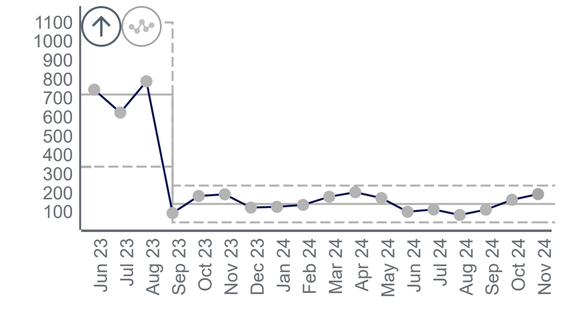


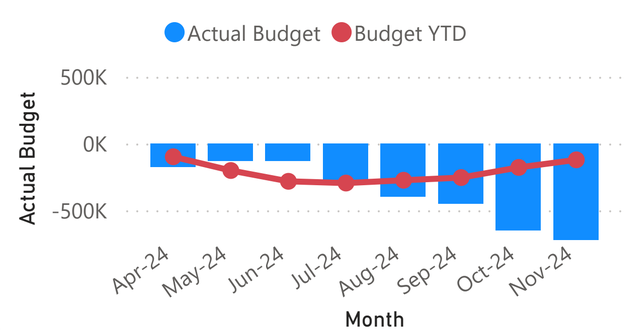
I&E Year End Forecast



Number of Patients Recruited into Research Studies



I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative met on 10th December 2024. Highlights from the November data include:

- Mandatory training remains stable at 93%.
- Short term sickness absence remains within Trust target at 2%.
- Proportion of BAME staff in workforce is currently sitting at 6%.
- Long term sickness has remained at 5% from the previous month.
- Staff survey completion rates for corporate services is 59%.
- 94% of CIP already identified and/or delivered at M08.
- Income ahead of plan at M08.

Areas of Concern

- PDRs for B7+ is currently sitting at 72%.
- PDRs for all staff is currently sitting at 83%.
- Overall sickness has reduced to 6.8% from 7.3% in previous month but remains above Trust target.
- Policy compliance is an area of concern with fifteen policies overdue within Corporate Services.
- Risk management compliance saw a worsened position with 7/52 risks overdue review.
- Whole Time Equivalent posts 112 over plan.

Forward Look (with actions)

- Continued focus on financial position, system finance and opportunities.
- Risk owners asked to ensure all overdue risks are reviewed as a priority.
- Call to action for Policy owners to update outstanding documentation and submit through the appropriate governance channels.
- Focussed piece of work to review whole time equivalent posts.

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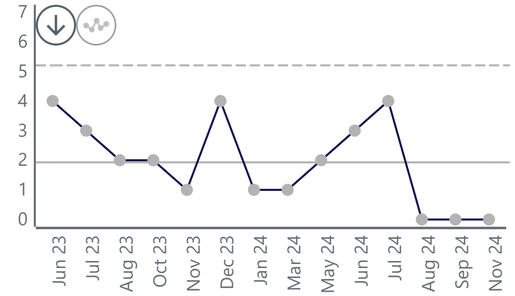
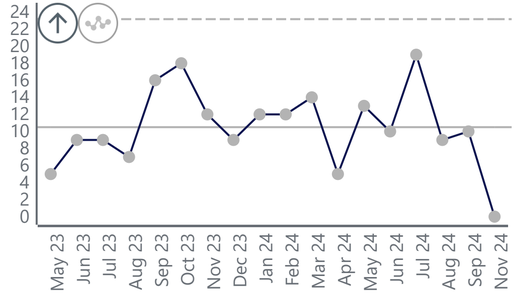
Divisional Performance Summary - Corporate

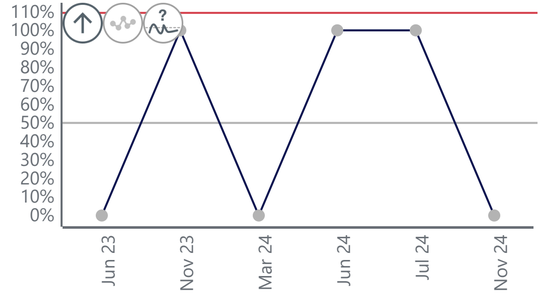
Patient Safety Incidents rated Low Harm & Above



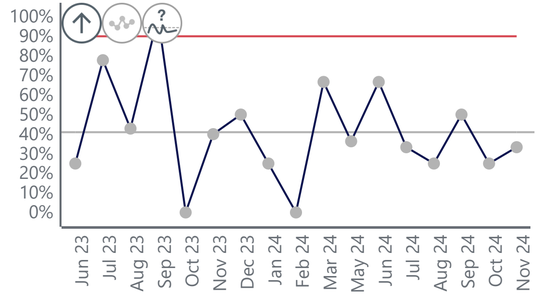
Patient Safety Incidents rated No Harm



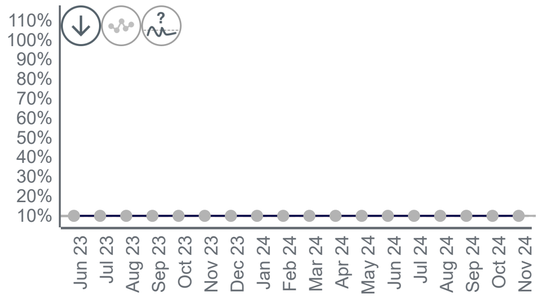
% Complaints Responded to within 25 working days



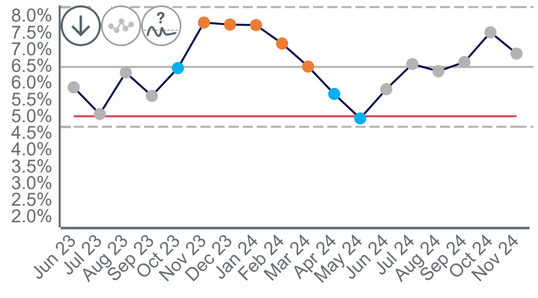
% PALS Resolved within 5 Days



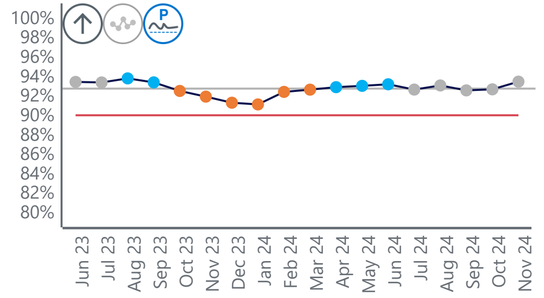
Staff Turnover



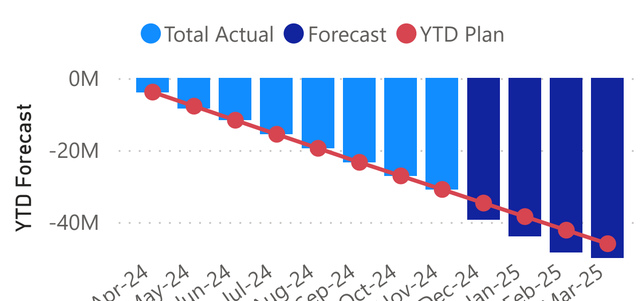
Sickness Absence (Total)



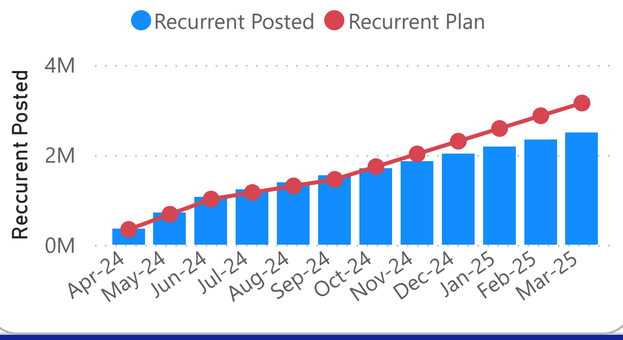
Mandatory Training



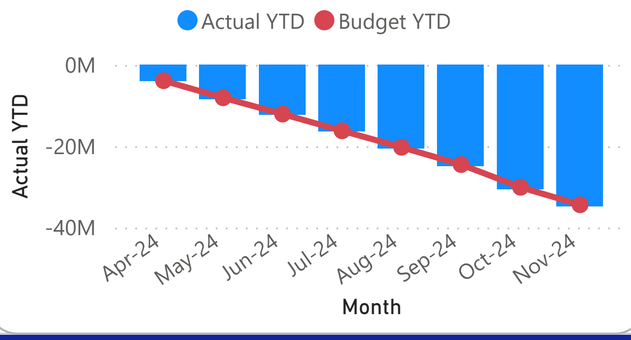
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



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

Safe Staffing & Patient Quality Indicator Report
October 2024 Staffing, CHPPD and benchmark

	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	105%	-	100%	-	101	21.1	21.61	-0.82	-5.00%	0.00	0%	0.00	0.00%	0.00	0.00%	9.75	1.78%	3.00	9.68%	2	47	0	1	6	100%	0	0
HDU	76%	55%	76%	43%	255	31.2	37.53	-3.66	-5.00%	3.33	62%	1.00	1.27%	0.00	0.00%	154.41	6.19%	0.00	0.00%	8	175	0	3	1	100%	0	0
ICU	85%	67%	83%	42%	475	36.1	36.36	2.88	1.70%	1.17	28%	2.92	1.87%	0.00	0.00%	288.85	5.88%	4.00	4.65%	7	237	0	1	1	100%	0	0
Ward 1cC	91%	86%	84%	100%	564	13.1	14.58	-5.82	-10.00%	0.30	6%	0.61	0.98%	0.00	0.00%	172.40	8.82%	18.99	12.18%	7	138	0	26	11	90.91%	0	0
Ward 1cN	93%	15%	102%	-	234	19.3	18.57	-3.31	-9.00%	1.63	67%	0.00	0.00%	0.00	0.00%	52.91	4.67%	0.00	0.00%	6	89	0	9	1	100%	0	0
Ward 3A	97%	63%	100%	126%	783	10.1	12.61	-8.09	-16.00%	2.96	19%	0.00	0.00%	0.00	0.00%	102.56	5.89%	64.41	15.80%	6	87	1	19	32	96.88%	0	0
Ward 3B	88%	79%	93%	-	319	16.7	15.41	0.75	1.70%	1.36	26%	0.00	0.00%	0.00	0.00%	116.35	8.43%	2.00	1.65%	4	142	0	9	2	100%	0	0
Ward 3C	92%	92%	84%	123%	771	11.4	12.81	-2.26	-3.60%	2.26	23%	0.00	0.00%	0.00	0.00%	77.20	3.87%	35.13	14.76%	13	158	0	7	3	100.00%	0	0
Ward 4A	90%	59%	89%	140%	847	10.3	12.28	-2.47	-3.70%	0.92	16%	0.00	0.00%	0.00	0.00%	153.52	7.08%	2.45	1.65%	6	106	0	5	40	90%	1	0
Ward 4B	66%	76%	64%	94%	628	13.8	15.32	-3.81	-11.00%	13.78	28%	0.00	0.00%	0.00	0.00%	26.53	2.28%	67.31	5.99%	4	142	1	8	9	89%	0	0
Ward 4C	98%	94%	98%	105%	554	15.1	14.32	0.34	0.60%	-0.44	-4%	0.00	0.00%	0.00	0.00%	82.50	4.74%	2.76	0.73%	4	287	0	9	13	100.00%	0	0

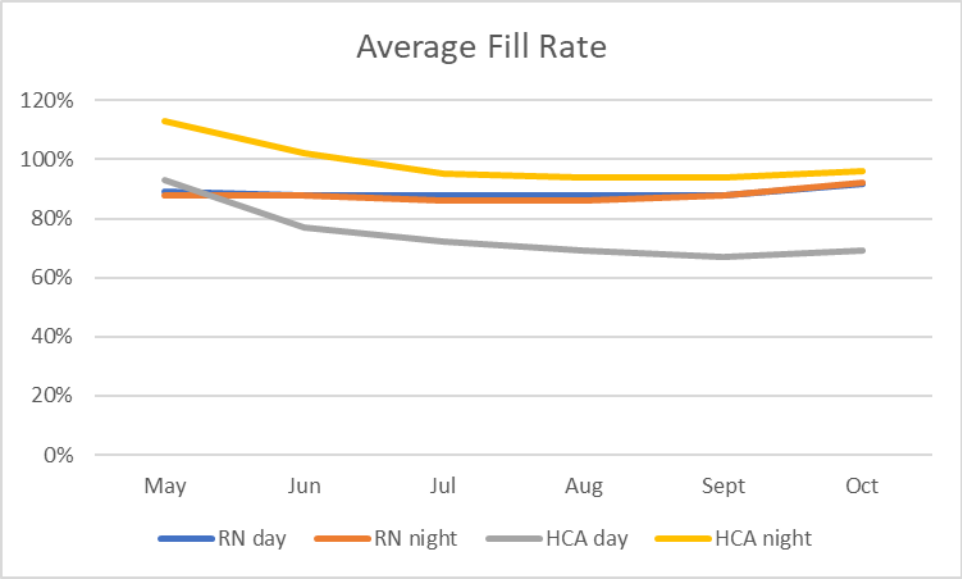
The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Fill rates are produced by setting out the planned number of hours required for Registered Nurses (RN) across days and nights and the same for Health Care Assistants (HCA) for a full month period and is captured daily. The electronic roster produces the percentage fill for the month and accurately reflects the hours worked against the planned number. The percentage fill rates include any hours worked by bank staff. The benchmark for CHPPD for the above tables is based on August 2024 data, this is the latest information from the model hospital so may not be comparable in relation to capacity and acuity of the wards and departments within Alder Hey in October Those areas highlighted red fall below this reported benchmark.

Summary

HDU was the only department to fall slightly below the 80% fill rate, however no staffing incidents submitted. 40% of patients were assessed as 1:1 in October (19% level 1 and 21% level 2)

The data for ward 4B is not a true representation as the model has been realigned, however the health roster required amending to reflect this. This is now complete and subsequent months will be reflected of actual staffing numbers required.

There are vacancies within HCA's in the majority of wards and increased 1:1's which impacts on the fill rate reported, in addition an increase in those requiring 1:1 care particularly overnight is reported in wards 3A, 3C, 4A and 4C.

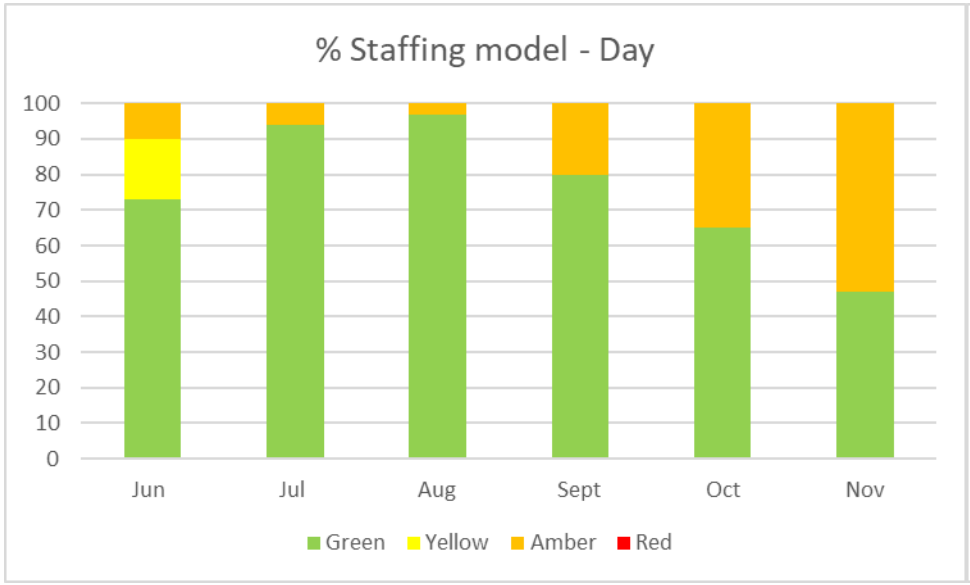


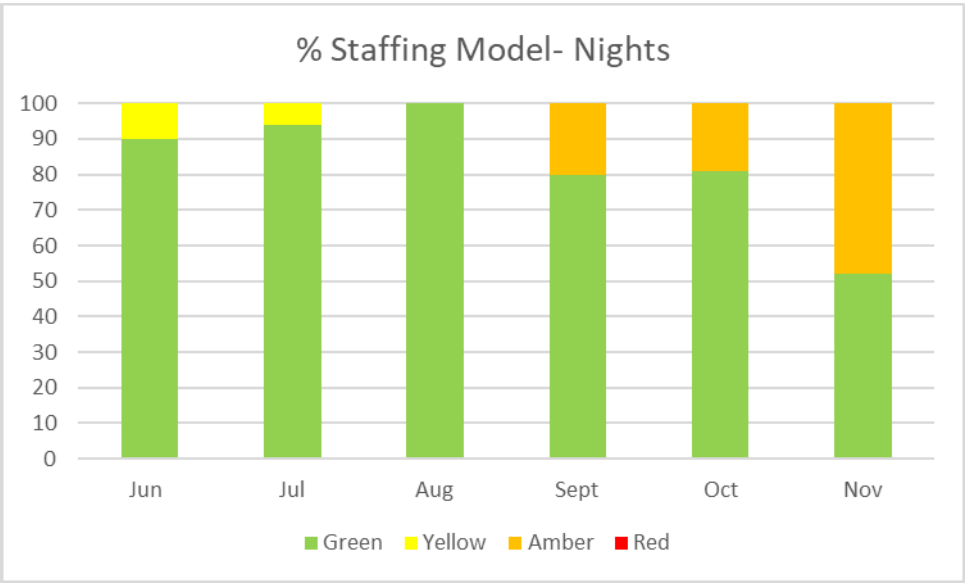
Nursing and care staff average fill rate October 2024	
Day and Night average fill rate	
Registered (%)	**Care Staff**
92% ↑	**82.5%** ↑

An overall improved position in relation to fill rates across day and nights has been noted since May 2024. The HCA fill rate for night duty for two of the areas is higher than the planned establishment with the highest being 140 % on Ward 4A. Predominantly this is due to the continuous need for additional HCA resources a result of those patients who require 1-1 and enhanced supervision as well as those with challenging behaviour or safeguarding need., There are vacancies within HCAs across the trust which impacts on the fill rate reported in some areas.

Summary of Staffing models June – November 2024

There has been an increase in an amber staffing model being reported in November which correlates to higher acuity and increased capacity across the wards with additional winter beds opened on Ward 4B and HDU medical. bay. The last reported red staffing model was October 2023.
To Note only Red, Amber, and Green staffing status is now reported via the staffing template.

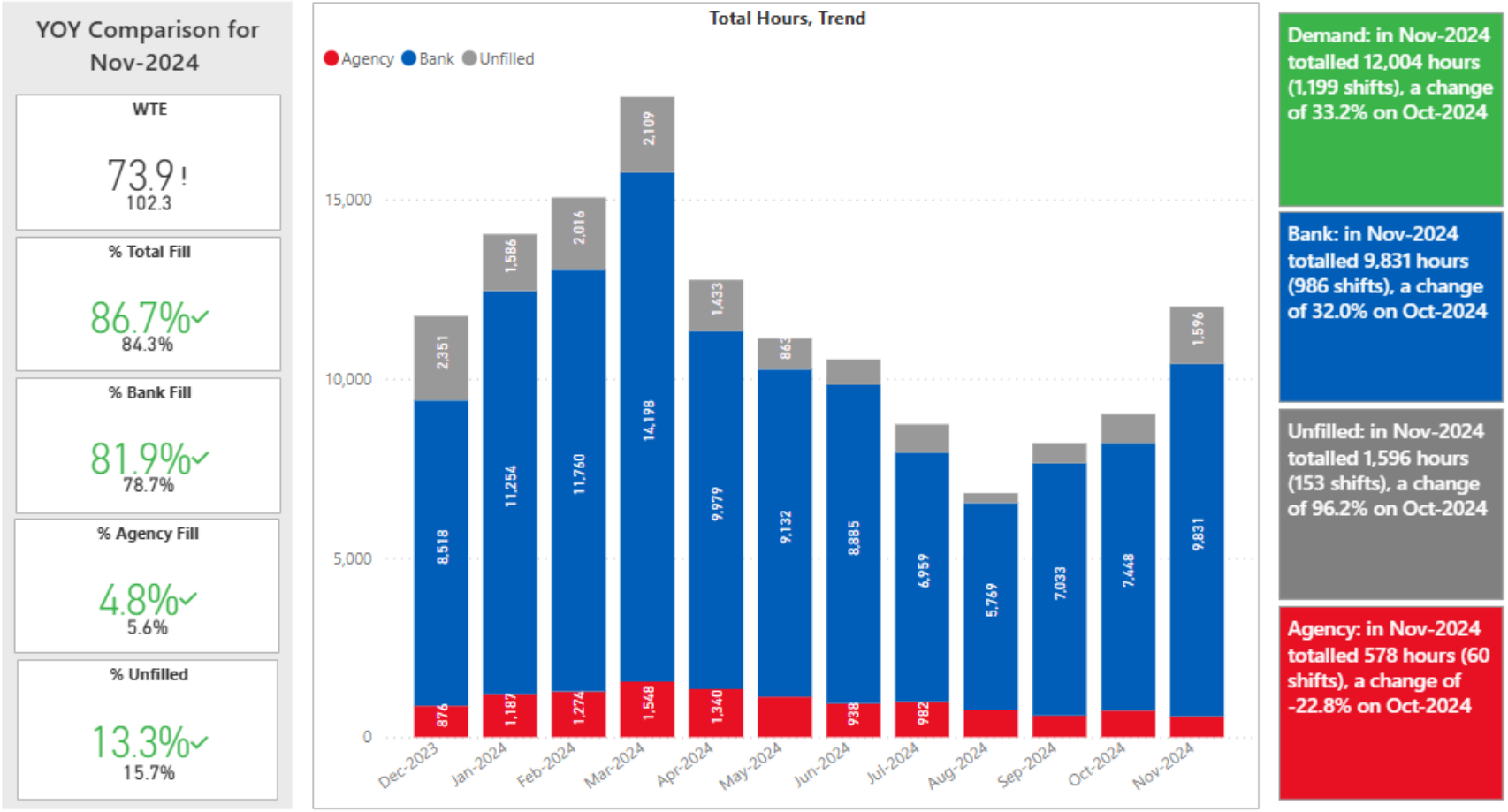




NHSP Bank Spend November 2024

Temporary staffing is monitored closely with weekly oversight from Workforce Efficiencies group attended and represented by senior staff from various disciplines including nursing. This group produced trust and divisional dashboards to support the monitoring of bank and agency use across all areas and has oversight from executives. Weekly monitoring of bank and agency occurs in each division as well as daily oversight from Safe Staffing Chair and Senior Clinical Site Practitioner out of hours. Since April 2024 and up until this month there has been a consistent reduction in the use of bank hours. November has seen higher usage of bank spend and is attributed to additional winter beds, increased capacity, and acuity. To note we had a number of new starters across the trust in October who were supernumerary and not in the numbers. From December all new starters will be reflected in the numbers, and we should therefore see a reduction in bank usage.

Registered Nurse Bank Spend



Unregistered Nurse Bank Spend

YOY Comparison for Nov-2024

WTE

57.1 !
73.4

% Total Fill

85.2% !
93.4%

% Bank Fill

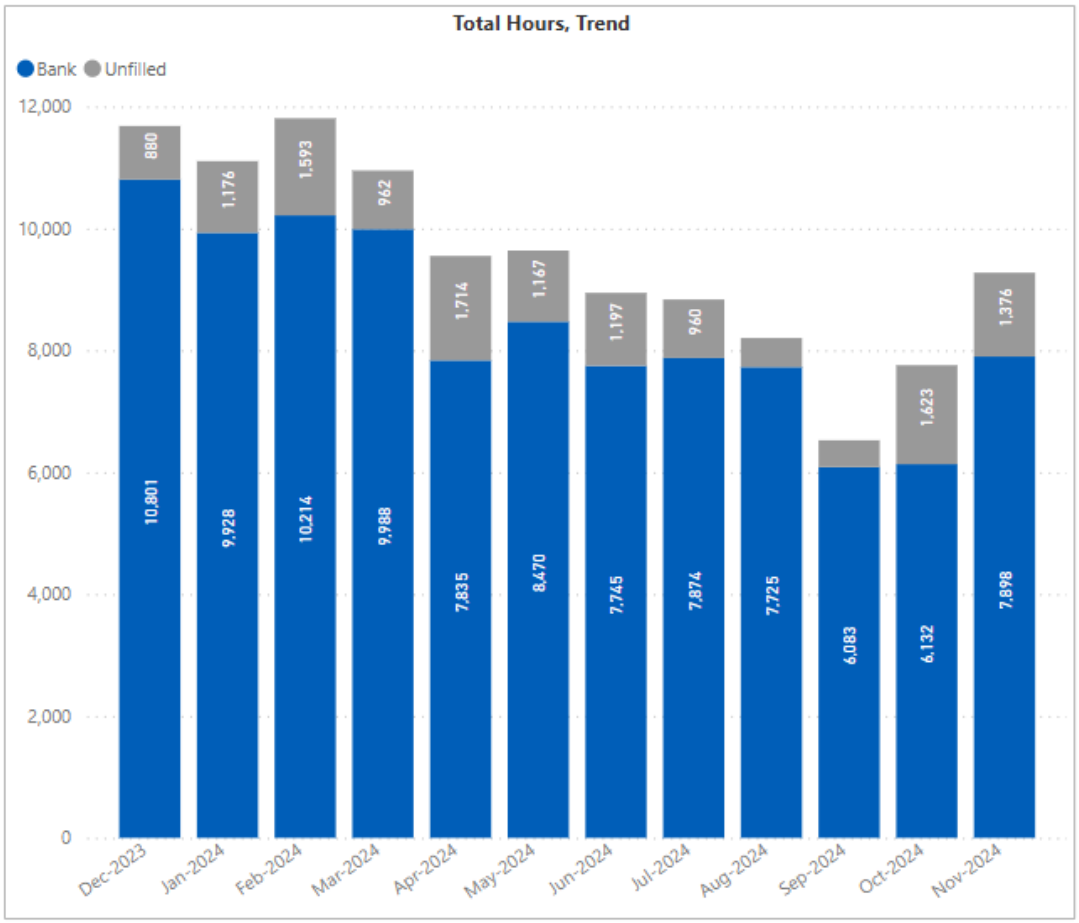
85.2% !
93.4%

% Agency Fill

(Blank)

% Unfilled

14.8% !
6.6%



Demand: in Nov-2024 totalled 9,274 hours (920 shifts), a change of 19.6% on Oct-2024

Bank: in Nov-2024 totalled 7,898 hours (785 shifts), a change of 28.8% on Oct-2024

Unfilled: in Nov-2024 totalled 1,376 hours (135 shifts), a change of -15.3% on Oct-2024

