Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 11th April 2024, commencing at 11:00am
Lecture Theatre 2, 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
PATIENT STORY (11:00am-11:15am)							
1.	**24/25/01**	**11:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/02**	**11:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/03**	**11:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **7th March 2024.**	**D**	Read enclosure
4.	**24/25/04**	**11:19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**24/25/05**	**11:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**24/25/06**	**11:30 (35 mins)**	• **Vision 2030 Strategy Update.** • **Draft Annual Plan; 2024/25.** • **Mobilisation Plan 2030 (Y2).**	L. Shepherd/ J. Grinnell R. Lea/ A. Bateman N. Palin	To receive an update on the current position. For discussion. To receive an update on the current position.	**A** **A** **A**	Verbal/ Read report Read report
Lunch (12:05pm-12:25pm)							

7.	**24/25/07**	**12:25 (40 mins)**	**Year-end Position 2023/24; including:** • **End of year achievements.** • **Integrated Performance Report for M11, 2023/24.**	Executives Executives/ Divisions	To receive an update on the current position. To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues.	**A** **N**	Read enclosure Read report
8.	**24/25/08**	**13:05 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell/ J. Halloran	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Unrivalled Experience							
9.	**24/25/09**	**13:15 (5 mins)**	**Learning from Patient Safety Incidents.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
10.	**24/25/10**	**13:20 (10 mins)**	**Fuller Public Inquiry - Phase 1 and 2.**	N. Askew	For discussion and approval.	**D**	Read report
11.	**24/25/11**	**13:30 (5 mins)**	**Mortality Report, Q3.**	A. Bass	To receive the Mortality Report for Q4.	**A**	Read report
12.	**24/25/12**	**13:35 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 20.3.24.** - **Approved minutes from the meeting held on the 21.2.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 21.2.24.	**A**	Read enclosures
Revolutionising Care							
13.	**24/25/13**	**13:40 (15 mins)**	**Alder Care Lessons Learnt Report.**	K. Warriner	To provide an update on the current position on AlderC@re reporting/lessons learnt nationally, with a specific focus on reports related to safety and quality.	**A**	Read report

14.	**24/25/14**	**13:55 (10 mins)**	**Gender Development Service (North Programme) Update.**	L. Cooper	To receive an update on the current position.	**A**	Read report
Collaborating in Communities							
15.	**24/25/15**	**14:05 (10 mins)**	**Liverpool Neonatal Partnership governance**	A Bass	To receive an update on the current position	**N**	Read report
16.	**24/25/16**	**14:15 (10 mins)**	**Children's Hospital Alliance End-year Report, 2023/24 and Workstreams for 2024-25.**	J. Grinnell	For information.	**N**	Read report
Pioneering Breakthroughs							
17.	**24/25/17**	**14:25 (5 mins)**	**Futures Committee:** - **Chair's verbal update on the plans for the inaugural meeting of the Futures Committee on the 16.4.24.**	S. Arora	To receive an overview of the plans for the inaugural meeting of the Futures Committee scheduled for the 16.4.24.	**N**	Verbal
Supporting our People							
18.	**24/25/18**	**14:30 (10 mins)**	**People Plan Highlight Report; including:** • **EDI update.**	M. Swindell M. Swindell	To receive an update on the current position. To provide an update on key areas and updates from the system on the workforce.	**A** **A**	Read report Read report
19.	**24/25/19**	**14:40 (5 mins)**	**People and Wellbeing Committee:** • **Chair's verbal update from the meeting held on the 20.3.24.** • **Approved minutes from the meeting held on the 24.1.24.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 24.1.24.	**A**	Read enclosure
Strong Foundations (Board Assurance)							

20.	**24/25/20**	**14:45 (5 mins)**	**Resources and Business Development Committee:** - **Chair's highlight report from the meeting held on the 25.3.24.** - **Approved minutes from the meeting held on the 26.2.24.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 26.2.24.	**A**	Read enclosure
21.	**24/25/21**	**14:50 (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
22.	**24/25/22**	**14:55 (5 mins)**	**Directors' Register of Interests.**	E. Saunders	To receive the Directors Register of Interests.	**A**	Read enclosure
Items for Information							
23.	**24/25/23**	**15:00 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
24.	**24/25/24**	**15:04 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 2nd May 2024, 9:00am, LT2, Institute in the Park							

REGISTER OF TRUST SEAL
The Trust seal was used in March/April: • 413: VAT/Land back. • 414: VAT/Land back. • 415: VAT/Land back. • 416: GDS Contract (Intermediate building contract with contractors; Design). • 417: Appointment of Quantity Surveyor in connection with the construction of the Neonatal Unit at Alder Hey.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M11, 2023/24	R. Lea
2024/25 Priorities and Operational Planning Guidance: 2024/25 priorities and operational planning guidance (england.nhs.uk)	R. Lea/ A. Bateman
Independent Inquiry into the issues raised by the David Fuller Case: https://assets.publishing.service.gov.uk/media/6565d4c762180b0012ce82e8/HC310-fuller-inquiry-phase-1-report-web-accessible.pdf	N. Askew
LNP Quality Assurance Report - LNP Integrated Governance Committee (March 2024)	A. Bass
PALS and Complaints Report, Q3.	N. Askew

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 7th March 2024 at 9:00am**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Communications	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 23/24/295	Dr. L. Crabtree	Beyond Programme Director	(LCR)
Item 23/24/297	Ms. J. Halloran	Acting Deputy Development Director	(JH)
Item 23/24/298	Ms. M. Cox	Guest Presenter	(MC)
Item 23/24/300	Ms. N. Palin	Assoc. Director of Transformation	(NP)
Apologies	Mr. M. Flannagan	Director of Marketing and Communications	(MF)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mr. D. Powell	Development Director	(DP)

Patient Story

The Chair welcomed Zoe who had been invited to attend March's Trust Board to share her journey with Alder Hey and her experience of transitioning to adult care. Emma Twigg; Consultant Clinical Psychologist and joint service lead, accompanied Zoe to support her.

Zoe explained that she became a long-term patient at Alder Hey as a result of being diagnosed with Limb Girdle Muscular Dystrophy around the age of ten. As her condition became associated with additional complications, she came under the care of other specialties. Zoe advised that she had a long and difficult road during her early years as a result of being very unwell and felt really angry that this was happening to her. Zoe informed the Board that she didn't communicate with her medical team until she met Emma who helped her gain her voice and advocate for herself. Emma helped Zoe process her feelings and share her thoughts with her consultants thus enabling the team and Zoe to communicate in a positive way.

Zoe pointed out that transitioning to adult care was daunting for her especially as she had been a patient at Alder Hey for so long. Zoe was worried that the care wouldn't be as good in the adult

sector but advised that Emma and Dr. Spinty made the process a smooth one whilst ensuring that she was comfortable with her forthcoming care plan.

Zoe informed the Board that the Psychology team are integral for patients with long-term conditions as they help communicate a patient's concerns with the medical team and they are a bridge to building relationships. Zoe advised that without Emma's support she would never have achieved the things that she has; attended university, lives independently, drives a car and getting married shortly.

Zoe felt that it would be beneficial for the Trust to have somebody like herself who could use her lived experience to help other patients going through similar situations. Zoe informed the Board that on many occasions she was told that she wouldn't be able to do particular things due to her illness but she never gave up and has achieved many of her goals as a result.

The Chair thanked Zoe for sharing her inspirational story with the Board and advised that Zoe's insights will be helpful in so many ways, especially in terms of learning. Thanks were also offered to Emma Twigg and her team for the work that they do and the support they provide to young people.

23/24/290 Welcome and Apologies

The chair welcomed everyone to the meeting and noted the apologies received. It was reported that the Secretary of State for Education is visiting the Trust on the 7.3.24 at 12:30pm therefore Fiona Beveridge will Chair the meeting in Dame Jo's absence.

23/24/291 Declarations of Interest

There were none to declare.

23/24/292 Minutes of the previous meeting held on Thursday 8th February 2024
Resolved:
The minutes from the meeting held on the 8th February were agreed as an accurate record of the meeting.

23/24/293 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions have been addressed.

23/24/294 Chair's and CEO's Update

The Chair advised of her attendance at the Charity's Trustees Board meeting that took place on the 6.3.24 and drew attention to the positive outcome of a request from the Trust for funding for three projects. Prior to approving the request, the Trustees raised a number of key questions about the impact that the projects will have and the difference they will make. The Chair emphasised the importance of thinking strategically in terms of reporting to the Charity on its investments. The Director of Research and Innovation, John Chester also provided the Trustees with an update on the innovative and creative work that is being undertaken by the Trust, which was well received.

Louise Shepherd reported as follows:

National Update – A regional call had taken place on the 6.3.24, with Amanda Pritchard and Julian Kelly in attendance, to discuss key developments/issues and receive an update on planning/priorities for 2024/25. It was reported that there is to be a change in the way inflation is assessed and there is a commitment from the Government on PBR (Payment by Results). It was reported that there is to be £3.4b investment of capital in data and technology which will enable the roll out of technology and digital services to improve access, waiting times and outcomes.

Planning guidance is due to be published w/c 11.3.24 and it is felt that there will be a focus on delivering targets on waiting times, productivity, and ring-fencing of funds for top ticket items, for example, children and young people's (CYP) Mental Health Services.

Local Update – Work is continuing with the University of Liverpool on the Child of the North project, which has parity of esteem at the heart of it. It was confirmed that a job description has been agreed for the foundation role for the lead of the Northern Institute of Child Health and Wellbeing.

Liverpool Strategic Partnership (LSP) – The Chief Executive of Liverpool City Council has initiated a refresh of the LSP to help improve health in Liverpool via collaboration with partners. During the second meeting of the LSP on the 28.2.24 an update was provided on the Prototype proposal for North Liverpool that has been agreed with the Government. There is to be a focus on persistent school absence in four wards in Anfield and Everton, and it was reported that Alder Hey has been invited to support this programme. Discussions have taken place with Children's Services about co-creating a children's strategy, and work is being undertaken to develop a framework to enable the LSP to move forward with its plans.

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

23/24/295 Beyond Update

The Board was provided with an update on the progress of the CYP's Transformation Programme; Beyond. One of the big changes in the Integrated Care Board (ICB) for CYP has been the prominence of the CYP agenda, which is bringing people together to improve outcomes for CYP via a shared vision. A number of slides were shared to provide the following information:

- Cheshire and Merseyside (C&M) Health Equity Collaborative Champions; Emily, Erin, Bella and Nel.
- *Beyond 2024 Conference* – It was reported that the conference provided an opportunity for information to be shared on the work of the Beyond programme which is also bringing the system together. Emily opened the conference, and Bella and Leah are accompanying Dr. Crabtree to another event in London w/c 11.4.24.
- CYP views on health, home community and education;
  - Work is taking place to look at how the views of CYP can be measured.
- CYP Health Equity Collaborative (CHEC) Framework;
  - Socioeconomic political system.
  - Social position.
  - Living conditions.
  - Health and wellbeing.

  - Personal characteristics and intersectionality.
  - Interaction with the system and services.
- Cheshire and Merseyside (C&M) Proposed Interventions;
  - Oral health intervention and supervised tooth brushing across C&M.
    - Beyond is hosting the supervised tooth brushing programme on behalf of the Integrated Care System (ICS).
    - Funding for this programme has come from the dental underspend.
    - Recruitment is taking place to appoint the programme team.
    - It was reported that Barnardo's Charity has donated £10k to support the Oral Health programme.
  - School readiness by supporting pre-school development.
  - Addressing food poverty via Healthy Start vouchers.
- The Beyond programme has reached over 45,000 CYP, families and professionals through 33 projects. Beyond is a developing programme and work is on-going in all areas.
- Diabetes Technology Pilot – This pilot took place in collaboration with Beyond, Arrowe Park Hospital and Warrington and Halton Teaching Hospitals, with a view to improve technology access for the most deprived CYP with Type 1 Diabetes to address health inequalities and improve the outcomes in this group.

Dr. Crabtree responded to a number of questions that were raised about whether the Beyond programme is able to apply to other charitable foundations for funding to support the Oral Health programme, how the supervised tooth brushing programme is to be rolled out, and what will happen when Barnardo's funding has been used.

It was queried as to whether there are any plans in place to tackle childhood obesity. The Board was advised that Beyond is rolling out a number of programmes but there is a need for a public health approach and Government support to deal with this serious issue. Locally there is a new City plan and the national team are focussing on policy and raising awareness of this matter. It was reported that all age obesity is a priority for the ICB who have reached out to the national team to discuss this area of work.

Attention was drawn to the importance of having strong CYP data to address the likes of childhood obesity. This matter was raised at the previous CYP Committee where it was agreed as an action for escalation to the ICB. Fiona Beveridge advised that a lot of universities are working on big data that would support this challenge and bring people together.

The Chair referred to the capturing of metrics and felt that it is imperative to have consistency across the board when collecting data. It is also important to capture the life opportunities and changes for CYP via the programmes of work.

Resolved:
The Board received and noted the update on the Beyond programme.

23/24/296 Operational Issues

Integrated Performance Report (IPR), M10

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

Unrivalled Experience – *Caring*

- There has been a significant improvement in the response to complaints with 80% of formal complaints being responded to within 25days and 79% of PALS being responded to within 5 working days.

Kerry Byrne made reference to the electronic roster KPI report and asked that a deep dive take place during SQAC in April/May to gain an understanding of the data that is included in the report.

23/24/296.1 Action: KB/NA

Well Led – *Supporting Our People*

- There has been a continued reduction in staff turnover for the 9th consecutive month (10% to 6%).
- There was a slight increase in sickness absence in January. Work is ongoing to improve sickness absence figures.
- PDR compliance remains an area of concern. Letters have been circulated to encourage staff to arrange for their PDRs to take place. A deadline for completion has also been set.

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

- In M10, the Trust is reporting a position of £1.5m adverse to plan as a result of industrial action *(£4m surplus against a plan of £5.5m YTD*).
- CIP is £0.6m ahead of plan YTD. Overall, £17m CIP has been transacted with £0.6m in progress. The CIP gap is closed in year, subject to delivery of amber schemes (£0.6m).
- Recurrent CIP remains a concern given the gap recurrently is £6.4m which will be carried over into 2024/25 if not identified. It was reported that a lot of work is taking place on benefits to try and address this matter.

Community and Mental Health Division

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

Division of Medicine

- *Recruitment in Neurology* – A new consultant is due to commence in post on the 1.5.24.
- The Division has been engaging with the HR team via bi-weekly meetings to discuss HR topics and address areas of concern raised by the Division.
- A re-orientation programme took place in February to support nurses returning to work after sickness absence, which was well received.
- The Division are focussing on risks in terms of making improvements sustainable and gaining an understanding of the various risk processes that are in place.

Division of Surgery

- There is a plan in place to concentrate on patients waiting over 52 weeks for treatment.
- Elective figures are reflective of the amount of work that has taken place. It was reported that the number of theatre sessions were increased as of the 4.3.24.
- The Division is going to launch a formal piece of work in May on capacity of demand to look at how the Division can accommodate the demands from all services.
- The Division is applying scrutiny from a governance perspective to incidents that that are occurring at the present time.

Research

- *Paediatric Medicines Research Unit* – The Trust received a national award from the Royal College of Paediatrics and Child Health (RCPCH)/National Institute for Health Research (NIHR) for excellence in patient and public involvement.
- *New Ecosystem Co-creation Partnership* - The Trust will be able to apply the capabilities of a new ecosystem co-creation partnership to child health issues. It was pointed out that this partnership is very important to the Trust.
- *Finance* - The Division is focussing on productivity and analysis.

A question was raised about the progress of the Trust's Green Plan. It was reported that the installation of solar panels is still planned to go ahead and agreed actions are being addressed. Going forward, the plan will focus on benefits realisation. It was agreed to review the strategic element of the plan to ensure this area is still being advanced.

23/24/296.2 Action: JG

Resolved:
The Board received and noted the content of the IPR for Month 10.

Operational Plan Progress/M11 Flash Report

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

Resolved:
The Board received and noted the Operational Plan Progress and the Flash Report for M11.

23/24/297 Alder Hey in the Park Campus Development Update

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

- *Neonatal and Urgent Care Development:*
  - The work on the pathway adjacent to ED has been completed and the outstanding hoardings will be erected w/c 11.3.24, along with the external wall vinyl illustrations.
  - Pipes have been removed to enable service directions to be progressed with the support of United Utilities.
  - The team is constantly reviewing the programme to ensure the contract deadline is met by Morgan Sindall.
- *Park Reinstatement;'*
  - The Trust is awaiting a safety inspection from Liverpool City Council (LCC) before the playground in the park can be opened.
  - Phase 1 of the lighting works has been completed.
  - A review of outstanding work is conducted on a regular basis.
  - Regular newsletters continue to keep the community updated on the reinstatement of the park.
  - A site walkabout has been arranged for the Friends of Springfield Park on the 12.3.24.
- *New Nursery* – It was confirmed that planning permission for the construction of the new nursery has been granted.

The Chair asked that a note be sent to LCC to highlight the importance of opening the playground as soon as possible.

23/24/297.1 Action: JH

23/24/298 Equality, Diversity and Inclusion: Focusing on Our People 2024/25

The Board received an update on the progress that's been made by the Equality, Diversity and Inclusion (EDI) Steering Group and the achievements of the last 18 months. It was reported that the Trust is meeting its obligations against the national NHS frameworks for EDI, including all required statutory compliance.

It was reported that every NHS organisation is required to comply with a range of national and locally defined EDI frameworks, action plans and statutory reporting duties. To simplify matters and to be able to identify, and communicate, an overarching action plan for the Trust, it is proposed that the actions from the national NHS Equality, Diversity and Inclusion (EDI) Improvement Action Plan are used to form the basis of an action plan for the Trust.

The Trust action plan was presented to the Board which included six high impact actions, as detailed in the report. An overview was provided of the work that will take place to support the high impact changes:

- *Action 1:* A deep dive of the Trust's EDI risk will be conducted during the next People and Wellbeing Committee (PAWC).
- *Action 2:* The Prince's Trust has agreed to arrange for an additional person to join the team to support this area of work.
- *Action 3:* The Trust is going to focus on pay gaps for ethnicity and conduct a piece of work to understand its data and expand the range of pay gaps for review.
- *Action 4:* Time is to be set aside to think about working in collaboration with partners in the community on health inequality. This will be led by the work conducted by the Academy Director, Katherine Birch.
- *Action 5:* – A plan is in place to support the Trust's international staff; working with the REACH Network who have implemented a survey to understand the requirements of the organisation's international staff, conversations taking place on a monthly basis to look at gaps and the deficit on education and career pathways of international colleagues. It was reported that Alder Hey is the first trust to achieve a pastoral care award.
- *Action 6:* The outcome of the 2023 Staff Survey is positive, there is a good framework in place for staff to speak up and for staff to access psychological support.

Garth Dallas thanked the Chief People Officer, Melissa Swindell for the amount of work that has taken place to create the report and commended the Chief Nurse, Nathan Askew for his collaborative work with the REACH Network. A discussion took place about the importance of linking in strategically with operations at ground level to progress the actions in the plan.

Jo Revill queried as to how the Trust will address action 6 strategically to ensure zero tolerance *(create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur)*. In response to this question attention was drawn to the importance of having a listening environment and a change in culture in terms of visually showing that when an individual speaks up an action is put in place to address the issue.

Fiona Beveridge offered her support for action 1 *(Board members having a specific and measurable EDI objective to which they will be individually and collectively accountable)*, and informed the Board of the 'Race Equality Hub' that was launched w/c 26.2.24 by the Liverpool City Region Combined Authority with one of the key objectives being to encourage people to work together on EDI challenges. It was suggested that the Trust make contact with the Combined Authority to gain further information on this programme.

Fiona Beveridge also drew attention to the importance of Trust wide communications in terms of having stories for all to raise awareness of issues and providing feedback on 'You Said, We Did' to give assurance to staff that change will takes place as a result of concerns being raised.

Reference was made to the National Clinical Excellence award and it was queried as to how the Trust can encourage ethnic women to put themselves forward for the award.

It was proposed that the six high impact changes become part of the Trust's EDI Action Plan and that the Board receive an update on a regular basis in order to monitor progress. The Board confirmed their agreement of the proposal and suggested that an update be provided on a six-monthly basis.

Resolved:
The Board:

- Noted the EDI update.
- Agreed that the six high impact changes should be included in the Trust wide EDI Action Plan and that an update be provided on a six-monthly basis.

Supporting a Culture of Equality, Diversity and Inclusion through Learning

The Chair welcomed Michelle Cox who had been invited to March's Trust Board to share her experience of being treated unfairly by her employer because of her race, which resulted in her successful Employment Tribunal claim.

Michelle informed the Board that due to the 'landmark' nature of her case; she now travels around the country imparting her story to raise awareness, share lessons, and encourage staff to talk about their issues and get them addressed before heading towards a big case. Michelle pointed out that staff are beginning to feel confident enough to raise concerns as a result of Black Lives Matter, the promises that were made, and Freedom To Speak Up, but staff still feel that they aren't being heard and this is transferring into cases.

Michelle provided an overview of the roles that she took on during her 30 year career with the NHS, and shared details of the incidents that occurred that led to her submitting a legal claim for race discrimination. Michelle drew attention to the prejudice that she suffered as a result of raising a complaint about a colleague; being excluded from team meetings, team events, being referred to the Nursing and Midwifery Council, etc. The first act of discrimination took place in December 2018 and the employment tribunal (ET) judgment was given in February 2023 in which time Michelle suffered extremely due to the impact of the overall situation.

Michelle explained that following the ET judgment so many people reached out to her to share their experiences of racism that they were experiencing at work. Michelle drew attention to the lessons that can be learned by organisations, as follows:

- Acknowledgement of racism.

- Apologise to staff for their experience.
- Understand the framework.
- Have a conversation without a drawn-out grievance process and flawed investigation.
- Have the right representation on grievance panels.
- Understanding issues complained of does not override allegations of racism.
- Understand the law and horizon scan cases.
- Onus is equally on the employer to prove acts complained of are not discriminatory.
- Unconscious bias is unlawful.
- If the same allegations had been made from a white member of staff would they have been treated unfavourably (*comparator*).
- Remain curious not defensive.

The Chair thanked Michelle for her powerful presentation and advised of her deep shock at the dreadful way in which Michelle was treated. The Board will reflect on what it has heard and the Chair asked Michelle if she would be willing to work with the Trust to enable it to progress its learning.

The Chief People Officer, Melissa Swindell, asked Michelle as to whether there was any advice that could be imparted that would help the Trust. It was suggested looking at the intelligence provided by the black staff network, look at how the organisation accesses its bank staff/night staff in terms of those who aren't involved in the staff networks, review complaints in the system, acquire external expertise to address racism and investigations, for example, mediation in a race discrimination case doesn't work as the majority of the time mediators aren't trained in racism.

Louise Shepherd thought that the presentation was very impactful and will help the Trust focus on some of the issues that it has. Michelle pointed out that Alder Hey means so much to the people of Liverpool, especially its black communities and felt that a case of race discrimination would impact the Trust and undo the work that has been done.

It was queried as to how unconscious bias can be addressed. It was suggested that having an awareness of the diversity in all teams will help, and meeting people in person to gain greater detail of a complaint will be more beneficial than relying on written information alone.

Garth Dallas thanked Michelle for accepting the invitation and advised that Alder Hey is trying to have bold EDI conversations Trust wide.

Resolved:
The Board noted the presentation provided by Michelle Cox.

23/24/299 2023 NHS Staff Survey

The Board received a presentation on the outcome of the NHS Staff Survey for 2023. It was reported that the 2023 response rate was 60% which is the highest response the Trust has ever had. Alder Hey is benchmarked against Acute and Acute and Community Trusts of which there are 122 in this group with the median response rate at 45%. It was confirmed that Alder Hey has improved in every single area of the People Promises elements and themes with the exception of a couple of questions.

A number of slides were shared that provided information on the following areas:

- Overview of People Promise elements and themes.
- Compassionate culture;
  - Q6a I feel that my role makes a difference to patients/service users – 89.6% in comparison to the average of 87.96% and the best result of 90.71%. This was an improvement for the Trust from previous years (2021/22).
  - Q25a Care of patients/service users is my organisation's top priority – 86.57% in comparison to the average of 74.83% and against a best result of 86.57%.
  - Q25b My organisation acts on concerns raised by patients/service users – 82.34% in comparison to the average of 69.78% and the best result of 82.34%.
- Staff engagement: Advocacy;
  - Q25c I would recommend my organisation as a place to work – 71.15% in comparison to the average of 60.52% and against a best result of 77.09%. This is an improvement for the Trust from previous years (2021/22).
- We are safe and healthy: Health and safety climate;
  - Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it – The response to this question has reduced from 56.52% in 2022 to 52.49% in 2023. This is an area that the Trust needs to look into to understand the reduction in reporting.
- We are safe and healthy: Negative experiences;
  - Q14b In the last twelve months how many times have you personally experienced harassment, bullying or at work from managers? – The response to this question has reduced from 9.70% in 2022 to 7.14% in 2023 which is positive for the Trust.
- We are safe and health: Other questions'
  - Q17a/Q17b are new questions; In the last twelve months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients, service users, their relatives, members of the public, staff/colleagues – The Trust scored well in both areas 0.93% and 1.44% respectively with both being best results, but it was pointed out that there is work to do to achieve a zero position.
  - Q16a In the last 12 months have you personally experienced discrimination at work from patients, service users, their relatives or other members of the public – 3.17% said that they had which is an improvement in comparison to 2022 which was 3.24%, but 30.78% said that that they had experienced discrimination as a result of their ethnic background. It was reported that there is to be a focus on these areas.

The Chair felt that the outcome of the survey was really positive and suggested rolling out comms in terms of 'You Said, We Did, We Listened' once local conversations have taken place with teams to look at the data, understand where the hotspots are and agree actions.

It was queried as to whether incident reports relating to harm discrimination should be reviewed as staff tend to tolerate behaviours to ensure the patient receives the best care.

Resolved:
The Board noted the outcome of the 2023 Staff Survey.

23/24/300 Brilliant Basics (BB) Update

The Board was provided with an update on the progress of the BB Delivery Plan for 2023/24, the Trust's involvement in the C&M Improvement Network and the progress against the NHS IMPACT standards. The following points were highlighted:

- The key message of the report is that accumulative progress is being made, year on year, towards the development of a culture of continuous improvement.
- *Teams coached through BB* – The Trust has exceeded the target that it set for 2023/24 with 16 teams planned and 24 achieved.
- *NHS Staff Survey Involvement Question* – Alder Hey has increased the involvement score and has now moved into quartile 4 (highest 25%) compared to all national providers. Within C&M ICS, Alder Hey is third from the top with a difference in score of 0.2 compared to the top provider.
- *NHS IMPACT Standards* – The Trust has conducted a review of the self-assessment that it carried out in November 2023 against NHS IMPACT standards in preparation for 2024/25 to enable the organisation to address the areas that require improvements thus moving to a stronger position.
- *BB Delivery Plan 2024/25* – The delivery plan will specifically build the improvement system further, supporting the delivery of the Vision 2030 alongside the immediate needs of the organisation.
- It was reported that the Trust has received positive feedback about the way it has embedded BB as a system way of working. Alder Hey has also been asked to be key note speaker at the C&M 'Leading for Improvement' Conference on the 30.4.24 to provide an overview of the work that it is conducting.

Resolved:
The Board received noted the Brilliant Basics update.

23/24/301 Safeguarding Children and Adults at Risk Annual Report, 2022/23

The Board received the Safeguarding Children and Adults at Risk Annual Report for 2022/23. The report was submitted to the Safety and Quality Assurance Committee (SQAC) on the 21.2.24 where it was fully approved. Attention was drawn to the investment that has taken place to build the Safeguarding team.

Resolved:
The Board received and noted the Safeguarding Children and Adults at Risk Annual Report for 2022/23.

23/24/302 Gender Development Service (North) Update

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

- *Estates* – There has been an issue with fire stopping in the building which has resulted in a delay. It was confirmed that this won't have an impact on the service in terms of it starting on the 2.4.24. Space on existing Alder Hey and Manchester sites will be utilised whilst the premises are completed. The Trust will move into the first floor of the building in May 2024 and all work will be completed on the overall building by the 30th of June 2024.

- *Recruitment* – The service will go live on the 1.4.24 supported by the first cohort of staff members. A further round of recruitment will take place w/c 11.3.24 before pausing until the first cohort is established. All posts will continue to be advertised until the workforce establishment has been met.
- *Open Case Load* – The initial transfer of data took place on the 21.2.24. The North Hub has received files for 105 CYP who will be triaged via a desktop review or a face to face meeting with their current clinician and potentially the young person. This will be the focus for Q1.
- *Finance* – It was reported that there are no current financial risks within the programme and expenditure remains on track.
- *Contracting* – The North and South Hubs have sent a contractual letter to NHSE. From a North Hub perspective, NHSE has agreed to honour the contract therefore the North Hub has entered into a contractual arrangement for the new service with NHSE.
- *Regulation* – The required paperwork has been submitted to CQC to ensure that the premises in Warrington are sufficiently registered.

The Board was advised that the North Hub is to be included in the NHSE shadow national incident arrangement which is being led by the National Director of Emergency Planning and Incident Response, Mike Prentice. It has been agreed that the North Hub will participate in daily huddles in order to raise concerns/incidents with the outcome being reported into the NHSE incident framework.

Reference was made to risk 132 (Gender Service Capacity) as detailed in the report, and it was queried as to whether this risk will be reviewed in the near future and the score reduced. It was confirmed that this will be the case.

Resolved:
The Board noted the Gender Development Service (North) update.

For noting
Dame Jo Williams, Louise Shepherd and Nathan Askew left the meeting to welcome the Secretary of State for Education who was visiting the Trust. Fiona Beveridge Chaired the meeting from this point onwards.

23/24/303 Learning from Patient Safety Incidents

The Board was provided with a summary of activity following the transition to the Patient Safety Incident Response Framework (PSIRF), including oversight of those incidents that have been reviewed in line with the Trust's Patient Safety Incident Response Plan (PSRIP), highlighting any identified areas of patient safety learning and improvement for the reporting timeframe the 1.2.24 to the 29.2.24. The following points were highlighted:

- All legacy SI investigations have now concluded. It was confirmed that the findings will be presented to SQAC in March 2024.
- It was reported that a business case has been approved for the recruitment of two Patient Safety investigators.

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

23/24/304 Update on Martha's Rule

The Board received an overview of the progress that has been made to date in terms of having processes in place for families to request a Martha's Rule review, the updating of the Trust's system to reflect the implementation of the National paediatric early warning system (PEWS), the process in place to respond to a concern (Response team/escalation framework), and the monitoring and understanding of culture and behaviours post concern.

A pilot of the response is planned for April 2024 but there are a number of risks that the Trust is in the process of addressing ahead of the launch; assurance regarding GDPR compliance of WhatsApp, capability of the digital solution to meet the end-to-end requirements for implementation, and agreement on routes of escalation for the 24 hour period.

It was reported that Alder Hey intends to submit an expression of interest to be part of the first wave of 100 acute providers to launch the full requirements of Martha's Rule.

A query was raised about whether a family can ask for a second opinion if they request a Martha's Rule review. It was confirmed that Martha's Rule is about having a second response to a child's deterioration being escalated and not having a second opinion.

Resolved:
The Board noted the update on Martha's Rule.

23/24/305 DIPC Report, Q3

A report was submitted to the Board to provide oversight of infection prevention control (IPC) activity/reporting for the Q3 period and assurance that the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice. The following points were highlighted:

- It was reported that the Trust monitors all central line-associated bloodstream infections (CLABSIs). The work plan to reduce CLABSIs across the Trust has continued during Q3, with a closer collaboration between IPC and the Microbiology laboratory to include in post-infections reviews (PIRs) all significant blood stream infections to engage with all stakeholders in the development of the CLABSI Steering Group.
- Reference was made to the red lines on the graphs in the report and it was advised that these relate to CLABSI targets set by NHSE for previous years. Anything above the threshold is classed as an improvement.

It was queried as to whether the Trust conducts assessments in year against the demographics of its patients. The Board was advised that the Trust is now in a position to purchase the software package that will allow the organisation to collect all of the antimicrobial data.

Resolved:
The Board received and noted the content of the Q3 Infection Prevention and Control report.

23/24/306 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 17.1.24 were submitted to the Board for information and assurance purposes.

It was confirmed that the work relating to the safe waiting list has been signed off and future updates will be submitted as per the Committee's annual work plan.

Resolved:
The Board noted the approved minutes from the meeting held on the 17.1.24

23/24/307 Futures Committee – Terms of Reference

The Board received the proposed Terms of Reference for a new governance structure in the form of the Futures Committee. It was reported that the new Committee will oversee synergistic working between the various components of the Trust's new Futures strategic initiative, forming a stronger internal partnership which will address the unmet need of 'Bring Me the Future'.

It was queried as to whether investment decisions will be deferred to RABD. John Chester drew attention to the importance of the new Futures Committee being able to have autonomy to approve financial decisions but agreed that a conversation should take place regarding this matter.

23/24/307.1 Action: SA/JC/JK

Resolved:
The Board approved the formation of a Futures Committee which will subsume the duties of the Research and Innovation Committee as detailed in the Terms of Reference.

23/24/308 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 16.1.24 were submitted to the Board for information and assurance purposes.

During February's meeting there was a focus on benefits and how the organisation will measure them. A deep dive also took place into the Division of Surgery and the Division of Medicine with the outcome showing traction.

Attention was drawn to the importance of re-looking at the organisation's metrics going forward in light of providers being asked to drive an improvement in productivity during 2024/25.

Resolved:
The Board noted the approved minutes from the meeting held on the 16.1.24.

23/24/309 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:

- Following a discussion at RABD it was agreed to review and update the risks relating to transformation.
- It was reported that work has recommenced on risk appetite.

Resolved:
The Board received and noted the content of the Board Assurance Framework report for January 2024.

23/24/310 NHS Leadership Competency Framework for Board Members

The Board was asked to note the new NHS leadership competency framework for board members published on the 28th of February 2024 as part of the response to the 2019 Kark review and the expectation of NHS boards to incorporate the competencies into PDR processes going forward.

It was reported that further guidance will be available in the autumn and will be submitted in due course to facilitate a more detailed discussion.

Resolved:
The Board noted the new NHS leadership competency framework for board members.

23/24/311 Any Other Business

There was none to discuss.

23/24/312 Review of the Meeting

Reference was made to the fantastic patient story that the Board received along with the presentation from Michelle Cox which it was felt was very thought provoking. Fiona Beveridge thanked Zoe and Michelle for attending Board and sharing their stories.

Fiona Beveridge reflected upon the meeting and drew attention to the steady progress that the Board is hearing about across a number of issues, the positive outcomes of the 2023 Staff Survey and Brilliant Basics which demonstrates that the Trust is moving in the right direction.

Date and Time of Next Meeting: Thursday the 11th April, 11:00am, LT2, Institute in the Park**.**

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for April 2024							
7.12.23	23/24/210.1	Neonatal Governance Review.	Meeting to take place between Dame Jo Williams, Louise Shepherd, the Chair and CEO of LWH before the Away Day session goes ahead, to look at developing a framework for the partnership. Alfie Bass to provide a briefing ahead of the meeting, detailing the Trust's thoughts for progressing the partnership, for discussion purposes.	Dame Jo Williams/ L. Shepherd/ A. Bass	11.4.24	Apr-24	**5.1.23** - Contact has been made with the CEO of LWH. An update will be provided in February. **30.1.24** - A meeting has been scheduled for the 10.4.24. An update will be provided during April's Trust Board. **ACTION TO REMAIN OPEN**
Actions for May 2024							
8.2.24	23/24/260.2	System Wide Update	Discuss a way forward for Research and Innovation to feed into systems/mechanisms.	D. Hawcutt/ D. Jones/ A. Prendergast	2.5.24	On-track May-24	**6.3.24** - This action is in progress. An update will be provided in April.
8.2.24	23/24/273.1	Freedom To Speak Up	Liaise with Jo Pottier to see if there is an opportunity via PAWC to link in with FTSU on the triangulation of discussions on culture and addressing concerns across the Trust. Compile a proposal and submit it to PAWC for approval.	K. Turner/ K. Byrne	2.5.24	On-track May-24	
7.3.24	23/24/296.1	Integrated Performance Report (M10)	*Green Plan* - Review the strategic element of the Green Plan to ensure this area is still being advanced.	J. Grinnell	2.5.24	On-track May-24	
7.3.24	23/24/296.1	Integrated Performance Report (M10)	*Electronic Roster KPI report* - Deep dive to take place during SQAC in April/May to gain an understanding of the data that is included in the Electronic Roster KPI report.	K. Byrne/ N. Askew	2.5.24	On-track May-24	
7.3.24	23/24/307.1	Futures Committee – Terms of Reference	Conversation to take place to decide as to whether investment decisions will be deferred to RABD or whether the Futures Committee will have autonomy to approve financial decisions.	S. Arora/ J. Chester/ J. Kelly	2.5.24	On-track May-24	
Actions for June 2024							
8.2.24	23/24/260.1	System Wide Update	Liaise with the Chairs of CMAST to discuss as to whether transition will be dealt with under mental health via CMAST.	Dame Jo Williams	6.6.24	On track June-24	
8.2.24	23/24/266.1	Gender Development Service (North) Update	Submit an initial draft risk register for the new Gender Development Service to the Audit and Risk Committee in April.	L. Cooper	7.3.24	On track June-24	**1.3.24** - The draft Risk Register for the new Gender Development Service will be submitted to SQAC on the 20.3.24.
8.2.24	23/24/267.1	Learning from Patient Safety Incidents	Schedule a Board Development Session on PSIRF in April 2024.	N. Askew	6.6.24	On-track June-24	**1.3.24** - This session will take place in June 2024.
Status							
Overdue							
On Track							

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

Alder Hey Children's NHS
NHS Foundation Trust

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
7.9.23	23/24/106.2	Operational Issues	*Finance* - Submit a half yearly report on the cash share model that is emerging and provide detail in terms of how it is being managed from a risk perspective in the system.	R. Lea	7.3.23	Closed	**1.3.24** - An update will be provided on the 7.3.24. 7.3.24 - A summary was included in the report that was submitted to the Board during part two of the meeting.
8.2.24	23/24/263.1	Operational Plan Progress/M10 Flash Report	Liaise with C&M about the possibility of including a write up about Alder Hey's transformation in the monthly C&M briefing.	A. Bateman	7.3.23	Closed	**1.3.24** - An update will be provided on the 7.3.24. 7.3.24 - If the Trust delivers the 80% standard for Q4 Adam Bateman will approach Anthony Middelton, ICB COO to ensure there is a write up on Alder Hey's performance and transformation.
9.11.23	23/24/173.2	Digital, Data and Information Technology Update	*External Reporting* - Discuss the possibility of compiling a report that focusses on the Trust's robust reporting processes and the lessons that have been learnt nationally, for submission to the Board.	J. Grinnell/ K. Warriner	11.4.24	Closed	**3.1.24** - This item will be included on February's agenda. 11.1.24 - This action has been deferred to April 2024. **5.4.24** - This item has been included on April's agenda (24/25/12). **ACTION CLOSED**
8.2.24	23/24/274.1	People and Wellbeing Committee	Liaise with Melissa Swindell to look at what can be done to understand the pay differentials of the organisation's workforce, especially in relation to race and disability.	F. Beveridge	11.4.24	Closed	**5.4.24** - This action has been addressed. **ACTION CLOSED**
7.3.24	23/24/297.1	Alder Hey in the Park Campus Development Update	Send a communication to LCC to highlight the importance of opening the playground as soon as possible.	J. Halloran		Closed	**5.4.24** - This action has been addressed. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	**Alder Hey 2024/25 Operational Plan**
Report of:	**Adam Bateman**
Paper Prepared by:	**Andy McColl**

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 the latest draft copy of the 24/25 Integrated Annual Plan. Due to the national planning guidance only recently being published, further work is required to finalise the plan ensuring that all national targets are reflected. It is proposed that the final version is shared with RABD at the end of April for final approval, ahead of submission to NHSE early May. The Board is asked to provide any comments on this draft version and to confirm agreement for RABD to approve the final version.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☑ Game-changing **research and innovation** ☑ **Strong Foundations** ☑
Resource Implications:	

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

Alder Hey Children's NHS Foundation Trust

Integrated Annual Plan 2024/25

(DRAFT)

Alder Hey Children's NHS Foundation Trust

Contents

1. Executive Summary

1.0 Our Vision for 2030

Our vision for 2030 is a "healthier, happier and fairer future where every child and young person achieves their full potential".

To achieve this vision, we will place the needs of children, young people and families at the centre, and we have identified four Areas of Need:

- Personalise My Care
- Get Me Well
- Bring Me the Future
- Improve My Life Chances

The 2024/25 Integrated Annual Plan sets out a single plan for Alder Hey Children's objectives for the year ahead – incorporating our Strategic Goals and Operational Objectives, along with underpinning details on activity, workforce and financial plans.

It is important to note that both strategy deployment and delivery of core operational performance work in tandem, representing two equal halves to achieve the needs-led objectives for 2024/25 and overall Vision of the Trust.

Strong core operational performance is required to provide the foundation for delivery of strategic goals. Equally, deployment of the strategic goals will achieve transformation which will further improve our core operational performance. This should lead to a cycle of inter-dependent continuous improvement:

Alder Hey Children's NHS Foundation Trust

1.1 Strategy Deployment for 2024/25:

1.1.1 Areas of Need

Placing the needs of children, young people and families at the centre, the Trust will have 4 high level objectives for 2024/25:

Personalise My Care	• We will provide co-ordinated care closer to home
Get Me Well	• We will improve local access to specialist and urgent care, maximising the use of virtual care
Bring me the Future	• We will embed innovation and research to harness the potential offered by cutting edge health tech for CYPF
Improve My Life Chances	• We will invest in prevention and public health

1.1.2 Strategic Goals

Our needs-led objectives for 2024/25 will be delivered through our 5 strategic goals:

Outstanding Care and Experience	• We will improve safety, quality and experience • Deliver PSIRF and advance our learning culture • Enhance relationships with families and implement Martha's Rule • CQC preparedness for Outstanding for Safety • Care of deteriorating Children and Young People.
Support Our People	• We will support our people to thrive and belong • We will strengthen workforce planning and drive value, and develop our people to meet our future needs • Empower our people to deliver Vision 2030, using our Brilliant Basics improvement system
Pioneering Breakthroughs	• Creating clinical capacity by deploying technology that reduces administration burden • Backing our researchers, educators, and innovators (through time and support services) • Powerful computing and secure data environment • Securing new investment • Northern Institute of Child Health and Wellbeing
Revolutionise Care	• We will develop new models of care (including a new Acute Care model – creating capacity to see more CYP) • We will harness digital advancement and data led intelligence • We will drive the CYP Alliance • We will deliver more care 'Home First' and improve co-ordination of care • We will develop networks at Place level • We will drive improvement in our efficiency and productivity through GIRFT and data insights
Collaborate for CYP	• We will work in partnership to improve the life chances of Children and Young People • We will ensure that the CYP landscape and system architecture is delivering benefits that improve the life chances of CYP

	• We will create a system that invests in children and puts them first and brings services together in a way that is better for CYP • Delivering against our Net Zero ambition • Continue our journey for our Campus that brings together physical and mental health and wellbeing

1.2 Core Operational Performance for 2024/25:

1.2.1 Patient Safety

The national Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The Trust acknowledges that PSIRF is a new approach to how we manage and approach patient safety and it is paramount that we advocate a coordinated and data driven response to patient safety incidents, prompting a significant cultural shift towards systematic patient safety management. We will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as required. The following metrics will be used to monitor our progress for the current financial year:

- Number of Incidents Rated Minor Harm (Physical and/or Psychological) and Above per thousand bed days: an indicator which should demonstrate a downward trend or remain within the top quartile of comparator organisations. The objective 2024/25 plan is a 5% reduction on 2023/24.
- Number of Incidents Rated No harm per thousand bed days: an indicator which should demonstrate an upward trend or remain within the top quartile of comparator organisations. The objective 2024/25 plan is a 5% increase on 2023/24.

1.2.2 Access and Recovery

We expect to meet, and in many cases exceed, all national access standards including urgent/ emergency care, elective waiting times, diagnostic waiting times and cancer access standards. In addition we will match the ambition to reduce long waiting times for our patients accessing community and mental health services:

Performance Standards	Target
ED, 4 hour performance	85%
RTT Long Waits	Zero > 52weeks
Diagnostic Waits within 6 weeks (DM01)	>95% by March 2025
Cancer access standards	Aim for 100% every month
Reduce waiting times for CAMHS, in line with interim national guidance	• Referral to Help: >90% within 6 wks • Referral to Treatment: >90% within 18 wks • Eating Disorder service: 90% within 7 days for urgent cases and within 28 days for routine referrals
ASD and ADHD diagnostic assessment pathways	• Maximum waiting time of 65 wks • >90% of referrals are triaged within 12 wks
Significant improvement in waiting times for Initial Health Assessments (IHAs)	>90% within 20 days of the Trust receiving the referral

To achieve these standards in the context high demand for our services, we will focus on improving productivity and transforming our models of care. We plan to support more patients to receive planned treatment this year, recovering our Elective and Day Case services to 108% and Outpatient services to 133% of pre-pandemic levels.

1.2.3 Our People

As part of the 2030 Vision, we will look after, support, develop and grow the people who work for Alder Hey, ensuring they have the right values, skills, knowledge and leadership to thrive, making Alder Hey an incredible place to work.

We will do this by continuing to focus on the core areas of 'business as usual', including:

1. Health & Wellbeing support.
2. Commitment to delivering equality, diversity, and inclusion.
3. HR information, advice, and guidance. We work in partnership with Trade Union colleagues to achieve this.
4. Learning and educational opportunities.

Our people plan will focus on leadership, recruitment and retention and developing the future workforce. We are striving to achieve an in-year step change in people availability and experience at work. The following metrics will be used to monitor our progress in 2024/25:

- Reduce sickness absence to 5%
- Reduce turnover to 10%
- Improve colleague satisfaction (thriving Index)
- Report and monitor workforce stability

1.2.4 Financial Sustainability

To meet our commitment to the ICB system, and enable investment to deliver our strategic ambition we will deliver on our obligations to ensure financial sustainability, including:

- I&E position: Financial balance (break-even), so our Income matches Expenditure of £401m.
- Income / ERF position:
    - Deliver 115% ERF value compared to pre-pandemic levels, with additional tariff income through improved productivity contributing to our cost improvement plan.
    - This includes 105% for NHSE specialist commissioning (104% target) and 146% for all ICBs (109% target)
- Recurrent Efficiency savings of £19.3m, with greater focus on benefit realisation from transformational schemes (£12m), aligned to the Trust Strategic Programme
- Capital spend (CDEL) (£12.8m) in 2024/25 will continue to be managed through the ICS at system level with allocation of spend distributed to each provider.
- Continue investment in our campus and estate, with schemes including Neonatal Unit, Same Day Emergency Care (SDEC), Outpatient / Fracture Clinic, Alder Park site.

2. Reflections from 2023/24

In the 2023/24 annual plan we identified 8 priorities for delivery. Our key achievements against these priorities are highlighted below:

Priorities	Key Targets identified in 2023/24 Integrated Annual Plan	Key Achievements in 2023/24
Kick-start the implementation of our 2030 strategy	• Develop transformational plans and commence implementation of projects, across 5 Strategic Initiatives	• 2030 Vision and Strategy Approved by Trust Board • Re-organisation of governance structures to align to strategic ambition • All 5 Strategic Goals developing transformation plans, with programme structures in place to oversee deployment and project implementation • Robust Benefit Realisation plans in place for 2024/25
Deliver our Patient Safety Strategy	• Reduce patient harms per 1,000 bed days • Increase reporting of risks, incidents and near-misses	• Maintained top quartile performance of reporting nationally • Patient Safety Strategy Board continues to deliver against key areas of focus, with 2 programmes returning to BAU • Delivered on plan against our Patient Experience workstream • Preparation work for Martha's Rule to enable pilot in April 2024

Increase people Availability and Wellbeing	• Reduce sickness absence by 1% • Reduce turnover by 1 percentage point to <13% • Improve colleague satisfaction (Thriving Index)	• Significant, sustained reduction in turnover of 5% • 71% of colleagues would "recommend the organisation as a place to work", ranking highest in the Northwest amongst our comparator group (Acute and community) • Nursery provider being awarded GOOD by Ofsted • Staff Advice and Liaison Service (SALS) won 2023 International Hospital Federation (IHF) award for "Excellence Award for HealthCare Workers Wellbeing" • Established the Armed Forces Community network and development of REACH, Disability & LGBTQIA+ staff networks. • Expanded the roll out of E-Roster to 96% of the organisation (exc. medical and dental workforce) • Launch of the Thriving leaders programme, Key workstream under the Trust People Plan
Advance our clinical research portfolio and innovation pipeline	• Number of Chief Investigator led studies • Number of innovation solutions deployed with real-world impact	• 1st Alder Hey participant recruited to a gene therapy trial Teddy's story - Alder Hey Children's Hospital Trust • Funding secured from NIHR for 3rd MRI scanner • Exceeded 23/24 commercial income target • 17 Automation solutions (RPA & Apps) deployed in AH • Little Hearts at Home innovation solution rolled out to 55 AH patients. Late stage discussion and roll out planned with Southampton to pilot LHAH as the first external customer. Sienna's Story - Alder Hey Children's Hospital Trust
Handover Springfield Park to the community	• Return Springfield Park to Liverpool City Council by November 2023	• Phase 1 ,Multi-Use Games Area, outside Gym, new Playground all handed over to LCC and open to local community. • Key next phases open in June 2024

Improve Access to Care and Reduce Waiting Times	• Zero patients waiting >65weeks (including ASD and ADHD) • 85% of patients attending the Emergency Department are treated or admitted within 4 hrs	• On track to eliminate RTT >65wks waits by end of March 2024 • ED Performance of 82% • Diagnostic waiting times typically between 85-90% within 6 weeks • On track to eliminate 52wk waits in CAMHS • Safe management of patient access during periods of Industrial Action.
Financial Sustainability	• Breakeven I&E position • 111% ERF Recovery Value • £17.7m CIP	• Expected to deliver £12.3m surplus, in line with control total agreed with ICB. • 108% ERF value (M1-11), noting impact of Industrial Action. • Delivered £17.7m CIP target in year (with £10.3m recurrent savings)
Safely Deploy Alder C@re	• All 15 Clinical Safety Criteria achieved before go-live • Alder C@re deployed in September 2023	• All 15 Clinical criteria were achieved and ratified via Medical Director and Chief Nurse • AlderC@re was safely deployed in September 2023 • AlderC@re has now entered into Phase 2 including the continuous optimisation of the platform

3. PART 1: Strategy Deployment for 2024/25

3.1 Our Vision for 2030

Our vision for 2030 is a “healthier, happier and fairer future where every child and young person achieves their full potential”.

3.2 Areas of Need

Placing the needs of children, young people and families at the centre, the Trust will have 4 high level objectives for 2024/25:

	Needs Led Objectives	Key Outcomes and Benefits (Driver)
Personalise My Care	• We will provide coordinated care closer to home	• To reduced missed education • Reduce burden for families to attend hospital appointments
Get Me Well	• We will improve local access to specialist and urgent care, maximising the use of virtual care	• Treat more children: Reduce waiting time to access planned and emergency care – activity target 115% • Improve our productivity ratio by (to be developed)
Bring me the Future	• We will embed innovation and research to harness the potential offered by cutting edge health tech for CYPF	• Provide a patient portal that supports empowerment and enhances experience • Pioneering treatments, services or diagnostics deployed to care • Secure £10m of inward investment – to enable us to be innovative and deliver cutting edge care. • Launch Alder Hey Global Health
Improve My Life Chances	• We will invest in prevention and public health	• Increase portion of system £ directed towards CYPF • Widen participation and generate at least £158k of social value • Reduce inequalities for CYP • Net Zero - reduce our carbon emissions to 15%
Cross cutting enabling – CYPF Outcomes		
All CYPF	• Outstanding care and experience	• To reduce patient harm by 5% (for physical) • Improve CYPF experience – 95% FFT
Our people	• Support our people	• Reduce sickness 5% • Reduce turnover to 10% • Vacancies • Headcount control – creating space, give the tools to do their jobs and reducing bureaucracy

3.3 Strategic Goals

Our needs-led objectives for 2024/25 will be delivered through our 5 strategic goals:

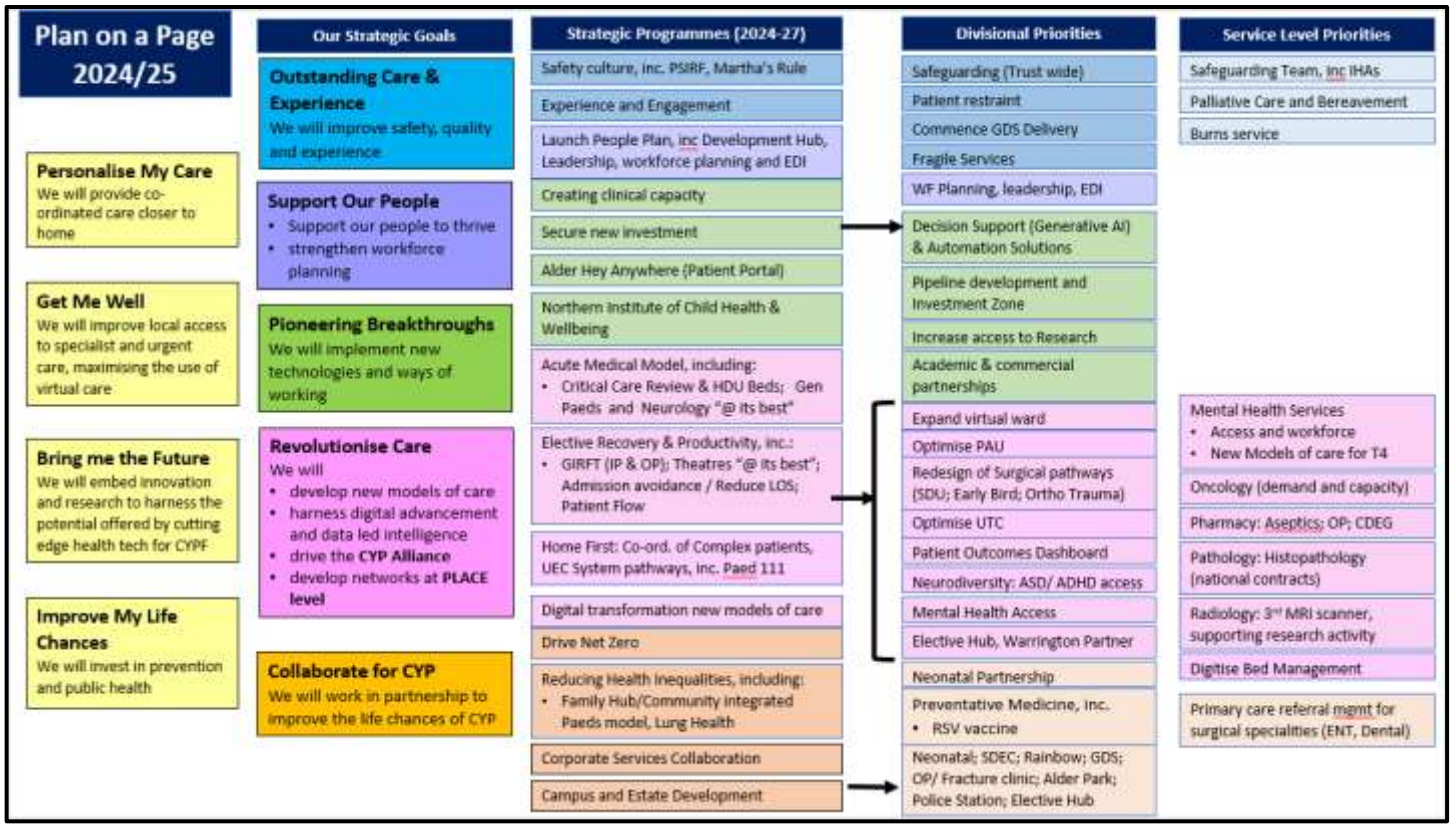
Strategic Goals	Goal for 2030	Focus for 2024/25
Outstanding Care and Experience	Push ourselves to always provide the best possible experience for children, young people, and families, continually testing this with them and building on their feedback.	• We will improve safety, quality and experience • Deliver PSIRF and advance our learning culture • Enhance relationships with families and implement Martha's Rule • CQC preparedness for Outstanding for Safety • Care of deteriorating patients
Supporting Our People	Understand our people better. What drives them. Develop shared motivations and ambitions by treating them as individuals and ensuring that they can have fulfilling careers.	• We will support our people to thrive and belong • We will strengthen workforce planning and drive value, and develop our people to meet our future needs • Empower our people to deliver Vision 2030, using our Brilliant Basics improvement system
Pioneering Breakthroughs	Provide the right conditions and infrastructure for inter-disciplinary collaboration that discovers and deploys pioneering breakthroughs in paediatric health care.	• Creating clinical capacity by deploying technology that reduces administration burden • Backing our researchers, educators, and innovators (through time and support services) • Powerful computing and secure data environment • Securing new investment • Northern Institute of Child Health and Wellbeing
Revolutionising Care	Harness the latest technologies to ensure delivery of the very best health and care outcomes for children, young people, and families. Do things differently. Do things better.	• We will develop new models of care (including a new Acute Care model – creating capacity to see more CYP) • We will harness digital advancement and data led intelligence • We will drive the CYP Alliance • We will deliver more care 'Home First' and improve co-ordination of care • We will develop networks at Place level • We will drive improvement in our efficiency and productivity through GIRFT and data insights
Collaborate for Children, Young People and Families	Use our combined knowledge and resources to develop and deliver a system that children, young people and families can find their way round and get the best out of.	• We will work in partnership to improve the life chances of Children and Young People • We will ensure that the CYP landscape and system architecture is delivering benefits that improve the life chances of CYP • We will create a system that invests in children and puts them first and brings services together in a way that is better for CYP • Delivering against our Net Zero ambition • Continue our journey for our Campus that brings together physical and mental health and wellbeing

		• Launch Alder Hey Global Health, widening our networks internationally, increasing our scale of impact on CYP, attracting and retaining the best talent, strengthening our brand and creating value.

3.4 Strategic Programmes

We have identified a number of key strategic programmes, alongside divisional priorities and service level priorities which align to our Strategic Goals. These have been shaped by a two-way iterative process with Executive colleagues and Divisional teams using the Brilliant Basics approach to refine and agree priorities.

This is summarised by the following image which shows our "plan on a page":



3.4 System Engagement

There is a growing recognition that providers will need to demonstrate different collaborative system behaviours to transform the models of care being delivered for CYP to ensure the delivery of safe, sustainable and affordable care. Additionally, under the Health and Care Act (2022), Provider Trusts have new duties to collaborate and work as part of the local Integrated Care System (ICS).

Achievement of certain elements of our strategic programme is dependent on working with our partners in the communities we serve, in a collaborative health and social care system, that has a

shared focus on the needs of CYP. Partner engagement will be a critical success factor and will depend on alignment of system priorities to progress appropriately.

The mechanism for system delivery will be transacted through newly establishing system architecture for CYP, such as the ICB CYP Committee, CMAST and MHLDC Provider Collaboratives, and their associated Alliances, and Transformation Programmes such as Beyond. Alder Hey are playing a key role in advocating for, and delivering on the necessary engagement and mechanics to ensure CYP are a priority cohort for the system.

4. PART 2 Core Operational Performance for 2024/25

The following table provides an overview of the top operational objectives for 2024/25 along with key metrics to measure our delivery through the year:

Theme	2024/25 Objectives	Target Metric
Patient Safety	• Reduce the number of Incidents Rated Minor Harm and above per thousand bed days, by 5% compared to 2023/24 • Increase the reported number of Incidents Rated No harm per thousand bed days, by 5% to demonstrate an open learning culture.	5% reduction from 2023/24 5% increase from 2023/24
Access to Care (Activity & Waiting Times)	• Improve access to urgent and emergency care • Eliminate 52 week waits for RTT services • Reduce the longest waits for ASD and ADHD pathways	4Hrs: >85% Zero >52wks Zero >65wks
Our People and Workforce Plan	• Reduce sickness absence to 5% • Reduce turnover to 10% • Improve colleague satisfaction (Thriving Index) • Report and monitor workforce stability	5% 10%
Financial Sustainability	• Achieve break even I&E Position • Achieve 115% ERF Recovery Value • Deliver £19.3m of recurrent efficiency savings	Breakeven 115% ERF £19.3m savings

4.1 Patient Safety

The national Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF is a new approach to patient safety - advocating a co-ordinated and data-driven response to patient safety incidents, prompting a significant cultural shift towards systematic patient safety management. PSIRF offers us the opportunity to learn and improve - to promote the safe, effective, and compassionate care for children and young people, their families and carers, whilst also protecting the well-being of our staff.

The Trust's Patient Safety Incident Response Plan (PSIRP) supports the requirements of the NHS England PSIRF and sets out how we intend to respond to patient safety incidents as part of our work to continually improve the quality and safety of the care we provide. Our PSIRP incorporates incidents that will be investigated as a Patient Safety Incident Investigation (PSII), as well as alternative methods for incident review, known as patient safety responses (PSRs), which no longer meet the new national reporting criteria. Alder Hey will take a flexible approach when deciding which patient safety incidents should be investigated through the PSII or PSR process. Our approach will be informed by national and local patient safety priorities, our patient safety profile, incidents with the most potential for learning, improvements that reduce risk / recurrence. It will be underpinned by the PSIRP and existing Trust Managing Incidents Policy. Patient safety workstreams and programmes are delivered using our Brilliant Basics Quality Improvement (QI) methodology.

National Patient Safety Priorities: Additional patient safety priorities are set nationally on an annual basis and require the completion of PSIIs with the intention of maximising learning opportunities. PSIIs include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

Local Patient Safety Priorities: Local priorities are set by the Trust in collaboration with key stakeholders each year. Each require a PSR and include a range of methodologies to identify areas of improvement and immediate safety actions. PSRs will also respond to concerns raised by the affected child, young person, family, carer, or staff member.

The Trust acknowledges that PSIRF is a new approach to how we manage and approach patient safety and it is paramount that we advocate a coordinated and data driven response to patient safety incidents, prompting a significant cultural shift towards systematic patient safety management. We will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as required. The following metrics will be used to monitor our progress for the current financial year:

- **Number of Incidents Rated Minor Harm (Physical and/or Psychological) and Above per thousand bed days:** an indicator which should demonstrate a downward trend or remain within the top quartile of comparator organisations. The objective 2024/25 plan is a 5% reduction on 2023/24.
- **Number of Incidents Rated No harm per thousand bed days:** an indicator which should demonstrate an upward trend or remain within the top quartile of comparator organisations. The objective 2024/25 plan is a 5% increase on 2023/24.

Following further developmental work, an additional metric will be added in due course to measure patient and staff safety culture across the organisation.

4.2 Access to Care (Activity and Waiting Times)

4.2.1 Performance Standards

We expect to meet, and in many cases exceed, all national access standards including urgent/ emergency care, elective waiting times, diagnostic waiting times and cancer access standards. In addition we will match the ambition to reduce long waiting times for our patients accessing community and mental health services:

Performance Standards	Target
ED, 4 hour performance	85%
RTT Long Waits	Zero > 52weeks
Diagnostic Waits within 6 weeks (DM01)	>95% by March 2025
Cancer access standards	Aim for 100% every month
Reduce waiting times for CAMHS, in line with interim national guidance	• Referral to Help: >90% within 6 wks • Referral to Treatment: >90% within 18 wks • Eating Disorder service: 90% within 7 days for urgent cases and within 28 days for routine referrals
ASD and ADHD diagnostic assessment pathways	• Maximum waiting time of 65 wks • >90% of referrals are triaged within 12 wks
Significant improvement in waiting times for Initial Health Assessments (IHAs)	>90% within 20 days of the Trust receiving the referral

To achieve these standards in the context high demand for our services, we will focus on improving productivity and transforming our models of care. We plan to support more patients to receive planned treatment this year, recovering our Elective and Day Case services to 108% and Outpatient services to 133% of pre-pandemic levels.

