Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 6th June 2024, commencing at 9:00am
Lecture Theatre 4, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
BOARD PHOTOGRAPH (9:15am-9:20am)							
1.	**24/25/68**	**9:20 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/69**	**9:21 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/70**	**9:22 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **2nd May 2024.**	**D**	Read enclosure
4.	**24/25/71**	**9:24 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**24/25/72**	**9:25 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**24/25/73**	**9:35 (10 mins)**	**Vision 2030:** • **Update on Delivery.**	J. Grinnell	To receive an update on the delivery of the 2030 Vision.	**A**	Verbal
7.	**24/25/74**	**9:45 (10 mins)**	**Transformation Programme.**	N. Palin	To receive an update on the current position.	**A**	Read report
8.	**24/25/75**	**9:55 (30 mins)**	**Cheshire and Merseyside System Wide Issues Update; including:**	L. Shepherd/ L. Weaver-Lowe/	To receive an update on the current position.	**A**	Presentation

			• **Place update – Moving to a programme approach.** • **C&M financial position update.** • **Letter from ICB re the Trust's Financial Plan for 2024/25.**	R. Lea			
Operational Issues							
9.	**24/25/76**	**10:25 (40 mins)**	**Evidence of our Performance:** • **Integrated Performance Report for M1, 2023/24:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.** • **M2 Flash Report/ Operational Overview.**	A. Bateman N. Askew A. Bateman A. Bateman M. Swindell L. Weaver Lowe R. Lea Divisional Directors A. Bateman	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A** **A**	Read report Read enclosure
10.	**24/25/77**	**11:05 (10 mins)**	**Gender Development Service (North Programme) Update.**	L. Cooper	To receive an update on the current position.	**A**	Read report
11.	**24/25/78**	**11:15 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Unrivalled Experience							
12.	**24/25/79**	**11:25 (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

13.	**24/25/80**	**11:30 (10 mins)**	**Nurse Staffing Report, 2023/24.**	N. Askew	To receive the Nurse Staffing report for 2023/24.	**A**	Read report
14.	**24/25/81**	**11:40 (5 mins)**	**PALS and Complaints Report, Q4.**	N. Askew	To receive the PALS and Complaint report for Q4.	**A**	Read report
15.	**24/25/82**	**11:45 (5 mins)**	**DIPC Report, Q4.**	A. Bass	To receive the DIPC report for Q4.	**A**	Read report
16.	**24/25/83**	**11:50 (5 mins)**	**2023-2024 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement.**	A. Bass	To receive and approve the 2023-2024 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement.	**A**	Read report
17.	**24/25/84**	**11:55 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 22.5.24.** - **Approved minutes from the meeting held on the 24.4.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 24.4.24.	**A**	Read enclosure
Lunch (12:00pm-12:20pm)							
Supporting our People							
18.	**24/25/85**	**12:20 (60 mins)**	**The People Plan:** • **Progress in 2023 and Next Steps for 2024 and Beyond.**	M. Swindell	To receive an update on progress and the next steps.	**A**	Read report
19.	**24/25/86**	**13:20 (5 mins)**	**People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 15.5.24.** - **Approved minutes from**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 20.3.24.	**A**	Read enclosure

			the meeting held on the 20.3.24.				
Strong Foundations (Board Assurance)							
20.	**24/25/87**	**13:25 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 23.5.24.** - **Approved minutes from the meeting held on the 29.4.24.** - **2024/25 Top Key Risk-May position.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 29.4.24. To receive an update on the top key risks for 2024/25.	**A** **A**	Read enclosure Read enclosure
21.	**24/25/88**	**13:30 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Items for Information							
22.	**24/25/89**	**13:35 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
23.	**24/25/90**	**13:39 (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, 25th of June 2024, 10:00am-11:30am, via Teams.							

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

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M1, 2024/25	R. Lea
People Plan highlight Report	M. Swindell
E-mail from Friends of Springfield Park	J. Grinnell

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 2nd May 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)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/51	Ms. K. Turner	Freedom To Speak Up Guardian	(KT)

Staff Story

The Chair welcomed Donna Phips from the Liverpool Parent//Carer Forum and Jenny Grimes; Clinical Lead for SEND who were invited to May's Board to provide an overview of the 'Autism in Schools Pupil Voice Project' that commenced in September 2023. A number of slides were shared that provided information on the following areas:

- The aim of the project;
  - Liverpool Local Authority, Liverpool Parent Carer Forum and Alder Hey are working together on the National 'Autism in Schools' Project. The project is working across mainstream secondary schools to improve knowledge and understanding of autism, of how to support autistic children/young people and their families and promote a person-centred approach in mainstream schools, so that teaching staff understand the challenges faced by individual students and are able to put reasonable adjustments in place where needed.
- Pupil Voice;
  - Asked for expressions of interest from pupils.
  - Had representatives from five schools within the city.
- Capturing young people's voices;
  - An artist captured the views of the pupils and lived experiences.
  - The pupils were asked to share some of the difficulties they experience and to think about solutions.
- The vision for the programme.

- The production of a video.
- Examples of what Autism means in one word provided by pupils.
- Summary;
  - This is only the beginning.
  - Our young people have been empowered and grown throughout the project along with those leading the project.
  - Further projects will be completed to give pupils a voice.

The Chair asked for her congratulations to be passed on to the young people who featured in the video as it was excellent. It was pointed out that the video is a powerful educational tool which could be used to access other schools and additional routes. Donna advised that it is far more difficult trying to access adult hospitals as there isn't the same empathy. The Chair offered to raise the profile of the project with other Chairs across Cheshire and Merseyside to create an opening. The Chair thanked Jenny and Donna for sharing their work with the Board.

24/25/36 Welcome and Apologies

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

24/25/37 Declarations of Interest

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

24/25/38 Minutes of the previous meeting held on Thursday 11th April 2024
Resolved:
The minutes from the meeting held on the 11th April were agreed as an accurate record of the meeting.

24/25/39 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 23/24/210.1: *Neonatal Governance Review (Meeting to take place between Dame Jo Williams, Louise Shepherd, the Chair and CEO of LWH before the Away Day session goes ahead, to look at developing a framework for the partnership. Alfie Bass to provide a briefing ahead of the meeting, detailing the Trust's thoughts for progressing the partnership, for discussion purposes)* – A productive meeting took place on the 25.4.24. During the meeting discussions took place about how both organisations can work together going forward, especially in terms of the Liverpool Neonatal Partnership. It was felt that it is important to establish a Partnership Board to enable oversight and take advantage of the opportunities to bring clinical teams together in a new way to think about future working. **ACTION CLOSED**

Action 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* – It was confirmed that there is lot of work being undertaken to progress the Green Plan, and the Trust is looking at where it will best fit in the programme.
ACTION CLOSED

24/25/40 Chair's and CEO's Update

Attention was drawn to the financial issues that are governing how NHS England (NHSE) are having to control the way in which the NHS is run, almost to the point where organisations are expected to focus the majority of their effort on performance targets. The Chair felt that it is crucial that Alder Hey progresses its Vision 2030 Strategy whilst delivering performance targets and supporting the system.

The Chair made reference to future Council of Governors meetings and asked that attendance be on a face to face basis where possible for those who live locally.

Louise Shepherd advised that the majority of the meetings that are taking place nationally and locally are focussed on money. Chief Executives of services were invited to a meeting on the 1.5.24 to discuss the current situation across the NHS. Conversations took place regarding local level challenges, the loss of empowerment, and how organisations will navigate financial issues whilst keeping teams motivated. It was recognised that there are many challenges facing organisations in 2024/25 and beyond. During the meeting a lessons learned session took place with NHSE's Chief People Officer, Prerana Issar, where Louise Shepherd advised of the work that Alder Hey has been undertaking; Staff Advice Liaison Service (SALS), Brilliant Basics, staff engagement, etc. It was reported that NHSE's Chief People Officer is keen to visit Alder Hey to see the work referred to in action.

Reference was made to the importance of receiving internal/external support for the Vision 2030 Strategy. It was pointed out that it is imperative for Alder Hey to be part of the digital element of work going forward and the £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.

The Board was advised of the meeting that took place with the Chair of the ICB, Raj Jain, who is grateful for Alder Hey's leadership and enormously positive about the work that the Trust is undertaking for CYP. A report is being compiled to request programme support for a small number of programmes that the Trust and the ICB can work together on in collaboration, including urgent care. This will be progressed over the next couple of weeks.

It was reported that the Trust has been approached by Liverpool City Council (LCC) with regards to putting a bid in for services for 0-19 year olds as they are in the process of putting them out to tender. Alder Hey has approached Mersey Care to see if it can work in partnership with them on the bid. It was confirmed that work is in progress ahead of receiving the service specification in July 2024.

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

24/25/41 National Context for 2024/25

A number of slides were shared with the Board that provided information on; Child Health GP Hubs (*integrated child health model of care*), a Primary Care Networks CYP Network, and an Urgent and Emergency Care (UEC) Recovery Plan that will focus on interventions to provide additional support to CYP.

Resolved:

The Board noted the update.

24/25/42 Vision 2030 Oversight

The Board was advised that the Trust is in strategy delivery mode. Attention was drawn to a number of key highlights, as follows:

- The Board agenda has been refreshed to ensure Vision 2030 is cutting through its agenda, as will Assurance Committee agendas in due course.
- The timing of Strategy Board meetings has been extended to provide additional time to focus/make sure the strategy is meeting the needs of CYP, which is work in progress. There will be a focus on 'Improve My Life Chances' during July's meeting.
- A lot of work has been undertaken following the launch of vision 2030 comms.
- A clinical leaders away day took place on the 19.4.24 with over eighty of the organisation's leaders. This event was one of the first of its kind for a long time. It was well attended and the outcome was really positive in terms of receiving a sense of commitment for Vision 2030 and the culture change that the strategy will bring about.
- Attention was drawn to the next phase of work that is taking place around culture which is indicating the importance of investing in leadership across the organisation to support the successful outcome of the strategy.
- It was reported that the inaugural meeting of the Vision 2030 Programme Board has taken place and will continue to do so on a monthly basis. An overview of the meeting was provided which included; a deep dive into 'Revolutionising Care', Divisional presentations and an update from all Senior Responsible Officers,
- *Other Activities* – Benefits realisation cases are being developed, a review of the BAF has been undertaken, and an additional session has been scheduled to discuss governance and assurance. An improvement event has also been arranged to showcase the organisations Brilliant Basics work.

It was felt that the clinical leaders' event has enthused leaders to be part of the culture change that the strategy will bring about. It was queried as to how the organisation will support leaders to amplify their voices. It was suggested that instead of the organisation taking a micromanagement approach it should allow the discretion of looseness to enable teams to focus and manage the areas that are important to the organisation, taking into account that safety is non-negotiable.

The Chair brought the agenda item to a close and thanked all those involved who provided an update.

Resolved:
The Board noted the update on the Vision 2030 Strategy.

24/25/43 Collaborate for Children and Young People

The Board received a quarterly update on the core relationships and system partnerships in which the Trust are engaged. These system relationships and partnership arrangements are core enablers to the delivery of Vision 2030. They provide the organisation's health and care system with the architecture, connections and communities required to meet the needs of CYP and families.

In addition to the detail in the report the Board was provided with an overview of recent highlights in relation to; the Women's Partnership, Place leadership, the strategy for North West Specialist Services, the work that is taking place with local authority colleagues/system partnership, and the North West Prototype model workshops.