Agency: in Nov-2024 totalled hours (shifts), a change of -100.0% on Oct-2024

KPI E-Roster November 2024

RosterPerform 11 Overview														
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 **(14th October - 10th November)**	% 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)	49.00	37.89%	80.00	634.38	0.00%	0.00	0.00	25.56%	12.86%	7.13%	0.00%	8.91%	0.00%	28.89%
Accident & Emergency - Nursing (912201)	44.00	40.53%	720.00	246.10	20.53%	2186.75	0.00	15.05%	12.83%	4.55%	2.16%	10.06%	8.91%	39.71%
Burns Unit (915208)	44.00	26.20%	140.00	-5.68	1.64%	38.00	3.00	3.31%	9.96%	2.73%	4.21%	2.20%	0.00%	21.27%
Critical Care Ward (913208)	44.00	25.93%	1200.00	1423.48	5.68%	1100.50	2.00	16.28%	11.71%	3.15%	0.58%	5.69%	3.84%	24.96%
High Dependancy Unit (HDU) (913210)	44.00	28.07%	640.00	168.24	3.32%	276.33	0.00	26.26%	12.69%	5.62%	0.67%	5.29%	8.45%	32.72%
Medical Daycase Unit (911314)	44.00	13.24%	50.00	-27.97	0.00%	0.00	5.00	12.64%	11.68%	1.71%	0.00%	0.00%	0.00%	13.39%
Outpatients (916503)	38.00	36.63%	420.00	703.67	10.91%	752.67	17.00	37.15%	10.38%	1.14%	1.40%	9.58%	2.78%	25.34%
Sunflower House (912310)	26.00	49.27%	190.00	1207.14	24.33%	957.00	13.00	27.66%	9.47%	0.00%	1.53%	11.32%	6.19%	33.45%
Surgical Daycase Unit (915418)	40.00	37.43%	85.00	-23.00	4.17%	116.75	4.00	27.46%	10.47%	1.52%	1.26%	11.20%	0.00%	24.46%
Theatres - Cardiac & Cardiology (915405)	44.00	28.70%	130.00	-0.50	5.16%	114.00	3.00	12.15%	9.97%	0.99%	3.51%	12.14%	0.00%	26.61%
Theatres - Emergency (915420)	44.00	15.22%	230.00	166.75	2.06%	45.00	0.00	1.75%	8.19%	0.91%	0.00%	1.25%	0.00%	11.49%
Theatres - IP Anaesthetics (915423)	44.00	20.05%	82.00	71.75	1.85%	65.50	0.00	2.05%	9.38%	0.22%	1.70%	7.93%	3.55%	22.78%
Theatres - IP Porters (915435)	41.00	28.48%	101.00	75.00	5.24%	70.00	0.00	9.41%	10.33%	0.00%	0.00%	7.41%	0.00%	24.00%
Theatres - IP Recovery (915422)	44.00	33.03%	103.00	-10.70	10.19%	160.25	0.00	3.85%	10.63%	0.53%	11.24%	5.65%	0.00%	28.04%
Theatres - IP Scrub (915424)	44.00	30.22%	128.00	68.93	14.37%	256.07	0.00	9.51%	6.87%	1.46%	4.44%	10.18%	0.00%	36.46%
Theatres - Ortho & Neuro Scrub (915436)	44.00	30.34%	37.80	-2.50	14.31%	325.75	0.00	9.41%	5.74%	1.57%	2.12%	9.02%	3.84%	37.37%
Theatres - SDC Anaesthetics (915429)	41.00	40.18%	58.40	-14.58	37.81%	392.50	0.00	16.15%	4.52%	0.91%	0.91%	20.81%	14.42%	41.57%
Theatres - SDC Recovery (915430)	41.00	32.78%	177.30	-6.62	6.45%	101.50	2.00	7.02%	10.69%	1.76%	0.40%	11.49%	0.00%	24.34%
Theatres - SDC Scrub (915421)	41.00	34.24%	532.00	-35.02	8.55%	218.50	0.00	8.81%	11.34%	0.36%	1.85%	19.59%	0.00%	33.84%
Ward 1C Cardiac (913307)	44.00	28.77%	361.00	910.49	3.74%	258.50	0.00	15.94%	11.55%	3.59%	0.90%	10.88%	5.73%	32.92%
Ward 1C Neonatal (913310)	46.00	48.88%	556.00	633.97	0.97%	54.00	0.00	10.69%	9.93%	5.89%	1.35%	4.66%	3.37%	33.31%
Ward 3A (915309)	44.00	33.04%	371.00	37.63	13.51%	1078.00	13.00	14.48%	13.30%	3.12%	2.91%	9.65%	6.78%	36.08%
Ward 3B - Oncology (911208)	38.00	22.31%	555.00	387.82	8.97%	458.00	61.00	17.32%	11.17%	5.20%	1.52%	10.31%	5.04%	36.19%
Ward 3C (911313)	41.00	35.19%	607.00	1491.52	18.03%	1636.00	14.00	16.37%	14.62%	3.90%	1.14%	4.92%	4.94%	32.00%
Ward 4A (914210)	30.00	32.03%	634.00	236.18	10.24%	876.98	15.00	17.89%	10.25%	2.97%	0.70%	11.01%	4.01%	31.30%
Ward 4B (914211)	44.00	33.22%	533.00	973.96	13.14%	1219.00	1.00	25.38%	11.88%	3.87%	1.32%	6.10%	6.88%	30.19%
Ward 4C (912207)	41.00	36.69%	280.00	132.98	12.33%	1054.50	15.00	10.32%	9.16%	3.01%	2.04%	5.64%	4.59%	27.52%

Summary

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

- Lead time has fallen below the agreed target of Min 42 days – Currently 41.8 Days. This is a result of the community division running at an average of 32 days.
- Net hours have increased from 8341 to 9443 with 19 0ut of the 27 units still within KPI.
- Bank hours/Agency has increased from 12326 to 13812 (9.54%) but remain below target KPI of < 10%
- Number of shifts created over establishment has continued to reduce and is at its lowest for the last 10 months.
- Annual leave is low with the average being 10.43%. Target is 15% but buffers run from 11%-17%. Low annual leave means some departments may struggle to fit everyone's annual leave in by the end of the year.
- Sickness remains high at 8.63%.

Monthly roster review meetings are now in place across the trust occurring in each division, led by Heads of Nursing and in conjunction with health roster team. Both ward managers and matrons attend these meetings. This meeting has proved to be successful and supports each ward to work within a set of Key Performance Indicators (KPI) which includes the important element of rosters being finalised by managers in a timely manner allowing staff to plan their personal life more easily around work. In addition, these meetings have been beneficial in highlighting where there are increased number of additional shifts as well as the requirement and utilisation of NHSP and Agency shifts. The meeting encourages the ward managers to track the range of KPI focusing on improvements within their own area. Reports are circulated monthly to the ACN and HON to share with their respective teams and take forward any agreed actions.

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**Tuberculosis (TB) Positive Case Update**
Report of:	**Chief People Officer/Chief Operating Officer**
Paper Prepared by:	Sian Calderwood-Jones and Hannah Morris

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides an overview of the identification and management of a TB-positive case in an rotational trainee doctor, the actions taken to ensure the safety and wellbeing of staff and patients, and the ongoing measures in place to manage the incident and support those impacted.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **R** **Collaborate** for children & young people **R** **Revolutionise** care ☐ **Support** our people **R** **Pioneering** breakthroughs ☐ **Strong Foundations** **R**
Resource Implications:	N/A

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

Remember to:

Remember to:

1. **Executive Summary**

The paper outlines the Trust's response to a confirmed Tuberculosis (TB) case in a rotational Trainee Doctor, including, support provided to the affected individual, Track and Trace approach, clinical criteria for screening and screening process for staff and patients impacted.

Key actions implemented included the establishment of tactical command to manage the incident, engagement with Public Health England (PHE) and UKHSA in addition to our Internal ID, Immunology and IPC teams, development of clinical criteria for screening and screening process for staff and patients and a communication strategy to inform those potentially impacted.

To date, no additional active TB cases have been identified; however, the screening progress remains underway. Recommendations for next steps include ongoing monitoring and management of those identified within the Trac and Trace process and future awareness campaigns to strengthen all employee's awareness of infectious disease to ensure prompt and adequate action is taken to prevent transmission.

2. Background and current state

Alder Hey NHS Foundation Trust was notified of a trainee doctor, on rotation from the Deanery, tested positive for pulmonary TB during their rotation at the Trust. TB is a notifiable disease under public health guidelines, requiring immediate action to minimise the risk of transmission and ensure compliance with health and safety protocols.

An incident was managed as a local business continuity response week commencing 9th December 2024 for a week. During this period essential information was gathered and appropriate actions put in place to manage the incident.

During the internal incident the Tactical Command Team worked alongside UKHSA, Warrington and St Helens Lead Employer, the ICB as well as internal colleagues including IPC, ID and Immunology, the General Paediatric team, Communications and HR to ensure the appropriate measures were taken and all parties were updated.

The individual

The individual was identified as a rotational doctor in General Paediatrics and undertook a two-week placement within Paediatric Surgery at Alder Hey. The individual was identified as part of the resident doctor allocation, employed by Warrington and St Helen's Trust.

The individual is no longer on rotation within the Trust; however, has been offered support by the Trust if required.

Diagnosis and Notification

The doctor started working at Alder Hey on 7 August 2024, and developed symptoms on 24 September 2024 and was diagnosed with pulmonary TB on 26 October 2024. The infectious period was considered from 16 September 2024, a week before symptom onset, until the 20 October 2024. During the infectious period, the doctor worked in both the general paediatric and surgical teams, potentially exposing patients and staff to TB.

The doctor had a positive TB test in July 2023; however, presented with a normal chest X-ray. After developing symptoms, an abnormal chest X-ray on October 17, 2024, indicated pulmonary TB, confirmed by sputum AFB and PCR tests.

The individual immediately informed his employer and took the relevant isolation steps; however, Alder Hey did not receive formal notification from his employer as the host trust for his rotation during this period.

Once made aware in early December, Alder Hey established the tactical command team to address the incident.

Contact Tracing and Risk Assessment

Following discussion and agreement with the Trust's internal ID/ IPC and Immunology team and the UKHSA and agreed criteria was found to support the contact tracing for children & young people, staff and visitors that were at risk of exposure. The criteria was based on a UKHSA agreed risk stratified criteria.

Exposure was determined as below:

Staff exposure:
88 staff members across the general paediatric team and surgical team who had potential exposure to the doctor. The exposure was assessed based on the 8-hour cumulative contact rule.

Patient exposure:
Electronic medical records were reviewed to identify patients who had contact with the doctor. This included reviewing notes, orders, and admissions under the diabetic team from September 16, 2024, to the doctor's last working day.

The Tactical Command Team identified the below numbers into different screening streams based on the agreed criteria.

- Full screening: 12 children & young people
- Patient Advice and Information: 76 children & young people
- Staff: 88 across all staff groups

3. Main body of report

Following the identification of the incident and the agreed clinical criteria and screening process detailed actions were created and implemented.

Full screening: 12 children & young people

All 12 children & young people requiring full screening have been called by a General Paediatrician to inform of the incident, explain the clinical steps for the screening process and offered reassurance and an opportunity to answer any questions.

All 12 families are reported to have responded well to the phone calls and.

Full screening process

Under 2 years old

- Community appointments were offered for TB skin testing on Wednesday 18th December.
- Clinic appointment at AHCH also undertaken to discuss patient results on Friday 20th December with Consultant Paediatric.
- 6/6 under 2years for the skin tests took place with them all attending clinic for assessment on 18th December.
- 5/6 negative and discharged.
- 1/6 appointment on Friday 2nd January as the individual has been away over festive period, with the blood result expected week commencing 6th January 2025.

Over 2 years old

- All individuals were contacted for a telephone review with a General Paediatric Consultant. 5 out of 6 have been undertaken.
- Phlebotomy test appointments are requested at AHCH. 4 out of 6 have these outstanding.
- All 6 patients will require a telephone follow up post their blood test. 5 of these are outstanding.
- 1child has had a negative result and been discharged.
- The outstanding results and appointments to be scheduled are being reviewed and managed by the General Paediatric Team as business as usual.

Advise and Information to be shared: 76

This group of children and young people we identified as low risk patients.

Patients and families who had direct contact with the individual received a telephone call, detailing the incident and low risk and were invited to attend assessment as per clinical risk stratification process.

All families were contacted via telephone, which took place throughout the week commencing 16th December 2024. All contacts were informed of the incident and symptoms from the ID and Immunology team. All clinical concerns were addressed within these phone calls.

All individuals were sent a letter detailing the incident and symptoms on the 27th December 2024.

Staff: 88

A comprehensive staff list was developed in conjunction with HR, occupational health, clinical teams and Alder Hey and the infected individual. All staff received a letter informing them of the incident and requested to attend an Occupational Health appointment as part of the screening process. This is being offered by the Occupational Health Team from Warrington and St Helen's Trust as the infected individual is their employee.

We will continue to monitor uptake of these appointments.

4. Conclusion

Once appropriate parties were informed the Trust acted swiftly and in alignment with public health protocols to manage the incident. Through robust infection control measures, comprehensive Trace and Trace processes, and clear clinical criteria for streaming, all possible individuals impacted have been informed and assurance with the processes and next steps to take.

The is a notifiable delay in the Trust being notified of the incident formally from the individual occupational health provider and as part of the original Track and Trace process. An external review has commenced into the occupational health processes to ensure learning is sought and improved collaboration between providers who host individuals as part of rotational placements are informed of any significant health and wellbeing concerns. The outcomes of this review will be shared with the Trust.

4. Recommendations & proposed next steps

- For the board to note the actions taken and outcomes achieved to date
- To continue running the incident under business-as-usual conditions within the Division of Medicine
- HR and operational teams to review with occupational health to ensure learning is identified from incident, from notification period and expected response.

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**Organ Donation**
Report of:	**Alder Hey Organ and Tissue Donation Committee**
Paper Prepared by:	Dr. Carla Thomas

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:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **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

Every family of a child who is approaching the end of their life and has the potential to donate organs, should be offered this choice and this choice should always be fully explored.

In Alder Hey Children's NHS Foundation Trust 2023-2024 there were no missed referrals to NHS Blood and Transplant (NHSBT).

There were 6 medically suitable eligible donors. The families of all 6 medically suitable eligible donors were approached for organ donation.

The specialist nurse for organ donation was present for 4/6 of the organ donation discussions.

Of the 6 families who were approached for organ donation in 2023/2024, 3 families gave consent for organ donation.

In 2023/2024, Alder Hey Children's NHS Foundation Trust had 3 deceased solid organ donors, resulting in 8 patients receiving a transplant. There were 2 DBD donors and 1 DCD donor. 6 solid organs were transplanted from 2 DBD donors and 2 solid organs were transplanted from 1 DCD donor.

2. Background and current state

Organ and tissue donation saves and improves the lives of thousands of UK citizens every year. It can offer comfort to the families of donors through the knowledge that something remarkable came from their loss.

National Strategic Plans

- **UK Paediatric and Neonatal Deceased Donation – A Strategic Plan [2019]**
    - Aim to significantly increase the rates of paediatric and neonatal deceased donation in the UK.
    - Aim to normalise practice, minimise variation and promote excellence in care, ensuring that donation is considered a routine part of end-of-life care, especially in the intensive care setting.
    - Aim to confidently assert that every family of a child who is approaching the end of their life and has the potential to donate organs, will be offered this choice and this choice will always be fully explored.
- **Organ Donation and Transplantation 2030: Meeting the Need – A ten-year vision for organ donation and transplantation in the UK [2020]**
    - Living and deceased donation will become an expected part of care, where clinically appropriate, for all in society.

3. Main body of report

Alder Hey Children's NHS Foundation Trust's Organ and Tissue Donation Committee (OTDC) was established in 2022. The primary remit of the ODTC is to influence local policy and practice to ensure that deceased organ donation is considered in all appropriate situations. Secondary roles include championing deceased donation within the Trust to hospital staff and visitors and promoting donation to the wider local community. These are the four domains of the ODTC which will be outlined in this report.

3.1. Performance – work to ensure there are no missed donation opportunities.
3.2. Policy – ensure the hospital policies and guidelines support organ donation, are up to date and are in line with national guidance.
3.3. Education – ensure that any staff who may care for a potential donor are adequately trained.
3.4. Promotion – engage the public through opportunities within both the hospital (like the annual Organ Donation Week) and your local community.

3.1 Performance

Every death on PICU is audited by NHS Blood and Transplant (NHSBT) to assess if best practice is followed in relation to the identification and referral of potential organ donors (Actual and Potential Deceased Organ Donation Audit).

Between 1 April 2023 and 31 March 2024, there were 73 audited deaths in Alder Hey Children's NHS Foundation Trust Paediatric Intensive Care Unit (PICU).

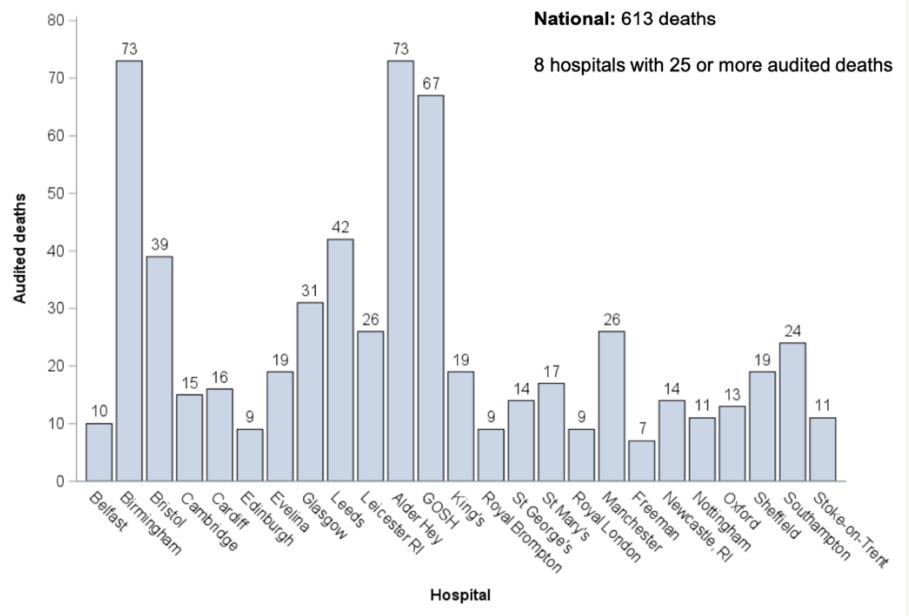


Figure 1.1 Audited deaths by hospital 1 April 2023 – 31st March 2024

3.1.1 Neurological death testing

Goal: Neurological death tests are performed wherever possible.

There were 4 patients where neurological death was suspected. 3 of these patients were tested for death by neurological criteria. 1 of these patients was not tested due to a clinician supported family request to withdraw life-sustaining treatment without testing.

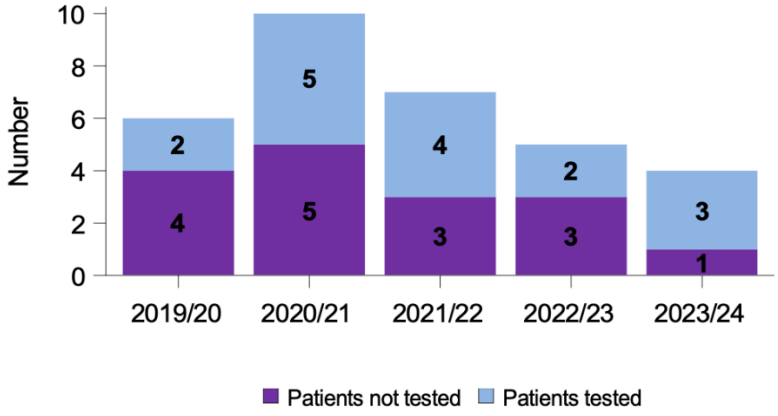


Figure 1.2 Number of patients with suspected neurological death at Alder Hey Children's NHS Foundation Trust

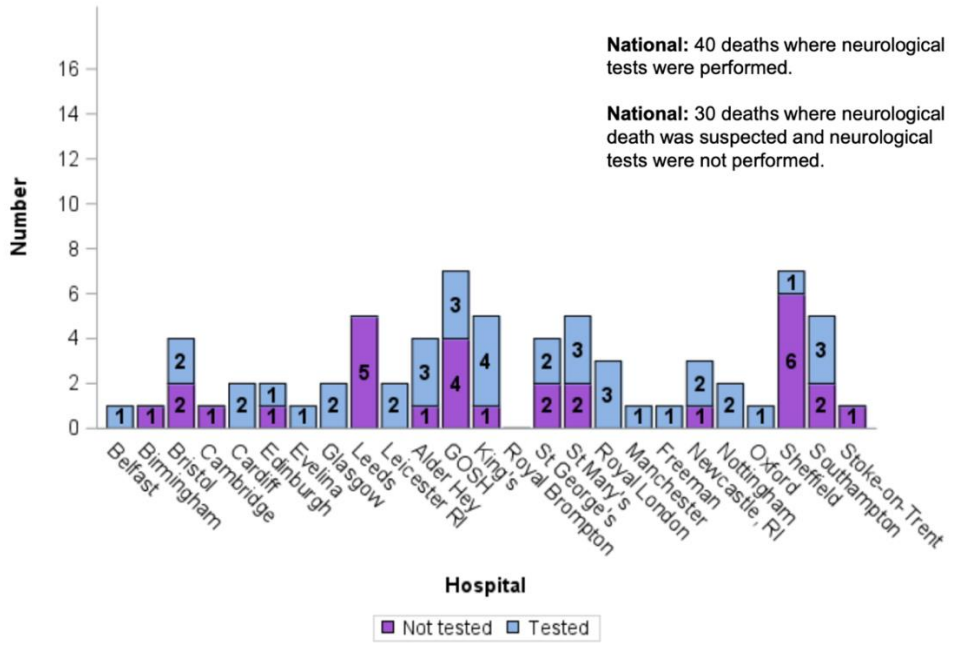


Figure 1.3. Number of patients with suspected neurological death by hospital 1 April 2023 – 31st March 2024

2 of the 3 tested patients were confirmed deceased by neurological criteria.

3.1.2 Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service.

Alder Hey Children's NHS Foundation Trust referred 57 patients to NHSBT during 2023/2024. 27 of these were considered potential organ donors. (Potential DBD donors – a patient with suspected neurological death. Potential DCD donors – a patient in whom imminent death following withdrawal of mechanical ventilation is anticipated). There were no occasions where potential organ donors were not referred.

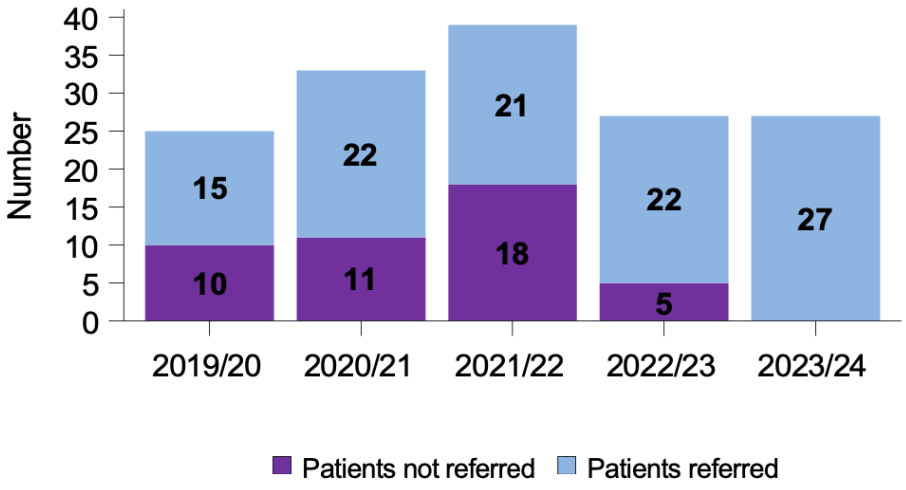


Figure 1.4. Referral of potential deceased organ donors at Alder Hey Children's NHS Foundation Trust.

22 of the referred potential donors were considered eligible donors (Eligible DBD donors – death confirmed by neurological tests and no absolute contraindications to solid organ donation. Eligible DCD donors – imminent death anticipated, and treatment withdrawn with no absolute contraindications to solid organ donation) by NHSBT.

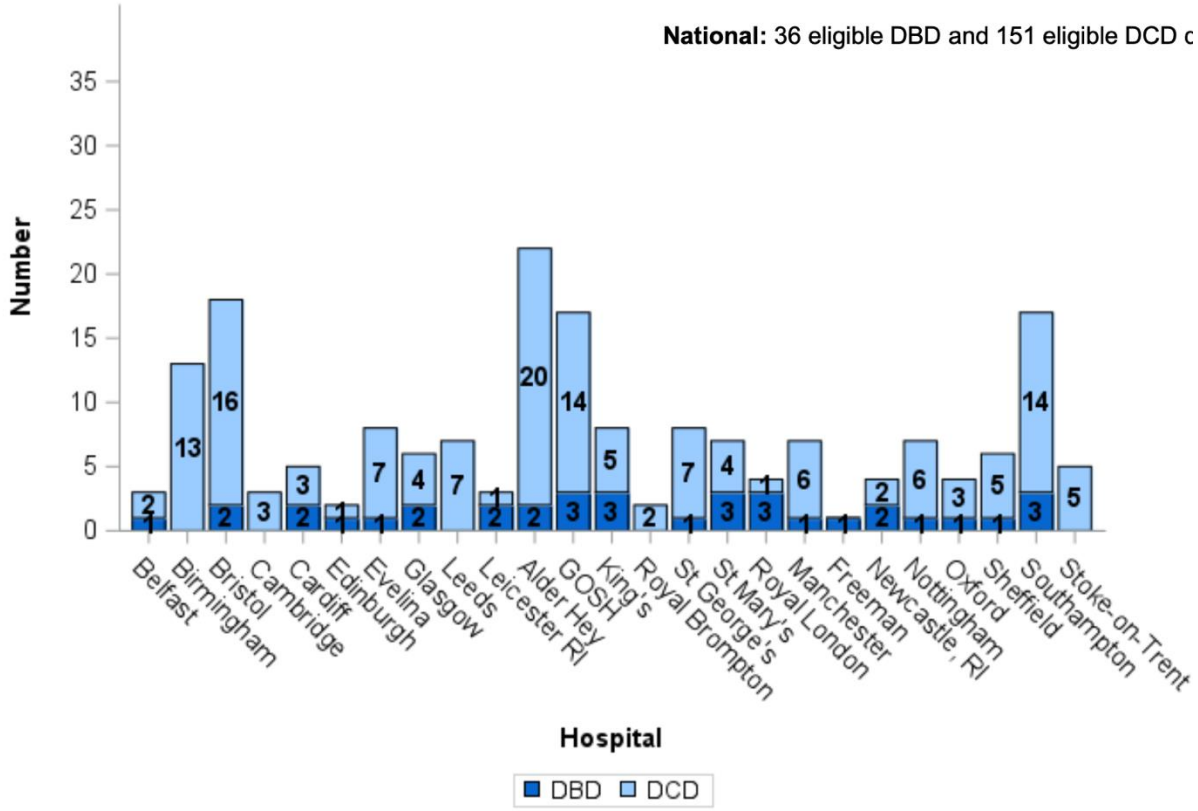


Figure 1.5. Eligible donors by hospital 1st April 2023 – 31st March 2024.

3.1.3 Medically suitable eligible donors

There were 6 medically suitable eligible donors at Alder Hey Children's NHS Foundation Trust during 2023/2024. The families of all 6 medically suitable eligible donors were approached for organ donation.

3.1.4 Specialist nurse for organ donation (SNOD) presence at approach for organ donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

A SNOD was present for 4 organ donation discussions with families during 2023/24. There were 2 occasions where a SNOD was not present.

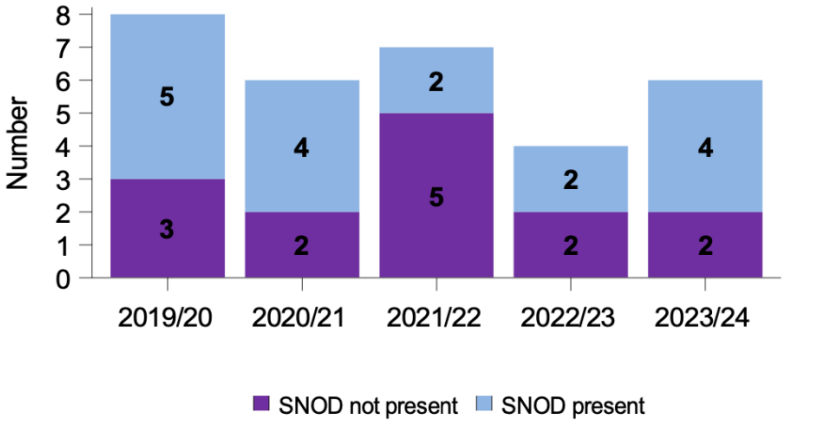


Figure 1.6. Presence of specialist nurse for organ donation during organ donation discussion with families at Alder Hey Children's NHS Foundation Trust 1st April 2019 – 31st March 2024.

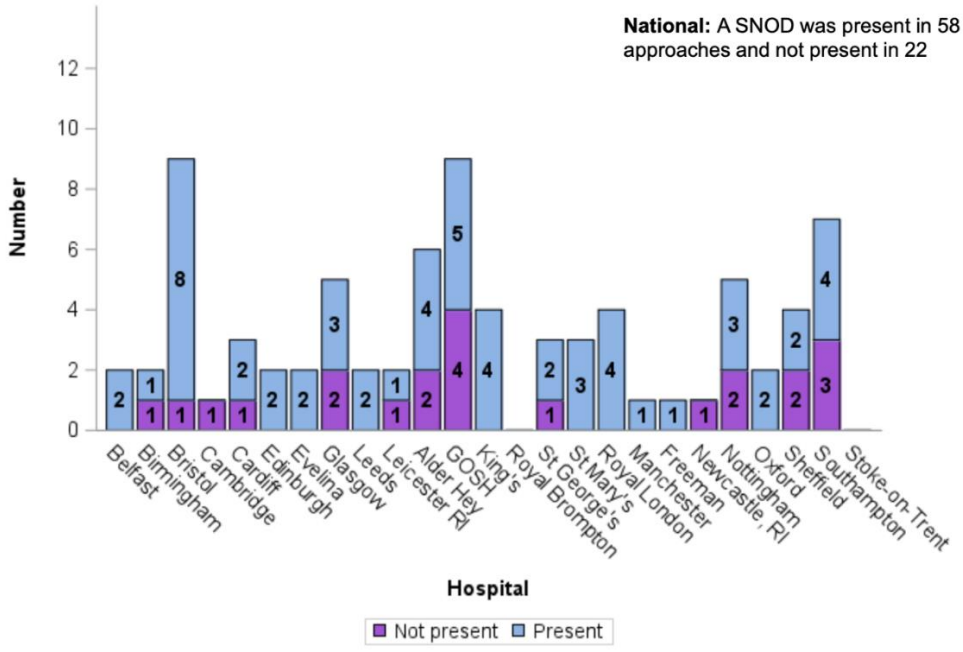


Figure 1.7. Presence of specialist nurse for organ donation (SNOD) by hospital 1st April 2023 – 31st March 2024.