In addition to the “headline” performance metrics in the table above, a number of other performance and access metrics will be monitored through the year, including specialty level performance such as:

- 12 Medical specialties to achieve compliance with 18 week pathways
- 5 Surgical specialties to achieve maximum wait of 30 weeks, and progress towards compliance with 18 week pathways
- Improvements in Mental Health and Community Therapy waiting times, towards 18 weeks
- Increase in Cardiac Surgery cases, with fresh focus on 400 paediatric CCAD cases
- Reduction in overdue follow up outpatient appointments, aligned to Safe Waiting List Management

4.2.2 Activity Planning

Detailed activity planning has been Divisionally-led, and has been triangulated with 2023/24 Plan and 2023/24 Actuals (noting unique issues in year including Alder Care Deployment and Industrial Action).

The aggregated activity plan is summarised in the table below, noting the following key assumptions:

- Alder Care impact "added back" in 2024/25 (following managed reduction in 2023/24)
- A&E activity plan reduced from 2023/24 plan, in light of UTC and PAU pathways
- Surgical case mix shifted from Elective to Day Case
- Increases in Outpatient plan includes UTC activity, and commissioned growth in Community and Mental Health services

POD	19/20 Actuals	23/24 Plan	23/24 Actual (M11 FOT)	24/25 Plan
A&E	61,903	69,709	60,980	67,104
Chemotherapy	1,947	2,590	1,793	2,111
Daycase	20,484	21,965	20,070	22,758
Elective	5,251	5,347	4,276	5,011
Non Elective	15,713	15,824	14,623	15,824
OP Imaging	26,710	26,779	24,248	26,779
OP Procedure	18,502	20,838	19,811	20,838
Outpatient Follow-up	177,859	182,791	190,042	194,897
Outpatient New	55,298	74,722	77,627	77,543
Regular Attenders	706	1,426	1,548	1,426
Total	**384,373**	**421,991**	**415,018**	**434,291**

This activity plan delivers an overall ERF value of 115%, which can be broken down as follows:

- By Commissioner: ICBs 145% NHSE 105%
- By POD: DC & Elec 108% OPNew & OPPROC 133%
- By Division: Community 151% Medicine 129% Surgery 107%

4.2.3 Urgent and Emergency Care Recovery Plan

We will continue to build on the improvements in ED performance we have seen over the last year,

- Sustaining improvements in culture following "ED @ its best" programme
- Optimise effectiveness of streaming pathways and the UTC, with direct bookings to reduce inappropriate ED attendances
- Optimise PAU to reduce emergency admissions to inpatient wards
- Further develop virtual care – including expansion of our virtual ward, and exploration of virtual urgent care models
- We will continue collaboration at Place level and with the Cheshire & Merseyside system to implement the following, with focus on UEC system pathways including Paediatric 111

4.2.4 Elective Recovery Plan

A demand and capacity model has been built to assess whether the activity plans are sufficient to achieve access standards in all RTT specialties for 52 week waits. The modelling has identified a significant risk that ENT, Dentistry will have patients waiting >52weeks by March 2025 without further actions, and a lower level of risk for Spinal Surgery. In response to this, we will deliver enhanced support to these specialties and work on recovery plans that will include:

- Demand management, with work focussed on primary care referrals for ENT and Dentistry
- Continue to apply the "opt in / opt out" approach, successfully implemented for ENT in 2023/24
- Focus on productivity improvements, including increase in theatre utilisation (touch time)
- Prioritised access to clinic and theatre capacity
- Partnership working, such as development of elective hubs and partnership with Warrington

In addition to these specific actions targeted at challenged specialties, all specialties will be asked to engage with our strategic and cross-cutting Elective Recovery and Productivity programme. This will apply the principles of Getting it Right First Time (GIRFT) for both elective (IP & DC) and outpatient pathways.

This will be supported with a "Theatres @ its best" initiative, recognising the importance of psychological safety and ensuring that staff are able to identify and implement quality improvements within a supportive culture.

4.2.5 Theatre Capacity

Alongside the GIRFT programme and productivity improvements described above, restoration of the full theatre schedule is critical to delivery of the access standards, activity plan and financial ERF target.

Significant progress has been made in this regard during the early part of 2024, and Theatres have successfully recruited additional staff alongside training current staff in specialist areas. Ongoing recruitment will continue which includes an international approach for ODPs.

Restoration of the full theatre schedule will be realised using an incremental approach:

- Successfully increased the schedule from 130 to 137 sessions per week during February
- Further increase is planned to reach 141 sessions from end of April
- Full schedule of 145 sessions to be delivered from July onwards

Date	Theatre sessions (p/w)
26/02/2024	137
29/04/2024	141
01/07/2024	145

There remains a risk to delivery as the plan is contingent on the current agency staff continuing to work for the Trust until we have fully restored the theatre schedule.

4.2.6 Bed Capacity

The elective activity plan for 2024/25 will see a significant increase in inpatient activity compared to 2023/24 actuals – but is less than 2023/24 plan, which equated to 83% bed occupancy, and less than 2019/20 actuals. Whilst this gives us confidence that this planned level of activity can be managed through our existing bed base, there are a number of workstreams which will seek to improve bed utilisation:

- Critical Care review, potentially increasing ward bed capacity on Ward 4A with more Level 2 patients being cared for in HDU.
- Elective recovery and productivity programme.
- Co-ordination of complex patients, with potential benefits of fewer admissions and reduced length of stay.
- Expansion of virtual ward to reduce length of stay.
- Redesign of emergency pathways to reduce bed occupancy such as optimising PAU (introduced in 2023), SDU, Orthopaedic trauma and the Early Bird pathways
- Improving patient flow, with refreshed focus on discharge planning and increasing number of discharges in the morning (between 07:00 and 12:00). This will be supported through digitisation of bed management processes to improve effectiveness and efficiency.
- Particular attention will also be given to Oncology demand and capacity model, to reduce the number of outliers and ensure these children and young people receive care in the most suitable ward location to meet their needs.

4.3 Our People and Workforce Plan

4.3.1 Priorities

As part of the 2030 Vision, we will look after, support, develop and grow the people who work for Alder Hey, ensuring they have the right values, skills, knowledge and leadership to thrive, making Alder Hey an incredible place to work.

We will do this by continuing to focus on the core areas of 'business as usual', including:

1. Health & Wellbeing support.
2. Commitment to delivering equality, diversity, and inclusion.
3. HR information, advice, and guidance. We work in partnership with Trade Union colleagues to achieve this.
4. Learning and educational opportunities.

In addition to these core areas, following success in 2023/24, we have identified four key deliverables which require focus and energy in 2024/25:

1. **Thriving Leaders Programme:** Following the launch of phase one, we will develop the next phase of our leadership plan, which will set out the requirements for our leaders of the future.
2. **Recruitment and retention**: 'Find and Keep' project. We will develop our plans for a fundamental review of recruitment processes and practices, alongside consideration of successful retention methodology and how to implement this Trust wide.
3. **Future workforce** The next steps will be to consider and propose a process by which we have a systematic and whole organisation approach to planning for the workforce of the future, supporting workforce planning across specialties.
4. **Professional Development Hub**

The following metrics will be used to monitor our progress in 2024/25:

- Reduce sickness absence to 5%
- Reduce turnover to 10%
- Improve colleague satisfaction (thriving Index)
- Report and monitor workforce stability

4.3.2 Workforce Plan

The workforce plan provides an overview of the changes anticipated between 2023/24 and 2024/25. Our workforce plan remains reliant on the following assumptions and information:

- Continued ability to attract and recruit, supporting both internal moves and progression and new and returning candidates to the Trust, including successful newly qualified recruitment and apprenticeship posts.
- Reduce levels of staff turnover, sickness absence and 'staff movement' (churn).

Whilst there will be movement in the workforce, there is an expectation that the total workforce will not increase from March-24 to March-25; the only exception being for the establishment of the Gender Service and ASD and ADHD additionally funded workforce.

Forecast changes in our workforce include:

- Establishment of the Gender Identity Dysphoria Service (GIDS) (+55.93 WTE)
- Increased workforce required for ASD and ADHD to keep up with demand (+27.88 WTE)
- Reduction of WTE to meet cost improvement plans (-32 WTE)
- Reduced targeted international recruitment, with a campaign solely focusing on theatres.

The projected movement in our workforce numbers for 2024/25 is summarised below:

	March 2024 Projected Staff in Post (Inc. Bank & Agency)	March 2025 Plan (Inc. Bank & Agency)	Difference
WTE (Whole time equivalent)	4292.51	4310.87*	+18.36 (+0.4%)

*Figure pending finalisation.

4.4 Financial Sustainability

4.4.1 Financial Overview

To meet our commitment to the ICB system, and enable investment to deliver our strategic ambition we will deliver on our obligations to ensure financial sustainability, including:

- I&E position: Financial balance (break-even), so our Income matches Expenditure of £401m.
- Income / ERF position:
    - Deliver 115% ERF value compared to pre-pandemic levels, with additional tariff income through improved productivity contributing to our cost improvement plan.
    - This includes 105% for NHSE specialist commissioning (104% target) and 146% for all ICBs (109% target)
- Recurrent Efficiency savings of £19.3m, with greater focus on benefit realisation from transformational schemes (£12m), aligned to the Trust Strategic Programme
- Capital spend (CDEL) (£12.7m) in 2024/25 will continue to be managed through the ICS at system level with allocation of spend distributed to each provider.
- Continue investment in our campus and estate, with schemes including Neonatal Unit, Same Day Emergency Care (SDEC), Outpatient / Fracture Clinic, Alder Park site.

4.4.2 Income & Expenditure Plan

The following table summarises the proposed financial plan for 2024/25, compared to our performance in 2023/24. At the time of writing this report, discussions are continuing across the region as ICB financial position is in a significant deficit and therefore our budgetary plan is still provisional. Table may need to be updated, pending further adjustments:

	Area	Forecast @ M9 £'000	24/25 Annual Plan £'000	Movement £'000
Income	Block Payments	217,371	227,493	10,122
	C&V drugs	45,054	51,649	6,595
	C&V devices	7,322	0	(7,322)
	ERF	91,705	93,305	1,600
	Clinical Other	2,964	2,374	(590)
	Non-Clinical	36,462	26,686	(9,776)
	Total Income	**400,878**	**401,508**	**630**
Expenditure				
	Pay Costs	(246,874)	(260,071)	(13,198)
	Non Pay	(118,507)	(121,389)	(2,881)
	Depreciation	(15,398)	(17,730)	(2,333)
	Other Technical Charges	(8,599)	(2,317)	6,282
	Total Expenditure	**(389,377)**	**(401,508)**	**(12,130)**
	Overall Position	**11,500**	**0**	**(11,500)**

The key principles that have been adopted in the development of the 2024/25 I&E plan include:

- Block contract income levels rolled over from 2023/24 uplifted by inflation and growth as per national guidance.
- Activity based contract income based on externally mandated activity plans with a view to exceed and maximise income opportunities.
- Pay award based on 2% as per the national guidance although this has not yet been awarded. Funding will flow to cover any agreement higher than the anticipated 2%.
- The depreciation charge includes £2.2m relating to assets that are hosted by Alder Hey on behalf of the C&M system and is funded by a corresponding increase in income.
- 60% of legacy cost pressures funded within divisional budgets with the remaining expected to be mitigated through switch off or additional CIP and will be monitored through the Sustainability Deliver Group.
- A recurrent efficiency target for the year of £11.6m (3%) with a further £7.7m carried forward from 2023/24 as identified non-recurrently, therefore totalling a recurrent requirement of £19.3m (5%).
- A full planning exercise has been undertaken on the Mental Health Investment required to deliver the standards as part of the C&M system mental health group. Included in the plan is the recurrent impact of the 2023/24 schemes, ASD/ADHD, CYP Mental Health eating disorders, FICC and the new Gender Development Service. Any further investment for 24/25 will be added to the plan as approved.

4.4.3 Efficiency Programme

In order to achieve a break-even budget, we will be required to deliver an extremely challenged Efficiency Programme, with recurrent savings of £19.3m. This represents circa 5% of our current budget and includes £7.4m of efficiency savings carried over from 2023/24 (as the savings were delivered non-recurrently). This re-iterates the importance of ensuring we collectively achieve the recurrent efficiency benefits in 2024/25 to remain financially sustainable – or we risk having even greater financial challenges in future years.

As this is such a large efficiency target, there will be greater focus on benefit realisation from transformational schemes (£12m, c.3%), aligned to the Trust Strategic Programme. The remaining 2% (c. £7m) will be delivered through both a reduction in divisional run rate through local budget management and also collective `sprints` with support from central functions such as procurement, innovation, Finance etc.

In order to allocate the 2024/25 efficiency targets to divisions and departments, the following principles have been followed:

- Opportunity arising from strategic transformation (this element of the target may need to be moved as further details are worked up under SRO leadership)
- Opportunity arising from `sprints` (as above, this element may need to be moved as further details are worked up)
- Unachieved recurrent savings carried forward from 2023/24
- 2% of 2024/25 start point budgets

Therefore, divisional efficiency targets range between 4.2-6.0% (variation due to a combination of strategic opportunity and under achievement in 2023/24), with the table below showing latest assessment of financial benefit from both the strategic benefit cases and the `sprint` areas. Work is continuing on the detail of plans, and will require EA/QIA assessments to be completed, with an expectation that that each area submits fully developed plans by 30th April.

	Medicine	Surgery	Community & Mental Health	Corporate Departments	Research, Innovation, Commercial	TOTAL
Elective Productivity (IP & DC)	900	2,600				**3,500**
Outpatient Productivity	600	200	200			**1,000**
Automation & Coding	300	550	150			**1,000**
Workforce - Absence & Turnover	700	700	500	100		**2,000**
Workforce - Skill Mix Planning £1m	160	160	160	520		**1,000**
Net Zero	50	50		1,400		**1,500**
Non NHS Investment					2,000	**2,000**
Sub Total - Strategic Transformation	**2,710**	**4,260**	**1,010**	**2,020**	**2,000**	**12,000**
Business Development and other income	200	200	800	150		**1,350**
Drugs, Blood & Medicines Management	1,200	300	100			**1,600**
Procurement, Stock & Non Pay Savings	200	200	100	100		**600**
Other Departmental Savings	900	1,420	530	900		**3,750**
Total Efficiency Target	**5,210**	**6,380**	**2,540**	**3,170**	**2,000**	**19,300**

From April we will be re-establishing the fortnightly Sustainability Delivery Group (SDG) that will oversee the delivery of the full efficiency programme but with particular focus on the divisional and sprint areas.

4.4.4 Capital Planning

Capital is an increasing scarce resource in the NHS and the level of spend is controlled by a Capital Resource Limit (CDEL) set nationally by treasury and then allocated to each ICS by way of a system CDEL envelope that must not be exceeded.

As a Foundation Trust, Alder Hey has previously had the autonomy to develop a capital plan that utilised internally generated cash with the approval of own Trust governance. The move to a system capital resource limit (CDEL) with allocations to each provider, removes this autonomy to ensure that the capital spend for the ICS is within the limits set nationally. The CDEL allocation is a 'permission to spend' our own cash reserves and not necessarily an additional cash allocation although, new national capital investments will take the form of new cash in addition to an increase in CDEL to spend it.

The table below sets out the summary of the capital requirements for 2024/25 based on a prioritisation process that has been undertaken, along with the confirmed CDEL of £12.1m and PDC funding of £0.6m resulting in a total capital plan for the year of £12.8m.

	24/25 Plan (subject to change) **£`000**
Neonatal/PAU	5,385
Medical Equipment	2,100
Eating Disorder Daycase	570
Campus Developments	1,350
Omincell Replacement	1,000
Digital/H&S/Other	2,382
Total planned year	**12,787**

At the time of writing, the Trust have not yet had confirmation that we will receive the additional capital related to the UEC incentive scheme which may therefore increase our allocation in 24/25.

Discussions continue internally on the allocation of any remaining CDEL for the year based on prioritised need.

The capital management group will meet throughout the year to review any new requirements and also monitor spend against the plan ensuring appropriate utilisation of the resources.

5. PART 3 Summary of Divisional Plans for 2024/25

5.1 Community and Mental Health Division

Theme	2024/25 Divisional Priorities	Target Metric
Strategy Deployment	• Single Neurodiagnostic assessment pathway for ASD and ADHD • Support to the Trust roll out of 'Virtual Ward' model • Complex discharge planning as part of co-ordination of complex children and young people • Development of Alder Park site for EDYS daycase unit and new therapy services clinical space • Collaboration to delivery Alder Hey Anywhere as tool to support engagement with outpatient pathways • Deliver new national Gender Development Service for North region • Continued place collaboration in roll out of MHST programme	
Patient Safety	• Restrictive practice (restraint) programme • Reduction in overdue follow up patients and safe waiting list practice • Named Doctor Safeguarding Children, Young People and Adults (corporate) & Children in Care • Ensuring all environment risk assessments are carried out for all locations • Medicine safety- prescribing and administration • Safe staffing (Tier 4) • Sepsis and resus training • Improvements in PALS and Complaints response timeliness	90-100%
Access to Care (Activity & Waiting Times)	• Deliver a maximum waiting time of 65 weeks for ASD and ADHD pathways • Improvements in mental health and therapy waiting times (RTT 18 weeks) • Reduction in overdue follow up outpatient appointments through a focussed programme of improvement in community paediatrics • Redesign of physical environment in OPD and expansion into community clinics to support OPD growth to ensure all clinical teams have access to appropriate clinics (no waiting list) • Initial Health Assessments for children and young people entering care completed within 20 working days (receipt at Alder Hey)	100% 90% 0 0 100%
Our People and Workforce Plan	• Development of divisional education and training programme for staff at all levels, focussing on deputy and middle management support to grow the workforce of the future with a focus on EDI and HR policy training • Implementation of e-Roster across all areas of the Division and the promotion of the various features which allow for better deployment of skills to reduce bank and agency spend where possible. • Ensuring job descriptions are fit for purpose prior to recruitment • Review staff survey responses to understand what areas the division can focus on for continuous improvement. • Implementing and embedding the 'Stay Conversation' within the Division and utilising that feedback to aid our recruitment and retention strategy. • Working in collaboration with Staffside colleagues to be able to address issues early and informally where possible. • Collaborative working with the Apprenticeship team to understand what roles could benefit from an apprenticeship to proactively 'grow our own'. • Embed the HR function into teams within the Division	
Financial Sustainability	• Delivery of balanced financial position • Achieve Recurrent CIP target • Recruit to substantive posts and reduce agency usage • Achieve activity targets from additional investment	Breakeven £2.5m

5.2 Division of Medicine

Theme	2024/25 Divisional Priorities	Target Metric
Strategy Deployment	• Re-design of the acute medical model and General Paediatric Offer at AHCH (including "General Paediatrics @ its best") • Offer Co-Ordinated care for Complex Children & Young People • Sustainable collaboration to ensure service provision is maintained: Haematology, Oncology, Neurology (including "Neurology @ its best")	18 weeks Review within 12 hours
Patient Safety	• Oncology service review • Re-design of palliative care and bereavement services	
Access to Care (Activity & Waiting Times)	• Emergency Department 4 hour target • RTT waiting times, maximum 52wks and 12 specialties working to 18wk pathways • Reduction of follow up backlog by 25% • Diagnostic waiting times within 6 weeks	85% 52 weeks / 18weeks 95% by Jan 25
Our People and Workforce Plan	• Divisional health and wellbeing agenda • Full integration of EDI within the division of medicine • Further develop workforce plans to expand into new roles to ensure long term sustainability e.g pharmacy technician assistant	
Financial Sustainability	• Achieve Recurrent CIP target • Continue to achieve activity plan • Achieve financial balance by mitigating cost pressures • Reduction in premium temporary pay spend	£0 >£0 £0

5.3 Division of Surgical Care

Theme	2024/25 Divisional Priorities	Target Metric
Strategy Deployment	• Elective Recovery & Productivity including elective hub development, strong GIRFT Programme & Patient Outcomes dashboard. • Theatres @ its Best • 'Get me Well' Surgical Pathways- Re-design of surgical emergency pathways to reduce LOS, improve flow & burden on theatre capacity. • Neurodiversity- Reduce variation in LD waits & tooth extraction.	
Patient Safety	• Embed change through Acutely Unwell Child Workstreams including full HDU Medical structure & cross divisional solution with Medicine. • Sustained optimal response to PALS & formal complaints along with further learning from patient experience. • Ensure sustainability in fragile services: Burns Service, Cardiology (Intervention), Cardiac Surgery • Completion of STAT programme	100% PALS 5 days Formal complaints 25 days
Access to Care (Activity & Waiting Times)	• Eliminate C&YP waiting over 52 weeks for treatment by March 2025 • Eliminate C&YP waiting over 30 weeks for treatment in Neurosurgery, Craniofacial, Gynaecology, Cardiac Surgery and Urology. • Diagnostic test to have completed within 6 weeks. • Eliminate C&YP overdue a follow up by 2 years.	52 weeks 30 weeks 95% 0
Our People and Workforce Plan	• Clear in-house development pathways & education for management teams/aspiring leaders. • Continued focus on staff retention & reducing turnover with departmental specific initiatives including review of flexible working options. Particular focus on Theatres. • 5-year sustainable workforce plans per department to ensure long term resilience, efficiency & staff wellbeing. Specific theatre initiatives to include in house ODP Apprenticeship scheme & targeted international recruitment. • Rolling programme of Aldercare masterclasses with clear training metrics to improve use of system and reduce validation.	
Financial Sustainability	• Delivery of balanced financial position. • Achieve recurrent efficiency target. • Delivery of activity targets. • Maximise growth & commercial opportunities.	Breakeven £6.4m recurrent savings

5.4 Clinical Research Division

Theme	2024/25 Divisional Priorities	Target Metric
Strategy Deployment	• Alder Hey Research Feedback survey – improved overall experience score and participant response rate • Deliver research in community settings • Develop robust evaluation processes to rapidly evaluate innovative technology • Introduce the Alder Hey Research Charter to ensure we can support the best researcher experience • Develop a capacity building programme for researchers • Launch Alder Hey Research Strategy 2024-2030 via a series of research awareness events within the hospital and in the community • Strengthen internal, local, and national partnerships to drive forward child health and wellbeing research • Achieve agreed objectives for existing research infrastructure and programmes including AH NIHR CRF and 3rd MRI scanner • Increase research participation for under-represented groups • Support Trust net zero ambition through our GREEN CRD sustainability group reducing single use items and reducing paper waste. • Ensure the patient voice is represented in Clinical Research Division decision making and progress reviews	>95% experience >10% response Increase studies outside hospital Processes implemented 100% PIs for new studies sign Charter Project objectives achieved Implement CRD green plan
Patient Safety	• Improve oversight and learning from research adverse event reporting	100% All adverse events to be captured centrally.
Access to Research	• Increase percentage of closed to recruitment portfolio studies which have achieved their recruitment target • Meet sponsor expectations for study set up of portfolio studies • Measure research participation and number of Chief Investigators by Clinical Division	>=80% studies recruited to time and target >=80% studies set up on time Increase in participants and CIs by Division
Our People and Workforce Plan	• Introduce the Clinical Research Division Staff Pledge • Ensure staff are supported to deliver the priorities of the Clinical Research Division staff via the staff engagement forum • Continue to build Clinical Research Division staff education programme to ensure staff are supported to be the best that they can be within their roles and to progress • Ensure that the Clinical Research Division continues to meet Trust workforce targets	100% CRD signed Increased staff wellbeing scores Trustwide target metrics
Financial Sustainability	• Reinvest capacity and capability funding to support areas of strength and potential growth via an open and transparent funding call • Ensure financial transparency by communicating to researchers how capacity and capability building funds are spent • Achieve commercial and non-commercial stretched targets • Seek additional non-NHS investment opportunities to support Trust £10m target once commercial and non-commercial targets are met • Coordinate approach to Alder Hey Charity for supporting research and innovation capacity building and new discoveries	Funding call operational Guidance document published £1.1m commercial and £215k non-commercial

6. Risks and Mitigations

Once the plan is finalised and approved, detailed underlying risk profiles will be worked up and the relevant risk registers updated to reflect the 2024/25 position. It is crucial that the risks are managed through the Trust's formal governance mechanisms to ensure full and timely oversight by the Board and its committees.

This means that underpinning structures such as Divisional boards, Operational Board and the Trust Risk Management Forum will need to hold accountability at operational level, jointly and severally, for the day-to-day housekeeping and scrutiny of key risks, in particular those relating to productivity and finance but with a particular focus on ensuring safety and quality, through ongoing monitoring of QIA/EIA's.

The assurance committees are currently reconsidering risk appetites and thresholds in the context of the more challenging environment in which we are now operating. Executive leads will need to ensure that the deep dive reporting process is completed for key BAF risks during the year, linked to the transformation programme.

It is envisaged there will be greater analysis of the corporate risk register during 2024/25 given the potential volatility of some of the highly scored operational risks.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 11th April 2024

Paper Title:	**2030 - Year 2 Mobilisation**
Report of:	Kate Warriner, Chief Transformation and Digital Officer Natalie Palin, Director of Transformation and Change
Paper Prepared by:	Natalie Palin, Director of Transformation and Change Natalie Deakin, Head of Service – DMO Colin Beaver, Deputy Director of Marketing and Communication Rachel Lea, Director of Finance and Development

Purpose of Paper:	Decision Assurance Information Regulation	☐ R R ☐
Action/Decision Required:	To note To approve	R **R**
Summary / supporting information	**Trust Board 22/23/06**: Operational Plan 22/23 Trust Integrated Performance Report **Strategy Board** – Strategic Scorecard (July 23) **Transformation Programme (Report Dec 2023)** Transformation programme (Feb 24) Annual Plan 24/25	
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	R R R R R
Resource Implications:		

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score
	We are continue to evolve our risk profile in relation to Vision 2030, and this work will be discussed at our strategy board.	

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

0057		applied and effective in practice				

1. Executive Summary

The primary purpose of this report is to outline the mobilisation plan for launching years 2-3 of Vision 2030. This approach marks a significant shift and aims to deliver an integrated annual plan for 24/25 and an aligned portfolio of programmes directly connected to realising Vision 2030. Our progress in developing an integrated strategic plan demonstrates an increasing maturity in incorporating our improvement management system, Brilliant Basics (BB), into our operations. The effect of this includes a direct alignment from vision and goals to strategic, divisional, and service improvements; and how we manage change being the BB way.

This report aims to provide a comprehensive overview of the following key areas:

- ✓ 24/25 integrated strategic plan and multi-year vision-led transformation.
- ✓ Governance and Assurance
- ✓ Benefit Realisation
- ✓ Review of Change Resources
- ✓ Communication Plan
- ✓ Highlighting Areas of Progress and Good Practice

The mobilisation plan was approved at RABD (25.03.24), for submission to Trust Board.

Key Risks:

A significant risk associated with the development and deployment of the Vision 2030 is the potential constraint imposed by traditional organisational silos. To address this, our approach to strategy deployment and governance oversight seeks to integrate our governance arrangements to ensure an enhanced alignment, visibility, resource management and control.

Recommendations to:

- Approve: The outlined mobilisation plan and benefit plan.
- Approve: A priority focus on the portfolio of programmes under Acute Medical Model, Productivity and GIRFT, Home First with the support of the enabling strategic goals
- Note: The revisions to the governance arrangements for 24/25 and beyond.

2. Background and Future State

Background: With the endorsement of Vision 2030, '**A Healthier, Happier, and Fairer Future for Children and Young People'**, we have embarked on a transformative journey, redefining our approach to address CYPF (Children, Young People, and Families) needs. In deploying our vision, and in responding to CYP needs, we have organised ourselves around four cohorts of patients (areas of need):

1. Get Me Well
2. Personalise My Care
3. Improve My Life Chances
4. Bring me the Future

Central to this transformation is an integrated programme of change, delivering new capabilities through our 5 strategic goals '**Outstanding Safety and Experience, Revolutionising Care, Supporting our People, Pioneering Breakthroughs and Collaborating for CYP',** all of which are in direct alignment with our overarching vison 2030.

The scope of Vision 2030 encompasses all aspects of our care, operations, innovations, partnership collaborations, people, and digital advancements. Given the complexity and scale of these goals, a cohesive and coordinated approach to oversight and programme management is essential. During 23/24 we commenced our journey in delivering 2030 and have made significant progress in initiating and delivering the programmes during year 1. Given the scale of change required to achieve 2030 we are continuing to ensure that our transformational programmes will take us on the journey towards 2030; plus strengthening how we deploy, oversee, and govern this portfolio of change (see governance section).

Future State: For 24/25 and beyond we have made a step change through the development of an Integrated Plan (see figure 1). The benefit of this approach includes direct alignment to CYPF areas of need, preventing siloed efforts and ensuring that our resources can be prioritised where they are most needed. The approach also simplifies the process of monitoring and evaluating progress.

Table 1: Strategic Goals Overview

Strategic Goals	Goal for 2030	Focus for 2024/25
Outstanding Care and Experience	Push ourselves to always provide the best possible experience for children, young people, and families, continually testing this with them and building on their feedback.	• We will improve safety, quality and experience • Deliver PSIRF and advance our learning culture • Enhance relationships with families and implement Martha's Rule • CQC preparedness for Outstanding for Safety • Care of deteriorating patients
Supporting Our People	Understand our people better. What drives them. Develop shared motivations and ambitions by treating them as individuals and ensuring that they can have fulfilling careers.	• We will support our people to thrive and belong • We will strengthen workforce planning and drive value, and develop our people to meet our future needs • Empower our people to deliver Vision 2030, using our Brilliant Basics improvement system
Pioneering Breakthroughs	Provide the right conditions and infrastructure for inter-disciplinary collaboration that discovers and deploys pioneering breakthroughs in paediatric health care.	• Creating clinical capacity by deploying technology that reduces administration burden • Backing our researchers, educators, and innovators (through time and support services) • Powerful computing and secure data environment • Securing new investment • Northern Institute of Child Health and Wellbeing
Revolutionising Care	Harness the latest technologies to ensure delivery of the very best health and care outcomes for children, young people, and	• We will develop new models of care (including a new Acute Care model – creating capacity to see more CYP) • We will harness digital advancement and data led intelligence • We will drive the CYP Alliance

0059	families. Do things differently. Do things better.	• We will deliver more care 'Home First' and improve co-ordination of care • We will develop networks at Place level • We will drive improvement in our efficiency and productivity through GIRFT and data insights
Collaborate for Children, Young People and Families	Use our combined knowledge and resources to develop and deliver a system that children, young people and families can find their way round and get the best out of.	• We will work in partnership to improve the life chances of Children and Young People • We will ensure that the CYP landscape and system architecture is delivering benefits that improve the life chances of CYP • We will create a system that invests in children and puts them first and brings services together in a way that is better for CYP • Delivering against our Net Zero ambition • Continue our journey for our Campus that brings together physical and mental health and wellbeing

In the context of the development of an integrated strategic plan, we are moving towards a balanced portfolio of vision led longer term transformational programmes, plus driving in year financial benefits through process improvements programmes designed to enhance efficiency. The combination of both aspects is essential to support the achievement of the in-year financial efficiencies (£19 m), alongside multiyear vision led transformation (£12M of efficiency target) which will enhance outcomes for CYPF and improve the working lives of our people.

Table 2: Big Aims for In Year and Multi Year Programmes

The below table (table 2) details the multi-year benefits that we will be tracking as part of Vision 2030 Strategic Scorecard, these are a combination of needs of CYP outcomes, and associated driver benefits which will advance meeting CYPF needs. Key outcome benefits relating to safety and our people, are detailed due to the cross-cutting and enabling impact for achieving improved outcomes for CYPF.

CYPF Areas of Need	Objectives	Key Outcomes and Benefits (Driver)
Personalise My Care	• We will provide coordinated care closer to home	• To reduce missed education (Baseline – in school time appointments) • Reduce burden for families to attend hospital appointments (Cost per appointment £35)

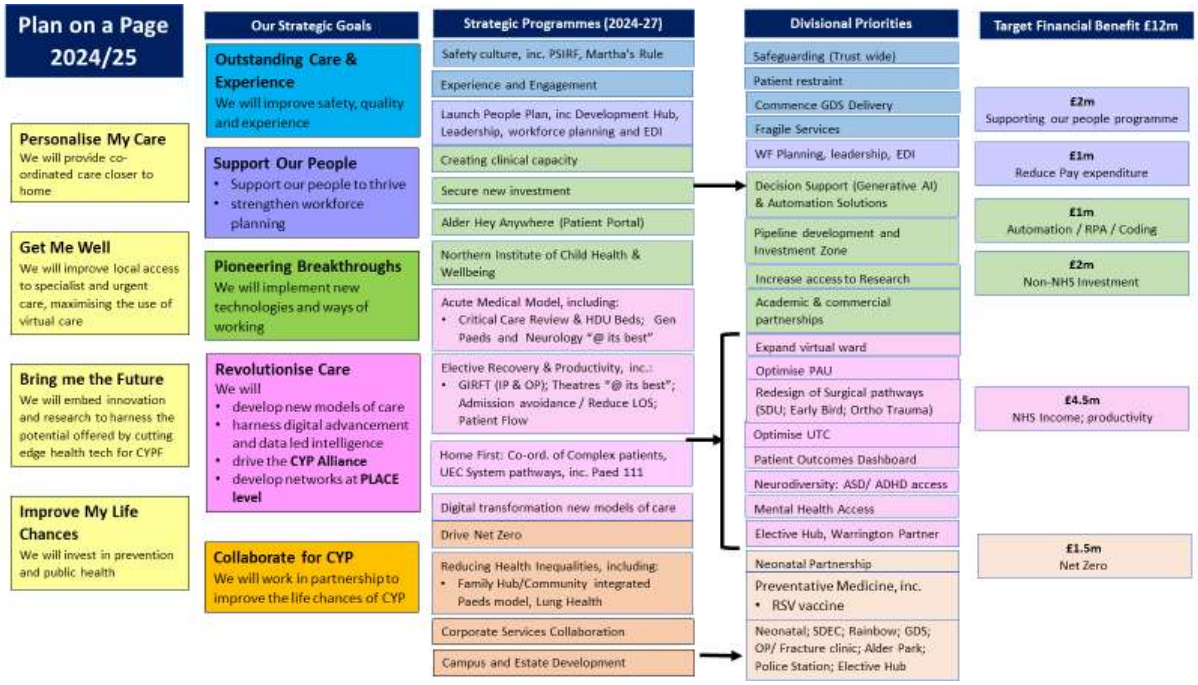
Get Me Well	• We will improve local access to specialist and urgent care, maximising the use of virtual care	• **Improve waits and experiences:**
		  • Reduce waiting time to access planned and emergency care – activity target 115%
		  • Improve our productivity ratio by (to be developed)

Bring me the Future	• We will embed innovation and research to harness the potential offered by cutting edge health tech for CYPF	• Empower families and children to have control of their care:
		  • Provide a patient portal that supports empowerment and enhances experience
		  • Pioneering treatments, services or diagnostics deployed to care

0060		• Secure £10m of inward investment – to enable us to be innovative and deliver cutting edge care.
Improve My Life Chances	• We will invest in prevention and public health	Ensure our change initiatives have positive impact on CYPF life chances (see above Personalised care) • Increase portion of system £ directed towards CYPF • Create education and employment opportunities for CYP and generate at least £158k of social value • Reduce inequalities for CYP • Net Zero - reduce our carbon emissions to 15%
Cross cutting enabling – CYPF Outcomes		
All CYPF	• Outstanding care and experience	• To reduce patient harm by 5% (for physical) • Improve CYPF experience – 95% FFT
Our people	• Support our people	• Reduce sickness 5% • Reduce turnover to 10% • Headcount control – creating space, give the tools to do their jobs and reducing bureaucracy

To ensure connected, effective programme planning, and to meet the emergent system productivity challenge, in 24/25 we will have a priority focus on the portfolio of programmes under Revolutionise my care - **Acute Medical Model**, **Productivity and GIRFT**, **Home First.** We will ensure underpinning support through the strategic goals where they enable these to go further, faster (*Experience / Safety, People and Pioneering Breakthroughs*). Alignment around these three goals, will enhance focus, improve co-ordination and collaboration, reduce silo working and is linked to improved agility in the allocation of our change resources.

Diagram 1: Plan on a Page



N.B. Please note appendix 1 – includes the high-level milestones plan

Leadership: The SRO (Senior Responsible Officer) accountability has not changed for 24/25, however the programme profile for Revolutionising Care has been realigned to reflect the expanded scope. The expansion of scope was essential to ensure effective management and oversight, and this has been undertaken alongside our Divisional ACOOs to ensure effective alignment.

Each of our strategic programmes, to varying degrees, will necessitate a system-wide approach, with our success being deeply tied to our capacity for partnership-level influence. As such, we have enhanced the connections among our strategic programmes that are aligned with **'Revolutionising Care and Collaborating for Children and Young People (CYP)**.' This enhanced coordination, especially in these domains, through meticulous planning and robust governance oversight, aims to minimise duplication and improve alignment. Such efforts will not only bolster our engagement with place level plans but also foster synergies across.

Governance and Assurance

Background: Effective programme governance is important as not only does it provide a structure to manage change, but it also ensures accountability for the leadership of change. In establishing our Vision 2030 a new structure of internal governance and delivery forums were developed (Vision 2030: April 23, Trust Board). At the December 23 (Trust Board), amendments to the governance arrangements were approved, which sought to ensure meeting effectiveness and most importantly minimal viable bureaucracy. Table 2 is designed to provide assurance to the Board that we have established these forums and have invested a significant leadership capacity in supporting the mobilisation of these structures.

Table 3: Strategic Plan Governance Structure

Governance forum	Purpose	Frequency	Chair	YTD – numbers 23/24
Trust Board	Strategic Plan – Governance and Assurance*(from Nov 23)	By-monthly	Trust -Chair	3
Strategy Leadership Board (SLB)	Strategic Direction and Outcome achievement* (From July 23)	Quarterly	Trust – Chair	2
Scrutiny Areas of Need	To review our success and progress in organising ourselves around CYPF Need. (From Sept 23)	Quarterly	CEO	2
SROs meeting	Alignment: align our initiatives, resources, and priorities, ensuring that they remain in sync with our overarching strategy. (From Dec)	Monthly	Managing Director	3
Strategic Leadership Group (SLG)	Programme Board - for our Strategic Deployment, with accountability for achieving the 2030 vision.	Monthly	Managing Director	5 *(stepped down during Alder Care deployment)*

The one area that we will seek to enhance as we move into 24/25 will be our approach to the Scrutiny group to Areas of Need, while it's helped to set direction its members have not been sufficiently separate from the design / delivery. The direct

voice of CYPF either directly, or through professionals with lived experiences also requires strengthening. It, however, must be acknowledged that this is part of our evolving journey, where iteration and continuous improvement plays a key role.

Future State: In developing a single plan, the requirement to integrate the governance controls alongside the usual business activities is essential. This alignment is required to ensure the entire breadth of organisational change is understood alongside the demand and capacity for resources. This can only be achieved through **visibility** and governance **control**, which will ensure that 2030 deployment is perceived as a collective responsibility, rather than as an isolated corporate activity which is independent of the wider organisation context.

The most significant recommended change proposed to the governance structure is a comprehensive revision of the Terms of Reference (ToR) for the Strategy Leadership Group (SLG) and the naming convention to enhance its effectiveness in overseeing the portfolio of programmes for 24/25 and beyond. The naming convention going forward will be 2030 Programme Board (2030 PB). The aim is to ensure that the SLG operates with a framework that promotes strategic alignment, operational efficiency, programme and governance oversight, and ultimately the achievement of our strategic vision. By enhancing its structure, clarifying its roles and responsibilities, and establishing clear processes for decision-making and communication, the SLG will be better positioned to drive Alder Hey towards achieving our goals and realising benefits.

As per the RABD terms of reference, RABD will have a responsibility for assurance of our integrated programme (Resource and Business Development Committee). This will ensure that we are realising our benefits and deliver against our benefit with a particular focus on those which will support our financial position. To support effective oversight of our transformational programme all our strategic programmes will be assessed against our programmes '**governance and assurance framework'.** This will sit alongside a standard BB Highlight Report and a strategic scorecard.

Programme Governance and Assurance Framework

Programme assurance plays a pivotal role in the successful deployment and delivery of change. This section of the report details the evolving assurance framework that will be used for the 2030 programme and is based on the Association for Project Managers (APM) toolkit. Appendix 3 details the criteria of assessment and a high-level description of expected evidence required to achieve standard. The framework will provide a common generic basis for the assessment of portfolios, programmes and projects of all sizes and at any point during the project life cycle.

Programme assurance reviews will take place bimonthly and objective evidence will be sought to assess projects using 10 key criteria outlined in the table below. The Programme Assurance framework will be applied to the entire 2030 vision strategic programme following endorsement by the Trust Audit Committee.

The assurance ratings will be available on a live dashboard and submitted to Vision 2030 Programme Board, and to RABD, as well as Trust Board on a bi-monthly basis.

Our Benefit Realisation approach

Background: As highlighted in the Transformation Report (Dec 23), our **Benefit Realisation Approach** was redesigned during the third quarter of 2023/24. A pivotal development in our approach is the creation of a **Benefit Case framework.** This framework is instrumental in pinpointing the baseline position and expected benefits derived from our transformational changes. It establishes a solid foundation for monitoring the benefits realised, including those leading to cash releasing savings, enhanced productivity, income generation, and social value return.

The importance of organisational financial sustainability cannot be overstated, especially considering the expected £19 million efficiency requirements for 2024/25. Moving forward, every investment decision and change initiative will necessitate the formulation of a benefit case.

Current state:
Over the past month, we have made significant progress in enhancing our suite of benefit cases. This includes responding to the recommendations from RABD (Feb 24), which involved conducting more in-depth analysis concerning our workforce and safety measures. Table 4 presents the updated status and introduces a RAG (Red, Amber, Green) rating. This rating distinguishes between savings that can be confidently implemented and those that need further refinement.

As we transition into the 2024/2025 period, we find ourselves in a favourable position, having established a programme that outlines clear benefits. This is despite the financial goals being set higher than those previously established. Consistent with our standard operating procedures, Equality Impact Assessments (EIAs) and Quality Impact Assessments (QIAs) will be necessary for these change programmes.

Table 4: Benefit Plan – summary table

	Implemented	Plans in Progress	Opportunity	Gap	TOTAL
Elective Productivity (IP & DC)	3,500				3,500
Outpatient Productivity	600		360	40	1,000
Workforce - Absence & Turnover		500	1,500		2,000
Workforce - Skill Mix Planning	80		920		1,000
Automation & Coding		300	636	64	1,000
Non NHS Investment			2,000		2,000
Net Zero	650		550	300	1,500
Sub Total - Strategic Transformation	**4,830**	**800**	**5,966**	**404**	**12,000**
Other Efficency Schemes	691	2,411	1,174	3,024	7,300
Total	**5,521**	**3,211**	**7,140**	**3,428**	**19,300**

Review of our widest Change Resource

Background: During our Trust Board meeting in December 2023, we made a significant move towards optimising our organisational resources by approving a vital recommendation. This recommendation focused on the alignment of our broader change resources, crucial for the support and implementation of our strategic goals. Our current centralised Delivery Management Office (DMO), with its 4.5 Full-Time Equivalents (FTEs), has been instrumental in this endeavour, underscoring our

commitment to a strategic and cohesive approach towards achieving our Vision 2030.

Current state: As of March 2024, our Trust is at a pivotal moment in the realisation of our Vision 2030 strategic plan. Following the agreement on our programme for the 2024/25 year, we are now in the process of reviewing and aligning our resources to the identified priority areas of focus. This crucial step ensures that our resources are not only effectively allocated but also that they are directed towards initiatives that hold the greatest potential for impactful outcomes in line with our strategic objectives.

In the initial phase of 2024, our engagement efforts with the Executive Team and Divisional Leadership teams have been productive. This collaborative approach facilitated a comprehensive assessment of our change resources, revealing a total capacity of 37.5 Full-Time Equivalents (FTEs) spanning across various corporate and divisional services. This assessment has been a cornerstone in the co-creation of a proposal focusing on four key elements for resource alignment and optimization:

1. **Integration of HR/Organizational Development and Transformation Resource**: Leveraging our '@ Its Best' methodology, this strategy aims to harmonize cultural and transformational change efforts, enhancing team-based improvements.

2. **Support Resource Alignment for Strategic Programmes**: This includes crucial areas such as Digital Transformation, Communication, Business Intelligence, and Finance, ensuring that these pivotal support resources are aligned with our strategic initiatives.

3. **Agility in Resource Allocation**: By aligning broader change resource specialists, we aim to support the delivery of specific projects, including those focused on Safety, Divisional PMO, and Innovation initiatives, enhancing our response to emerging needs and opportunities.

4. **Establishment of a Transformation and Improvement Hub:** Creating a unified access point and a dedicated physical space to facilitate easier access to centralized support and resources, promoting team-based improvements and universal access to change facilitation tools (based physically in the Innovation Hub).

With our programme for 2024/25 now agreed upon, our current focus shifts towards ensuring that our resources are not only aligned with but also fully supportive of our priority areas. This involves a strategic review and reallocation of resources to guarantee that our efforts are concentrated where they can achieve the most significant impact. The alignment process will respect the existing line management structures to ensure a smooth transition and swift adoption of the integrated approach, with an emphasis on maintaining agility and enhancing organizational capabilities.

As we continue to refine our strategies and realign our resources, we are guided by the principle of making meaningful progress towards our Vision 2030. This period of strategic alignment marks a critical step in our journey, setting the stage for a year of targeted action and transformative achievements.

Communication and Engagement Plan

The communications strategy to support Vision 2030 will involve all Alder Hey

communications (with some exceptions) being realigned and delivered under the 2030 ‘brand’. This will mainstream Vision 2030 as integral to everything we do.

Inherent to this will be Our People and the role they will play in achieving Vision 2030. Put simply: without them, we won’t. Appendix 2 details the communication plan including the key narrative and messages.

Capturing content

Narrative and key messages must be underpinned by evidence. This is the story behind the soundbites. Without them, it is all rhetoric. But capturing the stories can be difficult when adequate coverage is limited by resources.

To combat this, an Editorial Board will be established (actual name TBC). This will be Chaired by the DD, Marketing & Communications, and will sit monthly to capture available content both now and planned. The Board will comprise representation from agreed areas of activity, incl. each of the transformation workstreams, who will attend and pitch their content and it be discussed. The group will determine which of two groups the content falls into: ‘hearts and minds’ or ‘nuts and bolts’. The former will be considered for ‘hero’ coverage, to convince audiences, whilst the latter will be maintenance for those already bought in.

New communications channels

Tactics will be employed to increase traffic to the intranet, which will become the Trust’s primary source of information. Emails will be reduced in number and frequency, their content more focused on urgent and/or need-to-know communications.

Driving traffic to the intranet will be a monthly Vision 2030 (Alder Hey) newsletter, delivered electronically, by email, with a video/print counterpart made available to hard-to-reach staff groups – and everyone else why chooses to consume their content that way. The newsletter will be fully Vision 2030 branded and will feature the ‘hearts and minds’ content drawn from the Editorial Board.

For stakeholders, a regular Vision 2030 Stakeholder Bulletin will be created that uses the same content from the Editorial Board, linked to a dedicated space on our website where other resources will be available, e.g.: a ‘flip book’ version of the 2030 brochure, videos.

Delivery

The detailed plan in appendix 2, will be delivered on a phased basis, which will broadly run as follows:

- Phase 1 (April 2024): ‘Launch’, visible and practical, to raise awareness – environmental branding, intranet resource hub, etc.; establish Editorial Board; begin stakeholder newsletter development
- Phase 2 (May 2024): Plan for ‘Our People’, launch People Hub on Mezzanine, walkabout/profile raising for HR & OD ‘connecting’; first monthly newsletter and dedicated open meeting; realign social media
- Phase 3 (June 2024): First long form ‘areas of need’ video; first stakeholder newsletter, campaign development

3. Assessment of Progress

As we look ahead, gearing up for a dynamic and impactful year of activities, our commitment to excellence and strategic foresight remains evident in the accomplishments of the final quarter of 2023/24. The diligent execution of our milestone plan has not only kept us on the path to achieving our long-term goals but has also allowed us to set new benchmarks in operational excellence and innovation.

In accordance with our continuous improvement approach (Brilliant Basics), we are always seeking excellence; with that in mind this section also identifies opportunities to enhance our internal systems of control, to further advance our strategic deployment.

Table 5: Key Achievements and Areas of Good Practice

Goal	Baseline / Target	Highlights	Areas of good practice
Experience & Engagement	Target – 95% CYPF Satisfaction Score (FFT) 23/24 YTD – 93% (FFT)	**Experience driving the entire organisation** - ○ Year 2 programme scope agreed. ○ Filming is now complete for phase 1 of the Alder Hey virtual tour with a first reveal to the organisation scheduled for May 24. ○ Resource identified for in house customer service training through the L&D Team ○ Effort score utilised as a method to capture the ease/difficulty our CYPF have to interact with our organisation. ○ Alternative WhatsApp supplier identified and due diligence near complete with the view to pilot in March 24 with the soft launch of Martha's Rule. ○ Alder Hey warm welcome standards launched. ○ Spotlight on Warm Welcome Newsletter published written by the staff working group.	✓ Alder Hey warm welcome standards co-designed with children and young people from start to finish. ✓ Great feedback received for Experience & Engagement week. ✓ Another staff opportunity to get involved with delivering Alder Hey's vision for 2030 to assist with ensuring all of our patient information leaflets are accessible to all. ✓ Utilisation of A3 to allow deeper analysis into the use of the preferred name function on Alderc@re.
Our people	1% reduction in staff sickness rates 5.5% 1% reduce staff turnover to 13% YTD - 11%	**Thriving Leaders** ○ 8/14 management essential courses launched in February – progressing well, being booked up. ○ Remaining 6 courses launching soon **Preceptorship** ○ Trust successfully obtained National Preceptorship Interim Quality Mark. ○ AHP posts have gone through consistency panel now going onto Trac. ○ AHP Preceptorship self-assessment tool provisionally completed as part of C&M AHP workforce project. **Induction and orientation** ○ Launching new induction April 24 – on track ○ Moving to a more comprehensive 4 stage induction with pre and post work and full day induction onsite ○ Engagement and research complete ○ Working group in place	✓ Pivoting the collective resource around Preceptorship and Development of a Managers Essentials Offer. ✓ Staff thriving index question agreed and in development. ✓ Professional hub initiatives starting April 24 – focus group in place
Futures	No. Of solutions deployed to care +/- to market	○ Futures Leadership Group established and meeting regularly. ○ Engine room progressing well with baseline data collected. ○ Programme structure established and recruitment of workstream leads commenced. ○ Data and AI working group established.	✓ 124 staff members contributed to our thinking around the Futures strategy via engagement sessions. ✓ 1st commercial partnership agreement developed and signed (Strasys).

Collaboration in communities	0068 Generate Social Value across LCR 23/24 Baseline: 0 Target: £168k YTD – £107k Reduce variation in health care outcome- CORE20+5CYP metrics in development	**Family wellbeing Hub:** ○ Charity approved funding application – bringing together all support in one place. ○ Mobilisation set for April 24 – on track. **Advocacy:** ○ Year 1 focus agreed. (Respiratory, lung health) ○ 1. Children and Parent voices. ○ 2. Evidence and clinical research ○ 3. Crosscutting view of health inequalities **Employment and education** ○ 2 x B5 roles secured to progress work. ○ £107k of social value generated to date. ○ First draft of social value dashboard on Power BI ○ Delivering care leavers projects in C&M with Catch 22 - getting Care leavers into Careers ○ Young people from ACE group are curating a public exhibition at the Walker Art Gallery in partnership with Hope University **CYP System:** ○ CYP Committee and CYP Alliance established. ○ Workstreams for Elective Recovery and Urgent Care are emerging. **Greener:** ○ Energy optimisation project ongoing with SPV – focused on fixing heating. ○ Waste - compactors operational. ○ Circular economy grant bid submitted with LUHFT ○ Working on joint bid with ICS and reviewing option of LCRCA wide approach. **Air quality / housing / Respiratory:** ○ Post code data for respiratory patients analysed with LCC for housing issues.	✓ Engagement with youth forum to develop Family Hub idea and approach. ✓ Respiratory project presenting to Liverpool NHS execs in Feb. Housing/ environment proposed as workstream. ✓ Reviewing respiratory' 'high consumer / costs' by postcode and reviewing with LCC team to identify common suppliers & issues. ✓ Following up Marmot housing group work. Opportunity to combine TORUS air quality findings with LCC Net zero plans. Funding bids available in March.
Revolutionising Care	Efficiency / productivity Clinical Capacity (Elective Capacity) To be baselined	○ Development of the Alder Hey Anywhere at testing phase **Operational Improvement:** ○ Virtual ward pilot started, following successful lobbing to invest in paediatric care £200k investment secured. ○ Development of PAU – aligned to 'Get Me Well' ○ Gen Paeds '@ its best' listening sessions provisionally scheduled for May-24. **Virtual Urgent & Emergency Care:** ○ Technical configuration discussions underway to allow 111 to directly booked into our UTC slots. ○ Alder Hey agreement to continue to support Pharmacy First Service (went live 1st Feb 24). **Personalise My Care:** ○ 7 data methods tried and tested. ○ 50 CYP for proof-of-concept (PoC) identified. ○ Auditing of the PoC CYP cohort in progress. ○ Opportunities to transform appointment coordination. ○ Deeper process mapping in progress. ○ Booking & Scheduling PDSA due to go-live by w/e 15.03.24. ○ CYPF engagement commenced.	✓ Virtual ward, contributing to our areas of Need for both Get me Well and Personalised Care. Biggest paediatric virtual ward in country and consistent achieving 80% occupancy. ✓ Clinical Summits (2) ✓ **Personalised Care**: Clinical workshops (3) consensus on the definition of the level of complexity that warrants coordination as a starting point. Appreciative inquiry in progress – gathering learning and benchmarking.

4. Conclusion

In conclusion, this report provides a detailed update on our Vision 2030 Strategic Plan, marking significant strides since our last briefing in February 2024. It also signals the direction of focus and ambition for not least the next 2 years. Acknowledging the inherent risks posed by traditional organisational silos which might hinder the progress of our Vision 2030 Strategic Plan, we underscore the critical importance of advancing our Benefit Realisation and Integrated Plan for the 2024/25. This will not only ensure a seamless and strategic cohesion of our efforts but will also maximise the utilisation of our diverse capabilities and resources.

The development of our integrated plan and the aligned benefit approach we are adopting signifies our proactive stance in navigating the complexities of operational improvement alongside strategic transformation. By doing so, we are setting a precedent for operational excellence and strategic foresight, ensuring that our actions are continuously refined and aligned with our overarching goals for 2030.

Recommendations & proposed next steps

The key recommendation arising from this paper is to note the significant progress made to date. To approve the below areas, with reporting of progress to be included in the next board report.

To continue development of: -

- Approve: The outlined mobilisation plan and benefit plan.
- Approve: A priority focus on the portfolio of programmes under Acute Medical Model, Productivity and GIRFT, Home First with the support of the enabling strategic goals
- Note: The revisions to the governance arrangements for 24/25 and beyond.

Appendix 1: Multi-year milestone plan
Appendix 2: Detail communication plan
Appendix 3: Programme Assurance and Governance Framework

Appendix 1: High Level Milestone Plan

	Driver Metrics	CYPF Need	23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4
Experience	CYPF Effort Score	All	Interim target to reach a 95% CYPF Experience Score				Baseline to be established		Reduce CYPF Effort Score				
	Reduce Patient Harm	All	25% Reduction in Patient Harm			Need Measure							
Our people	Staff Turnover	All	1% Reduction in staff turnover			3% reduction in staff turnover							
	Staff Thriving Score	All	Interim target to reduce sickness by 1%			Baseline to be established		Improve Staff Thriving Score					
Pioneering	Innovation Adoption (revenue / investment)	Bring me the future	Baseline being established					Number of solutions deployed to care +/- to market					
	Clinical capacity to innovate	Bring me the future	Secure £10m external funding										
Collaborating	Social Value Generated	Improve my life chances	Baseline being established			£159k of Social Value generated							
	Reduce variation in health outcomes (Core 20+Plus)	Improve my life chances	Dentistry-0 CYP < 10 yrs waiting > 52 weeks; CAHMS-No. of CYP referred from BAME increases; LD-Reduce waiting times in line with non-LD										
Revolutionising Care	Efficiency / Productivity Target (Resource Optimisation)	All	Activity target 110%				Activity target 115%						
	To reduce avoidable missed education	All				Baseline Measures to be established							
	To improve timely access to care (Urgent and Elective)	Get me Well	Incr. Virtual Ward capacity from 15 to 20										

	Workstreams	CYPF Need	Q2 Jul	Aug	Sep	Q3 Oct	Nov	Dec	Q4 Jan	Feb	Mar	Q1 Apr	May	Jun	Q2 Jul	Aug	Sep	Q3 Oct	Nov	Dec	Q4 Jan	Feb	Mar	Q1 J-M	Q2 A-J	Q3 J-S	Q4 O-D
1.1	**CYP&F Engagement & Experience**	**All**																									
1.1/1	All CYPF receive a 'warm Alder Hey welcome'	All										✶															
1.1/2	CYP promises embedded	All								✶								✶									
1.1/3	Hotel & Customer Services providing outstanding customer service	All													✶												
1.1/4	Seeking the voice of CYP&F	All																					✶				
1.1/5	Effective and efficient communication channels	All																					✶				
1.2	**Thriving at Alder Hey**	**All**																									
1.2/1	Accessible and Diverse Recruitment	All																									✶
1.2/2	Enhanced Induction and Orientation	All										✶															
1.2/3	Thriving Leaders Framework	All															✶										
1.2/3/1	Management essential courses launched	All								✶																	
1.2/4	Enhancing Preceptorships	All													✶												
1.3	**Professional Development Hub**	**All**	To be initiated Q1 (24/25)																								
1.3/2	**Professional Development**	All																					✶				
1.4	**Future Workforce**	**All**	To be initiated Q1 (24/25)																								
1.5	**Futures**	**Bring me the future**	To be initiated April 24																								
1.6	**Collaborating in Communities**	**Improve my life chances**																									
1.6/1	Embed Health Inequalities & Prevention Programme	Improve my life chances												✶													
1.6.1/1	Launch Family Wellbeing Hub	Improve my life chances										✶															
1.6/2	Further embed Greener Initiatives	Improve my life chances																					✶				
1.6/3	Renowed advocates for CYP healthcare need	Improve my life chances																		✶							
1.6/4	Creating opportunities with social value for CYP	Improve my life chances																	✶								
1.6/5	CYP System	Improve my life chances																					✶				
1.7	**New Models of Care**																										
1.7/1	**Get me well -** Transfroming Respiratory	Get me Well																					✶				
1.7/2	**Get me well -** New UEC pathways	Get me Well								✶		✶															
1.7/3	**Personalised Care -** Care Co-ordination Proof-of-Concept	Personalised Care																		✶							
1.7/4	**Personalised Care -** Transforming Appointment Co-ordination	Personalised Care																		✶							
1.7/5	**Ops** - Enhancement of Virtual Ward Offer	All									✶																
1.7/6	**Acute Medical Offer:** Neurology '@ its best' listening	All										✶															
1.7/7	**Acute Medical Offer:** Gen Paeds '@ its best' listening	All											✶														
1.8	**Digital Centre of Excellence**	**All**																									
1.8/1	**Digital Centre of Excellence** - Alderc@re optimisation	All															✶										
1.8/2	**Digital Centre of Excellence -** Launch infrastructure strategy	All												✶													
1.8/3	**Digitally Enabled Personalised Care -** Launch Alder Hey Anywhere Phase 1	All									✶																
1.8/4	**Digitally Enabled Personalised Care -** Symptom checker expansion and Virtual Urgent Care Model	Get me Well									✶																
1.9	**Insight Led Decisions**		To be initiated Jan 24																								

Appendix 2: Detail communication plan

Narrative

“Alder Hey is committed to creating a healthier, happier, and fairer future for children and young people. We put their needs at the heart of everything we do.

“To us, ‘a fairer future’ means a world where educational opportunity, health and wellbeing isn’t limited by a child’s social, economic, or ethnic background. By addressing health inequities, we tackle the pressure on our services. If we focus our efforts locally and regionally, we can make an impact nationally and globally.

“Our People are our greatest strength. We are one of the busiest children and young people’s NHS Trusts in the UK and have been a world leader in healthcare and research for over 100 years.

“We have a determined focus on outstanding care and experiences, supporting our people to be their best, revolutionising care and delivering pioneering breakthroughs.

“We are here for children and young people. We improve their health and emotional wellbeing by providing the highest quality innovative care and working alongside our partners, through a collaborative health and social care system that has a shared focus on their needs. We do this so CYP can grow, unhindered, their opportunities not limited by circumstance, and fulfil their potential.”

Key Messages

- Our vision is for a healthier, happier and fairer future for CYP
- **We must put children and young people’s needs at the centre of everything we do**
- ‘A fairer future’ means a world where educational opportunity, health and wellbeing isn’t limited by a child’s social, economic or ethnic background
- By addressing health inequities, we tackle the pressure on our front door
- If we focus our efforts locally and regionally, we can make an impact nationally and globally
- Our People are our greatest strength. We need to create an environment that they can thrive in
- We must work alongside our partners, through a collaborative health and social care system that has a shared focus on the needs of CYP
- We won’t achieve our vision without the dedication and talents of our people, it's through fostering a culture of innovation, learning and improving that we can make our vision a reality.
- Our vision 2030 allows us to confront the economic challenges directly, by focusing on a fair and equitable future for CYP.

Delivering ‘Hearts and Minds’: Brand positioning for our Vision, and for Alder Hey

Some examples of what we could do:

- We will create long-form ‘documentary’ videos, one each quarter, each telling the story of one of the four areas of need. So, for instance, ‘Personalise my care’

0072could bring to life the work being led by our clinical leads, presenting startling evidence for change, and each featuring children and young people at their centre. This will help to create understanding and belief in what we're trying to achieve – and the work that we're doing **now** to achieve it

- We will create a 'People Hub' on the Mezzanine, repurposing and rebranding available space to create a People-centered zone, incl. SALS, the Tech Bar, FTSU and more. Launch will be supported by outreach from the HR & OD team, floorwalking and raising their profile and the profile of the support on offer, connecting with our staff base, and helping them to feel nurtured
- We will retool social media content so that it appeals to both our people and our public; we will hashtag curated content #outstanding, #pioneering, etc., to drive home our brand attributes, always maintaining eye-contact with our North Star: a healthier, happier, and fairer future
- To help position Alder Hey as a global leader in paediatric healthcare, we need to consider undertaking brand campaign activity such as, for instance, the development of an international practitioners' conference, supported by PR. This would allow us o target influencers in the international arena and so enable us to amplify our own brand by association. Associated papers, discussion, etc., would be the focus of a sustained PR campaign. Cost would obviously be a consideration, but sponsorship could be explored.