The Chair thanked the Chief Strategy and Partnerships Officer, Dani Jones, for the update and acknowledged the work that is being conducted in this field.

Reference was made to the Integrated Child Health Model of Care which will connect care for CYP outside of hospital. This is the model that is being promoted nationally that will bring schools, social care, etc. together to form PCNs. It was reported that this model will put GPs at the heart of care for CYP and is going to be promoted in Liverpool in terms of moving forward locally and across C&M. The Board was advised that the Director of Primary Care and Community Care for NHSE, Amanda Doyle, is going to visit Alder Hey to discuss community services working in collaboration on this model. The Chair felt that it would be beneficial for the Board to receive a presentation on Integrated Child Health Model of Care to highlight the implications for the Trust.

24/25/43.1 Action: LS

It was reported that the Trust is an exemplar for meeting ED targets and as a result has been invited to participate in the group that is being established around best practice. The Board was advised that NHSE are committed to improving Out of Hour services therefore the Trust is trying to acquire funding for virtual ward, the symptom checker, etc. and connect CYP into the Urgent Care Workstream.

The Chair felt that the Trust is in a remarkable place thanks to the national work that Louise Shepherd is involved in and the work that Dani Jones and her team are undertaking on partnerships and Vision 2030.

Resolved:
The Board noted the update on the core relationships and system partnerships in which the Trust are engaged.

24/25/44 Operational Issues

Integrated Performance Report Proposal

As part of annual planning and the implementation of the new 2030 Vision strategy the Integrated Performance Report (IPR) requires a refresh to reflect the objectives and priorities for the 2024/25 financial year.

The Board received an overview of the revised approach for 2024/25 and attention was drawn to the work that has taken place around the alignment of Vision 2030 to the annual plan, the new metrics that will be reported to the Board from June onwards, and the longer term measurements in respect to the strategic outcomes scorecard.

It was queried as to whether the Trust needs to track whole time equivalent (wte) metrics. The Board was advised that a stability index is in the process of being developed to show the movement across and outside of the Trust in addition to turnover metrics. This will link in with the churn rate.

Resolved:
The Board approved the proposed changes to the Integrated Performance Report.

M1 Flash Report/Operational Overview

An update was provided on the progress that has been made on the Trust's strategic goals to date and the areas of challenge, as detailed in the Operational Plan progress summary.

As part of the national pilot site for Martha's rule, it was reported that the Trust has been chosen as an implementation site. The Chief Nurse, Nathan Askew, has also volunteered to establish a North West group to look at best learning.

Garth Dallas queried the general progress around sepsis. It was reported that ED has achieved its targets for administering antibiotics for sepsis within 60 minutes to patients who require them, but there has been a reduction in ward sepsis patients who received antibiotics within 60 minutes (87%) which related to two patients. The Board was advised that the biggest challenge is wards not being aware when an antibiotic has been prescribed. It was confirmed that an educational session has taken place with wards to raise awareness.

Integrated Performance Report for M12, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 12. An update was provided on the following areas of the IPR:

Unrivalled Experience – *Caring*

- There were two cases of C difficile reported; one of which is understood to be hospital acquired therefore a Post Infection Review has been undertaken.

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

- The Trust is reporting a £10.3m surplus position for 2023/24. This is £2m away from the plan set at the start of the year. The deterioration from plan/forecast is due to a reduction in ERF income compared to forecast, mirroring ICB/Specialist Commissioners notification of expected ERF income.
- The full £17.7m CIP has now been achieved in year, with £10.2m identified as recurrent savings and the remaining £7.4m gap carried forward into 2024/25.
- Ernst and Young has commenced the audit of the Trust's financial accounts and will report the position and any movements to the Audit and Risk Committee on the 20.6.24.

Community and Mental Health Division

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

Division of Medicine

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

Reference was made to the sustained response rate of 100% for formal complaints for the fourth consecutive month, and it was queried as to whether any learning has been shared in terms of best practice. It was confirmed that there is an opportunity to do this.

It was queried as to whether Friends and Family (F&F) responses are collected electronically and if so, it was suggested looking at data from an ethnic, demographic, etc. perspective.

Division of Surgery

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

The Chair referred to the issue relating to the completion of clinic letters within ten days and asked as to how this matter can be addressed. It was reported that an Artificial Intelligence (AI) solution is being tested w/c 6.5.24 which captures clinic conversations and produces letters/notes. It was confirmed that measures are in place to protect patient data whilst testing the AI solution and risks are being managed.

The Chair queried the 22% sickness absence figure for Outpatients and queried the reason for this. It was reported that the roster is being developed and therefore there it is likely that the figure is incorrect. It was agreed to look into this matter.

24/25/44.1 Action: NA

Resolved:
The Board received and noted the content of the IPR for Month 12.

Digital, Data and Information Technology Update

The Board was provided with an update on progress against the Digital and Data Futures Strategy; including the overall service, key areas of transformation, and operational performance. The following points were highlighted:

- It was reported that the 2024 Digital Maturity Assessment is due to take place w/c 13.5.24.
- A timeout session took place on the 1.5.24 with the C&M Digital Lead around Place priorities and a programme that will underpin and provide support. It was confirmed that Alder Hey will participate in this work going forward.
- A workshop has been scheduled w/c 6.5.24 to progress Futures and Digital.

A discussion took place around the productivity dashboard and it was queried as to whether it will be submitted to the People and Wellbeing Committee. It was agreed that it was more appropriate to provide a demonstration of the document to RABD.

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

24/25/45 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 Centre* – Work is continuing on the Neonates project and the Trust is liaising with SPV regarding increased SPV costs.
- *Catkin & Sunflower House Building (retrospective claim)* – Meetings have taken place on two occasions with the contractors to finalise the contract position. A follow up meeting is due to take place towards the end of May 2024.

- *Park Reinstatement* – Progress is being made and it is expected that the majority of the park will be completed in the next month. The Board was advised of the issue relating to the drainage system (swale) that requires a solution in terms of draining the park and the Step Place site. It was reported that a conversation will take place with the community to advise of the problem/complexity of the swale drainage system.

A discussion took place about the importance of opening the park on the agreed date and dealing with the technicalities as an ongoing piece of work.

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

24/25/46 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 1.4.24 to the 30.4.24. The following points were highlighted:

- Bespoke training took place on the 1.5.24 for all staff involved in learning responses and acting in Family Liaison roles (FLOs).
- Interviews will take place in the next two weeks for the two Patient Safety Investigator roles.
- The piloting of a Multi-Disciplinary Team (MDT) approach for the delivery of comprehensive learning reviews is taking place for two incidents; Ward 4c safeguarding incident and SI 2023/18692 (*Death of a patient on PICU following elective craniofacial surgery).*
- Legacy action plans will be included in the report until they have been closed.

The Chair highlighted the importance of having the MDT learning reviews looked at independently via SQAC.

Resolved:
The Board noted the update.

24/25/47 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 20.3.24 were submitted to the Board for information and assurance purposes.

It was pointed out that a number of reports are in transition following a request from SQAC for papers to provide clearer data and be more informative.

Resolved:
The Board noted the approved minutes from the meeting held on the 20.3.24.

24/25/48 Gender Development Service (North) Update

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

- The final number of children and young people transferred to the new service was 109. An additional 2 files were received incorrectly which have been closed.
- CYP are being seen on a face to face basis for a full assessment, with the exception of two patients who have been seen virtually due to where they live. To date 28 CYP have attended the new service for assessment and the feedback received has been positive, as detailed in the report.
- Discussions are taking place with NHSE regarding the implementation of a National Youth Advisory Board.
- *Estates* – The project is on track for the service to take occupation from July 2024.
- *Recruitment* – To date the service has appointed 32.2 wte staff. It was reported that recruitment to clinical roles in the service has impacted on the Trust's mental health services with currently 12 wte securing roles in the service. There is a robust plan in place to support the induction of all staff into the service and Alder Hey but recruitment has been paused to ensure that all newly appointed staff have been inducted appropriately.
- *Process for Risk Management* - Discussions are ongoing about the inclusion of a risk on the BAF for a twelve month period for the new service.

Gerald Meehan queried the support available for staff who are working in the new service. The Board was advised that the new service is part of the Trust and therefore has the same processes in place for staff to raise concerns, etc. Alder Hey is also protecting the service from any rhetoric or media.

Resolved:
The Board noted the update on the progress of the new Gender Development Service.

24/25/49 Futures Committee

The approved Research and Innovation Committee minutes from the meeting held on the 18.1.24 were submitted to the Board for information and assurance purposes.

During the inaugural Futures Committee meeting in April there was a focus on the work that has been undertaken on the patient portal and the Futures Strategy from a delivery perspective. The Committee discussed the importance of having a network of partnerships, and a deep dive took place into the four pillars of the Futures Strategy. During the next meeting time will be set aside to receive the Implementation Plan. A risk appetite conversation will take place outside of the meeting to refine the Committee's risk level and appetite.

Jo Revill queried as to whether the Committee has given thought to investment in AI leadership. It was reported that the Trust has some resources and expertise in this sphere but there is a gap in leadership. This is work in progress

Resolved:
The Board noted the approved Research and Innovation Committee minutes from the meeting held on the 18.1.24

24/25/50 People Plan Highlight Report

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

- It was reported that the Mutually Agreed Resignation Scheme (MARS) has been launched and is open until July 2024. The response to the scheme has been positive.
- *Personal Development Reviews (PDRs)* – The Trust's compliance as at the 30.4.24 is 91% against a target of 90%. Thanks were offered to Gill Foden and the Divisions for the effort that has taken place to achieve this figure.

Equality, Diversity, and Inclusion (EDI) Update

The Board was provided with a high-level overview of the strategic and operational activity regarding EDI during April 2024. The following points were highlighted:

- The EDI team were invited to present at a Quality Ward Round supported by the Youth Forum and Patient Experience Team. Chris Browne from the EDI team has developed a survey for CYP and their families. The aim is to gather information regarding how inclusive their experiences have been whilst visiting Alder Hey and to discover how the organisation can better support them. The Youth Forum helped the team to gather this information from patients and staff on the wards, outpatients, and ED. Once all of the data has been collected and analysed, the Trust will use this to identify any key themes and areas for development.
- Staff have been invited to submit an expression of interest to take on the role of the REACH staff network chair. It was confirmed that two strong applications have been submitted for this role.

Resolved:
The Board noted the People Plan update and the EDI update.

24/25/51 Freedom To Speak Up Update

The Board was provided with a summary of the activities of the FTSU team for 2023/2024. The following key points were highlighted:

- The Freedom to Speak Up Guardian's hours were increased in March 2023, following this increase, and the FTSU visibility programme, there has been an escalation in prominence of the FTSUG across the organisations, thus allowing staff greater access to the FTSUG and their ability to raise concerns via this route. It was reported that staff are encouraged to use other routes to raise concerns too.
- *Contact by Professional Groups* – It was reported that nurses (40%) and HCAs (32%) tend to raise more concerns in comparison to other groups of staff.
- *Staff Survey* - The response to FTSU questions in the Staff Survey has positively increased, and whilst slightly below the national best, the Trust is significantly above the average results. The responses received are positive but there are still 26.02 % of staff who don't feel safe in raising concerns and 33.87% are not confident that their concern would be addressed, therefore further work is required to ensure that the Trust is creating the

correct conditions for staff to raise concerns and to feel that they are then acted upon.