3.1.5 Consent

Of the 6 families who were approached for organ donation in 2023/2024, 3 families gave consent for organ donation.

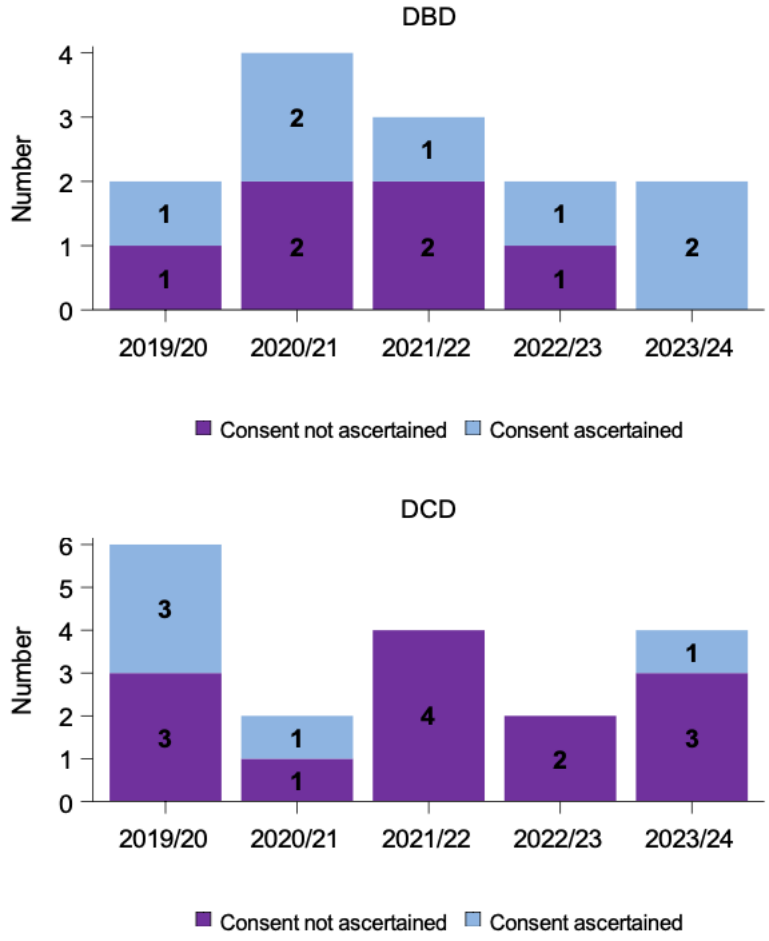


Figure 1.8. Consent for organ donation at Alder Hey Children's NHS Foundation Trust 1st April 2019 – 31st March 2024.

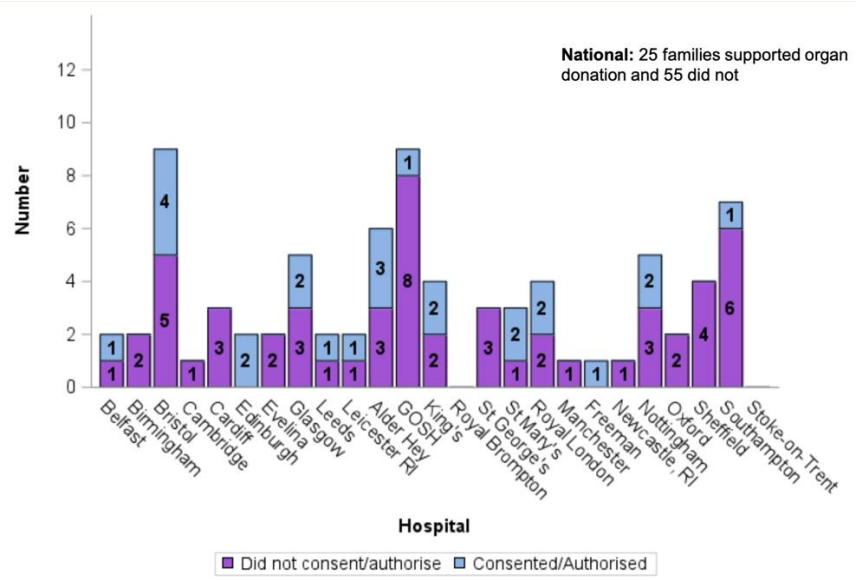


Figure 1.9. Consent for organ donation by hospital 1st April 2023 – 31st March 2024.

3.1.6 Donor Outcomes

Between 1st April 2023 and 31st March 2024, Alder Hey Children's NHS Foundation Trust had 3 deceased solid organ donors, resulting in 8 patients receiving a transplant. There were 2 DBD donors and 1 DCD donor. 6 solid organs were transplanted from 2 DBD donors and 2 solid organs were transplanted from 1 DCD donor.

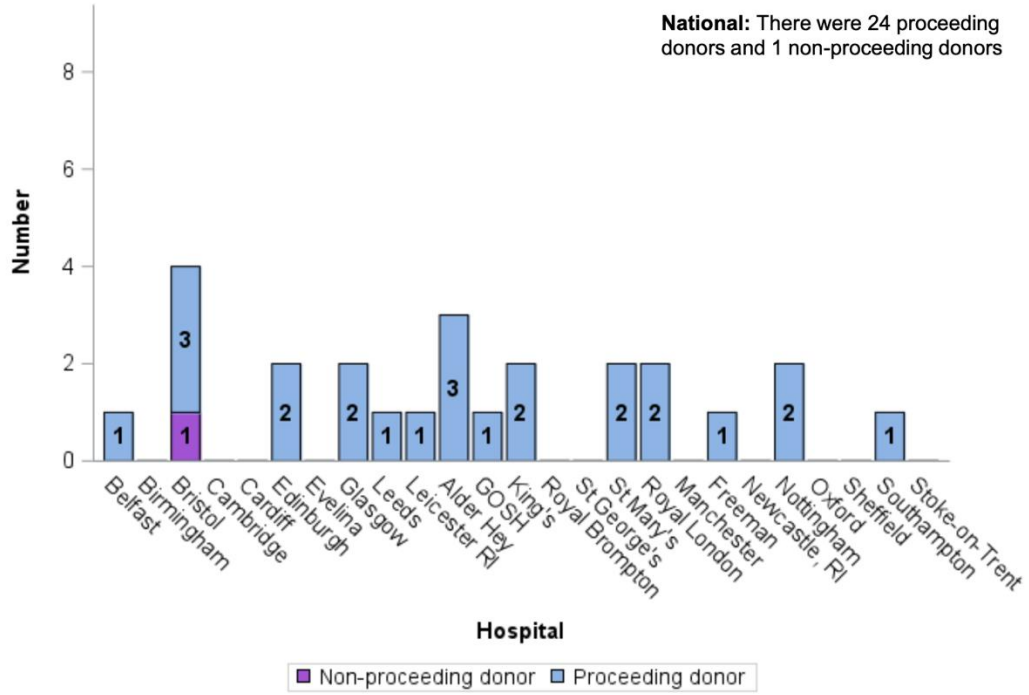


Figure 1.9. Proceeding heart donors by hospital 1st April 2023 – 31st March 2024.

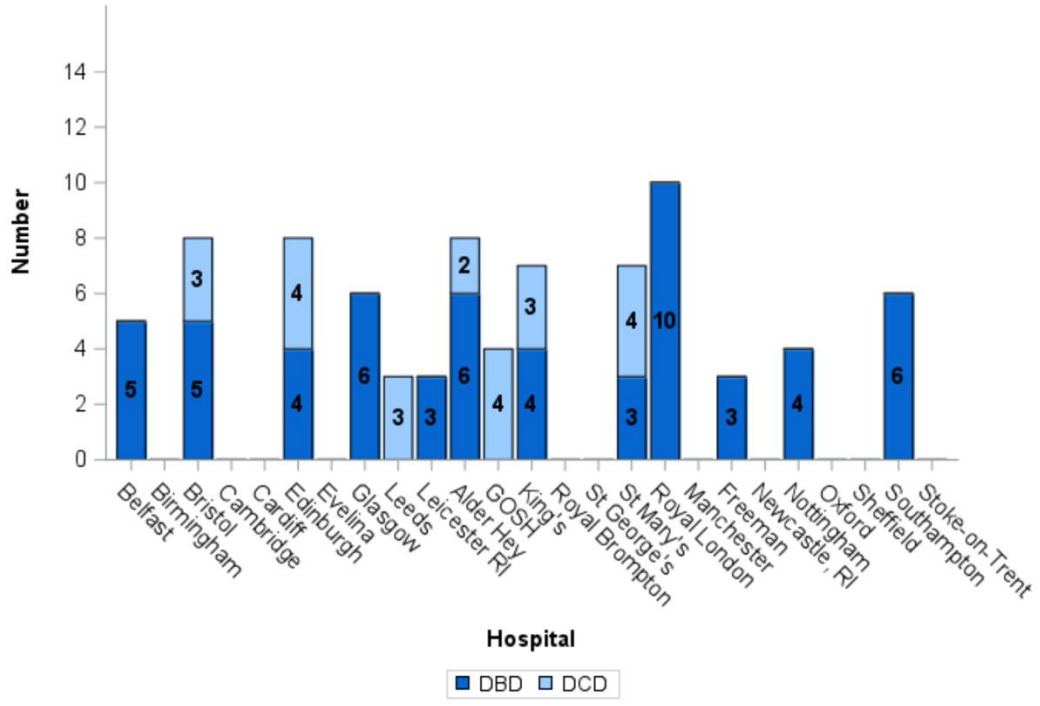


Figure 2.0. Transplants from proceeding donors by hospital 1st April 2023 – 31st March 2024.

3.2 Policy

There is an Organ and Tissue Donation Committee ratified clinical guideline, “Organ Donation [Paediatric intensive care]”. This will be updated from 1st January 2025 when the Academy of Medical Royal Colleges Code of Practice for the Diagnosis and Confirmation of Death is due to be updated and the national guidance for the diagnosis of death using neurological criteria is due to be updated.

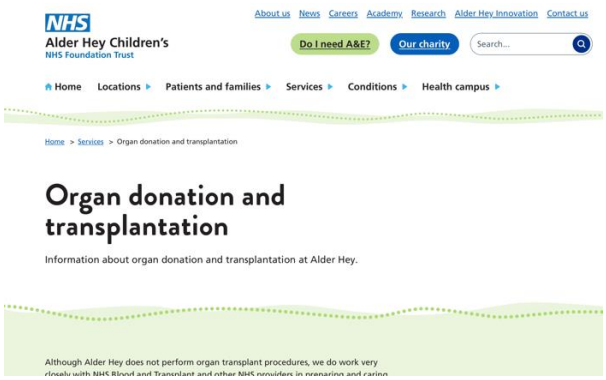
Additionally, there is an Organ and Tissue Donation Committee ratified standard operating procedure, “formal peer review of the process of organ donation as part of local PICU mortality review or other regular review meeting.”

3.3 Education

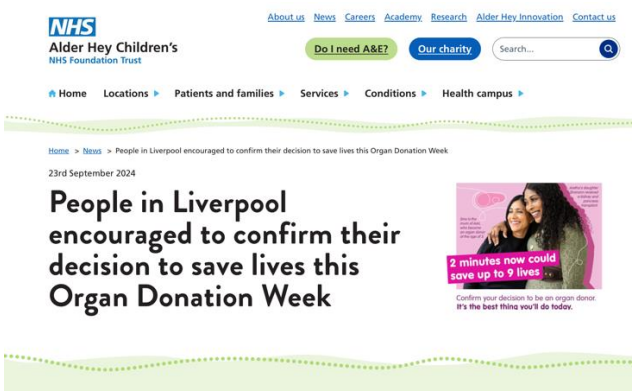
In 2023/2024 the Organ and Tissue donation committee delivered education to Alder Hey PICU staff and theatre staff who may care for potential organ donors as part of a regular education programme.

3.4 Promotion

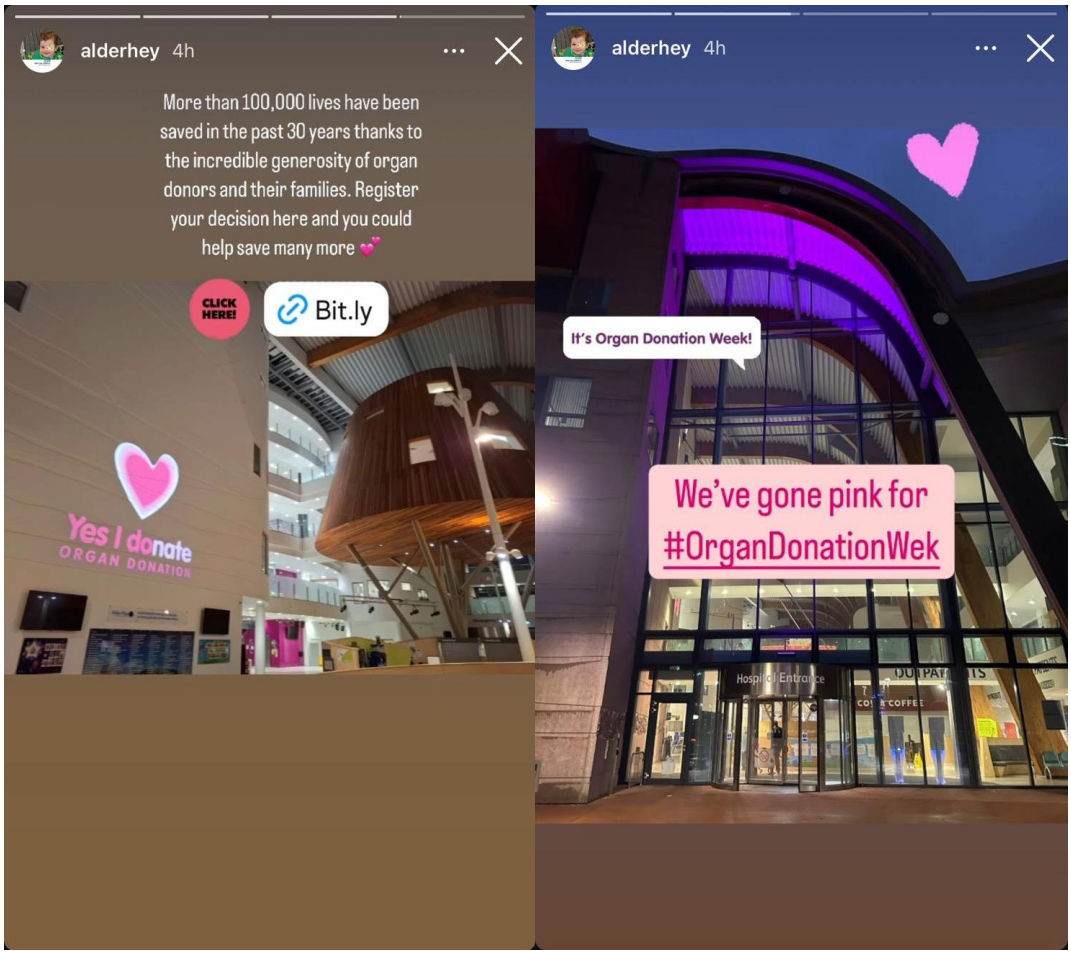
In 2023/2024 the Organ and Tissue donation committee produced a webpage about organ donation and transplantation on the Alder Children’s NHS Foundation Trust website.



We promoted organ donation on the Alder Hey Children’s NHS Foundation Trust website and across the social media channels.



We celebrated organ donation week Monday 23rd September to Sunday 29th September 2024.



4. Conclusion

The SQAC can be assured that that every family of a child who is approaching the end of their life and has the potential to donate organs, will be offered this choice and this choice will always be fully explored.

5. Recommendations & proposed next steps

- Work with NHSBT to improve specialist nurse for organ donation (SNOD) presence during organ donation discussions with families.
- Update Organ Donation [Paediatric intensive care] guideline from 1st January 2025 to reflect updates in national guidelines for diagnosis of death using neurological criteria.
- Champion and promote organ donation at Alder Hey Children's NHS Foundation Trust.
- Engage with the Alder Hey Youth Forum to promote organ donation within the local community.

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**Mortality Report, Q2**
Report of:	**Chief Medical Officer**
Paper Prepared by:	**Dr Julie Grice, HMRG Lead**

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:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☑
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☐

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

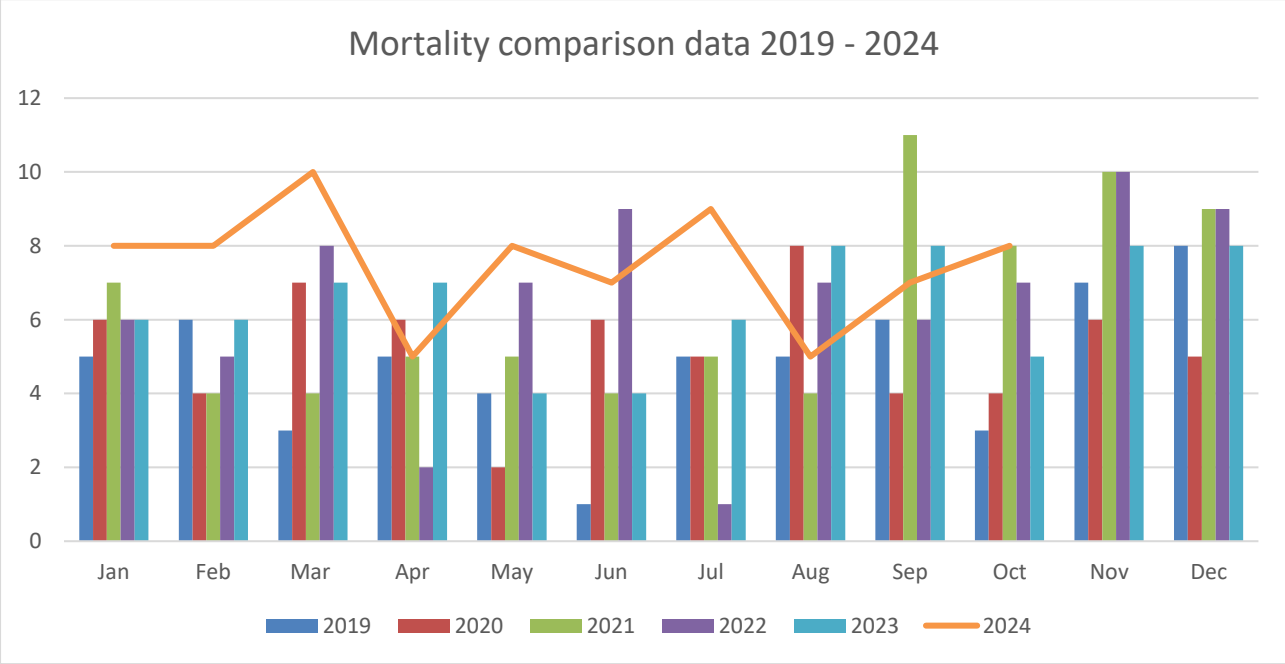
Risk Number	Risk Description	Score

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

The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number of deaths, types of death at Alder Hey (during the calendar year – present), and how the HMRG provide assurance in regard to targets.

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

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



This graph above denotes the number of deaths at Alder Hey. The trend shows that the higher death rate earlier in the year is now levelling off and the average over the year will probably be similar.

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

1) One of the most significant changes is the reforms to the death certification process, including the roll out of a new statutory medical examiner (ME) system across England & Wales. The aim of this system is to provide independent scrutiny of care provided, improve accuracy of information during the death certification process and most importantly giving bereaved people an opportunity to raise concerns.

The AHCH pilot for the ME process began in March 2024 and became a legal requirement from September 2024. The ME process at AHCH is being undertaken by the Liverpool University Hospitals NHS Foundation Trust Medical Examiner Service, and they are supported by two pediatricians (1 actively working & 1 recently retired from AHCH). There have been 64 paediatric deaths scrutinised by the ME team to date.

In the last quarter, there have been no incidents reported via InPhase. The clinical and bereavement teams are being encouraged to complete incident forms to ensure ongoing learning and improvement whilst the new system becomes embedded in practise.

It is worth noting that this new system may adversely impact on members of our population in whom an early burial is required for reasons of faith. There is a longer delay from when the death certificate is written, until it can be sent to the registrar to authorise the release of the body to allow burial.

The medical examiner has put on urgent services at the weekend and on bank holidays to support early burial for faith deaths and this has been updated in the Alder Hey medical examiner process flowsheet.

2) Recent cases have highlighted that there are issues with prehospital pathways; both in Liverpool and other areas. These have resulted in delays in transfer time and potential impact on care, not in AHCH. Work has already been initiated to try and resolve these issues. Transfers from out of region can be problematic as the CYP are not known to the AHCH team and can be very complex and transport time is increased. These issues can impact potentially significantly on the care and need to be considered before such transfers occur.

3) In recent meetings, recurrent issues have been raised with North Wales cases highlighting the variation with the PRUDIC (Procedural Response to Unexpected Death in Childhood) as opposed to the English SUDI /SUDIC (Sudden unexpected Death of an infant/childhood) pathways. The Welsh system lacks the ALTE (acute life-threatening event) aspect which means that the system must be activated when the child/YP arrives at AHCH. This means that there are delays which could potentially impact on the safety of other children. Understandably, the group has expressed concerns and work needs to be undertaken to try and resolve these problems with our Welsh colleagues.

4) One disconcerting issue identified is that if a CYP dies out of region (for example transferred to AHCH because of lack of available PICU bed in own region) that the family are responsible for the cost of repatriating the child after death. This is a significant financial impact on the family at an already difficult time. AHCH are liaising with the PICU network to find a solution.

5) Administration support remains an ongoing issue, so it is not possible to take the process forward as planned merely maintain what is currently in place.

Current Performance of HMRG

Summary of 2024 Deaths

Number of deaths (Jan. 2024 – Nov. 2024)	75
Number of deaths reviewed	36
HMRG Primary Reviews within 4 months (standard)	33/39 (85%)

The percentage of cases being reviewed within the 4-month target has improved from the last report and there is an extra meeting this month to clear the backlog. The group are very flexible and committed to their role to ensure that the reviews are completed in a timely manner with comprehensive scrutiny. To achieve this the group consists of members with a wide range of expertise including Alder Hey clinicians, NWTS (the regional paediatric transfer team), LWH (neonatology), psychology, and the Snowdrop (bereavement) team aiming for as robust process as possible.

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

Outcomes of the HMRG process 2024

Month	Number of Inpatient Deaths	HMRG Review Completed	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
					Internal	External		
Jan	8	8	7	8		2		1
Feb	8	8	8	8				1
Mar	10	8	6	8			1	1
April	5	4	4	4			1	1
May	8	8	8	8				
June	7							
July	9							
Aug	5							
Sep	7							
Oct	8							

Potentially Avoidable Deaths

There have been two potentially avoidable deaths in the 2024 cases reviewed so far. The avoidable factors were due to external factors and there were no issues relating to care received in AHCH.

Learning disabilities

The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 36 cases, so far reviewed in 2024, 11% were identified as having learning disabilities. In comparison, last year, 26% of the mortality cases were children /YP identified as having LD. It is not clear as to why the number is so much lower so far this year as the criteria the group use has not altered.

The Learning Disabilities Mortality Review (LeDeR) Programme was set up to ensure all deaths of patients with Learning Disabilities are comprehensively reviewed. Since July 2023 the requirement to report the deaths of CYP age 4 and over with a learning disability and/or autism to LeDeR has been removed. Now, all deaths of young people will be reported via usual child death processes. Then a national report will be produced via the LeDeR team with a focus on C/YP with a learning disability and/or autism deaths. As a trust, the plan is to continue to review all LD /autism deaths including less than 4 years old so they can be reviewed thematically and reported on to support internal

learning and overview. Interestingly, there are now discussions nationally to include this younger age group in the national data as there is no logical reason as to why they are currently excluded.

There have been no concerning themes or trends identified in the LD group of patients. However, the numbers are very low reviewing the cases covered so far. The group continues to work closely with the LD team aiming to ensure that any learning or issues are shared, working towards the best possible care for this complex group of patients who often have considerable and repeated exposure to the healthcare system.

Neonates

The definition of a neonate is a baby less than 28 days old. Of the 36 cases reviewed so far, there have been 13 neonatal deaths which is 36% of the total deaths. Of these cases, 62% had the diagnostic code of congenital, genetic, and chromosomal anomalies. The other causes were: 31% due to neonatal /perinatal causes and 7% SUDI (Sudden unexpected death of infant).

More detailed breakdown shows that:

1) 23% were born extremely prematurely
2) 54% were transferred from a unit a significant distance away, which can have an impact as transfer is an added risk to an already precarious premature baby
3) 38% death was considered to be inevitable regardless of care provided
4) 54% of these cases were cardiac and 31% surgical

The PMRT process states that the review should be undertaken in the Trust where the baby dies, however this is not possible in AHCH as no obstetric care is provided. Therefore, the current process is that the initial part of the PMRT is undertaken in either LWH or the DGH where the baby was born. This PMRT will then be shared with AHCH and the HMRG members will review this prior to completing the HMRG review. The HMRG form will be altered to enable the PMRT learning and summary of review to be shared. This linking of the two mortality processes will enable all the neonatal cases to have similar scrutiny.

Some trusts do not complete a PMRT review is the baby dies outside of same hospital. HMRG advocates that they review the obstetric history and will continue to work collaboratively to ensure robust processes.

Family

The Snowdrop (bereavement) team at Alder Hey provide an excellent service, supporting the family after a patient has died. There is ongoing work between

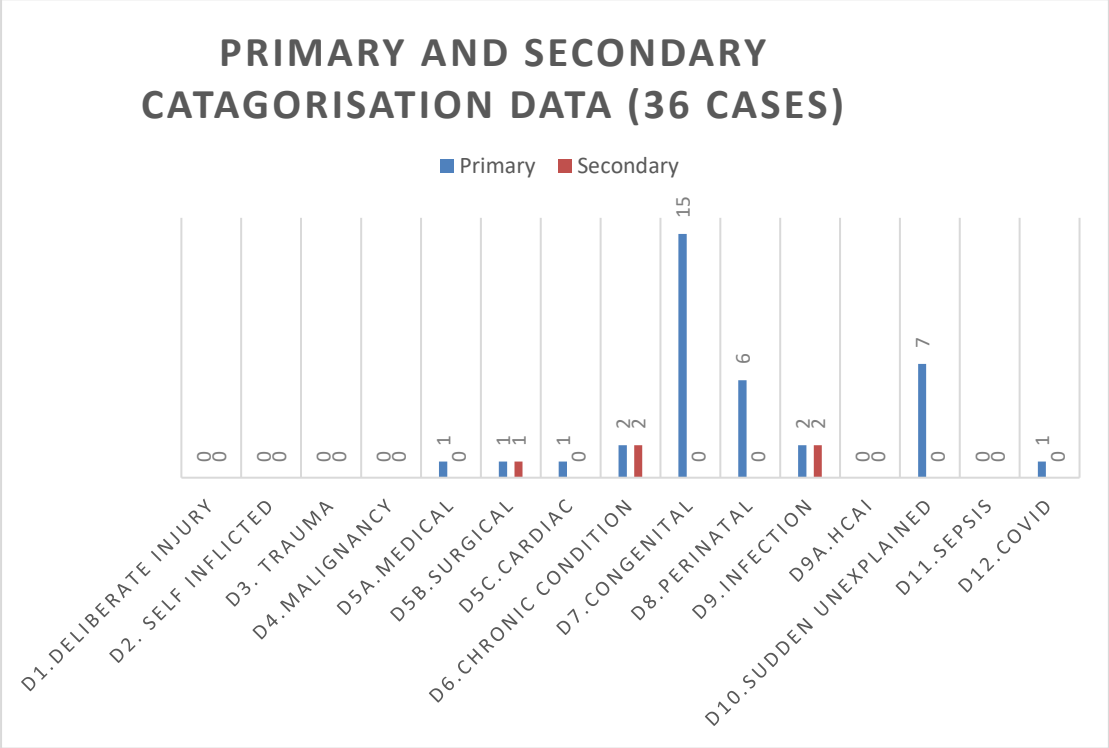
HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to inform future improvements of the care we provide. There have been an increasing number of families who are asking for a summary of the HMRG review relating to their CYP. This is provided.