Other tactical activity will include:

- Replace the old plan on a page ('two trees') throughout the Trust with the new 'sunflower' version. This includes current environmental branding e.g., on the mezzanine which will be removed and updated in line with the refreshed look and iconography of Vision 2030
- Intranet resource and associated: Create a dedicated space on the intranet for Vision 2030 comms, feat. news, updates, discussion and resources to view and/or download, incl. the plan on a page, brochure, videos, creative assets (templates/graphics)
- A monthly, virtual open meeting dedicated to each of the strategic initiatives, providing updates on activity and taking questions. This will be led by the Programme Teams to ensure authenticity
- Broadly accessible highlights summary of progress towards the objectives of Vision 2030; 'Vision 2030: Our Journey So Far…'

Table 4: Programme Governance and Assurance Framework

	Criteria	Criteria Description
1.	**Client & Scope**	clear and controlled baseline requirements, objectives, success criteria, business case, terms of reference, contracts and benefits realisation.
2.	**Risks & Opportunities**	management of risk and opportunity through the life cycle of the project.
3.	**Planning & Scheduling**	appropriately detailed execution strategies, plans and schedules.
4.	**Organisational Capability & Culture**	people, behaviours, teams, processes, systems and the working environment.
5.	**Supply chain**	procurement processes, engagement with, and capability of, both the internal and external supply chain.
6.	**Solution**	the deliverables and outcomes that meet the client requirements. This includes product and/or service quality and the impact of the finished product or service on the social, physical and economic environment.
7.	**Finance**	commercial management and administration.
8.	**Social Responsibility & Sustainability**	managing the impact of project delivery on the social, physical, ecological and economic environment; this includes health and safety.
9.	**Performance**	measuring all facets of performance against the baseline requirements, variance analysis and management action.
10.	**Governance**	the processes to align the interests and strategic direction of sponsors and stakeholders.

The primary rating for each category will be given on both a red/amber/green/blue (RAGB) basis and a 0 to 10 score. Projects will be:

- Red 0-2 – where critical issues that require urgent attention exist.
- Amber 3-5 – where significant issues exist that need to be addressed.
- Green 6-9 – for broadly adequate practice with some scope for improvement.
- Blue 10 – for best practice.

Strategic Goals	2023/24 Key achievements
Outstanding Care and Experience	• In partnership with children, young people and families, launched our promises, our standards and a review of the Family Charter. • Three-year Charity support for the arts for health and alder center to allow for longer term planning of support for children young people and families. • High levels of mandatory training in patient safety across the Trust. • Delivered thousands of meals and refreshments to family members through Sophie's Legacy, with excellent feedback from parents. • RCPCH members award given in recognition of the ACP curriculum framework. • Partnership commenced with Chester Zoo, to pilot 3 key areas of work together whilst developing a longer term partnership. • Hosted two experience weeks, with great involvement from children and young people. • Launch of Alder Hey Research Feedback Platform resulting in marked increase in research participant feedback that we receive.
Supporting Our People	• 71% of colleagues would "recommend the organisation as a place to work", highest ranked organisation in the North West in our group. • VCHA awarded with ongoing work to improve our offer to serving and veteran families and staff members. • Navajo assessment passed with ongoing work to improve our offer to members of the LGBTQIA community. • Signed up to the Sexual Safety Charter. • Launched a new Preceptorship Programme for AHP and Nurses, enhanced the preceptorship offer and updated the policy. • Pastoral care award given in recognition of our offer to internationally educated nurses. • Nursery awarded GOOD by Ofsted. • Staff Advice and Liaison Service (SALS) won 2023 International Hospital Federation (IHF) award for "Excellence Award for HealthCare Workers Wellbeing". • Awarded Armed Forces Employer Recognition Scheme (ERS) Silver Award. • Significant and sustained reduction in organisational turnover of 5%. • The Launch of the Thriving leaders programme.

	• Launched 8 new management essential courses for leaders and managers.
Pioneering Breakthroughs	• Pioneering neurosurgical procedure using a new advanced device to treat Dystonia. • Development and provisional approval of the Alder Hey Research Strategy 2024/2030 ready for roll out in April 2024. • Secured significant investment in research infrastructure including a third MRI scanner (£3.3m), a mobile research unit, and equipment for a translational research unit in the Eye Department. • Grant and PPI award success for the Paediatric Medicines Research Unit. • First Alder Hey patient participant in a gene therapy trial. • Cardiac Specialist Nursing team won 'Innovations in Your Specialty' Award at the national RCN Nursing Awards for 'Little Hearts at Home'. • Enhanced partnerships internally (with Innovation, Education and Digital through Futures) and externally with the Northern Health Science Alliance, Children's Hospital Alliance and GOSH (Great Ormond Street Hospital) Paediatric Excellence Initiative. • Ranked second for participant recruitment into research trials across the North West Coast Clinical Research Network. • 21 schools involved in the Research Ambassador programme. • Alder Hey led NIHR grant awards worth over £2m including PADDINGToN 2 Medicines Information Resources for NICU families (Louise Bracken), Myo-Scope (Clare Pain), Op or Non-STOP Study - Operative or Non-Surgical Treatment of Perthes' Disease (Dan Perry). • £10m awarded to Louise Oni to deliver 'The UK Kidney Ecosystem - a translational rare kidney disease centre with research reimagined' - a Lifearc Translational Rare Disease Centre Award. • Co-creation of novel remote monitoring product using photos, videos and sound between Isla and Alder Hey Innovation. 58% reduction in ED attendances, 100% readmissions avoided, 43% decrease in SSI infections. • 17 Live Robotic Process Automations launched for the Trust saving time and money. • 55 patients now live on Little Hearts at Home. £102k saving per patient due to earlier discharge. 80% reduction in calls to specialist helpline.

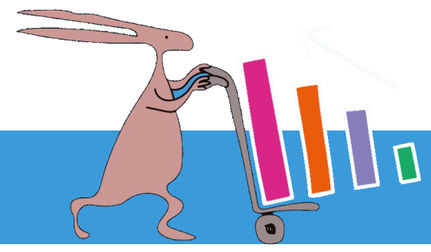
Revolutionising Care	<u>Operational</u> • Virtually eliminated C & YP waiting over 65 weeks for treatment in consultant-led care pathways. • Treated over 81% of patients within 4 hours of arrival to our Emergency Department. One of the best ranked Trusts in England. Our good performance has been driven by transformational change including: ▪ establishing a new urgent care service, providing convenient appointments for low acuity patients ▪ a consistent senior decision-making model, extended late into the evening ▪ transforming our acute medical service through a Paediatric Assessment service that enables primary care to send referrals direct to this unit, bypassing ED. ▪ Established the largest children's virtual ward in the UK • Delivery of increased activity across all areas of community services (66% more than 2019/20). • Outstanding access to critical care, due to a strong and resilient workforce and supporting be cared for within the North West. • Successful national contract award to provide pectus surgery. • Launched referral portal for ASD/ADHD and Developmental Paediatrics streamlined approach to referrals and improved communication. <u>Digital</u> • Alder C@re, the upgrade to the Trust's Electronic Patient Record, went live in September 2023. • New wesbsite and intranet site launched. • V.create diaries went live in the neonatal unit, allowing families to follow the journey of their babies during their stay at Alder Hey.
Collaborate for Children, Young People and Families	<u>System working</u> • Winners of Gold HSJ Partnership Awards 2024 – Alder Hey and Strasys for the innovative approach to our trust strategy, Vision 2030. • The Beyond Cheshire & Merseyside's (C&M) CYP Transformation Programme successfully delivered at-scale improvements for CYP across C&M in mental health, healthy weight/obesity, respiratory, diabetes, epilepsy and more – and during 23/24 was moved to recurrent funding • C&M ICB CYP Committee formally established; overseeing CYP priority improvements in mental health, oral health, neurodiversity, edging towards care and developing CYP system capability.

	• C&M CYP Alliance (providers) formally established – bringing together health delivery for CYP and driving major system improvement initiatives • Appointment of Alder Hey's first ever Consultant in Public Health Medicine – in partnership with Liverpool City Council's Public Health team. • Successful implementation of prevention initiatives such as Mini Mouthcare Matters (oral health), and a community-based Healthy Weight programme targeted in 7 of the most deprived wards in Liverpool. • Further expansion of Mental Health services including investment in Mental Health in Schools team (MHST), Eating Disorder Services and further funding for the Enhanced Support Team as part of the delivery of the Framework for Integrated care, jointly funded by NHSE and Health and Justice team. • Established partnerships with two key organisations (Health Junction and Liverpool Citizen's Advice Bureau) to deliver Family Wellbeing Hub on site. <u>Net zero and Clean Air</u> • Awarded funding from AH Charity to embed new Clear Air initiatives. • Successful implementation of new compactors to reduce energy usage. <u>Social Value</u> • Education and employment initiatives underway; work experience/internship programmes /care leavers project, YP supported into work and targeted schools programmes. • Developed an inhouse social value calculator and £107k of social value generated to date. • Developed a project focused on arts and mental health, working to develop involvement in extracurricular activity for young people and provide a range of skills and insight into the Arts. • The young people from ACE group are curating a public exhibition at the Walker Art Gallery in partnership with Hope University.

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: March 2024



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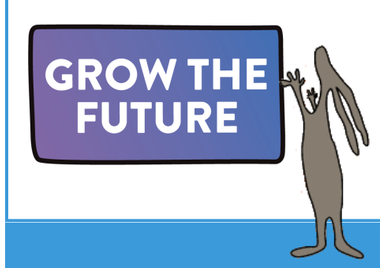
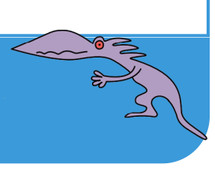




Icon Definitions

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

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

XmR chart

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

Process limits

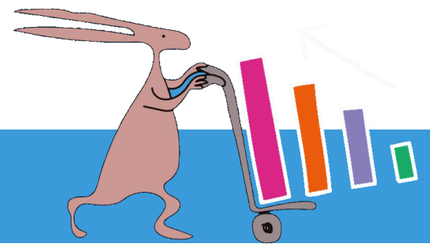
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

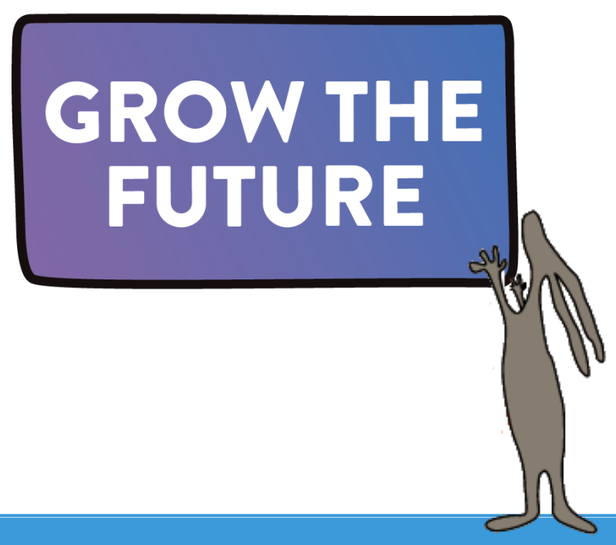
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

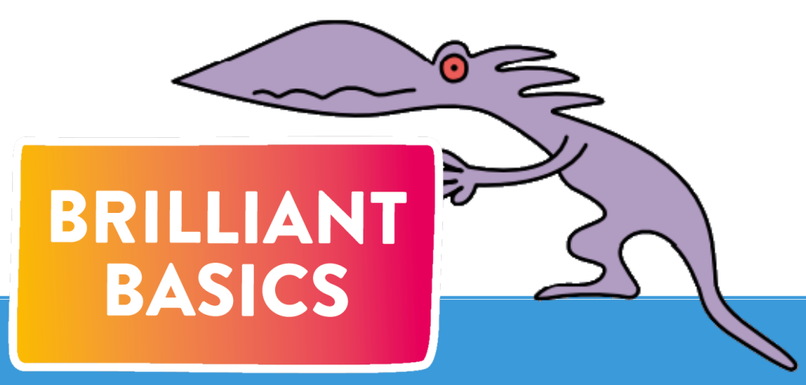
		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	C.Difficile demonstrates performance is consistently achieving target with an improving trend	Cancelled Operations, Stranded Patients, Staff Turnover, Deteriorating inpatients, Level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

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

- We are consistently passing 18.2% of our metrics.
- We are achieving 63.6% of our metrics inconsistently.
- We are not achieving the target for 18.2% of our metrics but experiencing improvement in 3 of these metrics.

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





Unrivalled Experience - Safety

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

Highlights:

As part of the new national PSIRF approach, incidents which are categorised as moderate or above are reviewed at the weekly PSIRI panel meeting and the previous SI (serious incident) framework is no longer in place. No Never Events reported. Review of unplanned admissions to Critical Care undertaken and reported on by the Response Team

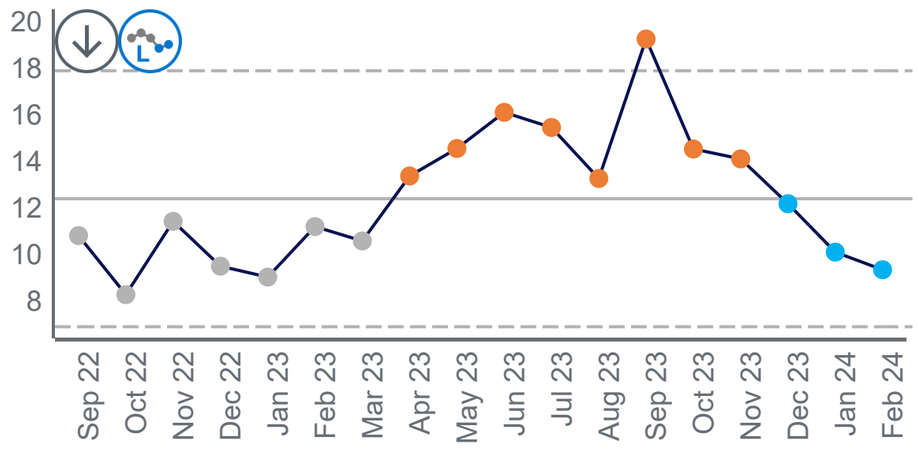
Areas of Concern:

Reduction in compliance in month of inpatients who received antibiotics within 60 minutes for sepsis; 86%. ED compliance 89% in month

Forward Look (with actions)

Must ensure all patients receive antibiotics within 60 minutes

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



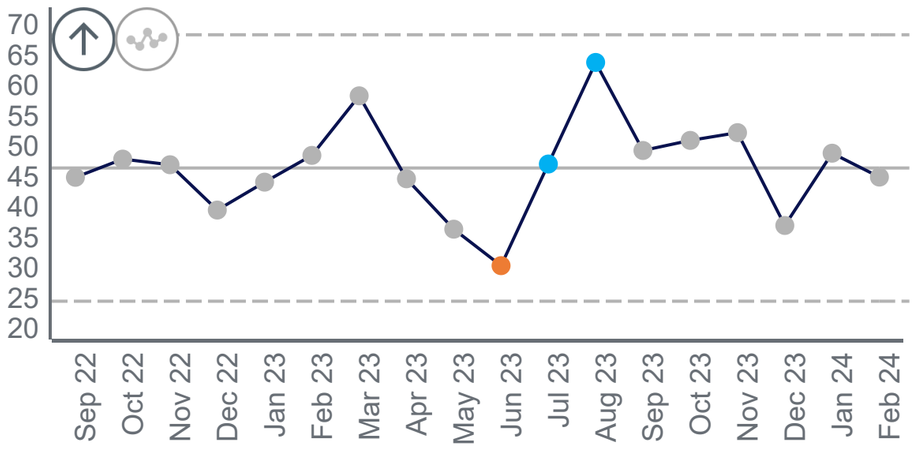
Technical Analysis:

Special cause variation has been observed with performance of 9 incidents of harm per 1,000 bed days, with a monthly average of x12 incidents during the period. 5th consecutive month of reduction, rates currently assessed on Physical Harm only.

Actions:

Reduction in the number of patients who have experienced harm related to a reported incident. All incidents of moderate or above reviewed at the weekly PSIRI panel meeting

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



Technical Analysis:

Common cause variation has been observed with performance of 45 incidents of no harm per 1000 bed days. With a monthly average of 46 during the period. Of the 418 patient safety incidents resulting in no harm in February 2024, this includes 35 who have no harm assigned as not involving a patient directly.
Rates currently assessed on Physical Harm only

Actions:

All staff encouraged to report Near Miss incidents and events

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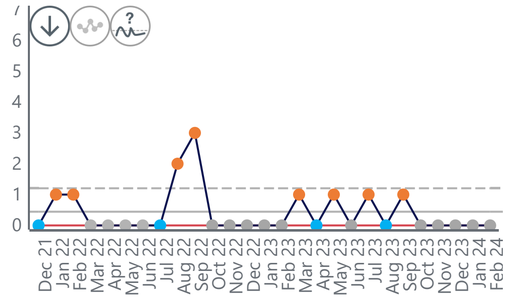
Integrated Performance Report | March 2024

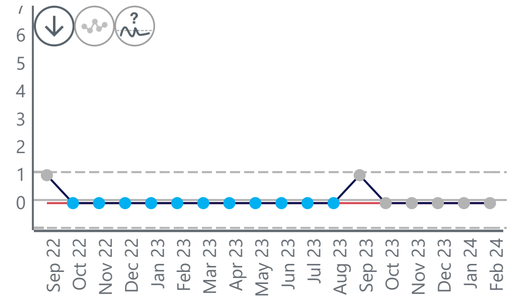
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

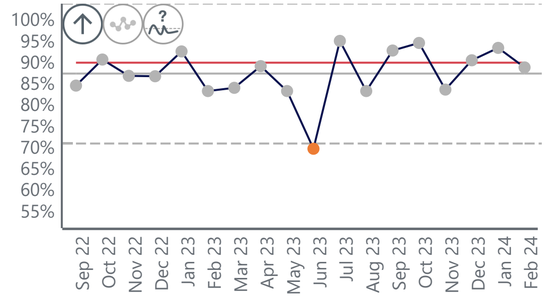
Number of Serious Incidents (Steis reported)



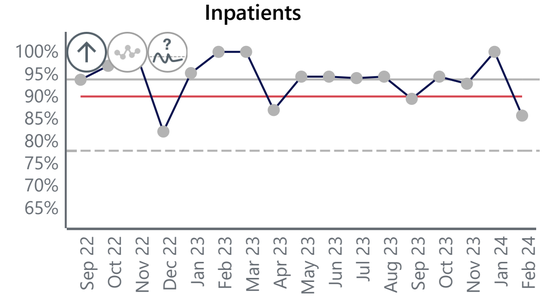
Number of Never Events



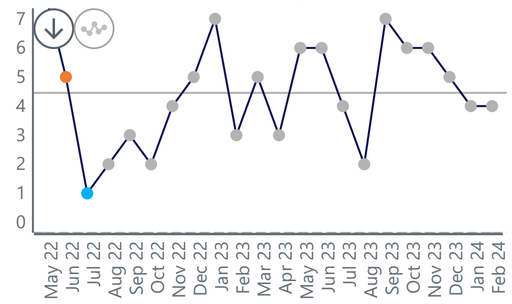
Sepsis % Patients receiving antibiotic within 60 mins for ED



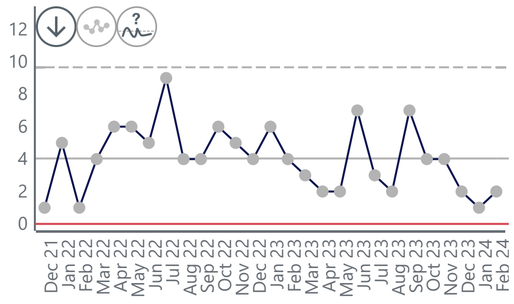
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



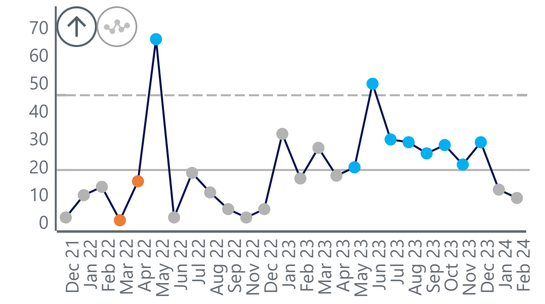
Medication Errors resulting in Harm



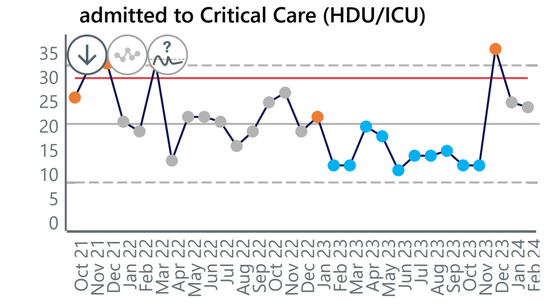
Pressure Ulcers Category 2-4



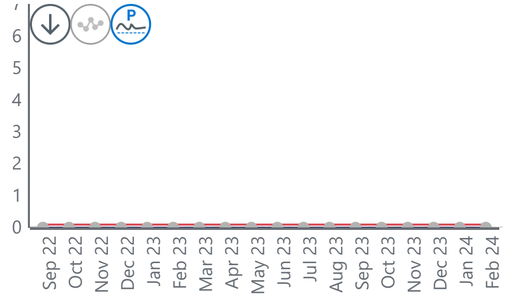
Recording of restrictive interventions



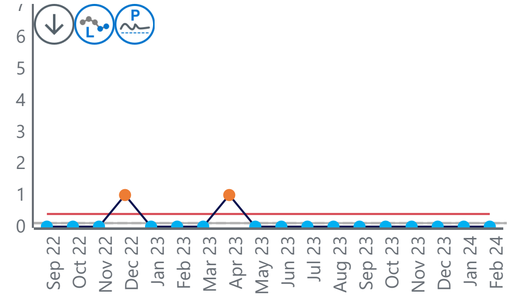
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



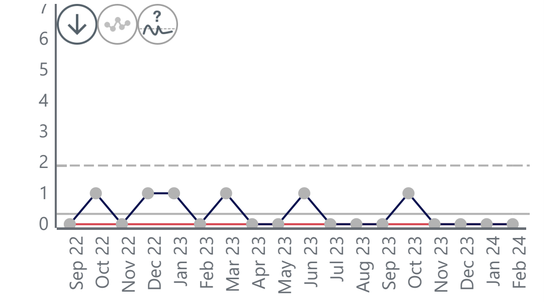
Hospital Acquired Organisms - MRSA (BSI)



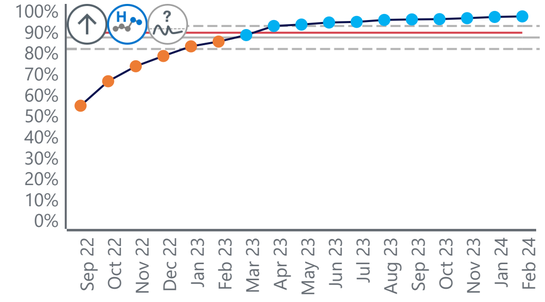
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Unrivalled Experience - Caring

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

Highlights:

Fairly static number of formal complaints received. Year 2 objectives agreed by the Patient Experience Strategy Group

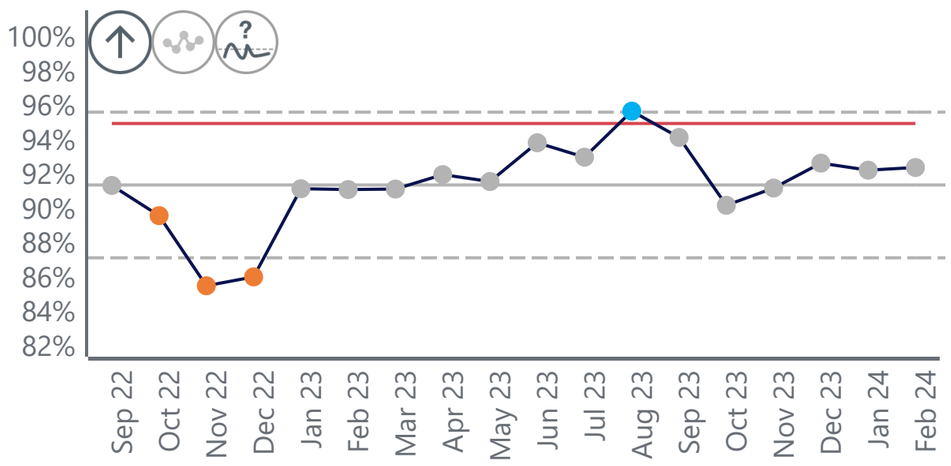
Areas of Concern:

Decrease in families who said they would recommend our ED; 79%.

Forward Look (with actions)

Review of patient and family feedback mechanisms underway through Patient Experience Strategy Group

F&F Test - % Recommend the Trust



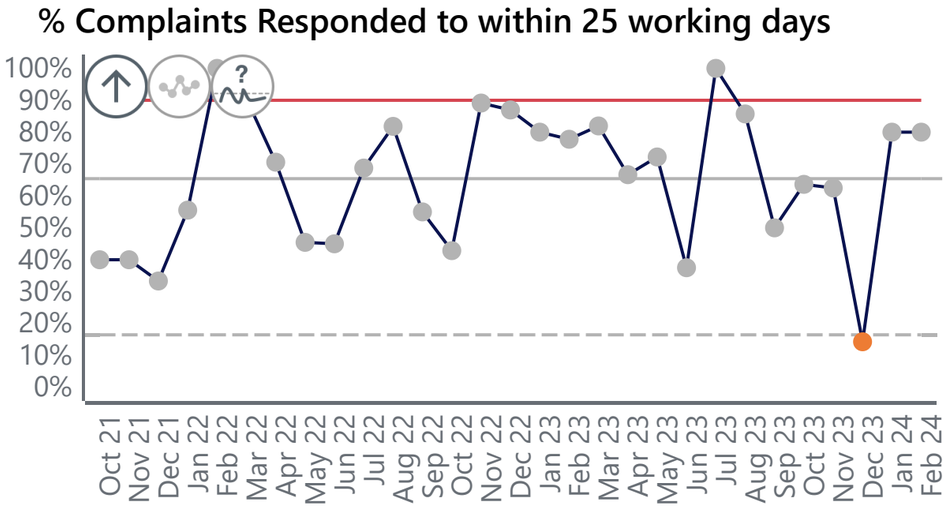
Technical Analysis:

Consistently not achieving the 95% target. February performance of 92.4% represents slight increase from January performance of 92.3%. However this is improvement from February 2022 with performance of 91.1% and represents fourth consecutive month above average of 91%.

Actions:

Review of patient and family feedback mechanisms underway through Patient Experience Strategy Group

% Complaints Responded to within 25 working days



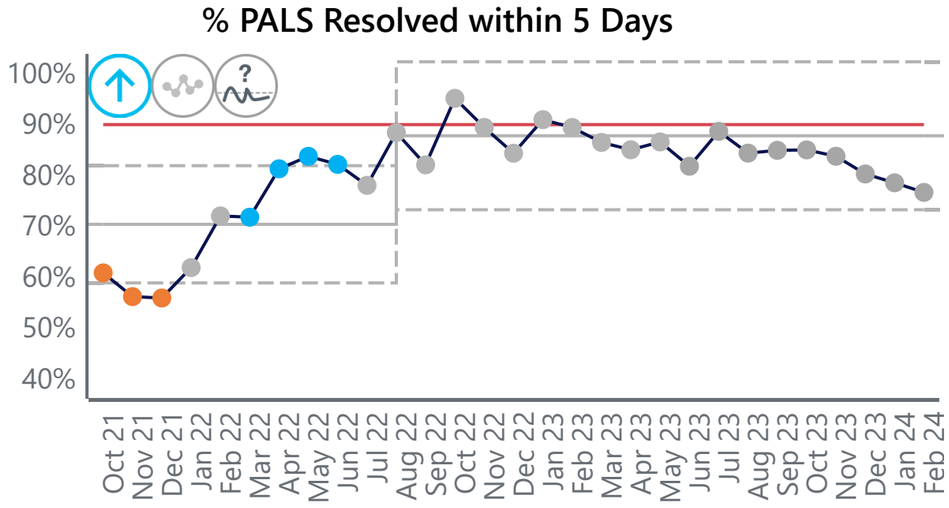
Technical Analysis:

Inconsistently achieving the 90% target with an average of 65% which shows significant fluctuation from month to month. Performance in February 2024 was 80% which represents 2 breaches out of 10 complaints due in the month. Consecutive months at 80%.

Actions:

8 of 10 complaints responded to within 25 working days; Divisions sighted on need to respond to family's concerns in a timely manner

% PALS Resolved within 5 Days



Technical Analysis:

Common cause variation has been observed. Inconsistently achieving the 90% target. February 2024 performance was 77% and is fourth consecutive month with declining performance and risk becoming special cause variation if the trend continues.

Actions:

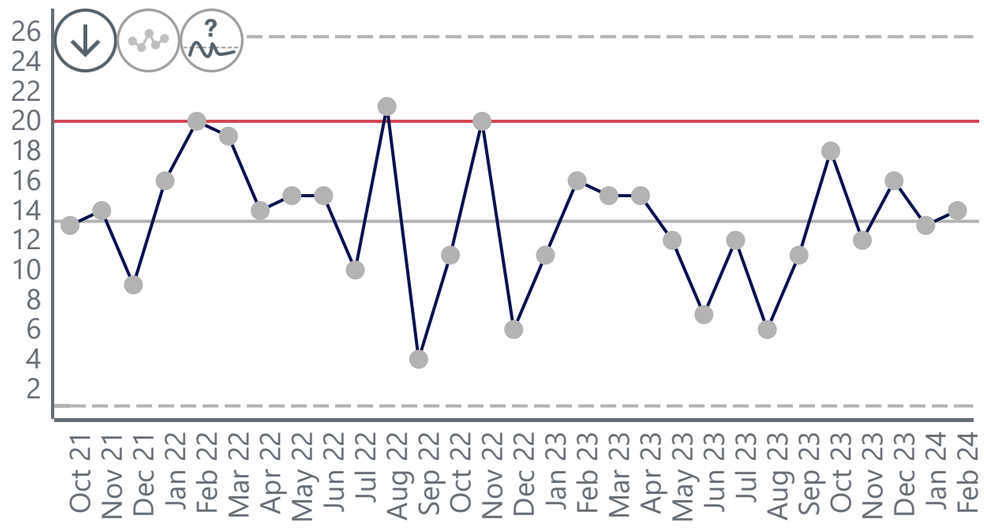
Divisions and services sighted on the need to respond to family's concerns within 5 working days

Integrated Performance Report | March 2024

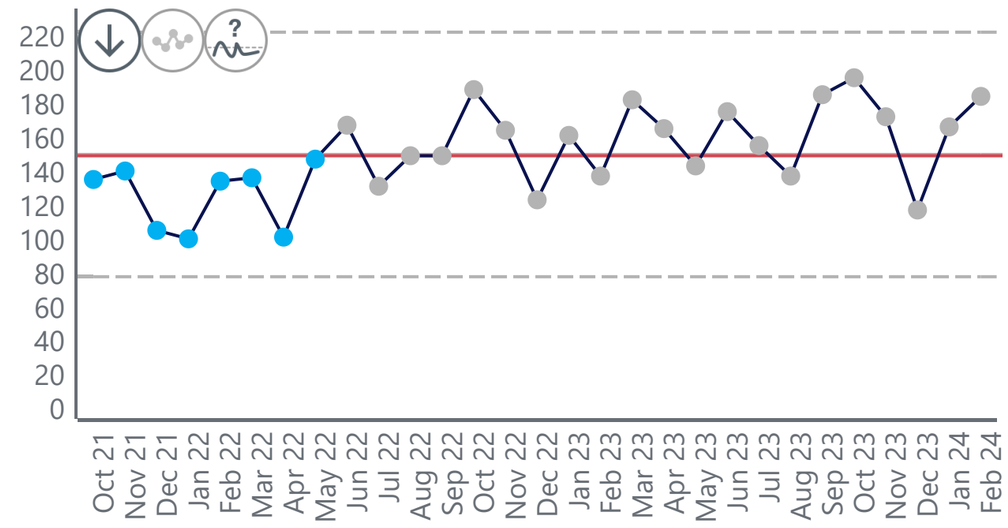
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

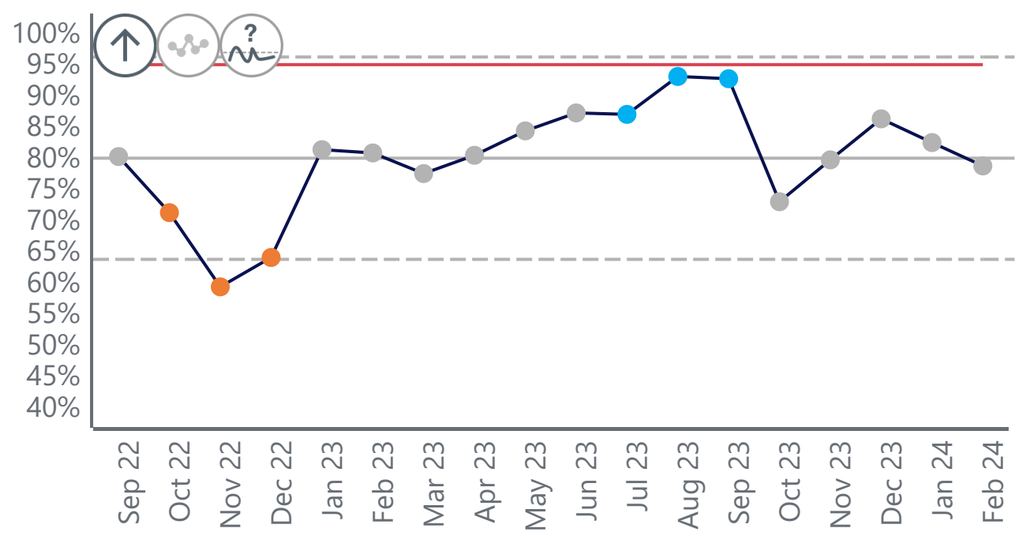
Number of formal complaints received



Number of PALS contacts



F&F ED - % Recommend the Trust



Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

We have seen a year on year improvement in theatre utilisation (statistical trend). There is a positive statistical trend in reducing cancellations on the day of surgery (with benefits for patient experience). We have delivered the standard for reducing the number of long stay complex patients to less than 30.
Top 5 performing Type 1 Emergency Department in Englan across M10 and M11.

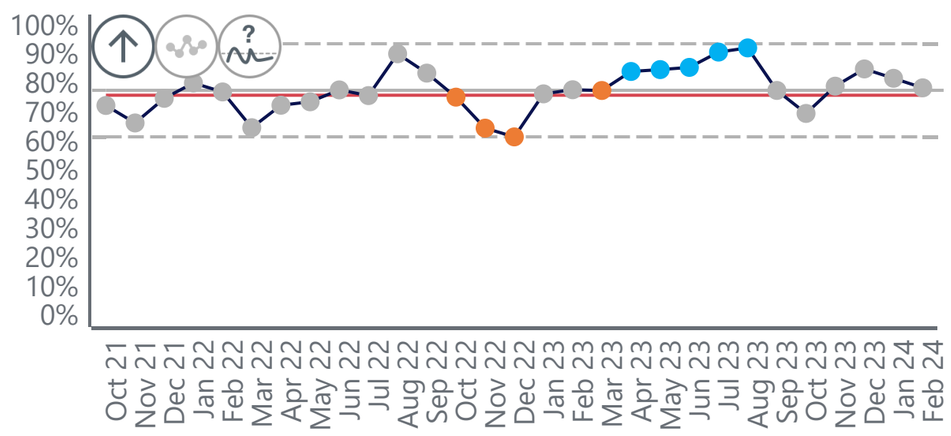
Areas of Concern:

No statistical improvement in WNB (although there is a year on year improvement) or the percentage of clinic letters signed off within 10 days

Forward Look (with actions)

Alder Hey Anywhere (Patient Portal) programme plan in development, with an expectation that patients and families will be empowered to manage appointment bookings. Studies show this reduces levels of WNB.

ED: % treated within 4 Hours



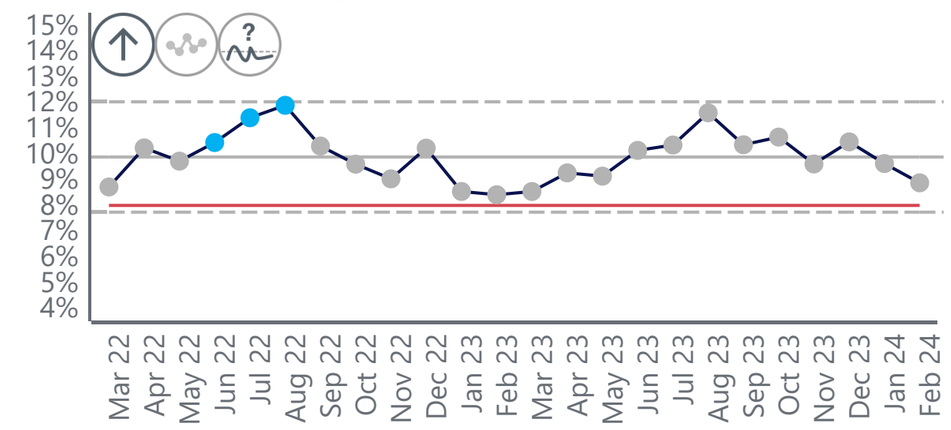
Technical Analysis:

Trust achieving the national target (>76%) in Feb-24. Common cause variation has been observed with performance of 78.6%, reduction from Jan-24 of 81.8%. Feb-24 performance is +0.7% compared to Feb-23 (77.9%) whilst also having on average +37 extra attendances each day in Feb-24 compared to Feb-23. 10/11 months achieving the national target in 23/24.

Actions:

Increase senior clinical decision-making during period of increase attendances. Re-launch of the ED escalation plan to ensure consistent, proactive interventions daily. Further increase to UTC utilisation to stream CYP out of the department. Divisional and departmental focus on achieving 80% for Q4 with a number of escalated interventions in place.

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



Technical Analysis:

WNB rates demonstrates common cause variation. Performance in February 2024 of 8.8% which is reduction when compared to January 2024 (9.6%). 2nd consecutive month showing a reduction although a number of bookings are still be actioned for the month which could alter February 2024 position.

Actions:

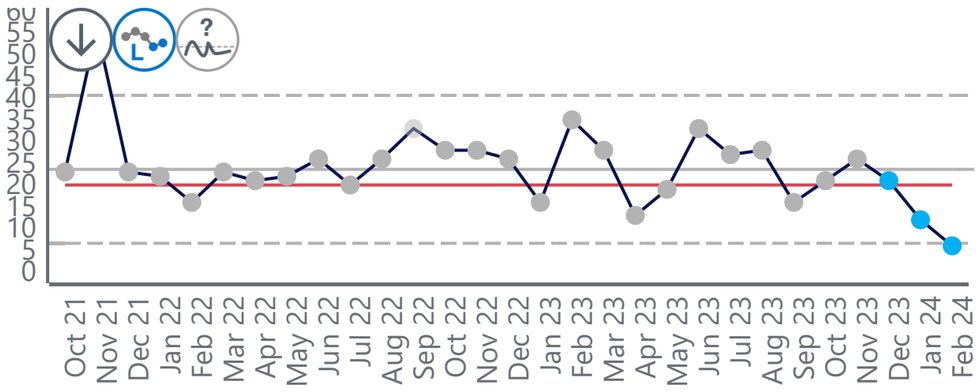
CAMHS transport pilot went live in February 2024 and opportunities for improvement will be shared once pilot complete. 37 families contacted during February.
Community Ophthalmology pilot commenced in January, results to be shared in April.

Integrated Performance Report | March 2024

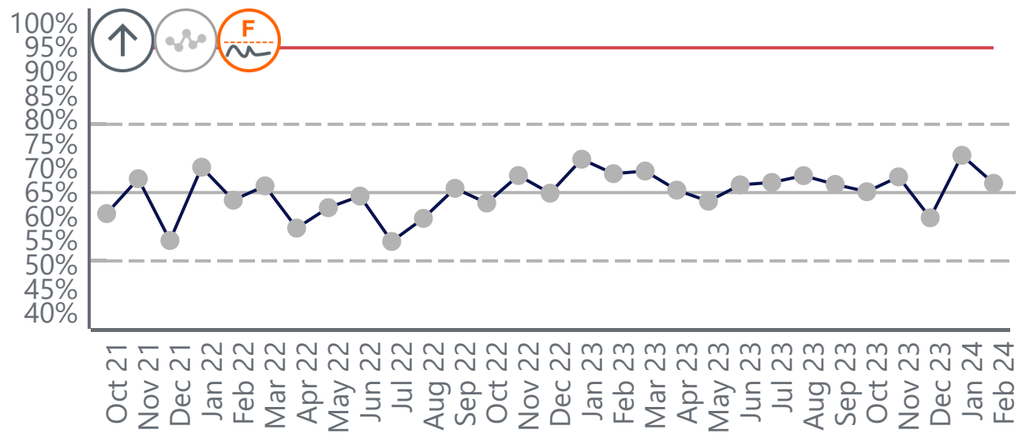
Alder Hey Children's NHS Foundation Trust

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

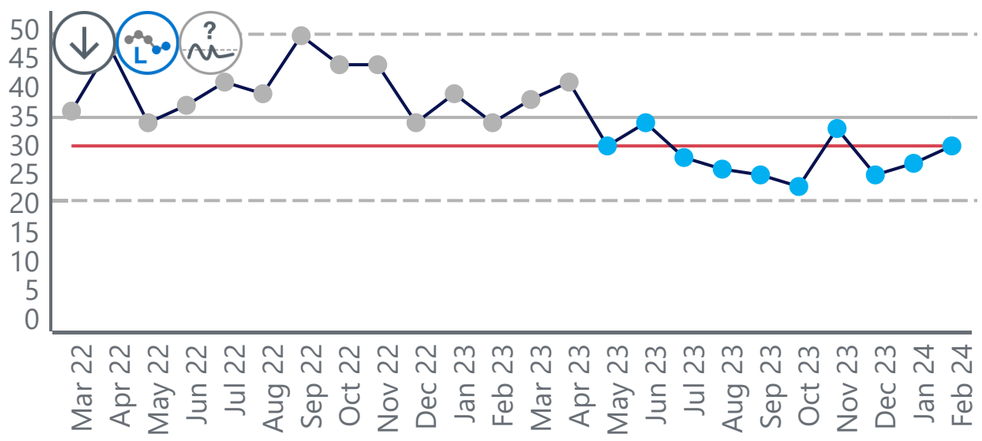
Number of Cancelled Operations (on day of admission for a non-clinical reason)



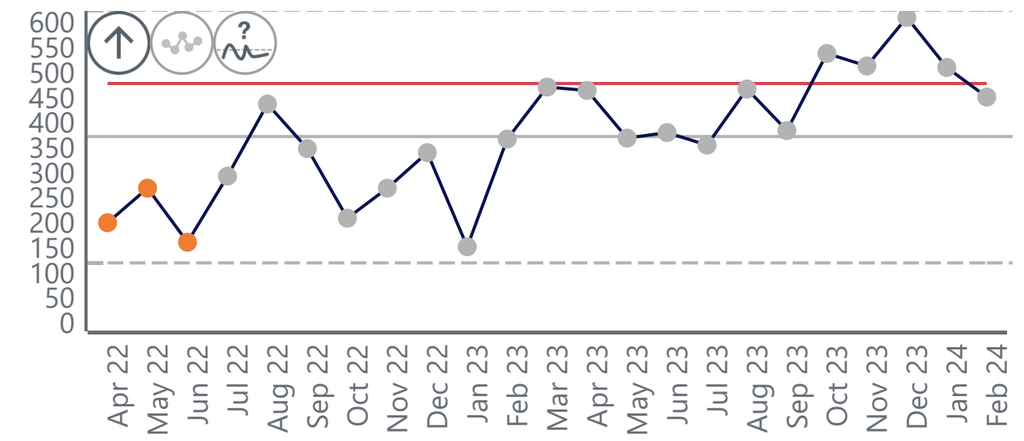
% of Clinical Letters completed within 10 Days



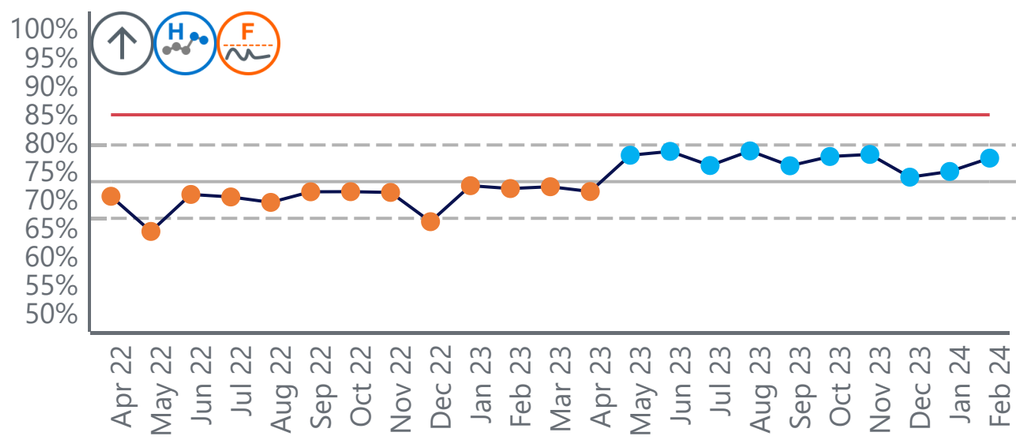
Number of Super Stranded Patients (21 days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

Sharp reduction in the number of patients waiting over 65 weeks for treatment and expect this to be zero by the end of Quarter 4 (with some possible exceptions relating to WNB and patient choice)

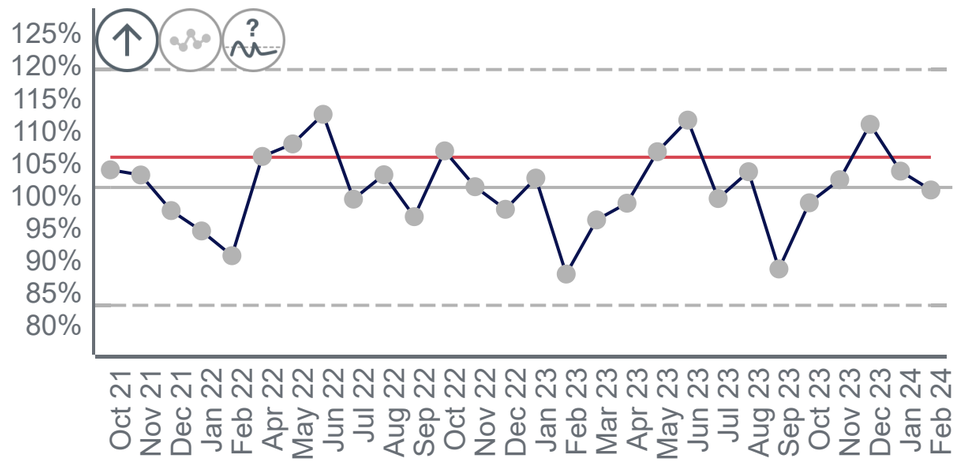
Areas of Concern:

Increase in number of children and young people waiting over 65 weeks for completion of assessment for ASD and ADHD

Forward Look (with actions)

- Launch of new programme to integrate assessment pathway for ASD and ADHD planned for April 2024
- Further work to increase theatre utilisation via productivity workstream targeting specialities with consistently low utilisation.

% Recovery for DC & Elec Activity Volume



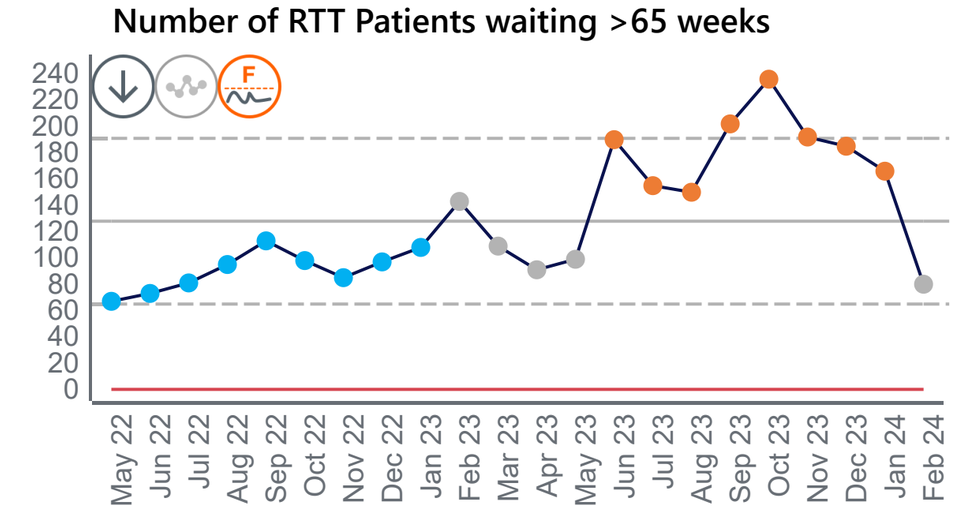
Technical Analysis:

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

Actions:

Expansion in the theatre schedule from April 2024
Focus on further improving theatre utilisation via productivity workstream targeting specialities with consistently low utilisation.

Number of RTT Patients waiting >65 weeks



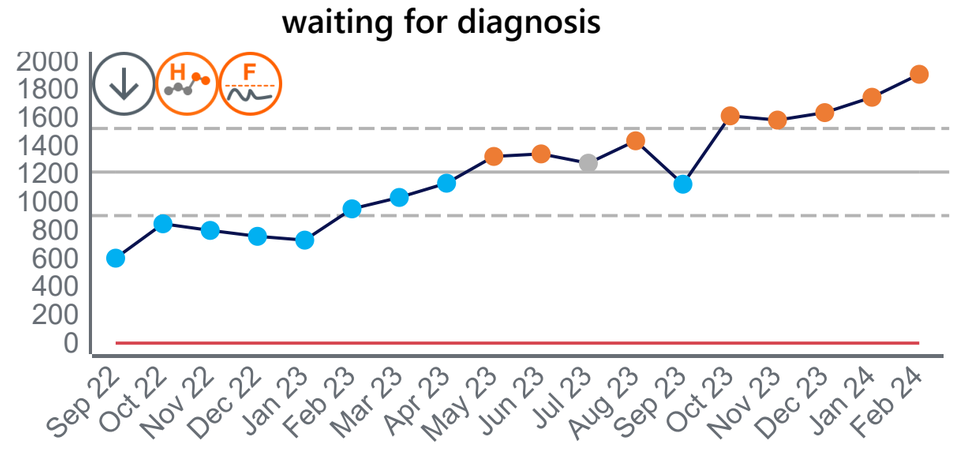
Technical Analysis:

Now demonstrating common cause variation with number of patients waiting > 65 weeks significantly decreasing to 80 in February 2024 (166 in January). Dentistry (n=25) and ENT (n=30) now make up 69% of the Trust total.

Actions:

Significant reduction (50%) in C & YP waiting over 65 weeks for treatment & on trajectory to hit 0 at the end of March. Some risk remains due to any WNB patients/sickness but being closely managed by the teams. Review of Neurology demand and capacity in light of service provision changes.

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



Technical Analysis:

February 2024 shows 1,908 patients which is above the outer control limits, now showing special cause variation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

Actions:

Launch of new programme to integrate assessment pathway for ASD and ADHD and creation of ADHD treatment team planned for April 2024

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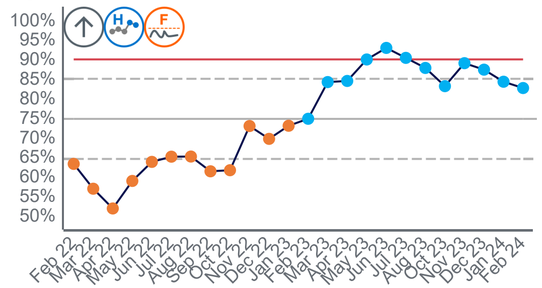
Integrated Performance Report | March 2024

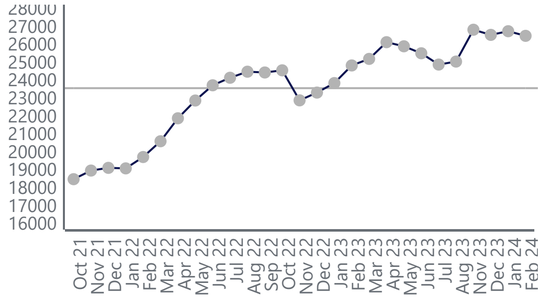
Alder Hey Children's NHS Foundation Trust

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

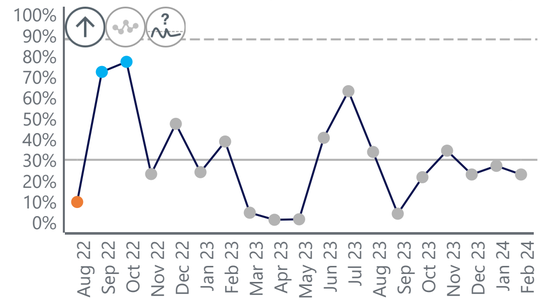
Diagnostics: % Completed Within 6 Weeks of referral



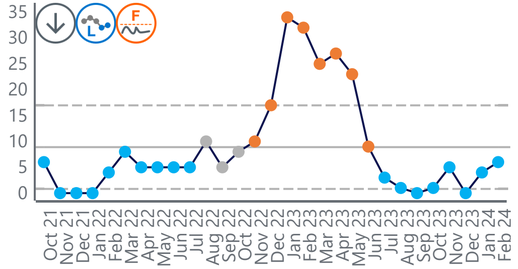
Waiting List Size



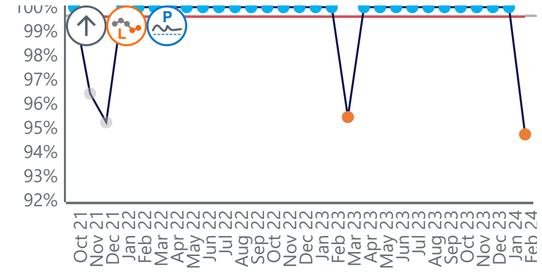
IHA: % complete within 20 days of referral to Alder Hey



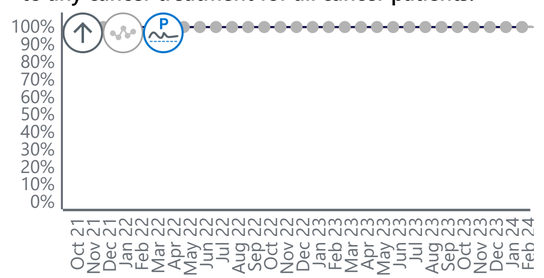
CAMHS: Number of children & young people waiting >52weeks



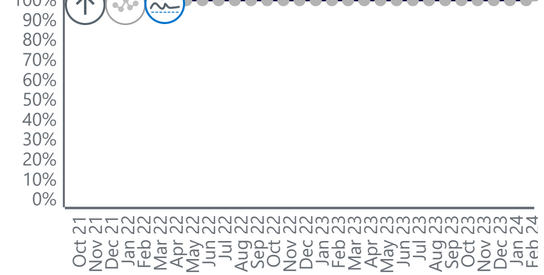
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



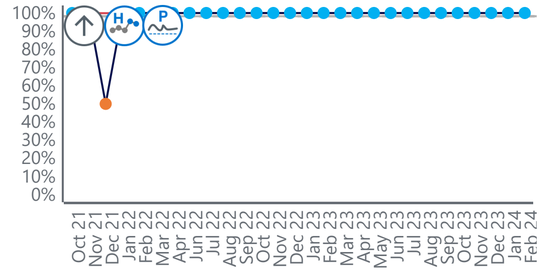
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



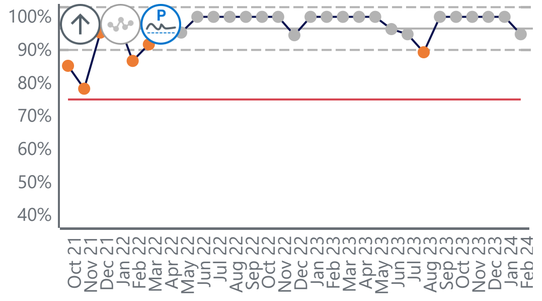
All Cancers: 31 day wait until subsequent treatments



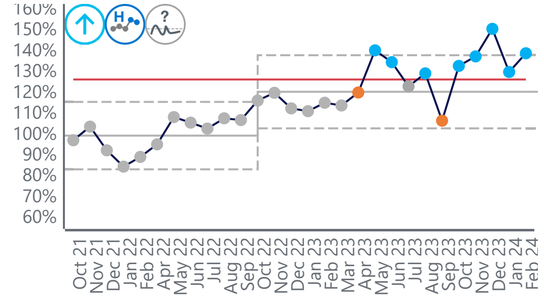
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Integrated Performance Report | March 2024

Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

A continued reduction is staff turnover that commenced in summer 2023, with a new leaver and exit process launching shortly, providing continued support to this.

Sickness absence has decreased to just below the 5.5% target, with a continued focus on long term sickness absence management and the completion and quality of return-to-work interviews

Areas of Concern:

PDR compliance remains an area of concern; the PDR window has been extended to 30th April 2024, to support completion of quality appraisals. Following a sizeable reduction in January, medical appraisal completion has seen a significant move in February back towards the target and more typically reported compliance level (above target).

Forward Look (with actions)

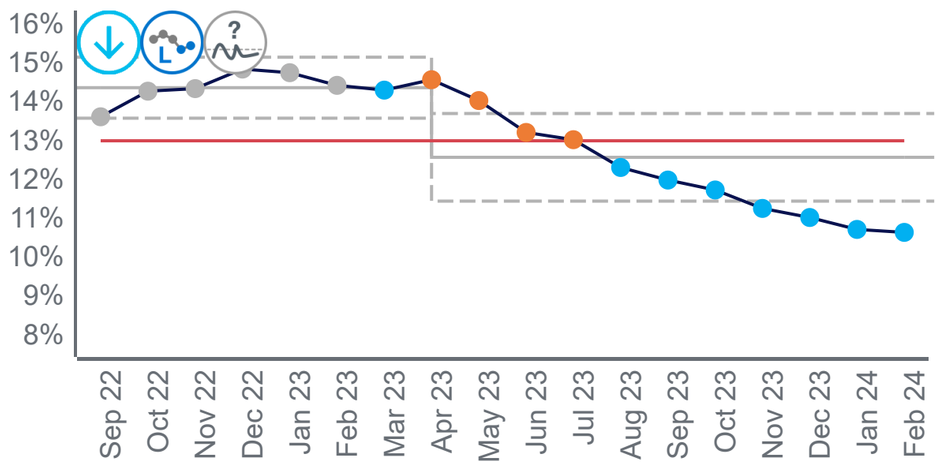
There is a focus on PDR completion with weekly reporting available to support and monitor plans to complete required appraisals.

Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

Staff Turnover



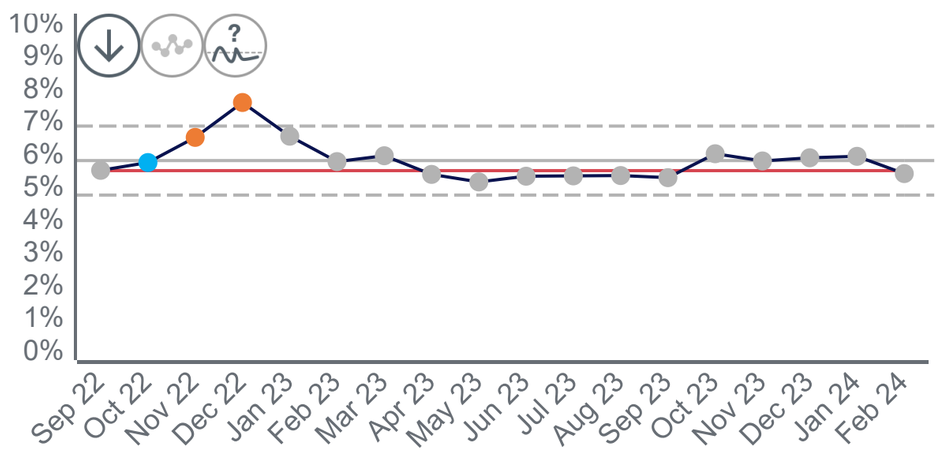
Technical Analysis:

Staff Turnover continues to demonstrate special cause variation, 10.7% is the 10th consecutive month with a reduction and 7th consecutive month within target.

Actions:

A continued reduction is staff turnover that commenced in summer 2023, with a new leaver and exit process launching shortly, providing continued support to this. Quarterly reporting to PAWC remains in place, including ongoing analysis and external benchmarking.

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in February 2024 is 5.39% which is below the 5.5% target. A decrease from January 2024 at 5.91%. February 2024 performance comprises STS at 2.04% and LTS at 3.34%. Still demonstrating common cause variation. First month below target since September 2023.

Actions:

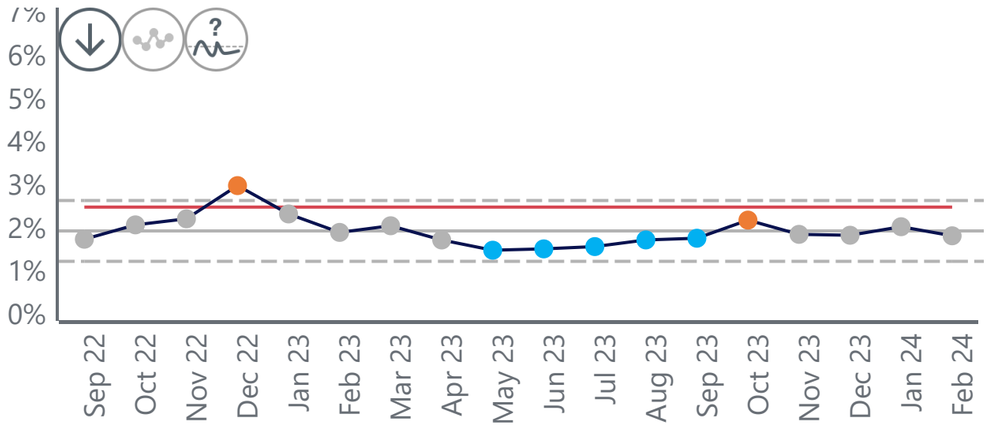
Sickness absence has decreased to just below the 5.5% target, having sat just above it from October 2023 - January 2024. Continued focus on long term sickness absence management and the completion and quality of return-to-work interviews, alongside divisional reviews and wellbeing activity.