- *FTSUG Visibility Programme* - This is a rolling programme and to date the FTSUG has visited 23 of the 30 wards/departments who expressed an interest in an FTSU visit.
- *MIAA Audit* - The FTSU service has recently been subjected to an MIAA audit, with an overall assessment of 'substantial assurance'. There are five recommendations outstanding, as detailed in the report.
- *InPhase* – It has not been possible to use the InPhase system to report and capture FTSU concerns. This matter has been escalated and the Trust is in the process of finding a resolution.
- It was reported that plans are in place to recruit a deputy FTSUG.
- *FTSU Champions* - The Trust continues to recruit into this role. Recently a Champion has been recruited from Alder Hey's consultant body and a meeting is scheduled with another consultant.
- *FTSU App* – The FTSU app has now progressed to the developer stage, with a timeframe for the first draft to be approximately 2 to 3 weeks. Discussions between the FTSUG and the assigned developer continue, this is to ensure that the app provides all aspects of a case journey and beyond, which will include regular reviews post closure to monitor detriment. It was pointed out that the app could be marketed once complete. A suggestion was made about marketing it for other areas as well as FTSU.

Freedom to Speak Up Review Tool for Boards

The report provides a snapshot of Alder Hey's FTSU arrangements against the various parameters set out in the National Guardian's Office review and planning tool, together with suggested areas for improvement, as follows:

- The Trust has excellent FTSU arrangements in place but it was felt that an evaluation needs to be undertaken to highlight what the organisation does.
- There isn't a standalone strategy in place for FTSU therefore it is recommended that the Trust develops a formal written implementation plan that links in with the FTSU report and includes an appendix to show progress, whilst continuing to link closely to the People Strategy outcomes.
- Evaluate feedback and the monitoring of detriment in a more structured way.

For noting
The recommendation of an FTSU Implementation Plan was supported and it was suggested that the FTSU tool be included in the cultural work that the Trust is undertaking rather than being a standalone document.

A number of questions were raised that Kerry Turner responded to regarding the processes in place to measure staff satisfaction once a case has been closed, whether a strategy will be implemented to bring all of the Trust's apps together, and the meaning of culture from an FTSU perspective. It was agreed to try and put more detail into the FTSU report to provide anonymised examples of culture going forward once the organisation has agreed a definition of culture.

24/25/51.1 Action: KT

Resolved:
The Board noted:

- The Freedom To Speak Up update.
- The Freedom To Speak Up Review Tool for Boards update

24/25/52 Statement of Going Concern

Having considered the specific factors as part of the assessment of going concern, the Trust's Directors have a reasonable expectation that Alder Hey Children's NHS Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements. The organisation currently has a significant level of its own cash resource available demonstrating strong liquidity *(£78.3m as at the 31st March 2024).*

The Board can take assurance that it is reasonable to expect that the 2024/25 funding levels will be maintained based upon the plans detailed in the report, as the actual income streams are not expected to be materially different. Arrangements beyond 2024/25 are yet to be confirmed but the Trust assumes similar arrangements to those in place for 2024/25 will be adopted.

The Chair of the Audit and Risk Committee (ARC) advised that there were no issues raised by Ernst and Young with regard to the 2023/24 annual accounts and associated financial statements being prepared on a going concern basis

Resolved:
The Board agreed that it is appropriate for the 2023/24 annual accounts and associated financial statements to be prepared on a going concern basis.

24/25/53 Audit and Risk Committee

The approved minutes from the meeting held on the 25.1.24 were submitted to the Board for information and assurance purposes.

During April's meeting the Committee focussed on a number of year end assurance reports for 2023/24 and forward plans for 2024/25. It reviewed the positive outcome from the review of Internal Audit effectiveness, approved an increase in days for the Internal Audit Plan following a benchmarking exercise to similar Trusts in C&M, and had a detailed discussion on the forward plan for the implementation of the remaining modules in InPhase and completion of the outstanding issues within the risk and incident modules. The Committee has asked that a detailed project plan for Phase 2 of InPhase be submitted to ARC in June.

Resolved:
The Board noted the approved minutes from the meeting held on the 25.1.24.

24/25/54 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 25.3.24 were submitted to the Board for information and assurance purposes.

It was reported that April's meeting was positive and the Committee is starting to see a step change in the way it is looking at performance across the Trust. The Chair of RABD, John Kelly, informed the Board that Divisional presentations are exceptional and now provide the Committee with rich data. It was confirmed that there is to be a focus on non-clinical performance during May's meeting.

The Board was advised that the Committee is starting to see the integration of the Transformation Programme in daily operations. It was reported that a decision has

been made to change the Committee's name to encompass all of the areas that it covers.

Resolved:
The Board noted the approved minutes from the meeting held on the 25.3.24 .

24/25/55 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:

- Risk appetite conversations have taken place with two of the Assurance Committees and an in depth review of BAF risk 1.1 *(inability to deliver safe and high-quality services*) will take place during SQAC in May.
- It was reported that RABD is in the process of identifying their top four risks that will be monitored by the Committee on a monthly basis.
- A discussion is to take place with the Chair and Executive leads of the Futures Committee to refine the risk level and appetite.
- A risk has been included on the Corporate Risk Register relating to the Gender Service which is linked to BAF risk 2.1 *(failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for CYP).*

It was pointed out that the risk rating for BAF risk 2.3 *(Workforce Equality, Diversity and Inclusion)* has decreased and a query was raised about the process for this decision. It was reported that a deep dive took place during the People and Wellbeing Committee and it was agreed that there were enough mitigations in place to reduce the risk from 15 to 12.

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

24/25/56 Any Other Business

There was none to discuss.

24/25/57 Review of the Meeting

The Chair felt that the Trust has ended the year in a good position but pointed out that 2024/25 will bring further demands that will require change. It was reported that the new Vision 2030 signage is having an impact across the hospital and is due to be distributed in the community.

The Chair drew the meeting to a close and thanked everyone for their contributions during the meeting.

Date and Time of Next Meeting: Thursday 6th June 2024, 9:00am, LT2, Institute in the Park

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for June 2024							
11.4.24	24/25/17.1	Futures Committee	Discuss the positioning of the Global Strategy in terms of it having its own autonomy and the Committee route that it will report into.	J. Grinnell	6.6.24	On-track June-24	
Actions for July 2024							
8.2.24	23/24/266.1	Gender Development Service (North) Update	Submit an initial draft risk register for the new Gender Development Service to the Audit and Risk Committee in April.	L. Cooper	6.6.24	On track July-24	**1.3.24** - The draft Risk Register for the new Gender Development Service was submitted to SQAC on the 20.3.24. It will also be submitted to ARC in July 2024. **ACTION TO REMAIN OPEN**
8.2.24	23/24/273.1	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	6.6.24	On track July-24	**11.4.24** - A meeting is in the process of being arranged. An update will be provided in due course. **ACTION TO REMAIN OPEN**
11.4.24	24/25/11.1	Mortality Report, Q3.	Look at how the Trust can benchmark itself following the change to the requirement for reporting deaths of CYP age 4 and above with a learning disability and/or Autism to the LeDeR programme.	A. Bass	6.6.24	July-24	4.6.24 - This action is in progress. An update will be provided in July. **ACTION TO REMAIN OPEN**
2.5.24	24/25/43.1	Collaborate for Children and Young People	Submit a presentation on the Integrated Child Health Model of Care to highlight the implications for the Trust	L. Shepherd	4.7.24	July-24	
2.5.24	24/25/44.1	Integrated Performance Report	*Division of Medicine* - Review the 22% sickness absence figure for Outpatients to determine whether this information is correct, taking into account the development of the e-roster.	N. Askew	4.7.24	July-24	
Actions for September 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	Sep-24	**5.6.24 -** This action is being progressed. An update will be provided during September's meeting. **ACTION TO REMAIN OPEN**
8.2.24	23/24/267.1	Learning from Patient Safety Incidents	Schedule a Board Development Session on PSIRF in April 2024.	N. Askew	6.6.24	On track Sep-24	**1.3.24** - This session will take place in September 2024.
2.5.24	24/25/51.1	FTSU Update	In order to show the meaning of culture from an FTSU perspective, it was agreed to include more detail in the FTSU report to provide anonymised examples of culture once the Trust has agreed its definition of culture.	K. Turner	5.9.24	On track Sep-24	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
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	Closed	**5.1.23** - Contact has been made with the CEO of LWH. An update will be provided in February. **30.1.24** - A meeting has been scheduled for the 10.4.24. An update will be provided during April's Trust Board. 11.4.24 - The initial meeting that was scheduled has been deferred to the 24.4.24. An update will be provided in May. **2.5.24** - A productive meeting took place on the 25.4.24. During the meeting discussions took place about how both organisations can work together going forward, especially in terms of the Liverpool Neonatal Partnership. It was felt that it is important to establish a Partnership Board to enable oversight and take advantage of the opportunities to bring clinical teams together in a new way to think about future working. **ACTION CLOSED**
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	Closed	**2.5.24** - It was confirmed that there is lot of work being undertaken to progress the Green Plan, and the Trust is looking at where it will best fit in the programme. **ACTION CLOSED**
8.2.24	23/24/260.2	System Wide Update	Discuss a way forward for Research and Innovation to feed into systems/mechanisms.	D. Hawcutt/ D. Jones/ A. Prendergast	6.6.24	Closed	**26.4.24** - This action is in progress. An update will be provided in June. **2.5.24** - Dan Hawcutt is liaising with Jenny Dalzell and the system, HIP, and a catch up meeting has been scheduled. **ACTION CLOSED**
7.3.24	23/24/307.1	Futures Committee – Terms of Reference	Conversation to take place to decide as to whether investment decisions will be deferred to RABD or whether the Futures Committee will have autonomy to approve financial decisions.	S. Arora/ J. Chester/ J. Kelly	6.6.24	Closed	**26.4.24** - This action is in progress. An update will be provided in June. **ACTION TO REMAIN OPEN** **5.6.24** - Discussion took place during the Futures Committee and it was agreed that RABD would only become involved at certain levels of expenditure. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	**2030 Transformation Programme Update**
Report of:	**Natalie Palin, Director of Transformation** **Kate Warriner, Chief Digital and Transformation Officer**
Paper Prepared by:	**Natalie Palin, Director of Transformation**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	**Trust Board 22/23/06**: Operational Plan 22/23 Trust Integrated Performance Report **Strategy Board** – Strategic Scorecard (July 23) **Transformation Programme (Report Dec 2023)** Transformation programme (Feb 24) Annual Plan 24/25
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
Resource Implications:	NA

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description					Score
3.2	Strategy Deployment					12
Level of assurance (as defined against the risk in InPhase)	☑	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

This report provides an update on the position for year 2 on our journey to Vision 2030, focusing on progress from April 2024 to the end of May 2024, highlighting key developments and performance metrics. It draws on data and insights from the Resource and Business Development (RABD) committee and programme governance.

The purpose of this report is to inform the Board of Directors about the current situation, benefits, and recommendations for future actions. Additionally, this report will assess our governance and assurance practices to determine if we are achieving our objectives and delivering them in accordance with a culture that supports our people to thrive.

Recommendations to:

- Note the progress made to date, and review the detailed actions scheduled across the remainder of quarter 1, into start quarter 2 (July 24).