We do not send families the HMRG forms as, in keeping with the child death review guidance, a plain English summary is written to try and prevent additional distress. These summaries are reviewed by palliative care/psychology to ensure they are high standard and compassionate. It has been recognised nationally that there is a trend for bereaved families to request written summaries and discussions are ongoing as to how to provide these causing minimal additional trauma to families.

External Benchmarking

AHCH has engaged with Birmingham Children's Hospital with the opinion that it was the Trust with the closest workload and demographics to us. It has enabled us to compare figures and trends and to work together to improve our processes and learn from each other and this will continue. There is also engagement with other Trusts to create a mortality network since we all face the same issues it can only be of benefit to learn from each other.

Primary and Secondary Categories

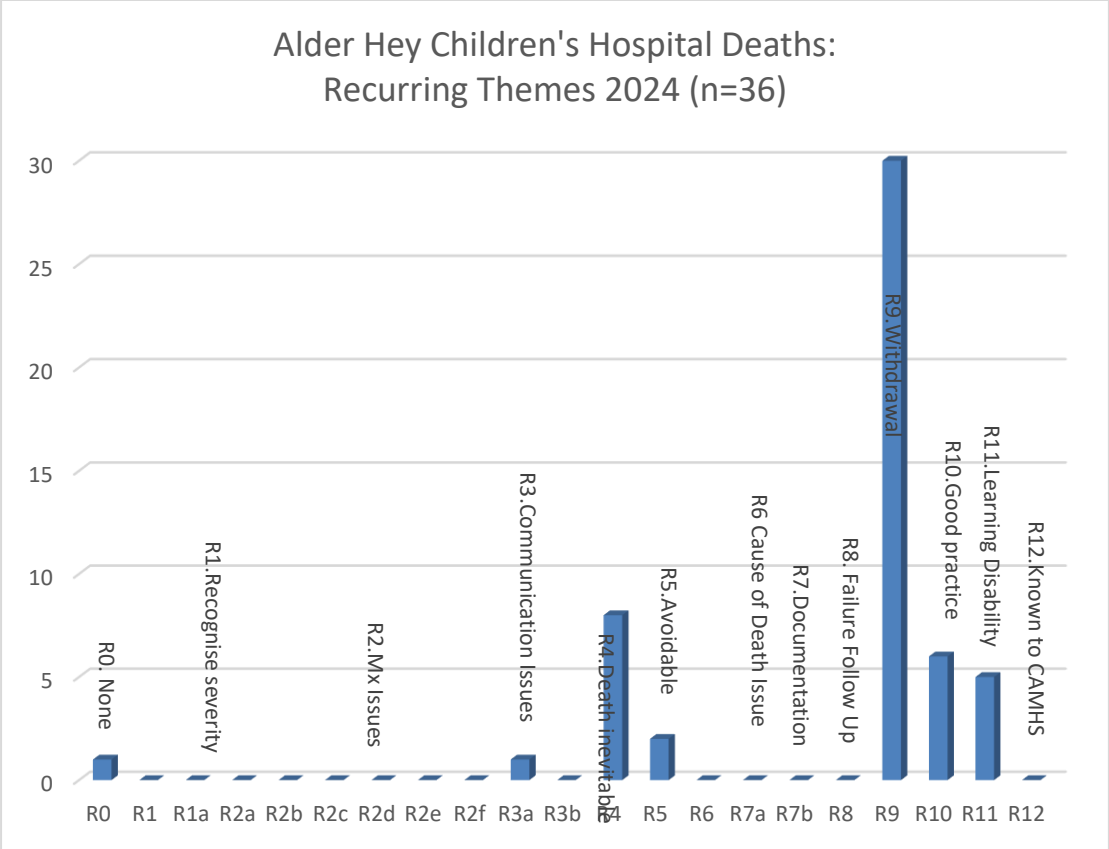


The cases reviewed in 2024 show that the highest diagnostic code is ‘children with underlying chromosomal, genetic and congenital conditions’ (42%). These are often complex and vulnerable patients. These conditions, depending on the case, may be life-limiting and often the care they have received by AHCH, other health professionals and their families have enabled them to live longer than previously anticipated.

Next most frequent, with 19% is the diagnostic code: ‘SUDI – Sudden unexpected death Infant /child. These are the cases which follow the coronial pathway so the coding will be changed if appropriate following PM or more information. This would include the out of hospital cardiac arrest which were mentioned above as increasing in frequency.

It is important to note that the numbers for 2024 are low although the diagnostic codes do stay consistent over the years.

Recurrent Themes



The main recurrent theme in 2024 to date is withdrawal of life-sustaining care (83%). This demonstrates that the intensive care team are working with families to ensure that no child/young person suffers unnecessarily when available treatment options or continuing treatment are no longer felt to be in the best interests of the C/YP.

Death was concluded to be inevitable in 22%, regardless of the care and expertise that was provided at AHCH. This category also includes the cases where death was inevitable with hindsight. These cases are included to highlight that it is not a reflection on the care AHCH provides as children are transferred for investigations which then indicate conditions which are life-limiting.

Good practice was allocated in 17% of cases which is unusual high as the group tend to be reluctant to use this code. It is only coded when the group believes that the care provided is beyond what should be provided.

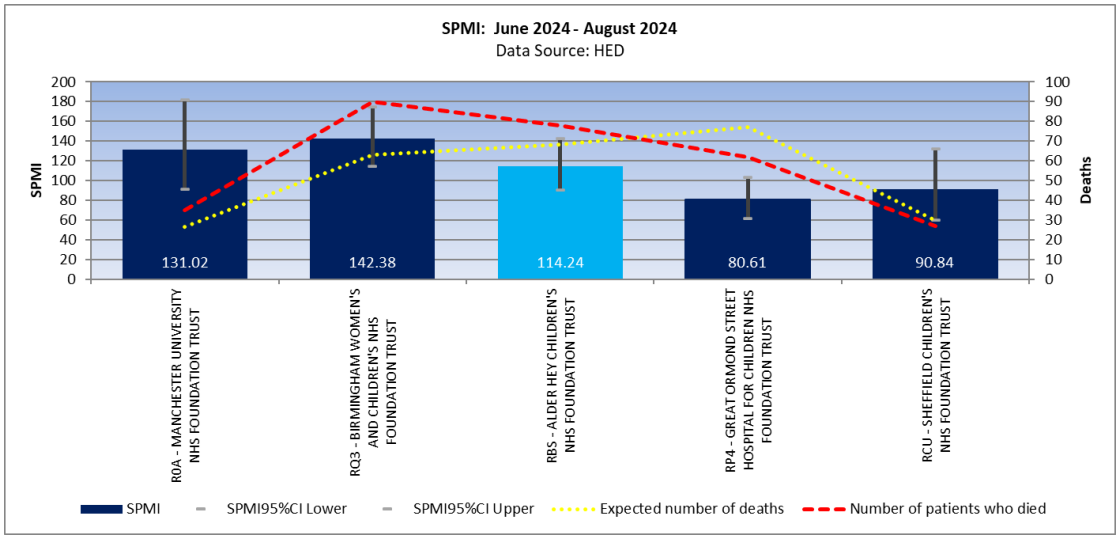
The LD and avoidable deaths have been discussed earlier in the report.

Section 2: Quarter 2 Mortality Report: July 2024 – September 2024

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering June 2024 to August 2024.



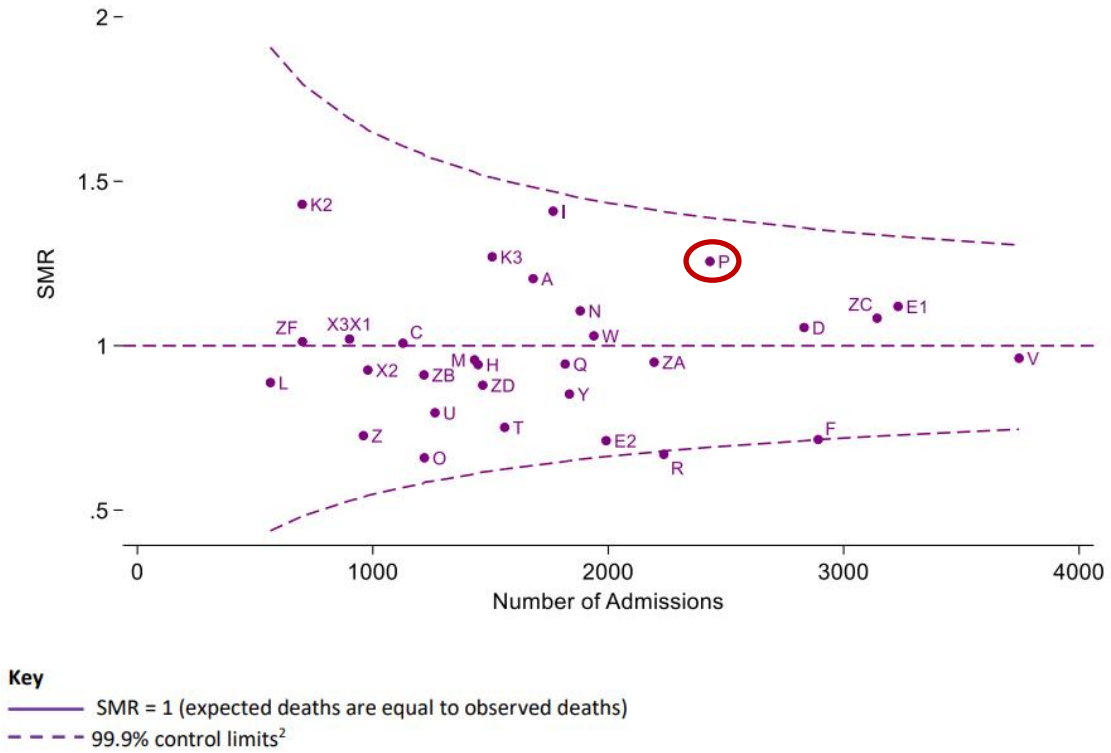
The chart shows that Alder Hey has performance of 79 deaths against 68 expected deaths which would be explained by the unexpectedly high numbers of out of hospital cardiac arrests and cases with death inevitable (17%) highlighted in recent reports. In these circumstances, there is no care that can be provided to alter the outcome, so it is not a reflection of care provided at AHCH. However, there needs to be careful consideration before accepting very unstable transfers and the impact on the families away from their support network. Interestingly, Birmingham, which is the organisation with the closest workload to us, has a much more significant rise of actual deaths against predicted. Great Ormond Street has no emergency department and Sheffield no cardiac and significantly less attendances.

PICU

It is important to recognise that 85-90% of our deaths occur in PICU, as in other Children's Trusts. In the most recent PICANet report (PICANet State of the Nation Report 2023, including data from 2020-2022), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.

There was no evidence that any PICU had an excess mortality rate compared to what would be expected based on the level of sickness at the time of admission across the three-year reporting period. This is illustrated in Figure 5 based on inclusion of all SMR estimates being contained within the control chart limits.

Figure 5: Risk-adjusted Standardised Mortality Ratio (SMR) by health organisation for under 16-year-olds, 2020–2022



Key

SMR = 1 (expected deaths are equal to observed deaths)

99.9% control limits[2]

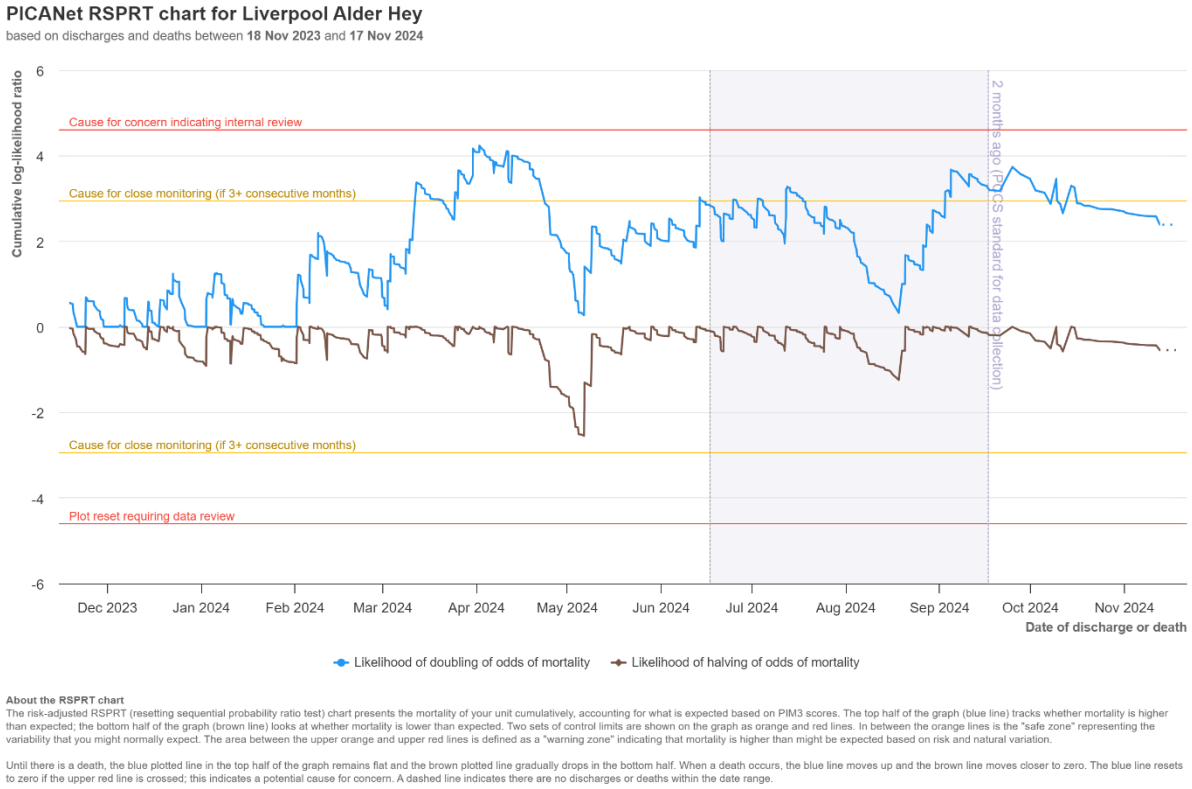
The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is within expected range.

Statistical analysis of mortality:

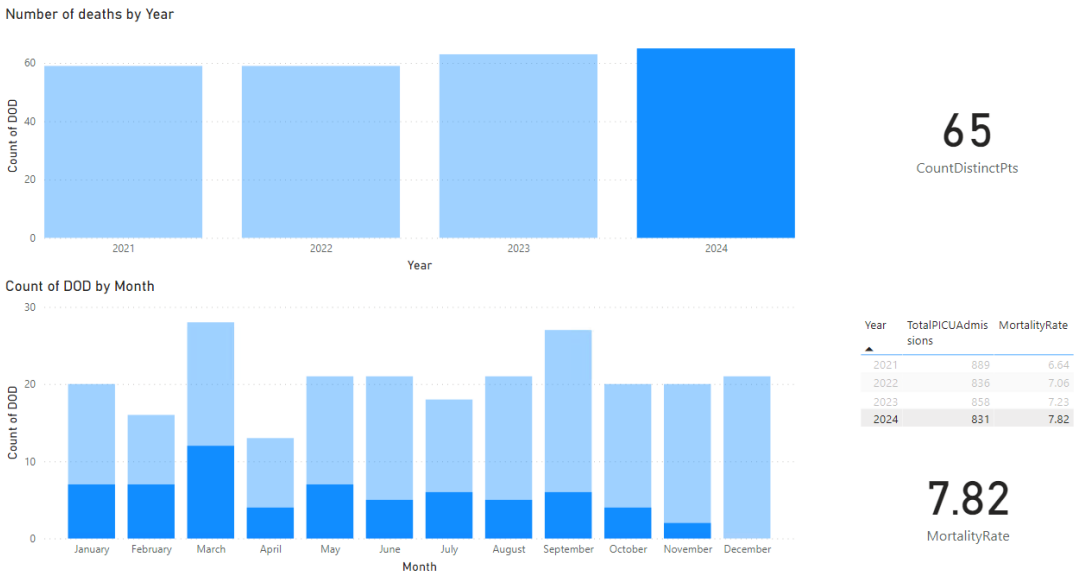
a) RSPRT (Risk-adjusted resetting probability ratio test)

The RSPRT (Risk-adjusted resetting probability ratio test) Plot presents the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'. Until there is a death, the top line stays flat and the bottom line

gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.



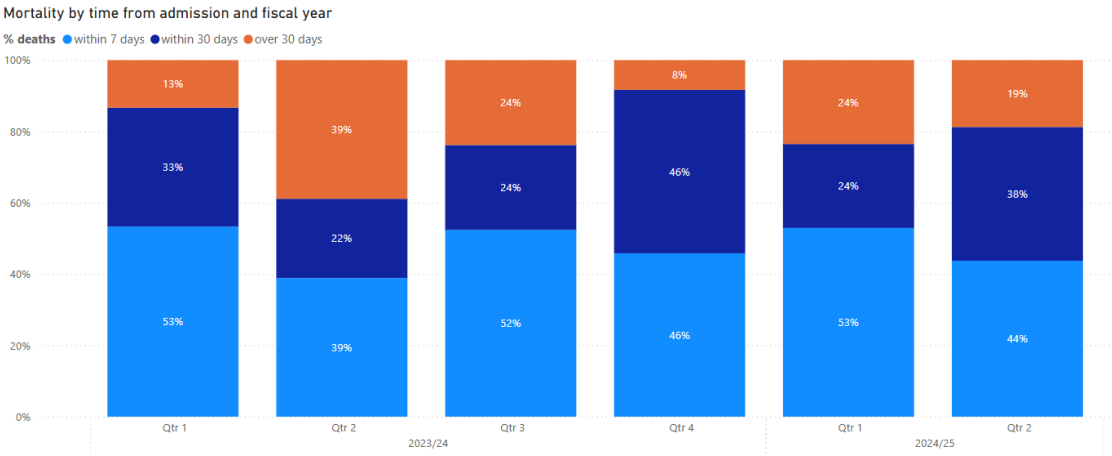
The mortality rate in PICU for 2024 to date (17.11.24) is 7.82. Although a slight increase, this is relatively consistent across recent years and given SMR and RSPRT remain within safe limits may simply represent a more concentrated number of higher acuity patients coming through PICU. Importantly, despite fluctuations, the RSPRT has not ‘reset’ and has auto adjusted back to the ‘safe zone’ with cumulative cases.



Real time monitoring of mortality

Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below the chart shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 39-53% of deaths occur within this time frame. In the recent quarter July 2024 – September 2024, 44% of deaths occurred within 7 days of admission, 38% occurred within 8-30 days from admission, and 19% of deaths occurred over 30 days from admission.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, and the 4-month target is running at an acceptable level in view of the workload and the complexity of the cases.

The issues raised at the beginning report are significant and need to be addressed. They may take time to resolve but it is vital that we start and identify the correct people to move things forward.

It will be interesting to review the learning disability and neonatal cases to review any trends /themes when the numbers are higher to identify any learning.

References

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

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html). **Pg 11**

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

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	Learning from Patient Safety Incidents Q3 October-December 2024
Report of:	Chief Nursing, AHP and Experience Officer
Paper Prepared by:	Associate Director of Nursing Governance and Risk Patient Safety Incident Investigation Leads

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide the Trust Board with a summary of activity and system-wide learning following the transition to the Patient Safety Incident Response Framework (PSIRF) for Q3 2024/25 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:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☑ **Pioneering** breakthroughs ☐ **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. Purpose

All NHS Trusts were required to transition to the Patient Safety Incident Response Framework (PSIRF) by the end of Q4 23/24. PSIRF replaced the current Serious Incident Framework, and the Trust transitioned on the 1 January 2024

The purpose of this report is to provide the Trust Board with a summary of activity during Q3 October-December 2024 following the transition to PSIRF, highlighting any identified areas of system-wide learning and improvement and next steps.

2. Activity to date

2.1 Learning from Patient Safety Events (LFPSE)

The Trust continues to meet the reporting requirements of the LFPSE v5. Next iteration of LFPSE v6 taxonomy is due to be released in February 2025 pending feedback from InPhase.

InPhase has provided a test system to NHSE to check taxonomies which has been reviewed and changes from InPhase requested. Following receipt of changes the aim is to test scenarios and implementation prior to national Go Live of LFPSEv6.

2.2 Patient Safety Responses (PSRs)

All PSRs are conducted locally across the Trust with different techniques adopted depending on the intended aim and required outcome.

During Q3 2024/25 there have been 30 learning responses (excluding PSIIs) commissioned to investigate those incidents initially reported as moderate physical or psychological harm or above. Table 1 below notes the current five broad categories of learning responses agreed with stakeholders being utilised across the Trust.

Table 1

Learning Response Types Q3 2024/25	Number Commissioned	Number completed
Initial Review: The initial review is completed within **7 days** of notification of an incident. This is an initial fact-finding that will inform whether a full patient safety incident investigation (PSII) or patient safety response (PSR) is required.	**23**	**17**
Situation, Background, Assessment, Recommendations, Decision (SBARD): Is structured communication framework that can help staff/teams share information about an issue that needs to be addressed. The detail provided in the SBARD can be used to help inform any further learning reviews if required	**1**	**1**
After Action Review (AAR): A method of evaluation that is used to analyse what happened, why it happened, and how it can be done better by the participants, in the future. It is not an investigation process, but its purpose is to learn, support	**2**	**1**

effective teamwork, motivation and implement improvements in a timely manner.		
Multi-disciplinary Team (MDT) Review: An MDT review supports teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to obtain staff recollections of events either because of the passage of time or staff availability.	**2**	**1**
Thematic Review (TR): A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.	**2**	**0**

2.3 Commissioned Patient Safety Incident Investigations (PSIIs)

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

At the 31 December 2024, the Trust had commissioned **two** PSIIs, both of which were related to national priorities. The commissioned PSIIs relate to the following:

- A never event (retained foreign object): *National priority.*
- A never event (wrong site surgery): *National priority.*

One PSII relating to a retained surgical instrument has been completed with findings and learning presented at both Patient Safety Board and SQAC December 2024 (details provided below).

The second PSII, a Never Event (Wrong site surgery) occurred in October 2024 within the Medicine Division. The incident related to Botulinum toxin (Dysport) injection given in the wrong limb. This incident remains under investigation by the Patient Safety Investigation Leads with an expected initial draft report due to be shared by the end of January *2025* and an expected date of completion of March 2025.

2.3.1 PSII: Retained surgical instrument.

15-year-old female, admitted in July 2024 underwent surgery to treat a large mass in her abdomen and right ovary. 3 days following surgery, the patient became unwell, and an abdominal X-ray identified that a copper malleable retractor used during surgery had been retained in her abdomen

Patient was taken back to theatre for remove of the retained copper malleable retractor.

The investigation identified that:

- The correct accountable items count process had not been followed and, on this occasion, and the process was inconsistent with guidance as outlined in Alder Hey LocSSIPs.

- The final consolidation count of sharps, swabs and instruments in this case was not completed in line with Trust Policy.
- NatSSIPs2 (National Safety Standards for Invasive Procedures, 2023) which aims to ensure standardisation, harmonisation and education across organisations and procedural teams has not been fully implemented and embedded within the Trust.
- A range of system, process and human factors issues were identified as part of this case and are presented in the full report.

2.4 System wide learning reviews -Thematic reviews

Thematic reviews:

As of December 2024, the Trust has commissioned **two** thematic reviews. The thematic reviews relate to the following:

2.4.1 Data Breaches

The organisation has experienced data breaches highlighting the need to review existing data protection practices. This themed review was commissioned to understand the common links, themes, or issues within a cluster of reported incidents.

The aim is to seek to understand the key themes and trends reporting in relation to data breaches and access effectiveness of current data protection controls currently in place across the Trust.

Progress to date: Data Breach project group established and working in collaboration with Brilliant Basics Team, to address and prevent harm or other unintended consequences of sharing data incorrectly. The following vision/goals have been identified:

- Develop a streamlined process for frontline colleagues to document parental responsibilities and communication requirements based on responsibilities identified.
- By December 2024: Understand the system, design an enhanced process, and align changes into existing data protection standard projects to be taken forward.

The draft report is anticipated to be completed by the end of March 2025.

2.4.2 Overdue/ Follow Up/Lost to Follow Up

AATD (Access, Admission, Transfer, Discharge) is a safety priority in the Trust Patient Safety Incident Response Plan. Due to reported incidents relating to overdue follow up's/ lost to follow up that have caused patient harm, the Trust commissioned a thematic review to gain a detailed understanding of the problem and offer recommendations for improvement.

The objectives of the thematic review are:

- To identify themes and trends in lost to and overdue follow-up to inform further analysis.
- To identify themes in lost to and overdue follow up and align with ongoing improvement initiatives currently commissioned.

Progress to date: The patient safety team are currently working in collaboration with the Safer Waiting List Programme Board. A weekly lost/overdue follow up project group has been established to develop a joint project plan and align priorities/ improvement work. The review is ongoing. The draft report is anticipated to be completed by the end of May 2025.

2.5 Training and Education

2.5.1 Patient Safety e-learning

The table below demonstrates the Trust compliance against three role specific patient safety e-learning modules, introduced to support PSIRF.

E-Learning Modules	%Compliance
Level 1a Essentials for Patient Safety (All staff)	**98.73%**
Level 2: Access to Practice Note: This training is not mandated with in the Trust.	20/65 of identified staff have completed training equating to **31%** compliance.

7 staff have completed oversight role training in line with PSIRF training standards.

2.6. Patient Safety Investigators

The two Patient Safety Investigators have now been in post since August 2024 and are core members of the patient safety team and PSIRF implementation group, delivering training to clinical and non-clinical staff and supporting delivery of patient safety improvement programmes aligned to our patient safety plan.

They have also been instrumental in supporting the development of an assurance framework aligned to the national PSIRF standards, undertaking internal audits, and supporting, and leading on PSLRs and/or PSIIs where relevant.

2.6.1 Internal Audit

An internal audit of patient safety incident reports recorded on InPhase between 1.1.24-30.9.24 was undertaken. The audit focused on:

- Inclusion of mandatory data
- Clarity of actions and outcomes
- Changes in harm status
- Timescales for learning responses/ open incident reports
- Reporting of near misses

Key audit findings:

- Identification and reporting of patient safety incidents is good across divisions and roles.
- Low harm/no harm incidents; recommendations and safety actions often recorded in different sections on the reports.
- Low harm/no harm actions routinely don't have updates/outcomes recorded.

Audit recommendations:

- To ensure teams are aware that Rapid Review has been replaced by Initial Review.
- Patient Safety Investigation Leads to conduct monthly review on InPhase:

2.6.2 Assurance framework

Twelve months after the initial launch of the Trusts Patient Safety Incident Response plan (PSIRP), the Patient Safety Investigation team proactively assessed the Trust's performance against the national standards that form the seventeen PSIRF competencies. The data used to inform the assessment was gathered via the following methods:

- Qualitative data (Learning response reports/ Incident reports/policies).
- Quantitative data (via InPhase audit/ training compliance figures).
- Stakeholder feedback.
- Meeting minutes (PSIRI meetings/ Patient Safety board meetings)
- Observation.

The audit findings evidenced the significant progress that has been made over the past year in embedding PSIRF across the Trust. Examples include systems that have been established which align with PSIRF and safety II principles, such as the weekly patient safety meetings where incidents, near misses and excellence reports are presented and discussed.

The assurance framework findings have identified areas for development. This includes improving how we share and embed learning and to further enhance awareness and understanding of PSIRF across all role types.

Objectives and milestones will be set for each of the identified areas for development which will be monitored via the Patient Safety Board.

2.7 Patient Safety Partners

In November 24 the Trust recruited 55 Patient Safety Partners (PSPs) following an active recruitment campaign supported by our Children and Young person's forum.

An estimated start date of February 2025 is planned with the development of a bespoke programme being initiated and lead by our Patient Safety Investigators to ensure that the Patient Safety Partners contribution to both investigations and improvement is optimised.

3 Next Steps

3.1 PSIRF Annual Review of the Trust PSIRF Plan

Following the first 12 months following the Trust's transition to PSIRF there is a requirement for the Trust to undertake an annual review of the original PSIRF plan or PSIRP. This is currently being undertaken as a mirror of the original 3-year data review in 2023 that led to the agreement of priority areas for investigation within our initial PSIRP.