Integrated Performance Report | March 2024

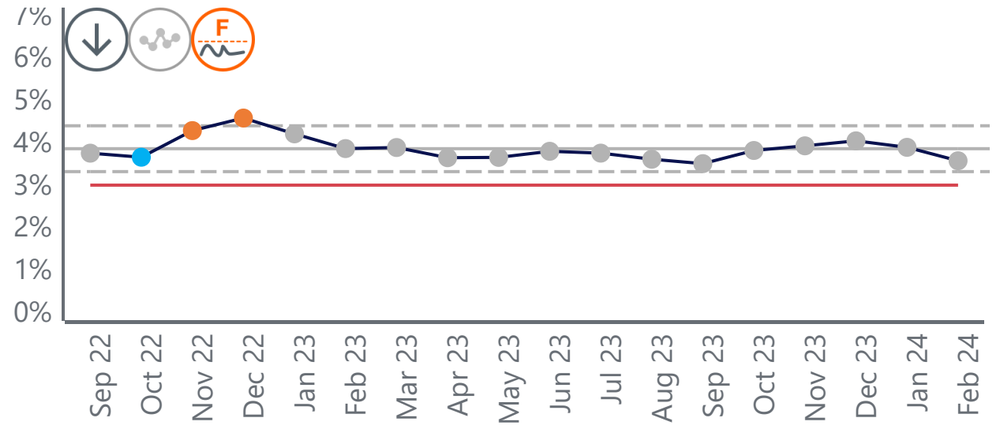
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

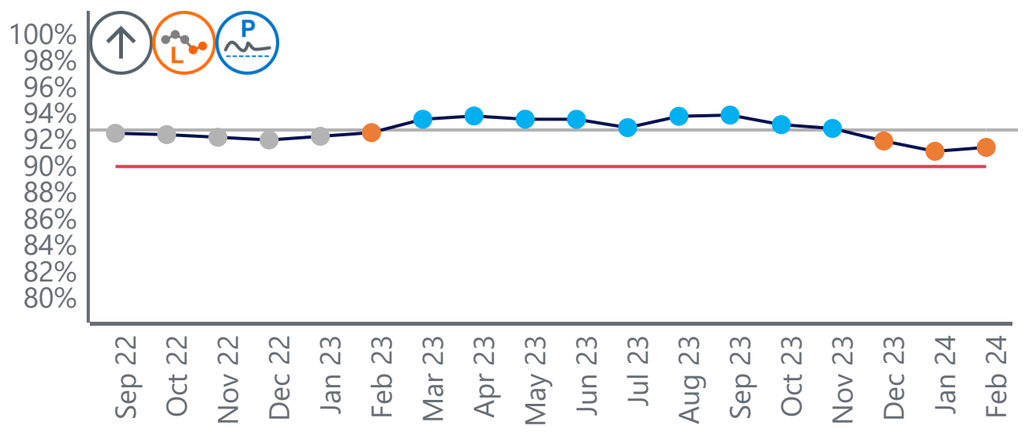
Short Term Sickness



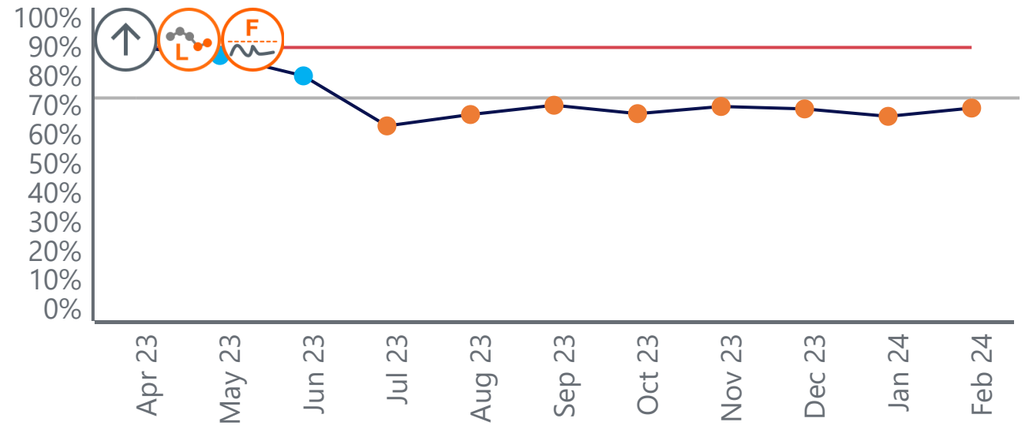
Long Term Sickness



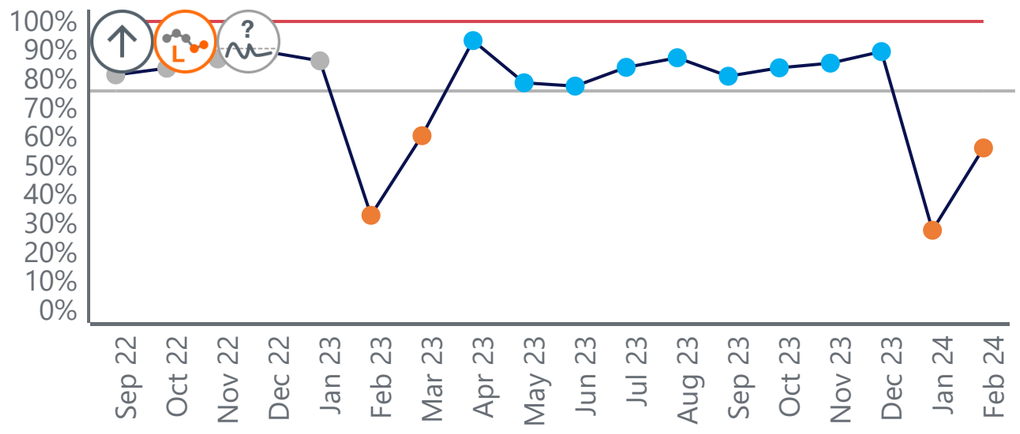
Mandatory Training



% PDRs Completed (Rolling 12 Months)



Medical Appraisal



Staff movement / Churn rate - In Development

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

In February (M11), the Trust is reporting a position £2.1m adverse to plan (£6.4m surplus against a plan of £8.5m YTD). This is due to industrial action. Forecasting to achieve £12.3m surplus. This is £0.7m away from the revised forecast submitted in November due to industrial action but in line with original plan. CIP is £0.5m ahead of plan YTD. Overall, £17.6m CIP has been transacted with a final £10k in progress. Recurrent CIP has decreased again in month from £11.2m in M10 to £10.3m in M11. Cash has remained high in line with plan & capital in line with expectations.

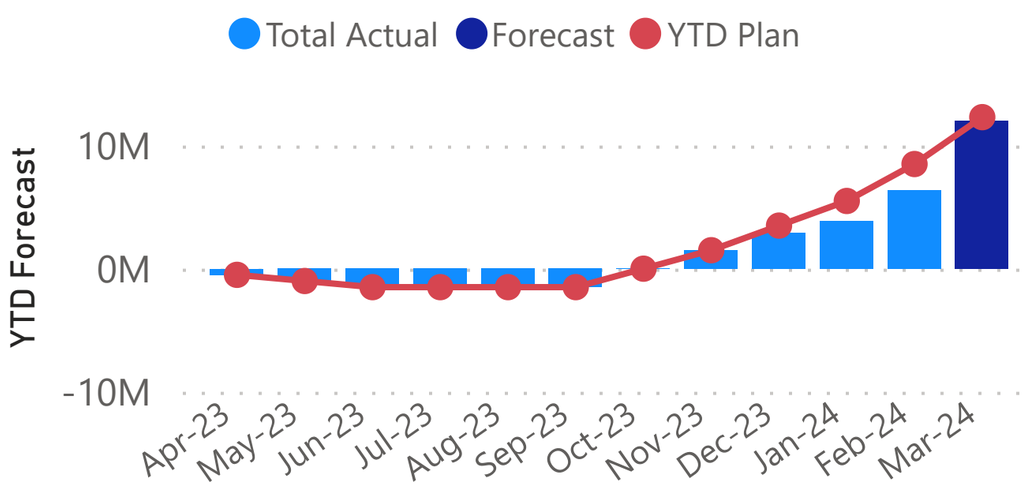
Areas of Concern:

CIP gap is closed in year. Whilst recurrent CIP has decreased in M11 (£10.3m now identified recurrently, down from £11.2m in M10), owing to a more realistic divisional forecast. This remains an area of concern given the gap recurrently is £7.4m which will be carried forward into 24-25. Challenging forecast plan by end of the financial year so achievement of activity targets is essential.

Forward Look (with actions)

Continued cost control to reach the year end position. Continued focus required on recurrent efficiency. Work also continues with divisions on transformation schemes to identify recurrent savings and benefits going into 24/25.

Revenue Position (Year End Forecast)



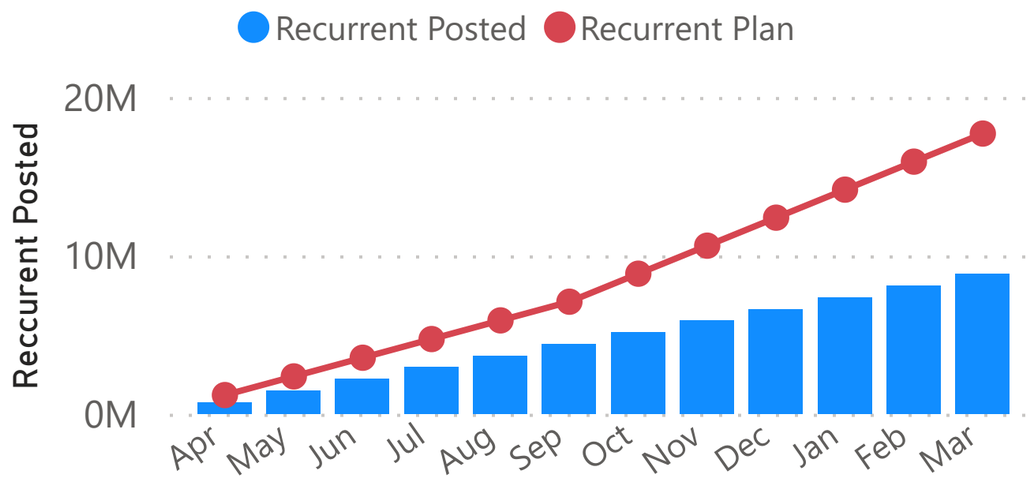
Technical Analysis:

Current forecast is £0.7m off plan due to industrial action, however, confirmation received that £1.1m of IA in Dec, Jan and Feb will be funded which is included in the forecast.

Actions:

Continue to monitor CIP opportunities and cost control for arising pressures to ensure year-end target is achieved.

CIP Position (Recurrent Full Year Effect)



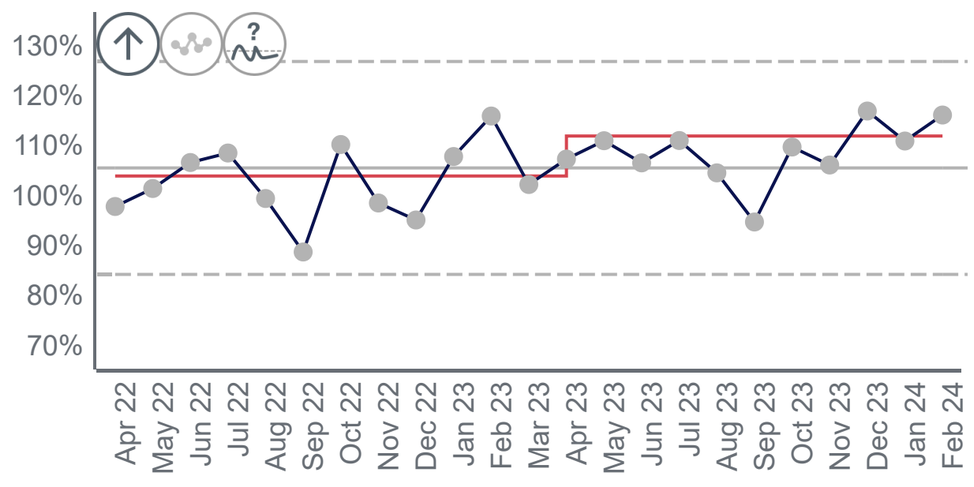
Technical Analysis:

In year CIP identified is £17.6m so achieved in full. Of this, £10.3m is recurrent.

Actions:

Support required with exec leads and transformation to identify the large-scale opportunities. Work continues on wider change programmes. Still large gap recurrently of £7.4m.

% ERF Value (Income)



Technical Analysis:

February performance estimated at 116.2%. YTD performance estimated at 108.3%.

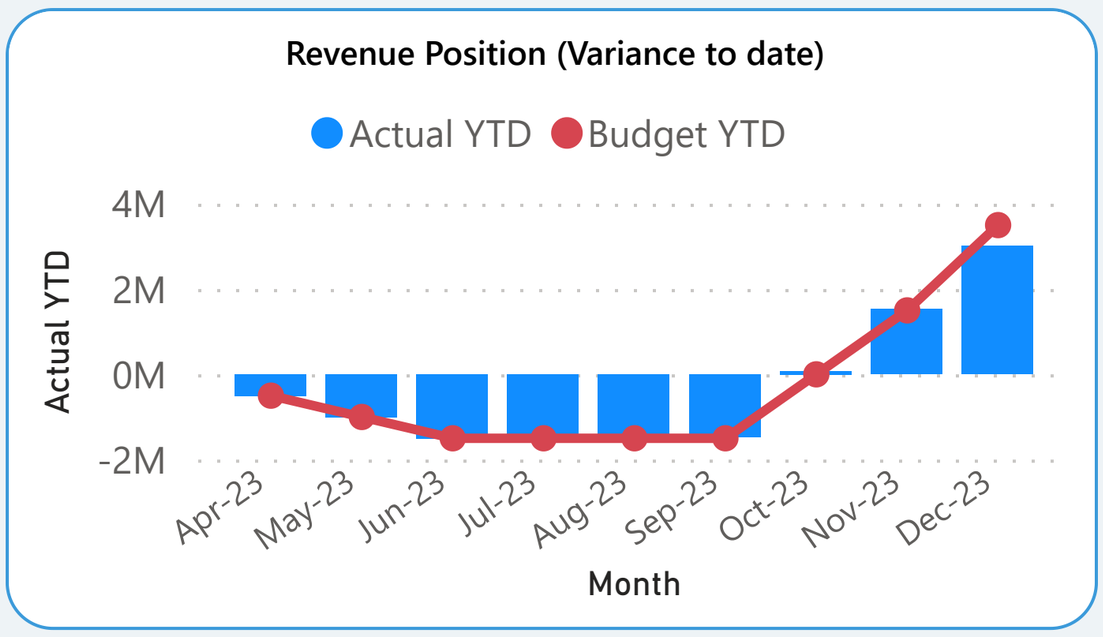
Actions:

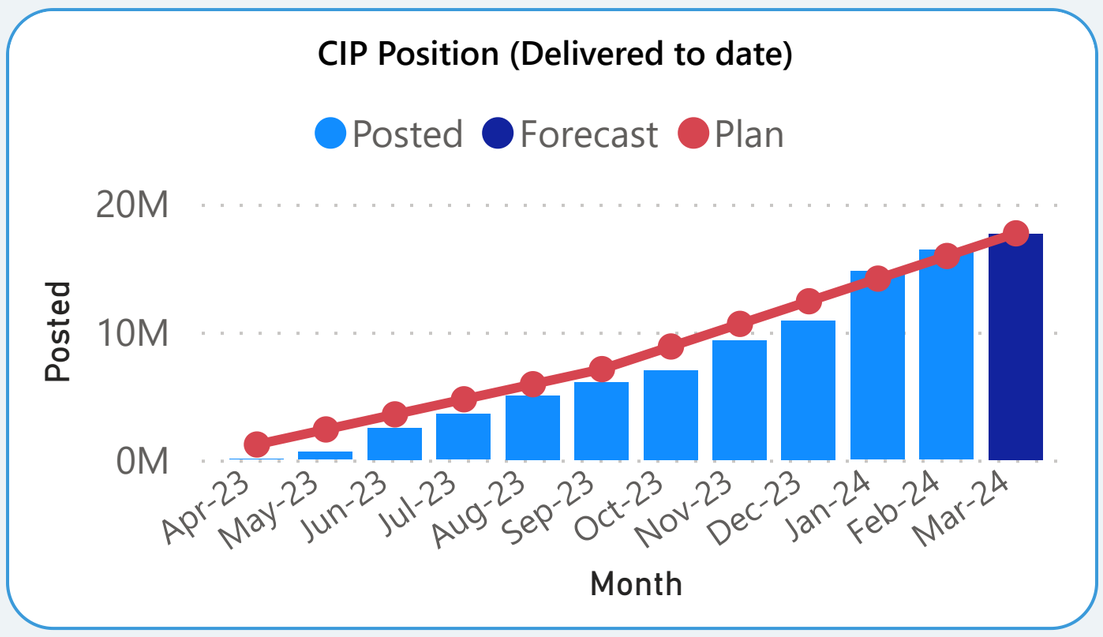
Continue to monitor those areas (at POD and speciality level) that are under performing versus plan.

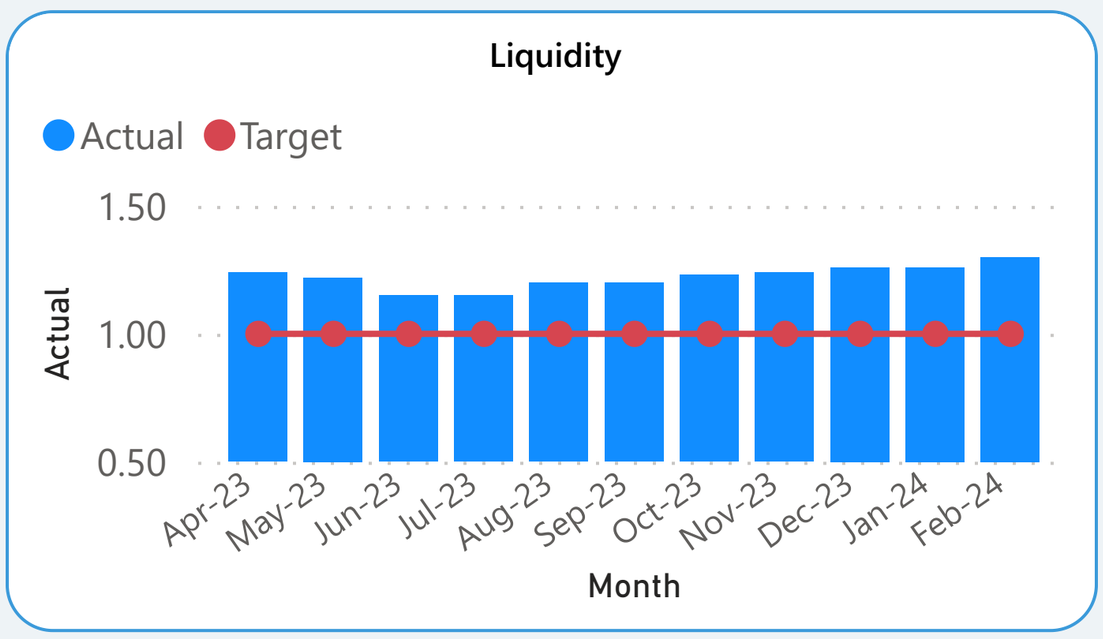
Integrated Performance Report | March 2024

Alder Hey Children's NHS Foundation Trust

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







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Oversight of risk reporting continues to be embedded within InPhase Report functionality improved.
Bullseye visualisation developed and incorporated into risk reports giving overview of all trust wide risks.

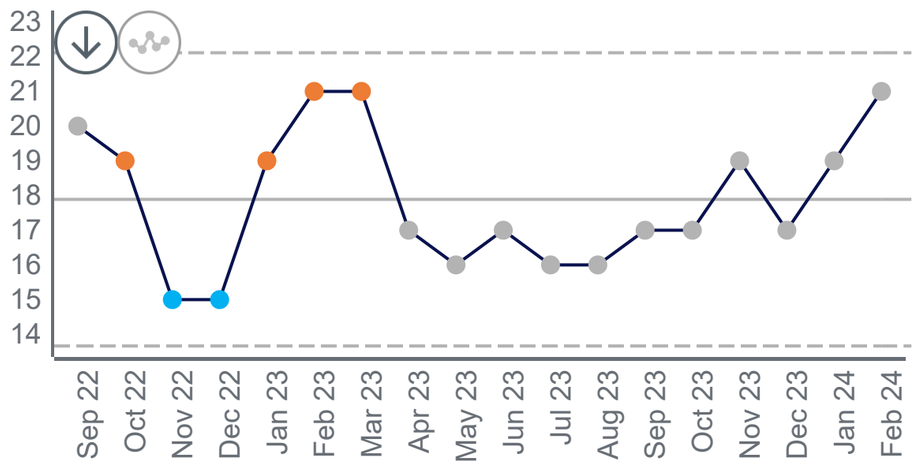
Areas of Concern:

Decrease in compliance of risk review since last month despite risk notifications being automated in InPhase.

Forward Look (with actions)

Continue to oversee and escalate overdue high risks to relevant divisional director and risk lead.
Overview of high risk continues at risk management forum

Number of High Risks (scored 15 and above)



Technical Analysis:

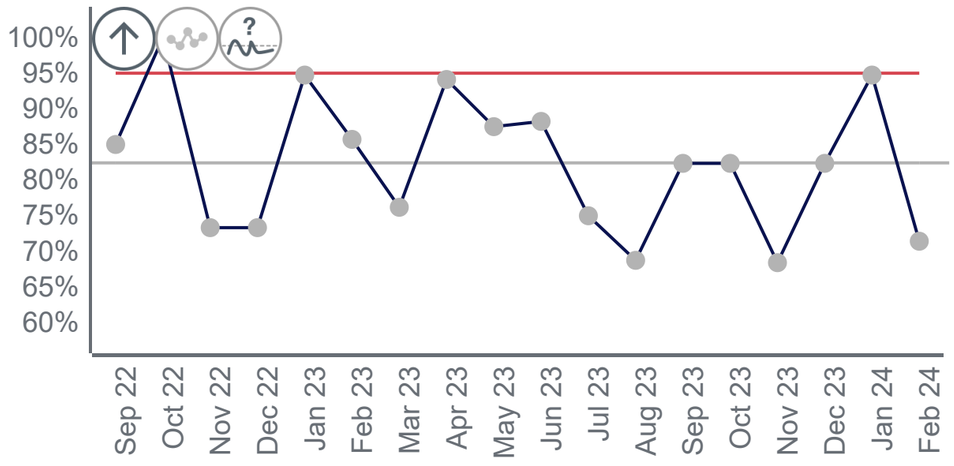
February position of 21 high risks open, demonstrating common cause variation with an average in the period of 18 a month.

Actions:

21 high risks identified and themed as:

Quality safety (9 risks) Workforce (6 risks) Compliance/Regulatory (2 risks)
Financial (2 risks)
Quality/Effectiveness (1 risk)
Reputational (1 risk)

% of High Risks within review date



Technical Analysis:

Demonstrating common cause variation and inconsistently achieving the 95% target with an average of 82% which shows significant fluctuation from month to month. February 2024 performance is 71% (15/21) of risks are within expected review date.

Actions:

All overdue actions escalated to divisional directors and have been actioned at the time of reporting. 6 overdue high risks have been escalated to the relevant risk owner and division as follows • C&MH Division: 1515 (Workforce) ,2745 (Reputational) ,2594 & 2748 (Compliance/Regulatory) • Medicine Division: 2547 (finance) 2623 (Effectiveness)

Smartest Ways of Working - Safe Digital Systems- Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

Following the receipt of the National Funding a multi-disciplinary workshop has been established in March to review and agree the plan for the next steps with AlderHey Anywhere.
Aldercare optimisation delivered 5 priority developments in February and two Priority 1 issues were resolved. These included a Specialty Package for the new Gender service, Outpatient Coding and Coroner review documents.
Work is underway to review the digital transformation programmes and ensure they align to Trust 2030 strategy.

Areas of Concern:

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

Forward Look (with actions)

A revised set of digital programmes aligning to 2030 along with a clear plan of action for the next steps of Alderhey Anywhere.

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

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

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

Collaborating for CYP - Green Plan: Well Led

SRO: Mark Flanagan, Director of Marketing and Communications

Highlights:

Funding bid submitted with LUHFT and partners for circular economy project.

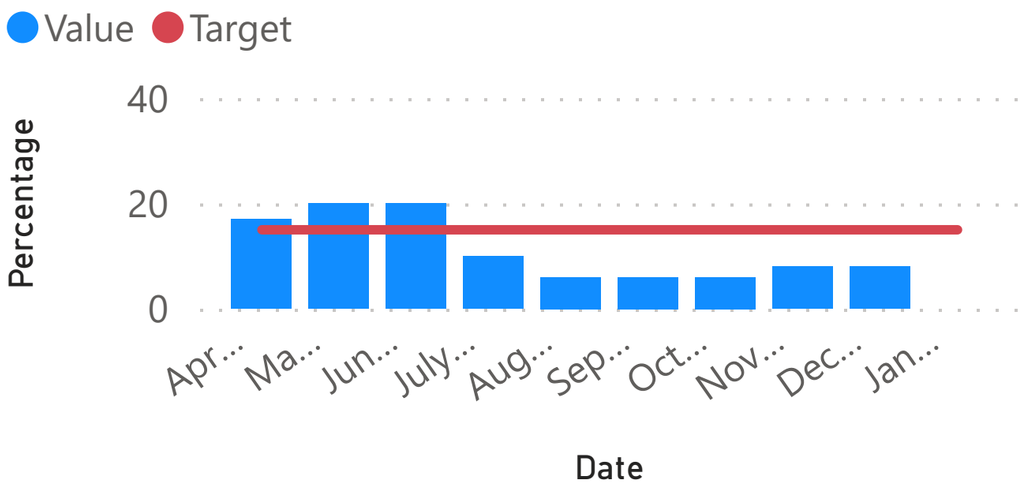
Areas of Concern:

Energy performance in the SPV is still worse year on year. CHP reliability is low with maintenance contract not in place. Heating still being forced on to resolve water issues and chillers now running extra as well.

Forward Look (with actions)

Gloves off project ready to kick off at end of March after final IPC approval. Developing funding bids for next round of low carbon funding. Prescott Road bus corridor design developing, planning to review with ATE & NHSE support alongside LUHFT and Whiston. Scoping "better bins" project.

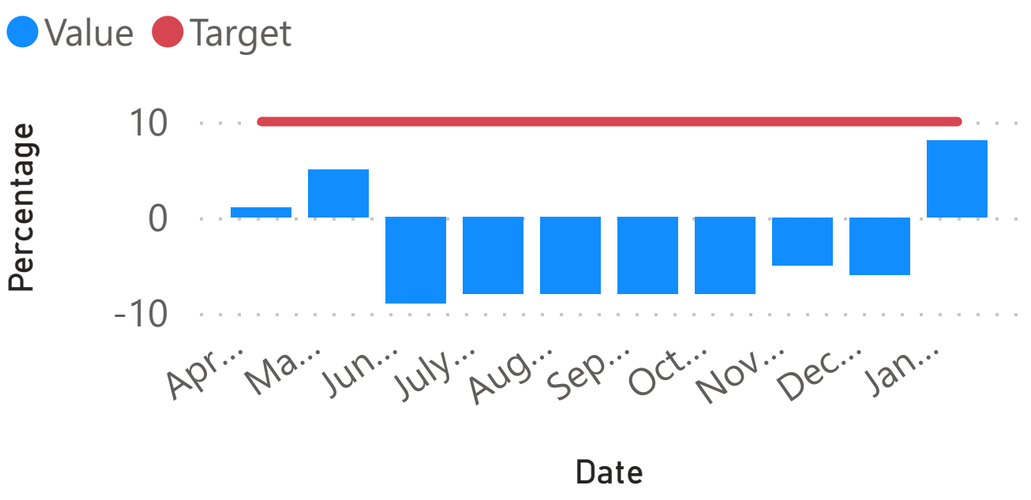
Green Plan: Reduce Carbon Footprint



Technical Analysis:

Actions:

Green Plan: Reduce Energy Usage



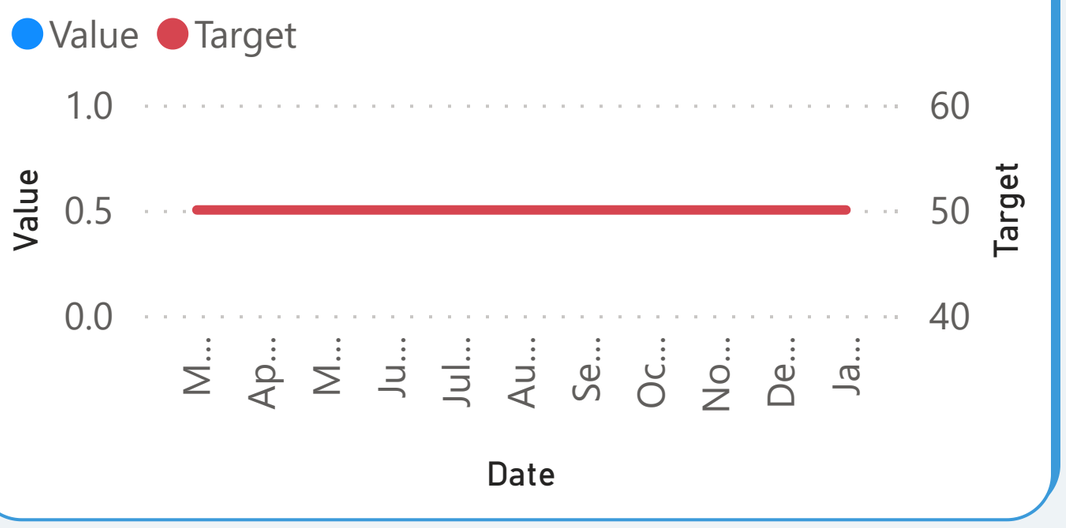
Technical Analysis:

Energy use still high due to heating and cooling equipment forced on.

Actions:

Developing plan for next phase of works once remedial work finished.

Green Plan: Reduce Waste



Technical Analysis:

Compactors and new baler in and working. No reduction reportable on visual.

Actions:

Complete post project review and confirm £ saving.

Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Continued improvement in staff who had had a PDR in the last 12 months with plan to ensure all completed by 31 March 2024

• Continued reduction in staff turnover (12%)

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

• Improvement in % of friends and family recommending outpatients (96%) and mental health services (100%)

• Further reduction in sickness absence rate (5%) which is mainly LTS

•Appointed to Liverpool CAMHS Clinical Lead post

• CYP Gender Service speciality package build (phase 1) completed in Expanse

• Appointed to 21 WTE vacancies for CYP Gender Service

• Improvement in RTT for CAMHS (63%)

Areas of Concern

• Impact of recruitment for Gender Service on Locality CAMHS teams

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

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

• Slight deterioration in timeliness of triaging referrals for ASD/ADHD – recovered in March 2024

Forward Look (with actions)

• Commencement of North Gender Service from 01 April 2024

• Task and finish group commenced to improve data quality; reporting via MHSDS and to meet new data reporting metrics from 01 April 2024

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

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

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

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

• Launch of improvement programme to integrate ASD and ADHD services

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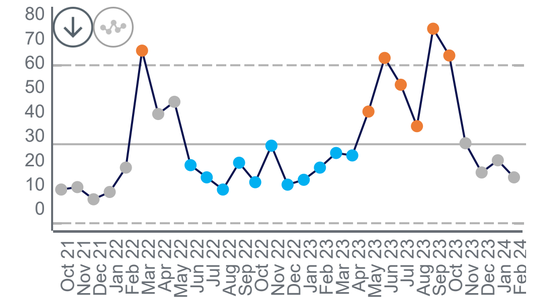
Integrated Performance Report | March 2024

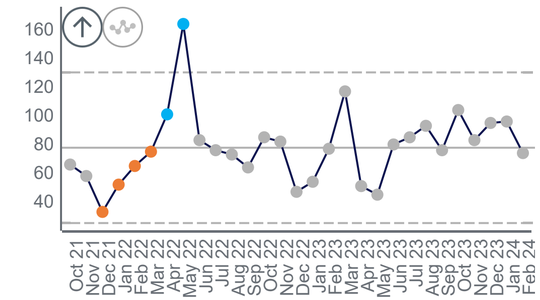
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

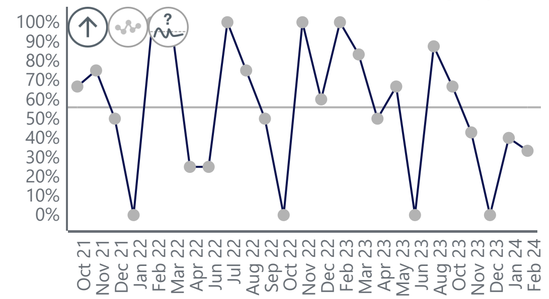
Number of Incidents rated Minor Harm and above



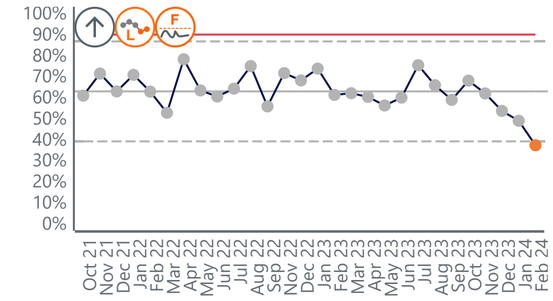
Number of Incidents rated No Harm and Near Miss



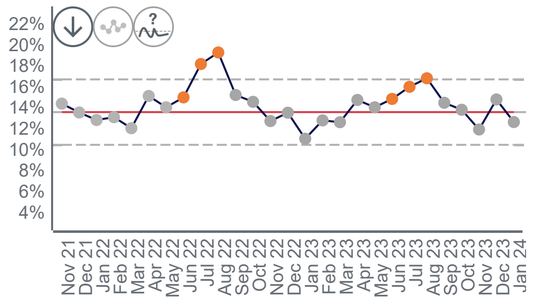
% Complaints Responded to within 25 working days



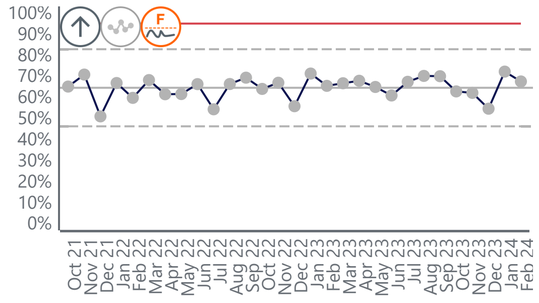
% PALS Resolved within 5 Days



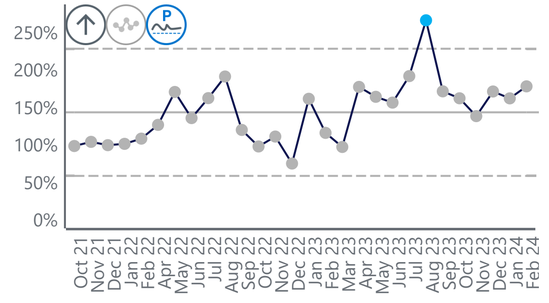
% Was Not Brought Rate (All OP: New and FU)



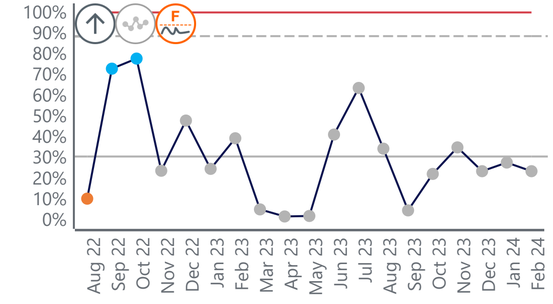
% of Clinical Letters completed within 10 Days



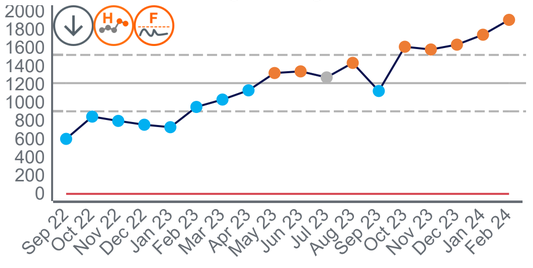
% Recovery for OP New & OPPROC Activity Volume



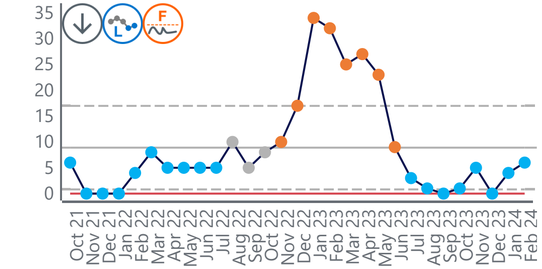
IHA: % complete within 20 days of referral to Alder Hey



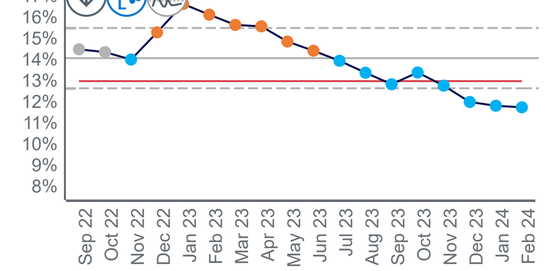
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



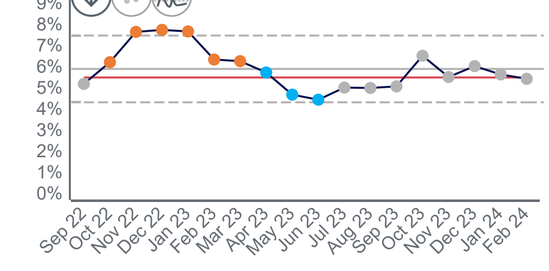
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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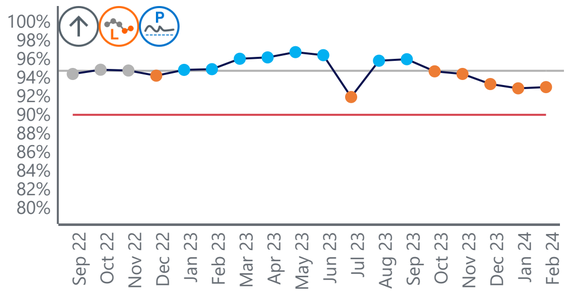
Integrated Performance Report | March 2024

Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

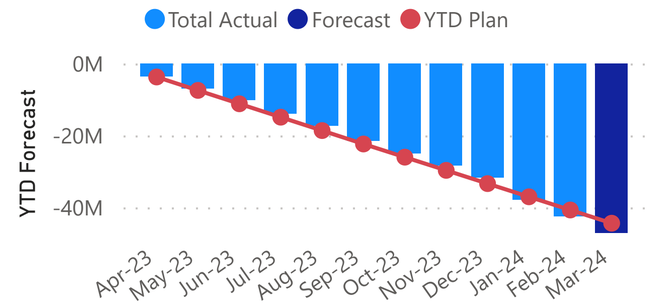
Mandatory Training



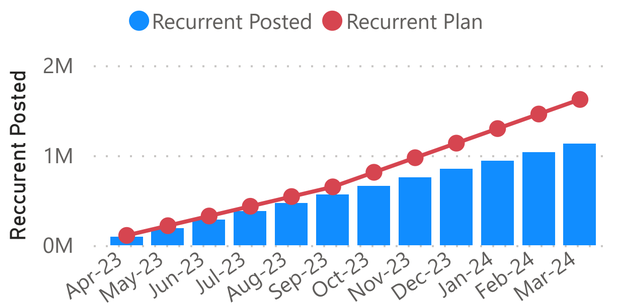
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

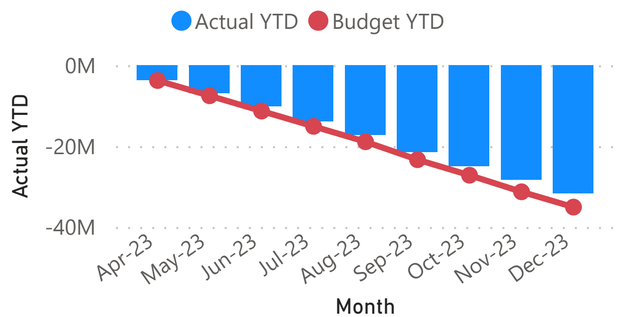
Revenue Position (Year End Forecast)



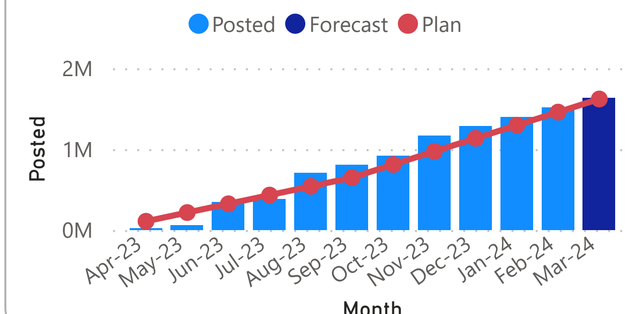
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• 100% response rate for formal complaints for 3rd consecutive month

• Significant movement in the number of staff who have a completed PDR within year. At the start of Feb 847 staff members required a PDR by the 1st March, this has reduced to 381

• 98% of PALS closed within 5 Days, achieving Trust target and improving further month on month

• Further reduction in WNB rate, now 6% achieving the Trust target

• Reduction in both short- and long-term sickness absence, 6% for February

• Secured investment from the cancer alliance to support the transformation of oncology services at AH, individual to be recruited within the next 3 months

• Maintained reduction in incidents reported for minor harm, correlating with increase in no harm & near miss incidents

Areas of Concern

• Reduction in ED 4 hours performance to 76% from 81%, still maintaining national standard; however, requiring further input to achieve 80% for Q4

• 14 C&YP waited for 12 hours + within ED, a slight increase from January

• Further reduction in ED F&F, associated with increase in waiting times. Deep dive scheduled if reduction continued during March

• Slight reduction in Sepsis compliance for ED and ward areas, clinical reviews underway to evaluate

• Increase in the number of C&YP waiting 65 weeks for treatment, now 10

• Diagnostic compliance reduced for third consecutive month, Gastro & LTV remaining the areas of key challenge within the division. Compliance trajectories in place to monitor improvement

• Slight increase in super stranded C&YP increase of 5

• Increase in hospital cancellations within 6 weeks; however, associated with industrial action within February

• Increase in theatre utilisation; however, further improvement work scheduled with key specialities

• Continued challenging financial position. Despite achieving in year CIP target long term sustainability plans remain in place

Forward Look (with actions)

• ED action plan in place to address reduction in performance and to ensure Q4 80% is achieved, impacted already experienced during first week of March

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

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

• DM01 trajectory in place to monitor performance and impact of improvement plans to ensure material difference seen month on month

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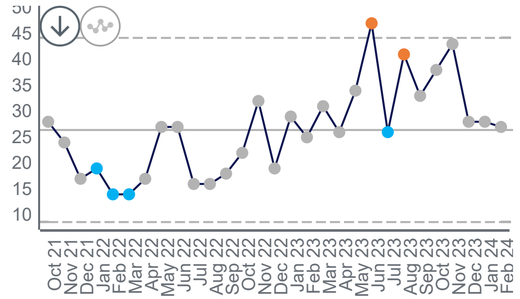
Integrated Performance Report | March 2024

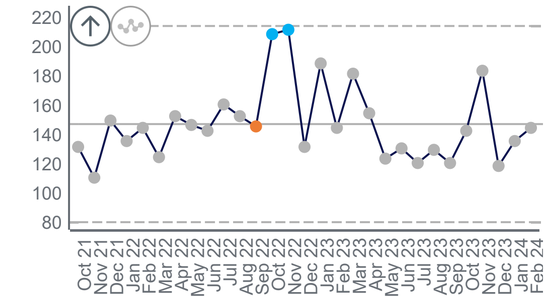
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

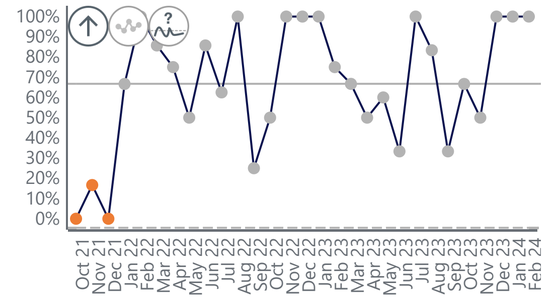
Number of Incidents rated Minor Harm and above



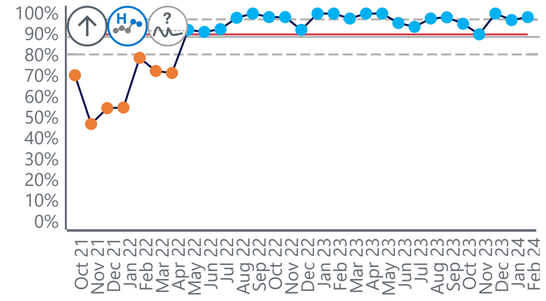
Number of Incidents rated No Harm and Near Miss



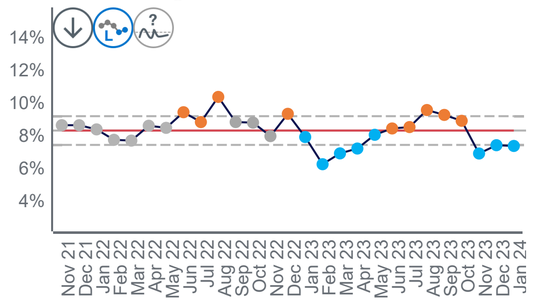
% Complaints Responded to within 25 working days



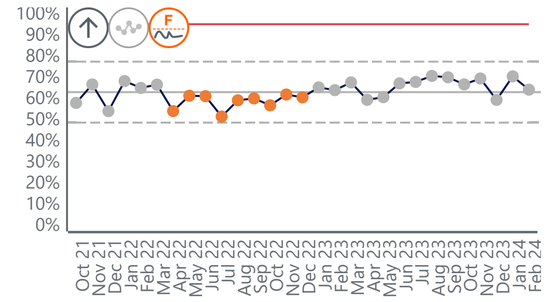
% PALS Resolved within 5 Days



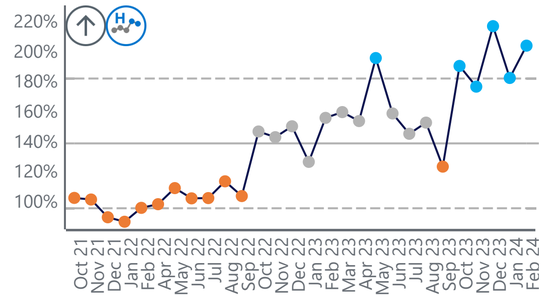
% Was Not Brought Rate (All OP: New and FU)



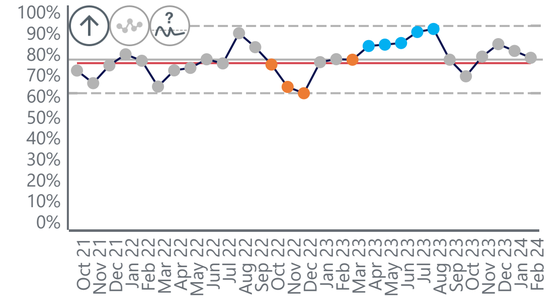
% of Clinical Letters completed within 10 Days



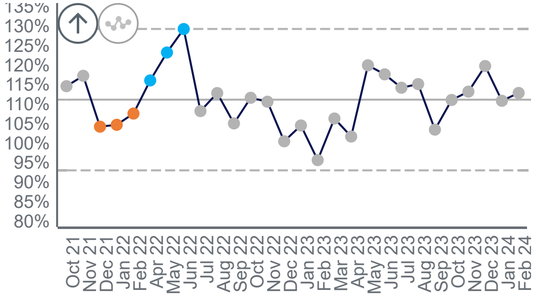
% Recovery for OP New & OPPROC Activity Volume



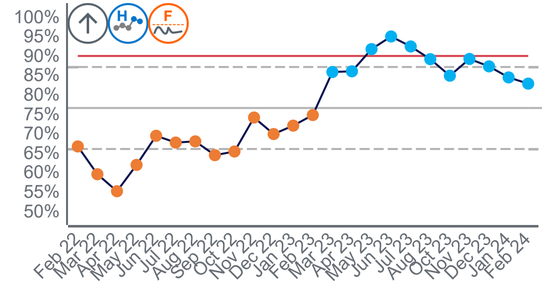
ED: % treated within 4 Hours



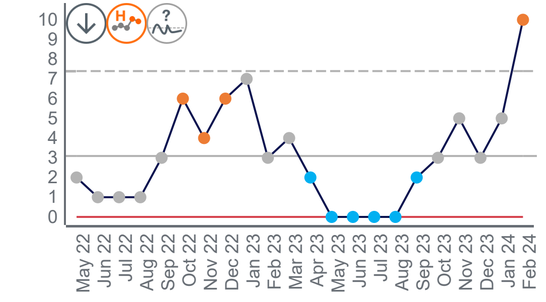
% Recovery for DC & Elec Activity Volume



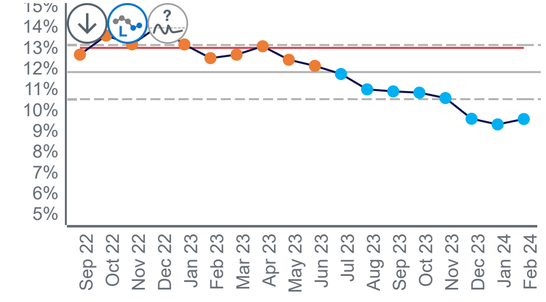
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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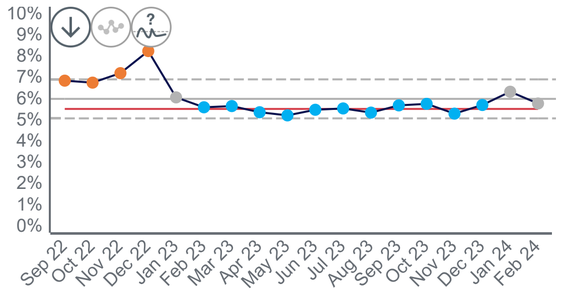
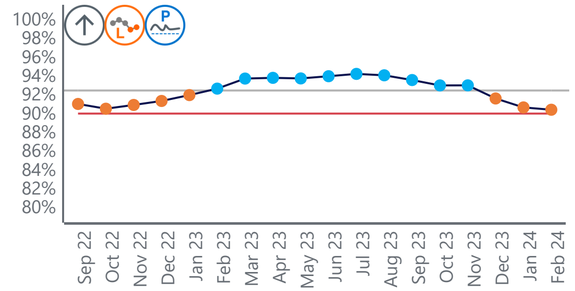
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

Sickness Absence (Total)



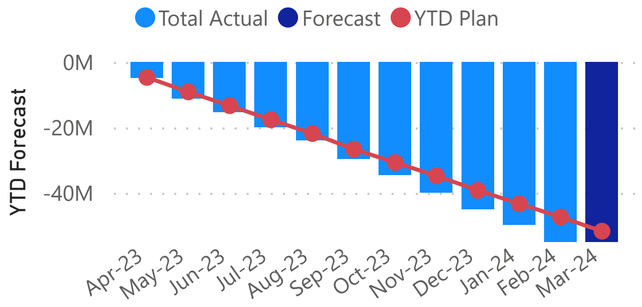
Mandatory Training



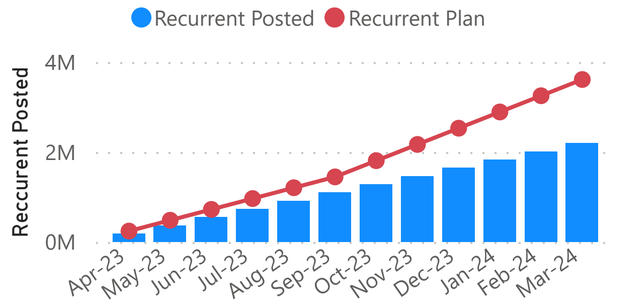
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

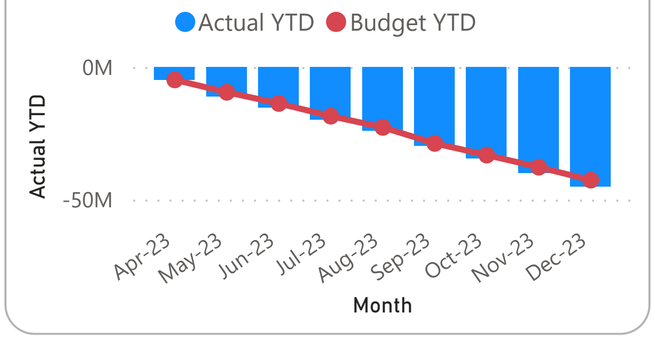
Revenue Position (Year End Forecast)



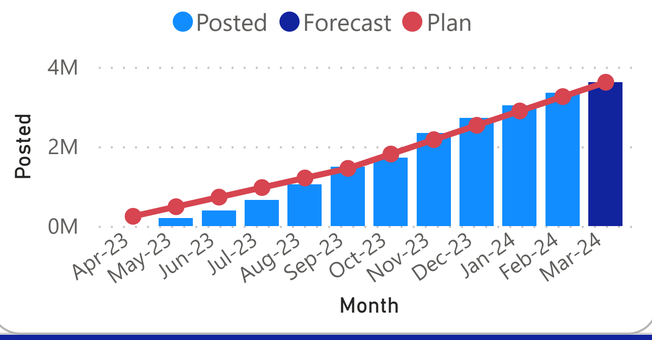
CIP Position (Recurrent Full Year Effect)

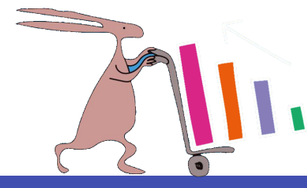


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Number of C & YP waiting over 65 weeks for treatment reduced in month by more than 50% with a high volume of ENT & Dental patients treated

• Maintained 100% response rate to PALS and formal complaints

• Recovery & activity volume increased in month

• Staff turnover decreased for 3rd consecutive month

• Sickness reduced in month below trust targets

• Mandatory training increased in month and remains above trust target. Key focus in March for anyone with less than 70% compliance & protected time allocated to teams

Areas of Concern

• WNB rate reduced in month but remains higher than trust target

• DC & IP reduction in % activity volume recovery in month however associate income positive due to case mix. Planned reductions due to IA in month.

• Diagnostics DM01 compliance reduced in month- fluctuates due to very small numbers- no significant concerns

Forward Look (with actions)

• Ongoing targeted work to reduce WNB rate- part way through pilot booking approach within Community Ophthalmology who have the highest WNB rate

• Ahead of trajectory for 0 > 65 weeks and work continues to ensure all patients receive treatment before end of March

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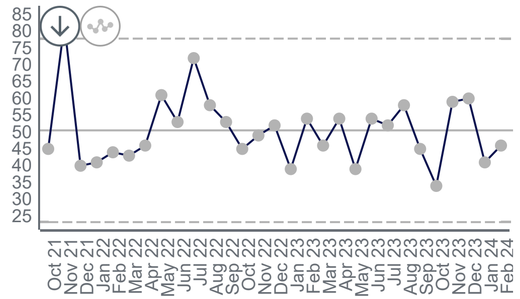
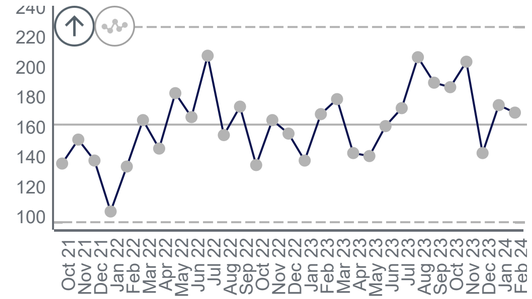
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

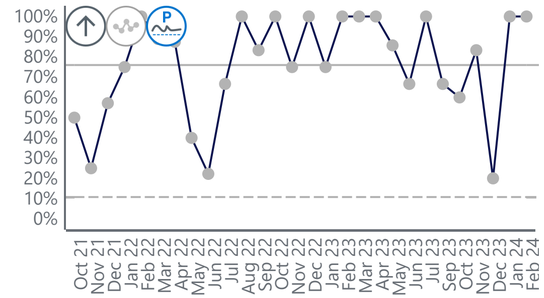
Number of Incidents rated Minor Harm and above



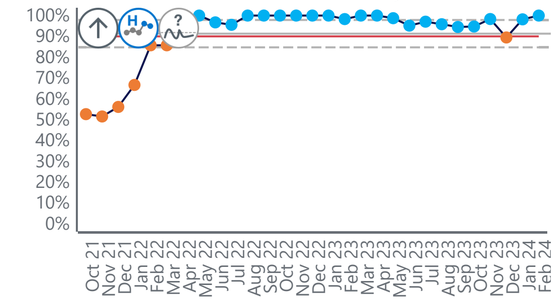
Number of Incidents rated No Harm and Near Miss



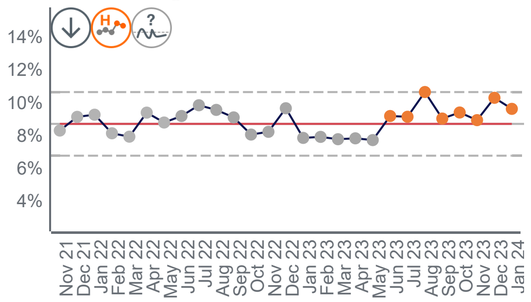
% Complaints Responded to within 25 working days



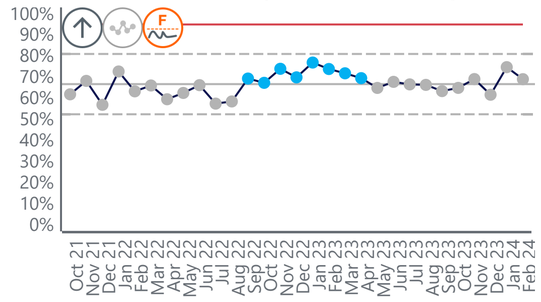
% PALS Resolved within 5 Days



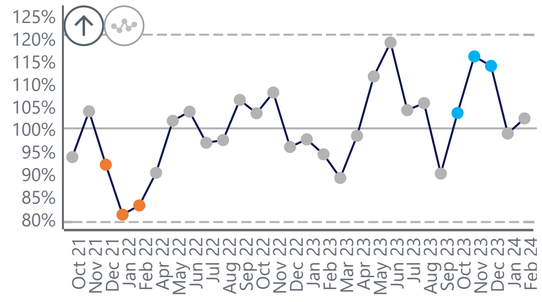
% Was Not Brought Rate (All OP: New and FU)



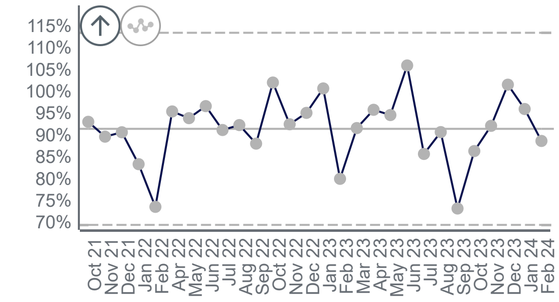
% of Clinical Letters completed within 10 Days



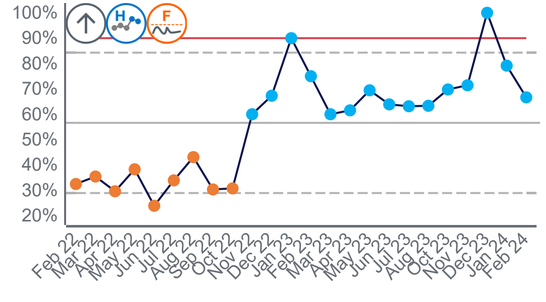
% Recovery for OP New & OPPROC Activity Volume



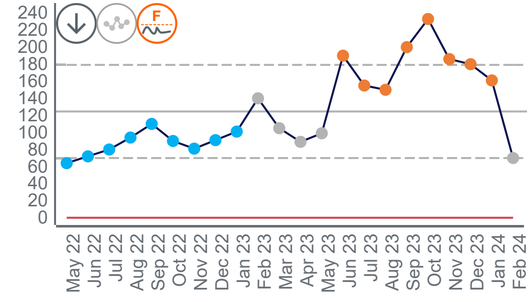
% Recovery for DC & Elec Activity Volume



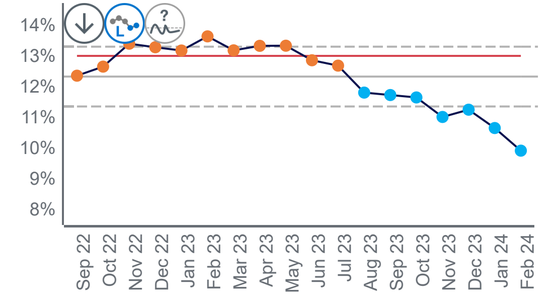
Diagnostics: % Completed Within 6 Weeks of referral



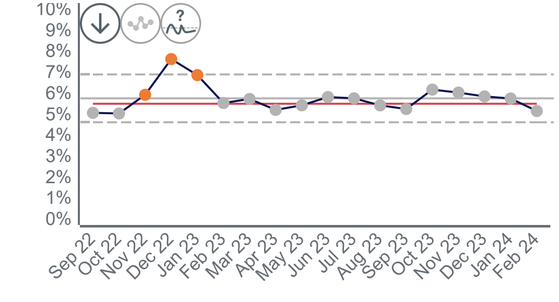
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)



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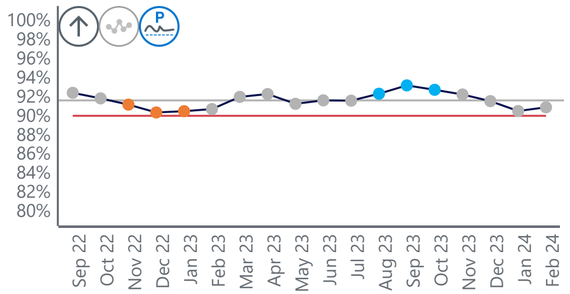
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

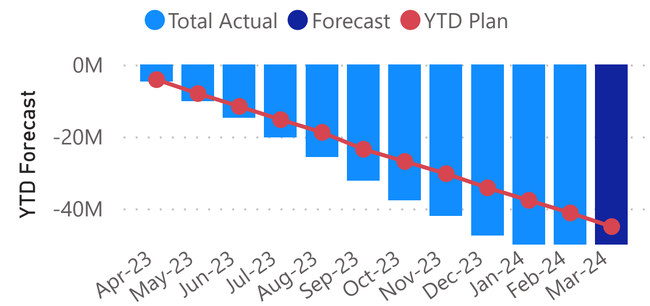
Mandatory Training



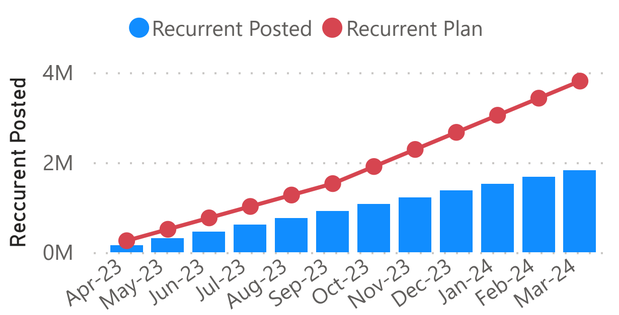
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

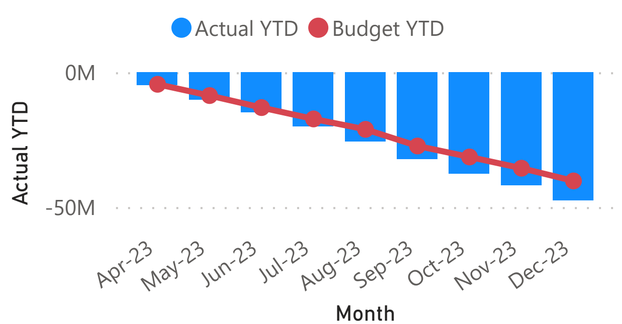
Revenue Position (Year End Forecast)



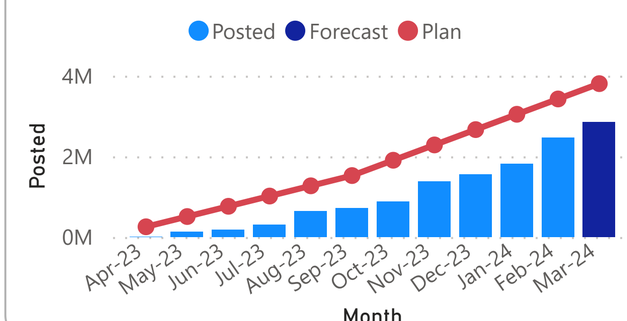
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• CRD staff sickness absence has decreased significantly in month to 2.7% (a decrease of 5.1% from previous month)

• Mandatory training remains on track

• Study successes in month include: Alder Hey recruiting the first UK participant for the commercial STEP YOUNG trial looking at Semaglutide and obesity (Dr Senthil Senniappan); the IgA vasculitis study (Dr Louise Oni) hitting a milestone of 150 recruits; AH remaining UK best recruiter for the PIC Bone study (imaging in paediatric osteomyelitis)

• Forecast to achieve £1.1m commercial income target by year end

Areas of Concern

• Staff turnover has increased slightly (small numbers)

• PDRs are slightly below target but plans are in place to ensure they are carried out and recorded

• Notification from NIHR that failure to hit 80% recruitment for time and target for trial will result in financial penalties for future infrastructure awards

Forward Look (with actions)

• Annual planning well underway with updated metrics and contribution to delivering non-NHS investment target

• Joint working, particularly with Innovation, continues through Futures

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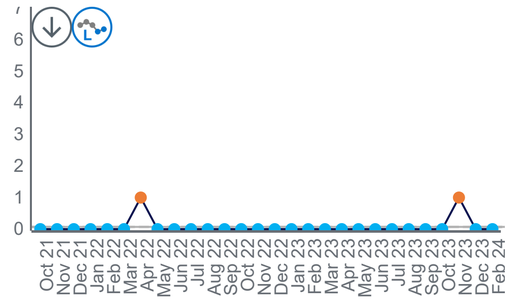
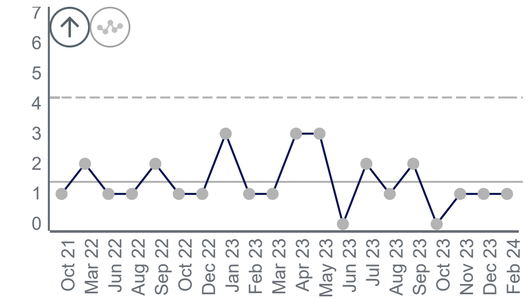
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

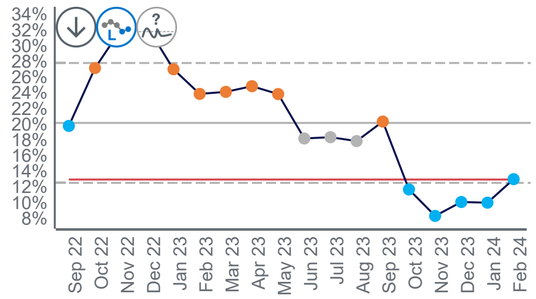
Number of Incidents rated Minor Harm and above



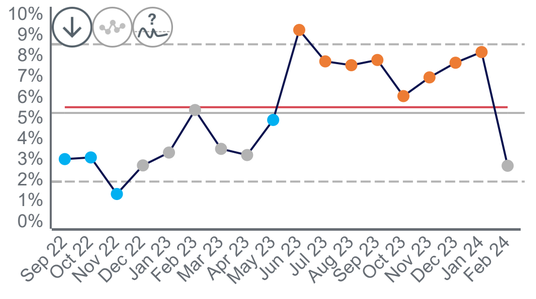
Number of Incidents rated No Harm and Near Miss



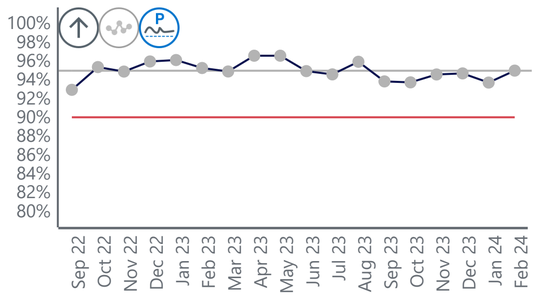
Staff Turnover



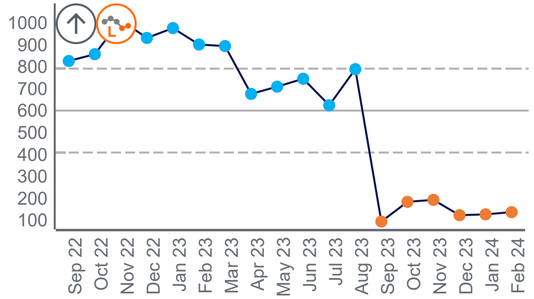
Sickness Absence (Total)



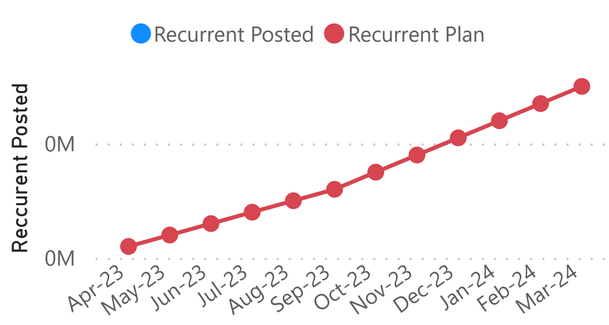
Mandatory Training



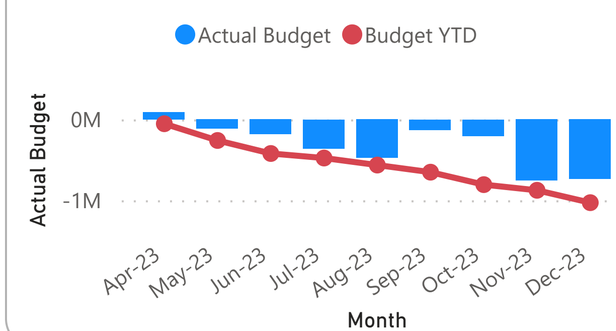
Number of Patients Recruited into Research Studies



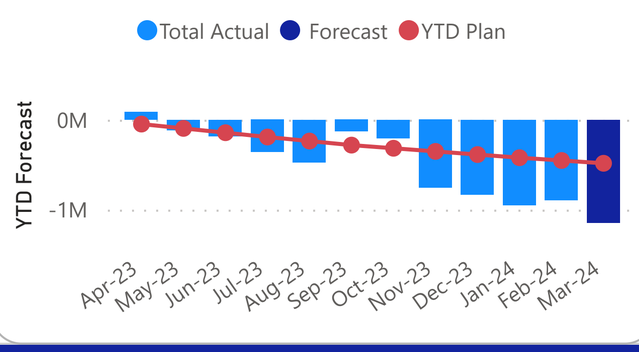
CIP Position (Recurrent Full Year Effect)



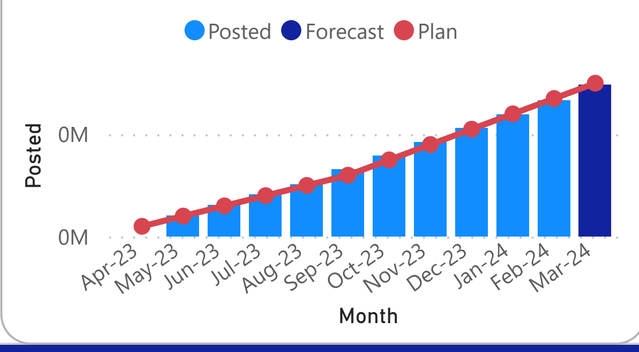
Revenue Position (Variance to date)



Revenue Position (Year End Forecast)



CIP Position (Delivered to date)



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Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative did not meet in March due to Corporate Annual Planning requirements. Highlights from the February data are as follows:

- Mandatory training for Corporate Services remains above the 90% target at 92%.
- Short term sickness remains at 2% and continues to below Trust target (2.5%).
- 100% of CIP already identified and/or delivered at M10.
- Staff Turnover remains steady at 13% which is below Trust target.
- Positive engagement in all service areas in monthly review of risks and actions required regarding any overdue risks.