2. 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):

Our starting focus for 24/25 as outlined in the April 24 Trust Board report, was directly aligned in support the achievement of a £20m efficiency target, enhancing operational efficiencies and achieving key performance targets; whilst also kickstarting programmes of change that will deliver the longer-term transformational change outlined in Vision 2030.

3. Current Situation – Our Journey to 2030

In recent months, significant efforts have been directed across our Strategic Goals to support our journey towards 2030. Each of the programmes have established effective routines and have programmes of change scoped and or have continued to implement change that directly supports our strategic vision. Table 1 provides a snapshot of the key initiatives implemented, which are designed to improve **outcomes** and **experiences** for children and young people (CYP), enhance our people's wellbeing and effectiveness, and deliver positive **efficiency** and direct financial benefits.

Table 1: Key Highlights

Quadruple Aim	Strategic Goal – Highlights
Experience: Children, Young People & Families	**Outstanding Care and experience:** CYP Charter Finalised **Collaborating for CYP:** Positive reduction in waiting for <10 for tooth extraction Learning Disability (May 24) **Revolutionising Care**: Proof of concept, Height and Weight Clinics in school, avoid travel and disruption to learning.
Experience: Our People	**Our people**: Enhancing staff engagement (Clinical Summit) and leadership development (Managers Essentials).
Improved Outcomes	**Revolutionising Care:** Cross divisional planning to ensure clear and concise approach to surgery productivity current ERF performance 108% (April 24) **Revolutionising Care:** Personalised Care proof of concept and scalable change improved, to operationalize aim of a named 'care coordinator'. Community and Mental Health division exploring the options to make happen.
Efficiency	**Transformation:** Target 2024/25 £12.6m and YTD £5.6 m posted Green, in efficiency plan. Improved position since April 24 (overall target £20m). **Our people**: Strengthening financial management and budget control. **Pioneering Breakthroughs:** 4 Futures Pillars mobilised, and programmes of work are commencing.

4. Benefits

During the period from April 2024 to the end of May 2024, 2030, the programme has made notable progress in several areas:

Table 2: Strategic Benefits

Metric	Month	Performance	Target	Average (23/24)	Variance	Assurance
Proxy Measure: F&F Test - % Recommend the Trust *Development of effort score in 24/25	Apr-24	93%	95%	93%		
Incidents of harm per 1,000 bed days (rated Minor harm and above)	Apr-24	9	14	13		NA
Number of Incidents rated No Harm and Near Miss per 1,000 bed days	Apr-24	55	46	46		NA
Staff Thriving Index	*** Due July 24 ***					
Number of patients benefitting from Futures solutions or products deployed to care	*** In Development ***					
Increase activity IP /EL – ERF Value %	Apr-24	108%	115%	102%		
Improving Clinical Outcomes	*** In Development ***					
Social Value Generated	*** Due July 24 ***					
Strategic Transformation: Financial Benefits	Apr-24	47% (44%)	£12m Revised to £12.6m (16.05.24)	NA		

As illustrated in Table 2, two strategic measures are scheduled for implementation in July 2024, with an additional two measures currently in development. In the interim, a suite of driver measures is being used to monitor performance, supported by robust governance and assurance processes aligned with our defined milestone plan. A notable area of continued improvement is workforce management, with a reduced sickness absence rate of 3.2%.

For Month 2 (M2), we are reporting a positive position against the efficiency target, with current achievements at £5.6m out of the £12.6m target assigned to transformation, as part of the broader £20m goal. This indicates that these programmes are generally on track or have manageable issues. However, a gap remains that needs to be addressed. Additional focus on workforce efficiency has been identified as a key mitigation strategy to help close this gap. Assurance and scrutiny of the workforce efficiency programme is scheduled for review at the RABD meeting in June 2024.

Securing Investment: A proposal presented at the May (2024), 2030 Programme Board (2030 PB) comprehensively detailed the current state and outlined various strategies for securing additional investment. This proposal encapsulates the management framework and key principles for a trust-wide investment approach, under the stewardship of the SRO of Pioneering Breakthrough. An in-depth mobilisation plan, predicated on these outlined strategies, is scheduled for review by the 2030 PB in July 2024.

5. Governance

Our assurance and governance processes are crucial in determining whether we are achieving our set objectives and delivering them in the right way. Since April 2024, new governance arrangements have been implemented. This includes the establishment of our 2030 Programme Board (2030 PB), which report directly into the Resource Committee, ensuring better oversight and alignment with our long-term strategic goals.

Governance alignment of Vision 2030 into the Trust Board and sub-committees is being scoped for July implementation. This alignment will ensure that our long-term vision is integrated into our governance structures, facilitating better oversight and strategic coherence.

Programme Governance: As detailed in Table 3, effective programme management is a core component of the Trust's 2030 programme management approach. The overall shape of the programme is assessed as part of a standard report to the 2030 Programme Board (PB) and then shared and updated following the Resource Allocation and Budget Development (RABD) meetings.

Each Strategic Goal has established a programme board and provides a highlight report to the 2030 PB, along with a detailed milestone plan. Time is scheduled as part of the standard work of the 2030 PB to spotlight each of these areas appropriately.

The new programme governance and assurance process was approved in April 2024. Four of the Strategic Goal programmes have been assessed using this framework, and all have scored green. This positive position indicates the high level of commitment and oversight by SROs and the wider programme team.

In accordance with the Terms of Reference of the 2030 PB, change control is a duty of this board. A scope change was approved at the 2030 PB meeting in May 2024 to include an additional programme supporting workforce efficiencies.

Table 3: **Programme Governance Overview (May 24)**

Benefit Cases	All strategic programmes for 2024-2026 are expected to have a completed benefits plan. The year-to-date progress is as follows: • 10 out of 17 benefit cases have been completed. • The remaining benefit cases are scheduled for completion across quarters 2 and 3.
Scope Definition	The scope has been defined for all strategic goals. Strategic programme level scope is required for aspects of Revolutionising Care, People, Collaborating, and Futures.
System Collaboration – supporting 2030	Urgent Care System work continues, with data packs shared with Primary Care networks for frequent attendees to support target intervention and education.
Milestones	Milestones have been defined at the strategic goal level, though gaps remain at the programme level. RABD Feedback: Reassess the resource plan, to ensure the achievability of milestone given numbers scheduled for completion June 24.
Programme Governance	Good programme governance is reflected in four green ratings for Experience, Thriving, Net Zero, and Reducing Health Inequalities.

6. Culture Alignment

Given the significance of culture in determining the success of our ability to create a movement across all levels of the organisation to realise our Vision 2030, alignment with our culture work is crucial.

Clinical Summit Summary

On 19th April 2024, Alder Hey hosted a Clinical Summit, bringing together over 80 clinical leaders to discuss leadership and learn more about Vision 2030. The event was highly positive, fostering connections among colleagues and facilitating co-design of actions to support the journey to 2030.

Key Themes from the Clinical Summit:

- Clinical Leadership, Empowerment, and Culture: Enhanced leadership support and effective training are needed to empower clinical care professionals.

0026
- Process and Operational Efficiency: Suggestions included optimising recruitment, patient care protocols, resource management, and digital infrastructure to improve overall efficiency.
- Data Management and Utilisation: There were calls for better data systems and access, ensuring colleagues are aware of data use at individual, organisational, and system levels.
- Innovation and Continuous Learning: Participants expressed a desire to sustain a culture of innovation and continuous improvement, leveraging the Brilliant Basics Improvement System and Futures.
- Community and Specialist Care Integration: Recommendations were made to better integrate community and specialist care to streamline patient services.
- Engagement and Strategy Implementation: Feedback highlighted the need for clearer communication and effective engagement strategies to align team members with the strategic vision.

Following the summit, all results were shared with attendees, and a commitment was made to further explore clinical leadership at Alder Hey. Using the @Its Best methodology, all clinical leaders will be offered one-to-one interviews, with thematic results to be shared at the next clinical leaders' session on 11th October 2024. Solutions will be co-designed, and SROs will review results from the world café sessions to explore the ideas suggested during the summit.

7. BAF Risk: 3.2 Strategy Deployment

The risk of failure to execute 2030 vision and make a positive impact on children and young people, is current rated at a 12, and has remained static across year to date. The unprecedented financial environment compels us even more to deliver the level of change that we foresaw through our vision 2030, whilst ensuring that we are sensitive to the need to bringing our people with us.

In aligned with good practice this risk is reviewed as part of 2030 PB rhythms and routines. A key element of the risk that will be explored in more detail as part of next programme board, is the split between longer-term transformations versus in year process optimization programmes to ensure that the balance of the portfolio.

A specific risk regarding potential lost income due to new ways of working is currently being evaluated to understand the level of risk and identify mechanisms to mitigate it.

Conclusion

This report provides a comprehensive overview of our current position and outlines clear actions to drive further improvements. We look forward to discussing these plans in more detail at the upcoming Board meeting.

Recommendations

To note the progress made to date, and review the detailed actions scheduled across the remainder of quarter 1, into July 24.

Next Steps

1. Review programme milestones and resource plan to support success.

0027 2. Continue to Monitor Financial Performance: Focus on workforce efficiencies strategies to address the current financial gap.

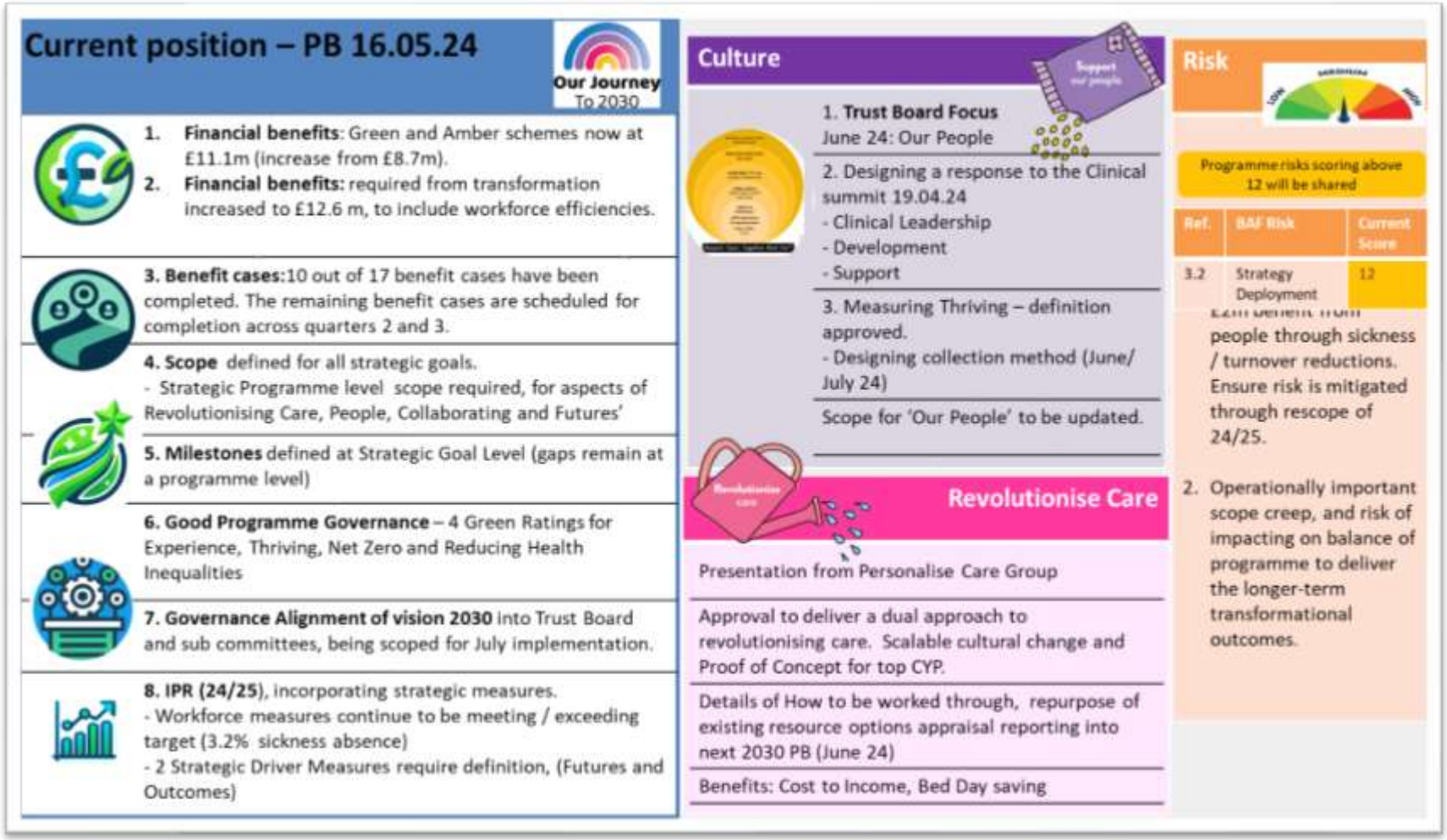
3. Clinical Leadership: Progress with actions to enhance Clinical Leadership.