The full 12 months of data captured during 2023-24 period has been extracted and is currently being analysed to assess for pockets of variation between the original agreed priority areas, and any new or emerging areas of significant risk. The data to be reviewed will include:

- All reported incidents
- All complaints
- All claims
- All FTSU concerns

- All learning from death themes
- Staff survey results (psychological safety indicators)

In addition, a quality round was held on 9 December facilitated by our patient safety investigators seeking the feedback from children young people, their families, and staff as to their views and priority areas of patient safety.

The output of the quality round and data analysis will be presented to the Patient Safety Strategy Board in February 2025, with a consensus agreement to consider our patient safety priorities for 2025/26 and altering our original 1-year plan.

The output from the review will be shared with Cheshire and Mersey Integrated Care Board (ICB), and a meeting is planned for February 2025 to confirm acceptance and ratification of the trusts PSIRP for a further 12 months.

3.2 MIAA Audit Activity

Mersey Internal Audit Agency (MIAA) are currently undertaking an internal audit into the Trust's PSIRF arrangements to evaluate the operating effectiveness of controls and level of consistency in place for the management, recording, monitoring, and reporting of incidents following the adoption of PSIRF. This is due to be completed in January 2025 and findings presented at Audit and Risk Committee in Q1 2025/26. An update of MIAA audit findings will be provided in the next quarterly report to Trust Board

3.3 Operational delivery

There is further work required as the Trust continues to navigate and embed the PSIRF framework and ensure that there is a focus on shared learning, implementation of actions and consideration of the resources required to continue to maximise the value of the PSIRF approach. A review of PSIRF processes and roles and responsibilities will be undertaken to consider the group operating model during Q4 2025/26.

4. Recommandation

The Trust Board is asked to note the activity that has been undertaken during Q3 2024/25 following the Trust's transition to and embedding of PSIRF and next steps.

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 18th December 2024**
Report of:	**Fiona Beveridge, Committee Chair**
Paper Prepared by:	Governance Manager

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 18th December 2024, along with the approved minutes from the 20th November 2024 meeting.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐

Risk Number/s	Risk Description	Score
BAF Risks 1.1 1.2 1.4	• Inability to deliver safe and high-quality services • Children and young people waiting beyond the national standard to access planned care and urgent care • Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	3x3=9 4x5=20 3x5=15

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

1. Introduction

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

Minutes of the meeting held on 20.11.24	Minutes approved
Antimicrobial Resistance Deep Dive	Presentation received
ED Monthly Report	Report noted
Nuclear Medicine CQC Report	Report noted for information
Divisional Updates	Reports x4 noted
Quarterly IPC Report	Report noted
Safeguarding Quarterly Report Q2	Report noted
Fuller Inquiry Action Plan Update	Deferred to January meeting
Patient Safety Strategy Update	Report noted
Never Event – Retained Surgical Instrument	Report and assurances noted
Clinical Effectiveness & Outcomes Group Report	Report noted
Liverpool Neonatal Partnership Monthly update	Report noted
Mortality Report	Report noted
Organ Donation Annual Report	Report noted
Bi-Annual Aggregate Analysis Report	Report noted
Gender Development Service	Report noted
Confidential Enquiries Report	Report noted
Board Assurance Framework Report – Nov 2024	Report noted

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

- The Committee noted the challenges within the Emergency Department during November due to increased attendances namely:
    - For the first time since October 2023, the Trust did not meet with 4-hour standard of 78% and only achieved 73.7%.
    - Time to be seen by a clinician had increased to 52 minutes above the national target; this was due to an increase in attendances and workforce challenges which is being managed on the risk register. Children and Young People waiting longer than 12h in ED had also seen an increase in month (40 in total) but remained within target. Long waiting patients were being well managed in all cases.
- Divisional updates
    - Clinical Research – The Division had seen an increase in information governance incidents namely relating to new staff not being aware of Trust procedures. Training reminders have been issued to staff and spot checks would be undertaken during December 2024.

    - Community and Mental Health – Children and Young People with additional needs being supported within the hospital setting is continuing to increase. Actions are underway to work more proactively in this space.
      Sickness absence within the Division has increased and colleagues are working closely with HR, occupational therapy and SALS to understand why this is.
      Getting new or replacement posts approved for recruitment is becoming a challenge in terms of the new process required by the ICB which is causing delays. The Division are continuing to seek alternative ways of managing without additional resource in the affected teams.
    - Surgery – One moderate harm relating to delayed follow up in orthodontics. A review is underway.
      Sepsis compliance remains a continued focus to improve compliance.
- 6 healthcare associated *Clostridiodes difficile* infections were identified during quarter 2, all of which were from Oncology. However, PIR's for the cases identified that there were no identified lapses in care.
- Level 3 safeguarding training is still slightly under the 90% trust target (85.80%). A charge for 'no shows' is now being implemented and communicated out to all Departmental Managers where appropriate.
- Patient Safety Strategy update - Two issues had been raised following the Trauma peer review:
    - Rehab clinical lead – unable to recruit to. Work is ongoing with to seek mutual aid with other major trauma centres to offer support for this role.
    - Psychology services - the current trauma load is placing pressure on the psychologist allocated to the service. A business case has been written and is currently under review by 3 ACOOs prior to submission to IRG.
- Quarterly Research Report - the risk relating to NIHR funding being capped should performance not be met was highlighted. This was being actively managed, however.
- Liverpool Neonatal Partnership Integrated Governance Report – 24/7 medical cover on the Alder Hey site was still not in place, but a plan was in place for this to be implemented in April 2025 for AH.

4. Positive highlights of note

- Divisional updates
    - Clinical Research – had held its first wellbeing week which had been very well received.
    - Community and Mental Health – Speech and Language Therapy have reduced the wait for first assessment and have achieved a 95% RTT. The risk relating to this issue has now been reduced.
    - Surgery – Critical care capacity had been maintained despite huge pressures on resource.
    - Excellent and compassionate team working in supporting a complex patient on 3A.
    - Medicine - Sepsis training compliance had reached 90.37% compliance.
- The positive proactive approach to combat antimicrobial resistance was welcomed by the committee.
- Safeguarding Report - The Named Doctor for Safeguarding now commenced in post.
- Mortality Report – no concerning trends in relation to the mortality data.
- Organ Donation Report – the Trust was performing well against its peers and meeting the expectations of the NHS Blood & Transplant.
- Patient Safety Strategy Update - Recruitment of Patient Safety Partners had been a huge success with 55 recruited and a proposed start date of January 2025. 98.7% compliance for L2 patient safety training.

- Despite the disappointment of receiving a never event report, the Committee was assured by the improvement actions to date and welcomed sight of the action plan at the January 2025 meeting.
- Clinical Research quarterly report -
    - Increased integration/joint working with between Research and Innovation (Futures) particularly in areas including grants.
    - Growing activity in relation to strategic research programmes and partnerships.
    - The CRD had been successful in securing funding from the Children's Hospital Alliance for a Research Project Manager post based at Alder Hey to drive forward research priorities for children and young people.
    - Funding of 1.1M secured from NIHR for new research equipment (ophthalmology, MRI and dentistry/max fax/rheum).
    - The Committee celebrated securing £1.1m in capital funding from the NIHR for 3 new pieces of research equipment in addition to last year's £3m award for the MRI scanner.

5. Issues for other committees

None to report.

6. Recommendations

The Board is asked to note the contents of the report.

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

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing, AHP and Experience Officer	NA
	Alfie Bass	Chief Medical Officer	AB
	Kelly Black	Head of Nursing & Allied Health Professionals	KBK
	Kerry Byrne	Non-Executive Director	KB
	Lisa Cooper	Divisional Director – Community & Mental Health	LC
	Ian Gilbertson	Deputy Chief Digital and Information Officer	IG
	Jacqui Pointon	Associate Chief Nurse – Community & Mental Health	JP
	Laura Rad	Head of Nursing – Clinical Research	LR
	Erica Saunders	Director of Corporate Affairs	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Gary Barker-Begley	Head of Nursing – ED and Urgent Care	GBB
	Jacob Gray	Emergency Preparedness, Resilience & Response Manager	JG
	Jill Preece	Governance Manger (minutes)	
	Jackie Rooney	Associate Director for Nursing & Governance	JR
	Pete White	Chief Nursing Information Officer	PW
Item 24-25-167	Gemmel Johnston	General Manager – Medicine	GJ
24-25-168	Ram Dhannapuneni	Consultant Cardiac Surgeon	RD
24-25-170	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	NO
24-25-177	Sue O'Neill	Acting Head of Neonatal Nursing, LNP	SON
Apologies:	Gerald Meehan	Non-Executive Director	
	Adam Bateman	Chief Operating Officer	
	Urmi Das	Director of Medicine	
	John Grinnell	Chief Executive Officer	
	Melissa Swindell	Chief People Officer	

	Welcome and Apologies The Chair welcomed everyone to the meeting and apologies were noted.
24/25/162	**Declarations of Interest** None declared.
24/25/163	**Minutes of the Previous Meeting** The Committee members were content to APPROVE the notes of the meeting held on 23rd October 2024.
24/25/164	**Matters Arising/Review of Action log** The action log was reviewed and updated.
	---- *Delivery of Outstanding Care* ----
24/25/165	**Antimicrobial Resistance Deep Dive** Item deferred to the December meeting – BL had been requested to attend a meeting with NHSE and no longer able to present today.
24/25/166	**ED monthly report: MH attendances and ED@its best** CW presented the Emergency Department (ED) Monthly Report sharing key highlights and challenges:

	Highlights: • During October 2024, the Emergency Department achieved 81.7% compliance against the national 4-hour standard of 78% despite a significant increase in attendances. • The Urgent Treatment Centre saw a 13% increase in capacity utilisation from previous month. • Children and Young People waiting 12 hours + within ED significantly reduced from September and was below the target of <2%. • Implementation of a new Primary Care provider within the UTC saw a smooth transition with benefits already being realised. Challenges: • Median time to clinical assessment was 79 minutes, 19 minutes above the national standard. Senior workforce remains a challenge in this area and is being closely monitored via the risk on the risk register. • The number of C&YP who attended the Trust's ED with mental health concerns saw a slight increase, this was noted as symptomatic of the start of the new school year. • Decline in NWAS handover performance. CW reported that a deep dive had been undertaken to understand the decline and provided assurance that compliance for 1st July - 31st Oct 2024 was 87%. The review found no significant safety concerns and a plan was in place to remain in communication with NWAS to further understand discrepancies with the data. FB thanked CW for the comprehensive report and acknowledged the difficulty with managing staff shortages during busy periods. **Resolved:** SQAC received and **NOTED** the ED Monthly Report.
24/25/167	**Nuclear Medicine CQC Improvement Notice** ES presented the CQC nuclear medicine improvement plan and reported that good progress had been made since the October report. The full plan to address the actions required within the improvement notice had been submitted to CQC who are satisfied with the proposed actions and progress made to date. Oversight meetings continue on a weekly basis to discuss progress and monitor all actions through to completion. GJ provided assurance that the working group would maintain oversight and ensure actions remained on track for delivery within the specified timescales. He reported that the majority of procedural documents had been ratified and that the final plan was on schedule be submitted to CQC by the 13th December 2024 deadline. The last remaining action related to implementation of a digital platform (IRefer) to ensure referrers have the correct information available when requesting radiology examinations. This had now been approved for procurement. FB sought assurance that support had been identified from iDigital and communications regarding the roll out of this new system. GJ stated that a project group would be established to oversee its implementation to include representation from iDigital and communications. ES reported that a debrief would take place following submission of the final action plan to CQC to review lessons learned and develop best practice, the outputs would be brought to a future meeting. FB welcomed this as a source of assurance. Action. **Resolved:** SQAC received and **NOTED** the Nuclear Medicine CQC Update
24/25/168	**Cardiac Surgery Action Plan** RD presented the report from the internal review into systems and processes within cardiac surgery following concerns raised about some practices within the department. In summary, the review highlighted several areas of good practice along with areas for improvement. Good progress had been made against all actions with most already implemented. Only a small number remained outstanding. FB welcomed the report and progress but referred to the cultural changes needed to sustain new changes within the department and the challenge this presents. A request was made for a further report

	to a future meeting in order to be fully assured that these continue to be implemented long term. ES and RD to agree the timing for this report. Action. KB also welcomed receipt of the report and action being taken to promptly address the issues identified. She requested that actions be RAG rated going forward along with timescales for implementation. NA undertook to take the discussion offline in relation to monitoring of longer-term cultural issues which don't lend themselves easily to an action plan and RAG ratings. ES & NA to discuss. Action. IG requested a meeting with the team in order to expedite some of the remaining digital solutions required. Action. ES informed SQAC that she was part of the senior group overseeing this review and would continue to support colleagues and ensure a further report back to Committee. ES commended the open and honest fashion in which the review was undertaken. FB thanked RD and the team in engaging in such an open and honest fashion and offered the support of the Committee if needed going forward. **Resolved:** SQAC received and **NOTED** the Cardiac Surgery Update.
24/25/169	**Divisional Updates** **Community and Mental Health Division** LC presented the Community and Mental Health Division update and drew attention to a few key points from the report including: • Achievement of full QNIC accreditation for Sunflower House (until 2027) • The Eating Disorder Service was undergoing its QNIC accreditation the following day. • Ongoing challenges with interpreter service plus letters not going out in 1st language. The Division has commenced a piece of work started with OPD team and presented a paper to Execs to redress the organisational structure and cultural challenges. This piece of work has been done with the input of the FTSU Guardian. KB alluded to the ASD risk and presented the challenge as to whether we should apply an 'at its best' type review. LC confirmed that this was in place but named differently as the ASD/ADHD Transformation Programme established with parents and carers. Work continues to progress well here with the outputs scheduled to be presented to a future Board meeting. **Division of Medicine** CW presented the Medicine Division update and drew attention to a few key points from the report including: • Both the neurology & haematology transfusion lab services remain challenged. Action plans were in place to address these issues with a view to reduce risks. • No overdue actions for investigations for the last six months. • No overdue reviews or actions on the risk register for the last three months. KB welcomed sustained focus on risks. • Focus remains on sepsis compliance and the administration of antibiotics within 60 minutes. The challenge here is administering IM injection antibiotics if IV access is not available. The steering group is looking into why there may be a reluctance here. Discussion ensued regarding the potential cultural issue and reluctance to administer IM injection antibiotics. CW informed the committee that this is being picked up through the working group to try and get to the bottom of this issue. NA asked for thought to be given as to whether additional skill support is needed from the response team for nursing staff given that this is a rare and unusual procedure. FB commented that a large volume of highly rated risks across the Divisions relate to workforce sustainability and stressed the need to review and ensure all mitigations are in place. **Surgery Division** KBK presented the Surgical Division update and drew attention to a few key points from the report including:

	• Successful transfer of the vitro retinal service in October 2024 with surgery now being undertaken at Alder Hey. This has improved the overall experience for C&YP and their families. • Work underway in theatres to improve wellbeing including the development of a staff wellbeing area. • Young person on 3A with complex physical and mental health needs. Multi agency collaborative work ongoing and support plans in place for patient and staff. Regular MDTs are ongoing, but the Division is concerned that they are now seeing staff sickness (work related stress) specifically associated with this case. FB requested that this matter be escalated. Action. • No grade 2 pressure ulcers for three months. NA commended this position but in terms of challenging ourselves, asked the team to give thought to the next objective in terms of pressure ulcers. The Pressure Ulcer Team would be asked to provide a report via the existing Patient Safety Board workstream. KB requested for best practice relating to pressure ulcers to be shared more widely in Cheshire & Mersey and nationally. KBK undertook to feed this back. **Clinical Research Division** LR presented the Research Division update and drew attention to a few key points from the report including: • Clinical Research Division recently selected to undertake a pressure ulcer study so will link in with the tissue viability team. • Mobile Research Unit now on site with relevant risk assessments being prepared. A communications plan is now underway to engage staff in activities. • Medical cover out of hours remains a challenge although thought not to be a high risk for the Division. Work is underway to determine an optimal model. • Research lab support also remains a challenge and the Division are considering adding this to the risk register. The issue continues to be monitored closely but will affect capacity for delivering research. KB referred to the SPC charts within all Divisional reports and asked if these could be looked into as they were reporting incorrect percentages. IG reported that some issues had been experienced with the supplier and undertook to pick this up with the BI team. Action. **Resolved:** SQAC received and **NOTED** the Divisional Assurance Reports.
	---- *Safe* ----
24/25/170	**Safeguarding Assurance Report (Q1)** NO introduced the Safeguarding Assurance Report detailing the work completed during the period 1at April – 30 June 2024. The following key points were highlighted: • Scrutiny visits undertaken by C&M ICB for the commissioning standards; a summary of the finalised ratings will be provided in the Q2 Report. • Level 3 safeguarding training remains below the 90% target at 86.62%. The team continue to strengthen the approach to cancellations and no shows and are introducing a charge for 'no shows' from January 2025. This will be communicated to all Departmental Managers. • Multi-Agency Safeguarding Hub audit undertaken to look at any actions/learning from request breaches. • Work was undertaken to review the 17 recommendations made in the Fuller Inquiry. This report would be presented to the December 2024 SQAC meeting. • The Named Nurse for Safeguarding commenced in post on 1st May 2024. NA thanked NO for report and its clear format. He went on to make a plea for a review of the training needs analysis for level 3 safeguarding training to be undertaken in order to be fully assured that the right staff are being asked to undertake it. Action. FB welcomed the report and the assurance it provided the Committee with.

	Resolved: SQAC received and **NOTED** the Safeguarding Quarterly Update and assurances within the report to ensure the Trust fulfils its statutory safeguarding responsibilities.
24/25/171	**Patient Safety Strategy update** JR introduced the report detailing the work undertaken by the Patient Safety Programme Board (PSPB) and drew attention to the following key highlights: • Quarterly assurance reports received from medical devices, medication safety and sepsis. • The PSPB focussed on workstream 1 'suite of safety metrics' at its October meeting noting an upward trajectory of incident reporting following a downward trend seen during the Summer. • Sepsis – an upward trend for patients receiving antibiotics within 60 minutes with compliance sitting at >90%. • Downward trajectory of restrictive practice being reported. • Upward trajectory of patients deteriorating on HDU being admitted to PICU. The team are looking at this to understand the clinical picture of the cohort of patients being transferred. • All assurance reports being requested in A3 format going forward with support from BB team. • It was noted that the Business Case for Safespace Beds was still not approved. NA requested an update outside of the meeting to understand why. • In relation to implementing the Alaris Nexus CC Guardrails, NA sought clarity on the delay with implementing this project and was advised that training had been completed but that the team were awaiting clinical input in relation to the validation of new profiles. KB referred to the observations from the DMO within the A3 report and sought assurance how we track and monitor these. NA agreed that this section needed revisiting to reflect Vision 2030 and asked JR to discuss with N Palin. Action. **Resolved:** SQAC received and **NOTED** the Patient Safety Strategy update.
---- Caring ----	
24/25/172	**Q2 Compliments, Complaints and PALS Report** The Committee received and welcomed the new style (A3) report. NA drew attention to the success highlights which shows 85% of formal complaints responded to within 25 days during the quarter and continued compliance across the Medical and Surgical Divisions. It was acknowledged that there are some challenges within the Community & Mental Health Division owing to the large volume of PALS relating to ASD/ADHD pathways. It was also noted that the reporting in relation to compliments was underrepresented and work continues to strengthen the report. FB welcome new style reporting and requested further insight into the challenges relating to low compliance within the Corporate Division. NA explained that a different structure was in place for corporate services which was causing some delays in the process. A piece of work was underway to identify an appropriate lead to take forward and progress would be reported to the next meeting. ES suggested the Corporate Services Collaborative as a mechanism for scrutiny and oversight of this issue. ES to discuss with NA. Action. LR highlighted that the Clinical Research Division had not been included in the data. NA agreed that this should be included despite the small numbers and undertook to pick this up for the next report. Action. **Resolved:** SQAC received and **NOTED** the Q2 Compliments, Complaints and PALS Report.
24/25/173	**Patient Experience and Engagement / Family Feedback Report Q2 2024/25** NA introduced the report detailing the work of the patient experience subgroups during the quarter. The report included some emerging thinking around the Patient Experience Strategy workstream moving into 2025/26. An away day had been held with the Executive Team w/c 18th November, the outputs from which would feed into the next report.

	A recruitment drive for Patient Safety Partners was held recently which received a fantastic response. The successful candidates would now be pooled and called to undertake individual pieces of work when needed. FB was pleased to see the level of participation of Children & Young People throughout the report. A soft launch of the Family Wellbeing Hub was held during November with case studies now being gathered from families who have benefited from the various support mechanisms available. The service will continue to expand and roll out to be readily available for families to access from 2025/26. FB sought clarity on the direction of travel for the report to ensure consistent reporting across all areas and questioned the name of the report and whether it was reflective of the work involved. NA agreed that the title of the report required some further thought and assured colleagues that as the report continues to evolve, more of the outcomes would be reported in A3 format. FB welcomed this and asked for information to be included on things such as food which is often a theme in complaints. NA agreed to pick this point up for future reporting. Action. **Resolved:** SQAC received and **NOTED** the Q2 Patient Experience and Engagement / Family Feedback Report.
24/25/174	**Q2 Children & Young People Engagement Leads Report** LC introduced the report which detailed key activities the Alder Hey Youth Forum had undertaken during the second quarter of the year. Linking back to the previous agenda item (24/25/173) LC informed the Committee that The Forum had created a video to help with the recruitment of Patient Safety Partners. She went on to state that there are over 120 Children & Young People involved in The Forum and made a plea for Divisions/services to make contact with the Engagement Leads and involve them wherever possible in order to gain their views. KB commended the report stating that it was amazing to see breadth of work the C&YP are involved with. She went on to suggest the C&YP report back to SQAC via a pre-recorded video in the future if possible. Action. **Resolved:** SQAC received and **NOTED** the Q2 Children & Young People Engagement Leads Report.
----- *Effective* ----	
24/25/175	**Clinical Audit Assurance Report** JR presented the report detailing clinical activity undertaken to 31st October 2024. The committee was asked to note the completed audits within the period and attention was drawn to the challenge in relation to submission of the Epilepsy 12, cohort 6 audit due to lack of resources within the team. The Trust has been identified as an outlier in this respect and the matter has been escalated to senior staff within the Medicine Division. CW assured SQAC that she would escalate this with colleagues and ensure there is a plan to ensure submission despite the resource challenges. CW was asked to provide an update via email regarding progress. Action. Any overdue or audits exceeding their completion dates have been escalated to the relevant Divisions for assurance of delivery. The risk in relation to the Renal Register data submission would be reviewed as the submission was being undertaken manually and did not pose a risk to the Trust. **Resolved:** SQAC received and **NOTED** the compliance with Clinical Audit within the Trust.
24/25/176	**Clinical Effectiveness & Outcomes Group Chairs Highlight report** JR presented the Clinical Effectiveness & Outcomes Group Chairs Highlight report from the meeting held on 08.11.24. Attention was drawn to the following key highlights: • Continued compliance with learning from clinical audit and NICE Guidelines. • Aligning reporting to BB going forward and Vision 2030. • Continued compliance with CAS alerts and responding to the national team.

	• SQAC was informed of the work ongoing to move away from the current Document Management System and consider alternative options in order to comply with NHS Digital Standards. A full project plan is in development and costing information is being obtained on the preferred option and will be presented to Executive Team for consideration. **Resolved:** SQAC received and **NOTED** the Clinical Effectiveness & Outcomes Group Chairs Report.
24/25/177	**Liverpool Neonatal Partnership Monthly Update** SON introduced the Liverpool Neonatal Partnership update report and highlighted the following key points: • PDRs for 1C was reported as 47%, assurance was provided that the current rate was 80% and that it had become apparent that PDR completion was not feeding through into ESR. Work continues to ensure that the outstanding PDRs are completed within a three-month window. • A review of the turnover on 1C had been undertaken and assurance provided that exit interview data showed that staff are not leaving because they are unhappy with the partnership. • Activity remains high across both sites with occupancy over 80% at LWH and 96% on 1C. Assurance was provided that safer staffing has been maintained. • In relation to the BAPM Standard to have a Speech and language therapist within the Neonatal Team, SON was disappointed to report that the role had been back out to advert but had not received any applications. The team were continuing to reach out through their networks for support. NA suggested looking into a shared job role model for this particular post. CW agreed to link in with the team in terms of a potential solution. Action. • In terms of mortality, SON reported that there had been an increase in deaths across the partnership in October (8 in total), these related to extreme prematurity and expected deaths relating to congenital abnormalities. SON stated that she did not have the data on the deaths at Alder Hey as these are subject to a separate internal review process. FB stressed the importance of having complete oversight of mortality reviews across both sites. Action. **Resolved:** FB thanked SON for the comprehensive report and specific assurance in relation to the deep dive into turnover. NA welcomed new format of the metrics.
24/25/178	**National Institute for Health and Care Excellence (NICE) Compliance Update** JR presented the National Institute for Health and Care Excellence (NICE) Compliance Update report for the month of October 2024 drawing the Committees attention to the following: • Continued trend in compliance with baseline assessments and revisions of action plans since the last reporting period. • Of the twelve NICE Guidelines currently open across the trust (four at baseline assessment stage and eight at action plan stage) one baseline assessment had been completed with four open guidelines at assessment stage, of which two are outside of the three-month standard review. Assurance gained from Divisions that all assessments are on track for completion with specified timescales. **Resolved:** SQAC received and **NOTED** the National Institute for Health and Care Excellence (NICE) Compliance Update
	---- *Well Led* ----
24/25/179	**Board Assurance Framework** ES presented the Board Assurance Framework for the month of October 2024 and drew attention to the Executive Summaries within the report. Risk 1.1 had been subject to thorough review in terms of articulating actions and controls. In terms of risk 1.2 the sharp focus on follow ups was highlighted as a gap in control currently. ES would speak to AB to include in the next report. **Resolved:** SQAC received and **NOTED** the Board Assurance Framework.

	---- *Responsive* ----
24/25/180	**Emergency Preparedness Resilience & Response Report** JG introduced the Emergency Preparedness Resilience & Response (EPRR) Report highlighting the progress made towards increasing the Trusts EPRR Core Standard compliance. He was pleased to report an improved position of 61% compliance against a previously reported 50% with over 100 actions completed during the period, however this position was still not within the compliance target. The Emergency Preparedness Group continues to work closely with the ICB to work through the core standards. This risk is being monitored through the risk register. Three main key challenges were highlighted with remainder of self-assessment including duty to maintain plans, business continuity and hazardous materials. Significant input and engagement would now be needed across the organisation in order to turn localised plans into trust wide plans. JG reported that, following a Trust level debrief in relation to the Southport incident, investment has been made for a new cascade system which is due to be implemented in 2025, this will allow notifications to whole organisation in less than 5 minutes (current standard 45-60 minutes). FB thanked JG for the comprehensive report welcoming the progress made and work that continues to address the remaining actions. **Resolved:** SQAC received and **NOTED** the EPRR Report.
	---- *Any Other Business* ----
24/25/181	No further business was raised.
	---- *Board Assurance* ----
24/25/182	The key assurances and highlights report was presented to the Board meeting held on 5th December 2024.
	Date and Time of Next Meeting: 18th December 2024 at 9.30 – 11.30 am via Microsoft teams

Liverpool Neonatal Partnership

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**Liverpool Neonatal Partnership Board - Co-Chair's Report to Trust Board**
Report of:	**Co-Chairs of the LNP, Alf Bass and Lynn Greenhalgh**
Paper Prepared by:	Natalie Rixon - Programme Advisor (LNP)

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:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☐ **Pioneering** breakthroughs ☐ **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. Introduction

The Liverpool Neonatal Partnership (LNP) is a collaborative partnership between Alder Hey Children's NHS Foundation Trust (AHC) and Liverpool Women's NHS Foundation Trust (LWH) to provide care and treatment to neonatal babies across two hospitals which meet national service standards for neonatal care and improve the quality of care and families' experience of neonatal services. The LNP will deliver a Neonatal Service within 22 neonatal Intensive Care Cots at AHC and 44 neonatal cots at LWH providing Intensive Care, High Dependency and Special Care cots. The service is expected to go live in January 2026, following completion of a new building at AHC.

A Board (the "LNP Board") has been introduced to oversee the implementation of the new service. Existence of the LNP does not impinge upon the legal sovereignty of AHC and LWH, each of whom will retain responsibility for meeting all expected quality and service standards, including performance to the relevant regulatory standards including the Care Quality Commission's *Fundamental Standards* and the requirements set out in NHSI's *Single Oversight Framework*. The Board of Directors of each organisation continue to be accountable for its own service provision in accordance with its Constitution, Provider License and statute.

2. Overview of Partnership & Activities

Partnership

The LNP model brings AHC and LWH together, with a foundation built upon the Memorandum of Understanding agreed by both trusts. Both AHC and LWH are equal partners and bring a wealth of knowledge and expertise to help shape the future model of care.