Areas of Concern

- Long term sickness remains stable at 5% with assurance that current cases are being managed in line with Trust Policy.
- Overall PDR completion rate increased to 65% but is still below Trust target and for B7+ is 79%

Forward Look (with actions)

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

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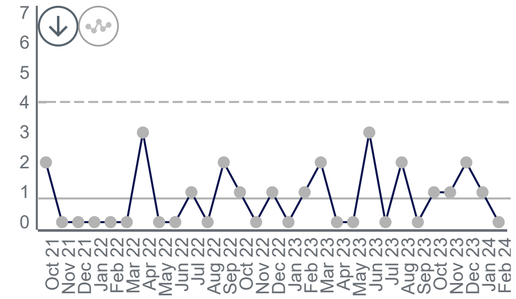
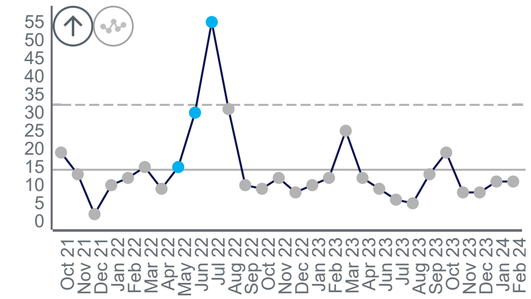
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

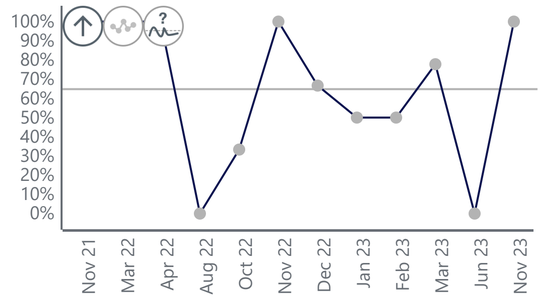
Number of Incidents rated Minor Harm and above



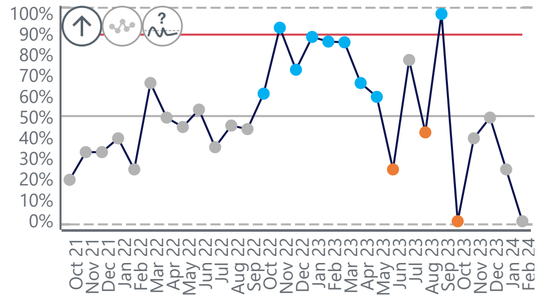
Number of Incidents rated No Harm and Near Miss



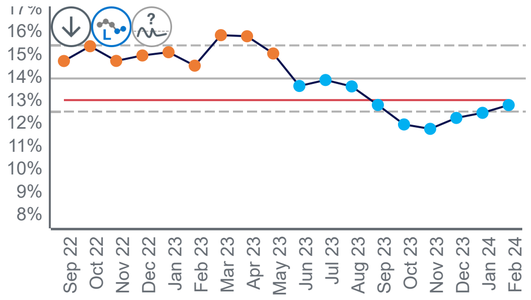
% Complaints Responded to within 25 working days



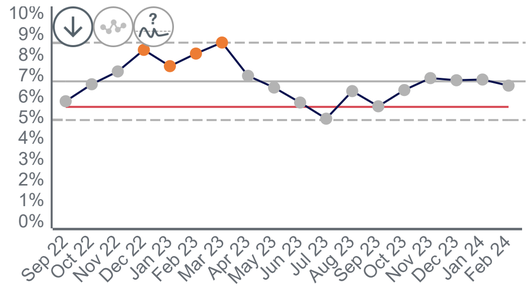
% PALS Resolved within 5 Days



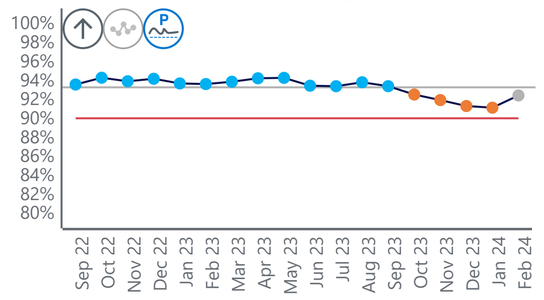
Staff Turnover



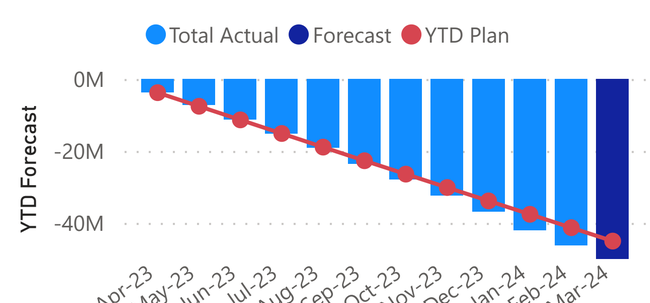
Sickness Absence (Total)



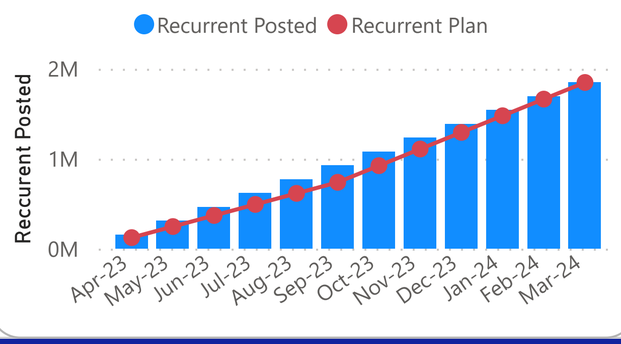
Mandatory Training



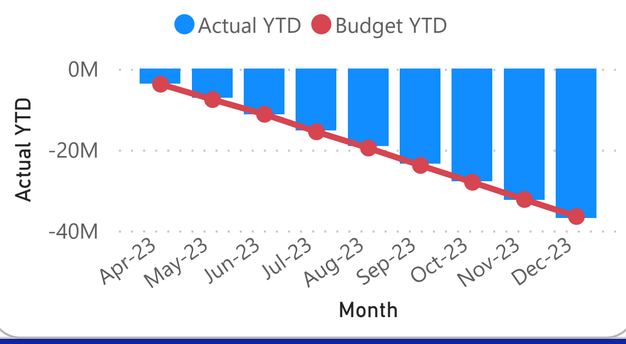
Revenue Position (Year End Forecast)



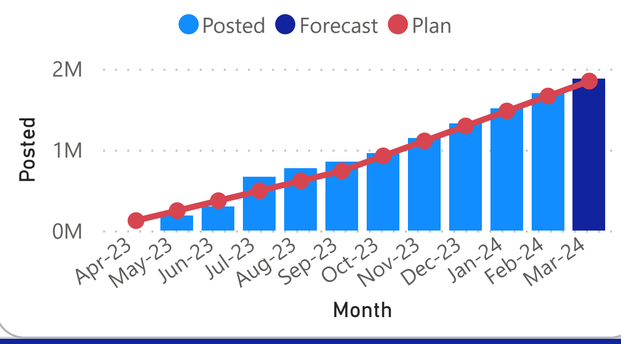
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



0110

Safe Staffing & Patient Quality Indicator Report
November Staffing, CHPPD and benchmark
March Board Paper

	Day		Night		Patients	CHPPD	National benchmark	Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registere	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients	CHPPD Rate		RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of response	% Very good and good		
Burns Unit	100%	-	100%	-	66	31.9	14.73	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	4	33	0	1	6	100%	0	0
HDU	78%	62%	78%	57%	296	28.2	34.24	1.61	1.03%	0.00	0.00%	173.37	3.25%	14.87	8.08%	7	80	0	3	2	100%	1	1
ICU	96%	81%	93%	80%	306	62.1	34.24	1.00	1.23%	0.00	0.00%	153.18	7.13%	0.00	0.00%	11	144	0	1	1	100%	1	1
Ward 1cC	85%	73%	80%	39%	339	18.6	18.64	0.00	0.00%	0.00	0.00%	56.13	3.10%	63.68	23.87%	1	63	1	14	11	90.91%	0	0
Ward 1cN	59%	3%	72%	-	138	21.2	21.18	0.00	0.00%	0.00	0.00%	28.84	2.83%	4.00	6.06%	2	43	1	8	5	80%	0	0
Ward 3A	98%	90%	100%	159%	695	11.9	11.99	0.61	1.11%	0.00	0.00%	113.92	6.88%	86.85	19.35%	1	44	1	12	45	95.66%	0	0
Ward 3B	71%	131%	77%	-	311	16.8	15.07	0.00	0.00%	0.00	0.00%	85.24	7.16%	28.60	15.66%	9	64	0	6	9	100%	1	0
Ward 3C	94%	116%	79%	157%	642	13.8	11.32	0.00	0.00%	0.00	0.00%	125.48	6.69%	62.52	17.74%	7	91	5	6	36	91.67%	0	0
Ward 4A	77%	84%	79%	110%	646	12.1	12.03	0.00	0.00%	0.00	0.00%	193.85	9.52%	0.00	0.00%	3	49	1	4	30	96.67%	0	0
Ward 4B	59%	86%	58%	73%	429	16.7	12.74	2.00	4.91%	0.00	0.00%	107.00	8.69%	153.27	12.62%	8	69	0	4	5	80%	0	0
Ward 4C	104%	98%	101%	103%	736	11.0	12.01	1.00	1.75%	0.00	0.00%	72.36	4.25%	49.32	14.96%	19	181	2	4	24	100%	1	0

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

Medicine

3B: Fill rate for RN's is below 80% due to a combination of short term sickness 7.16% and 1.7 WTE vacancy. The ward was supported at this time via safer staffing to ensure patient safety maintained. Turnover continues to improve with no leavers during February.

3C: Fill rate for RNs on night duty is below 80% due to an increase in short term sickness, 7 WTE RN's supernumery in addition to a patient requiring an RN 1:1. The ward is also supporting 3 x HCA 1:1 on a long-term basis. There was an increase in overall 1:1 for HCA's overnight. The ward had no leavers during this period.

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

4C: Have seen a significant improvement in fill rate and low vacancy at 2.4 WTE and improved sickness.

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

Surgery

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

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

Ward 4A : RN maternity leave high at 9.49 WTE, LTS 2.84 WTE. HCA vacancy 1.73 WTE

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

Critical Care

HDU: average fill rate is less than 80% is due to the Band 4s that are in post awaiting NMC pins and other supernumerary staff. 11 WTE supernumery RN's for this period. Activity increased with 49 admissions to HDU in addition to the elective programme.

ICU: Had LTS and staff redeployment in this reporting period

Both ICU and HDU have made some changes to their Healthroster and the way shifts are allocated which may explain the underfill rates. Additional shifts were being creating in error which has impacted on fill rate reporting. This will be rectified in the February roster reports.

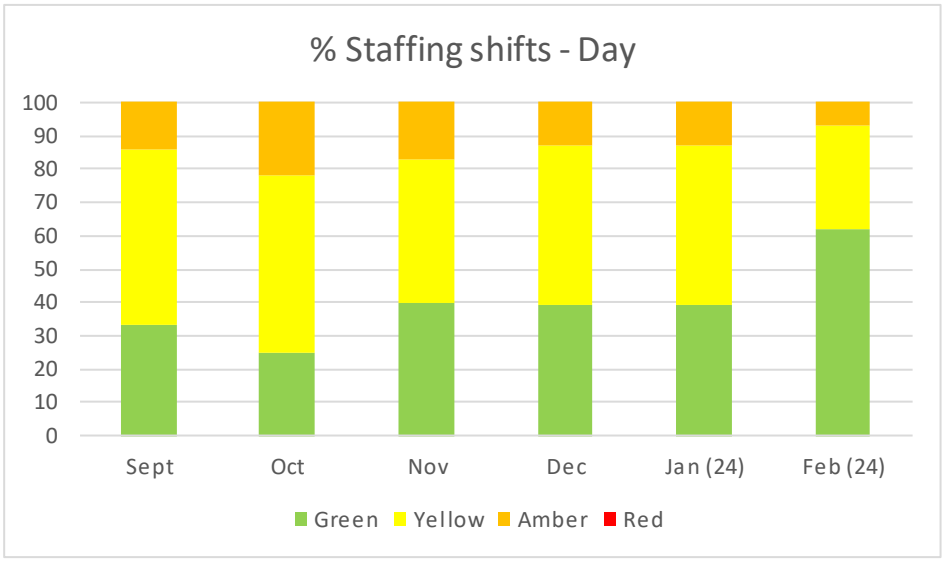
Summary

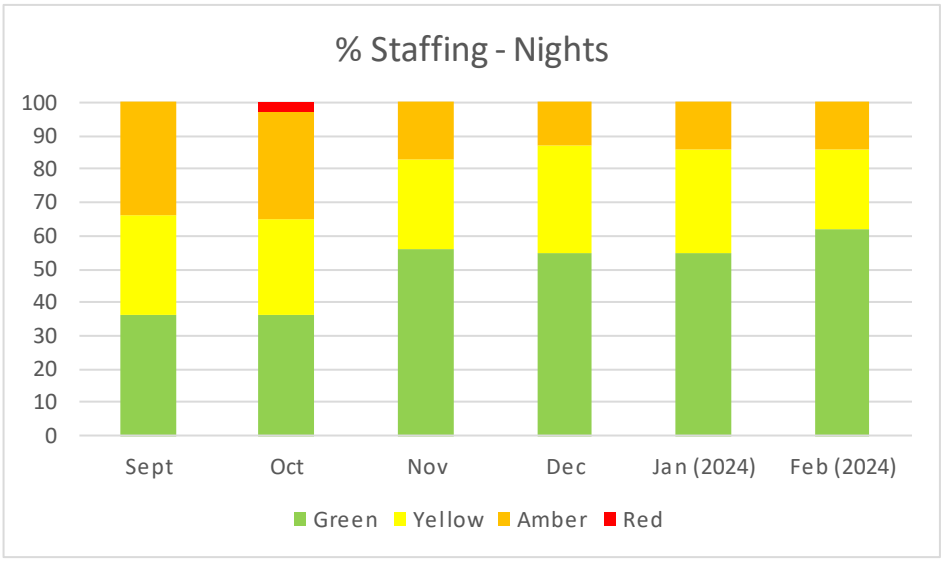
Alder Hey are above the National Benchmark in wards 4B, 3C,3B, and within critical care whilst the other areas are comparable.

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

Summary of Staffing models September 2023 – February 2024

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


% Staffing shifts - Day
100
90
80
70
60
50
40
30
20
10
0
Sept
Oct
Nov
Dec
Jan (24)
Feb (24)
Green
Yellow
Amber
Red


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

Electronic Roster KPI Report

February Board Paper

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

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 **(5th February - 3rd March)**	% Changed Since Approval	Net Hours (1 pro rated day per person)	Net Hours	Bank / Agency Use %	Bank / Agency Usage Hours	Additional Duties	Unfilled Roster %	Annual Leave %	Study Day %	Other Leave %	Sickness %	Parenting %	Total Unavailability %
Accident & Emergency - APNP (912201)	54	27.01%	80.00	431.25	0.00%	0	4	37.74%	16.29%	7.01%	0.53%	3.99%	0.00%	27.83%
Accident & Emergency - Nursing (912201)	39	47.09%	720.00	70.48	19.87%	2396.17	28	9.58%	15.81%	2.96%	1.38%	9.24%	4.58%	34.14%
Burns Unit (915208)	24	29.95%	140.00	409.22	17.26%	384	3	7.22%	22.58%	2.53%	0.75%	6.35%	0.00%	32.63%
Critical Care Ward (913208)	51	37.11%	1200.00	3386.75	7.96%	1585.5	90	16.43%	13.99%	0.06%	0.14%	5.49%	5.64%	25.32%
High Dependancy Unit (HDU) (913210)	32	27.18%	640.00	464.55	10.50%	857	5	26.86%	15.10%	5.50%	0.27%	9.92%	11.43%	43.54%
Medical Daycase Unit (911314)	31	35.96%	50.00	76.53	5.48%	57	6	23.25%	12.71%	1.97%	0.81%	0.81%	0.00%	16.31%
Outpatients (916503)	27	40.92%	420.00	1150.64	16.59%	1086.08	9	36.36%	10.79%	1.35%	0.96%	18.11%	2.38%	34.20%
Sunflower House (912310)	12	52.87%	190.00	1212.88	34.92%	1538	16	9.33%	15.73%	0.19%	0.90%	4.04%	13.42%	37.08%
Surgical Daycase Unit (915418)	33	40.33%	85.00	522.37	10.40%	342.25	0	26.72%	8.14%	0.21%	4.61%	9.73%	0.00%	22.69%
Theatres - Cardiac & Cardiology (915405)	48	26.20%	130.00	409.5	18.18%	261.5	0	14.73%	14.17%	2.76%	8.02%	1.41%	0.00%	47.99%
Theatres - Emergency (915420)	46	47.14%	230.00	3.42	15.83%	354	3	2.05%	23.41%	1.72%	0.00%	2.39%	0.00%	27.52%
Theatres - IP Anaesthetics (915423)	48	36.28%	82.00	-65.05	12.47%	452.42	14	0.59%	23.02%	1.34%	2.86%	0.64%	4.47%	34.04%
Theatres - IP Porters (915435)	45	51.50%	101.00	-5.75	12.66%	196.5	13	17.65%	18.67%	0.00%	2.13%	7.17%	0.00%	30.46%
Theatres - IP Recovery (915422)	44	44.18%	103.00	-243.45	17.54%	337.5	18	10.47%	14.86%	3.72%	5.44%	0.00%	0.00%	24.02%
Theatres - IP Scrub (915424)	46	34.92%	128.00	97.57	22.60%	366.75	0	14.55%	16.85%	3.50%	0.00%	17.95%	0.00%	42.15%
Theatres - Ortho & Neuro Scrub (915436)	46	34.57%	37.80	25.35	21.15%	491.75	0	4.43%	18.17%	0.37%	0.00%	8.86%	4.45%	35.32%
Theatres - SDC Anaesthetics (915429)	48	52.63%	58.40	45.42	18.21%	125.5	0	38.46%	24.72%	0.00%	5.68%	5.24%	9.27%	44.92%
Theatres - SDC Recovery (915430)	44	47.14%	177.30	237.57	12.11%	147.75	2	16.29%	16.89%	4.75%	5.37%	6.19%	0.00%	33.21%
Theatres - SDC Scrub (915421)	44	59.55%	532.00	542	18.62%	506.75	9	56.23%	14.02%	1.35%	2.76%	24.85%	0.00%	42.98%
Ward 1C Cardiac (913307)	24	36.56%	361.00	2131.37	15.75%	1120.65	1	11.71%	13.49%	3.86%	1.60%	7.70%	9.23%	42.28%
Ward 1C Neonatal (913310)	45	23.39%	556.00	262.01	0.73%	34.5	0	32.01%	13.29%	5.64%	1.23%	7.70%	0.00%	31.06%
Ward 3A (915309)	38	37.31%	371.00	40.72	18.10%	1534.5	11	9.63%	17.36%	2.36%	1.29%	7.35%	3.76%	33.19%
Ward 3B - Oncology (911208)	30	26.33%	555.00	3262.08	15.53%	807.75	0	13.87%	18.74%	2.19%	1.16%	5.20%	5.63%	35.94%
Ward 3C (911313)	33	41.66%	607.00	1910.89	25.78%	2326.25	22	24.89%	18.55%	3.96%	0.63%	8.37%	3.62%	37.44%
Ward 4A (914210)	24	22.74%	634.00	1259.13	10.75%	884.5	0	19.35%	20.68%	4.50%	0.56%	4.83%	6.37%	39.89%
Ward 4B (914211)	30	36.57%	533.00	8004.13	14.48%	1066	6	26.89%	22.18%	4.39%	3.77%	9.17%	5.81%	47.52%
Ward 4C (912207)	45	31.37%	280.00	320.19	19.62%	1544.5	1	17.40%	17.76%	3.81%	1.15%	5.09%	0.36%	31.60%
Feb-24	**38**	**38.09%**	**9001.50**	**25961.77**	**15.30%**	**20805.07**	**261**	**19.43%**	**16.96%**	**2.67%**	**2.00%**	**7.33%**	**3.35%**	**34.64%**
Jan-24	**31**	**35.00%**	**9001.00**	**29114**	**13.60%**	**20742**	**409**	**21.22%**	**15.84%**	**2.08%**	**2.17%**	**8.89%**	**3.48%**	**34.06%**

Summary Narrative

This is our third E Roster KPI data set, and we are starting to see some impact of the work between the Roster team and the ward managers, with some more green colouring starting to populate the table. The key elements that have been highlighted from the February KPI data are summarised below:

Lead time has improved by a full week from 31 days in January to 38 days in February (target is 42 days) - Staff are receiving on average 38 days' notice of shifts to be worked. This is a significant improvement in month and helps staff with their work life balance and assures managers well in advance that they have the correct skill mix and staffing numbers to provide safe and effective care. The Roster team continue to work with the Ward and Divisional leads to improve these lead times and achieve our target of 42 days.

Roster changes since approval (target is <25%) – we have seen a slight increase in month from 35-38.09%. This mainly relates to rosters now going out a week earlier. The Roster team plan to work with Managers to improve the initial roster. This work will commence in April with improvements expected by Q2.

Net hours 25961 reduced from 29114 – Continued improvement has been made in this area. These are hours in the roster that are unaccounted for. The E Roster team are working with the departmental managers to correct any administrative errors so there is full assurance that the data is correct, and a true reflection of what colleagues owe or are owed. These hours can be used in place of booking temporary staffing via NHSP when managers are confident that they are correct.

Bank/Agency use has risen in February from 13.6% to 15.3% (target is <10%) - This figure relates to the fact that 15.3% of all shifts are identified through NHSP. Fill rate has increased in line with this, and Managers have fed back that they generally utilise their own staff so helping with patient continuity. The monthly figure may be affected by staff that are using outstanding annual leave before the end of March. The impact of a rise in bank use is twofold. Managers are now only able to cancel and direct book shifts via roster.

Additional duties have reduced from 409 to 261 (target is 0) – Continued improvements in this area. These hours reflect staff booked over the funded establishment. The E Roster team are working with Managers to ensure additional duties are only being created and used for legitimate reasons and if they aren't used, they are deleted (Many of these shifts have previously remain unfilled).

Unfilled roster reduced from 21.22% to 19.43% - (target is <15%) Another slight improvement. This could be in part due to some roster template reviews and an increase in bank fill rates. The E Roster team continue to work with Managers to review templates.

Annual leave, other leave, and parenting leave- well within the KPI target.

Sickness is 7.33% from 8.89% (target <5%) - continues to be above target but definite improvements in areas, and the figure is affected greatly by one or two areas where the rate is very high.

Study leave has seen a slight increase from 2.08% to 2.67% (target is <2%). It was noted that Medical Division allocation is high at 3.7%.

Total unavailability is 34.64% (target is <30%) - slightly over target. This could indicate there are too many people not on clinical duties/counted as being able to deliver care. This indicator covers sickness, suspension, maternity leave, study leave etc.

Progress

Some really good progress this month in most areas including additional duties, unfilled roster, net hours, roster changes and importantly lead times. Lots of green in the leave area as well, and of note is the continued reduction in the % age staff on parenting leave matrix.

Roster sign off meetings are live in Surgery and the Medical Division. Community Division are in the process of setting their meeting up.

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

Alder Hey Children's NHS Foundation Trust

Board of Directors

Thursday, 11 April 2024

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

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

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

Campus Development Report on the Programme for Delivery

April 2024

1. Executive Summary

The purpose of this report is to keep Trust Board informed of progress, risks and actions on capital projects as they arise. Budget position & forecast by project is reported through RABD.

Good progress has continued to be made to deliver projects:

2024/25 Q1 & Q2:

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

2024/25 Q3 & Q4:

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

2. Key Risks

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

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

In addition to the risks above, a number of projects are affected by external resource issues which we are reliant on in order to meet delivery milestones. In particular Mitie project management resources and groundworks (Lorne Stewart). Regular escalation meetings are in place to check, challenge and manage any implications.

Key/High Risks Descriptor

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

3. Programme Delivery Timetable (Critical Path)

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

4. Programme Delivery Timetable (Associated Projects)

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

5. Project Updates

Neonatal and Urgent Care Centre

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Service Diversion Works: • Essential works completed on the rusty main 25.03.24. • Hoarding installation commenced. Vinyl information & image displays will be installed from April '24.		Completion of works ahead of main construction. Impact on budget. Management of noise and site access routes during peak works.	Monitor via monthly Construction Progress meeting. On-going site management plan, including enhanced communications to patients & families.
Full final phase of construction contract signed 21.12.23. • Instruction issued to MSC to complete full ground floor layout works ie: to include construction completion of the 'shelled' space (Urgent Care Centre/SDEC).		Increased construction & SPV costs. Delay to unit opening.	Development Team are working with the SPV and Mitie to identify mitigation plans in relation to increased SPV / other costs. An update report will be shared 15.04.24 with RABD members. Review of shell space bids 22.04.24. Agree EDU design and decant plan.
Equipment Specification & Procurement: • Proposals for monitor selection and options & recommendations paper for incubators presented at 09.04.24 Neo Natal/SDEC Programme Board.		Coordination of technologies and flow of patient data between component systems: incubator, monitoring, alarms and line of sight elements.	Finalise equipment requirements.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Trust meeting with contractor held 06.03.24 and follow up meeting 09.04.24.		Possible contract claim.	An update report will be shared 15.04.24 with RABD members.

Deliverable (Catkin & Sunflower House Building cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Sprinkler System Under-Croft Car Park: • Principal contractor to be appointed to undertake works and installation. • Procurement framework route established.		Fire compliance. Potential loss of overall car park numbers. Budget TBC.	Finalise scope of works and costs.
Water Safety Issues: • To ensure statutory temperatures are maintained.		Continued contamination.	Microbiological sampling will continue.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Immediate priorities are being progressed: • Permanent solutions for those staff currently accommodated on a 'temporary' basis. • Alternative accommodation for teams/services currently based in the Histopathology building, to allow demolition of the building. • Potential increased scope: meeting rooms and storage.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for works/kit.	Space pressure plan being developed for Executive Director support & approval. Budget and scope of works to be finalised.
Former Police Station Refurbishment: • Main contract signed with contractor 12.02.24 and works commenced for completion June 2024.		Operational date currently assessed as June 2024.	On-going bi-weekly senior Principals' meeting & design team site visits. Pre-move planning with service senior leadership team.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: • FOSP site walkabout with Trust 09.04.24.		Inconsistent communications.	Continued and maintained input & communications from all key stakeholders. Quarterly newsletters and regular website updates.

Deliverable (Park Reinstatement cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Completion Works: • New playground opened for use 28.03.24. • Drainage works and final seeding to the football pitches expected April 2024. • Lighting, planting, street furniture & signage, path works completion Q2 2024.		Delays in completion football pitches. Completion of existing Infrastructure works.	Programme currently being assessed to develop potential options for bringing forward work package handovers where possible. Trust discussions on-going with LCC to confirm and gather required documentation for the handover of Springfield Park to LCC.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Work ongoing in line with programme. • 3 tender submissions returned. • Tender Evaluations: 08.04.24. • Appoint Construction Contractor: Spring 2024. • Start on Site: 03.06.24. • Construction Completion: 16.12.24.		Timely appointment of a construction contractor. Delay to completion, impact on operational running of the services. Mitie PM resources.	Regular meetings. Close monitoring of critical risks. Discussion with wider estates community re: potential short-term decant facilities, and internal capacity assessment to help manage patient activity during works.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

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

Elective Surgical Day Case

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

Rainbow Centre Refurbishment

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

Gender Development Services (GDS) – Estates Solution

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Contract executed. Construction works progressing in line with programme and furniture in place.		Programme, available budget. Suppliers lead in times.	Non-furniture equipment & sundries procurement. Delivery schedule and move plan to be developed.

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

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

6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 11 April 2024.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	Learning from Patient Safety Incidents 1st-31st March 2024
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director of Nursing and Governance

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

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

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

1. Purpose

The purpose of this paper is to provide the Trust Board with a summary of activity following the transition to Patient Safety Incident Response Framework (PSIRF), including oversight of those incidents that have been reviewed in line with the Trusts and Patient Safety Incident Response Plan (PSRIP), highlighting any identified areas of system wide learning and improvement for the reporting timeframe 1st – 31st March 2024.

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

2. Background

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

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

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

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

3. Local context

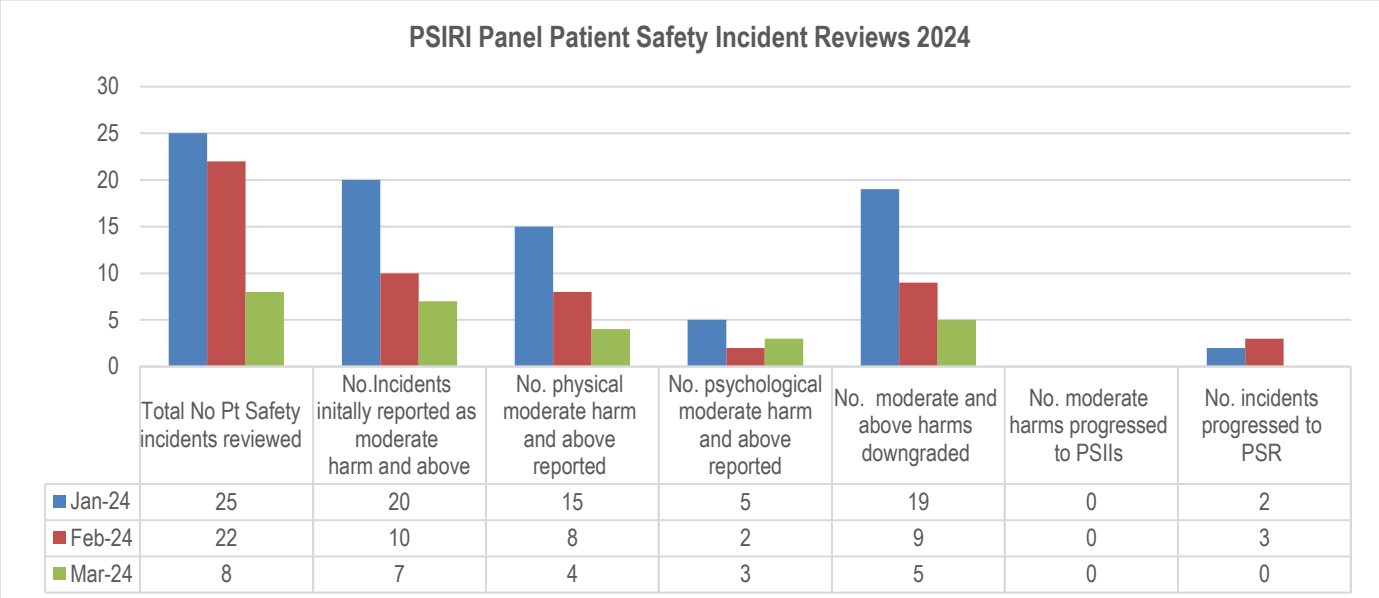
PSIRF replaces the methodology of root cause analysis with a systems-based patient safety incident investigation (PSII) approach or more locally a Patient Safety Response (PSR).

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

3.1 Patient Safety Incidents.

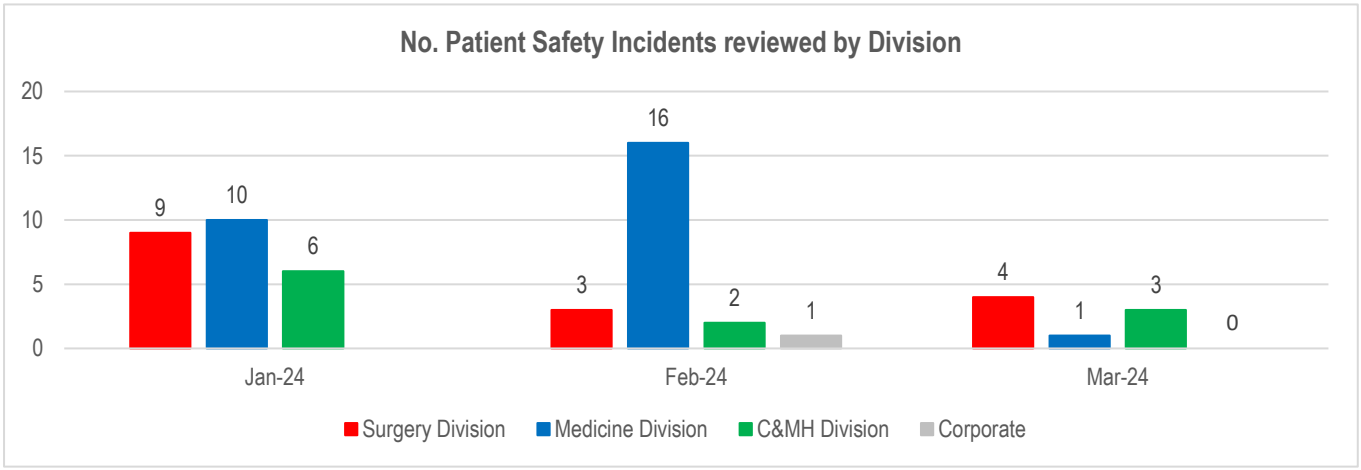
Table 1 below notes the number of patient safety incidents reviewed at PSIRI panel throughout March 2024. Table 2 notes the number of patient safety incidents presented and reviewed by division.

Table 1



	Total No Pt Safety incidents reviewed	No.Incidents initally reported as moderate harm and above	No. physical moderate harm and above reported	No. psychological moderate harm and above reported	No. moderate and above harms downgraded	No. moderate harms progressed to PSIIs	No. incidents progressed to PSR
Jan-24	25	20	15	5	19	0	2
Feb-24	22	10	8	2	9	0	3
Mar-24	8	7	4	3	5	0	0

Table 2



A total of 8 incidents were reviewed at the weekly PSIRI panel during the reporting period 1st -31st March 2024, of which 7 incidents had been initially reported as either moderate and above physical or psychological harm.

Following discussion and review of the reported incidents presented a collective decision was made by PSIRI panel and divisional leads to downgrade the initial reported moderate harm levels for 5 incidents based on incident findings and use of the NHS England harm grading criteria .

3.2 Patient Safety Incident Investigations (PSIIs)

A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences,

not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

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

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

3.3 Patient Safety Responses (PSRs)

Zero PSRs were commissioned in March 24. However, several incidents were incomplete and sent back to the relevant division for further scrutiny and MDT discussion before being re-presented back to the PSIRI panel for discussion, oversight and assurance as outlined below:

3.3.1

- # **8227 Severe physical harm (Medicine Division)** *Patient attended ED morning of 2/3/24, streamed to UTC. Parents brought back to ED later that day as still concerned. Patient had PEW overnight between 1-3. The next day patient started to become more unwell with increased PEW. Parents raised concern. Nurses on the unit alerted medical team, there was a delay in the patient being reviewed. Patient admitted to PICU. Discussed deterioration and concern raised by parents that they felt escalation was not being listened to.*

PSIRI panel discussion: SBAR presented and discussed on 7/3/24. PSIRI panel felt SBAR lack information to fully understand the incident. No mention of input from parents or potential DoC given the harm level. Severe harm to remain and duty of candour applies. Division asked to review further with full MDT involvement and include any notes from parents. Divisional MDT panel discussion reconvened for 3/4/24. Incident to be re-presented to PSIRI panel within with correct information.

3.3.2

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

Learning noted: Missed opportunities to communicate swab results to surgical team. Lack of documentation. WHO checklist ticked without swabs being checked by bedside nurse transferring to theatre. WHO list wording currently notes 'known infections'. Microbiology to be added to form. Theatre team to check microbiology when setting up for patient.

PSIRI panel decision: - Post infection review undertake by ward manager and matron without involvement of IPC.PSIRI panel requested further post infection review (PIR) of incident with IPC team involvement and use of correct PIR documentation.

4. Duty of Candour

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

3 Duty of Candour responses were required during the reporting period.

5. Learning from patient safety incidents

5.1 System learning

The PSIRI panel identified 1 incident presented in March 24 that would benefit from linking into an existing quality improvement workstream to inform system learning as outlined in table 3 below:

Table 3

Brief incident description	PSIRI Panel findings /Learning	PSIRI Panel Recommendations
Surgery Division		
#8367 Complex patient with Apert's Syndrome, based in Greater Manchester, who had received some specialist surgical intervention from Alder Hey in the past. Has severe deformity of right proximal humerus leading to the right hand being held in a non-functional position Patient did not have pre-op bloods because it was difficult to get blood at pre-op assessment. This was undertaken at induction.	Found to have low platelets and fibrinogen level and borderline abnormal prothrombin time. Haematologists advise to wake the patient up and investigate the cause as patient having major surgery The review had been undertaken and reviewed thoroughly; however, it was not clearly documented who had been assigned actions. Division to complete outcomes / learning / actions assigned on SBAR as form submitted did not provide assurance of who was reviewing actions.	Remain as moderate harm - formal DOC required. Consent discussed. Incident to feed into the Trust wide consent workstream.

5.2 PSIRI panel follow up.

3 PSRs were commissioned in February 24 to investigate the reported incident as outlined below in table 4, details and learning of which were provided in Februarys Board report. All 3 PSRs are due to report updates on findings and actions in May 24

Table 4

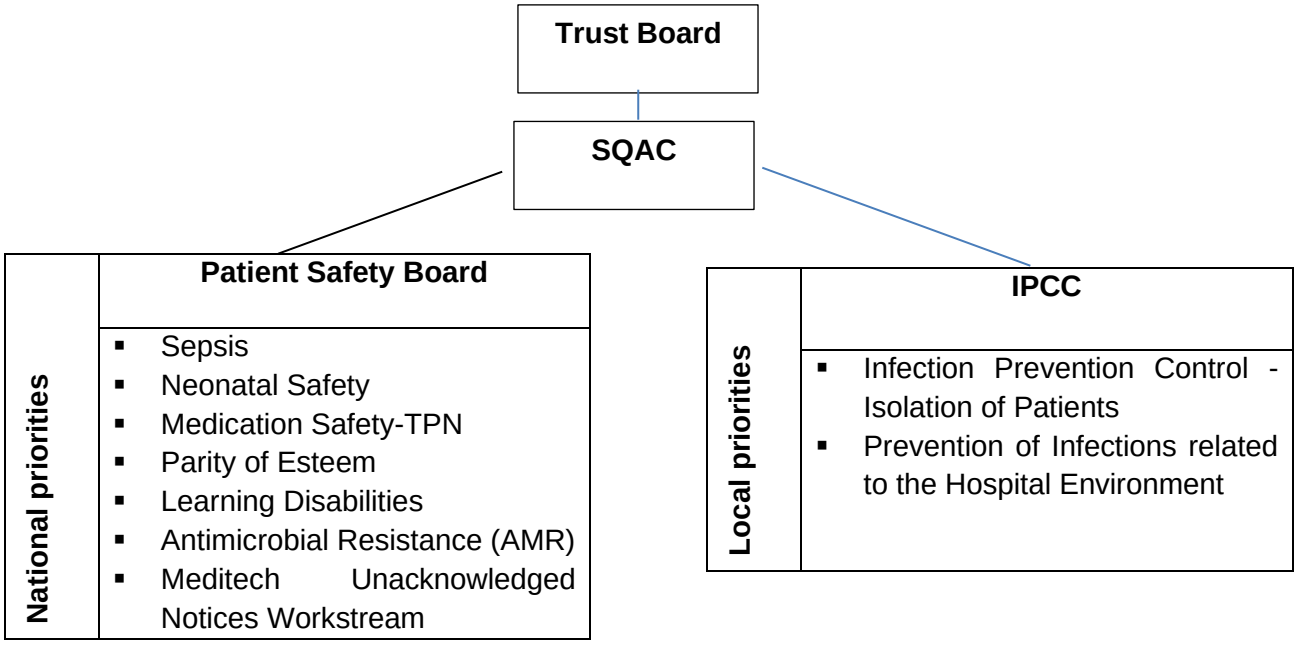
Brief incident description
5492 No physical harm (Surgery Division) - *Neuroblastoma resection undertaken on 7/7/23. Request for ovarian harvest on consent form but no laterally noted. Ovarian harvest took place 11/8/23, right ovary taken. Potential that incorrect ovary was harvested.*
Cluster of no harm incidents (Medicine Division) - *7 reported incidents related to supply of liquid antimicrobial medicines out of hours from the Urgent Care Centre at AlderHey managed by Go2Doc on behalf of the Trust via SLA.*
7544 Moderate physical harm (Surgery Division) – *Child with developmental delay and autism presented with abdominal pain and fever. An ultrasound scan was performed which could not visualise appendix but did note some pelvic fluid and ovarian changes. The patient was discharged with safety net advice. The patient reattended on 04/02/24 with ongoing abdominal pain and clinical evidence of peritonism. Taken directly to theatre following CT scan.*

5.2 Quality Improvement (QI)

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

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

Figure 1



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

6. Training and Education

6.1 Patient Safety E-Learning

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

E-Learning Modules	%Compliance
Level 1a Essentials for Patient Safety (All staff)	**98.16%**
Level 1b: Essentials of patient safety for boards and senior leadership teams	**100%**

7 Legacy Serious Incidents (SIs)

All legacy SI investigations have now concluded (Appendix 1). Findings from 2 legacy SI investigations (2023/18692 and 2023/12980) were presented at SQAC in March 24 (Appendix 2).

8 Next Steps

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

Areas of focus include the following:

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

- **Monthly PSIRI Panel learning session:** As we continue to embed PSIRF it was agreed that a monthly meeting to share learning and ensure consistency of implementing PSIRF across divisions would be established. The main points from the initial learning meeting are highlighted below:

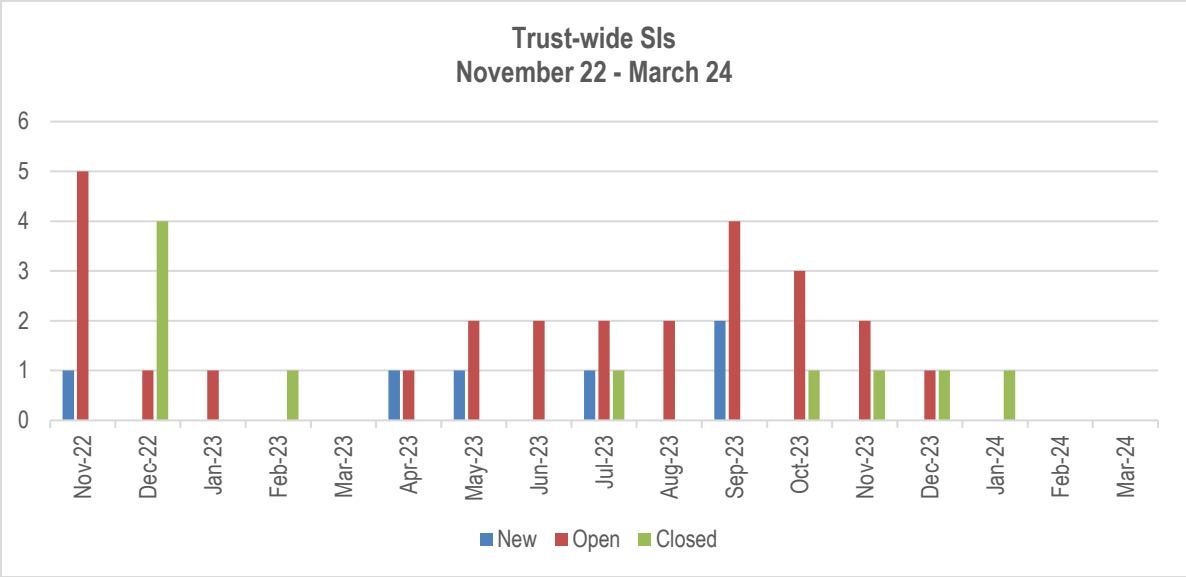
- Standard process currently; initial review - deeper insight - reporting stages and progress into PSIRI panel
- Exact timing of Duty of Candour initiation to be standardised, time of incident reporting versus harm level identification after initial review.
- Documentation to be improved; one template to be used and continuously updated to demonstrate progress in review status, outcomes, and actions.
- Learning gained will inform subsequent PSIRP.

7 Recommendations

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

Appendix 1 Legacy Serious Incidents (SIs)

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



Legacy SI reports

0 legacy SI investigations were completed and submitted to commissioners during the reporting period (1st – 31st March 2024).

Immediate lessons learnt are outlined where applicable in this report.

Legacy SI action plans: During the reporting period (1st – 31st March 2024), **3** SI action plans remained open and within their expected date of completion. Full details of the SI action plan position can be found at appendix 2.

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Number of extensions
Surgery Division							
2023/12980	02/07/2023	05/07/2023	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	9 6 actions completed.	31/01/2024	30/04/2024	2
2023/17791	15/09/2023	21/09/2023	Never Event – Wrong implant / prosthesis used.	9 5 actions completed.	01/05/2024		0
2023/18692	29/09/2023		Death of a patient on PICU 02/10/2023 – Elective craniofacial surgery 29/09/2023. Cardiac arrest on ward 4A post-operatively, transferred to PICU. Cardiac arrest secondary to tension pneumothorax.	11 4 actions completed.	29/02/2024	05/04/2024	1

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11 April 2024

Paper Title:	Fuller Public Inquiry - Phase 1 & 2
Report of:	Nathan Askew Chief Nursing, AHP and Experience Officer
Paper Prepared by:	Nichola Osborne Associate Director Safeguarding & Statutory Services

Purpose of Paper:	Decision ■ Assurance ☐ Information ■ Regulation ☐
Action/Decision Required:	To note ☐ To approve ■
Summary / supporting information	The briefing paper provides an overview of the Independent Inquiry into the issues raised by the David Fuller case, the recommendations outlined in the Phase 1 Report published in November 2023, the subsequent self-assessment work undertaken within Alder Hey in response to this, the actions required to achieve full assurance and Phase 2 of the Inquiry. **It is important to highlight that this briefing paper contains information that is distressing and difficult to read.**
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	Resource requirements will be assessed through the self-assessment and if required will be addressed through usual Trust processes.

Does this relate to a risk? Yes ☐ No ■

Risk Number	Risk Description	Score

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

Executive Summary

1. The briefing paper provides an overview of the Independent Inquiry into the issues raised by the David Fuller case, along with the recommendations outlined in the Phase 1 Report published in November 2023, the subsequent self-assessment work undertaken within Alder Hey in response to this, the actions required to achieve full assurance and Phase 2 of the Inquiry.

2. In November 2021 the Secretary of State for Health and Social Care announced he was replacing the Trust-commissioned investigation with an Independent Inquiry which will continue to be chaired by Sir Jonathan Michael. The new Inquiry would build on the work already completed by the Trust commissioned investigation. The Inquiry was established as a non-statutory inquiry and is being conducted in two phases.

3. The first phase investigated how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries of NHS hospitals in Kent and why this activity went unnoticed. The Phase 1 Report was published in November 2023 and made 17 recommendations for Maidstone and Tunbridge Wells NHS Trust.

4. The second phase of the inquiry will consider the broader national picture and the wider implications for the NHS and for other settings where the deceased are cared for before burial or cremation. The second phase will also review the adequacy and effectiveness of the regulatory arrangements for the care of the deceased.

5. Whilst the recommendations made in Phase 1 of the Fuller Inquiry pertain to Maidstone and Tunbridge Wells NHS Trust it is important that our own Trust arrangements are considered to ensure the security and dignity of the deceased children and young people in our care.

6. In February 2024 work commenced to review the 17 recommendations made in the Fuller Inquiry Phase 1 Report and self-assess Alder Hey's mortuary arrangements against these recommendations.

7. There are good arrangements in place within the Trust to ensure the security and dignity of the deceased children and young people in our care. The self-assessment work has highlighted areas where current arrangements need to be strengthened to ensure they are fully embedded.

8. A working group will be established to take forward this work and develop an action plan to fully address all areas highlighted within the self-assessment against Phase 1 recommendations. The working group will be led by the Associate Chief Nurse for the Division of Medicine and the Associate Director for Safeguarding and Statutory Services and will report progress into the Safety and Quality Committee (SQAC).

9. Trust Board is asked to receive the above information and support the proposal for future work to be reported into and overseen by SQAC.

Introduction and Background

10. This purpose of this briefing paper is to provide the following:
    - An overview of the Independent Inquiry into the issues raised by the David Fuller case.
    - Outline the recommendations from the Phase 1 Report published in November 2023.
    - A summary of the subsequent self-assessment work undertaken within Alder Hey.
    - Provide recommendations and actions required by the Trust to achieve full assurance.
    - Outline the next steps for Trust participation in Phase 2 of the Inquiry.

11. It is important to highlight that the Fuller Inquiry contains information that is distressing and difficult to read.

The Independent Inquiry into the issues raised by the David Fuller Case

12. In November 2021 the Secretary of State for Health and Social Care announced he was replacing the Trust-commissioned investigation with an Independent Inquiry which will continue to be chaired by Sir Jonathan Michael. The new Inquiry would build on the work already done by the Trust commissioned investigation. The Inquiry was established as a non-statutory inquiry and is being conducted in two phases.

13. The first phase investigated how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries of NHS hospitals in Kent and why this activity went unnoticed. The Phase 1 report was published in November 2023 and made 17 recommendations for Maidstone and Tunbridge Wells NHS Trust.

14. The second phase of the inquiry will consider the broader national picture and the wider implications for the NHS and for other settings where the deceased are cared for before burial or cremation. The second phase will also review the adequacy and effectiveness of the regulatory arrangements for the care of the deceased.

15. Whilst the recommendations made in Phase 1 of the Fuller Inquiry pertain to Maidstone and Tunbridge Wells NHS Trust it is important that our own Trust arrangements are considered to ensure the security and dignity of the deceased children and young people in our care.

The David Fuller Case

16. In December 2021, David Fuller, an electrical maintenance supervisor with Maidstone and Tunbridge Wells NHS Trust, was convicted of the murders of Wendy Knell and Caroline Pierce in 1987. On his arrest for the murders of Wendy and Caroline, in December 2020, police officers conducted a search of his home address. This search uncovered video images, held on several hidden computer hard drives, together with printed photographs of David Fuller performing sexual acts on deceased people.

17. The subsequent police investigation identified that David Fuller had sexually abused deceased people in the mortuaries of the hospitals in which he had worked. David Fuller was convicted of the mortuary offences under the Sexual Offences Act 2003, at the same time as his conviction for the murders of Wendy and Caroline. He received two whole-life sentences for the murders of Wendy and Caroline and a 12-year prison sentence for the mortuary offences, which will run concurrently with the life sentences.

18. The available evidence identified that David Fuller had committed the mortuary offences from 2005 until the time of his arrest in December 2020. During this time, he had been working initially at Kent and Sussex Hospital and later at Tunbridge Wells Hospital.

19. The evidence used to convict David Fuller of the mortuary offences indicated that he had committed the offences against at least 100 women and girls. It was his arrest for the murders of Wendy and Caroline that brought his criminal offending in the mortuaries to an end. In December 2022, following the identification of a further 13 victims, David Fuller was sentenced to an additional four-year prison sentence.

Initial response to David Fuller's crimes by the NHS

20. In October 2021, after receiving an initial briefing from the internal investigation, NHS England contacted all NHS Trusts that provided either mortuaries or body stores and asked them to ensure compliance with existing guidance from the Human Tissue Authority (HTA) and ensure implementation of the following actions:

    - To review security arrangements and ensure that access points to mortuaries are controlled by swipe card security wherever possible and, if not possible, that sufficient mitigations are in place to ensure facilities are secure and access is auditable.

    - That effective CCTV coverage of 'mortuary areas' must be in place and reviewed systematically.

    - To undertake a risk assessment of the operation, security and construction of the mortuary or body store.

    - Ensure that there is consistent application of the appropriate levels of Disclosure and Barring Service checks for all Trust and contracted employees.

21. The Alder Hey Designated Individual for the mortuary worked with colleagues to review the above and submitted a response to NHS England on behalf of the Trust on 16 November 2021 via an online portal.

Phase 2 of the Fuller Inquiry

22. In February 2024 Alder Hey was contacted by Cheshire and Merseyside Integrated Care Board (ICB) to advise that the NHS England Inquiry Team had met with the Fuller Inquiry to understand its approach to how organisations will be asked to contribute to Phase 2.

23. Subsequently the Fuller Inquiry conducted a short survey of Trusts via a questionnaire which has been completed by the Associate Director for Safeguarding and Statutory Services along with the Mortuary Team and submitted directly to the Fuller Inquiry on 15 March 2024.

24. The questionnaire consisted of 82 questions across the following key lines of enquiry:

    - General details about Mortuary/Body Store Provision
    - Management Accountability
    - Regulation and the Mortuary/Body Store
    - Information about the Designated Individual
    - Mortuary Service and Management
    - Mortuary Staffing
    - Access to the Mortuary and Body Stores
    - Serious Incidents in the Mortuary
    - Relationship with the Local Authority and Coroner

25. NHS England suggested that Trusts should designate an internal Inquiry lead who can support these matters going forward. The designated lead has been identified as the Chief Nursing, AHP and Experience Officer who will be supported by the Associate Director for Safeguarding and Statutory Services.

26. NHS England have advised that the quantitative data from the questionnaire may be used in the Inquiry's report to secure the best learning outcomes for the future.

27. The Trust awaits further communication from NHS England and the Fuller Inquiry once the responses to the questionnaire have been reviewed and analysed.

Self-Assessment Undertaken by Alder Hey

28. In February 2024 work commenced to review the 17 recommendations made in the Fuller Inquiry Phase 1 Report and self-assess Alder Hey's mortuary arrangements against these recommendations. A copy of this self-assessment work has been provided in Appendix 1 of this briefing paper.

Action Required and Next Steps

29. The self-assessment work completed following the conclusion of Phase 1 of the Fuller Inquiry and the Trust responses to the Fuller Inquiry Phase 2 questionnaire have highlighted that work is required to clarify and strengthen mortuary arrangements in the following areas:

    Governance and Oversight

    - Governance and oversight of the work of the mortuary within the Division of Medicine including compliance with Human Tissue Authority requirements and inspections.
    - The level of oversight required by Trust Board.
    - Policies and Standard Operating Procedures to be updated to clearly outline mortuary arrangements and stored on the Trust Document Management System (DMS).

    Security and Access

    - Repeat the previously completed 'Security Walkaround' to identify current security arrangements within the mortuary including swipe card access points, and oversight of swipe card access permissions.

- Establish frequency of audit of swipe card access.
- Review CCTV coverage in the mortuary and consider Recommendation 9 from Phase 1 of the Fuller Inquiry to install CCTV cameras in the post-mortem room.
- Fully explore and consider Recommendation 10 regarding regular review of mortuary CCTV footage and the associated implications.

Mortuary Designated Individual

- Explore the role of the Designated Individual and associated work plan.

Mortuary Management

- Outline arrangements for management and oversight of the mortuary.
- Complete Bereavement Team organisational change.

Conclusion

30. There are good arrangements in place within the Trust to ensure the security and dignity of the deceased children and young people in our care. The self-assessment work has highlighted areas where current arrangements need to be strengthened to ensure they are fully embedded.

31. A working group will be established to take forward this work and develop an action plan to fully address all areas highlighted within the self-assessment against Phase 1 recommendations. The working group will be led by the Associate Chief Nurse for the Division of Medicine and the Associate Director for Safeguarding and Statutory Services and will report into the Safety and Quality Committee (SQAC).

32. Trust Board is asked to receive the above information and support the proposal for future work to be reported into SQAC.