4. Address BAF Risk 3.2: Ensure that short-term financial benefits do not compromise long-term strategic goals.

5. Personalised Care Proposal: Present an options appraisal for scalable personalised care and care coordination at the next programme board.

Appendix 1: Key messages 2030 PB

Appendix 1: Key messages 2030 PB



NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: May 2024

VISION 2030

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

OUR ASPIRATION
To be world-leading

Our Journey
To 2030

The Needs of Children, Young People and Families

Get me well

Personalise my care

Improve my life chances

Bring me the future

Outstanding care and experience

Collaborate for children & young people

Revolutionise care

Support our people

Pioneering breakthroughs

respect

excellence

innovation

together

openness

Contents

VISION 2030

Our Journey To 2030

IPR Summary

The matrix below provides a summary of performance 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	Level 1 patient safety training is consistently achieving target with an improving trend	Staff Turnover and Sickness (Total) are inconsistently achieving target with an improving trend	Long Term Sickness and PDRs are not achieving targets but demonstrating improvement
	Common Cause	Category 3 & 4 Pressure Ulcers, Deteriorating inpatients, Mandatory Training, Cancer (All) and MRSA metrics are achieving targets	Complaints, PALs, Sepsis (IP & ED), WNB rate, ED 4hr, ERF, C.Diff/MSSA and Risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation, Diagnostics and F&F Trust are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern		.	

From an overall perspective the headline analysis summary based on SPC metrics (assurance icon) is as follows:

- We are consistently passing 22.2% of our metrics, with 72% of the evaluated SPC metrics achieving the target in the month of April 2024.
- We are achieving 61.1% of our metrics inconsistently.
- We are not achieving the target for 16.7% of our metrics but experiencing improvement in 2 (33.3%) of these metrics and 0 are showing special cause of concern.

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

Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

No serious incidents or Never Events; significant decrease in the number of medication errors resulting in harm; no Category 3 or 4 pressure ulcers; 94% of inpatients and 93% of ED patients received antibiotics for sepsis management; 4th consecutive reduction in patients admitted to Critical Care unexpectedly from inpatient wards

Areas of Concern:

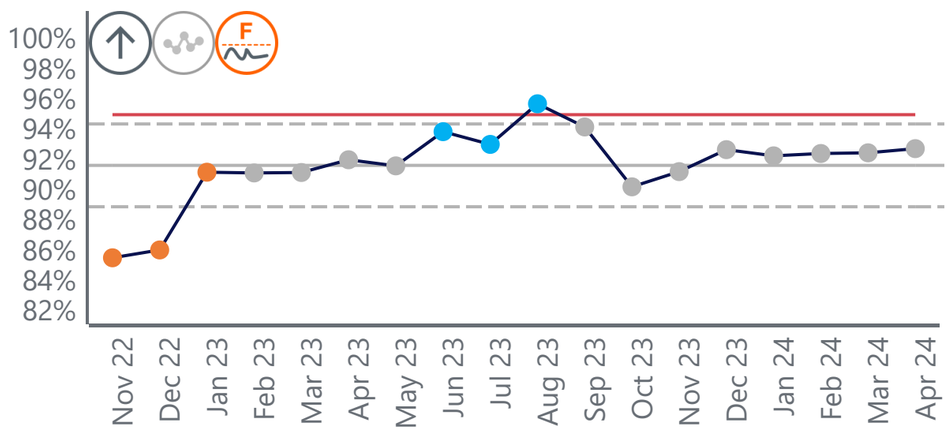
Increase in the number of PALS concerns received in year which is comparative to 2022/23 but significant increase to pre pandemic. Average of 82% of PALS concerns resolved within 5 working days in year

Forward Look (with actions)

Local resolution of concerns wherever possible

F&F Test - % Recommend the Trust

Target: Statutory



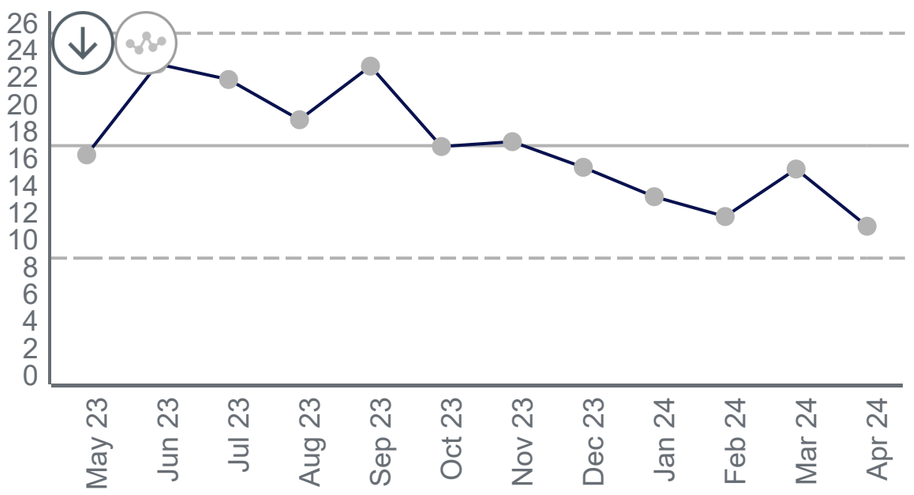
Technical Analysis:

Consistently not achieving the 95% target. April performance of 92.8% represents slight increase from March performance of 92.5%. This does represents fifth consecutive month above average of 92%.

Actions:

Consistent response rate above 92% from children, young people and families rating the Trust as good or very good. Survey underway to ascertain the views of staff in collecting FFT data

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



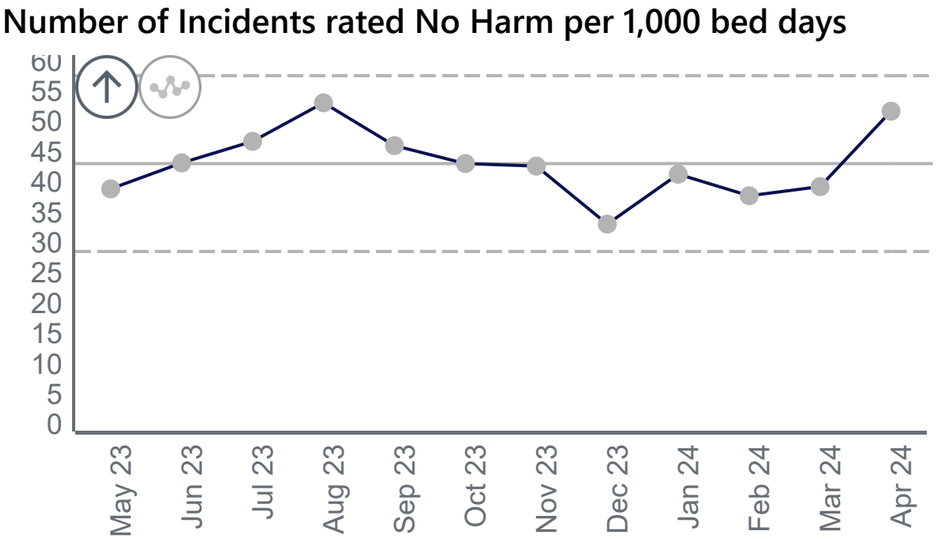
Technical Analysis:

Common cause variation has been observed with performance of 11 incidents of harm per 1,000 bed days, with a monthly average of x17 incidents during the period. Incidents are now assessed on Physical and Psychological Harms. The period illustrated covers from May-23 only, the month the trusts risk management system InPhase went live.

Actions:

Reduction in the number of incident reports submitted which is positive. PSIRF panel becoming well embedded and learning reviews have been planned and / or undertaken

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



Technical Analysis:

Common cause variation has been observed with performance of 52 incidents of no harm per 1000 bed days. With a monthly average of 43 during the period. This includes 43 incidents who have no harm assigned due to not involving a patient directly. Incidents are now assessed on Physical and Psychological Harms. Period illustrated covers from May-23 only, the month the trusts risk management system InPhase went live.