Commissioning

The LNP are working closely with the specialist commissioners to deliver the agreed neonatal capacity. Appendix 1 provides a breakdown of the 22 cots that will transfer to AHC from across Cheshire and Mersey once the new unit is built. AHC have undertaken a comprehensive capacity and demand review, utilising the most up to date information to confirm that the demand remains in line with the business case assumptions and the approval gained from specialist commissioners. The planned transfer of activity will take place in a phased approach between January and March 26.

Assurance Provision

The LNP leads are planning to undertake a review of the information and assurance that is currently being reported to Trust Boards, LNP Board, SQAC (AHC) and the Quality Safety Executive Group (LWH) to ensure that the content and level of detail is appropriate for each committee.

Programme Approach

The LNP have developed a clear structure to deliver the new model of neonatal care for Liverpool. This is underpinned by a comprehensive project plan that will be delivered through six distinct workstreams, with associated subgroups to ensure that all the necessary tasks have been identified and completed in the timeframes agreed.

The team adopt a matrix working model, recognising the crossover of key workstreams such as pathways, training and workforce for example. The key milestones can be seen in Appendix 2.

Clinical Processes, Education & Simulation
The LNP have developed a thorough training schedule for all staff groups which includes weekly simulation sessions.

Data sharing and dashboard development
The information governance leads from AHC and LWH have worked diligently to achieve a Data Sharing Agreement between the two trusts, this authorises the safe transfer of data and patient information between trusts to enhance patient care. The Business Intelligence leads are now working through the technical requirements to develop a comprehensive partnership dashboard.

Workforce
The workforce plans remain on track to ensure the new unit can open safely from January 2026.

Collaborative working, safety and culture
The LNP Board members have requested a focused piece of work in relation to collaborative working, safety and culture recognising the importance of aligning core values and providing psychological safety for staff members and the new teams formed. A proposal will be presented to the January LNP, with a view to commence from February 2025.

Integrated Services
There has been significant engagement with the subject matter experts across multiple disciplines to help ensure all areas of care have been built into the new NICU delivery model (e.g. radiology, pathology, physiotherapy, occupational therapy, dietetics, psychology, ophthalmology etc).

A business case is being developed across these areas as it is important to highlight that the BAPM standards and other professional recommendations have been updated in some areas since the original business case was approved in 2017/2018.

Build Update
The build timeframes and costings will be very much dependent upon the decisions made in relation to water safe requirements. This is moving at significant pace, and further updates will be shared at the earliest opportunity.

Financial position
The financial position in currently under review, with a full report detailing pay and non-pay to be presented to the next LNP Board.

From a build perspective, again the impact of water safe requirements is currently being assessed and will be presented to the executive leads as soon as possible.

The build leads hold a monthly finance workshop to work through all build, digital, medical equipment and furniture, fitting and equipment requirements in detail, chaired by the Finance Director.

3. Key risks / issues to escalate to Trust Boards

- The AHCE Executive Team have authorised a review of the NICU design to take into consideration the recently released bulletin focused upon water safe practice. A thorough review is underway with all key stakeholders engaged in the process.
- The ability to appoint to the SALT role continues to be a challenge.
- Alignment of key policies and procedures has been highlighted and discussed at a recent Exec to Exec meeting.

4. Positive highlights of note

- Introduction of a Project Plan and Plan for each workstream recording tasks and milestones to be monitored and reported against.
- Signing of a Data Sharing Agreement between the two Trusts.
- Mindray chosen to provide the monitoring equipment in the new build.
- On track for new build handover in Oct 25 (subject to water safe requirements).
- Recruitment is progressing in line with planned requirements.
- All subject matter experts are engaging well with the programme to ensure the highest level of care can be provided once the new unit is operational.
- The AHC capacity and demand assessment is complete.

5. Next steps

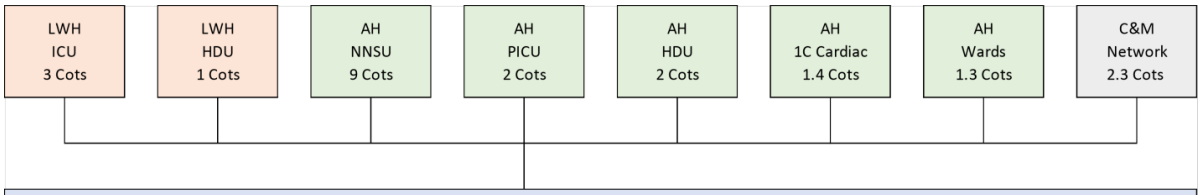
- Review of the build schedule, timescales and costs associated with the water safe requirements and obtain executive approval on preferred option.
- Review and update the LNP Memorandum of Understanding and Terms of Reference and Work Plan for the LNP Board and Integrated Governance Group.
- Review the information and assurance needs of Trust Boards, Safety & Quality Committee (AHC), Quality, Safety Executive Group (LWH) and LNP Board.
- Launch of the collaborative working, safety and culture workstream.
- Develop a business case to recognise the enhancement identified within the BAPM standards (updated since the first business case was approved).

6. Recommendations

The Trust Boards are asked to **note** the LNP Board Chairs Report.

Appendix 1 - Cots to Transfer to Alder Hey Neonatal Surgical Unit

Cots to transfer to Alder Hey Site



Total Cots Transferred to LNP Alder Hey Site = 22

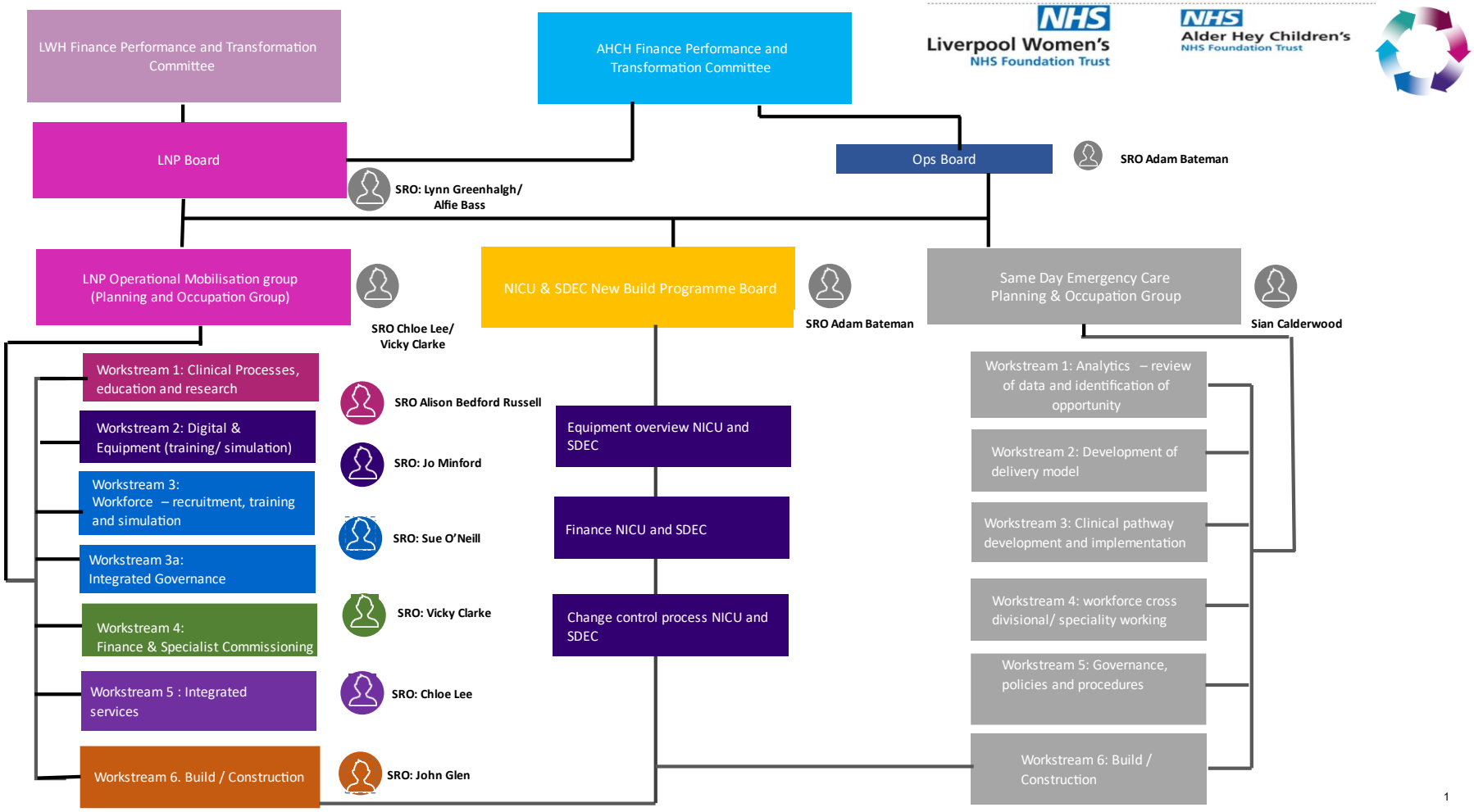
Note

4 cots from LWH

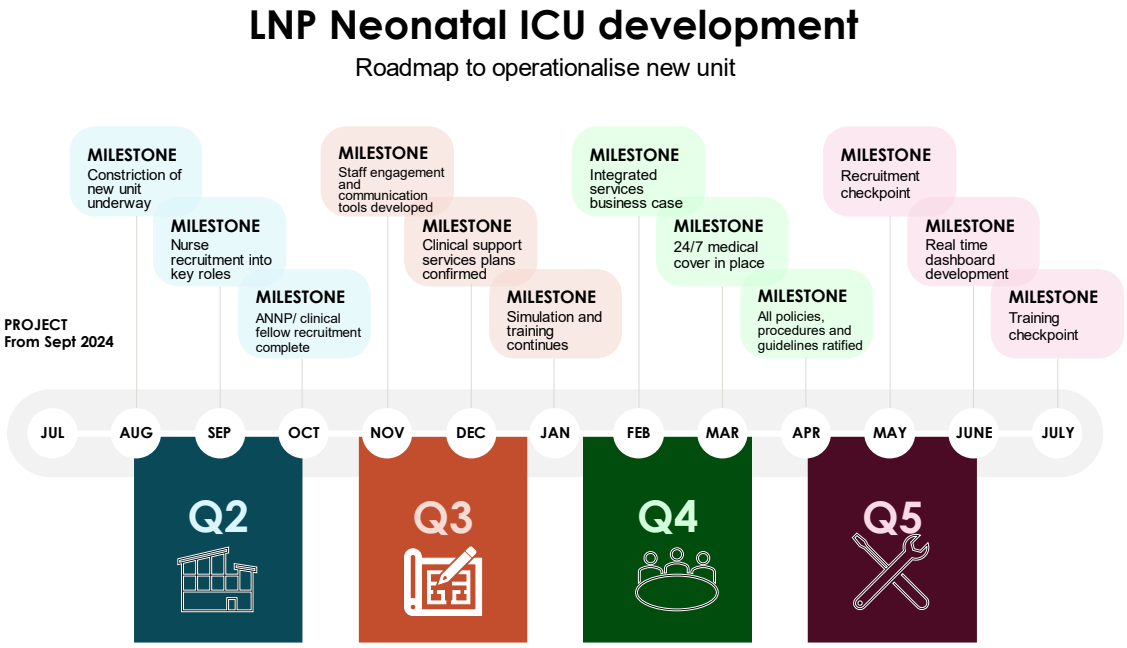
15.7 cots from AH

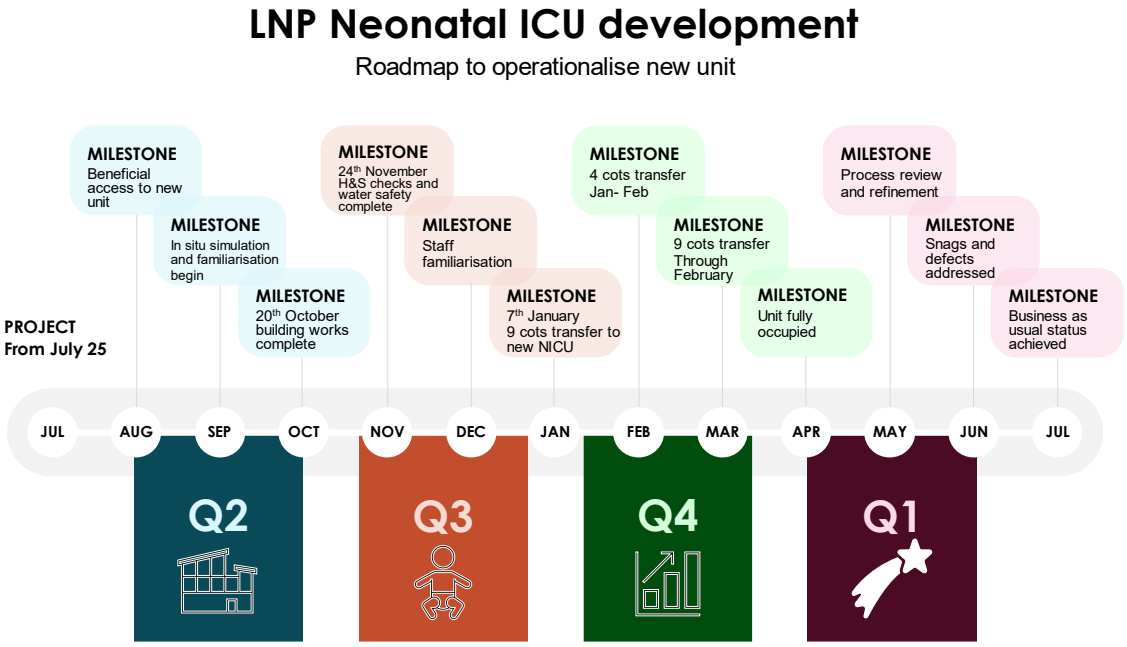
2.3 cots from C&M Network

Appendix 2 – Overview of LNP Programme and Workstreams



Appendix 3 - Current project milestones





BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**People Plan Highlight Report**
Report of:	Melissa Swindell, Chief People Officer
Paper Prepared by:	Jo Potier, Associate Director of Organisational Development Sharon Owen, Deputy Chief People Officer Katherine Birch, Director, Alder Hey Academy

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To provide an update to the Board of progress against core workstreams within the People Programme
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☐ **Strong Foundations** ☑
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
2.2 2.1	Culture Workforce Sustainability	 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

1. Executive Summary

This paper outlines the progress made against core workstreams of the People Programme, as agreed at Trust Board October 2024. Together they comprise the key elements of our culture evolution, creating the right conditions for our people to thrive, learn and work differently to deliver a healthier, happier fairer future for CYP.

It will focus on the priority actions agreed at October Board in these workstreams for 2024-26 which are: inclusion & belonging (EDI), a revised set of values, restorative just and learning culture, thriving leader's framework, thriving teams index and thriving staff index. These are complemented by a refreshed framework to support personal and professional development, alongside a focus on our Future Workforce.

Significant progress has been made in EDI and the thriving leader's framework with progress also being made in restorative just and learning approaches and support. Progress against the Thriving Staff Index has been slower than anticipated due to internal resource constraints. Scoping is underway to develop the Thriving Teams Index and the work to revise our values is yet to be scoped. Progress against key actions within the Professional Hub workstream are on track. Wider discussion will be required into 25/26 in respect of talent management to support this programme.

Inaugural discussions have taken place in respect of the diversified and accessible recruitment workstream. Some immediate interventions have been identified to removing barriers and taking positive action to promote more inclusive practises, whilst identifying key strategic work to achieve the vision of becoming a great place to work that attracts and retains the best talent, as well as becoming and exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside.

Both the ED&I steering group and Networks are identified key stakeholders and ‘critical friends’ to the diversified and accessible recruitment workstream. Regular meetings into 2025 are currently being scheduled to support this wider programme of work.

2. Background

To achieve Vision 2030, the Board have agreed that by 2030 our aim is to have:

- One vision for CYP and staff
- One Alder Hey where everyone belongs
- One inclusive community united by a core set of values expressed by everybody, everyday, everywhere, in every interaction
- One unifying approach for individuals, leaders, teams, organisation, reducing inconsistency of experience & performance
- One integrated safety culture
  AND
- Values & behaviours that are clear, agreed, visible and translated into lived experience for every member of staff
- A real time feed of staff & team functioning (measuring success & difficulty)

- Intelligence that is used effectively to create systems that continually improve the quality of management (& intervene early when problems arise)
- Empowered teams able to manage issues themselves with clear guidance on where to go if need support
- Development opportunities which are more personalised, more frequent and cover the whole life cycle of people's time with us, whatever their job role or level
- Colleagues feeling supported to develop new skills (aligned to our core priorities/Futures) and to adopt new ways of working
- A great place to work that attracts and retains the best talent
- An organisation that is an exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside
- Exemplar People Practices. Working in Partnership with staff side and unions to create a positive working environment and adopting best people practises, thus preventing avoidable employee harm
- Business Critical roles that are identified with a diverse and readily available pipeline for replacement.
- Embedded new roles that focus on the skills, values, tasked and competencies to complement our existing roles to deliver future models of care.
- A clinical strategy that is underpinned by sustainable workforce models and workforce plans

3. Priority actions:

One Alder Hey & Thriving

A full list of the priority actions can be found in Appendix 1. Of note for the Board is progress against the following actions:

Inclusion & belonging:

- At the November Trust Board, the networks presented their 'asks' to the board in terms of support and actions and we are working with the network leads to support these actions. These actions included support with the following:

  REACH Staff Network: *Development of International Staff Leadership Programme.* A meeting took place in December to discuss the first steps towards developing a specific leadership programme for internationally educated staff. We are working with the REACH staff Network and our internationally educated nurses to identify their development needs. We will meet again in February with a detailed proposal designed by our staff.

  Unconscious Bias was a training need highlighted by the REACH Network. There is a module available on the new online EDI Plus training programme available to all staff. It has also been incorporated into the new Recruitment & Selection training for managers. We will continue to promote the EDI Plus training to staff, working with Learning and Development to identify training needs.

Reverse Mentoring was highlighted by the REACH network as an initiative that they would like to explore.

LGBTQIA Staff Network: The staff network highlighted the need to work closely with the Gender Identity Service to provide support to their team regarding training and education.

Armed Forces Staff Network: *Developing Little Troopers Packs.* Little Troopers is a charity that supports healthcare professionals with resources and tools to better support children and young people with parents serving in the armed forces. The staff network has registered with the charity and are developing communications and resources pack which will be shared with all departments. They are also exploring training options to provide staff with an awareness of supporting children and young people from armed forces families.

ACE Disability and Long-Term Conditions Staff Network: *'Me and My 'poster campaign* will be launched in early 2025. "Me and my…" would share the experiences of individuals living with a particular disability or long-term condition, telling their own story, from their own perspective. Each story would be headed "Me and my [disability or condition]", so for instance "Me and my… ADHD", or "Me and my… dyslexia". An editable template 'poster' will be created and adapted to focus on individual stories. Many volunteers have already been identified.

- We continue to implement the NHS EDI Improvement Plan and the 6 High Impact Actions. The accompanying action plan is monitored through the Trust ED&I steering group.
- We are developing EDI objectives which we will be sharing at the EDI steering group in January 2025. The objectives are part of our specific Public Sector Equality Duty. Our equality objectives will reflect what we want to achieve to make progress on the aims of the general duty.
- We will continue to promote our Anti-Racism Statement and Commitment with plans to work towards the NW BAME Assembly Bronze Status in 2025.

Values:
Revised values work to be scoped and agreed

Integrated safety culture:

- Avoidable Employee Harm workshop held with senior HR team to reflect on current state and assess work needed to embed restorative just and learning approaches into all people practices. Agreed to convene a second workshop to collectively define avoidable employee harm and assess changes needed to policy and practice to reflect the evolving culture.
- Ensure work relating to staff safety culture and patient safety are aligned and visible to the People Committee and Patient Safety Boards.

Thriving Leaders framework:

- Clinical Leads listening exercise complete with 50 interviews held with clinical leaders from across the 3 main professional groups. Feedback presented to

Clinical leads at the Clinical Leaders summit in November. Programme of work to commence to focus on leadership design, development and support based on the data gathered.
- Management Essentials programme reviewed with core HR training programmes now to be developed for inclusion.
- Aspiring Chief Medical Officer programme announced at the Clinical Leaders summit with call for expressions of interest from medical colleagues.
- Coaching offer in development with Transformation colleagues for groups of leaders across the trust to engage them with and empower them to deliver Vision 2030.

Thriving Teams:
- Thriving Teams MDT operational to more effectively, and collectively, address the needs of fragile teams and services
- Thriving Teams Index currently being scoped including resource and capability needed to develop the Index. To be explored further with Futures with a view to harnessing expertise from research, digital and innovation.

Thriving Staff Index:
- Resource and capability secured to further develop the Index for full implementation in January 2025

Professional Development / The Development Hub
A full list of the priority actions can be found in Appendix 2. Of note for the Board is progress against the following actions:

- Detailed mapping of roles and **career pathways** is underway, capturing the opportunities available for staff across a number of core staff groups, grades areas and roles.

- Development of **virtual hub**. The design and development of a virtual hub is on track. The new Hub will provide a range of information, advice and guidance (IAG) for colleagues as well as offering the opportunity for 121 discussions. IAG will include, inter alia, information on career pathways, preceptorship and preceptorship+, apprenticeships, coaching and mentoring as well and signposting to internal and external workshops and courses, signposting and funding support. Colleagues will also be able to access a detailed and focused skills scan which will inform and support next step discussions, as applicable. Discussion is ongoing as to the location of the physical hub.

- Following feedback from colleagues about the nature and type of support which they would find useful (recruitment focus), **new sessions and guidance** have been developed to support staff in applying for new roles / redeployment. These are currently being piloted.

- An **extended programme of learning and development** opportunities is now in place (including a wide range of clinical and non-clinical opportunities). Full details are in the Prospectus, available on the Intranet and also accessible from staffs' ESR landing page. These are complemented by additional local development

opportunities. The L&D are working with subject matter experts and key leads to continually review and refresh the programme.

Future Workforce

A full list of the priority actions can be found in Appendix 1. Of note for the Board is progress against the following actions:

- **Diversified and accessible recruitment –** The Trust wide Recruitment & Selection was signed off in December 2024 and will include much more interactive practice on ED&I and will include input/sessions from our Network chairs. Recruitment and Selection training is scheduled to be relaunched in February 2025 for all those who are involved in Trust recruitment processes. Review of all traditional recruitment methodologies is underway and introduction of enhanced and user-friendly assessments, with particular review on neurodiversity and the impact of the traditional panel interviews on candidates who are neurodiverse.

- **People Practices -** The Deputy Chief People Officer is working closely with the Staff side Chair as well as union leads to enhance the partnership agreement and approach by adopting an approach of everyone learning to improve in respect of people practices and embedding a just and restorative culture. Sessions led by the Deputy Chief People Officer and Associate Director of Organisational Development will take place Jan/Feb 2025 with Staff side and HR colleagues on avoidable employee harm through people practices.

- **Supporting Services and Teams –** review of Trust Workforce planning is underway and aligned to the workforce efficiencies programme that is currently in place and led by the DCPO. Comprehensive workforce planning templates will be used to shape ongoing discussions in January 2025 in respect of sustainable workforce models aligned to vision 2030 as well as operational need. HR and finance colleagues working closely on Trust workforce numbers currently.

4. Conclusions & next steps

Whilst there has been good progress against some of the priority actions, focus needs to be given now to the revised values, safety culture and the development of the new thriving metrics alongside embedding refreshed approaches linked to staff development and establishing strong partnership working to embed just and restorative people practises.

Appendix 1: One Alder Hey & Thriving Priority actions

Our Strategic Ambitions	How are we doing?	Priority Actions	Evidence of success?
One Alder Hey where everyone is included and belongs	Staff networks fully established and active Improved WRES & WDES indicators	Assess belonging across the Trust through listening events and data gathering Inclusive teams to share learning with teams who are struggling and mentor/buddy Enhance EDI training including Inclusive Leadership component of Strong Foundations Ensure that our recruitment and development practices are values-based and inclusive	Improved WRES & WDES Staff Survey Thriving Teams Index
One core set of values expressed by everybody, everyday in every interaction	Our current values are not fully owned or understood, not observable or embedded in all of our processes and practices. Our behavioural framework has become obsolete and needs revision with local ownership	Engage organisation in conversation via service based listening events around a revised set of values Develop corporate and locally "translated" behavioural frameworks to enhance meaningfulness and ownership Develop and deliver training in the new values Revise branding and make new values visible	Values are visible, usable and translated into a lived experience for everyone who works here Staff Survey data Improved safety culture indicators (Thriving Teams Index) Improved Thriving Staff Index Improved WRES and WDES

		across the organisation Incorporate meaningfully into recruitment, PDRs, job descriptions etc.	
One integrated safety culture where patient safety and staff safety are connected and viewed through a unifying restorative, just and learning lens.	Safety culture part of new Patient Safety framework Safety culture training developed and piloted in PICU Proposal for implementation across the Trust developed and being considered Restorative, just & learning approaches trialled through recent Learning Review HR policies reviewed through a restorative, just & learning lens and workshop planned to discuss Avoidable Employee Harm (AEH) and restorative, just and learning practices with HR team	Roll out Safety Culture training with Human Factors across the Trust (combining resources and expertise from the STAT programme) Define Avoidable Employee Harm in the context of all People processes and practices with a view to enhanced recognition, prevention and mitigation of risks and harms identified. Implement restorative practices into people processes Progress the development of an Integrated Safety Committee/Forum	Improved Safety Culture indicators Increased error reporting Incidence of Learning Reviews Staff and family experience of learning reviews Improved learning from errors Staff Survey Thriving Teams Index Reduced contacts to SALS and FTSU following employee investigations, organisational change processes. Reduced incidence of detriment after speaking up to FTSU

Our Strategic Ambitions	How are we doing?	Priority Actions	Evidence of success?
Thriving Leaders framework to develop and support our leaders to deliver Vision 2030	Strong Foundations reviewed and refreshed with increased capacity to train more leaders every year. New programme includes sections on Culture,	Clinical Leadership programme of work to be agreed following feedback from listening sessions at next Clinical Leaders summit	Staff Survey Thriving Teams Index Standardised leadership job descriptions with agreed set of core leadership

	Kindness and Belonging Management Essentials programme launched and being reviewed Clinical leaders listening sessions underway to inform Clinical Leadership design, development and support Operational leaders programme proposed and being scoped Internal coaching and mentoring service active Leadership induction developed including focussed leadership development conversation for all new leaders Links with NW Leadership Academy strengthened by CPO Board membership	Progress development of Operational leaders programme with key stakeholders Continue to develop the Management Essentials programme with priority focus on key HR training and EDI Develop Leadership Faculty (see Professional Hub) Embed measure of leadership in Thriving Teams Index	competencies reflecting values and responsibility in building culture
Thriving Teams Index to provide a real-time measure of team functioning to reduce inconsistencies in team	Thriving Teams MDT operational and building shared intelligence and effective intervention with teams. Currently	Thriving Teams Index to be developed to measure: Safety culture (including FTSU data); Wellbeing/stress;	Thriving Teams Index developed and used routinely by teams. Data reported to People Committee

experience and performance across the Trust	not formally reporting Working Safe & Well team temperature check developed and used by OD team as diagnostic and outcome measure for team-based interventions	Belonging (include data relating to discrimination); Engagement; and Management for sustainable engagement. Linked to relevant worforce metrics, patient experience measures and relevant qualitative data. Secure resource and capability to develop and pilot the Index	
Thriving Staff Index to provide a real-time measure of staff personal and professional wellbeing	Index developed and pilotted. Being scoped for further development by the Innovation team	Resource and capability secured to further develop the Index for full implementation in January 2025	Roll out of the Thriving Staff Index TSI response rates increasing

Appendix 2: PERSONAL & PROFESSIONAL DEVELOPMENT			
Our Strategic Ambitions	How are we doing?	Priority Actions	Evidence of success?
Development opportunities which are more personalised, more frequent and cover the whole life cycle of people's time with us, whatever their job role or level	Progress on track Enhanced programme of L&D opportunities available (now moved to BAU) Core pathways being mapped Generic support and guidance to support staff in applying for new roles / redeployment	Establishment of the Hub (virtual 24/25; physical 25/26) Detailed mapping of a number of core roles and career pathways 24/25; 25/26 Suite of clear career pathways guidance and advice in place Effective information, advice	Hub (virtual) offering IAG which is positively rated by staff (detailed metrics in development – also linked to Matrix accredidation for IAG) Increase in staff survey metrics (we are always learning) across all staff groups

	[currently being piloted] 25/26 detailed analysis of participation to inform discussion re. enhanced offer for under-represented groups Some **challenges remain** in terms of time to learn and differential in funding available by staff group	and guidance in place to support those new to the organisation and under-represented groups Expand programme of L&D opportunities	Enhanced focus on personal development within appraisals and talent conversations L&D embedded from the outset (induction onwards)
Colleagues across the organisation actively engaging in conversations about their role, their development, their ambitions and feeling supported to achieve these	Revision to TNA framework (24.25) Review of PDR process Some **challenges remain** in terms of time to learn and differential in funding available by staff group Talent management strategy required	Refreshed approach to PDRs and TNA at team and individual level Managers Toolkit reflects team and individual expectations	Enhanced focus on personal development within appraisals and talent conversations Increase in staff survey metrics (we are always learning and feeling suported) Hubusage and associated KPIs
Colleagues feeling supported to develop new skills (aligned to our core priorities/Futures) and to adopt new ways of working	Initial mapping underway Refreshed L&D programme (to reflect different ways of working) being explored Clarity required from wider leads as to the knowledge, skills & behaviours implications of new ways of working	Incusion of Futures focus in career mapping exercise 25/26 Refreshed programme which links shifts required in terms of knowledge and skills to development opportunities.	L&D offer reflects core workstreams across Vision 2030. Targeted suport for specific roles / groups

Appendix 3.