Fuller Public Inquiry Phase 1 – Alder Hey Self-Assessment Document

NHS
Alder Hey Children's
NHS Foundation Trust

Fuller Public Inquiry Phase 1 – Alder Hey Self-Assessment Document

KEY - Red, Amber, Green (RAG) Rating		
RED	**AMBER**	**GREEN**
Not Assured Evidence indicates poor effectiveness of controls	**Limited Assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness.	**Full Assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice.

Fuller Inquiry Phase 1 Recommendations	Alder Hey Current Practice	RAG Rating	Action Required
Recommendation 1 Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.	Systems in place to manage non-mortuary staff and external visitors which are not currently outlined in Policies/SOPs. Access permissions on ID Badges is granted by the Security Team, plan to be managed by the Mortuary Team. Mitie or external maintenance staff make arrangements to visit mortuary with Lead APT. Maintenance staff are accompanied by Mortuary Team when in the mortuary.		• Mortuary Policy/SOPs – to be updated to include how non-mortuary staff and external visitors to the mortuary are managed and lone worker arrangements. • SOP to be created to outline swipe care access permissions and associated audit activity. • Clarify remit of the Bereavement Team as part of Organisation Change Process.
Recommendation 2 Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the	Human Tissue Authority (HTA) Standards and Codes of Practice and UKAS Accreditation in place. Incidents reported via Trust incident management		• Divisional governance and oversight to be clarified regarding HTA Standards and UKAS Accreditation.

mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.	system and overseen within the Division in line with usual Trust processes.		• Mortuary Policies/SOPs to be updated. • Align Mortuary Team and Bereavement Team documentation processes.
Recommendation 3 Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.	Alder Hey is fully compliant with NHS Safer Recruitment Practices. Evidence has been provided to Cheshire & Merseyside Integrated Care Board (C&M ICB) Designated Professionals for Safeguarding in relation to Safer Recruitment in accordance with the Safeguarding Contractual Standards • E2 Recruitment and Selection Policy, Approved: May 2022, Review Date: May 2025.		• C&M ICB Commissioning Standards Scrutiny Visit by C&M ICB 26/04/2024.
Recommendation 4 Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.	HTA License Holder – Chief Medical Officer. Mortuary Team managed by appropriately qualified APT. Designated Individual is a Consultant Pathologist.		• Develop Mortuary Team governance and management structure charts. • Clarify and agree governance and oversight of the Mortuary Team within the Division of Medicine.
Recommendation 5 The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.	Mortuary Management sits within the portfolio of the Histopathology Manager. Day to day management of the mortuary - Lead APT.		• Review management structure and arrangements of the mortuary.
Recommendation 6 Maidstone and Tunbridge Wells NHS Trust	Access to the mortuary is via swipe card.		• Standard Operating Procedure

must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.	The Security Team currently oversee swipe card access permissions to the Mortuary – plan for this responsibility to transfer to the Mortuary Team by April 2024.		to be developed which outlines the roles and responsibilities in relation to the management and oversight of mortuary access.
Recommendation 7 Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.	Current practice includes a review of those accessing the mortuary. This needs to be formalised in relation to responsibility and frequency.		• Standard Operating Procedure to be developed which outlines the roles and responsibilities in relation to the management and oversight of mortuary access. This will include responsibilities regarding the download and review of monthly reports of swipe card access data, and outline frequency of audits to be undertaken on swipe card access data. • Main door to post-mortem room to be fitted with a swipe card entry access point.
Recommendation 8 Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.	Security is treated as a corporate responsibility and the Mortuary Team work closely with security colleagues.		• Roles and responsibilities regarding mortuary security to be formalised within Standard Operating Procedures to ensure this is clear.
Recommendation 9 Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.	CCTV in place in the mortuary but not currently in the Post-Mortem Room. Need to risk assess use of CCTV in post-mortem room and explore security concerns and governance issues. Need to consider: • Who should review CCTV footage? • Monitoring and audit of CCTV – what prompts review? • Psychological support and training needs.		• Exploration of this recommendation to be considered via the Working Group. Options paper to be produced. • Security Walk Around to be completed by relevant members of the Security, Mortuary and Safeguarding Teams.

	3 points of entry – could be considered. • Fridge Room • Changing Rooms • Bin Store		
Recommendation 10 Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.	See narrative outlined in Recommendation 9 above. CCTV in place in some areas of the Mortuary but this is not currently reviewed on a regular basis.		• Exploration of this recommendation to be considered via the Working Group. Options paper to be produced. • Standard Operating Procedure to be developed which outlines responsibilities regarding the download and review of monthly reports of swipe card access data, frequency of audits to be undertaken on swipe card access data and CCTV.
Recommendation 11 Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.	HTA reports are shared with commissioners as appropriate. HTA Reports are available upon request and available online.		• Identify all relevant key stakeholders and explore if HTA reports can be more proactively shared.
Recommendation 12 Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.	Service Level Agreements and contract monitoring arrangements in place. Key Performance Indicators – Placental Service and Post-Mortem Service Agreement with Coroners – Home Office Post-Mortem examination. Alder Hey serves multiple Coroners areas.		• Explore if commissioning arrangements are clearly outlined

	As Alder Hey mainly provides services in relation to children there are no contractual arrangements in place with Local Authorities.		
Recommendation 13 We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.	Arrangements are in place but these need to be formalised.		Update the following documentation: • Governance Charts • Organisational Charts Clarify and outline level of Trust Board oversight in policies and SOPs.
Recommendation 14 Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.	Designated Individual – Dr R Shukla There are no PAs assigned to this role currently. Reporting to HTA License Holder – Chief Medical Officer		• Review work plan and required PA allocation for the Designated Individual. • Governance Chart to be reviewed. • Points of contact need to be clearly identified for mortuary. • Trust Board reporting requirements to be clarified in response to lessons learned from the Fuller Inquiry Phase 1 and Phase 2.
Recommendation 15 Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.	Alder Hey is compliant with HTA standards.		• Complete actions as outlined above for Recommendation 14. • Await Phase 2 Fuller Inquiry recommendations.

Recommendation 16 The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.	Chief Nursing, AHP and Experience Officer is the Executive Lead for Safeguarding and has been identified as the Fuller Inquiry Lead for the Trust. HTA License Holder – Chief Medical Officer. Need to establish appropriate Board oversight in light of the Fuller Inquiry.		• Working Group to consider Trust Board reporting requirements and Executive Level oversight of the mortuary. • Await Phase 2 Fuller Inquiry recommendations.
Recommendation 17 Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.	Compliance with HTA Standards and UKAS Accreditation. Policies and SOPs Mortuary Team and Bereavement Team Offer Safeguarding Contractual Standards		• Action Plan to be developed by the Working Group following self-assessment with oversight from the Safety and Quality Committee (SQAC).

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2023

Paper Title:	**Trust Mortality Report Quarter 3**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass/Julie Grice

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

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

Alder Hey Children's NHS
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TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

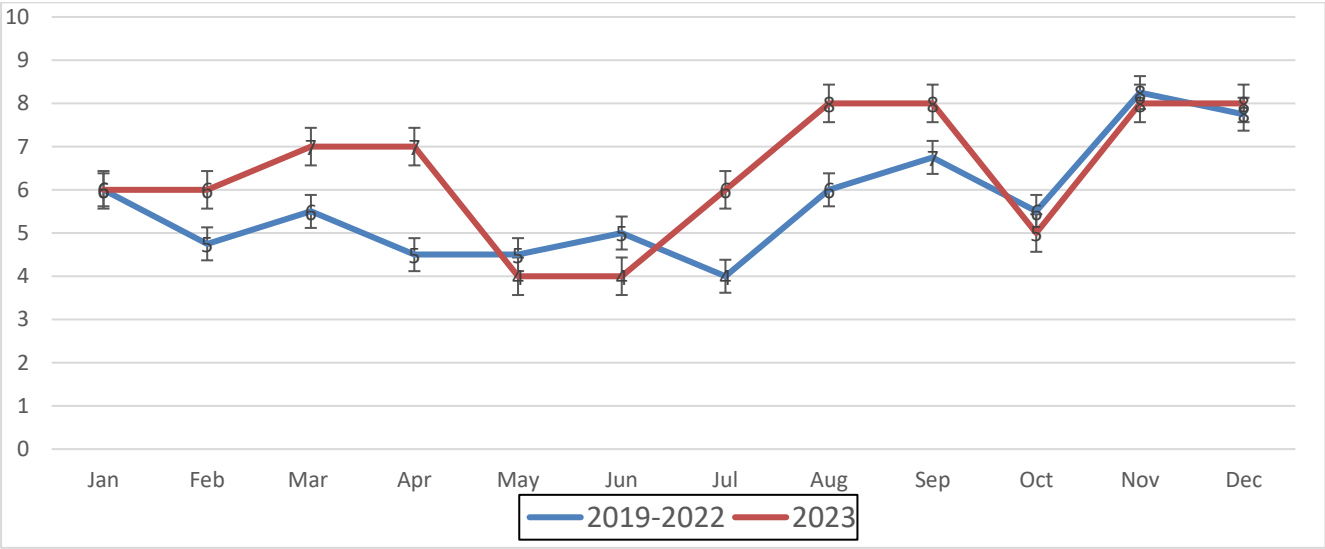
Medical Director's Mortality Report

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

Section two is the Quarter 3 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)

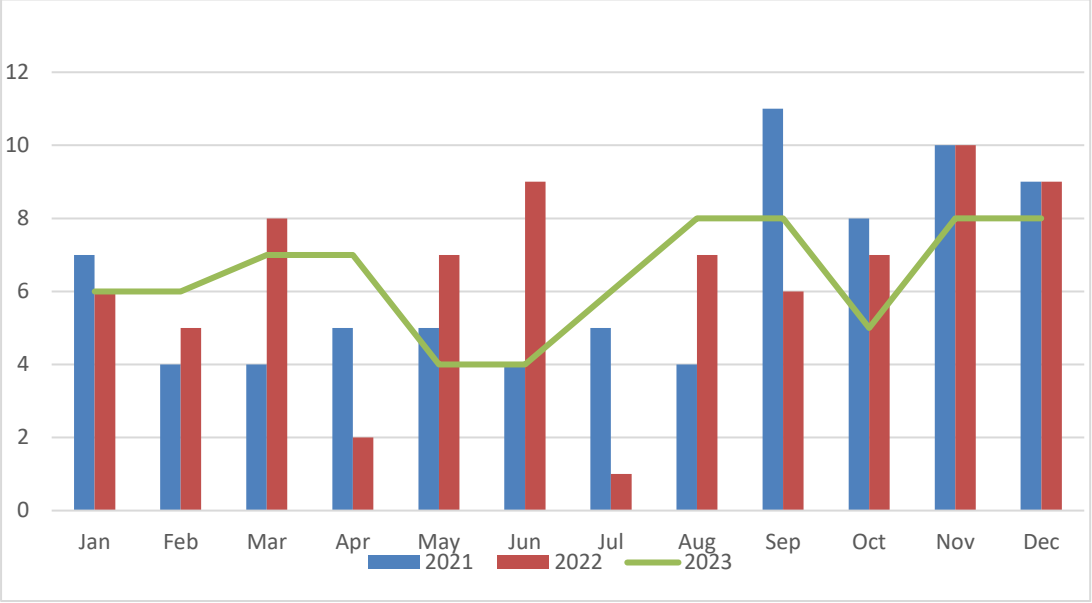
Summary of all in-patient deaths
2023 compared with Mean 2019-2022 (incl. standard errors)



This graph initially looks concerning in that it appears that there have been more deaths in 2023. However, as commented on in previous quarterly mortality reports the way that the data was collected changed the beginning of 2021, due to the introduction of the new child death review process. Prior to this, the Emergency Department deaths had not been included in the figures if there was no possibility that the child /YP could be resuscitated regardless of care

provided by the Trust. The deaths were reviewed in the ED mortality and morbidity meetings and under the joint multi- agency review process that is undertaken following any unexpected /unexplained death of a child /YP.
To obtain a better comparison, the graph below compares 2023 with the two preceding years when the method of data collection had changed.

Comparison -inpatient deaths 21-22 with 23 overlay



This shows that the number of deaths were higher earlier in the year but then have dropped to very similar levels to 21/22 so there are no concerning trends.

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

1) One of the most significant changes is the introduction of the Medical Examiner (ME) process. This was due to be a legal requirement in April 2023 but has now been delayed until April 2024. Alder Hey has appointed two paediatric medical examiners to join the LHUFT Medical examiner team. The pilot for this begins the end of February and then any issues will be identified ready for April 2024.

2) Currently there is no administration support for the HMRG process due to staff leaving. This is impacting on the process and has been identified on the risk register. The plan going forward is to create a full-time administrative role which will support both the HMRG and CDOP (child death overview process). It is a statutory requirement that information is released to the various CDOP panels, and this has been problematic in

recent times due to the pressures on the safeguarding team. By having one person working on both processes, it will provide consistency and continuity with the plan to ensure that there is no one point of failure.

3) There have been some on- going issues with the community deaths and there is work finalising the pathways to prevent these in the future.

Current Performance of HMRG

Summary of 2023 Deaths

Number of deaths (Jan. 2023 – Dec. 2023)	77
Number of deaths reviewed	47
Departmental/Service Group mortality reviews within 2 months (standard)	45/48 (93%)
HMRG Primary Reviews within 4 months (standard)	46/47 (98%)

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

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

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Outcomes of the HMRG process 2023

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

Potentially Avoidable Deaths

There has been one potentially avoidable death due to external factors in this reporting period. This relates to a drowning, which by definition is potentially avoidable. 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 47 cases, reviewed so far in 2023, 23% were identified as having learning disabilities. The Learning Disabilities Mortality Review (LeDeR) Programme was set up to ensure all deaths of patients with Learning Disabilities are comprehensively reviewed. Since July 2023 the requirement to report the deaths of C/YP age 4 and over with a learning disability and/or Autism to LeDeR has been removed. Now, all deaths of young people will now be reported via usual child death processes. Then a national report will be produced via the LeDeR team with a focus on C/YP with a learning disability and/or Autism deaths.

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

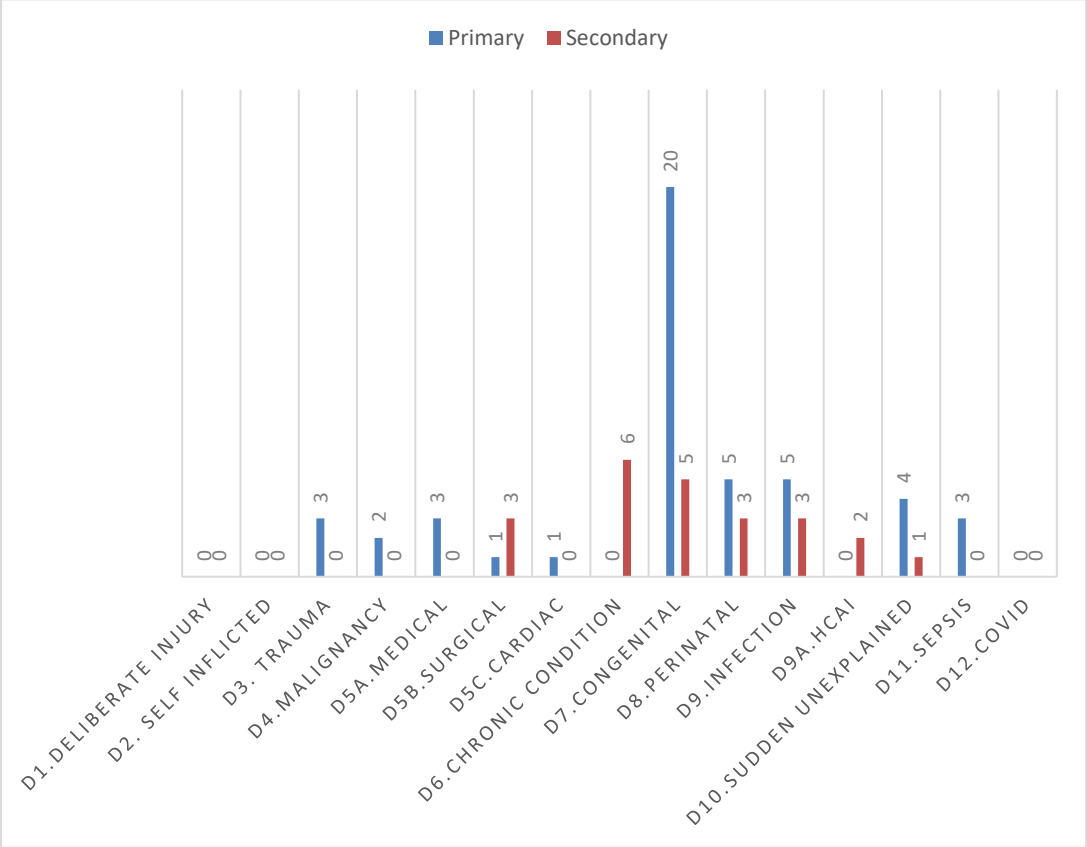
Family

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

External Benchmarking

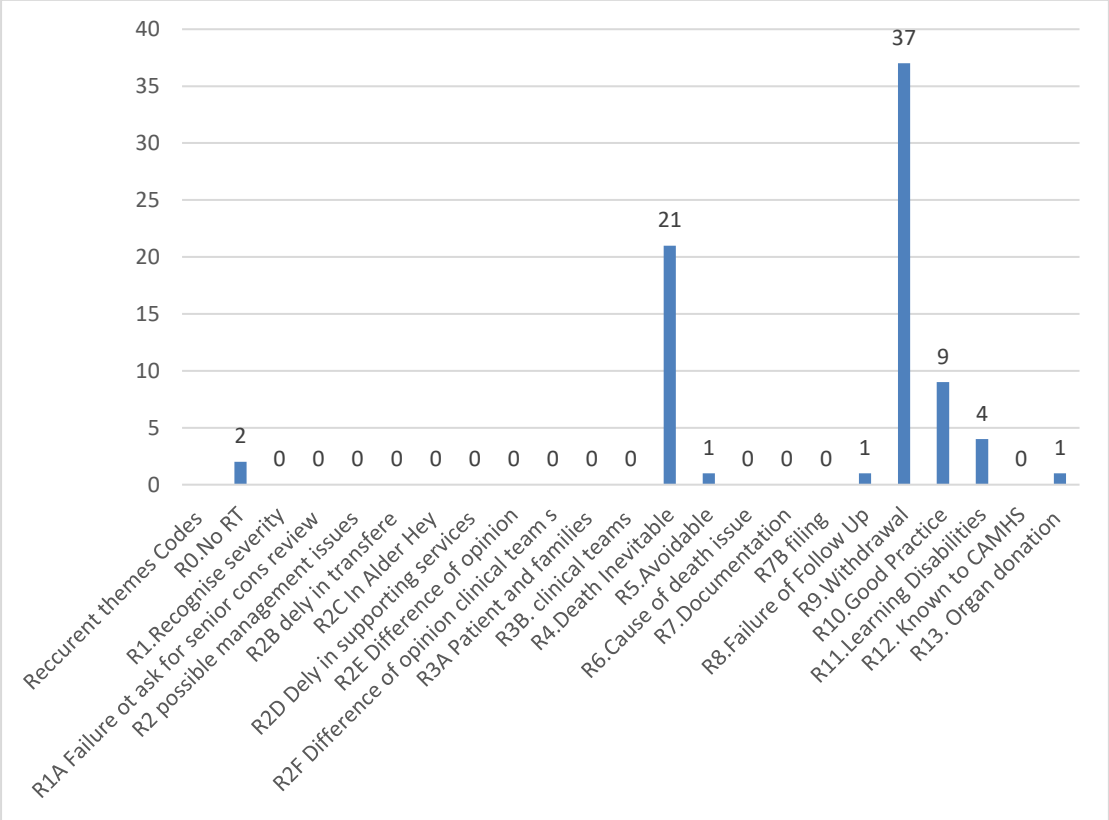
In the last year, AHCH has engaged with Birmingham Children's Hospital with the opinion that it was the Trust with the closest workload and demographics to us. It has enabled us to compare figures and trends and to work together to improve our processes and learn from each other and this will continue.

Primary and Secondary Categories



The cases reviewed in 2023 show that the highest diagnostic code is ‘children with underlying congenital conditions’ (43%), these are often the most complex with several issues on going and are the most vulnerable patients. Next, with 13 % is the diagnostic code: ’chronic condition’ which relates to the children with underlying conditions and then ‘infection’ and ‘perinatal’ both with 11%. Infection is different to sepsis and perinatal covers all the complications of prematurity.

Recurrent Themes



The main recurrent code for 2023 was withdrawal of care (79 % of cases), which demonstrates that the intensive care team are working with families to ensure that no child/young person suffers unnecessarily when all treatment options are explored but are not suitable.

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

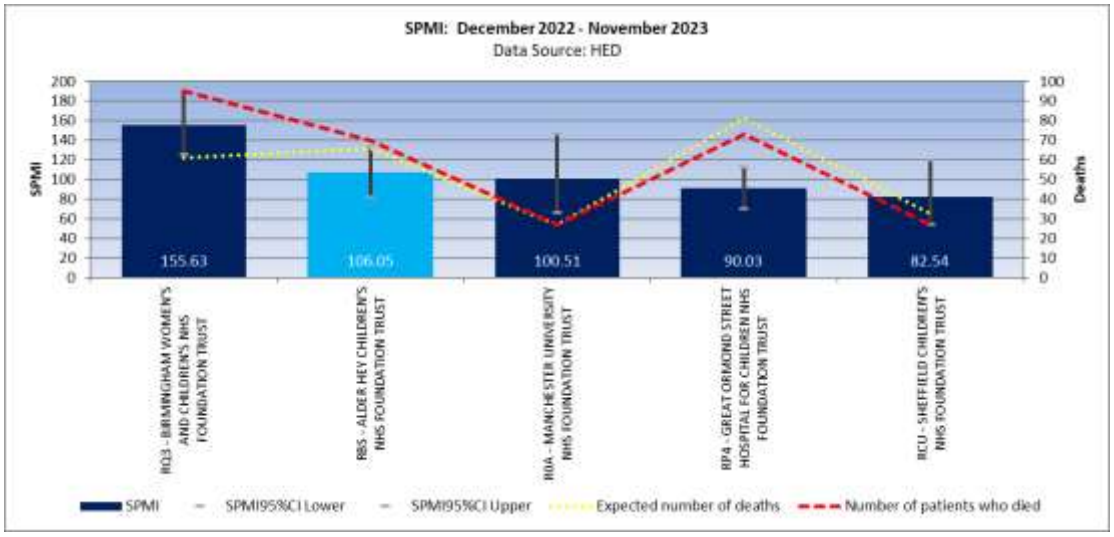
It is interesting to note that the group recorded 19 % of the cases so far in 2023 as good practice since the members tend to be very reticent at allocating this. They believe the standard of care, we as a Trust aim to achieve is extremely high. Therefore, to achieve 'good practice 'is when the team concerned has clearly gone way 'beyond the normal'.

Section 2: Quarter 3 Mortality Report: October 2023 – November 2023

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

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



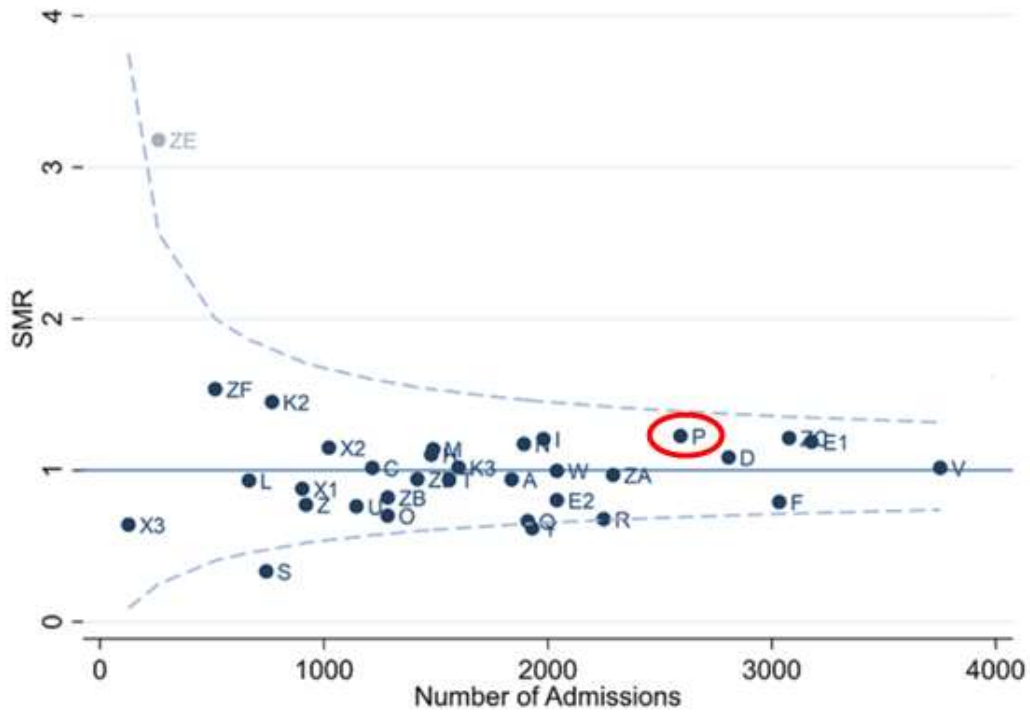
The chart shows that Alder Hey has performance of slightly higher than expected number of deaths. The caseload over the period shown by HMRG reviews that there is a very high number of cases identified as death inevitable. This suggests that the caseload over this period has been children/YP that regardless of the care provided there was no possibility of changing the outcome. This does raise the question of whether some of these cases should have been transferred and whether we are importing mortality impacting on the

figures. It is interesting to compare with Birmingham which is the Trust most closely aligned to AHCH with caseload and demographics who have a higher number of deaths to expected than ourselves.

-PICU

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

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

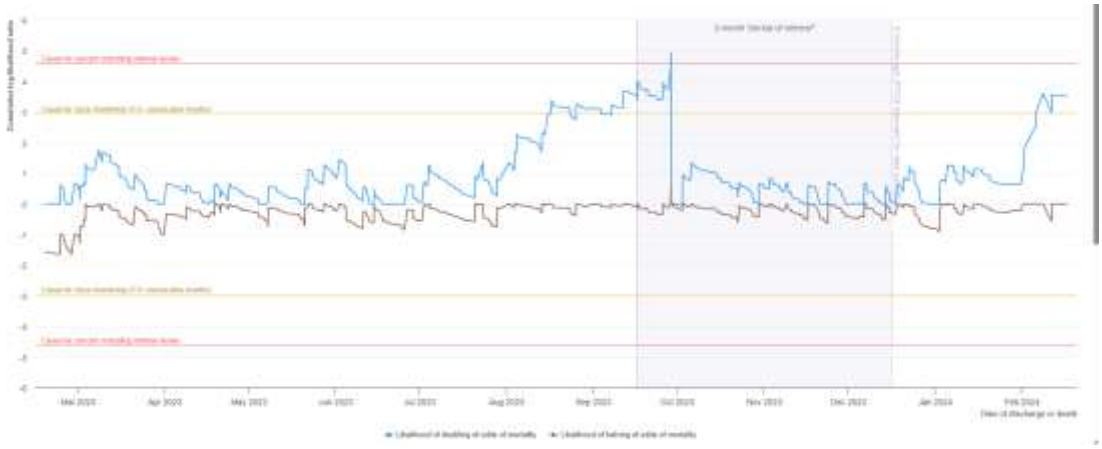


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

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

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



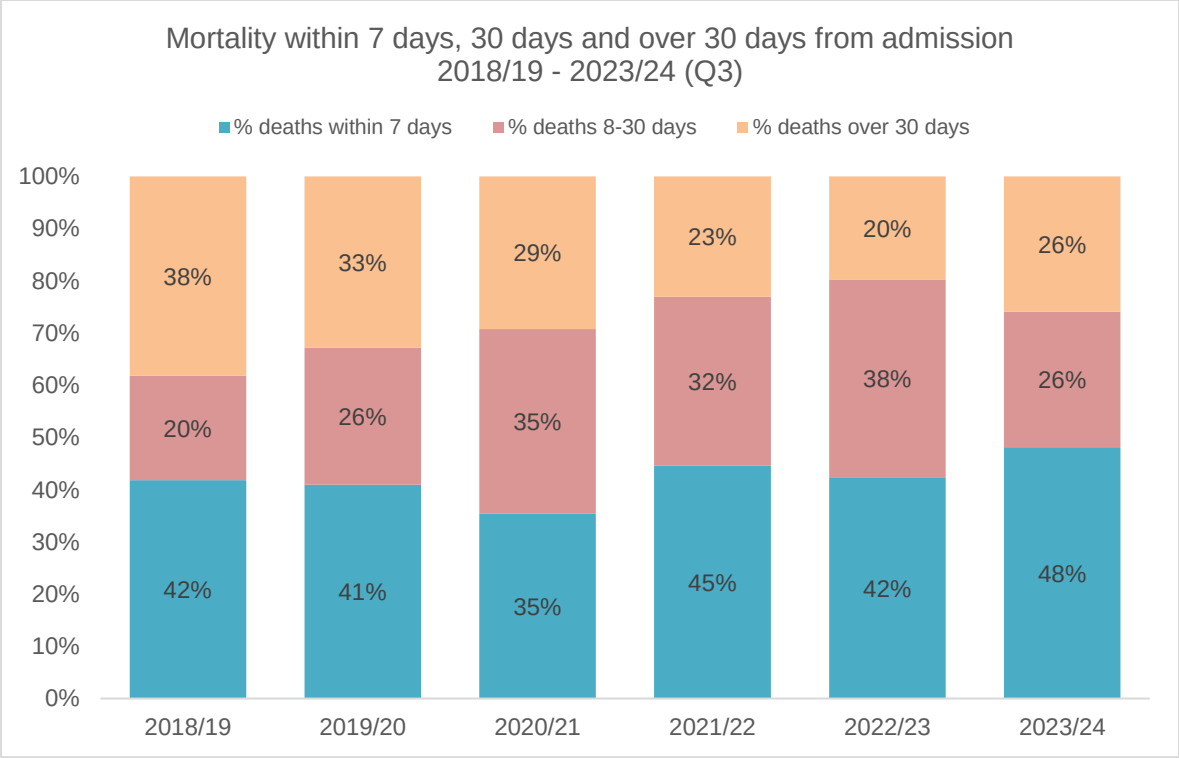
During the 'period of interest' which is adjusted due to PIM3 we have largely remained in the 'safe zone'. Towards the end of August / early September the cumulative log-likelihood ratio has crept into the close monitoring section. During this period, we noted a series of cases that at service group review were considered to represent cases where death was inevitable in hindsight including acute trauma and patients with life-limiting conditions entering a terminal phase. PICU continue to review all cases within 4-6 weeks that feeds into further review at HMRG. The subsequent resetting of the graph displayed above has triggered a further checking and review process to feedback to PICAnet. It appears that factors currently unaccounted for in the PIM3 score (such as significant co-morbidities) resulted in a lower mortality risk adjustment for these cases than would be clinically expected. This is a known limitation and will help inform

further development of the PIM3 score. We will continue to monitor the RSPRT closely as it enters the adjusted 'period of interest'.

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 42-46% of deaths occur within this time frame. In quarter one to three of the financial year April 2023 – December 2023, 48% occurred within 7 days of admission, 26% occurred within 8-30 days from admission, and 26% 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.

There are no concerning trends that have been identified for patient deaths and the issues that have been raised by staff or families there is work underway to try and resolve them. The administrative solution should enable the mortality process to improve going forward.

Work is continuing to improve the process and engaging with other Trusts to ensure that we are optimising the learning from any child/YP's death.

References

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

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), congenital cardiac disease http://nicor4.nicor.org.uk and oncology. **Pg 9**

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 9**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 20th March 2024, along with the approved minutes from the 21st February 2024 meeting.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐

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

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

0160 **1. Executive Summary**

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

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

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

- SQAC received the positive Patient Safety Strategy update, and was pleased to note progress on the workstreams scrutinised in month.
- SQAC received the ED monthly report and recognised the continuing high volumes of patients compared to same time last year, and a level of performance which was remarkable given this challenge. SQAC was pleased to note the continued focus on managing patient flows and achieving targets in this area.
- SQAC received the Quarterly Diagnostics Notification update, with comprehensive discussion held regarding the current position. A further report is requested in three months, which it is hoped will demonstrate progress in teams where the numbers of unacknowledged reports is mounting month on month.
- SQAC received the Quarterly IPC Report
- SQAC received the Inphase update and lessons learned report: the learnings are relevant across the Trust and will be shared at Audit and Risk Committee.
- SQAC received the Baby E learning slides, with good discussion held; and
- SQAC received the Neonatal sepsis RCA's, with good discussion held. Common themes around escalation and communications are identified in both reports and subject to action plans. As early incidents utilizing the PSIRF methodology, retrospective review of the process will be useful in due course: meanwhile the Committee explored engagement with families, staff and CQC, and the progress of action plans.
- SQAC received the Board Assurance Framework
- SQAC received the Quarter 3 Mortality Report, noting that the incidents discussed above were not yet reflected in data; however MRG had reviewed both incidents thoroughly and engaged with families.
- SQAC received the Clinical Audit & Effectiveness Annual Plan, highlighted the high level of activity and the need to seek to align activity to strategic priorities as far as possible, and to ensure loops are closed.
- SQAC received the Clinical Effectiveness and Outcomes Group Chairs Highlight report
- SQAC welcomed Rachel Isba and received the Health Inequalities & Prevention Steering Group (HIPSG) update 2023-February 2024. SQAC welcomed future update regarding future plans regarding health inequalities and the public health agenda, and noted the need to pursue this inequalities agenda through other aspects of the Committees assurance work.
- SQAC received the Divisional updates with good engagement across all divisions.

0161
- SQAC received the Commissioning for Quality & Innovation (CQUIN) Programme 2023/24
- SQAC received the Quality Assurance Rounds – Themes & Risks Biannual update and Quality Assurance Round Annual Report 2023/24
- SQAC received the Ward accreditation report and Annual Report, and noted the good work being undertaken here.
- SQAC received the Mobilisation of the Children and Young Peoples Gender Service (North) Report
- SQAC received, noted and APPROVED the Record keeping policy, and agreed that this would be further reviewed in 6 months' time.
- SQAC received, noted and APPROVED the High Consequences Infectious Diseases (Airborne) Policy
- SQAC received, noted and APPROVED the Management & Prevention of Clostridioides Difficile (C.difficile) Policy.

4. Recommendations & proposed next steps

The Board is asked to note the Committee's regular report. The Inphase update and lessons learned report is recommended to all Board members, noting that Audit and Risk Committee will also scrutinise.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 21st February 2024
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Divisional Director Community & Mental Health Services	(LC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	John Grinnell	Managing Director/Chief Financial Officer	(JG)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RP)
	Jacqui Pointon	Associate Chief Nurse–Community & Mental Health Division	(JP)
	Laura Rad	Head of Nursing-Research	(LR)
	Jo Revill	Non-Executive Director	(JRe)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Office	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)
In Attendance:			
23/24/189	Will Weston	Medical Services Director	(WW)
	Peter White	Chief Nursing Information Officer	(PW)
	Ian Gilbertson	Deputy Chief Digital and Information Officer	(IG)
	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	(NO)
	Jill Preece	Governance Manager	JPr)
23/24/199	Jane Ratcliffe	Consultant -Complex Chair, Interim Chair Medical Ethics	(JR)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)
Apologies:	Alfie Bass	Chief Medical Officer	(ABa)
	Pauline Brown	Director of Nursing	(PB)
	Dani Jones	Director of Strategy	(DJ)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Paul Sanderson	Chief Pharmacist	(PS)

23/24/185 Welcome and Apologies

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

23/24/186 Declarations of Interest

None

23/24/187 Minutes of the Previous Meeting

Committee members were content to APPROVE the notes of the meeting held on 17th January 2024

23/24/188 Matters Arising/Review of Action log

Safeguarding Accountable Officer – update to be provided within the Safeguarding update.

Sepsis training data update – CW advised that a great deal of progress had been made, a meeting had taken place with BI and the Learning & Development Team team. CW referred to previous queries regarding increasing numbers which was confirmed was due to new staff, staff leaving and there had been some corrections to training requirements where a clinical practitioner/ nurse had been greyed out, this has been corrected immediately.

Sepsis steering group had recently completed a deep dive to assess all staff roles to assess the appropriateness of Sepsis mandatory training. CW advised that the Sepsis Steering Group had recommended a couple of significant changes, one of which is extremely positive regarding the introduction of a basic sepsis training package, as not all staff require the full sepsis training.

CW provided SQAC with assurance that all staff details who should be assigned sepsis training had now been sent to L&D and all staff would be communicated with confirming that they had been assigned.
CW confirmed that the ED dashboard and the inpatient dashboard is now in place. CW advised that from an ED dashboard perspective the dashboard is functioning and requires no change and all staff are really pleased with it.

From an inpatient dashboard this does require some further work to remove manual steps in the process. IG provided further assurance that the dashboards are now in place, and the delay was post Alder Care and that the issue regarding the manual validation has been a long standing issue, however this requires optimisation to reduce manual intervention and enable automation.
IG provided assurance that the data is accurate, and this just requires an improved way of being more efficient with the data.

FB stated that it is good to hear the discussions had taken place regarding the dashboard and the data. FB stated that within the divisional reports there is a range of positions in terms of training compliance. FB highlighted importance of all Division to continue to ensure staff have the time to undergo training, and ensure clear communication with staff to enable staff to attend Sepsis training to aid high level compliance by April 2024.

KB stated that it is a really useful exercise to ascertain the level of errors and queried whether the Trust have other modules of mandatory training with similar errors, and queried whether there is a requirement to look across all levels of mandatory training or review a sample of 2 or 3 modules to see if it is replicated across the organisation.

MS stated that for a lot of the mandatory training it is applicable for everybody, as the data for all staff would be correct. There would be other mandatory training that is role specific, MS stated that she could request K Birch to review some topics that may be worth reviewing.

KB stated that it would be useful to receive this assurance. It was agreed this work would be requested from the PAWC.

Resolved: MS to request K Birch to undertake a review of a sample of mandatory training modules to ascertain whether there are any anomalies or errors with regards to staff roles, with findings and oversight to be reviewed through PAWC.

FB thanks to all for ongoing attention to this issue.

Assurance on Key Risks
23/24/189 *Delivery of Outstanding Care*
Safe

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

- Patient Safety Strategy colleagues had applied careful scrutiny to workstreams 1, 6, 7, 8, 10, 15, 21 and 22. WW referred to workstream 1 and advised that there had been a downward trend in relation to both the number of incidents related minor harm and above, and for the number of incidents rated no harm and near miss.
- During the Patient Safety Strategy meeting discussion took place regarding the use of physical restrictive intervention were according to the graph an increase was recorded as bad, whereas the Trust is wanting to see more reporting of increased restrictive intervention. Patient Safety Strategy colleagues had been in liaison with BI colleagues and are grateful to BI colleagues for them agreeing to make the necessary changes to that report.
- Negligence and litigation – the GIRFT review is now complete with themes for learning, details regarding this, in addition to a range of other contents from Hill Dickinson is also available on the negligence & litigation sharepoint site, it was agreed at Patient Safety Strategy Board that further work would be required with regards to cascading the learning across the organisation.

- Education and training - there is a large range of internal and external resources available for staff, however there was some concern regarding not appointing any patient safety investigators and that any patient safety investigations may not be carried out to the appropriate standard in accordance with the recommendations made in PSIRF, this issue would be mitigated following the very recent funding approval for the investigators.
- PSIRF Patient Safety 1 and 2 highlight the challenges faced as the Trust move to a more autonomous style of working and different types of reporting to Trust Board, in essence there would be three areas of reporting.
- JP provided an update on Parity of Esteem which highlighted that there would be a reduced risk score, partly due to the recruitment of new staff in this area which would allow for faster progression and focus for the workstream.
- Hospital optimisation highlighted an upcoming meeting to review scoping requirements since the complexity and coverage of the workstream is expanding and encompasses general paediatric models, discharge from recovery and clinical escalation in relation to various parts of the organisation especially out of hours. WW advised that he would be in a position to provide feedback to SQAC once the strategic meeting had taken place.
- Within the same workstream within Hospital Optimisation colleagues welcomed the PAU closure report which outlined the benefits achieved to date and the shift to business as usual.
- Dr. M Neame, presented the unacknowledged notices update which summarised that the analysis generated from the workstream had allowed for targeted meetings within the relevant clinical teams to improve compliance.
- Patient Safety Strategy Board had maintained good levels of governance, resulting in an overall green rating for the programme.

JG referred to the unacknowledged notifications update and sought clarity regarding performance and outstanding acknowledged notifications. WW stated that there appeared to be a conflict between what has been described in the challenge section and the total amount which appeared to be nearing 7,000.

NA suggested that it would be beneficial to invite Dr Neame to attend SQAC to provide detail on the external requests process and the growing number of internal unacknowledged notifications.
JoR stated that around 1/3 of clinicians are unaware of the 28 day standard for acknowledging notification which is a high figure and questioned if further education and training was required.

UD stated that there are regular updates provided to divisional leads regarding performance and was aware of some additional challenges such as when a clinician is on leave.
FB stated that colleagues had previously discussed the need for a team approach to address such circumstances.
LC stated that there is also a dashboard available that Division Directors which is helpful to show what teams or clinicians are due to breach or are approaching a breached position. LC stated that the Community & MH Division have a performance process regarding notifying appropriate colleagues.

PW alluded to celebrating success as some teams had really adopted the unacknowledged notices process, and that there had been some outstanding work undertaken to date. FF alluded to colleagues who often reviewed the notifications within a significant increase - 38% to 77%, with 85% stating that the system is useful.

SQAC **NOTED** the importance of the ongoing monthly discussions which are held with the CMO and leads, to ensure that the unacknowledged notices are established into clinicians regular routines and workplan, and ensuring individual discussions continue with those clinicians who are not reviewing the notices.
FB alluded to the PAU closure report. This was helpful to share reflections and learning from the process and sought clarity whether there would be a lessons learned aspect that would capture learning for future programmes.
JG stated that this is a great discipline and welcomed this. JG stated that he is not certain that PAU has been fully explored and that he is particularly interested in the impact which PAU is having on the flow into the hospital. JG stated that it remains a large part of improving flow and productivity at Alder Hey with further work to do in this regard.

FB alluded to the final section of the report and the importance of being clear where there is scope to build and develop and the benefits of describing future intentions and detailing who would be addressing future scope and developments.
JG welcomed this approach and stated that the Surgery Division is not yet linked in at present and that this would evolve. JG sought assurance from SQAC whether the base model is acceptable. FB supported this, and stated that it is extremely useful to have an established mechanism for closing workstreams, but understanding what the impact had been could be strengthened.

FB expressed thanks to WW and Patient Safety colleagues for ongoing support and for the comprehensive update.

Resolved: SQAC welcomed the good progress made in month and **NOTED** the continuous improvement across an array of patient safety workstreams.
Resolved: SQAC received and **NOTED** the good progress in month and welcomed future Patient Safety Strategy updates.
Resolved: SQAC welcomed an update from Dr. M Neame regarding unacknowledged notices at the March 2024 meeting.

23/24/190 ED MH monthly report

CW presented the ED report.

- During the month of January 2024 there had been a reduction in ED 4 hour performance at 82% this has remained above national standard, and is an improvement on 2023 performance, despite the reduction.
- ED had seen a continuing improvement in the 12 hour wait which is a reduction from the 3 previous months.
- Median time to triage in January 2024 was 1 minute above the national standard of 15 minutes, which is a slight reduction from the previous 4 months.
- Increasing time to clinical assessment in January 2024 was 90 minutes, 30 minutes higher than the national standard, with ongoing focus as this has been persistent.
- ED had 1,157 more attendees in January 2024 compared to January 2023.
- Sepsis compliance in ED – administrating antibiotics within 60 minutes in January 2024 was positive at 94%, this is a continued improvement for the second consecutive month. Division are wanting to see consistent improvement, with ongoing focus.
- ED had seen a reduction in the friends and family test results as waiting times had increased slightly and there is a correlation between the two.
- Medicine divisional colleagues are working on further expansion of consultant on every shift, and evaluation of the effectiveness of this, colleagues are seeing an improvement in the four hour targets, this is being worked on at present.
- Review of diagnostic delays - with ongoing work required as colleagues are seeing a waiting time from diagnostics and radiology which is impacting on the four hour target.
- CW advised that the data was not ready for the report regarding those patients who had left ED before being seen, CW presented the detail to committee members.
  - CW advised that the biggest impact relating to patients leaving ED before being seen is the waiting times which is the root cause. CW stated that colleagues in ED continue to work through a number of key actions to reduce waiting time in ED. CW stated that there had been a positive improvement in year to date compared to 2022/23 position.
  - Team remain focussed on continuing to improve the left before seen rate in ED and the division will continue to monitor on a monthly basis.
  - CW provided SQAC with assurance that all patients who leave before being seen have their triage and attendance notes clinically reviewed with the appropriate follow up care established if required.

NA commended the division regarding the reduction by 50% of patients left before seen, compared to the previous year. NA welcomed the informative graph of month on month comparison from 2023/24 and recognising that there was only 1 month with reduced performance, given the increase in attendees.

NA sought clarity whether the report could further evolve and queried whether the data set could be expanded further to incorporate in future reports detail regarding PAU, UTC data, those patients who had left before seen and those patients who had been followed up in the 24 hour period.
NA offered to help the division with further development of the report. CW thanked NA for helpful feedback to widen the data set for inclusion in future reports.

FB echoed NA comments and stated that the ED report had significantly evolved, and these additional suggestions are all welcome, and highlighted the importance of using data to pinpoint issues and being responsive to those issues, and try to provide the additional help and support where and when needed.

FB acknowledged that the ED department is still under significant pressure, recognising that January 2024 had been a busy month and stated that JG and Executive Team colleagues are mindful of pressures on staff. FB thanked CW for update.

Resolved: SQAC received and **NOTED** the ED monthly update report

23/24/191 **Quarter 3 Safeguarding Quarterly Assurance Report (1st October 2023 – 31st December 2023)**

NO presented the Safeguarding Quarterly Assurance Report

- Ongoing work had taken place with regards to Safeguarding training, despite this ongoing work there had been a decrease of nearing 5% in this quarter, NO stated that it is not unusual to see a decrease in Safeguarding training over the festive period as staff take annual leave.
- During quarter 3, the Safeguarding team had delivered additional sessions to address compliance, particularly for level 3 Safeguarding training.
- The Safeguarding team have had some capacity issues during quarter 3, despite this safeguarding training sessions had remained a focus and no safeguarding training sessions had been cancelled.
- The Safeguarding team had seen a significant increase in the number of training sessions that are fully booked.
- NO alluded to previous discussions regarding consideration of having divisional Safeguarding Accountable Officers, NO confirmed that this had been discussed at various safeguarding forums, and that following discussions it was felt that Safeguarding training is addressed through Safeguarding and Statutory Services Assurance group (SSAG) which is attended by the Associate Chief Nurses and the relevant Heads of Service, there is also the Safeguarding Operational group and the Safeguarding Policy is very clear regarding accountabilities regarding being responsible that staff are trained in regards to safeguarding this would include Divisional Directors, Heads of Nursing, Service leads, matrons, wards managers and all line manager across the Trust. NO stated that it was felt that at this stage that it may confuse matters to have divisional Safeguarding Accountable Officers as there are already those responsibilities set out within the Safeguarding governance arrangements.
- Sexual Safety in the NHS – NO stated that the Trust Board agreed to sign up to this Sexual Safety in the NHS charter which is positive for the organisation.
- Quarter 3 challenges regarding the Named Doctor and the Named Nurse. The Named Nurse has had a period of absence in quarter 3 and is due to leave the Trust at the end of this week, with interviews planned for this role week commencing 26.2.24. There had been some difficulties with regards to the safeguarding medical rota, which did not impact on any children being seen, however this did provide challenges for the Safeguarding service.
- Achievements related to recruitment and Safeguarding colleagues had spent a significant amount of time in the last financial year compiling business cases and securing additional resources for the team. The Integrated Care Board significantly invested in the Children in Care element of the team for a medical advisor for fostering and adoption, and there is a new specialist nurse for children in care which is a new role and a welcomed addition for this group of vulnerable children.
- The first safeguarding and statutory services away day was held on 6th November 2023 which was well received by the team.
- Priorities for quarter 4 regarding refining child death policies and processes, and ensuring all of the Safeguarding Policies and Safeguarding Standard Operating Procedures are updated.
- The division now have resources to aid reviewing the Safeguarding patient pathway, with the intention to digitalise Safeguarding services in the future, which is currently mostly paper based at present.
- Priorities for quarter 4 – Recruitment of Safeguarding Named Nurse and Safeguarding Named Doctor.

FB thanked NO for informative report.

FB alluded to the recruitment process for the Safeguarding Named Doctor given this is a really important recruitment process, and sought clarity whether there are any additional measures for this recruitment process.
NO stated that the Named Doctor role is usually an individual who is employed at the Trust, as the requirements have statutory elements, and that unfortunately currently there is no interest expressed in that role, next steps are to advertise externally.
KB sought clarity whether the workload is increasing, or decreasing, and if there were any trends which could be made available in the report. NO referred to the balance between what needs to be reported from a statutory perspective and giving the committee relevant operational detail. Previous reports had included a lot of operational data. NO agreed to review the data set which could be included as part of this report.
NO confirmed that the Safeguarding Team are seeing an increase in the complexity of cases and an increase in the number of children seen, and some of this detail could be included. NO would discuss with LC and NA offline regarding how this could be incorporated in Quarter 1 report, and to potentially include some case studies.
JG referred to the MASH increase in referrals, and sought clarity on what is driving this increase in referrals. The largest referrals are from Sefton social care and Alder Hey are providing comprehensive data and overview of this demand, this had increased by 135%, however these figures had only been collected for 12 months. NO stated that the Safeguarding Team are seeing the remnants of the covid pandemic and children being hidden and children returning back to school with some of those these cases now evident.
NA referred to Safeguarding training, particularly regarding the level 3 safeguarding training, and stated that there is no improvement with regards to safeguarding training attendance for corporate functions and that SQAC would want assurance that those corporate functions all have their staff booked onto safeguarding training. JG confirmed this would be discussed at Executive Team meeting to enable improved compliance of corporate staff.
JoR requested whether colleagues could have a timescale for the recruitment for the Safeguarding Named Doctor given that there had been significant efforts made to recruit to this post from within the Trust, JoR welcomed an update on timeline for recruitment.
Resolved: SQAC to be provided with timeline of recruitment process for Safeguarding Named Doctor.

IG referred to the Digitisation of the Safeguarding service and sought clarity from NO whether any I.T. support is required, NO confirmed that I.T support would be required and IG would ensure that I.T. colleagues would make contact with NO to progress this further.

Resolved: SQAC received and **NOTED** the Safeguarding Quarterly Assurance Report (1st October 2023-31st December 2023).

23/24/192 Safeguarding Children & Adults at Risk Annual Report

NO/LC presented the Safeguarding Children & Adults at Risk Annual Report

- NO highlighted the challenges as this report is usually presented to SQAC in September, NO alluded to the challenges in 2022/23 given the changes in safeguarding leadership.
- Successes - with improved governance and assurance regarding safeguarding by implementing the Safeguarding & Statutory Services Assurance group.
- Improved relationships with the designated professionals within Safeguarding Integrated Care Board and Commissioners regarding openness and transparency.
- The Trust has had a Section 11 scrutiny visit from Liverpool Safeguarding Children Partnership with was extremely positive.
- NO alluded to the resource review to obtain additional investment, which the Trust had been successful in achieving.

FB expressed thanks to NO for ongoing work and support.
Resolved: SQAC received and **NOTED** the Safeguarding Children & Adults at Risk Annual Report.

23/24/193 NatSSIPs Report

RP presented the NatSSIPs report

- RP alluded to NatSSIPs trajectory which detailed timeline of delivery and advised that this had been slightly delayed by 1 month, as it was slightly ambitious launching at the Christmas period, with challenges and delays experienced given annual leave of staff.
- RP stated that a review of all checklists is ongoing to reduce the number used across the Trust and variation in standard.
- A working group had been established which meet fortnightly reviewing checklist to reduce variability
- Review of Theatre NatSSIPs had been updated in line with NatSSIPs 2 and a draft had been circulated to colleagues for review, which would follow the divisional and Trust sign off processes.
- Colleagues are working on an overarching NatSSIPs framework for the Trust to contain the localised approaches defined by areas to reduce variation in practice and ensure consistency. The Trust overarching framework would set out a more consistent standard.
- Business Intelligence support is required to produce a dashboard which would detail quantity of procedures undertaken.
- Once the core work had been undertaken colleagues plan to engage further with stakeholders and produce the overarching framework.

IG welcomed discussions with RP regarding Business Intelligence support.
KB alluded to oversight of the process and queried whether oversight is through the Clinical Effectiveness & Oversight Group. RP stated that the NatSSIPs report is currently presented to Patient Safety Strategy Board and then to SQAC.
FB stated that it would be helpful to have a conversation regarding what is presented to SQAC, and whether or not this item needs to be presented to SQAC by exception. FB would address this offline with NA.
Resolved: SQAC received and **NOTED** the NatSSIPs Report.
Resolved: Offline discussion to take place with FB & NA

23/24/194 Safe Waiting list update

AB presented the Safe Waiting list update

- AB advised that all actions associated with the action plan had been closed. The Trust had now introduced into the EXPANSE system a new ward discharge process which is more robust and effective.
- Challenges regarding data quality post EXPANSE, there are new processes and new user interfaces which are resulting in some challenges in terms of how colleagues are accurately recording patient outcomes and RTT management. 8% of patients on the waiting list have a query regarding data quality from the dashboard used. The Trust has a data assurance team who are working through this issue and together with the training it is important to return to the low data error rates. Safe Waiting list oversight group is managing this, with a clear plan in place to address, however this has deteriorated post go live.
- AB referred to follow up care and the backlog. A Business Case had now been approved to target those patients who are recorded as being higher risk who are overdue a follow up appointment. There are 11,000 high risk patients on the follow up waiting list who are overdue. With approved priority investment to ensure some resource to administratively and clinically validate these patients, this would be tracked through Operational Delivery Board and this project would be evaluated regarding the impact on what patients are on a PIFU pathway and whether there are any cause for safety concerns, together with any learning from the evaluation. AB stated that this is significant work to address the high risk overdue backlog.

FB thanked AB for comprehensive report and welcomed the progress regarding addressing the back log issue, FB stated that she is hopeful that the programme of work has positive impact.
JG alluded to data quality post EXPANSE go live and stated that colleagues had agreed to obtain an external lens on this as a future report. JG sought clarity on the status and queried the most appropriate forum for this report to be shared.
JG referred to the follow up list and how this had been logged as a risk, and whether there is sufficient oversight on the corporate Risk Register and the Board Assurance Framework as this is a significant clinical risk.

AB stated that he had requested R Viner , Independent waiting list management support, to deliver this reconciliation report which is due at the end of February 2024. AB stated that this could be shared at Operational Delivery Board and SQAC if required.
AB stated that the risk had been updated to reflect the follow up risk, AB would follow this up to ascertain that this is reflected, as work had been undertaken on Inphase to update the risk.

IG stated that he had been in discussions with third parties, as this is something that is not widely available and could not be procured off the shelf.
NA proposed that the Safe Waiting List oversight ceases at SQAC given that the action plan is now complete and that it would be helpful for a discussion at Operational Delivery Board regarding where the backlog issue would be presented and that it may potentially be SQAC in the future.
FB supported the proposal to the cessation of SQAC receiving the Safe Waiting list updates, as the initial work is now complete, and that this is now an optimisation programme regarding data and pathways.

AB stated that for completeness it would be beneficial to share the evaluation of the follow up work in 6 months time with SQAC as a one off update once the validation work had been completed FB was supported of receiving the outcome of the validation work for completeness.

Resolved: SQAC received and **NOTED** the Safe Waiting list update
Resolved: SQAC agreed to the cessation of the Safe Waiting List update.
Resolved: SQAC would receive the outcome of the validation work once completed

23/24/195 Quarter 3: Children & Young People Engagement Leads Report

LC presented the Quarter 3: Children & Young People Engagement Leads Report
LC provided an overview to SQAC on the power of youth engagement and highlighted the importance of the youth voice, resulting in the power of change for children and young people.

FB welcomed the Quarter 3: Children & Young People Engagement Leads Report which detailed the wealth of engagement. FB referred to the Promises and stated that this should be using on the Trust website. FB stated that she is pleased to see the 'I will' and stated that this empowerment approach is extremely welcomed.
Resolved: SQAC received and **NOTED** the Quarter 3: Children & Young People Engagement Leads Report

Caring
Effective

23/24/196 Board Assurance Framework

ES presented the Board Assurance Framework
ES advised that both ES & KB had discussed a slightly wider regroup with regards to how these risks are articulated and expressed in the 2030 context and how these link to the SQAC specific risks.
ES detailed a working group that would be used with the sub board committees which would review the risks and also the risk appetite approach.

FB stated that the continued work is very welcomed and that a discussion offline would be held regarding the experience risk. FB noted many of the 2.1. and 2.2 risks have an overlap with the main care risks from section 1 and that colleagues needed to be really sighted on the impact these risks have to quality and safety of care.
KB alluded to deep dives of each risk and queried whether this is scheduled into the SQAC workplan.
NA stated that this would be included on the workplan from April 2024.

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

23/24/197 Clinical Effectiveness & Outcomes Group – Chairs Highlight report

JR presented the Clinical Effectiveness & Outcome Group – Chairs Highlight report
- A successful Clinical Effectiveness & Outcomes Group meeting was held on 9th February 2024.

- CEOG acknowledged the continued compliance with NICE guidance and the continued improved oversight and learning from clinical audit.
- The Clinical Audit Report format had slightly changed for future reports.
- Weekly meetings continue to be held regarding NICE and Audit, with policy and Standard Operating Procedures compliance also now included as agenda items for these meetings
- Working group had also been established to review the document management system as there is disparity across the Trust, with a report being presented to a future Executive Team meeting.
- National Perinatal Mortality Review Tool (PMR)) Learning from Standardised Reviews when Babies Die – 2023 Annual Report shared with Trust HMRG led and surgical division – JR would present findings at a future update, there are no actions for Alder Hey.
- Clinical Audit awareness week and study day is planned for 24.6.24
- There are no formal issues to escalate to SQAC, with the exception of one of the CEOG chairs has been appointed on 20.2.24 to the National Paediatric Rheumatology GIRFT lead and has tendered his resignation, JR would follow this up offline with CMO to ensure that momentum is maintained.

FB thanked JR for comprehensive update

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

23/24/198 **Divisional Update and Deep Dive regarding:**

Surgery Division – RP provided the Surgery Divisional update

- PICU maintained admitting capacity during January and were the only unit to consistently offer a bed
- Focus within the division regarding return to work compliance, with upward trend.
- Concerns within the division related to waiting list with some instances for children who have long waits for appointments or procedures.
- Challenge regarding temporary spending in nursing, with actions in place to reduce the nursing spend over the coming months.
- Sepsis training compliance in January 2024 was lower than expected, this is currently at 89%, there are still some issues regarding compliance recording, RP is meeting with G Foden to address.
- The Division of Surgery continue to have low numbers of pressure ulcers and this is a continual focus.
- The Division of Surgery had maintained 100% PALS compliance, with 3 formal complaints in January 2024.
- There are no risks at 15 or above.
- RP alluded to an issue which had been raised at the Capital sub group meeting which had been chaired by RP on 20.2.24 with regards to a risk regarding a EOS scanner, as the Trust need to procure this year a EOS scanner, there is currently no space to move the new scanner to. RP requested clarity on the most appropriate forum for this to be raised. RP would raise this issue at Risk management Forum.

FB referred to the incidents which are overdue for review and requested feedback, FB also requested feedback regarding the very low levels of sepsis training in a couple of areas, as this is very variable. RP referred to the overdue incidents and stated that the division are focussing on closing incidents in a timely manner, and that the largest area of those overdue incidents is within the specialties. RP stated that the ward based incidents are regularly reviewed on a monthly basis via the challenge board, and that the ward based incidents are being closed within the necessary timeframe. RP advised that the division are going to have to think differently regarding how medical colleagues are supported with closing the overdue incidents.

- RP alluded to sepsis compliance and stated that small numbers of team members led in most cases to the large changes in percentage compliance.
- JG alluded to the pressure ulcer numbers and stated that the pressure ulcers appear to be higher compared to previous trends. RP stated it would be beneficial to review where the Grades 1 and 2 were happening, RP stated anecdotally if felt like more pressure ulcers are coming through critical care, and whether this could be attributed to the volume of patients on critical care which had increased, and that the lower level incidents seen at Grade 1 would be a red area as the child has had to lay still or irritation from a tube RP agreed that she would review this.

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

- Community & Mental Health division are not currently achieving the PALS 5 day target, the division had recently recruited some admin support for the divisional governance team, part of this postholders remit would be to ensure that the PALS 5 day target is achieved.
- The risk detailed on the Risk register for the Safeguarding Named Doctor and the Safeguarding Named Nurse risk score had increased from 12 to 20.
- The Arts blues project is making good progress, which is important research in partnership with Edge Hill University, with the research undertaken within Children & Adolescent Mental Health Services, the project is regarding increasing the evidence base for Children & Young People regarding interventions for anxiety and depression, which could be a really important additional tool for children and young people.

FB thanked JP for update and stated that all had noted the increase in the risk score for the Safeguarding Named Doctor to 20.

FB alluded to sepsis training which is at 84% and sought any feedback to why this remains at 84% JP stated that there is a proactive work regarding ensuring that the correct people are on the list. JP stated that there are a number of people who had completed the training and that there were some challenges regarding accessing the training and that compliance had not reached above 83-84% since September. FB requested focus from the division on increasing Sepsis training compliance, JP advised that this would be an areas of focus and that she would provide an update on this during the March Divisional update.

FB referred to the Divisional Quality Assurance template and that the same template had been used slightly different across the Divisions. FB referred to the level of detail contained within the Community & MH Report and stated that this could be reviewed to reduce some of the detail.

Resolved: NA would meet with Associate Chief Nurses to agree a standardised approach for the Divisional Quality Assurance Reports submitted to SQAC.

Medicine – CW provided the Divisional update

- Success related to risk management governance with no overdue reviews or actions, ongoing focussed work over the last 3 months, resulting in a positive impact.
- Challenge regarding an increase in measles prevalence in the UK and a requirement for the division to lead on and prepare business continuity plans and preventative measures, the Trust are in a good position should there be a surge of measles presentation at the Trust.
- Sepsis - 100% in inpatients which had been consistent for the last 7 months & 94% in ED.
- There were no hospital acquired infections for the month of January 2024, there were a couple of cases in December 2023 within Oncology, with focussed work undertaken within the division with Oncology colleagues.
- There had been no pressure sores at grade 2 and above for the last 6 months.
- Complaints were 100% closed within the 25 day target and PALS were 100% closed within 5 days
- NICE continued to demonstrate a greatly consistent improved position.
- Focus work to continue to close incidents greater than 30 days, there had been a marked reduction, with a continued focus with daily oversight.
- Division would focus on improving sepsis training compliance.
- Focus work on reducing low harm incidents.

FB thanked CW for update and stated that for a large division there are a high number of positives and expressed thanks to all for ongoing work.
JG reiterated FB comments and stated that the statistics look extremely positive, and that this should be recognised and commended.

Research Division - LR presented the Research Divisional update

- Research Quality Assurance Round & Ward Accreditation was held in January 2024, with formal feedback awaited, with initial informal positive feedback from both.