Actions:

Increase in the number of incident reports of no harm and near miss submitted which is positive; all staff are encouraged to report all incidents

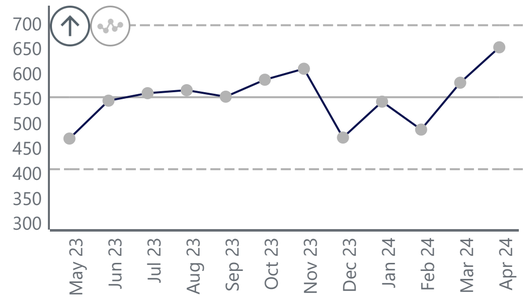
0033

Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

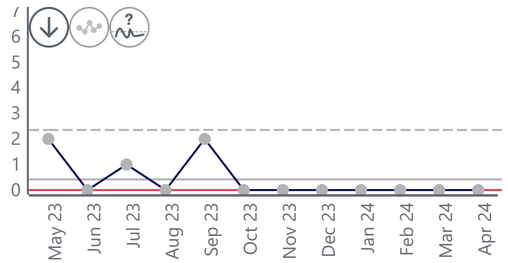
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



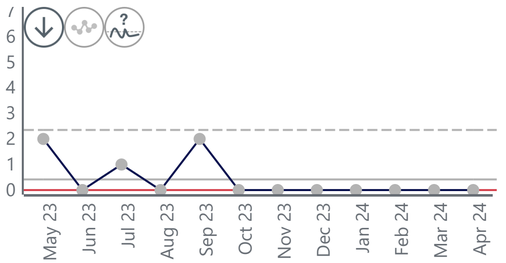
Severe or Fatal Incidents – Physical only

Target: Internal

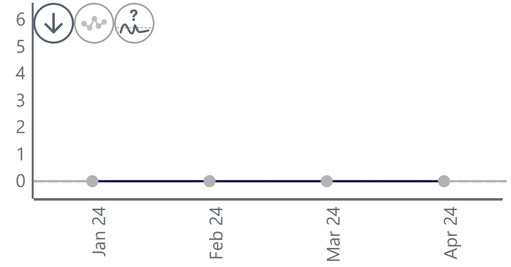


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

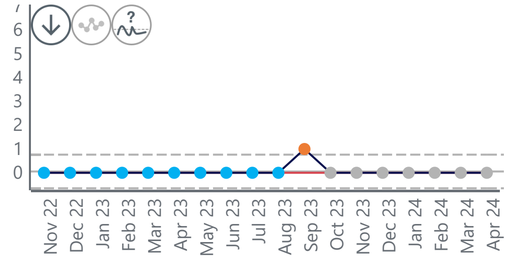


Number of PSIIs (Patient safety incident investigation) undertaken



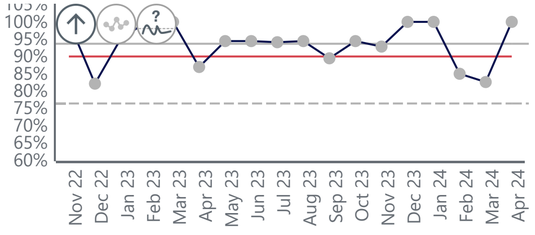
Number of Never Events

Target: Internal



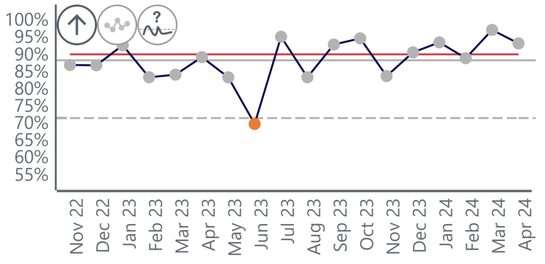
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

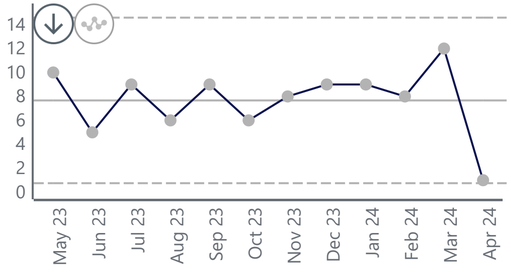


Sepsis % Patients receiving antibiotic within 60 mins for ED

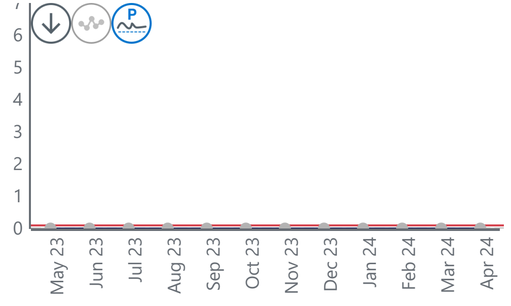
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

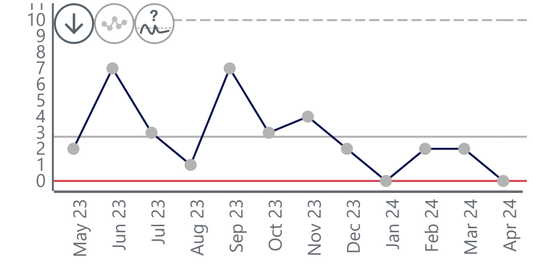


Pressure Ulcers Category 3 and 4

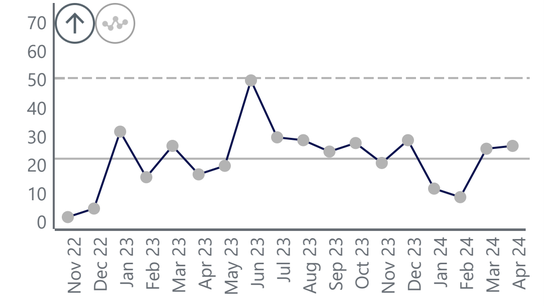


Pressure Ulcers Category 2

Target: Internal

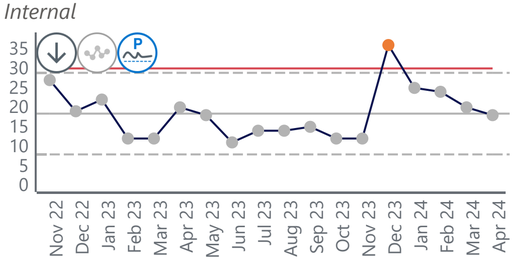


Recording of restrictive interventions



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

Target: Internal



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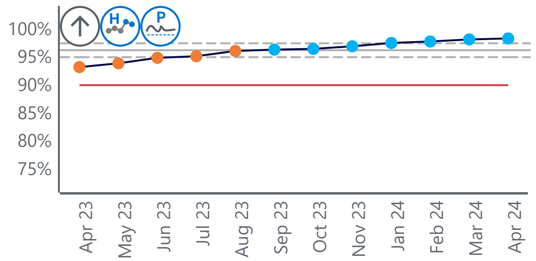
Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

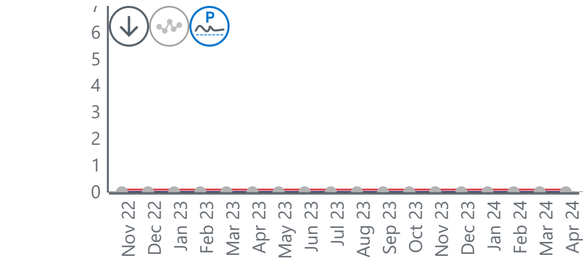
Employees trained in new Level 1 of Patient Safety

Target: Internal



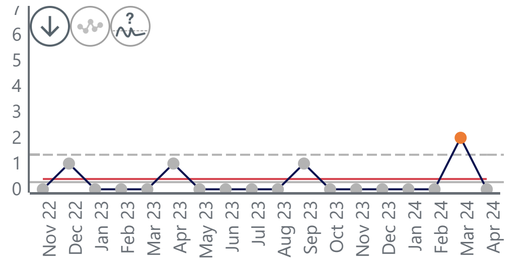
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



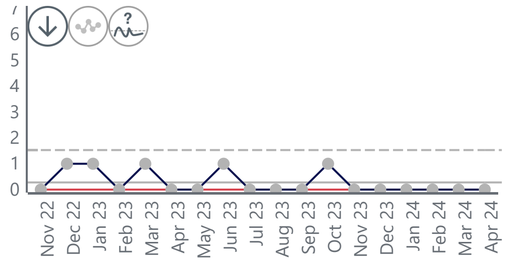
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



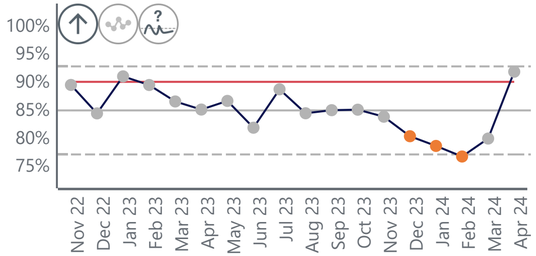
Hospital Acquired Organisms - MSSA

Target: Internal



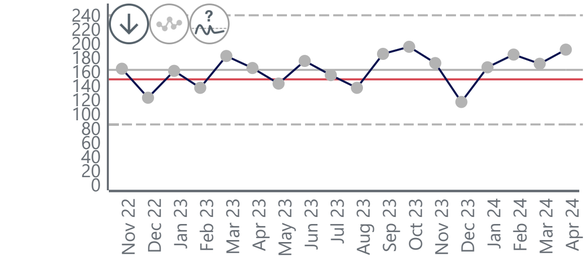
% PALS Resolved within 5 Days

Target: Internal



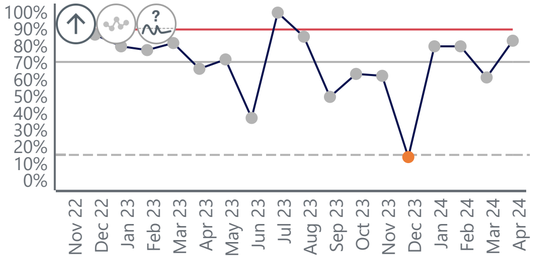
Number of PALs contacts

Target: Internal



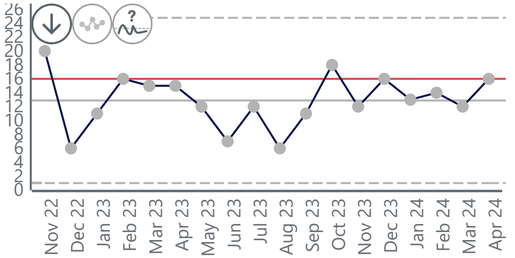
% Complaints Responded to within 25 working days

Target: Internal



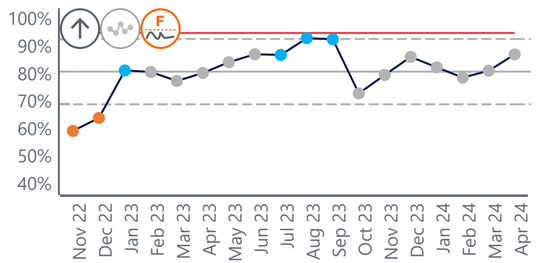
Number of formal complaints received

Target: Internal



F&F ED - % Recommend the Trust

Target: Internal



Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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

Highlights:

- ED performance achieved 87.5%, exceeding the national target of 78%
- Productivity measures aligned to Model Hosptial are now included
- "ADHD: % Referral to triage <12 weeks" shows sustained performance of 100%
- 100% compliance for access to cancer services, exceeding national standard
- 735 patients waited over 52weeks for treatment against an external trajectory of 800. Capacity planning required to reduce to zero by March
- Transformation programme commencing delivery including progress with urgent care system and primary care network engagement and height and weight clinic trials in some schools

Areas of Concern:

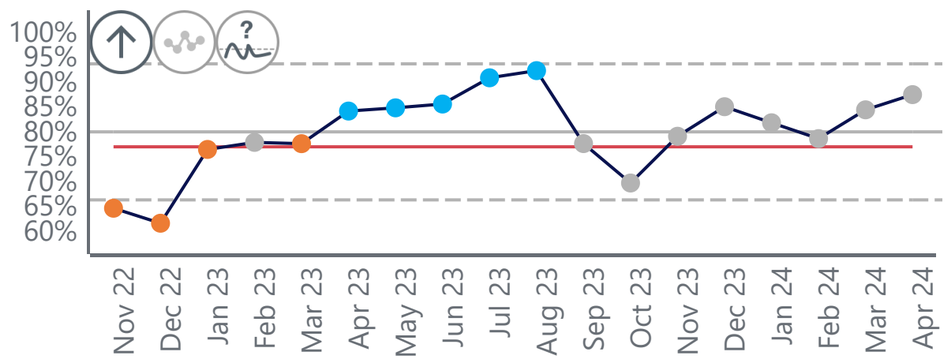
- DM01 currently at 85%, and national target is 95% for year end
- There are 5,761 patients waiting 2 years (and longer) for their follow up. There is an ambition to reduce this to zero by year end. Safe Follow Up Care project underway in four areas
- Theatre utilisation remains below the national target of 85%, achieving 77/78% for third consecutive month