Our Ambitions	Progress	Priority Actions	Evidence of success
We are seen as a great place to work, that attracts and retains the best talent **&** **We are an exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside**	Digital capabilities have streamlined and improved transactional recruitment processes. Candidate experience is largely positive. Reductions seen in time to hire as a result of automation. These changes have now allowed for review of candidate experience	Focus on enhanced employer brand – (Vision 2030), as part of our attraction strategy. What makes us stand out from other employers (USP) – Develop Values based recruitment (Link to Culture) Develop suite of recruitment material for advertising- bespoke packages for hard to fill roles. Recruitment tailored to meet needs of those from under presented backgrounds, working with local community organisations and LCR. WRES/WDES actions to be embedded. Including removing barriers via traditional recruitment methodologies (Golden ticket – for supported interns) Review and enhance Consultant recruitment, induction and development process. Using new approach as a blueprint.	Stable turnover rates. Diverse pool of experienced candidates Positive candidate and Recruitment Manager experience. Increased % of underrepresented groups appointed. Reduced time to hire. Improved patient and colleagues experience (Staff/patient survey) Reduced Vacancy rate

A leader demonstrating best practice in people Practices. Working in partnership with staff side and unions to create a positive working environment, and adopting best people practices, thus preventing avoidable. employee harm	Policies relaunched in line with a just and restorative approach. Working closely with Staff side colleagues	The implementation, coaching and education of the people policies is crucial in creating a positive working. environment. It is therefore the vision that training and education on people practices is also undertaken in partnership, also adopting a learn & improve approach.	Reduced Grievances, Disciplinaries & ET's
Ensuring business critical roles identified, with a diverse and readily available pipeline for replacement	Job redesign/review currently in place, at point of Organisational change. Enhanced processes in respect of Job evaluation in place.	Future Talent management development Identify plans for Executive roles and critical service roles AH Community Portfolio careers (beyond retirement) Future entrepreneurs Identify future role requirements for revolutionising care.	Staff identified for all business critical roles Reduced time to hire for business critical roles Increased job satisfaction (staff survey) Workforce pipeline identified with increased stability reduced turnover

We will create new roles that focus on the skills, values, tasks and competencies to complement our existing roles to deliver future models of care. **We will ensure that delivery of the clinical strategy is underpinned by sustainable workforce models and workforce plans**	Annual operational planning in place. Development of Workforce planning templates in development to support consistent workforce plans across the Trust	Consistent methodology for developing robust plans at divisional level	Reduced Temporary and variable workforce spend

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**EAO inquest 9th- 10th December 2024 - Summary of coroner's findings and residual actions for the Trust**
Report of:	**Chief Medical Officer** **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 purpose of this paper is to provide a briefing to the Board with regard to the outcome of the inquest into the death of Eleanor Aldred-Owen following elective cranio-facial surgery at Alder Hey, including a summary of the coroner's findings and the current status of actions that the Trust is taking to address the issues identified.	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care **Support** our people **Pioneering** breakthroughs **Strong Foundations**	☑ ☑ ☑ ☑ ☑ ☑
Resource Implications:	To be identified	

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks 1.1	• Inability to deliver safe and high-quality services					3x3=9
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Purpose

The purpose of this paper is to provide a briefing to the Board with regard to the outcome of the inquest into the death of Eleanor Aldred-Owen following elective cranio-facial surgery at Alder Hey, including a summary of the coroner's findings and the current status of actions that the Trust is taking to address the issues identified.

2. Context

The Board is being provided with a detailed briefing of Eleanor's case due to the significance of the events and the profound impact that they had on not only those staff who were directly involved in Eleanor's care, but the wider organisation. Sincere personal condolences and a written apology were offered to Eleanor's parents by the Chief Executive on behalf of the Trust in March 2024. Extensive work has taken place in support of Eleanor's family in recognition of their tragic loss and in order to properly understand and learn from what happened to Eleanor. As well as a full Root Cause Analysis and action plan, a learning review has been undertaken under PSIRF to re-test the RCA by way of a detailed debrief process, including involvement from the family's advocate. Further learning has already been drawn from the inquest, as described below and a working group will now focus on additional actions associated to this.

3. Background information

Eleanor was a 21-month-old girl with a medical history of bicoronal synostosis. Eleanor was admitted to Alder Hey for elective craniofacial surgery on 29th September 2024. Eleanor had no associated medical problems or genetic abnormalities and was otherwise well. Eleanor went to theatre under the care of the craniofacial team. Eleanor's surgery (fronto-occipital advancement and remodelling) was uneventful except that Eleanor's tracheal tube dislodged toward the end of the procedure, but she was re-intubated uneventfully. Eleanor spent time in recovery when it was noted that she was tachycardic. Whilst this was expected following surgery, her persistent tachycardia was at a higher than acceptable level and she appeared pale. Blood gases were taken to assess Eleanor's haemoglobin levels, which were not concerning, but other abnormalities in the test results were not reviewed.

Eleanor was returned to the ward, despite the discharge from recovery criteria not having been met in that her observations were not in line with the normal or expected parameters for Eleanor and the cause of the persistent tachycardia had not been identified. Further investigations and clinical examination were not undertaken prior to Eleanor returning to the ward. On admission to the ward Eleanor's PEWS score did not include a score for parental concern regarding Eleanor's breathing and colour as a result an appropriate and timely clinical review and assessment of Eleanor was not triggered. A review was undertaken of Eleanor, as a result of which it was advised that AIRVO oxygenation be provided to Eleanor if required, however there was no record of this review. Eleanor was heard grunting shortly after this and AIRVO was requested. No prescription for AIRVO was in place in accordance with the hospital policy. A full medical review was not completed and a documented treatment plan was not implemented before commencing AIRVO.

Over a period of several hours Eleanor deteriorated with increased work of breathing and respiratory distress. No basic observations or a PEWS score were recorded at the appropriate time post operatively, in accordance with Trust policy. The Response Team attended the ward to check the AIRVO machine as it was alarming; this was rectified but it was noted that Eleanor was increasingly unwell. A full clinical assessment was requested, the first since Eleanor had returned from theatre. Observations recorded at this point did not reflect Eleanor's increase effort in breathing or parental and nurse concerns in relation to Eleanor's heart rate. Ward staff were advised to contact the

neurosurgeons for a review; a plan was agreed for an urgent portable chest x-ray, blood transfusion and continuous observation monitoring. The chest x-ray was grossly abnormal, but this was not raised, nor concerns escalated with any of the medical or nursing staff on the ward which meant that it was not reviewed until 40 minutes after it was ordered. Had it been reviewed sooner, the right tension pneumothorax would have been identified and treated and Eleanor would have had a greater chance of survival.

By this point Eleanor's PEWS score had increased to 8, but as Eleanor had recently been reviewed and a plan agreed and implemented, she was not reviewed at this time. The deterioration in Eleanor's condition was not escalated in accordance with Trust policy so it was not recognised that Eleanor was now in peri-arrest and required an immediate clinical review. Sadly, Eleanor then collapsed and suffered a cardiac arrest. She required full resuscitation over the course of a 20-minute period. The cardiac arrest response team were initially unaware of the grossly abnormal chest x-ray and the presence of a right tension pneumothorax. The requester of the x-ray was bleeped to urgently review the x-ray whilst resuscitation was underway, although they had received a bleep to attend a major haemorrhage on Eleanor's ward and had not received the cardiac arrest call. There was a period of approximately 30 minutes between the x-ray being taken and bilateral needle decompression being performed. Effective resuscitation was unlikely to have occurred until the bilateral needle decompression was undertaken.

There was subsequently a return of spontaneous circulation. Eleanor was then transferred to PICU for ongoing management and neuroprotective measures. An MRI scan was performed on 30th September 2023, which demonstrated some changes including in the basal ganglia, caudate nuclei and thalami. Over the course of 1st October 2023, Eleanor became progressively less stable having had an episode of supraventricular tachycardia and then became hypertensive, tachycardic with abnormal pupillary reaction. An urgent CT head scan was obtained which sadly showed catastrophic hypoxic-ischaemic change with evidence of coning. A decision was taken to withdraw care and Eleanor passed away peacefully in the arms of her parents on 2nd October 2023.

Given the unexpected nature of Eleanor's death, an inquest was ordered by the Liverpool and Wirral Coroner. Causal admissions in respect of Eleanor's death were made by the Trust to the coroner in April 2024 for the purposes of the inquest and these were shared with Eleanor's family.

4. Inquest outcome

The inquest was held on 9th and 10th December 2024, with oral evidence heard from seven Trust witnesses as well as Eleanor's parents. The coroner adjourned the proceedings until 18th December when she delivered the outcome in person.

A summary of her key findings is as follows:

There was sufficient evidence that a finding of neglect was open to the coroner in this case. It is rarely appropriate in its own right - the failure must be sufficient. Neglect carries a specific legal definition, which is failure to carry out basic care and that this more than minimally contributed to the death.

It is not the role of the inquest to criticise every element of the patient's clinical journey. However, there is a requirement to demonstrate causation based on the balance of probabilities. In order for neglect to be considered it must be established whether the individual was dependent upon those charged with their care. Eleanor was vulnerable and dependent upon the clinicians looking after her during her admission.

The coroner noted that there were a number of missed opportunities during the course of Eleanor's care:

a) Blood gas results not checked in theatre.
b) Discharge from theatre recovery to the ward was not carried out within Trust policy.
c) PEWS scores were inaccurate.
d) The grunting heard by staff on the ward was not acted upon.
e) There was no documented plan in place for the treatment by AIRVO.
f) No observations of Eleanor were recorded at key times and no PEWS score.
g) There was a delay in escalation of the x-ray result identifying the tension pneumothorax.
h) There was no escalation to a clinical team ahead of Eleanor's cardiac arrest.

The coroner stated, '*In my view there were basic omissions which amounted to gross failures*' and that on the balance of probabilities, the lack of increased vigilance and escalation likely caused or contributed to the development of the pneumothorax which led to Eleanor's death. The coroner was satisfied that the omissions in Eleanor's care did amount to neglect.

The coroner's report received on 19th December includes a detailed narrative of Eleanor's clinical course. Her short form conclusion was *Misadventure contributed to by neglect*. Misadventure is defined as the unintended consequence of an intended act, ie. on the balance of probabilities, the pneumothorax, although potentially spontaneous, arose from the fact that Eleanor had had surgery.

5. Prevention of Future Deaths

The coroner noted the Trust's thorough investigation and associated action plan as a result of this case. She referenced Mr Bass' evidence relating to the actions already taken and implemented, the learning review now underway and that further improvement measures had been taken in response and are ongoing.

The coroner noted Eleanor's parents' concerns conveyed in their evidence, in particular with regard to PEWS and the issue of escalation being addressed in the context of a proposed new national system that does not take parental concerns into account as the existing local system currently does. The coroner also noted that the Trust was part of the national pilot for Martha's Rule which has parental concern at its core.

The coroner stated that Alder Hey had done all that was possible but there may still be a national issue for all NHS acute trusts in relation to the role of radiographers in escalating clinical concerns they identify and that this should be included in a standard operating procedure. She therefore stated that her duty under Regulation 28 (Prevention of Future Deaths) was invoked at national level and she would make a report to NHS England to provide a response rather than the Trust. This was subsequently issued on 19th December 2024 with a timescale for response of 12th February 2025.

6. Trust Actions

Since Eleanor's tragic death there has been intense focus within the organisation to understand precisely what happened in this case and to take immediate key steps to prevent any similar events from occurring in the future. The Root Cause Analysis process resulted in 11 immediate actions, with a further 27 actions following review of the RCA report; all of these actions were completed within the planned timescale.

In response to evidence given and comments made during the inquest, the Trust provided further information to the coroner prior to the hearing on 18th December. The coroner noted that specifically the Trust had or are in the process of addressing the following:

- Key Trust policies have been reviewed, updated and simplified with flow charts including a new action to revisit guidelines for when AIRVO should be stopped.

- Implementation of post-op treatment plans following accidental extubation.
- Routine second clinician review in recovery.
- Ensure clarity and certainty around the decision maker when there are multiple teams involved in the care of a patient.
- Clear guidelines for bleeping the on-call surgeon/registrar when they are in theatre.
- The introduction of additional documentation post op including anaesthetic discharge.
- Established principles of core ownership of diagnostic tests lying with the requesting clinician.
- Implementation of a Radiology SOP to define the role of the radiographer as part of clinical escalation.
- Clarity on expectations of the correct use of observations and escalation in accordance with policy, particularly where the timings straddle a handover time and incorrect use scoring of PEWS is a risk.
- Care plans and plans for what should be done if there is no improvement and following further interventions/investigations should be clear – a retrospective audit of 100 post-op patients has been commissioned by the CMO to report back in January 2025.
- Training in relation to all of the above was in the process of being rolled out to nursing staff.

The coroner noted that the RCA action plan had been completed in full and was satisfied that those actions not yet fully in place will be acted upon and that the proposed internal working group will consider the findings from the inquest in detail.

7. Recommendation

The Board is asked to note the contents of this briefing and to support the further actions being taken in addition to the completed action plan in response to Eleanor's parents' comments and the coroner's conclusion.

Alfie Bass
Erica Saunders
30th December 2024

BOARD OF DIRECTORS

Thursday 9th January 2025

Paper Title:	**Chair's Report from the Finance, Transformation & Performance Committee meeting held on 16th December 2024**
Report of:	**John Kelly Committee Chair**
Paper Prepared by:	Amanda Graham, Executive Assistant

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☑
Summary / supporting information:	Finance, Transformation & Performance Committee minutes from the meeting that took place on 28th October 2024.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks	1.2, 1.3, 1.4, 3.1, 3.2, 3.4, 3.6, 4.2					
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. Introduction

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

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

- Top Five Risks update
- M8 Financial update including forecast for year end.
- 5-Year Capital Plan including CT business case & Alder Park business case
- M8 Integrated Performance Report
- Campus update

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

- Potential risk within 2025/36 Planning Guidance around ERF cap on activity from day 1 in 2025/26 – Finance team working through scenarios to assess impact.
- Cash position ahead of review by ICB – to be discussed by Non-Exec Directors ahead of January Board

4. Positive highlights of note

- Approval given to CT business case.
- Approval given to Alder Park business case.
- Operational performance is good.

5. Issues for other committees

- Cyber incident and associated mitigations to be taken to Audit & Risk Committee in January.

6. Recommendations

The Board is asked to note the Chair's Highlight report for the Finance, Transformation & Performance Committee meeting that took place on 16th December 2024.

Finance, Transformation and Performance Committee
Minutes of the meeting held on Monday 2nd December 2024 at 14:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Dame Jo Williams	Non-Executive Director	(JW)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	CEO	(JG)
	Rachel Lea	Director of Finance & Development	(RL)
	Melissa Swindell	Chief People Officer	(MS)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Katherine Allsopp		
	Nathan Askew	Chief Nurse	(NA)
	Dani Jones	Chief Strategy & Partnerships Officer	(DJ)
	Jane Halloran	Deputy Development Director	(JH)
	Emily Kirkpatrick	Deputy Director of Finance	(EK)
	Andy McColl	Deputy Director of Finance	(AMC)
	Natalie Palin	Associate Director Transformation	(NP)
	Jill Preece	Governance Manager	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Amanda Graham	Executive Assistant (*minutes*)	(AG)

24/25/122 Apologies

Apologies were noted from:

Shalni Arora	Non-Executive Director	(SA)
Audrey Chindiya	Associate Finance Director	(AC)
Gary Wadeson	Associate Finance Director	(GW)

24/25/123 Minutes from the meeting held 28th October 2024

The minutes were approved as a true and accurate record.

24/25/124 Matters Arising and Action log

Actions were either completed or on the agenda for further discussion.

24/25/124.1 Workforce Efficiency Programme

KA gave an overview of the Workforce Efficiency Programme report as at M7, noting an increase in WTE to plan which is not expected to revert next month. An extensive discussion followed around the points contained within the report, notably:

- October showed a significant rise in workforce numbers, partly due to bulk nurse recruitment.
- Strategies are in place to manage workforce efficiency, focusing on bank/agency usage and medical rostering.
- Concerns about future restrictions on bank/agency staffing and its impact on flexibility.
- Strategic focus is suggested for managing long-term workforce optimization, including potential role freezing or removal.

24/25/125 Declarations of Interest

There were no declarations of interest.

24/25/126 Top 5 Risks

1. **Immediate financial performance including system position**
   Residual pay award gap of £1.2m for the year after non recurrent funding has been received from ICB.
   The forecast for the year still remains under review, with scenarios ranging from a "most likely" to a "worst-case" scenario. The optimistic "best-case" scenario feels unachievable given the pressures outlined.
   Challenges remain in the system for the year end and discussions remain ongoing with national team with a significant reduction in WTE to meet plan by March.

2. **Capital Programme**
   Two major capital cases (CT equipment and Alder Hey Park development) are scheduled for final review by December 16.
   National capital underspends are anticipated, which might create opportunities for additional funding.

3. **Efficiency Programme**
   Forecast for recurrent delivery has reduced to £12m following review by medicine division however further work is underway. The inability to achieve these savings in-year will carry over as a £7m for the next fiscal year.

4. **Benefits realisation, governance and prioritisation of change programme to 2030**
   To be discussed under agenda item.

5. **The Campus & Park developments**
   To be discussed under agenda item.

24/25/127 Finance Report

Month 7 Financial Position

EK gave an overview of the financial position as at M7, noting the following:

- Pay award pressure in year emerged. The organisation is working to mitigate this with various measures, but risks remain.
- Updates on the capital program and CIP (Cost Improvement Plan) reveal significant challenges, with a notable shortfall in achieving recurrent savings.

Resolved:
FTPC received and noted the M7 Finance report.

24/25/128 5-Year Capital Plan

To be brought to January meeting for discussion.

Resolved:
FTPC noted that the item was deferred until January 2025.

24/25/129.a 2030: Review of Strategic Progress

RL summarised the report, noting that mapping has been done of patient segments which align with the original four areas of need using a framework and integrated with the Trust's income and cost data. From this work, a new internal dashboard has been developed segmenting all costs and activity by patient segment and allowing performance analysis in real time.

Key findings have identified the costlier but high-income work within Personalise My Care, that Get Me Well is the strongest financially performing area and there are

potential growth areas within Improve My Life Chances through preventative care and hosting networks. Bring Me The Future is currently limited to research and innovation, with expansion expected as programmes develop.

Finally, focus will shift to delivering tangible benefits from next year's transformation programs and creating the structured approach required to ensure the Trust can manage its financial challenges while evolving to manage the changing needs of patients.

JK asked that discussion be held outside the meeting to clarify details.

24/25/129.1 Action: RL

Resolved:
FTPC received and noted the report on Strategic Progress

24/25/129.b 2030: Shape of AH

NP gave a presentation, sharing an overview of progress following recent benefit review and stock take processes which have evaluated progress, ensured alignment, and measured impact. There is a focus on continuous learning to refine approaches and avoid past mistakes.

Key outcomes include identifying strengths such as a strong governance framework, operationally embedded patient-centric approach and notable programme success for both children & young people and staff.

There are several areas for improvement, namely better prioritisation of high-impact areas, addressing resource limitations and shifting from piecemeal changes to broader transformations across the whole organisation.

Next steps are to use a forthcoming Board session to validate plans and refine ambitions based on these reviews and to continue embedding a focus on scalable, high priority initiatives to drive forward transformation across the Trust.

Resolved:
FTPC received and noted the presentation on 2030: Shape of AH.

24/25/130 Month 7 Integrated Performance Report

AB gave an overview of the IPR as at M7, and highlighted the following:

- Strong performance in elective and diagnostics activities.
- High ED attendance (10% increase year on year) and RSV surges impacted emergency services, with the hospital at capacity on several occasions but with no elective cancellations on those days.
- Nationally critical care has been at 105% capacity.
- Improvements in metrics such as those for elective cases per clinician, elective & day case activity and diagnostic wait times were highlighted as positives.

Areas that continue to be reviewed and supported include seeking additional capacity in neurodiversity pathways and exploring new digital systems in pharmacy.

JW asked whether the ENB predictor tool is a benefit; AB agreed to follow this up across other services.

24/25/130.1 Action: AB

Resolved:
FTPC received and noted the M7 Integrated Performance report.

24/25/131 Corporate Division

EK presented an overview of Corporate Services position as at M7 with ES, LS & KB contributing, noting the following:

- Year-to-date overspend in several areas (Academy, Digital, Exec, HR, Facilities).
- Notable underspend in Finance, Strategy, and Medical Services.
- Positive progress on achieving savings, with 94% of corporate target delivered.
- Legal fees for employment tribunals and healthcare inquests continue to strain the budget. Discussions emphasised the value of balancing legal expenditures and early settlements where feasible, in line with NHS guidance.
- Facilities are holding a number of pressures and challenges across the department, notably within Catering, Car Parking and Uniform & Linen, with potential mitigations being developed.
- Apprenticeship levy cost pressures are due to its linkage to the pay bill, with inaccurate forecasting resulting in unexpected budget strains.
- Overspend has been noted for consultant posts linked to education and training; however, funding gaps exist when the core education budgets do not fully cover mandatory requirements.
- Reduced conference & event income is due to service pressures and broader factors impacting conference viability.

Resolved:
FTPC noted the positive areas and challenges within the Corporate divisional update.

24/25/132 Liverpool Neonatal Partnership

CL gave a brief overview of progress of the NICU / SDEC development, noting that completion dates are still on track for Autumn 2025 for both areas, despite some challenges and potential delays due to design changes. Financial workshops are being held to explore capital expenditure, potential charity contributions and avoid further shortfalls.

Resolved:
FTPC received and noted the Liverpool Neonatal Partnership report.

24/25/133 Campus update

JH shared the Campus update, highlighting the following points:

- Progress is on track for December completion of Phase 3 of the Park, with a Council walkabout scheduled to pre-check phases one and two of the playground before handover.
- Focus is moving towards master site planning and lessons learned for future large schemes for 2030 and beyond.
- Post project evaluations are underway.
- Net Zero and Green Strategy work is ongoing and future reporting will include these as well as construction updates.
- The elective surgical hub is holding risks around the indicative costs & programme and new Building Safety Act regulations. Mitigations are being developed and all parties informed.

Resolved:
The FTPC received and noted the Campus update report.

24/25/134 **Digital Update**

KW gave a brief overview of the recent cybersecurity incident.

Resolved:

FTPC noted the Digital update.

24/25/135 **Procurement Update**

To be brought to January meeting for discussion.

Resolved:

FTPC noted that the item was deferred until January 2025.

24/25/136 **Board Assurance Framework**

The BAF report was included in the meeting pack and taken as read. ES & KW are working on communications regarding cybersecurity issues. The digital risk score has been updated in light of recent events, and actions related to cyber risk are being incorporated into strategic reviews.

Resolved:

FTPC noted risks recorded within the Board Assurance Framework.

24/25/137 **Any Other Business**

Occupational Health Provider Contract – KA noted that the tender process for OH services is now complete and approval was requested for the new supplier,

24/25/138 **Review of Meeting**

The Chair noted ongoing financial pressures despite operational successes, emphasising the need to monitor and address these financial challenges to avoid falling into any compliance issues.

Date and Time of Next Meeting: Monday 16th December, 3pm via Teams.

24/25 FTPC Key Risks – Month 8 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M8
Financial Performance including system position	Challenging 24/25 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	Month 8 position reported £0.1m favourable to plan in month and a £0.6m deficit to plan ytd. In month medicine and surgery were off plan, however this was offset by community and corporate underspends, and technical benefits (circa £0.8m) supporting the position. Forecast for year remains in line with plan £3.3m, however this now includes stretch of £1.2m to mitigate pay award risk. It is unlikely that ambition to go £1m further than plan will now be possible given pay award pressure. A number of mitigations are being explored, including finance improvement workstreams (workforce, drugs, coding) as well as increased technical improvements, income opportunities and programme/vacancy slippage giving the trust assurance to continue to report a forecast to plan at ICB level. If divisional positions continue to deteriorate additional grip and control may be required to hit plan. System gap remains with ongoing national discussions . Weekly gold command now in place FICC return from all providers.	High
Capital Programme	Limited CDEL allocation in 24/25 Significant capital investment required and prioritisation required.	Medium	Capital Management Group continue to provide oversight for 24/25. 2nd CT and Alder Park redevelopment business case included in the papers. Paper submitted to execs on 11th Dec to request drawing forward some Medical Equipment spend from 25/26 (end of life and service) in order to mitigate risk of underspend of CDEL if national funding is forth coming, or there is slippage in build programmes. Some head room (circa £0.8m) created by loss on disposal of IT assets in year (disposal of assets with NBV). National funding recently made available for bids that fit certain criteria (e.g. revenue reduction, decarbonisation or national programme at risk). Number of requests submitted – currently awaiting outcome. TIF bids for 25/26 are also being requested.	Medium
Efficiency Programme	Plan assumes delivery of £19.3m recurrent savings. Highest level set in any one year. Managing of message to organisation alongside delivery of 2030 vision.	High	M8 reporting in line with plan and forecast to achieve in full in year. Recurrent CIP forecast now stands at £13m (green and amber schemes) significantly higher than previous year achievements. Planning underway for 25/26 CIP development	Medium
Benefits Realisation	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	Medium	We have completed a stock-take on our approach to 2030 delivery and the results from the which have been reviewed alongside the benefit review and assessment on our delivery milestone.	Medium
Campus	Complex campus programme across multi sites.	Medium	All schemes progressing as detailed in the Campus Update within the full Committee pack. Two risks are highlighted for the attention of Committee members in relation to construction completion dates for Elective Surgical Hub and Alder Park (EDYS).	Medium

BOARD OF DIRECTORS

Thursday, 9th January 2025

Paper Title:	**Board Assurance Framework (BAF) Report November 2024**
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:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **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 November 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 2024/25

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 15 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	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Finance, Transformation and Performance Committee
1.4	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.5	Lack of visibility at Board level across the Gender Service	Trust Board
1.6	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board
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	People 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 Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	Finance, Transformation and Performance Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	Finance, Transformation and Performance Committee
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	Finance, Transformation and Performance 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	Futures Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Finance, Transformation and Performance Committee

3. Summary of the BAF at 11th December 2024

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	FT&P / SQAC	**4x5**	3x3
1.3 AB	Building and infrastructure defects that could affect quality and provision of services	FT&P	4x3	2x3
1.4 LC	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	FT&P / SQAC	**3x5**	3x3
1.5 LC	Lack of visibility at Board level across the Gender Service	Trust Board	4x2	4x1
1.6 LC	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board	**4x4**	4x2
STRATIC OBJECTIVE: 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.	People Cttee	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	People Cttee	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	FT&P	4x2	3x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	FT&P	4x3	4x2
3.4 JG	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	FT&P	**4x4**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	**4x4**	3x3
STRATEGIC OBJECTIVE: Pioneering breakthroughs				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Futures	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families ***(score increased in month)***	FT&P	**4x4**	2x4

4. Summary of November 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk 1.1 has been updated to reflect some of the emerging 2030 strategy work programme. IV antibiotic administration has improved but will remain on the BAF pending further improvement. Gaps and control in assurance have been reviewed.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  All actions reviewed but are longer term therefore no change this month.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Review of BAF risk and actions completed. Work remains ongoing to support children & young people to access medication despite national shortages. Ongoing discussion with executive team regarding support needed.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  The Trust is focused upon achieving the 78% 4 Hour access standard within ED. Whilst October, and YTD, has been positive, November has been challenged with a significant increase in attends, which led to a performance of 73.6%

  The trust achieved the national target of 95% for DM01 compliance in November. This was due to continued monitoring, additional activity, and targeted clinical validation of patients awaiting a sleep study.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. Whilst the trust had zero patients waiting longer than 78 weeks in November, there was 10 patients waiting over 65 weeks at the end of the month; four for a complex patient, four for patient choice (all eight are dentistry) and one due to capacity issues within Rheumatology. The Trust is focused on sustaining zero patients above 65 weeks, and working towards the Cheshire & Merseyside ICB ambition to have zero patients waiting over 52 weeks by end of March 2025.