- Informative meeting had been held with the University PPIE Parent Forum regarding the feedback platform with meaningful feedback received regarding how questions could be merged or improved wording for families. Although the questions are mandated by NIHR, plan is to use this feedback as part of a project to explore with the NIHR if the survey is not fit for purpose for children and families. They are also open to Alder Hey research colleagues taking future topics to the group with the aim of sharing the future Research strategy to them for feedback.
- Serious adverse event (SAE) reporting is not routinely reported to SQAC previously, following discussions with D Hawcutt and L Rad, both feel that they would like to identify in the same way as clinical incidents regarding governance which would be reviewed and incorporated into the 24/25 Research Annual Plan.
- The number of patient feedback had decreased in January 2024, an established patient and experience engagement group had been established and has met twice to ensure momentum.
- LR alluded to the late risk updates which were corrected by the time of the report, but were noted on Inphase as being late.
- LR referred to the IPR and stated that patient recruitment looks like it had dropped off, however the portfolio is changing, LR is aiming to trying to get the data of what the target is per study within the portfolio. LR provided assurance that the Research Division are on trajectory

FB thanked LR for good positive report.

Deep Dive Review of ED Mental Health Presentations, including referrals to crisis care – with a postcode analysis of end users and what the Divisions are doing to address - CW presented the deep dive

- The total numbers of MH attendees to ED for the last 3 months is very low at 134 which is a small percentage of the total attendances to ED. Significant work had taken place by the crisis team to prevent some of the patients actually having to attend and having to be admitted. All patients attended with MH issue should be considered for referral to crisis care, of those not referred to crisis case with a physical health presentation or a cause that has to be dealt with first. Other referrals where patients are referred to the crisis case include referral to an eating disorder team or referral to safeguarding, or where a family has been sign posted to another appropriate service.
- During the three month period 22 patients were admitted to an inpatient ward. This was an increase from the previous months, however during December 2023 there were low admissions and low acuity across the Trust, therefore this aligned with the December 2023 activity.
- The Trust is seeing less inpatients being admitted to date in February 2024, this continues to be monitored.
- Largest reason for admission is intentional overdose of medication followed by eating disorders.
- Liverpool and Sefton areas are the highest number of ED attendees and ED admission.
- Mandatory training in Mental Health Act for ED staff is 97.5 compliant.
- The Emergency Department have monthly meetings with crisis care and general paediatrics and all incidents are reviewed and complex issues are discussed.
- During January 2024 the ED had its first monthly ED/CAMHS educational meeting.
- Recommendations to continuation of monitoring monthly attendance/admission with any concerns discussed at monthly ED and crisis care meetings. Use huddle and teaching to remind all staff that referral to crisis care is required for all mental health related attendances.

FB expressed her thanks and welcomed the % of MH attendances of the whole attendance load and stated that the figures are extremely clear within the report, FB stated that it was useful to see where patients are presenting from.

Deep Dive on the impact of PAU - CW presented the Deep Dive

- CW stated that the PAU had been extremely positive and had now transitioned to business as usual with further analysis underway, colleagues would continue to review analysis over the coming months.
- Plan to review in depth the future staffing model across the Trust, this is ongoing work.
- Agreed new metrics for January 2024, there had been positive improvements in all but one of the metrics, which is median time for patients waiting to be seen by an ED clinician, with focussed ongoing work to address.

- Improvement in ED regarding 4 hours performance of 3% in January 2024 compared to previous years in 2022 and 2023.
- There had been a reduction in the number of children and young people waiting over 12 hours in ED this winter compared to 2022 & 2023.
- There had been a significant reduction in emergency admissions to 4C this winter compared to last year
- There had been a reduction in emergency admission staying more than 48 hours on 4C.
- There had been a reduction in emergency admissions staying less than 12 hours on 4C.
- There had been a decrease in the average number of general paediatric outliers from 4 to 1 compared to the winter of 2022/2023

CW stated that this had been extremely positive this year, and that colleagues had seen less outliers within surgical wards and an increase in oncology outliers.
CW stated that the analysis conducted is mainly quantitative and is based from the data, which colleagues had awaited for some time. Divisional colleagues acknowledged iteration requires a further review of qualitative measures and actual feedback from the children and young people, users and families, together with staff feedback which is important.
Key next steps:-

- Continue PAU model and further embed as business as usual.
- Continuation of monthly analysis through PAU audit group.
- Deep dive to be undertaken of times of discharge 24/7 – this data would be presented within future report.
- CW provided assurance that discharges are taking place 24/7, and are obviously lower at night with the highest number of discharges taking place within the afternoon
- Colleagues would continue to work with finance regarding any associated CIP opportunities.
- As part of the annual planning colleagues are reviewing whether it is possible to close increased number of beds throughout the summer period – this is currently being discussed.
- Work towards further improving the PAU model ready for the new build in 2025.

FB expressed her thanks to the divisions for the divisional updates and for the Deep Dive review of ED Mental Health Presentations and for the Deep Dive on the impact of PAU.
AB expressed his thanks to the whole team for the ongoing support with regards to the ongoing improvements regarding PAU.

AB stated it would be helpful to see the number of direct admissions from GPs and to obtain GP evaluation which would be helpful to capture this information, and alluded to whether there is anything that the Trust could do further for further evaluation.

Resolved SQAC received and **NOTED** the Divisional updates and the Deep Dive review on ED Mental Health Presentations and the Deep Dive on the impact of PAU.

23/23/199 *Well Led*
Responsive

Clinical Ethics Committee Annual Report
JR presented the Clinical Ethics Committee Annual Report

FB expressed her thanks to JR for her ongoing support and acknowledged that this was JR last meeting prior to JR upcoming retirement.
JR advised that she is pleased to advise that the interview panels for the Chair of Clinical Ethics Committee and the Chair of the Clinical Professionals Support Group interviews are scheduled for 8th March 2024 for both the Clinical Ethics Chair, both the internal and External Chairs.

JR stated that the Clinical Ethics Committee were getting very few direct referrals, the Clinical Professional Support Group had been active. JR stated that there had been perceptions that ethics was regarding doctors and not about everyone, and therefore the thrust is to ensure that Clinical Ethics Committee is a multidisciplinary committee to ensure that all have a voice e.g. Bedside nurses, play specialist - anyone who has concerns can raise.

JR stated that the Trust had been approached by the University of Liverpool and in partnership with GOSH, and that colleagues at Alder Hey are working with them and hope to have a three year's Master's course

FB thanked JR for the update and highlighted the importance of ethics being for everyone and alluded to multi-disciplinary discussions and stated that sometimes issues are about the care and working with parents.

FB acknowledged the ongoing developments and welcomed hearing the outcome of the interviews to appoint the Chairs.
FB reiterated her thanks to JR for ongoing support.

Resolved: SQAC received and **NOTED** the Clinical Ethics Committee Annual Report

23/24/200 Quarter 3 2023/24 Complaints, PALS and Compliments Report

NA presented Quarter 3 2023/24 Complaints, PALS and Compliments Report

- NA advised that for the next year, hopefully for Quarter 1 report that the layout and the content of some of the complaint reporting would change.
- Report highlighted good compliance of the 3 day acknowledgement target, and decreased compliance against the 25 day response.
- The Trust remains a low % of second stage complaints at approximately 10%.
- There had been no further referrals to the Ombudsman, since the closure of the last case.
- NA advised that there is still attention required regarding resolving PALS within 5 days. NA advised that as part of the opening of the family hub next year that there is a review planned of PALS process and to review how colleagues could facilitate more of an incident resolution service for families.

FB thanked NA for Quarter 3 2023/24 Complains, PALS and Compliments Report
Resolved SQAC received and **NOTED** the Quarter 3 2023/24 Complaints, PALS and Compliments Report

Deep Dive of complaints themes over the last 5 years

NA presented the Deep Dive of complaints themes over the last 5 years

- NA advised that the 3 top categories remained the same - treatment and procedure, admission, transfer and discharge and communication. On review of the deep dive it is evident that the volume against each of the categories had significantly decreased, whilst they remain the most common categories there had been significant ongoing work undertaken to decrease complaints.
- NA advised that there are some actions within the report that the team would follow up. NA advised that whilst the categories may not change the volume had decreased, therefore the work undertaken is continuing to make an impact.

FB alluded to the significant decrease in communication being the cause for the complaint or the PALS.
NA stated that there is still further work to do.

Resolved: SQAC received and **NOTED** the Deep Dive of complaints themes over the last 5 years.

23/24/201 Patient & Family Feedback Quarterly Report

NA presented the Patient & Family Feedback Quarterly Report
NA advised that the Trust had undertaken a PLACE audit this year and that colleagues can note within the report that this would now be classed as a PLACE light audit, as the guidance had changed which the Trust was not aware off which required at least 50% of assessors to be non staff, and on the day of the audit, due to illness of one of the non staff assessors this had resulted in an inequitable audit approach. NA stated that there is good indications in the initial feedback on receipt of the detailed report, and alluded to 2 areas regarding privacy and dignity and disability that the Trust would need to develop robust development plans, this would be managed through the Patient Experience Group.
ES sought clarity regarding how the governors are classified within the new guidance and queried whether they are classed as staff or not. NA advised that it depends on their role, and that the lay governors are non staff. ES queried if the Trust could ensure a larger group of appointed governors whether this could be overcome for any future PLACE audits, NA stated this would be helpful.

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

23/24/202 Patient Experience Framework and EDS2022

NA presented the Patient Experience Framework and EDS2022
NA stated that this is the first year of the change from EDS2 to EDS2022, with the most significant difference being that the organisation previously was rated as a whole, and stated that for the Patient element the Trust now have to pick 3 services under the category of someone who is doing well, someone who has work ongoing but has scope for improvement and an under developed service that would value a clear action plan to move forward with the equality and diversity agenda.
The 3 areas were chosen in the assessment for this year is Speech and Language Therapy network, Oral Health and Spiritual Care. NA stated that it had been extremely helpful to undertake the self-assessment to provide a comprehensive action plan. NA advised that each year 3 areas would be selected.

The largest benefit is to provide clear guidance on where people can make significant improvements within their departments. This had also been incorporated with some assistance from the EDI Lead.

Resolved: SQAC received and **NOTED** the Patient Experience Framework and EDS2022

23/24/203 Any other business - None.

23/24/204 Review the key assurances and highlights to report to the Board.

- SQAC received an update on Sepsis training and noted the good ongoing discussions which had taken place to address this issue. SQAC noted the importance of all the divisions continuing to pursue improved compliance levels.
- SQAC received a positive Patient Safety Strategy update, and noted the first closure report which was welcomed by SQAC, with 1 or 2 issues that SQAC enquired into.
- SQAC received the ED monthly report and noted the improved report which enabled SQAC to have a good understanding of progress in those areas.
- SQAC received the Safeguarding Quarterly Report (1st October 2023-31st December 2023), SQAC received a detailed update on the investment into Safeguarding and the improved capacity of the Safeguarding team. SQAC noted the challenges in relation to the recruitment for the Safeguarding named nurse and the Safeguarding named doctor, with assurance received that colleagues are aware of the issues and are working hard to address.
- SQAC received the Safeguarding Children and Adults at Risk Annual Report
- SQAC received the NatSSIPs report
- SQAC received the Safe Waiting List report and noted the extremely good progress made against the original piece of work. SQAC were supportive of the Safe Waiting List management becoming business as usual, SQAC agreed to the cessation of receiving the quarterly Safe Waiting list update to SQAC. SQAC agreed that for completeness that they would receive an evaluation of the follow up work in six months' time
- SQAC received the Board Assurance Framework, with discussion held regarding the experience risk and understanding the intersection of the different risks and the various parts of BAF, and how colleagues fully understand and manage the intersections.
- SQAC were delighted to receive the Children & Young People Engagement Leads report
- SQAC received the Clinical Effectiveness & Outcomes Group – Chair's Highlight Report.
- SQAC received the Divisional updates and the deep dive regarding a review of ED Mental Health Presentations, including referrals to crisis care with a postcode analysis of end users and what the Divisions are doing to address and the Deep dive on the impact of PAU.
- SQAC received the Clinical Ethics Committee Annual Report
- SQAC received Quarter 3 2023/24 Complaints, PALS & Compliments Report
- SQAC received a Deep dive of complaints themes over the last 5 years
- SQAC received the Patient and Family Feedback Quarterly Report
- SQAC received the Patient Experience Framework and EDS2022

23/24/205 Date and Time of Next Meeting: 20th March 2024 9.30 – 11.30 am via Microsoft teams

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	NHS England – Digital System Support Post Go-Live Assurance Report - AlderCare - EPR Programme
Report of:	Kate Warriner – Chief Digital and Transformation Officer
Paper Prepared by:	Ian Gilbertson – Deputy Chief Digital & Information Officer

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

Does this relate to a risk? Yes ☑ No ☐

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

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

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

1. Executive Summary

The purpose of the paper is to provide Board of Directors with an overview of the findings from NHS England independent assurance review on the Trusts transition to a new version of its Electronic Patient Record (EPR) – AlderCare.

Alder Hey implemented a new Electronic Patient Record (EPR) system in September 2023. This programme branded as Alder Care, replaced the legacy Meditech 6 EPR system with Meditech Expanse 2.1.

Given some of the challenges other organisations have encountered when implementing new EPRs, and to provide an external view to triangulate feedback collated through the Trust's own lessons learnt exercise, Alder Hey sought independent assurance through NHS England. This resulted in an exercise being commissioned, to provide the Trust with a view on the adoption and safety of the new EPR solution, which is in live use. The Post Go Live assurance was undertaken by the Digital Support System (DSS) team in NHS England.

The external assurance exercise has identified a number of positives associated with the transition to AlderCare including additional assurance on its safety. This is coupled with the identification of some improvement areas. The review has outlined two recommendations for the Trust to implement in the future which relate to establishing an Operational Forum with Meditech, to deal with any ongoing issues and to perform as much due diligence as possible before embarking on future upgrades. NHS England have offered to support the Trust in mobilising these recommendations.

Board of Directors is asked to:

- Note the contents of the review.

2. Background

Alder Hey implemented a new Electronic Patient Record (EPR) system in September 2023. This programme branded as Alder Care, replaced the legacy Meditech 6 EPR system with Meditech Expanse 2.1.

Internally, the Trust completed its own Lessons Learned exercise in early 2024. This was conducted through multiple discussions an interview's with a range of staff who were involved in the Programme at Alder Hey. Overall, the feedback was extremely positive. The review highlighted some examples of excellent working practices including a multi-disciplinary approach to implementation and planning, command and control structure during go-live and the support provided for staff throughout.

In terms of areas of improvement, remote working was highlighted as a hindrance to building relationships on the ground with staff, technical issues with 'Flex Buttons' and problems with Role Based Access were all identified as key lessons to be learned for any future deployments. This report can be found in Appendix A.

To seek independent assurance and to identify a further perspective on lessons learned an exercise was commissioned by Alder Hey to provide the Trust with a view on the adoption of the new EPR solution which is in live use. The Post Go Live assurance was undertaken

by the Digital Support System (DSS) team in NHS England. The report can be found in Appendix B.

As part of this exercise, DSS spoke to a range of stakeholders across the trust who are using Meditech Expanse on a day to day basis. These included Consultants, Nurses, Alllied Health Professionals and staff in administrative roles. Staff interviewed were across from a cross section of professions and divisions in the Trust.

End user (i.e. staff operating the Alder Care system) feedback was solicited against the following themes:

1. Performance, Usability and Safety of the new system
2. Experience during the Go Live phase of the new system

Feedback was also sought from the Information Technology division on the overall experience of supporting the Go-Live phase and post go-live support to end users.

3. Findings

3.1 Performance, Usability and Safety

This theme relates to how the new system is performing against user expectation in terms of the speed of response from the system when undertaking their day-to-day tasks. As part of this discussion, end user were also asked to compare their experiences of using the previous system Meditech 6. The theme also explored if end users felt that the new system reduces the likelihood of risk to the patient.

What went well	What can be improved
General feedback was that the new system is quicker than the previous system	Issues with Flex Buttons used as shortcuts to access other systems
Consensus is that the system is safe for patients	Viewing information in multiple windows compared to Meditech v.6
Consultants indicated that having all the required information accessible on a single view greatly helps with their day-to-day tasks	Some staff when asked felt that the driver for moving to a new system was because it was due for an “upgrade” as opposed to a means to transform ways of working in the Trust as per the vision of Alder Care
No episodes of system disruption such as frozen screens or prolonged duration of slow performance were highlighted	

3.2 Staff Experience during the Go-Live Phase

This theme to the staff experience in the lead up to the Go-Live of the new system and support provided in the initial weeks of Go-Live to enable staff to get familiar with the new ways of working.

What went well	What can be improved
Good levels of communication and awareness	Unforeseen technical delays during cutover
Training provision	External staff from other NHS organizations who supported the Go-Live lacked knowledge of the Trust
Floorwalking support	More tailored/bespoke training
Super Users	

3.3 Feedback from Implementation Team

The new system was developed by the Digital Team working collaboratively with the clinical divisions and teams in the Trust. This team is referred to as the Implementation Team in this report and comprises staff in technical, clinical, operations, corporate and leadership roles. This feedback is specifically from members of this team who were interviewed by DSS.

What went well	What can be improved
MDT approach across the Trust	First of type in the UK
Subject matter experts where a positive	Technical issues with reporting
Good partnership with supplier	Post Go Live support has not been at the same level as during Go Live
Support from Trust Leadership	

4. Recommendations & proposed next steps

4.1 Expanse Operational Forum

To maintain the user adoption journey and maximise the benefit from the new system, it is essential that urgent issues and enhancements be delivered in a timely manner.

It is recommended that the trust set up a fortnightly Post Go-Live operational forum with MEDITECH to discuss the following:

- Delivery of priority items required to improve the user experience on the new system
- Monitoring of clinical safety and prompt delivery of fixes for any issues deemed to have an impact on patient safety

This forum should consist of a technical lead, a clinical lead and an operations lead from the Trust. And similarly, from MEDITECH there should be a named technical lead and a clinical lead.

By the end of the calendar year, it is anticipated that two more organisations in the region will implement the MEDITECH Expanse. Hence from a strategic point of view it is recommended that the operational forum is evolved to form a strong working group for all trusts who are live with this solution in the region.

4.2 Due diligence for future phases

A number of other NHS organisations will be implementing MEDITECH Expanse, but Alder Hey is likely to be the pioneering trust in their care setting for any new functionality they are

planning to take in the future phases. This includes moving to a later version of the product, Expanse 2.2.

To leverage the learning from the Expanse 2.1 implementation, it is recommended that future phases be informed by robust due diligence exercises, in particular in understanding the technical process for enabling new functionality and upgrades.

DSS noted that the Trust has plans to develop a new data-warehouse to move to a more modern platform for their reporting solution. Scheduling of the new Datawarehouse project needs to be carefully considered alongside the uptake of new functionality in future phases of the MEDITECH Expanse programme.

DSS can provide inputs into this due diligence exercise if requested by the Trust.

5. Conclusion

In summary, the external assurance exercise has identified a number of positives associated with the transition to AlderCare at Alder Hey and provided assurance that the system is safe. In particular, the speed of the new platform, the multidisciplinary approach to implementation and support during the go-live were highly commended.

In terms of areas for improvement, better technical planning around migration, reporting and flex buttons were highlighted. DSS Team have provided two clear recommendations to be reviewed and actioned by the Trust.

Board of Directors is asked to:

- Note the contents of the review

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 11th April 2024

Paper Title:	**AlderC@re Phase 1 – Lessons Learnt**
Report of:	Lessons learnt for Phase 1 of AlderC@re programme
Paper Prepared by:	Kirsty Brown – Head of Clinical Digital Systems Victoria Furfie - CCIO (Community & Mental Health)

Purpose of Paper:	Decision **Assurance** **Information** Regulation
Background Papers and/or supporting information:	N/A
Action/Decision Required:	
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Impact:	

Alder Hey Children's NHS Foundation Trust

1. Executive Summary

This paper provides a reflective view of the main operational and technical lessons learnt during the stages preceding and following the AlderC@re Phase 1 programme, which went live in September 2023. This phase of the programme involved moving the Trust from MEDITECH v6 to MEDITECH Expanse 2.1.

The Digital Oversight Collaborative is asked to:

- Note that the AlderC@re system is now live for all services
- Note the lessons learnt summary
- Apply lessons learnt into future implementation of the system going forward, where possible

2. Background

MEDITECH 6, the Trust's Electronic Patient Record (EPR) system went live in July 2015. The AlderC@re Programme is overseeing the deployment of the updated version of MEDITECH referred to as AlderC@re.

Phase 1 of the AlderC@re programme, which involved the deployment of Meditech Expanse 2.1, went live at Alder Hey in September 2023. This phase of the programme included a complete rebuild of the system to allow the move to version 2.1, allowing web-based functionality for some users.

Lessons learnt was a key step in the programme management of Phase 1. It is important to learn from the positive experiences to replicate the best practice that leads to success as well as learning from the areas of improvement. The successes and areas for improvement have been outlined in this paper, this will enhance future phases of the AlderC@re programme and improve usage of the existing system, encouraging a collaborative approach for continuous improvement.

2.1. Lessons Learnt Approach

NHS England's lesson learnt methodology was adopted to maximise the ability to rapidly identify lessons learnt. The following techniques were used to collect the lessons learnt throughout the implementation journey:

- Engagement across all services including clinical, operational, and leadership representatives.
- 1:1 Interviews and group workshops
- Consistent capturing of lessons learnt with standardised headline areas of the EPR implementation roadmap.

2.2. Alderc@re Programme Aim and Objectives

The Alderc@re Programme aims to provide a safe and user friendly EPR, a working environment that is easier for all, supporting staff to deliver outstanding, consistent, and the safest care possible for all our patients.

The high-level priorities of the programme are to deliver:

- A clear, complete, and accessible electronic patient record
- Effective communication and handover of patients
- Improved accessibility and user experience
- Clearly defined user experience benefits, enhancing patient safety

3. Programme Stages and Key Lessons Learnt

The points are categorised for reference into the following programme stages, Re-baselining, Go-live Preparedness, Go-live and Post Go-live. The positive practices observed, and lessons learnt for each programme stage have been outlined based on input from clinical, operational, and technical teams.

3.1 Program Re-baselining

The AlderC@re programme was established and resourced to manage a system upgrade. Although, Meditech considered the move from version 6.08 to Expanse as an upgrade, the level of change involved in upgrading to Expanse required an elevated level of support in line with the implementation of a new EPR system.

As the scale of the project was re-evaluated a new team was brought in to support the programme management. This re-evaluation led to the need for a full programme reset, there was a change in Executive Leadership, who in turn recruited a different style of leadership group to oversee the AlderC@re programme.

3.1.1 Lessons Learnt - Successes

3.1.1.2 NHSE Relationships

Project Success
The collaborative working which occurred between the Alderc@are Programme Board and NHSE was a success. Having a good relationship meant that NHSE were able to support with issues and help in identifying potential issues with the system and work through the solutions based on their previous experience nationally.

Factors that Supported Success
The importance of establishing strong relationships with regional and national stakeholders recruiting external staff with experience of working with NHSE. Ensuring clinical safety is at the heart of every decision.

3.1.1.3 Meditech Board Members

Project Success
Following the re-baselining of the Alderc@re programme, it was important to revisit our supplier support and get the right people from Meditech to attend the programme board. We had strong USA Meditech sponsors on the project board.

Factors that Supported Success
Getting the right people and appropriate level of seniority to attend the Programme Board from the supplier in future phases is key. This enabled collaborative working by including the supplier throughout the programme.

3.1.1.4 Successful Communication

Project Success
The approach the Trust took to communication was successful and demonstrated that the multiple channels utilised effectively kept colleagues informed and up to date, including sign posting, demonstrations and stands throughout the Trust.

Factors that's supported Success
Utilising our internal communication team was extremely helpful, using our internal methods, language and style of communicating was beneficial and engaging. This will be important in future phases of the programme.

3.1.2 Lessons Learnt - Areas for Improvement

3.1.2.1 Upgrade vs Full Deployment

Issue Identified
When the programme was originally initiated it was built as an upgrade. However, on re-evaluation this programme should have been considered as a full deployment. The impact of this was that the budget and timescales were aligned to the scale of the project.

Lessons Learnt
In the future all elements of impact both upstream and downstream will be considered and detailed conversations with the supplier to understand any levels of 'rebuild' will occur. This will help inform how much SME time is also required.

3.2 Go-Live Preparedness

Six weeks prior to Go-live of AlderC@re, the programme went through the Go-Live preparedness stage. During this stage there were several Project Managers allocated to key areas of the programme, they carried out ongoing readiness assessments, and provided monthly progress reporting to the board to provide assurance and highlight any escalation that may impact go live.

3.2.1 Lessons Learnt - Successes

3.2.1.2 Clear Vision

Project Success
The clinical team created a clear vision for the programme. Sharing the vision was important to sell the benefits of Expanse to enable staff to buy into a new picture of the future and understand what it meant for them. This vision was shared using roadshows, education and awareness sessions so everyone understood what was required to deliver the EPR.

Factors that supported Success
The programme always centred around the vision of a 'clinically safe' Go Live. This was supported by agreed clinical safety criteria which supported the teams to be clear as to whether the system could Go Live safely. This allowed the programme to refer to these defined criteria and have clear Go/No Go decisions.

3.2.2 Lessons Learnt - Areas for Improvement

3.2.2.1 SME resource and BAU balance

Issues Identified
Within all workstreams there were challenges balancing the SME's resource focusing on new development and BAU development. The impact of which was that if an urgent BAU request had to be completed, resource had to be taken from the new development time.

Lessons Learnt
In future development BAU capacity and new development capacity will be communicated widely in the trust and governance in place to demonstrate the impact to new developments, if BAU must be prioritised.

3.2.2.2 Administrative Leadership

Issues Identified
The involvement of Administrative Leadership in some of the planning could have been more consistent and in hindsight there should have been a dedicated administrative lead working alongside the CXIOs within the Programme team. The significant level of change for administrative staff using AlderC@re was not fully appreciated.

Lesson Learnt
The value of ensuring the administrative workforce is well represented on future phases of the AlderC@re Programme. Ensuring we take a more administrative focused approach to change management.

3.3 Go - Live

Directly after the cutover, this phase commenced when the new Expanse started to be used within Alder Hey. Go-live was split in two elements, the technical and business go-live.

Alder Hey Children's NHS Foundation Trust

3.3.1 Lessons Learnt – Successes

3.3.1.1 Command and Control

Project Success
The command centre located on the Mezzanine floor at Alder hey was effective with clear ownership of issues and decision making. The decision point calls were clear, inclusive, and organised. The setup was well-structured and at no point during go-live did it feel chaotic.

Factors that supported success
The command centre being based onsite and staffed 24/7. This setup was successful, with escalation and communication clear. Having the Emergency Preparedness team present ensured continuity throughout the go-live period.

3.3.1.2 Staff Support

Project Success
The pastoral support for colleagues was crucial providing hugs in mug, onsite ice cream and refreshments for staff during the cutover weekend. The support was well received and made a dramatic difference to the onsite teams.

Factors that supported success
Establishing a culture of caring and mutual respect is conducive to learning, staff need to be fit and well to be able to do their job and continually improve.

3.3.1.3 Multi-Disciplinary Team Working

Project Success
There was a huge sense of teamwork and pride taken by the teams involved. All teams stepped up to the challenge, they were visible and co-located and this allowed for true multi-disciplinary team working.

Factors that supported success
The visibility and co-location of teams was valued by colleagues and an approach to continue with this should be considered for the future.

3.3.2 Lessons Learnt - Areas for Improvement

3.3.2.1 Remote working - Programme Team

Issue Identified
The AlderC@re Project team were predominantly home based, improvements in the relationships between clinical teams onsite and offsite consultants could have been supported by creating more opportunities for collaborative face to face working during the programme and particularly to support go-live.

Lessons Learnt
In future deployments continue to champion close working between all disciplines: digital, clinical, and operational – hybrid working can be utilised to encourage engagement between programme and clinical staff.

3.3.2.2 Flex Buttons

Issues Identified
There were multiple issues with the flex button functionality at go-live preventing clinical users from using the click through to other systems, a number of issues were reported that were not identified during testing or end user training**.**

Lesson Learnt

Flex buttons rely on multiple systems, we do not have test environments for all systems accessed using the flex buttons. For future implementations we will work with suppliers to ensure they are able to provide test environments for all systems to allow end to end testing to take place.

3.4 Post Go – Live

During this period, onsite 24/7 support was in place, after one week this support was reduced. System issues were reported to the ServiceDesk and resolved appropriately or escalated to the appropriate person. The aim of this phase was to stabilise the system and move safely towards a business-as-usual model of support.

3.4.1 Lessons Learnt – Successes

3.4.1.1 Training Masterclasses

Project Success
The training masterclasses were well received, and more detail was quickly provided to help clinical and clerical colleagues to understand their workflows in more detail needed for their role.

Factors that supported success
Although training issues were encountered during the go-live, the CXIO team responded quickly to support staff, running daily training masterclasses on different subjects based on the feedback and themes received from Floorwalkers and the ServiceDesk.

3.4.1.2 ServiceDesk queues reduced quickly

Project Success
A blended service desk approach worked well (QR Codes for logging ServiceDesk, Floorwalkers, Mezzanine Support). Calls were logged into a central ServiceDesk queue before being assigned to the appropriate team and there was a clear escalation process to Meditech colleagues on site. This enabled ServiceDesk calls to be actioned without delay and resolved within the estimated time limits.

Factors that supported success
The blended approach was a success, this involved digital and clinical teams supporting to resolve issues logged on the ServiceDesk.

3.4.2 Lessons Learnt - Areas for Improvement

3.4.2.1 Limited Regression Testing

Issues Identified
In numerous workstreams there were cases where the supplier delivered a fix into the system which then had knock on effects on other parts of the system. This was linked to limitations in regression testing.

Lessons Learnt
Work with the supplier to ensure regression testing is more robust in the future. Have a more formal testing process before go-live, if possible, would also have an agreed testing prioritisation list.

3.4.2.2 Role Based Access Control

Issue Identified
The initial problems were pin related, as is typical for a go live. The subsequent problems were related to access (users not having the functionality they wanted or expected). In some cases, roles have been given expanded access until this can be crafted more carefully to bring the intended transformation. The access issues could be split into two main categories, the first being the understanding of what functionality each role has, and secondly issues around the copy of the users being a number of years out of date.

Lesson Learnt
Ensure the functionality required for each role is understood and signed-off by operational leads and ensure a recent copy of users is taken to ensure it is an accurate reflection of the current workforce.

3.4.1.3 Reporting

Issue Identified
There was no clearly defined and stable detailed data migration specifications provided by the supplier and not all systems had testing environments. This caused a number of issues within the reporting workstream including inaccurate PTL reporting and delays producing external submissions.

Lesson Learnt
For future implementations we will work with suppliers to ensure they are able to provide test environments for all systems and establish clearer data migration load information to support migration assurance allowing end to end testing to take place.

4 Summary

It is important as a programme that we not only do we capture the lessons learnt, but that we evaluate them so that we can apply these to future projects.

The above paper summarises some examples of excellent working practice which it is important are continued in future programmes of work, but also highlights some area of improvement, which are also important to apply learning onto future programmes.

A strength of the programme is the collaborative working which occurred between clinical/digital and operational teams. This enabled a significant amount of work to be completed within a short time frame and therefore, it is vital that this collaboration continues as we progress onto the next phase of the programme.

Whilst progressing into new phases we have already applied lessons learnt around programme and governance and this has been established ahead of the detail of the programme starting to ensure this is centre.

The lessons learnt have highlighted the importance of clear scoping of all elements of the impact of the developments and therefore, in future phases significant focus will be given to ensuring that timescales are correct and that detailed specifications from the supplier around re-build time for future phases are fully understood.

Alder Hey Children's Hospital NHS Trust

Alder Care EPR Programme

Digital System Support Post Go-Live Assurance Report
Version 0.3 (Draft)

14 March 2024

0189

Contents

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Post Go-Live Assurance

Scope

- Alder Hey implemented a new Electronic Patient Record (EPR) system in September 2023. This programme branded as Alder Care, replaced the legacy Meditech 6 EPR system with Meditech Expanse 2.1.
- This assurance exercise was commissioned by Alder Hey to provide the Trust with a view on the adoption of the new EPR solution which is in live use.
- The Post Go-Live assurance was undertaken by the Digital Support System (DSS) team in NHS England

Approach

- As part of this exercise, DSS spoke to a number of stakeholders in the trust who are using Meditech Expanse on a day-to-day basis. These included consultants, nurses and staff in an administrative role.
- Staff interviewed were across from a range of professions and divisions in the Trust.
- End user (i.e. staff operating the Alder Care system) feedback was solicited against the following themes
    1. Performance, Usability and Safety of the new system
    2. Experience during the Go-Live phase of the new system
- Feedback was also sought from the Information Technology division on the overall experience of supporting the Go-Live phase and post go-live support to end users

0191

Feedback on Performance, Usability and Safety

Description of this feedback theme

This theme relates to how the new system is performing against user expectation in terms of the speed of response from the system when undertaking their day-to-day tasks. As part of this discussion, end user were also asked to compare their experiences of using the previous system Meditech 6. The theme also explored if end users felt that the new system reduces the likelihood of risk to the patient.

What is working well

- General feedback was that the new system is quicker than the previous system
- Consensus is that the system is safe for patients
- Consultants indicated that having all the required information accessible on a single view greatly helps with their day-to-day tasks
- No episodes of system disruption such as frozen screens or prolonged duration of slow performance were highlighted.

What can be improved

- A shortcut offered (Flex Button) in the system which is seen as a very good feature and allows to quickly access information relevant to a patient is not working as consistently as expected. End users stated the need for this to be addressed on a priority basis
- Some users liked the ability to view information in two separate windows in Meditech 6. The process to access this in the web modules of the new system is different and some frustration was expressed by staff who felt that they would have preferred to have the ability to view the information in two windows as in the previous system.
- Some staff when asked felt that the driver for moving to a new system was because it was due for an “upgrade” as opposed to a means to transform ways of working in the Trust as per the vision of Alder Care.

0192

Staff experience during the Go-Live Phase

Description of this feedback theme

This theme to the staff experience in the lead up to the Go-Live of the new system and support provided in the initial weeks of Go-Live to enable staff to get familiar with the new ways of working

What worked well

- Staff generally stated that they were well informed about the events leading up to Go-Live e.g. training, roles and responsibility during the transition from old system to the new system and support that is available for them to access in the event of unforeseen issues.
- Training provided in the new ways of working was deemed to be largely adequate
- The Digital team provided “at the elbow” support during the initial days of Go-Live which the users felt was generally good and very responsive. Floorwalkers were positioned at all the areas of Go-Live and were very approachable if a staff member had a query or experienced issues
- The support provided by “Super Users” i.e. staff who had volunteered to champion the change and spent additional time to become “experts” in the new ways of working has been excellent

What could have been better

- During the switchover to the new system, unforeseen delays were experienced by the technical team. While end users acknowledged that all effort was put in by IT staff to address this delay, communication around the extent of the delay could have been better.
- The Trust secured additional staff from other NHS organisations to offer floorwalking support, who were very responsive in relaying the staff concerns to the Digital Command Centre and Super Users. However, being external staff, they did not have the in-depth knowledge to troubleshoot the actual issue. Staff understand it is a major undertaking but would have preferred a larger proportion of internal floorwalkers.
- Some staff also stated that they would have benefited for a more tailored training experience and this would have helped them get familiar with the new ways of working and the new system quicker

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Feedback from the Implementation Team

Description of this feedback theme

The new system was developed by the Digital Team working collaboratively with the various divisions in the Trust. This team is referred to as the Implementation Team in this report and comprises staff in technical, clinical, operations, corporate and leadership roles. This feedback is specifically from members of this team who were interviewed by DSS.

What worked well

- The multi-disciplinary working across the various divisions within the Trust was seen as a key enabler to a successful implementation of this major transformation project
- A blended team approach comprising of internal and external subject matter experts was also perceived as a positive.
- Good partnership with the system provider, MEDITECH UK was also acknowledged.
- The implementation team stated that they had good support from the Trust leadership team in this complex implementation journey.

What could have been better

- Being the first organisation to implement the product, Expanse, in a specialist care organisation, Alder Hey had a long discovery journey with the supplier MEDITECH. Some valuable lessons were learnt as is expected in these flagship programmes. These learnings will benefit future NHS organisations taking this product. However, it is felt that some technical discovery activities could have been initiated earlier to reduce the pressure on implementation teams, e.g. the implementation of the reporting solution and planning the duration of transfer of data from the old system to new system.
- The momentum and responsive to address urgent issues which was attained prior to the Go-Live has dropped since the new system was implemented and needs to be addressed.

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Recommendation #1 : Expanse Operational Forum

To maintain the user adoption journey and maximise the benefit from the new system, it is essential that urgent issues and enhancements be delivered in a timely manner.

It is recommended that the trust set up a fortnightly Post Go-Live operational forum with MEDITECH to discuss the following:

- Delivery of priority items required to improve the user experience on the new system
- Monitoring of clinical safety and prompt delivery of fixes for any issues deemed to have an impact on patient safety

This forum should consist of a technical lead, a clinical lead and an operations lead from the Trust. And similarly, from MEDITECH there should be a named technical lead and a clinical lead.

DSS can assist in the establishment of this Operational Forum.

By the end of the calendar year, it is anticipated that two more organisations in the region will implement the MEDITECH Expanse. Hence from a strategic point of view it is recommended that the operational forum is evolved to form a strong working group for all trusts who are live with this solution in the region.

Hence longer term, it is recommended that the Cheshire and Merseyside Integrated Care Board (ICB) lead this forum to drive optimisation of the solution across the region.

Recommendation #2 : Due diligence for future phases

A number of other NHS organisations will be implementing MEDITECH Expanse, but Alder Hey is likely to be the pioneering trust in their care setting for any new functionality they are planning to take in the future phases. This includes moving to a later version of the product, Expanse 2.2.

To leverage the learning from the Expanse 2.1 implementation, it is recommended that future phases be informed by robust due diligence exercises, in particular in understanding the technical process for enabling new functionality and upgrades.

DSS noted that the Trust has plans to develop a new data-warehouse to move to a more modern platform for their reporting solution. Scheduling of the new Datawarehouse project needs to be carefully considered alongside the uptake of new functionality in future phases of the MEDITECH Expanse programme.

DSS can provide inputs into this due diligence exercise if requested by the Trust.

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Overall impressions from Digital System Support (DSS)

- The NHSE Digital System Support team (previously TSSM) has been a long-standing assurance partner for Alder Hey in their journey to implementing a new EPR.
- DSS's primary objective has been to act as a "critical friend", working collaboratively with the trust on the known challenges, and raising new concerns based on our experience of working with many NHS organisations over several years.
- DSS have found the Alder Hey organisations openness and transparency to be exemplary throughout the engagement.
- An organisation acting as a first-of-type for a new product is required to do additional due diligence and preparation prior to implementation and DSS feel that Alder Hey have invested significant effort in this area.
- From an overall perspective, the DSS team recognised the excellent Digital and Clinical leadership throughout the implementation journey.
- The Trust's approach to Clinical Safety, recognising the paramount importance of this, was also noteworthy
- Also, commendable and noted by the DSS Team, was the Trust's approach to looking after staff and staff communications
- For the Go-Live itself, the command-and-control arrangements were well planned and executed.
- Alder Hey have invested time in undertaking a detailed lessons learnt from the implementation and continues to remain focussed towards the needs of the end user, whilst recognising the need to balance new needs, planned changes and improvements against current operational and cost pressures.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	Children and Young People's Gender Service (North): Programme Update
Report of:	Lisa Cooper, SRO Children and Young People's Gender Service (North)
Paper Prepared By:	Emily Gardner, Programme Director Children and Young People's Gender Service (North)

Purpose of Paper	Decision ☐ Assurance ☒ Information ☐ Regulation ☐
Summary / Supporting information	Previous Trust Board papers (2023 & 2024)
Action required	To Approve ☐ To Note ☒
Strategic context **This paper links to the following:**	Delivery of **outstanding care** ☒ **The best people** doing their best work ☒ Sustainability through **external partnerships** ☒ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource implications	

Does this relate to a risk? Yes ☒ No ☐

Risk Number	Risk Description	Score
132	Gender Service Capacity: There is a risk that clinical and/or contractual responsibility is held by Alder Hey prior to having adequate resource in place to deliver the agreed CYP Gender Service.	16
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	16
167	Risk that the new location for the Gender Service will not be ready for seeing patients by the service start date	10
168	Children and young people using the gender service are expected to only be able to access a medical pathway if they consent to taking part in a research trial.	12

1. Purpose of report

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

2. Background

The Gender Identity Development Service (GIDS) was commissioned by NHS England and provided by Tavistock and Portman NHS Foundation Trust, for children and young people who experience difficulties in the development of their gender identity. The service closed on 31 March 2024.

In 2020, NHS England commissioned Dr Hilary Cass to review gender identity services for children and young people, because of several factors including significant increased demand; long waiting times and lack of evidence to support clinical decision making. In July 2022, in a letter to NHS England, Dr Cass recommended that the new regional centres for the re-named Gender Development Service (GDS) are led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services. Alder Hey Children's NHS FT and Royal Manchester Children's Hospital (MFT) have developed the GDS North Hub. Great Ormond Street Hospital for Children NHS FT (GOSH), Evelina London Children's Hospital (GSST) and South London and Maudsley NHS FT have formed the South Hub. Both Hubs are jointly known as the Phase 1 Providers.

The updated interim service specification has been released. The final service specification is due to be released following the publication of the final report from the Cass Review, which is now expected in April 2024.

3. Summary of progress

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

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

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

4. Estates

Renovation works continue at premises in Warrington, and the project is on track for the service to take occupation from mid-May 2024. This revised date is due to the issue with fire stopping, as updated to Trust Board in March 2024 and no further delays have been reported. In the interim the service will operate from Alder Hey and Manchester sites until the move to Warrington.

5. Workforce and Recruitment

Recruitment has continued with a focus on clinical roles which has been successful and there is a robust plan in place to support the induction of all staff into the service and Alder Hey. Staff

will be commencing employment throughout April - June. To date the service has appointed 31.3wte staff with an additional 15wte equivalent scheduled to be interviewed in April – May 2024.

6. Open Case Load

Prior to the closure of the previous service provider on 31 March 2024, the service received additional files and documents relating to the children and young people who have now transferred to the North service. This included 6 additional children and young people, giving a total of 110 children and young people who transferred as the open caseload to the North service. The service continues to work with NHS England and staff at the previous provider to ensure that all relevant documents have been received.

All children and young people transferred as the open caseload have been triage by the North clinical team to ensure appointments are booked appropriately. Welcome letters and information have been sent to children and young people on the open caseload and appointments have commenced booking, with the first appointments being undertaken w/c 08 April 2024. The service remains committed to ensuring all children and young people within the open caseload have an appointment within Quarter 1.

7. Finance and Contracting

The North and South hubs have worked together, with legal support, to develop a legally binding side letter, to sit alongside the contract. The side letter has been agreed by NHS England and will ensure protection for the Trusts ahead of the contract being agreed.

8. Regulation

Alder Hey has submitted documentation to the CQC to ensure that the premises in Warrington are sufficiently registered, there are currently no known risks in relation to this.

9. Recommendations

It is recommended that Trust Board note the commencement of Phase 1 of the Children and Young People’s Gender Service (North).

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	**Liverpool Neonatal Partnership Governance Review – Update and Position Paper**
Report of:	**Chief Medical Officer**
Paper Prepared by:	Director of Corporate Affairs

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

BOARD OF DIRECTORS

Liverpool Neonatal Partnership Governance Review – Update and position paper

The purpose of this paper is to :-

1) Outline to the board the present governance and assurance arrangements that exist for the LNP

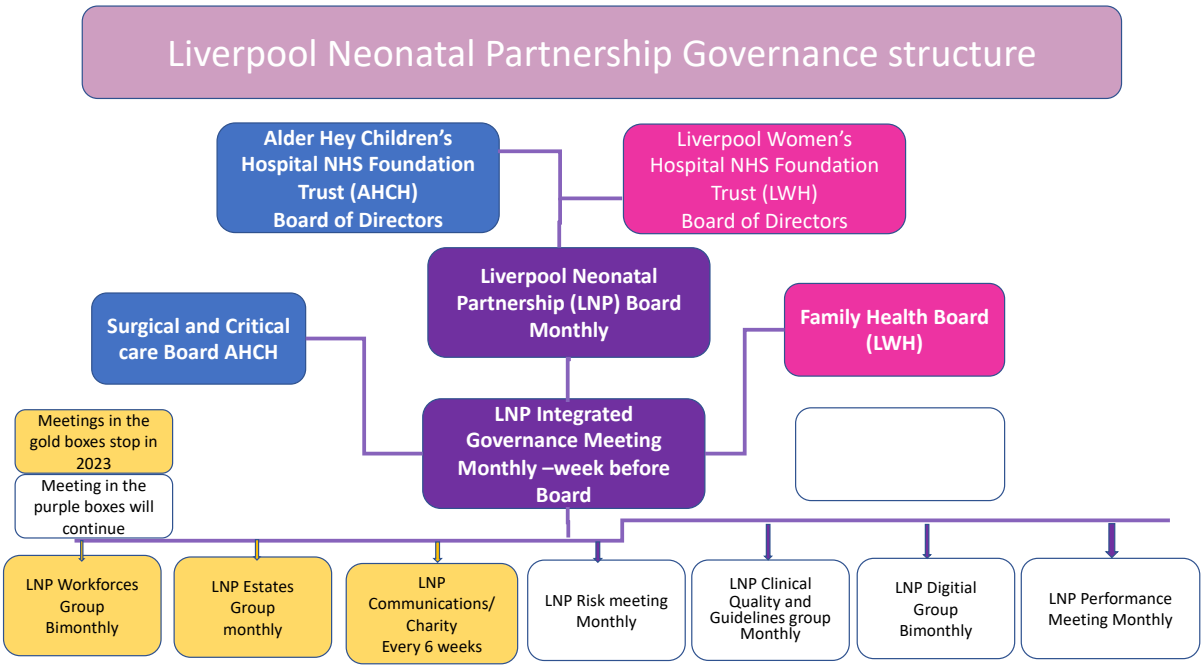
2) Propose a review of the assurance report to ensure robust oversight at both Trust boards

3) Propose an enhancement to the reporting structure that will strengthen assurance across the Partnership.

Neonatal governance

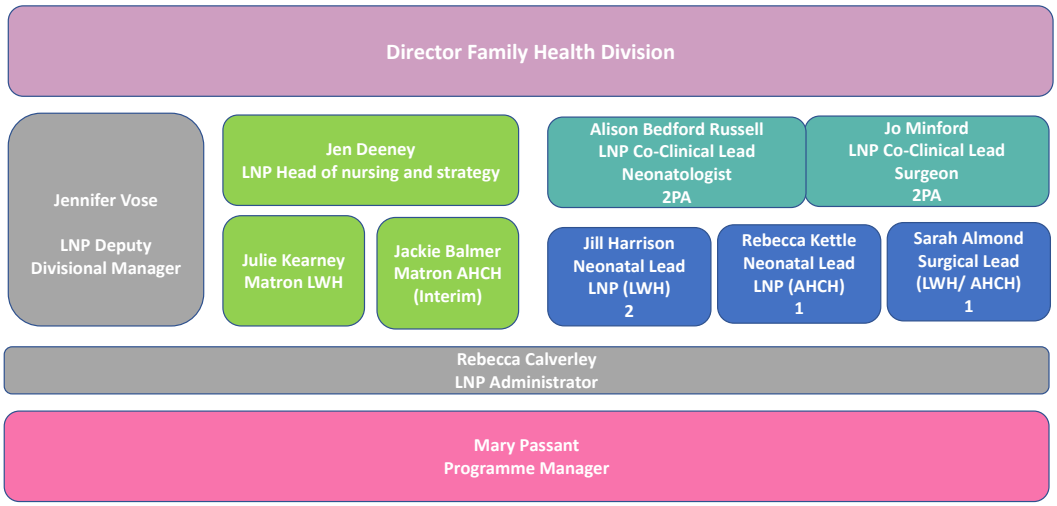
Construction of the new Surgical Neonatal Unit on the Alder Hey site is underway and the LNP is maturing and evolving as a partnership. The delivery of both the single service and current 'business as usual ' are overseen through the Partnership Board which is presently jointly chaired by the Medical Directors from Alder Hey and LWH.

The governance process was established in 2021 and is reported to the LNP board and consequently into both trusts as outlined:



The present management structure that oversees the development of the LNP and its day-to-day operation is outlined below.

LNP Reporting Structure



The partnership is maturing and as the two sites develop, they are merging into a single service that reports into the two trust boards. Neonatal and maternity services have been, and are the subject of a number of national reviews and considerable external scrutiny. In addition, PSIRF has also recently been introduced which provides an entirely new framework for the response to safety issues with learning at its heart.

Consequently it is appropriate and timely to review the content of reporting and the governance structure of the partnership so that it will provide both boards equal oversight of the totality of activity and safety issues involving the delivery of neonatal services in Liverpool.

A working group led by Jen Deeney, has been established and is developing a new comprehensive governance report that will be scrutinised by the LNP board and submitted to each trust board for oversight and assurance.

Proposal for board consideration

Various reviews of maternity and neonatal services have concluded that there should be much closer scrutiny at board level of provider organisations. Guidance has suggested that the board should receive a quarterly report and that a lead non-executive director should be assigned to oversee these services.

The proposal considers these recommendations.

1. Develop a single LNP integrated governance report that will go to both boards this should include all aspects of governance including risk, incidents, complaints, and performance criteria relevant to each service as required by national guidance, for example *Every Baby Counts*.

2. Align and understand the terminology and metrics by which neonatal outcomes are reported nationally and the associated improvement plans where they are in place.

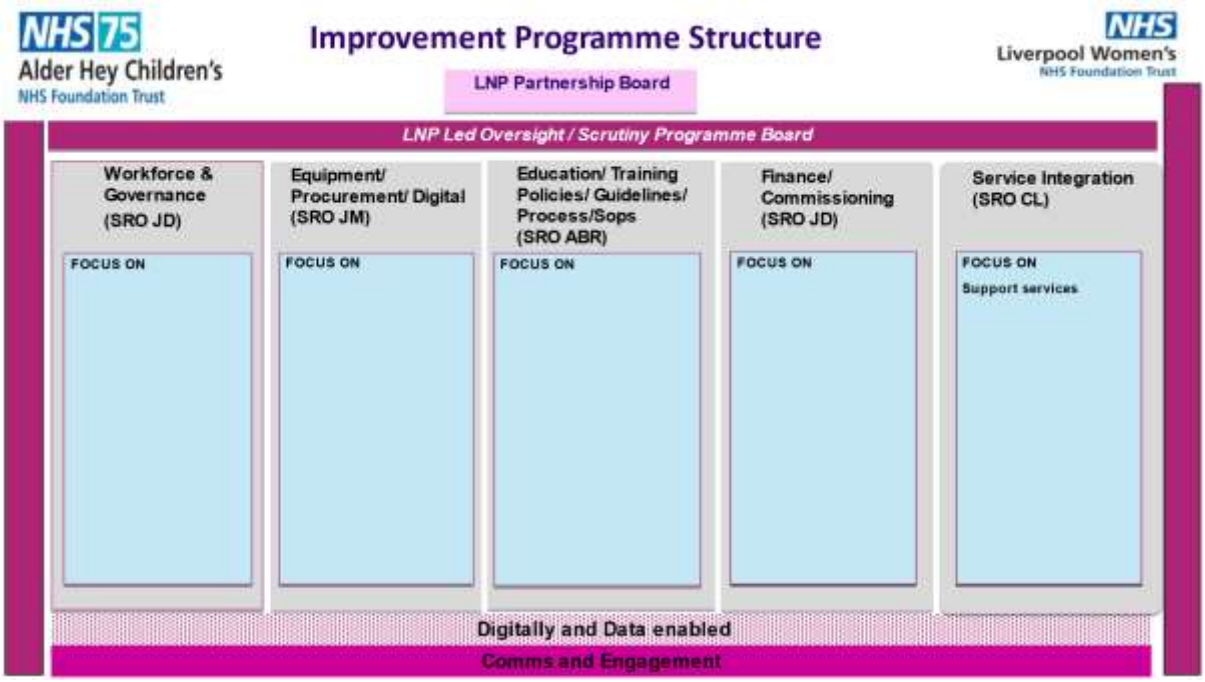
3. Incorporate Neonatal mortality explicitly into our mortality report (see appendix 2)

4. Redefine how the LNP report escalates through the trust assurance committee structure to board.

5. Ensure robust Board oversight of LNP governance on a quarterly basis.

6. Identify a lead NED to be allocated to oversee the LNP for additional assurance and oversight.

A workshop between the two trusts was held on 8th January 2024 to scope this and to refresh the delivery of the LNP in anticipation of the new build opening in the Autumn of 2025. This resulted in a redefined set of workstreams with designated SRO's, which is structured as outlined below.



Internal meetings are planned to develop both the content of and how the report will flow to both boards resulting in a standardised shared single version of the truth for both organisations.

Recommendations

The Board is asked to:

- Note the content of this update.
- Support the planned review of the governance report and associated reporting structure
- Indicate preferred frequency for further updates as to progress.

Alfie Bass
April 2024

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	**Children's Hospital Alliance End-year Report; 2023/24 and Workstreams for 2024/25**
Report of:	**Children's Hospital Alliance**
Paper Prepared by:	Children's Hospital Alliance

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

NHS
Children's Hospital Alliance
A Partnership for Child Health

Children's Hospital Alliance

End-year Report 2023-24 & Workstreams for 2024-25

Trust Boards, March 2024

Summary

0206

- Over the last 12 months, the Children's Hospital Alliance has supported a larger number of workstrands than ever before.
- **We have raised the profile of CYP at national level**, e.g. through shaping the approach to Martha's Rule, contributing to national policy on outpatients, and engaging with politicians of all parties in the run up to a General Election;
- **We have developed a collaborative approach to shared challenges**: providing personalised briefing for Trusts on the impacts of specialised commissioning, developing options for mutual aid
- **We have shared intelligence across Trusts**: we provide weekly updates from national policy meetings with NHSE, and Trusts have shared information on financial, clinical and operational issues including the real impact of strike action, and CIP opportunities between Directors of Finance
- **Clinical and operational staff have learned from each other** across clinical services: we have showcased good practice around theatres productivity, reducing was not brought rates, tackling health inequalities
- **We have delivered major programmes rolled out across multiple Trusts.** We have supported 4 Trusts in successful bids for ICB funding for virtual wards, and are bidding for funding for the other Trust; we have worked together to provide meals to >10,000 families of patients on our sites.

0207 Feedback

"to **learn** from other organisations is so valuable"

"TO KNOW YOU'RE **NOT ON YOUR OWN**"

"the work of the CHA is incredible and **really powerful**"

"**Data** is really rich and of a very high quality"

"You have **really added value**"

"an incredibly helpful platform to share with our **peers**"

"we are so strong when we **work jointly**"

"**really rich learning**"

"the **networking** is PRICELESS"

"the **advocacy** helps us to get into places I didn't even know existed"

"WE'RE **NOT ALONE**"

"has really put a rocket under our **research**"

"**data packs** have been enormously helpful"

"**collective** power that individually you don't have"

"**raising the voices of children** in a larger organisation"

Evelina London · Oxford University Hospitals NHS Foundation Trust · Sheffield Children's NHS Foundation Trust · Great Ormond Street Hospital for Children NHS Foundation Trust · Alder Hey Children's NHS Foundation Trust · Bristol Royal Hospital For Children · Manchester University NHS Foundation Trust · Leeds Children's Hospital · Southampton Children's Hospital · Birmingham Women's and Children's NHS Foundation Trust · The Great North Children's Hospital · Nottingham Children's Hospital

The power of shared working

Children's Hospital Alliance

VISIBILITY

We made compelling arguments, underpinned by data and frontline insights, for better attention to children's health in national policy, delivering content for national strategies (including UEC and outpatients); putting paediatrics onto the radar of the Opposition in the run up to a General Election; and targeting a wide range of influential groups & individuals.

SUPPORT

Member Trusts have used the analysis we supply to raise awareness of children's issues within their own Trusts, and have successfully made the case to their Boards for more resources for CYP

NEGOTIATION

Trusts have used the personalised analysis and briefing that we have provided with their ICBs, both to negotiate business planning and to educate them around the implications of specialised commissioning

SHARING

Clinicians and operational colleagues from across dozens of services and areas have generously shared their expertise and knowledge. Collaborations have sprung up organically between groups of Trusts, as colleagues have supported each other across organisational boundaries.

Our workstreams

Our work streams

0211 Innovation

Research and Innovation

- **The AI Was Not Brought programme completed in July 2023.**
  - WNB rates amongst the most at risk children fell from 68% to 16%
  - As the Fast Follower site, Sheffield Children's continues to work with Alder Hey Innovation on a commercial model that will be made available to the whole NHS.

- **CHA is advocating for Paediatric Virtual Wards** with the centre and ICBs.
  - **4 Trusts have successfully used work** developed for the original 2022 business case to argue for ICB funding for paediatric virtual wards
  - **The CHA PMO is working with the trust Charity CEOs** to develop a shared business case for funding from NHS Charities together, whose next call is focused on CYP. If successful, even Trusts without ICB funding will have seed funding to proceed, and we will develop a consistent national paediatric Virtual Wards programme.
  - **The Virtual Wards Steering Group** is sharing best practice and experience between those Trusts who are running or planning VWs.

Research

0212

Research and Innovation

- **We set up a new work strand of research collaboration** across CHA members.
- **The aim is to use the scale and scope** of the patient population and the data available across the CHA Trusts to strengthen research and open up new potential for collaborations.
- **Researchers from each Trust have been working on developing joint research bids** for NIHR's Child Health Programme Development Grant. The CHA sourced collaborators across CHA Trusts to be active contributors towards these projects.
- **This has been overseen by a regular Oversight Group** bringing together the research leads from each Trust, to explore potential submissions
- **The CHA supported 3 bid submissions to the Child Health round 1 in January 24 and will support up to 8 more** for round 2 in May 24:

Mental health	Innovative tools and methods for longitudinal research into mental wellbeing and health among young people (submitted Jan 24)	Paul Patterson, Birmingham; 3 CHA Trusts involved
	Integrated Paediatric Eating Disorder Network	Nadia Ranceva, Alder Hey
	Evaluating low intensity psychological interventions	Steve Jones, Sheffield
	Effects of prolonged hospitalisation beyond the neonatal period	Emily Hoyle/Hannah Brophy, Alder Hey
Neuro-diversity and disability	Functional Neurological Disorders in children (submitted Jan 24)	Ashley Liew, Evelina; 7 CHA Trusts involved
	Assessing interventions for children with neurodiversity and disability	Evangeline Wassmer, Birmingham
	Codesigning an organisational toolkit to ensure safe, equitable health and social care for neurodivergent CYP and/or those with LD	Kate Oulton, GOSH
Inequalities / other	Establishing linkages between the Local Health Care records with the National Pupil Database (NPD) to address inequalities in childhood illness (submitted Jan 24)	Shruti Garg, Manchester; 4 Trusts involved
	Social prescribing for children with complex chronic health conditions and their families	Anna Basu, Newcastle
	Improving Child Health: Health Systems Research to Inform Policy	Ingrid Wolfe, Evelina
	A programme to scope the variation in paediatric healthcare capacity across England	Robin Marlow, Bristol

Shared responses to clinical challenges

Transforming Services

- **High cost drugs:**
  - the CHA convened a workshop of chief pharmacists to identify the frontline challenges and ethical dilemmas from a clinical and pharmacy perspective
  - This delivered an article for publication; we are now gathering data and identifying shared solutions.

- **Martha's Rule:**
  - The CHA contributed to the development of national policy on Martha's Rule. A data collection across Trusts helped NHSE to understand the realities of existing services; and representatives from some CHA Trusts participated in the workshops to develop the policy proposals

- **Mutual aid:**
  - The NHSE mutual aid tool was not felt to be sufficient. We engaged with our members and set up communications channels between clusters of Trusts, and devised an interactive tool to support conversations between providers.
  - Four cluster meetings took place Oct-Nov2023, and were both an opportunity for shared learning and to devise practical strategies for mutual aid.

Shared learning

Transforming services

- Some events were cancelled due to industrial action; the following went ahead:

Operational/clinical shared learning sessions

- **Improving theatre productivity: High Intensity Theatres**
  - 26.4.2023.
  - 3 presenters;
  - 29 attendees from 9 member Trusts
- **Virtual wards**
  - 04.07.23.
  - 5 presenters,
  - 30 attendees from 9 member Trusts
- **Innovation in Outpatients**
  - 26.09.23.
  - 3 Presenters
  - 20 attendees from 9 member Trusts.

Workshops:

- **High cost drugs**
  - 20 attendees from 7 member Trusts
- **Outpatients strategy**
  - 3 workshops with c. 30 attendees

Showcase events:

- **Reducing Was Not Brought rates using the AI tool:**
  - 14 presenters running 4 breakout sessions;
  - 45 attendees from 13 member Trusts

Visits:

- CEO visit to Leeds
- PMO visits with shared best practice:
  - Alder Hey, Birmingham, Leeds, Newcastle

Elective recovery: CHART

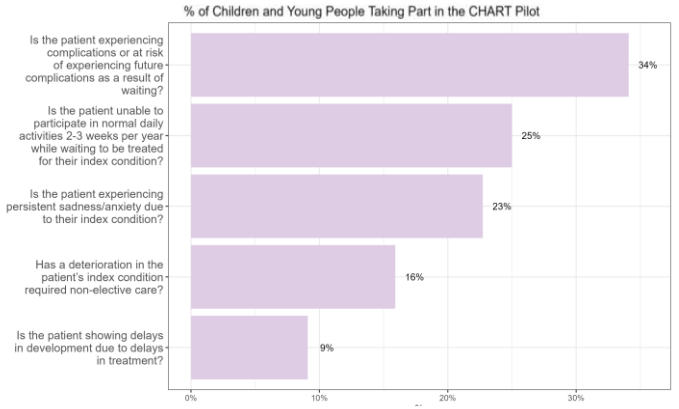
Transforming Services

Challenge

- The current national ‘P’ system assessing risk of mortality and time waited does not adequately capture the impact of prolonged waits on children. To address this, the CHA worked with clinicians to develop the Children’s Hospital Alliance Risk Tool (CHART). It uses a 5-question questionnaire to capture holistic risk to patients on waiting lists.

Results

- In the pilot with 100 patients, 34% of participants are or are at risk of experiencing complications.
- Patients could be successfully differentiated into risk categories by their number of ‘Yes’ responses.



Pilot data showed 32% of P2 patients are at serious risk of being impacted long-term as a result of continued waiting – CHART captures this risk.

CHART provides an evidence base for more effective and granular elective prioritisation, and a more accurate measure of P2 demand.

Next steps

- **We have engaged with NHSE** on how CHART could be implemented alongside the P prioritisation system and they are looking at funding it next year
- **Trusts within the CHA and wider** including Norfolk and Waveney ICS are implementing CHART to better manage CYP waiting lists.

0216 Sophie's legacy: feeding families in hospital

Health Inequalities

"I am a single low-wage parent in for an extended stay, and I am so grateful for these meals. They have taken the financial strain off our stay" – Sheffield parent

- **The CHA was awarded £90k from NHS England** to develop learning around feeding resident parents or caregivers.
- **More than 10,000 meals or vouchers went to families who needed them**
  - Each pilot site was given £10k, to offer free/subsidised meals for resident parents and carers during their child's hospital stay
  - CHA trusts collaborated with the NHSE Food Provision group to test various approaches to reduce financial stress and improve the well-being of parents and caregivers.
  - 182 surveys from patients, caregivers and staff showed significant improvement in the well-being of caregivers, as well as helping staff to ensure compassion is central to care and reducing stigma in the health inequalities interventions.