Forward Look (with actions)

- Slight increase in WNB rate in April compared to previous month. Patient Portal project delivery plan due to empower families to manager their appointments with greater control
- Decision on the capacity investment and benefits case to achieve the 52 week standard
- Productivity measures to be reviewed to identify areas of improvement and next steps
- Plan within Division of Medicine for sleep studies to be compliant with the 6 week standard by Q2.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

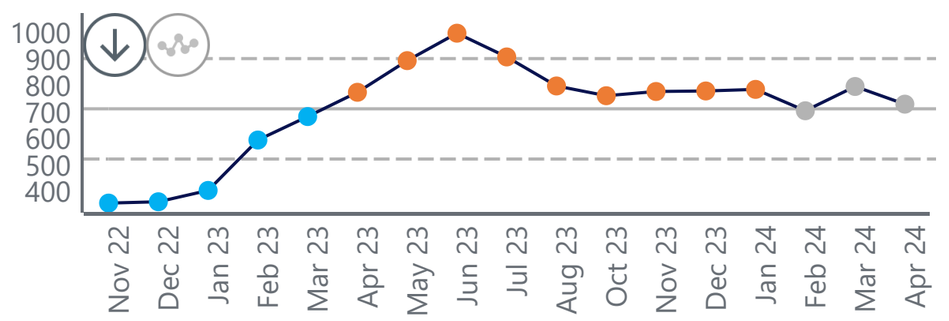
Trust achieving the new national target (>77%) in Apr-24. Common cause variation has been observed with performance of 87.5%. Improvement from Mar-24 of 84.4%. Apr-24 performance is +3.3% compared to Apr-23 (84.2%) whilst also having +569 extra attendances in Apr-24.

Actions:

ED have a set an internal target of 85% for 2024/25. Department is currently performing well; however, a plan is required for loss of PAU and EDU beds due to the Neonatal build and mitigation plan is currently in discussion with surgical division.

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

Target: Internal



Technical Analysis:

Demonstrating common cause variation with number of patients waiting > 52 weeks at 735 for April 2024. This is a decrease from March 2024 position of 802. The top 3 services with waiters >52 weeks: Dentistry (n= 308), ENT (n=195) & Neurology (n=59). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

Actions:

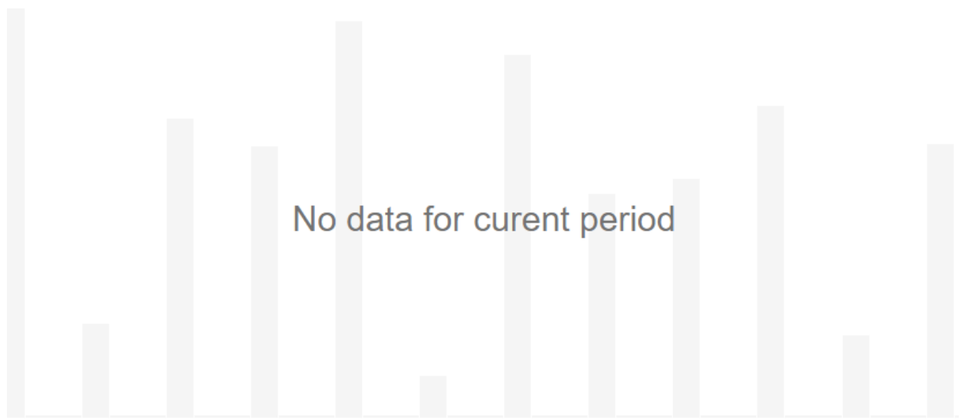
Operational teams are working on capacity & demand, as well as forecasting performance. A paper for additional capacity for the surgical division is being presented in May Operational Delivery Board.

Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

Improving Clinical Outcomes - Metric in Development



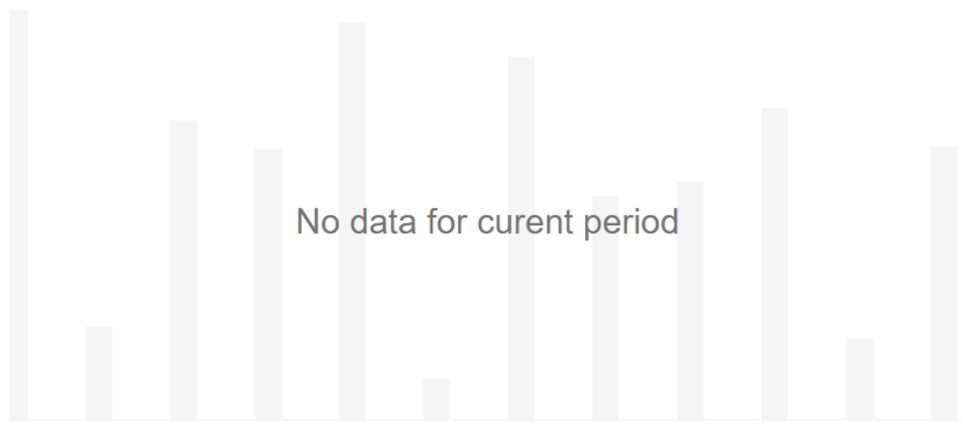
Technical Analysis:

This metric is under development

Actions:

This metric is under development and is one of the strategic driver measures for the 2030 Strategy.

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



Technical Analysis:

This metric is under development. The previous measure of 'Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis' is temporarily included as a watch metric on page 11 whilst the new measure is in development.

Actions:

This metric is under development with the Community & Mental Health division after altering the measure from the previous "Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis". The numbers waiting the end of April 2024 was 2,238.

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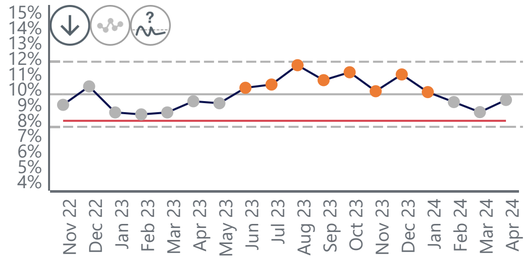
Integrated Performance Report | May 2024

NHS
Alder Hey Children's
NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

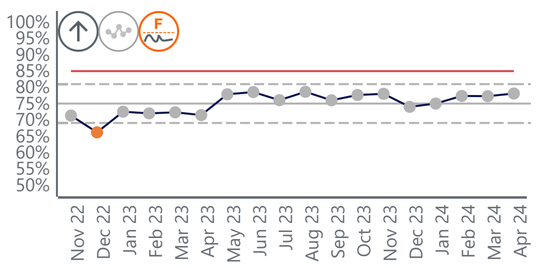
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

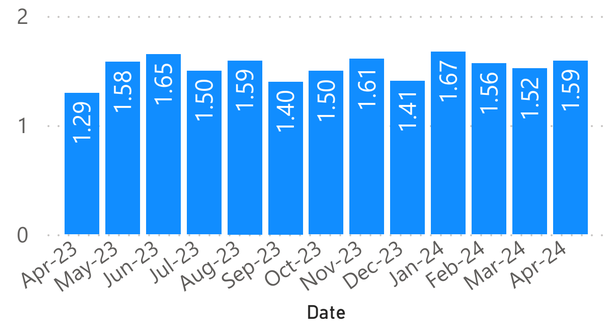


Theatre Utilisation (Capped Touch Time)

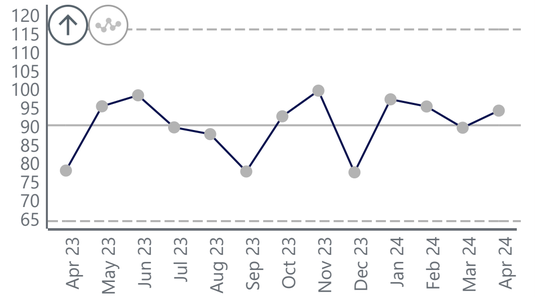
Target: Internal



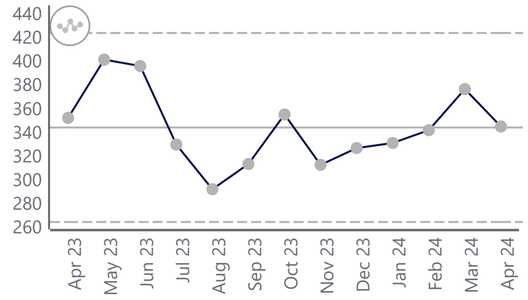
Elective admissions (IP & DC) per clinical WTE



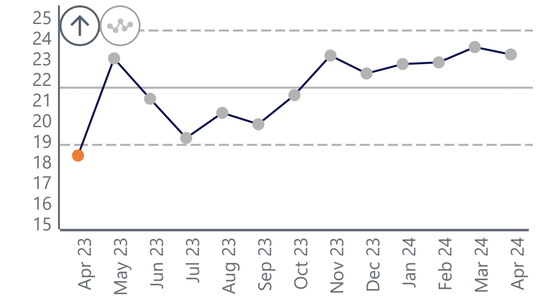
Outpatient attendances per Consultant WTE