- ***Building and infrastructure defects that could affect quality and provision of services (AB).***
  An updated report is due to be received confirming red and amber status of corroded pipework repairs. This will be uploaded to the risk as soon as it lands. Further information on full resolution has been requested.

  Internal AH staff pipework meetings have also taken place.

  Out-of-range water temperatures continue to be monitored and local mitigations are in place such as filters on water outlets. Booster pumps installed on the hot water system have proved effective and this will now be discussed as to introduce to cold water.

  Dosing system is now on hold due to improved controls.

  Five chillers in operation out of six. Awaiting details of fully commissioned sixth unit.

- ***Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (LC).***
  BAF risk reviewed and actions updated as required. Issues relating to MHSDS and reporting remain the same and are not resolve, agreed with relevant exec director that a priority for action and divisional will support with additional funding for a temporary post to resolve. Temporary post within Digital team in place and weekly meetings to monitor progress.

- ***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 reviewed, actions on track and aligned to priorities set out in the people plan 2030. No current change to risk score.

- ***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 all controls and actions reviewed and updated. No change to risk rating

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risks reviewed. Actions on track and progress being made.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed - no change to score. Phase 1 and Phase 2 works complete. LCC site walkabout 10.12.24 to view completed works. On target to complete phase 3 in line with Dec 2025 target date.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (KW).***
  The position remains static but may change follow the Strategy refresh.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (JG).***
  Risk reviewed with no changes to the risk score. A deep dive into the current year financial position and forecast is to be reported at FTPC in December with a clear assessment of any risks to delivery noting the recent pay award and divisional pressures from M8. SDG is continuing to focus on 4 key areas and development of controls and parameters to further strengthen financial performance. Annual planning for 25/26 is underway pending national planning guidance with reporting timetable for Q4.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; no change to score in month. Controls and actions reviewed and updated.

- ***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).***
  All actions reviewed and updated including completion of actions associated with commercial research portfolio. Investment Zone application remains under review. No change to risk score in month.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  In light of recent Cyber issues, the risk rating has been increased. A robust Cyber Hygiene plan and checklist is currently being worked through to improve resilience. Long term cyber plan and resource will need also need a thorough review as the threat of attack increases. Plans underway to improve user experience in Outpatients. AlderCare stabilisation phase drawing to a close with plans for 2025 being finalised.

5. Corporate risks (15+) linked to BAF Risks (as at 2nd December 2024)

There are currently 22 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
2450	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	2.1	Jul 2021	Mar 2024
2635	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services ***(NEW)***	4x4	Medicine	2.1	May 2022	Oct 2024
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4	Dec 2019	*Apr 2023
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Business Support	2.1	Jan 2020	*Apr 2023
2487	Disruption in patient's supply of medication and / or treatment	4x4	Community		Apr 2023	July 2024
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	4x4	Surgery	3.4	Aug 2022	Feb 2024
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	Aug 2022	Jan 2024
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service	4x4	Medicine	2.1	Feb 2023	Oct 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	could have a significant impact on the health and wellbeing of the IR Consultant currently in post.					
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	2.1	Apr 2023	June 2024
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	2.2	Feb 2023	*Apr 2023
2290	A child may be harmed in the process of holding them to complete an intervention anywhere in the Trust	4x4	Business Support		Oct 2020	Sept 2024
117	Safe follow up care	4x4	Business Support	1.2, 2.1 & 2.2	Dec 2023	Dec 2023
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.6	Jun 2024	Jun 2024
253	Loss of GRID posts	4x4	Business Support		Sept 2024	Sept 2024
2606	Children at risk of a decline in clinical condition requiring Emergency Department attendance and/or Hospital admission	3x5	Community		Apr 2022	Sept 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	2.1	Oct 2022	Sept 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support	1.2, 2.1 & 2.2	Feb 2024	Feb 2024
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties	3x5	Business Support		Mar 2024	Mar 2024
189	EPRR Assurance Non-Compliance	3x5	Business Support		Jul 2024	Jul 2024
271	Safeguarding Nursing Team Capacity ***(NEW)***	5x3	Community	2.1	Nov 2024	Nov 2024
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	Jul 2021	*Apr 2023
117	Safe follow up care	4x4	Business Support	1.1, 2.1 & 2.2	Dec 2023	Dec 2023
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (3x5=15)						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1	Dec 2019	*Apr 2023
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2	Jul 2021	*Apr 2023
1.5 Lack of visibility at Board level across the Gender Service (4x2=8)						
	None					
1.6 Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (4x4=8)						
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.2	Jun 2024	Jun 2024
STRATEGIC OBJECTIVE: 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)						
2450	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	1.1	Jul 2021	Mar 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	1.1	Oct 2022	Sept 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
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	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.2	Dec 2023	Dec 2023
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	1.1	Apr 2023	June 2024
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Business Support	1.1	Jan 2020	*Apr 2023
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post.	4x4	Medicine	1.2	Feb 2023	Oct 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2635	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services ***(NEW)***	4x4	Medicine	1.1	May 2022	Oct 2024
271	Safeguarding Nursing Team Capacity ***(NEW)***	5x3	Community	1.1	Nov 2024	Nov 2024
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)						
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
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	Feb 2023	*Apr 2023
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	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.1	Dec 2023	Dec 2023
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)						
	None					
STRATEGIC OBJECTIVE: 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 Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (3x4=12)						
	None					
3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x4=16)						
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Programme	4x4	Surgery		Aug 2022	Feb 2024
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: 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)						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (3x4=12)						
229	PIMP end-of-life server which is no longer supported by the supplier ***(NEW)***	4x4	Business Support		Jul 2024	Sep 2024

* risk movement data not available pre-move to InPhase

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	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

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.

Dec 2024	
Control Description	Control Assurance Internal
Monitoring of KPIs at SQAC and within divisional governance structures	Monitored monthly through SQAC
The Trust has a quality improvement programme 'Brilliant Basics', where quality improvement is at the heart of everything we do and provides staff with the skills, knowledge and confidence to learn, lead and deliver in an improvement style.	Formal and informal training and coaching available to support departments to make positive changes. Outcomes shared through the SharePoint site and reported to board bi-annually against agreed plan.
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
Proactive programme of work to reduce medication errors	Monitored via Patient Safety Board

Gaps in Controls / Assurance

1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis
2. Robust Programme in the number of medication incidents and near misses
3. Compliance with Ionising Radiation (Medical Exposure) Regulations 2017
4. The CQC will move to a new oversight framework which may reduce our CQC ratings

5. The 2030 vision sees a shift to a consumer focussed experience with 5 workstreams with key deliverables for year 1, without any additional resource
6. The new models of care workstream will need to redefine the delivery of services whilst maintaining the principles of the strategy
7. Alder Care (Expanse) has been implemented across the organisation which poses risks until stabilisation.

Action	Description	December 2024	
		Due Date	Action Update
7. Alder Care (Expanse)	7. The risks to quality and safety need to be monitored during the period of stabilisation	30/11/2024	No further controls required, monitoring controls are in place.
1. 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.	31/03/2025	There has been improvement in administrations times which continue to be monitored through SQAC to embed improved performance.
3. Compliance with Ionising Radiation (Medical Exposure) Regulations 2017	3. Working Group formed to review the recommendations from the CQC Inspection of the nuclear medicine department	12/12/2024	
2. Medication Errors and Near Misses	2. Proactive programme of work in place to reduce medication errors	31/03/2025	Monitoring control in place – no further controls required
4. New CQC Assessment Framework	4. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2025	Monitoring control in place – no further controls required
6. New Models of Care	6. Clinical leaders will need to be appointed to oversee the process and provide challenge on the principles of the strategy	31/03/2025	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	Outstanding care and experience

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Responsive		Adam Bateman

Risk Rating		
Actual	Target	Assurance Committee
20	9	Finance, Transformation & Performance 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.

Dec 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 reports to Operational delivery group -@ Performance reports to FTP 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 FTP 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 SAL T -@ Corporate report and divisional Dashboards -@ Performance reports to FTP 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	
Control for overdue follow up – Working Group established which focus on eliminating patients waiting over 2 years past their intended review date by March 25	Fortnightly meeting - Group has created a process for recording clinical validation and automated part of the process to reduce workload - follow up dashboard created on power bi and specialty data packs created - Specialties with the highest volume will present to safe waiting list programme board.

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	December 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	30/09/2024	Deadline extension to achieve zero 65 weeks extended by NHSE to 30th September 2024. Vast majority of services have already reached this target but concern remains in Paediatric Dentistry and Paediatric Neurology. Whilst there is capacity in dentistry within the month of September to meet target there is a risk due to to patient cancellations or was not brought that the target may not be met. Within the Paediatric Neurology service there are concerns regarding capacity which are being reviewed by the service, currently a risk of 7 patients not meeting the 65 week target.
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
Follow up working group	Aim: zero patients waiting >2 years for a follow up appointment by March 2025. Tasks: Submit paper to request funding to undertake clinical validation – complete, funding granted. Follow up dashboard to track progress – in development. Specialty specific action plans to achieve zero patients waiting over 2 years for a follow up. Specialties with a high volume are due to present at safe follow up programme board.	31/03/2025	

Building and infrastructure defects that could affect quality and provision of services

Risk Number	Strategic Objectives
1.3	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

Risk Rating		
Actual	Target	Assurance Committee
12	6	Finance, Transformation & Performance Committee

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

Dec 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 (FT&P)	Monthly report to FTP 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	December 2024	
		Due Date	Action Update
Corroded pipework report	from Project Co on corroded pipe work and plans to resolve.	30/11/2024	Reports continue to be received from Project Co on the current status. These reports will continue until a permanent solution is agreed. I have extended the date range for completion. A board to board meeting was held on the 5th June where option where discussed with Exec reps.

Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies

Risk Number	Strategic Objectives
1.4	Outstanding care and experience

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

Risk Rating		
Actual	Target	Assurance Committee
15	9	Finance, Transformation & Performance Committee

Description

Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies.

Dec 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 Place and approved. This is now being fully implemented.	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	December 2024	
		Due Date	Action Update
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting.	31/01/2025	Extended date due to MHSDS work ongoing.
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/12/2024	email sent 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
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/03/2025	

Lack of visibility at Board level across the Gender Service

Risk Number	Strategic Objectives
1.5	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
Safe Responsive		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
8	4	Trust Board

Description
The role of host/contract holder of the Children and Young People's Gender Service (North West) presents a wide range of risks which could impact the organisation in terms of clinical quality, service and corporate capacity reputationally and financially.

Dec 2024	
Control Description	Control Assurance Internal
Dedicated communications lead and communications plan in place to manage internal and external communications and media.	Internal and external communications plan
Monthly Operational and governance meeting to be in place to review service delivery and escalate key issues to Division and Trust Board.	Divisional governance meeting minutes
All identified risks within the Gender Service are reflected on the risk register. Appropriate controls and actions are in place and are reviewed on a fortnightly basis with Gender Service Senior Leadership Team.	risks on InPhase being managed closely
Regular operational performance report (to be further developed as the service embeds) to SQAC	Operational Performance Reporting
Regular reports to Parts 1 and 2 of Board from Director Community & Mental Health Services on development of the GDS within Alder Hey and nationally, and on the relationships with other providers	Board reports received

Gaps in Controls / Assurance
o Extensive media attention o Risk of involvement with a range of legal proceedings o Unknown changes or asks to the service

Action	Description	December 2024	
		Due Date	Action Update
Escalation of Key Issues to Divisional Integrated Governance Meeting	Key Issues to be reported to Divisional Integrated Governance Meeting on a monthly basis.	25/06/2025	reporting into Divisional Integrated Governance to be embedded.
Annual Review of Gender Service to Board	Provide an annual review of Gender Service to Board / SQAC to consider learning from current and prior years to identify potential changes in treatment pathway and follow up of prior CYP to understand if they subsequently dropped out of the service or transitioned / de-transitioned and potential learning from this.	15/10/2025	
Comprehensive suite of KPIs to be developed	Comprehensive suite of KPIs for GDS to be developed and reported to Board / SQAC including: demographics or referrals (1), compliance with services specification relating to number of appointments / interventions and time taken (2), compliance with the % drop out rates at the various assessment stages in the service specification (3), any contact from external activists / pressure groups (4), trends in active caseload and waiting list size (5), referrals to research trials, income/expenditure v budget (6), complexity of cases (e.g. what % have eating disorders, ASD/ADHD/OCD (7), details of % staff time spent inside / outside of the service by individual (8), gap between appointment versus service specification requirements (9), compliance with data recording requirements (10).	30/09/2025	

Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.

Risk Number	Strategic Objectives
1.6	Outstanding care & experience

CQC Domains	Linked Risks	Owner
Effective Safe Responsive		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
16	4	Trust Board

Description
Risk that ADHD treatment will be interrupted due to unavailability of the prescribed medication, that commencement of ADHD treatment is delayed due to unavailability of medication and waiting times for assessment will increase, due to workforce being deployed to support the safety of prescribing activity.

Dec 2024	
Control Description	Control Assurance Internal
High frequency huddles established with ADHD nurse team/developmental peadiatrics/pharmacist/prescription team/operational management.	
Move to generic prescribing of Methylphenidate	
Move to one item per FP10 so that partial fulfilment is possible.	
Prescribing 30 day's supply rather than 90-day supply for the affected ADHD preparations	
Alder Hey external website updated to reflect the information we have.	
Dedicated queries phone line established with a daily rota of ADHD nurse to support.	
Registered with specialist pharmacy service, supply tool to gain direct intelligence Shortage of Methylphenidate prolonged-release tablets - SPS - Specialist Pharmacy Service - The first stop for professional medicines advice	

Gaps in Controls / Assurance
• A shortage of raw ingredient • Issues with manufacturing across Europe • Significant (unexpected) increase in demand since 2020

Action	Description	December 2024	
		Due Date	Action Update
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	30/06/2025	
Risk 236 - Action 2	Increase capacity to the prescription rota to cover the additional work.	31/12/2024	This work continues as the medication shortage continues. More nurses have now completed their V300 training and will be ready to support the rota by February 2025. Pharmacy technician is being recruited to support the advice and guidance and support elements of the prescription rota.
Action 9	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary.	30/09/2024	Ongoing
Risk 236 - Action 6	Plan for a “Super Saturday” with clinical teams and Pharmacy	31/12/2024	Some challenges regarding the availability of medics to support additional Saturday clinic. Also further review of records as needed as medication type in short supply has now changed so different cohort requires follow up.
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	31/10/2024	Medication shortage continues; still reviewing this weekly (not on a daily basis). This is because all other stocks of ADHD medications are now at sufficient supplies within our area. 12 hour medications prep still unable to obtain supplies, Alder Hey ADHD CYP being moved over to different medications. Currently no end date.

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	Support our People

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

Risk Rating		
Actual	Target	Assurance Committee
12	6	People Committee

Description

Failure to maintain a suitable workforce which impacts on the trust’s ability to deliver high quality care for children and young people.

Dec 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 intranet
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 PC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PC 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 PC
Nursing Workforce Report	Reports to PC, SQC and Board
Nurse Retention Lead	Bi-monthly reports to PC
Recruitment Strategy currently in development	progress to be reported PC
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
Ensuring we have inclusive practices embedded throughout the organization, is addressed in the People plan 2030	

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	December 2024 Due Date	December 2024 Action Update
1. Not meeting compliance target in relation to some mandatory training topics	Head of L&D has a full action plan in place to increase compliance across the organisation and this is supported by the Academy Director	31/03/2025	Mandatory training activity is monitored by Education Governance Committee as a standard agenda item. As at May 24 overall trust compliance was 93.00%. Areas of concern are highlighted, discussed and supported with subject experts. The current area under review is SEPSIS.
2. Sickness absence levels higher than Trust Target	Ongoing interventions remain in place to support the management of sickness, however until the absence has had a sustained reduction it will continue to be monitored as a risk impacting on this overall BAF Risk.	31/03/2025	
3. Future Workforce	3. Review of skill mix, talent and succession planning across the organisation against full demographic analysis. Annual operational plans are in place, Establishment control in place.	31/03/2025	Establishment control project close to completion before commencing the wider workforce planning project
4. Lack of Robust talent and succession planning	The next stages of the People Plan and key deliverables for 24/25 were presented to Trust board on 6th June 2024 and the plan approved. The plan requires key strategic areas of focus, one of those three areas is the development plans for Future workforce. Succession and Talent management is a workstream that sits beneath this strategic initiative. HR, OD and Academy will work together to review skill mix, talent and succession planning, prioritising those areas were there is the most need over the next 12 months.	11/06/2024	
5. Lack of a robust Trust wide Recruitment Strategy	The next stage of the people Plan 24/25 there is a key work stream related to the Future Workforce, which addresses accessible and diversified recruitment and the Trust recruitment strategy. This action is addressed through the 24/25 People Plan.	31/03/2025	Action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased. A Business Case has been shared with Exec Team - outcome awaited.
6. Lack of inclusive practices to increase diversity across the organisation	A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes.	31/03/2025	

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	Support our People

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

Risk Rating		
Actual	Target	Assurance Committee
9	4	People Committee

Description

Failure to develop and sustain an organisational cultural that enables staff to thrive and deliver outstanding care to children and families.

Dec 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to PC
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PC (agendas and minutes)
Values and Behaviours Framework	Stored on Trust Intranet and accessible for staff
People Pulse results to People and Wellbeing Committee quarterly	PC reports and minutes
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	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 PC as part of the People Paper
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PC
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 PC bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PC
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	December 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. Thriving staff index and Thriving Teams Index to be developed.	31/03/2025	Draft People Plan presented to October Board with agreement for priority actions for 25/26 to include development and roll out of Thriving Staff Index and Thriving Teams Index. Capability and resource to be scoped for both in discussion with Innovation Team (Futures).
Culture strategy development to include governance framework culture work	Culture strategy to be developed and to include review of governance framework and reporting processes for culture work including via Patient Safety Strategy Board and People Committee. supporting	16/12/2024	Culture presentation given at June Trust Board and broadly supported with agreement to move into next steps/agreeing and defining actions. Further meeting to be held with MD and CPO to agree actions with comms and engagement plan. Will inform reporting.
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	31/03/2025	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 steps in terms of building capability across HR and other supportive People functions.
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.	29/09/2025	No further progress with this action. Proposal still with execs and resource to be agreed for the delivery of the training. Meeting held to look at integration of safety culture training and STAT programme running in theatres. Further meeting to be arranged by Patient Safety lead to be confirmed
Thriving Leaders framework	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focused review and development and Operational Leaders programme.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.	31/03/2025	Clinical leads listening session complete and feedback to be presented at Clinical Leads Summit on 15th Nov with a view to agreeing next steps in consultation with clinical leads. Management essentials session reviewed with plans for further development of the programme agreed.
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.	31/03/2025	Draft People Plan presented to October Board with proposal to undertake values work as priority action 25/26 to support Vision 2030. Work to be scoped as part of new culture workstream (One Alder Hey).
Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training.	31/03/2025	Avoidable employee harm session delivered to senior HR colleagues on 9th October to discuss this concept and reflect together on how we need to develop as an organization to understand and minimize the risk of harm to employees that can come through people and change practices/ Agreed to run a second workshop with case examples on 13th November and then agree next steps in terms of implementation of this approach in policy and practice.

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation

Risk Number	Strategic Objectives
2.3	Support our People

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

Risk Rating		
Actual	Target	Assurance Committee
12	4	People 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

Dec 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	Mandatory EDI Training for all staff. current compliance 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	
People Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PC
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	monitored through PC
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 PC.
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 PC.
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 PC
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 Committee

Gaps in Controls / Assurance

1. Multi-factoral issues spanning training and education
2. Sufficient EDI resources to support the EDI agenda
3. Cultural awareness and understanding

Action	Description	December 2024	
		Due Date	Action Update
1. Multi-factoral issues spanning training and education	Education and training programme launched. Conversations underway to implement EDI training as mandatory	13/12/2024	
2. Sufficient EDI resources to support the EDI agenda	Business case for additional resource to be developed.	08/11/2024	
3. Cultural awareness and understanding	Programme of awareness in train including establishment of Staff Networks, devoted sessions at 'Ask the Execs'. Regular commutations, atrium events, celebrations and awareness raising emails issued to all staff.	31/03/2025	

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus

Risk Number	Strategic Objectives
3.1	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Responsive		Rachel Lea

Risk Rating		
Actual	Target	Assurance Committee
8	6	Finance, Transformation & Performance 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

Dec 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 FTP 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 FTP via Project Update
Monthly reports to Board & FTP	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. Park Handover
3. Weather conditions causing potential delays

CAMPUS:
1. Stakeholder Engagement
2. Successful realisation of the moves plan.
3. Funding availability and potential market inflation.

Action	Description	December 2024	
		Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	30/11/2025	Meetings will continue with LCC until full legal agreement of transfer of Park to the Council.
Adoption of the SWALE by United Utilities	Engaged with planning consultants to assist with planning requirements.	09/05/2024	
Funding availability and potential marketinflation	Continual monitoring of market inflation	30/04/2025	Regular updates continue to be provided to FTP and Trust Board as appropriate
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	30/04/2025	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves: 1) Vacate 3SM & move staff to former police station and other (Summer 2024) 2) Vacate Histopathology and mover staff to alternative accommodation (Winter 2025)	28/02/2025	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell
Weather conditions causing potential delays	Dry season now upon us – all works now in accordance with revised programme and on target.	30/11/2024	

Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan

Risk Number	Strategic Objectives
3.2	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Kate Warriner

Risk Rating		
Actual	Target	Assurance Committee
12	8	Finance, Transformation & Performance 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.

Dec 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. 2030 delivery programme and plan in development
2. Failure to develop capacity for delivery
3. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy
4. Failure to deprioritise to enable requisite focus on areas of need and transformational change
5. Risk of 'mission creep' associated to the Strategy

Action	Description	December 2024	
		Due Date	Action Update
1. 2030 delivery programme and plan (24/25) .	The Annual Plan / Strategic Plan for 24/25 was approved April 24. The strategic delivery of the programmes has formed the basis of the plan, which is monitored through Vision 2030 Programme Board, FTP and Trust Board	31/03/2025 31/03/2024	
2&3 Developing skills and capacity to deliver the Strategy 2030	This approval of the People Plan on 24th September by the Trust Board marks a significant milestone in ensuring we understand the skills and capabilities needed for our Future Workforce 2030. The upcoming phase in our strategic plan, Shape of Alder Hey 2030, will further allow us to access the broader skills and capabilities our workforce will require to meet future needs.		
4. Failure to deprioritise to enable requisite focus on transformational change	Focus on transformational chance	12/12/2023	
5. Risk of mission creep associated to the Strategy	Sharp focus at Strategy Board on core mission	12/12/2023	

Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments.

Risk Number	Strategic Objectives
3.4	Collaborate for children & young people

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

Risk Rating		
Actual	Target	Assurance Committee
16	12	Finance Transformation & Performance Committee

Description

Failure to meet financial NHSI/E targets. Inability to invest in the capital programme.

Dec 2024

Control Description	Control Assurance Internal
Organisation-wide financial plan.	Monitored through IPR and the monthly financial report that is shared with FT&P and Trust Board.
NHSi financial regime, regulatory and ICS system.	- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FT&P) - Attendance at ICB DoF Group
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, FT&P, and trust Board -@ Financial recovery plans reported through SDG and FT&P -@ 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. Updated 5 year capital plan shared with FT&P and Trust Board.
Divisional performance discussed at FT&P with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through FT&P with divisional leads ('3 at the Top')
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / FT&P and SDG for the relevant transformation schemes.
FT&P deep dive into any areas or departments that are off track with regards to performance and high financial risk area	FT&P Agendas, Reports & Minutes
Financial Review Panel Meetings	Any area/division that is off plan is expected to attend a financial review panel meeting with DOF with action plan detailing mitigation to bring back into budget.
Financial Improvement - SDG Meetings - Oversight of Plan delivery	Minutes from SDG

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. Funding models not aligned to 2030 creating a shortfall.
6. Deliverability of high risk recurrent CIP programme
7. Increasing inflationary pressures outside of AH control
8. Divisional budget positions are not achieved due to emerging cost pressures and impact of Industrial Action.

November 2024

Action	Description		
Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan.	31/03/2025	
Delivery of 5 year programme	4. Risks around Capital Plan to be monitored	31/03/2025	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 FTP and TB once full risk is known.
Devolved specialist commissioning	3. Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk	31/03/2025	
High risk recurrent Efficiency programme	6. Transformation efficiency schemes now in place and monitored through Sustainability Group to ensure financial saving captured.	31/03/2025	
Inflationary pressures	. 7. Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.		
Shortfall against Long Term Financial Plan	5. Long Term Financial Plan to be updated for latest position and to take us to 2030 as part of financial strategy.	31/03/2025	
Underfunding of Long Term tariff arrangements for complex children	2. Regular reporting to strategic execs and assurance to FTP and Trust Board. Use of SLR and PLICS to understand tariff shortfall and reasons and then build case for discussion with commissioners.	30/09/2024 31/03/2025	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.

System working to deliver 2030 Strategy

Risk Number	Strategic Objectives
3.5	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

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.
Risk of lack of focus on CYP agenda in febrile system environment; leading to lack of pace, resource and investment.

Dec 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. System finance and productivity challenges creating risk of short notice reprioritisation of system level work and resource

Action	Description	December 2024	
		Due Date	Action Update
1. Uncertainty over future commissioning intentions	Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services.	31/03/2025	Continual influencing of commissioning priorities to align with AH Vision 2030 ambitions e.g. Place priorities, C&M CYP Committee priorities, influencing NHS 10YP at National Level
2. Future delegation of Specialist Commissioned services into ICSs	Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2025	Delegation in shadow form of specialised services completed into ICBs. NW Joint Specialist Committee established – leadership via 3 x ICB CEOs. Low emphasis on specialist services in current NHS policy / 10 year plan development – however Alder Hey and Children's Hospital Alliance incorporating clear asks pertaining to acute CYP illnesses into 10YP engagement process.
3. Executing the comprehensive Stakeholder Engagement Plan	Complete partner engagement	01/10/2024	
4. National mandates forcing us to prioritise unexpected programmes of work	Horizon scanning	31/03/2025	Formal contribution to NHS 10 YP development on behalf of both Trust and CYP being undertaken by Chief Strategy Officer and Policy Lead/Advisor to CEO – in order to optimise reference to CYP and AH priorities within 10YP.

Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact

Risk Number	Strategic Objectives
4.1	Pioneering Breakthroughs

CQC Domains	Linked Risks	Owner
Well-Led		John Chester

Risk Rating		
Actual	Target	Assurance Committee
9	6	Futures 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.

Dec 2024

Control Description	Control Assurance Internal
Finance, Transformation & Performance Committee (FTP) 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 FTP
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	December 2024	
		Due Date	Action Update
2a. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2025	
2b. Activity Levels	Review of CRD trials portfolio. Activity levels currently stable and building capacity to increase AH led research.	31/03/2025	
3a. Financial Model	Case for internal and multi-sector inward investment. Plans underway through £10m club to secure external funds for internal investment to grow through Futures. Futures bid coordinator started in post in July.	30/06/2024	
3b. Financial Model	Development of new commercial partnerships Commercial pipeline in research - multiple studies in set-up. New partnerships being explored by commercial research working group.	31/03/2025	
4. Capacity and capability	Greater engagement with and education of R&I communities Futures people pillar established, Futures programme Board to commenced in May 2024. New infrastructure being established following approval of business case in August	31/03/2025	
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	
5. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy. New post agreed (CRD funded) to support marketing and comms for Futures - est start date Sept 24	31/03/2025	

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families

Risk Number	Strategic Objectives
4.2	Revolutionise Care

CQC Domains	Linked Risks	Owner
Effective Responsive		Kate Warriner

Risk Rating		
Actual	Target	Assurance Committee
16	8	Finance, Transformation & Performance 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.

Dec 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 FTP	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. Continual review underway to assess additional requirements.
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
5. Aging hardware / device estate and financial restrictions preventing all equipment being replaced, mostly notably in clinical areas

Action	Description	December 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	30/08/2024	Programme to commence Nov 2023
Cyber Assurance Framework	This has replaced the action around Cyber Essentials +.	31/07/2025	
Strategic Review of Cyber Security	Strategic Review of Cyber Security	31/03/2025	
Experienced Resources	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce	28/02/2025	