Trust	Delivered
Alder Hey	Approximately **600 meals** in the first four weeks, the scheme ran for **12 weeks**.
Birmingham	Funding supported approximately **402 vouchers to 58 parents**
Bristol	The pilot supported **341 parents' interventions** for **three months.**
GOSH	GOSH served **2601 parent/carer meals** over their **4-month scheme**
Manchester	One voucher per parent of a paediatric in-patient admission was offered during **20 weeks** on two wards, giving **2,622 vouchers issued with 1,059 used.**
Leeds	Approximately **400 vouchers** meals per month, and the scheme ran for **12 weeks**.
Newcastle	Throughout our three-week project. Providing **a total of 2,396 meals,** 1,210 lunches and 1,186 evening meals
Southampton	**280 additional carers received vouchers** in the 2-month pilot
Sheffield	**91 meals within four weeks**

Children's Hospitals Inequalities Research Project (CHIRP)

0217

Health Inequalities

The CHA allocated £100k in 2021 for research on how children's hospitals view their responsibility to reduce socioeconomic health inequalities:

- **Lancaster University** conducted the Children's Hospitals Inequalities Research Project (CHIRP)

Research approach:

- **Nine CHA trusts participated in the research which used a mixed-methods research design and data** from three sources to produce paediatric-specific research and outputs:
  1. A scoping review of grey literature **https://bmjopen.bmj.com/content/14/1/e079744.abstract**
  2. Review of policy and strategy documents from CHA trusts.
  3. Interview and focus group data with staff members across the sites.
- **Additional articles being developed** in collaboration with BMJ Open and the American Academy of Paediatrics journal, further building on a compelling body of evidence. Further articles will be uploaded to the CHA website.

Results:

- **The research has provided a benchmark of how Trusts are currently tackling health inequalities and identified recommendations** for future work: well-being hubs, poverty-proofing services, co-production, and accessible communication
- **Trusts shared best practice** and each Trust received 1:1 feedback from the research team on how they could develop their approach.
- **Feedback from Directors of Nursing** was very positive

0218

Analysis of specialised commissioning

Insight and Metrics

Background

- NHSE set in motion a novel delegation of Specialised Commissioning to ICBs, initially set to take place in April 2024 and later postponed to April 2025. As approx. 65% of all specialised Paediatric activity is carried out at CHA Trusts, this policy had significant material impacts on our members.

Analysis and advocacy

- We undertook analysis to understand risks, coordinate expertise and advocate. Initially, we conducted an ad-hoc data collection and analysis of specialised finance flows. This, together with central data from our GIRFT agreements, led us to quantify impacts of SpecComm delegation on each member Trust and their patients. Our analysis included benchmarking of the volume of patients affected, down to the number of individual ICB contracts members would need to undertake with the new policy.
- By bringing together Finance leads from member Trusts, we gathered their views and concerns on the upcoming changes, and we devised a series of mitigations to meaningfully engage in conversations with NHSE.

Outcome

- We engaged with NHSE's SpecComm team and discussed our members' concerns. The team were receptive to providers' concerns and agreed to introduce a series of mitigations to the policy. They also asked us to coordinate the provision of a list of high-risk pathways unlikely to be fit for delegation, which is being fed into national policy making.

0219

Policy and Advocacy at national level

Policy and Advocacy

- **CHA policy messaging has been used by trust leaders in discussions with a wide range of NHS influencers** including the NHSE CEO, CFO and Chair; the Secretary of State for Health, the Leader of the Opposition and the Shadow Health Secretary.
- **CHA calls to action** resulted in greater CYP input at national events. For example, a series of bespoke CHA workshops developed a set of recommendations to share with NHSE for the Outpatients Strategy.
- **CHA PMO colleagues regularly shared policy and member insights** with the CYP Transformation Team; the RCPCH; and the Prime Minister's Delivery Unit and spoke at a range of conferences to spread the word.
- **We worked with a range of strategic partners** to amplify our messaging, including powerful all-age lobbying/influencing groups such as NHS Providers, the Federation of Specialist Hospitals and the European Children's Hospitals Organisation and the King's Fund.

0220

Engaging with our members

Comms & member engagement

- **We have shared regular intelligence** on national issues, such as weekly updates on NHSE meetings and briefings on relevant policy papers or political issues
- **We ran a range of peer-to-peer groups** to support learning and sharing. These groups have led to significant sharing of information e.g. sharing of CIP plans between Trusts
- **We shaped and delivered our work programme** in partnership with our governance and leadership groups
- **We supported new groups** including lead AHPs and quality leads in finding each other
- **We expanded our community**, welcoming new members (Nottingham, Cardiff) and have opening discussions with more.

0221

Work Programme for 2024-25

Children's Hospital Alliance

Evelina London
NHS Oxford University Hospitals NHS Foundation Trust
NHS Sheffield Children's NHS FoundationTrust
NHS Great Ormond Street Hospital for Children NHS Foundation Trust
NHS Alder Hey Children's NHS FoundationTrust
Bristol Royal Hospital For Children
NHS Manchester University NHS FoundationTrust
leeds children's hospital
Southampton Children's Hospital
NHS Birmingham Women's and Children's NHS Foundation Trust
The great north Children's Hospital
Nottingham Children's Hospital

In 2024-25 we will focus on the priority areas identified by our member Trusts

0222

- Quarterly benchmarking
- Deep dives to support other workstreams

- Building research network
- Collaborative bids
- Develop innovation testbed
- Virtual wards

- Associate member offer
- Develop website
- Shared learning incl support for UAE Field Hospital,Gaza

- Fragile services
- Neurodisability
- Mental health
- Palliative care

- Engagement ahead of the General Election
- Advocacy on CHA workstreams

- High cost drugs
- Transition

These will be spread over the next 12 months

0223

	April – June 2024	July – Sept 2024	Oct – Dec 2024	Jan – March 2025
Core projects	• Fragile services incl. PICU, pathology	• Neurodisability	• Mental health	• [To be confirmed post-election]
Shared learning	• Reducing GA use • Support for UAE Field Hospital,Gaza	• Transition • Palliative care	• MH support in hospitals	
Insights & metrics	Quarterly benchmarking: waiting lists, PICU, bed capacity			
	• Community data • ADHD drugs • FS incl. PICU	• Palliative care • Transition • High cost drugs	• Mental health data	• [To be confirmed post-election]
Policy and advocacy	• ADHD drugs • Community data • Pre-election briefing	• [Purdah]	• Resources for CYP	• [To be confirmed post-election]
Innovation	• Virtual wards • Innovation test bed / InSites			
Research	• Joint applications for grants • Quarterly sharing sessions on research			
Comms and member services	• Associate member offer • Website	• Developing reporting to Boards	• Analysis of election implications	• [To be confirmed post-election]

And we will provide regular support for our members

0224

Children's Hospital Alliance

Resources and updates

- **Board reports & member newsletters** 2 x per year
- **Website**: Quarterly updates, with shared resources, case studies and SOPs
- **Ad hoc support** to answer member questions & connect Trusts with each other
- **Quarterly benchmarking** of core paediatric data between peers

Face to face meetings

- **Annual conference** and six monthly meetings of CEOs, Steering Group, clinicians
- **PMO site visits** bimonthly to all Trusts in rotation

Regular meetings

- **Monthly**: Clinical Reference Group, Innovation, Directors of Finance
- **Bimonthly**: Steering Group, Working groups, Shared learning sessions
- **Quarterly**: Research leads, Comms leads
- **Six monthly**: CEO and Partnership Board meetings
- **Ad hoc:** engagement with self-directed groups eg AHPs, Chief Pharmacists

Stakeholder engagement

- **Partnership Board** meetings with key stakeholders: NHSE, RCPCH etc
- **NHSE**: weekly meetings, with updates to all Trusts
- **No. 10**: Monthly meetings with Delivery Unit Group
- **Ad hoc**: collaboration with King's Fund, RCPCH, Health Foundation, NHS Providers
- **Policy statements** on advocacy topics
- **Expand membership**: Cambridge; associate members incl. Glasgow, Belfast

To all of our partners and collaborators -

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

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

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

Does this relate to a risk? Yes ☑ No ☐

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

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

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

0227 **1. Executive Summary**

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

2. Current Position

2.1 Workforce Metrics

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

Key highlights from the workforce metric data:

Sickness at 5.39% is below the Trust target of 5.5% and has decreased since the reported January 2024 position. Sickness absence is largely driven by long term sickness absence at 3.3% with 2% Short Term sickness absence. Divisional HR Business Partners are supporting divisions to ensure that there are action plans in place to support all staff on long term sickness. HR Advisors are currently undertaking a detailed review of areas of high sickness, identifying correlations with low levels of Return-to-work compliance and Occupational Health DNAs to explore bespoke interventions to improve the position.

Turnover at 10.7% has reduced month on month consecutively and below the Trust's annual target of 13%. Retention initiatives are proving successful in reducing high levels of turnover.

Personal Development Reviews (PDR's) PDR compliance remains an area of concern; the PDR window has been extended to 30th April 2024, to support completion of quality appraisals. Following a sizeable reduction in January, medical appraisal completion has seen a significant move in February back towards the target and more typically reported compliance level (above target).

There is a focus on PDR completion with weekly reporting available to support and monitor plans to complete required appraisals.

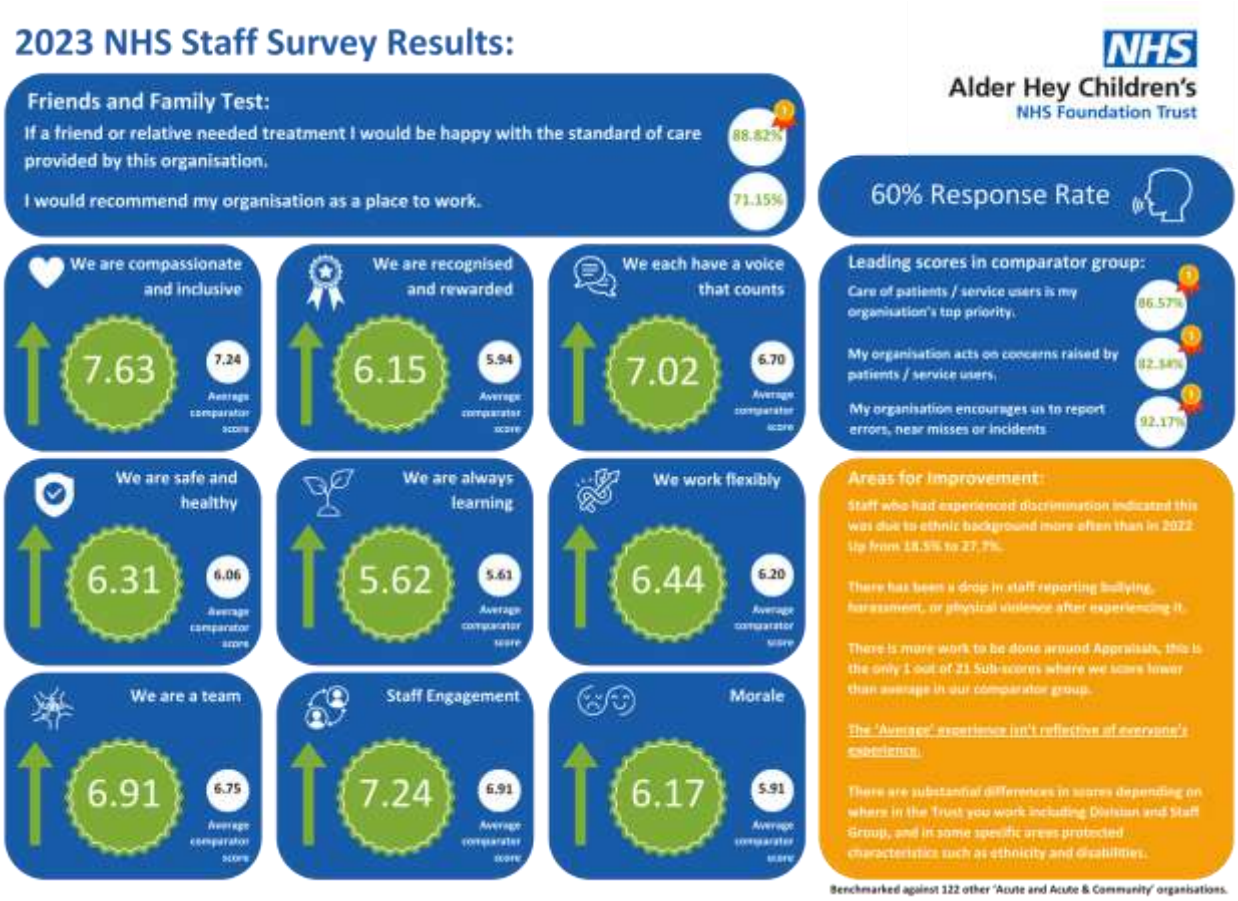
2.2 Industrial Action

A **new pay offer** has been negotiated between the Government and BMA **Consultant** Committee which the BMA are recommending to members. The offer has been put the members, the referendum is open until 3rd April 2024. The main changes from the previous offer are additional pay for consultants with between 4 & 7 years' experience, changes to the pay review body, and removal of proposed changes to Supporting Professional Activities (SPA) time.

A pay offer was put to BMA **SAS doctor** colleagues from 29th January - 28th February 2024; this **offer has been rejected**. The SAS committee have indicated that they will enter discussions with the Government about another pay offer ahead of calling for strike action (which they have a mandate for).

0228While no further strike dates from **junior doctors** have been announced, further strike action is expected. The BMA **successfully re-balloted** junior doctor members (ballot closed 20th March 2024). 61.86% of those eligible voted in the ballot, with 97.97% voting in favour of strike action, and 97.08% voting in favour of action short of strike. The BMA have not yet indicated what action short of strike might be taken if successful. Junior doctors employed in Wales have further strike planned from 7am on Tuesday 16 April for two days; there are 5 junior doctors on rotation to Alder Hey from the Welsh Deanery.

2.3 Staff Survey



The results of the 2023 National NHS Staff Survey are now available for all to see on the internet including each Trust's individual results and their results against their comparator group, for Alder Hey this is Acute & Acute and Community and included 122 other organisations.

Some highlights of the results for Alder Hey include:

- Compared to 2022, our scores improved in every one of the People Promises (7), Themes (2) and Sub-Scores (22).
- Our scores for all People Promises, Themes and 21 of the 22 Sub-scores were higher than the average for our comparator group.
- We were ranked number 1 nationally in our comparator group for 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' with 88.82% of respondents agreeing with the statement.

The areas that we will be looking to improve are:

- Reaching more staff, so we can ensure that all voices are heard.

0229- Improving the experience for all staff across the Trust, we can see from the results that there is a difference in experience dependant on division and staff group as well as in specific areas protected characteristics such as ethnicity and disabilities.
- Appraisals are the 1 sub-score that we are currently below average for our comparator group, despite some big improvements this year.
- There has been a drop in the likelihood of reporting from those staff who unfortunately experience bullying, harassment or physical violence whilst at work.
- Those staff who unfortunately experienced discrimination have stated that ethnic background is a more common reason for this than in 2022.

Big Conversation packs are currently being produced and issued to Divisions and Departments throughout April with Big Conversations expected to take place April - June 2024. These conversations provide the opportunity for teams to discuss their own results in more detail, celebrate their accomplishments and identify areas for improvement that the team can work on throughout 2024.

2.4 Organisational Health and Wellbeing

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

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

3 Conclusion and next steps

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

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

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

1. Introduction

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

2. Equality, Delivery System 2022 (EDS22)

. The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports organisations in England – in active conversations with patients, the public, staff, staff networks, community groups, and trade unions – to review and develop their approach to addressing health inequalities through three domains:

- Services,
- Workforce,
- Inclusive leadership.

The EDS22 was implemented for the first time at the Trust this year. We engaged with key stakeholders throughout the year to ensure a range of support and guidance to effectively implement EDS22. The EDS22 report was published in March 2024. The process will commence again in early 2024, with early engagement.

3. Learning and Development

Alder Hey is dedicated to creating a positive learning experience for our staff ensuring the provision of inclusive training, learning and development. Our staff networks have provided insight and feedback into the limitations of the current EDI training offer. This enabled collaborative working with the Learning and Development team and our staff networks to develop a more robust, comprehensive training offer which will be delivered to managers, providing them with information and tools to enhance the support they provide to staff. Online training resources have also been acquired which will complement existing programmes. We will continue to consider the needs of our staff, monitoring current training and increasing the EDI learning and development offer. In March 2024, a new series of Lunch and Learn sessions was launched, designed to help educate and expand knowledge, connections and understanding for all staff. Delivered via Microsoft Teams on different days of the week, but always during lunchtime the sessions focus on a range of different topics, including Ramadan, Pride, Autism, Mental Health awareness and more. The sessions are an opportunity for staff to enjoy their lunch and at the same time learn

something new. Our first session focused on Ramadan and the Imam from Manchester Foundation Trust joined the session to provide information and insight into the holy month of Ramadan.

4. Iftar Celebration

The Spiritual Care Team and our Muslim Doctors hosted a Ramadan Iftar Buffet in the Sanctuary, supported by many colleagues, children, young people, and their families. The celebration event took place at sunset, and we came together to break the fast during Ramadan. It was well attended, and we were joined by members of the executive team. It was a special way to share the spirit of Ramadan. The local Imam attended to support and provide prayers and break the fast.

5. Staff Networks

Our fantastic developing staff networks are growing from strength to strength and have been welcomed by our workforce.

- The **LGBTQIA+ staff network** continues to support the Head of EDI in implementing the recommendations from the Navajo assessment. The network has developed an Allyship training programme which they have delivered to the Finance team. The programme is aimed at providing staff with an understanding of Allyship and how they can actively support the staff network by becoming an Ally. The network members are also supporting the Learning and Development team to create lived experience videos which will support and complement manager training. Plans for Liverpool PRIDE which will take place in June 2024, are already underway.
- The **REACH staff network** continues to make positive changes. The network chair has recently left the Trust to take on a new role. We want to thank her for all her hard work and commitment whilst in the post. We have recently asked for Expressions of Interest from staff who are interested in taking on the role of REACH Network Chair. Our deputy chair, Raji Thomas remains in post and will continue to support the REACH network.
- The **Armed Forces staff network** is engaging with the local Armed Forces community and will be holding a series of events to mark this occasion. They are also organising a coffee morning to encourage any armed forces children,

young people, and their families to come together in a safe space with others from armed forces backgrounds. They continue to work with the local community cadets and will be inviting them to attend our Remembrance service later this year.

- The **ACE Disabilities and Long-Term Conditions staff network** continues to grow. The meetings continue to be extremely positive generating ideas to make Alder Hey a great place to work. The group have recently been working with the Head of Facilities to provide insight into the Alder Hey environment, identifying ways of improving facilities which will not only benefit our staff but also our children and young people.

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

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 24th January 2024
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director **(Chair)**	(FM)
	Fiona Beveridge	Non-Executive Director	(FB)
	Adam Bateman	Chief Operating Officer	(AB)
	Garth Dallas	Non-Executive Director	(GD)
	Jo Revill	Non-Executive Director	(JR)
In attendance:	Katherine Birch	Director, Alder Hey Academy	(KB)
	Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
	Audrey Chindiya	Finance Manager	(AC)
	Angela Ditchfield	EDI Lead	(AD)
	Rachel Greer	Associate Chief Operating Officer, CAMHS	(RG)
	Sharon Owen	Deputy Chief People Officer	(SO)
	Jo Potier	Associate Director of Organisational Development	(JP)
	Darren Shaw	Head of Organisational Development	(DS)
	Kerry Turner	FTSU Guardian	(KT)
	Jason Taylor	General Manager, Research	(JT)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Apologies:	Nathan Askew	Chief Nursing Officer	(NA)
	Kathryn Allsopp	Head of Operational HR	(KA)
	Alfie Bass	Chief Medical Officer	(AB)
	Adam Bateman	Chief Operating Officer	(AB)
	John Chester	Director of Research & Innovation	(JC)
	Urmi Das	Director, Division of Medicine	(UD)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	Gill Foden	HR Manager	(GF)
	Rachel Hanger	Associate Chief Nurse – Surgery	(RH)
	John Kelly	Non-Executive Director	(JK)
	Natalie Palin	Director of Transformation	(NP)
	Jill Preece	Governance Manager	(JP)
	Chloe Lee	Associate COO – Surgery	(CL)
	Sarah Leo	Head of Research	(SL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MSW)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
	Julie Worthington	Staff Side Chair	(JW)

22/23/233 **Declarations of Interest**

No declarations were declared.

22/23/234 **Minutes of the previous meeting held on 22nd November 2023.**

The minutes of the last meeting were approved as an accurate record.

Alder Hey Children's NHS Foundation Trust

22/23/235 **Matters Arising and Action Log**

Action log was updated accordingly.

FM informed the Committee that Jo Revill, Non-Executive Director will be observing today's committee meeting and will formally take over as Chair from March 2024 going forward. Committee members welcomed JR.

22/23/236 **Monitor Progress against the People Plan**

The Committee noted the content of the current progress of the People Plan. SO present an overview on the progress of The People Plan development.

The plan remains focused on the 3 strategic initiatives:

- Thriving @ Alder Hey
- Professional Hub
- Future Workforce

Recent focus of the fundamental changes include Thriving Leaders led by Darren Shaw, Head of Organisational Development and Jo Potier, Associate Director of Organisational Development, and Preceptorshipled by Lisa Westley, Lead for Nurse Retention which will enhance the skills set for improved retention.

SO highlighted that the Preceptorship Policy was at final sign off stage.

Metrics remain on target and continue to make good progress.

Resolved: The Committee received The People Plan update and noted progress.

22/23/237 **Monitor Progress against the People Plan**

- **Divisional Metrics**

<u>Surgery Division</u>

The Committee received the Surgery Division metrics report (December 2023) data and noted progress to date within the presentation.

Resolved:
The Chair acknowledged good communication and engagement displayed across the division and noted positive progress being made.

<u>Clinical Research Division</u>

The Committee received the Research Division metrics report (December 2023) data and noted progress to date. JT highlighted the following:

- Sickness absence showed a decrease but remains above trust target. Plans in place to work with Senior Leadership to manage and control capacity.
- Headcount data position remains at 75 in total.

- Return to Work completion has reached 100% compliance and noted a good trend displayed.
- PDR position at 66% and continues to remain stabilised.

The Chair reminded colleagues of the previous request to present Research & Innovation into one report moving forward.
Action: R&I metrics to be combined into one presentation

Resolved:
The Chair acknowledged good communication and engagement displayed across the division and noted positive progress being made.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (December 2023) data and noted progress to date. RG highlighted the following:

- Sickness absence remains consistent and on course.
- Staff Turnover continues to be monitored and remains stabilised.
- Time to Hire continues to be challenging with plans in place to address. Senior Leaders continue to work closely with Recruitment to explore a deep dive into some significant areas to understand growth including development and mental health needs.
- PDR remains stabilised at 66% with actions plans in place to help improve and drive compliance forward and ensure deadlines are met.

Resolved:
The Chair acknowledged and noted positive progress is being made.

Medicine

The Committee received the Medicine Division metrics report (December 2023) data and noted progress to date. SC highlighted the following:

- Sickness showed an increase for long term. Short Term remains at 2% position.
- Turnover has shown a slight improvement with a reduction from 11% to 10%.
- Time to Hire showed an overall improvement position from November 2023. Further work will be conducted to focus on internal/external data.
- PDR will undergo a reset on target completion dates to ensure and maintain a focus on key timeframes.
- BAME Representation within the Division showed a forward increase compared to the following year – Further piece of work will be explored in order to drive improvements.

Resolved:
The Chair acknowledged good communication and engagement displayed across the division and noted positive progress being made.

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Corporate

The Committee received the corporate metrics report (December 2023) data and noted progress to date. SO highlighted the following:

- Return to Work showed a decrease of 57% to date. Initial focus remains a key area of priority across. HRBPs will continue to work with Managers to help control and stabilise. Action plans have been created to conduct a deep dive.
- PDR compliance shows 67% to date and remains under review.

Next Steps:

- Corporate metrics will continue to monitor and record all hot spots with internal focus on priority cases.

Resolved:
The Chair noted the slight rise in short term sickness across areas and highlighted good efforts are being made to complete targets including staff survey results.

Trust Wide Metrics
The Committee received and acknowledged data report and noted progress being made across the organisation.

The Committee acknowledged the Trust Wide Metrics is making good progress.

Resolved: Committee received and noted progress made to date from each division.

22/23/238 **Staff Survey Results**

The Committee received the Staff Survey Report and noted good progress being made. DS presented the following to the committee:

- Staff Survey overall position reached 60%.
- Staff Groups overall 69% good work achieved.

DS stated that the staff response rate provided rich, valuable data from across the organisation which was a positive outcome. Full details of the data will be shared with the Trust in due course.

Next steps:

- Staff Survey results will be shared across the trust and data will be feedback to teams once available to enable divisions to take forward local conversations with colleagues. The Team are currently working with BI to improve the dashboard and continue to support big conversations.

DS formally thanked all colleagues for their help and efforts in pushing to achieve this Result..

Resolved:
The Committee received and acknowledged the Staff Survey Report.

22/23/239 **Freedom to Speak Up**

The Committee received the Raising Concerns/ FTSU report and noted progress to date. KT highlighted the following:

- Information on quarters 2 & 3 will be submitted to the National Guardian Office in accordance with reporting timelines.
- Attitude & Behaviours and Policy & Processes continue to remain high. Darren Shaw, Head of OD will undertake a project in relation to Management Essentials which will improve the impact on the themes and remains ongoing.
- FTSU Visibility Programme continues to run on course with the aim to elevate the role to help promote FTSU Champion network.
- MIAA Audit has been completed and Alder Hey's pilot and was given substantial assurance. Further details will be shared across the trust accordingly.
- FTSU Champions matrix was formed to provide assurance and continues to offer support with continues encouraged for colleagues to join.
- FTSU Phone App was created to help follow and track referrals to align with national guardian office submissions data and will generate report and will have platform on Inphase as part of the electronic reporting. This has now moved into the next stage of development and remains on course.

KT provided assurance to the committee of a trust and confidence test audit which is being piloted through Inphase to ensure all data remains secure and anonymous.

The Chair asked for an update in relation to the current module training package. First results reported back at 77% since August 2023. KT confirmed this data will be shared quarterly moving forward for oversight and assurance.

Next Steps:
- Training Module data will be shared quarterly going forward.

Resolved:
The Committee noted the FTSU update and new app development which is making good progress.

22/23/240 **Apprenticeship Update**

The Committee received the Apprenticeship Update and noted progress to date. KB highlighted the following:

KB reintroduced the Apprenticeship Strategy stating the overall position following last year's submission data. Apprenticeships have has formed a key part within Alder Hey's

workforce strategy to help drive forward and diversify the portfolio with a continued push to increase the number of staff who are going through apprenticeship pathways.

The committee noted the success in diversifying the portfolio to the point of which we now had one of the largest portfolios in terms of diversification of subjects across the trust in the North. There are 41 subjects being offered as an apprenticeship programme delivered by 31 different training providers across England. This aligns with our vision 2030 supporting our colleagues which continues to make good progress.

KB drew the committee's attention to the risk in terms of potential changes at national policy level that may come into force over the next 12 months. Assurance was provided noting teams are delivering complex portfolios with a tight resource of 2.8WTE which will be considered in growth as part of the apprenticeship offer.

Next steps:

- Apprenticeship Week will commence on w/c 5th February 2025.

Resolved: The committee noted the apprenticeship update.

22/23/241 **Equality, Diversity & Inclusion Plans – Monitoring Process**

The Committee received the Equality, Diversity & Inclusion Plans update and noted progress to date. AD highlighted the following:

- A newly formed Menopause Support Group was launched with action plans in place to established and enhance a way forward to provide the best experience for our colleagues.
- The Spiritual Care Team and Wellbeing Team are holding several events within the Division to help promote and progress the EDI by showcasing what we are conducting as an organisation.
- EDI Team continue to work with ICS to bring external organisations together across the region. Team remains working in collaborative and is making good progress with the BAME Assembly.
- EDI Sub-Group chaired by Community Division continues to meet monthly to review challenges and share messages across divisions.
- Navajo Charter Plan remains on course and the continue to work through all recommendations.
- Anti Racist Framework is working to achieve Bronze accreditation.
- EDI Improvement Plan remains working through deliveries for team growth on leadership. Actions plans are in place to manage.
- Annual Report continues to progress forward alongside the WRES/WDES within the network to review all action plans.

Next Steps:
Team continues to work with FTSU and ensure safety across the trust supported by the EDI Network chairs.

The Chair thanked AD for the comprehensive update and noted good progress being made.

Resolved: The Committee received and noted the Equality, Diversity & Inclusion Plans and noted progress being made to date.

22/23/242 **Gender Pay Gap Report 2023**

The committee received the Gender Pay Gap Report 2023 and noted progress made to date. The following was highlighted to the committee:

On average, female employees earn 27% less than male employees. This is reflective of the NHS which has a higher proportion of females in lower banded roles and a predominantly male workforce in the higher banded Medical & Dental professions. Last year female employees earned 29% less than male employees which shows that there has been some improvement in closing the gap.

The Trust gender pay gap remains mainly within our Medical and Dental staff groups and is reflective of an ageing male workforce within this staff group. Medical & Dental female workforce profile is evolving with an increased number of female consultants being appointed.

Women's Staff Network will be explored within the workforce as part of project development and remains on course.

The Local Clinical Excellent Award was awarded for medical and dental consultants as part of recognition and demonstration of achievements in developing and delivering high quality parent care.

JR asked what the difference in data showed between men and woman receiving this award. AD commented advising that data showed that woman received 17% less than men on average and the median bonus displays females are more equal to male staff.

Action: AD to review the Gender pay gap report to develop more specific action plans. FM noted good data showed a good plan to reduce gaps and asked to set an objective for 6 month's time for committee oversight and assurance.

AD provided assurance to the committee noting an improved collection of data will be collated to show in comparison against other organisations.

Action: FM noted good data showed a good plan to reduce gaps and asked to set an objective for 6 month's time for committee oversight and assurance.

GD commented this project has come a long way and noted good progress being made involving the EDI Champion introduction which continues to make good headway.

The Chair acknowledged the current developments which remain ongoing and noted good progress being made.

Resolved: The Committee APPROVED the Gender Pay Gap Report 2023 documentation.

Action: Gender Pay Gap progress report to come back in July 2024.

22/23/243 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

The Committee received the Board Assurance Framework for the month of December 2023.

Resolved: The Committee received and noted the Board Assurance Framework for the month of December 2023.

22/23/244 **BAF Deep Dive (Risk 2.3)**

The committee received the Board Assurance Framework. SO provided an update on the following 2.3 Equality Diversion & Inclusion highlighting the following:

The Committee noted there is a current risk of 15 with a target of 4.

There are controls and mitigations that remain in place with continued regular reporting. 5 established networks through EDI Steering Group continues to be managed.

Next steps:

- Assurance and evidence continue to be provided monthly and reported to Trust Board.
- Additional resource has now been approved which will help improve capacity.
- EDI strategy progress continues driving improving with support from GD/AD.
- Navajo Charter Mark will be obtained and shared accordingly.

Controls remains in place to stabilise all ongoing developments and continues to be closely monitored.

Resolved The Committee NOTED the report.

22/23/245 **Health & Safety Committee (HSC) Minutes**

The Committee received the approved minutes of the HSC meeting held on (25th September 2023)

22/23/246 **Joint Consultative and Negotiation Committee (JCNC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on (19th December 2023)

22/23/247 **Local Negotiation Committee (LNC) Minutes**

The Committee received the approved minutes of the LNC meeting held on (10th October 2023)

22/23/248 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on

(12th October 2023)

22/23/249 **EDI Steering Group Minutes**

The committee received the approved minutes from the EDI SG held on (18th September 2023)

22/23/250 **Any Other Business**

No further business was raised.

22/23/251 **Review of Meeting – Chair's Report to Board**

Strategy Update: The People Plan
Progress of the People Plan continues to progress forward in line with vision 2030. Good achievements being made to manage preceptorship and management Essentials.

Divisional Metrics:
Divisions metrics is showcasing some good trends within sickness and turnover. Time to Hire will be monitored regularly.

Return-to-Work compliance figures will continue to be closely monitored with plans in place to improve across the organisation.

Staff Survey:
The Committee noted an overall position of 60% response rate.

FTSU:
The Committee noted the completion of the MIAA Audit and App Development which continues to make good headway.

New Champions will be formed as part of training and development to improve service needs across the organisation.

Apprenticeship:
The Committee noted positive feedback from recent data reported to date. Apprenticeship Week will form a good part of communication and engagement.

Gender Pay Gap:
The Committee noted additional resource for EDI and future progression plans.

The Chair noted good progress being made across all areas.

Date and Time of Next meeting
Wednesday 24th January 2024 at 2pm via MS Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	Resources and Business Development Committee
Report of:	John Kelly, Non-Executive Director
Paper Prepared by:	John Kelly, Non-Executive Director

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Resources and Business Development Committee meeting held on 25th March 2024, along with the approved minutes from the 26th March 2024 meeting.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

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

To provide an update to the Trust Board on the previous Resource and Business Development Committee held on 25th March 2024.

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

- M11 financial position
- Q3 Service Line Reporting
- M11 Integrated Performance Report
- 24/25 Draft Plan
- Drugs Deep Dive
- AlderCare
- Innovation and Commercial Activity
- Procurement – quarterly update
- Benefit Transformation Programme
- ODN Network – bi annual report
- Campus update
- Board Assurance Framework
- PFI
- Communications and Marketing Paper

3. Recommendations & proposed next steps

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

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Minutes of the meeting held on Monday 26th February 2024 at 13:30, Room 11, Level 1, Alder Hey Children's NHS Foundation Trust

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	
	Fiona Marston	Non-Executive Director	
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	(JG)
	Kate Warriner	Chief Digital and Information Officer	(KW)
	Melissa Swindell	Director of HR & OD	
In attendance:	Nathan Askew	Chief Nurse	
	Sian Calderwood	ACCO, Medicine	
	Audrey Chindiya	Associate Finance Director – Operational Finance	
	Dani Jones	Director of Strategy and Partnerships	
	Emily Kirkpatrick	Deputy Director of Finance	
	Jane Halloran	Acting Deputy Development Director	
	Graeme Montgomery	Accountant, Surgery	
	Andy McColl	Deputy Director of Finance	
	Natalie Palin	Associate Director Transformation	
	Gary Wadeson	Associate Director Income, Costing & Commissioning	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
	Erica Saunders	Director of Corporate Affairs	(ES)

23/24/176 **Apologies:**

Emma Hughes	Acting Manging Director for Innovation	
Rachel Lea	Deputy Director of Finance	(RL)

23/24/177 **Minutes from the meeting held 16th January 2024**
The above minutes were approved as a true and accurate record.

23/24/178 **Matters Arising and Action log**
Coding Backlog:
KW updated RABD noting there is no further back log and coders are up to date.

General Paediatrics: Tariff is not correct as losing money on this services. It was agreed this would be discussed further at the March RABD under the SLR data.
Action: GW/CMc

23/24/179 **Declarations of Interest**
There were no declarations of interest.

23/24/180 **Finance Report**
Month 10 Financial Position
£1m surplus was reported for M10. The year to date gross impact of industrial action is £6.2m which includes £4.5m loss of income from cancelled activity & £1.7m in additional costs of cover. The trust has seen a £1.6m increase YTD in income to support the impact of IA through revised ERF baselines. The remaining pressure is being mitigated by one off benefits including release of contingency £2.1m, vacancies across divisions, & continual review of provisions elsewhere, however the most recent costs in December and January are showing as unmitigated.

RABD discussed financial benefits, the Chair queried if all recurrent benefits are being tracked. JG advised that whilst we don't currently have that intelligence we are working towards.

SA asked for an update in relation to drug expenditure within the Medicine Division. SC agreed to provide an update at the March RABD.
Action: SC/AC

Resolved:
RABD received and noted the M10 Finance report.

23/24/181 Month 10 Integrated Performance Report

AB highlighted:

- Number of patients waiting over 65 weeks continues to decrease with the aim to have 0 patients in this category by April 2024.
- The last Junior Doctor strikes lost 6 Theatre sessions. There will be no further strikes in March 2024.

Resolved:
M10 IPR report was received.

23/24/182 24/25 Draft Financial Plan

EK went through the key assumptions made to submit a draft position to ICB as £3.5m (1%) deficit. Plans were shared on how a breakeven position may be achieved noting increase of risks and non-current assumptions.

The workforce return that was submitted on 21st February 2024 notes a reduction of 32 posts for CIP linked to Workforce benefits stream and an increase of 31 posts linked to activity. 109 posts are to be funded externally.

Activity submission higher than 23/24 based on collation of divisional activity plans. A discussion was held around cases with Ears, Nose, Throat moving to day case. An assumption of no further Industrial Action has been included. External target for ERF remains unchanged and is 105%.

Resolved:
RABD noted the current position on the 24/25 Draft Financial plan.

23/24/183 Bad Debt Write Off

RABD noted the previously circulated paper to APPROVE a write off £8,298.03 of bad debt. The debt relates to three salary overpayments that have been chased by CCI, but efforts have now been exhausted, and CCI have advised to close the file.

Resolved:
RABD APPROVED the debt relating to three salary overpayments total £8,298.03.

23/24/184 Surgery Division

Due to time constraints the paper was taken as read.

Resolved:
RABD noted the further update following the face to face divisional update in January 2024.

23/24/185 Benefit Realisation

KW introduced benefit realisation noting the ask today was to agree for the programme to return to March RABD and to be approved at April Trust Board.

A presentation was given covering: Needs led by objectives and how they will be delivered through the 5 strategic goals. 2030 Financial challenge and how the programme will support. KW went through a plan on a page for 2024/25. Where we are financially now and the current gap.

The Chair queried Get Me Well section and asked for the wording to be clearer before wider circulation. The Chair also queried when the programme would commence with resourcing, KW advised that with Board approval this was due to commence in April 2024.

A discussion was held around 2030 vision. NP said strategic score cards would be developed.

A discussion was held around when benefits would be received, ES noted that litigation time flag can be around 5 years.

A discussion was held around the opportunity to realise financial benefits through improved patient safety. NA discussed the contractual requirements to implement PSIRF under the NHS Standard Contract and our low incident rate. It was agreed that a discussion would be taken offline, and an updated position reported for RABD March 24.

Resolved:

NP thanked RABD for their comments noting the programme is in draft and will use the feedback to develop further.

23/24/186 Campus Update

Due to time constraints the above paper was received.

Resolved:

RABD noted progress to date of the Campus projects.

23/24/187 Digital Futures Strategy

Due to time constraints the above paper was received.

Resolved:

RABD noted progress to date.

23/24/188 Board Assurance Framework

Resolved:

RABD received and noted the Strategic Risks.

23/24/189 PFI

Resolved:

RABD received and noted the current position.

23/24/190 Any Other Business

No other business was reported.

23/24/191 Review of Meeting
RABD noted the good discussion on benefit realisation programme.

Date and Time of Next Meeting: Monday 25th March 2024 at 1pm, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

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

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

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
As detailed in the report	This report provides an update against all Board Assurance Framework Risks for the month of February 2024.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2023/24

1. Purpose

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

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

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

2. Review of the BAF

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

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

3. Summary of BAF at 12 March 2024

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

4. Summary of February 2024 updates:

- ***Strategy Deployment (DJ).***
  Risk reviewed; no change to score. Vision 2030 progressing as per agreed timeframes. Benefits case underway and being mapped against the annual plan.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; Current risk evidence, actions and controls assessed and no change to score in month. Specific updates include:
  1. System commitment to CYP continues through the new ICS CYP Committee, and new provider collaborative Alliances (CMAST and MHLDC).
  2. Trusts are awaiting the annual planning guidance from NHSE, including the financial guidance. The output of this may significantly impact this risk, and change the score; however at present there is no change until further clarification is provided by the system. This risk will closely align to BAF risk 3.4 (Financial Environment) and it will be necessary to keep abreast of emerging changes collectively.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed; work continues to update in line with the 2030 Vision and improvements made. Additional resource has been agreed to support EDI and anticipated reduction on risk score once in post. No change to risk rating currently.

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

  Project Co have issued the Jan pipework update, we are awaiting the February update.
  To date in 2023, leaks have decreased by 53% compared to 2022.
  In overall terms the leaks in 2023 amount to 4% of the total leaks between 2017 to 2023.

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

  Joint water safety workshop to discuss water issues took place on 22nd Jan. AB has developed and shared action plan to work to. Key take away proceed at pace to install dosing system safely.

  Chiller commissioning works have re-commenced in Jan Project Co expect to provide an update early Feb to the Trust.

  Works on the skylights will recommence April 2024.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in February maintained performance above the national standard of 76%, achieving 78.5%. Current (Jan-Feb) quarter 4 position is at 80%. Focus for March 24 is to maintain/improve this percentage for the full quarter.

  Continued improvement plans are in place for Sleep Studies (sickness) and Gastro (availability of theatres) to improve the Overall DMO1 compliance.

  Capacity to reduce long waits (RTT) continues to remain the focus for services to achieve zero 65 week waits by 31st March 24. There is available capacity in month to achieve and we currently meeting the agreed trajectory with Cheshire & Merseyside Improvement team.

  There are a cohort of patients waiting 78+ weeks. All patients in this cohort (Dental & ENT) have TCI dates and a plan.

  Risk remains for both 78 and 65 week cohorts regarding cancellation of agreed appointments but these patients are being closely monitored on a daily basis by services.

- ***Inability to deliver safe and high-quality services (NA).***
  This risk remains as articulated and will be under a formal review in March where it will be aligned to the 2030 vision fully and there will be consideration given to the articulation of the experience element of the strategy.

- ***Access to Children and Young People's Mental Health (LC)***
  Full review of actions undertaken and monthly review meetings in place.

- ***Financial Environment (JG).***
  Overall risk score remains at 16. 2024/25 initial financial plan has been submitted, however with high risk on efficiency delivery and also a challenging system position.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed, no change to score in-month. Actions updated and target dates amended accordingly.

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

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

- ***Failure to deliver the best experience for Staff, Children and Young People and their Families (MS).***
  Risk reviewed. Risk descriptor amended pending full review of risk with CPO to reflect broader focus on organisational culture and not only staff wellbeing. Actions updated. No change to risk rating.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  No change to risk score in month. Financial framework for Futures under development. Potential delay in investment zone funding being addressed

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

There are currently 21 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked
STRATEGIC OBJECTIVE: The best people doing their best work *(Outstanding care and experience)*				
1.1 Inability to deliver safe and high-quality services (3x3=9)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.4
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	3.4
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support	1.2, 2.1 & 2.2
117	Safe follow up care	4x4	Business Support	1.2, 2.1 & 2.2
2677	We are now in Year 7 since the Alder Hey in the park building became operational. Most of the Trusts Medical Devices were purchased or replaced at this time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 years. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital equipment. This year (22/23) we had planned to replace £6.3m of this capital equipment. However, external capital expenditure restrictions have been placed upon the Trust by the ICS which means we only have £2.3m allocated for device replacements. the remaining £4m is "at risk" and will roll over into next year's replacement budget which will then stand at £9.5m	4x4	Surgery	3.4
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2
2657	As there is no consistent method for recording and communicating resuscitation decisions across the trust there is a child may be resuscitated inappropriately and receive inappropriate and potentially harmful treatment. A child may not receive resuscitation when it is in their best interests to do so.	5x3	Medicine	
91	Junior doctor staffing in general paediatrics	5x3	Medicine	2.1
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	2.2

Risk	Risk Title	Score (IxL)	Division	Linked
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	2.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	2.1 & 2.2
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	2.1 & 2.2
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	2.1
132	Gender Service	4x4	Community	2.1
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	3x5	Community	
111	Anaesthetic cover out of hours	5x3	Medicine	1.2, 2.1 & 2.2
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)				
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.4
2019	Delay in treatment for Speech and Language Therapy	3x5	Community	1.2
2360	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18 week referral to treatment target for routine).	3x5	Community	1.2
117	Safe follow up care	4x4	Business Support	1.1, 2.1 & 2.2
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)				
	None			
1.4 Access to Children and Young People's Mental Health (3x5=15)				
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.1
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2
STRATEGIC OBJECTIVE: Delivery of Outstanding Care *(Support our people)*				

Risk	Risk Title	Score (IxL)	Division	Linked
2.1 Workforce Sustainability and Development (3x5=15)				
91	Junior doctor staffing in general paediatrics	5x3	Medicine	1.1
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.2
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support	
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.2
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2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	1.1
132	Gender Service	4x4	Community	1.1
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.2
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.2
2.2 Failure to deliver the best experience for Staff, Children and Young People and their Families (3x3=9)				
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.1
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support	
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.1
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Risk	Risk Title	Score (IxL)	Division	Linked
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.1
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.1
2.3 Workforce Equality, Diversity and Inclusion (3x5=15)				
	None			
STRATEGIC OBJECTIVE: Sustainability through external partnerships *(Collaborate for children and young people)*				
3.1 Failure to fully realise the Trust's vision for the park and Alder Hey campus (3x4=12)				
	None			
3.2 Strategy Deployment (3x4=12)				
	None			
3.4 Financial Environment (4x4=16)				
2579	Risk of failure to achieve financial balance due to existing and emerging cost pressures, impact of Industrial Action on the delivery and recovery of NHS services, reduced effectiveness of services, inability to invest and innovate and potential of increased workforce pressures	3x5	Medicine	
2677	We are now in Year 7 since the Alder Hey in the park building became operational. Most of the Trusts Medical Devices were purchased or replaced at this time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 years. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital equipment. This year (22/23) we had planned to replace £6.3m of this capital equipment. However, external capital expenditure restrictions have been placed upon the Trust by the ICS which means we only have £2.3m allocated for device replacements. the remaining £4m is "at risk" and will roll over into next year's replacement budget which will then stand at £9.5m	4x4	Surgery	
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	
3.5 System working to deliver 2030 Strategy (4x4=16)				
	None			
STRATEGIC OBJECTIVE: Game-changing research and innovation *(Pioneering Breakthroughs)*				

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

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

Erica Saunders
Director of Corporate Affairs

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

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

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

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

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

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

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

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

CQC Domains	Linked Risks	Owner
■ Effective ■ Responsive		Adam Bateman

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

Description

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

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

Gaps in Controls / Assurance

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

Action	Description	March 2024	
		Due Date	Action Update
Reduce the long-wait backlog for planned care	Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	31/03/2024	All services working towards zero 65 week waiters by 31st March 2024. Particular concern in ENT, Dental and Spine where additional investment continues in insourcing and theatre time protection for services.
Urgent and Emergency Care Standards	Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	31/01/2024	Actions implemented to date have led to improved access to A&E, which is now exceeding the 85% national standard

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

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

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

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

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

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

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

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

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

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

Description

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

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

Gaps in Controls / Assurance

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

Action	Description	March 2024	
		Due Date	Action Update
Action plan to reduce was not brought rate	Action plan to reduce was not brought rates across Liverpool and Sefton CAMHS including: - using WNB predictor to identify CYP at higher risk of non attendance - A3 exercise to monitor improvements - Transport pilot - ongoing, due to commence 31.10.2023	31/03/2024	
Continued workforce planning	Continued workforce planning including: - introduction of new roles - continued representation at C&M workforce meetings - review of all job descriptions and person spec to ensure consistency and ability to progress - development of preceptorship/development pathway	31/03/2024	
Data / BI - case load monitoring	Case load size reporting and monitoring to be improved including: - BI dashboard to be created - validation of data	31/03/2024	Still a couple of issues to iron out with accuracy of case load. Raised at Extended Leadership on 21st Feb with Hollie Funcks. To be reviewed over next couple of weeks in 1:1s to see if this is better.
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/03/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/03/2024	- Decision has been made to take PIFU Discharge to parent/carer forums and participation groups before implementation. Implementation takes at least 28 days. The initial delay will be taking it to the groups for discussion and then the 28 days for implementation will create a further delay. - Jo M to discussed with Kate W 03.11.23 to agree a new due date
Proceed with changes to CAMHS internal waiting times measures	Proceed with changes to CAMHS internal waiting times measures including: SOP/Pathway to be created Training plan for clinical and admin staff to be created and rolled out Data and reporting	31/03/2024	
Referral triage process to be reviewed	To review referral triage process across CAMHS	31/03/2024	
Review of KPIs and Reporting Measures	Review of KPIs and reporting measures for Sefton & Liverpool place	31/03/2024	
Review of standard booking processes	Review of booking and discharge processes across Liverpool and Sefton CAMHS to ensure consistency in approach, and management in line with trust processes.	31/03/2024	Choice booking now 4 weeks in advance which is supporting reduction in DNA/Cancellations and wasted appointment slots. Date extended to end of March to ensure this is embedded and consistent before action is closed.

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

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

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

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

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

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

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

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	
Risk Number	Strategic Objectives
2.2	The Best People Doing Their Best Work

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

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

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

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

Gaps in Controls / Assurance
1. Increase in self-reported rates of burnout and work-related stress as assessed via 2023 Staff Survey and consistent with national picture for NHS staff. 2. Our people have the time, space and opportunity to improve

Action	Description	March 2024	
		Due Date	Action Update
Stress risk assessments	Skills and capacity gap to conduct good quality stress risk assessments for staff affected by work-related stress	30/04/2024	Email sent to Head of L&D who is leading on sourcing training for SRAs requesting update as part of wider Management Essentials training for leaders and line managers
Suicide Postvention planning and process	Suicide Postvention guidance and team to be developed and establised to provide effective and compassionate response in the event of the death by suicide of a staff member.	30/04/2024	Deputy CPO and Associate Director of Organisational Development met on 30.1.24 to start drafting organisational postvention guidance and strategy. Agreed to draft guidance and then consult key stakeholders before finalising and communicating.

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

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

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

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

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

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

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

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

CQC Domains	Linked Risks	Owner
		Rachel Lea

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

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

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

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

Action	Description	March 2024	
		Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	31/05/2024	Meetings will continue with LCC until full legal agreement of transfer of Park to the Council.
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2024	Regular updates continue to be provided to RABD and Trust Board as appropriate
Infrastructure works	Weekly coordination meetings, site walkarounds, RAMS, mitigation measures identified	31/05/2024	
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	31/03/2024	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves	30/06/2024	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell

Strategy Deployment	
Risk Number	Strategic Objectives
3.2	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

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

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

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

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

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

Financial Environment	
Risk Number	Strategic Objectives
3.4	Strong Foundations

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

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

Description

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

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

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations and overall financial position of Trust.
2. Long Term tariff arrangements for complex children shows underfunding of c£3m for Alder Hey
3. Devolved specialised commissioning and uncertainty impact to specialist trusts
4. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
5. Long Term Plan shows £3-5m shortfall against breakeven
6. Deliverability of high risk recurrent CIP programme
7. Increasing inflationary pressures outside of AH control
8. Divisional budget positions are not acheived due to emerging cost pressures and impact of Industrial Action.

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

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

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

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

Description

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

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

Gaps in Controls / Assurance

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

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

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

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

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

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

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

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

CQC Domains	Linked Risks	Owner
		Kate Warriner

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

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

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

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

Action	Description	March 2024	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2025	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023 Date Entered : 01/09/2022 08:28 Entered By : Kate Warriner ---------- Some issues highlighted with programme, risking dates to delivery. Review underway Date Entered : 02/12/2021 16:45 Entered By : Kate Warriner ---------- Programme progressing, a number of work streams with challenges being progressed. Date Entered : 06/05/2021 08:51 Entered By : Kate Warriner ---------- Programme progressing well against Plan. Progress monitored through digital reports at RABD Date Entered : 11/01/2021 14:20 Entered By : Jill Preece

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 11th April 2024

Paper Title:	**Directors' Register of Interests 2023/24**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	The Declarations of Interests Register enables all staff to be as open as possible and declare any actual or potential conflict of interest.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■

Alder Hey Children's NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS 2023/24

	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
Dame Jo Williams (Trust Chair)		✓
Nathan Askew (Chief Nurse)		✓
Shalni Arora (Non-Executive Director)		✓
Alfie Bass (Chief Medical Officer)		✓
Adam Bateman (Chief Operating Officer)		✓
Fiona Beveridge (Non-Executive Director)	**Declaration Type:** Loyalty Interest **Body/Organisation/Individual name**: University of Liverpool **When did loyalty interest begin:** 01/04/2022 **How is this relevant to the Trust:** Employed at University of Liverpool in senior role which could, on occasion, give rise to Loyalty conflict of interest. Managed by transparent dealing and declaration where relevant and by agreement with Chair of Alder Hey NHS Trust and Vice Chancellor, University of Liverpool.	

0275	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
Kerry Byrne (Non-Executive Director)	**Declaration Type:** Outside Employment **Outside Employer**: South Lakes Housing. **Outside Employer Description:** Non Executive Director for South Lakes Housing. Sit on Board and Audit & Risk Committee **When did business interest begin:** 01/09/2018 **How is this relevant to the Trust:** No conflicts of interest. **Declaration Type:** Outside Employment **Outside Employer**: Ernst & Young LLP **Outside Employer Description:** Internal auditor in the financial services team of Ernst & Young based in their London office. I do not believe there are any conflicts with this role as it ended in 2014, some years before I joined Alder Hey as a Non-Executive Director. Despite this, I am declaring it now (July 2022) due to the current external audit tender process for which Ernst & Young have submitted a tender (the only tender). I am a panel member for selecting the external auditor. I do not know any of the Ernst & Young external audit team, other than through my professional dealings with them as an Alder Hey NED. **When did business interest begin:** 2012-2014 ***ACTUAL EMPLOYMENT DATES 03/01/2012 to November 2014*** **End Date:** November 2014 **How is this relevant to the Trust:** No conflicts of interest. **Declaration Type:** Outside Employment **Outside Employer**: Liverpool John Moore's University **Outside Employer Description:** I sit on the LJMU Board and am the Chairman of the	

0276	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	Finance Committee **When did business interest begin:** 13/11/2019 **How is this relevant to the Trust:** This is a "general" conflict rather than relating to any specific matter. If any agenda items or discussions take place at Board or any sub committees that relate to LJMU I will excuse myself from such discussions as appropriate.	
John Chester (Director of Research & Innovation)	**Declaration Type:** Outside Employment **Outside Employer:** University of Leeds/ Leeds Hospitals Charity **Outside Employer Description:** Chair of External Strategic Advisory Board for CHORAL - panel of independent experts advising on CHORAL (Children's Health Outcomes Research at Leeds) health research programme Uncertain amount of work, at present, as the Advisory Board has not yet had its first meeting (as of 11th Sept 2023) Not expected to be more than a dozen or so hours per year, associated with an annual meeting NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 14/04/2023 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The work being undertaken is to support a partner in the Children's Hospital Alliance This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Imperial College London - Clinical Trials Unit **Outside Employer Description:** Independent Data Monitoring Committee - panel of	

0277	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	experts overseeing data from the REFINE-Lung trial New role, from Sep 2022 A few hours per year, associated with annual meeting NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/09/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Institute for Cancer Research **Outside Employer Description:** Independent Data Monitoring Committee of international experts overseeing data from InPACT trial in penile cancer Continuation of long-standing role, pre-dating my employment with the Trust - chair of Committee for several years A few hours per year, associated with annual meeting NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. This is pro bono work - no salary or honorarium – and the work undertaken is either done	

0278	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Medical Research Council Clinical Trials Unit at University College London **Outside Employer Description:** Trial Steering Committee for cancer trials - panel of experts overseeing a portfolio of clinical trials Continuation of long-standing role, pre-dating my employment with the Trust Asked to step up to chair the Committee, July 2023 A few hours per year, associated with annual meeting NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** University College London - Cancer Trials Centre **Outside Employer Description:** Trial Steering Committee of experts overseeing a portfolio of cancer trials - mainly haematological malignancies and brain tumours Continuation of a long-standing role, pre-dating my appointment with the Trust - as Chair since October 2018 A few hours per year, associated with an annual meeting	

0279	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Stratified Medicine Paediatrics (Cancer Research UK/University of Birmingham) **Outside Employer Description:** Chair of Study Steering Committee Continuation of long-standing role, pre-dating my employment with the Trust Only a few hours per year NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Cancer Research UK - Protocol Safety Review Board	

0280	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	Outside Employer Description: Panel of expert clinicians advising CRUK's Centre for Drug Discovery on development of clinical trial protocols for studies of new anti-cancer drugs Appointment taken up, following standing down from CRUK's New Agents Committee in December 2022 Few hours per month and attendance at short monthly meeting Unpaid and no honoraria, to date NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/01/2023 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. This is pro bono work - no salary or honorarium - and the work undertaken is either done in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Cancer Research UK - Clinical Research Monitoring Panel **Outside Employer Description:** Panel of clinical experts who review progress against time and targets of a broad panel of clinical trials supported (funded or endorsed) by CRUK Approx 8 hours' work, 3 times per year NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my	

0281	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	employment with the Trust. Honoraria to a total of £600 were paid in 2022-23, but the work undertaken is either done in my spare time, or made up outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Royal Marsden Hospital/Institute for Cancer Research **Outside Employer Description:** Independent external examiner for MSc Oncology course (post-graduate taught course for specialist trainees in oncology, across the UK) Approx 16 hours per year, divided into 2 segments, aligned with the twice-yearly course management board meetings. NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. An honorarium is paid (£500, twice a year), but the work undertaken is either done in my spare time, or made up by additional work for the Trust, outside of contracted hours. **Declaration Type:** Outside Employment **Outside Employer:** Cancer Research UK - New Agents Committee **Outside Employer Description:** Committee which reviews experimental cancer medicine early phase trials, including an emphasis on Phase I trials conducted with commercial partners. Long-term membership, pre-dating my arrival in the Trust by many years. Membership discontinued, December 2022.	

0282	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	Approx 8 hours' work, 4 times per year NB The work is conducted outside of contracted hours, as below. **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** No perceived conflicts of interest; I am submitting this for full declaration purposes. The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust. Honoraria to a total of £450 were paid in 2022-23, but the work undertaken is either done in my spare time, or made up outside of contracted hours.	
Lisa Cooper (Director of Community and Mental Health Services)	**Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** Empower the Invisible Project **Description of Loyalty Interest:** This project is supporting adults with lived experience of abuse. I have been asked to be an ambassador for the project and support them with promotion of their work. **When did business interest begin:** 06/04/2021 **End date:** 31/03/2022 **Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** The Princes Trust **Description of Loyalty Interest:** I am a mentor for the Princes Trust. This is not a paid position and I undertake this outside of work. I provide mentorship and support to young people seeking employment within health and social care settings.	✓

0283	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
	When did business interest begin: 01/04/2022 **End date:** 31/12/2023 **Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** Survivors Trust UK **Description of Loyalty Interest:** I am a trustee of the charitable organisations Survivors Trust UK. I held this position previously and stood down in 2020 due to personal reasons. I have been reappointed to this position in April 2022. **When did business interest begin:** 01/04/2022 **End date**: 31/03/2024	
Benedetta Pettorini (Director of Surgery)		✓

Garth Dallas (Non-Executive Director)		✓
Urmi Das (Director of Medicine)		✓
Mark Flannagan (Director of Marketing and Communications)		✓
John Grinnell (Managing Director/Director of Finance)	**Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** Playworld Ltd./Grinnell Holdings Ltd **Relationship:** Company Secretary (no dealings with hospital) **Description of loyalty interest:** Spouse companies **When did business interest begin:** 19/11/2019	
Dani Jones (Director of Strategy and Partnerships)		✓
John Kelly (Non-Executive Director)		✓
Rachel Lea (Director of Finance and Development)		✓

Fiona Marston (Non-Executive Director)	**Declaration Type:** Outside Employment **Outside Employer:** University of Reading **Outside Employer Description:** Royal Society Entrepreneur in Residence - personal grant from The Royal Society to support the University in specified commercial translation activities **When did business interest begin:** 26/03/2023 **How is this relevant to the Trust:** no conflict **Declaration Type:** Outside Employment **Outside Employer:** Northern Gritstone Limited **Outside Employer Description:** Review and approve investment, divestment and follow-on investments. Review and exercise the company's investor consent with regard to underlying investment agreements with portfolio companies. Monitor & evaluate portfolio company performance. Review the adequacy of the Capital Allocation Policy and recommend changes to the Board **When did business interest begin:** 01/08/2023 **How is this relevant to the Trust:** no conflict **Declaration Type:** Outside Employment **Outside Employer:** Erebagen Limited **Outside Employer Description:** Chair, CEO (Interim) and Non-executive Director of a synthetic biology company undertaking drug discovery and development **When did business interest begin:** 01/04/2022 **How is this relevant to the Trust:** no conflict	

0286	**Declaration Type:** Outside Employment **Outside Employer:** NC3Rs **Outside Employer Description:** Member of Advisory Panel reviewing and assessing applications for grant funding by NC3R. NC3Rs is a UK-based scientific organisation that works nationally and internationally with the research community to replace, refine and reduce the use of animals in research and testing. **When did business interest begin:** 01/02/2021 **How is this relevant to the Trust:** no conflict	
Gerald Meehan (Non-Executive Director)	**Declaration Type:** Outside Employment **Outside Employer:** Liverpool City Council **Outside Employer Description:** Independent Chair of Liverpool's Children's Services Improvement Board. **When did business interest begin:** 02/04/2024 **How is this relevant to the Trust:** I will declare this interest if specific consideration is given at Board or Committee to the work of Children's Services at Liverpool City Council. I will not take part in discussion of Liverpool City Council services. I will declare my position as a NED at the next meeting of the Liverpool Children's Services Improvement Board-completed on 7th March 2024. **Declaration Type:** Outside Employment **Outside Employer:** Wirral Community Health and Care (NHS) Trust **Outside Employer Description:** Non Exec Director and Vice Chair of the Trust. **When did business interest begin:** 02/04/2024 **How is this relevant to the Trust:** I have declared my role as NED with Wirral Community Health and Care (NHS) Trust and will not take part in any consideration of the Wirral Trust by Alder Hey at Board or Committee.	

0287	**Declaration Type:** Outside Employment **Outside Employer:** St Helens Citizens Advice **Outside Employer Description:** A charity in St Helens that gives advice to citizens. **When did business interest begin:** 01/12/2023 **How is this relevant to the Trust:** I will not take part in any consideration of CASH **End date**: 02/04/2024	
David Powell (Development Director)		✓
Jo Revill (Non-Executive Director)	**Declaration Type:** Outside Employment **Outside Employer:** Authors' Licensing and Collecting Society **Outside Employer Description:** I am chair of ALCS, a not-for-profit body which supports authors and illustrators and distributes money due to them through royalties. **When did business interest begin:** 01/01/2023 **How is this relevant to the Trust:** No conflict. **Declaration Type:** Outside Employment **Outside Employer:** Copyright Licensing Agency **Outside Employer Description:** I am co-chair of the CLA, a not-for-profit body which provides licensing solutions to the public sector, companies and others to enable copyright to be upheld and to support publishers, writers and artists. **When did business interest begin:** 01/01/2023 **How is this relevant to the Trust:** No conflict.	
Erica Saunders (Director of Corporate Affairs)		✓

0288 Louise Shepherd (Chief Executive)	**Declaration Type:** Outside Employment **Outside Employer:** NHS England **Outside Employer Description:** Chair National Children's Transformation Board. **When did business interest begin:** 01/03/2023 **How is this relevant to the Trust:** No conflict. **Declaration Type:** Loyalty Interests **Body/Organisation/Individual name:** Royal Liverpool Philharmonic Society **Description of loyalty interest:** Appointed Chair of the RLPS Charity for a term of 3 Years **When did business interest begin:** 14/11/2022	
Melissa Swindell (Chief People Officer)		✓
Kate Warriner (Chief Digital and Information Officer)		✓