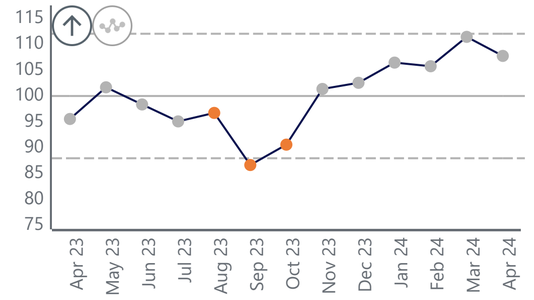
A&E Attendances per ED Consultant WTE



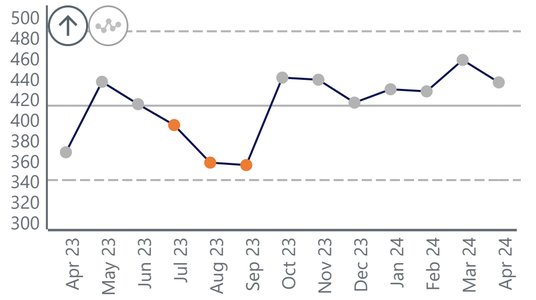
Inpatient Discharges per working day



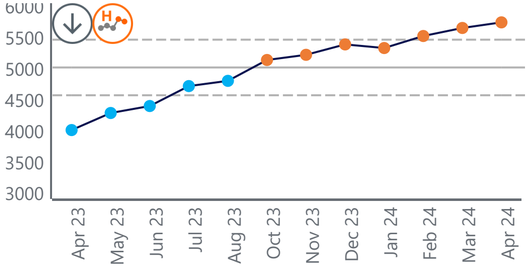
Day Cases per working day



Outpatient New & OPPROC per working day

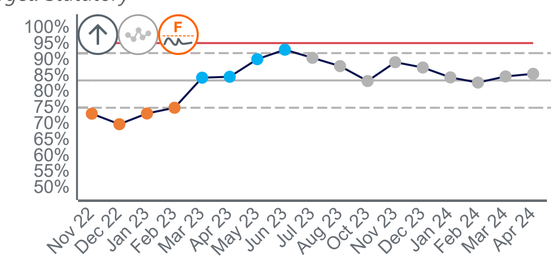


Reduce overdue Outpatient Follow Up Waits - 2 years & over

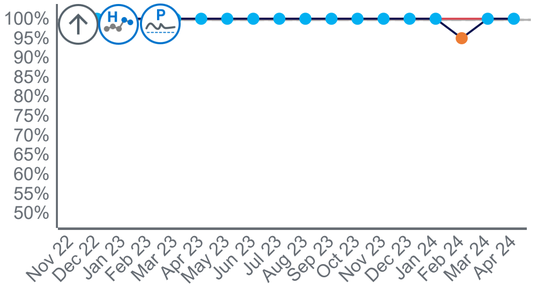


Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



ADHD: % Referral to triage within 12 weeks

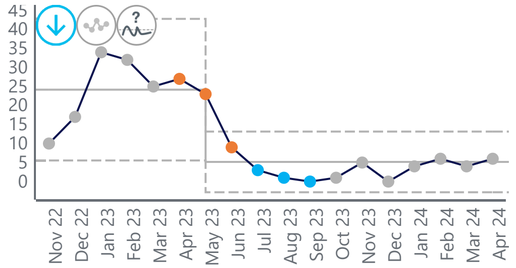


Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

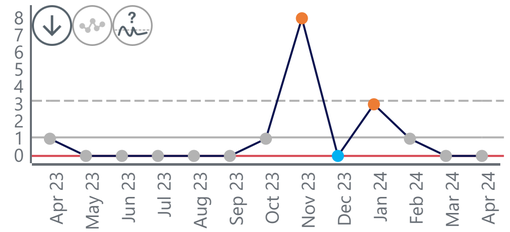
Revolutionise Care - Effective & Responsive - Watch Metrics

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



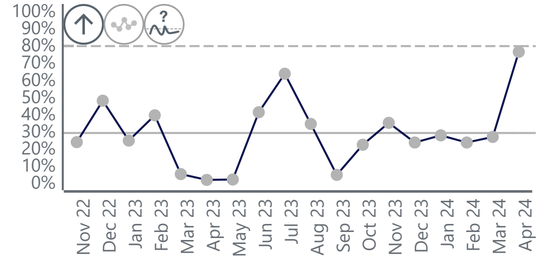
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal

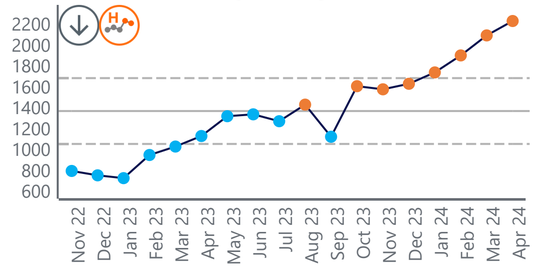


IHA: % complete within 20 days of referral to Alder Hey

Target: Internal

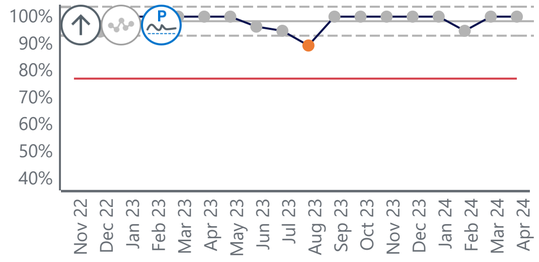


Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



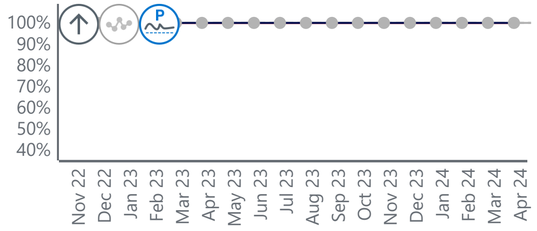
Cancer: Faster Diagnosis within 28 days

Target: Statutory



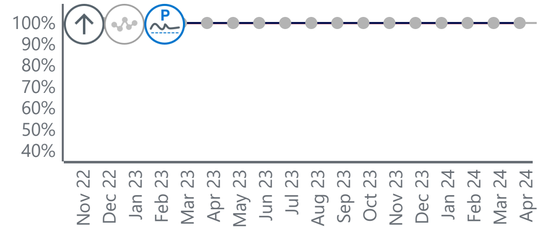
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

Target: Internal (Stretch)



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

- PDR completion increased from 76% in March 2024, to 90% in April 2024
- Mandatory training completion remains over 90%
- Turnover continues to approve and in April 2024 has achieved the revised 10% target
- Sickness absence is 4.8%, below the 5% target

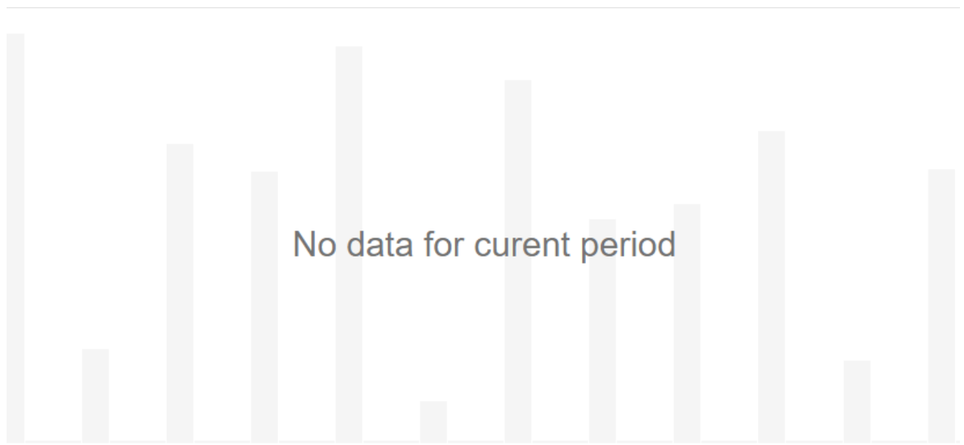
Areas of Concern:

The medical appraisal completion recovery is ongoing, with an increase of +8% from March to April 2024

Forward Look (with actions)

Workforce Stability is reported for the first time in April 2024. Previous months data will be added in the June (May performance) report. For the first 12 months, there is no target for the measure. For reference, workforce stability % = number of people who are in the same division and band* as they were 12 months ago ÷ current total workforce in that area (*for the medical and dental workforce, job role is used instead of band).

Staff Thriving Index - In Development



Technical Analysis:

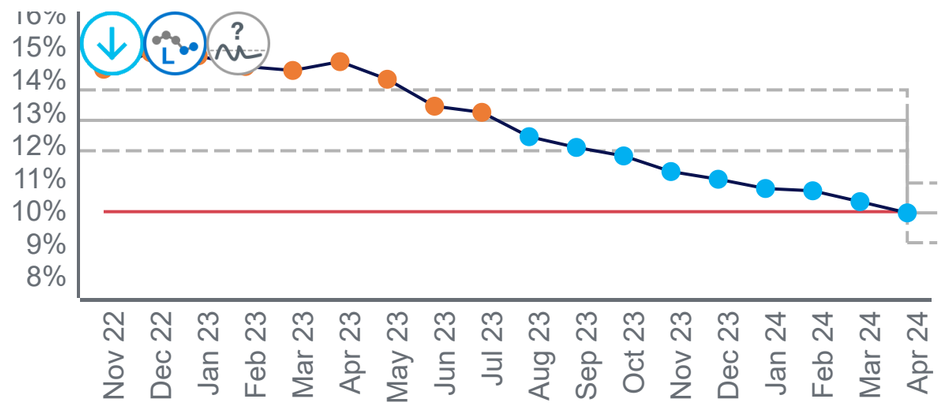
This metric is under development

Actions:

NA - Plan for roll out in development following a successful pilot in April and May 2024.

Staff Turnover

Target: Internal



Technical Analysis:

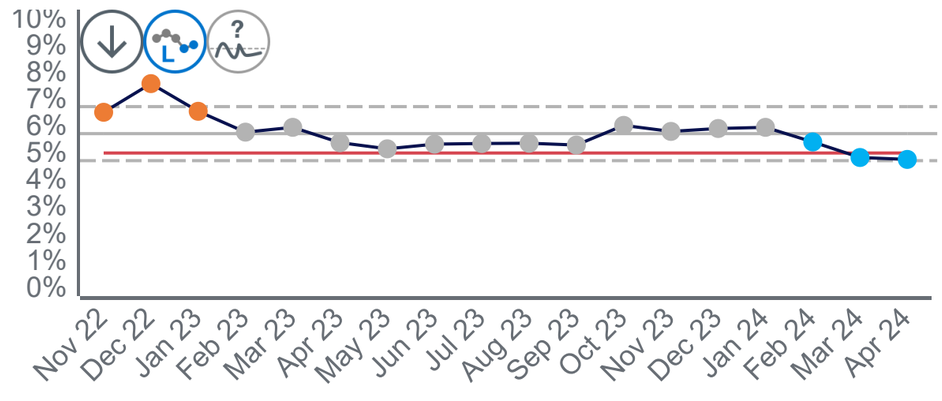
Staff Turnover continues to demonstrate special cause variation, 10.0% is the 13th consecutive month with a reduction

Actions:

There is continued reduction in turnover, with it reducing further to 10% in May 2024. This meets the reduced target of 10% from April 2024. On going analysis and external benchmarking remain in place alongside quarterly reporting to PAWC.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in April 2024 is 4.77% which is below the 5% target. A decrease from March 2024 at 4.83%. April 2024 performance comprises STS at 1.58% and LTS at 3.18%. Still demonstrating common cause variation with lowest sickness rate in 18 month period illustrated.

Actions:

Sickness absence target has been reviewed has been reduced to 5% from April 2024 (3% long term and 2% short term sickness). The following remain in place • Discussions at Divisional Boards • Management meetings • Divisional wellbeing activities • Focus on Stage 3 long term sickness • Return to Work discussions are being reinforced.

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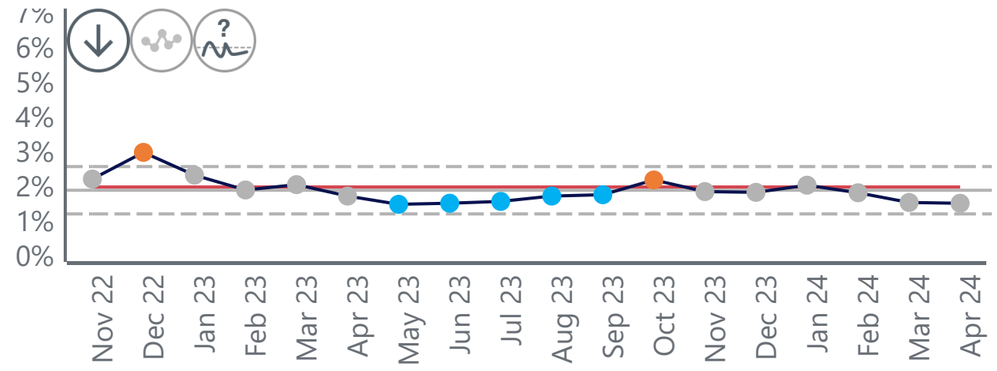
Alder Hey Children's NHS Foundation Trust

Supporting Our People - Watch Metrics

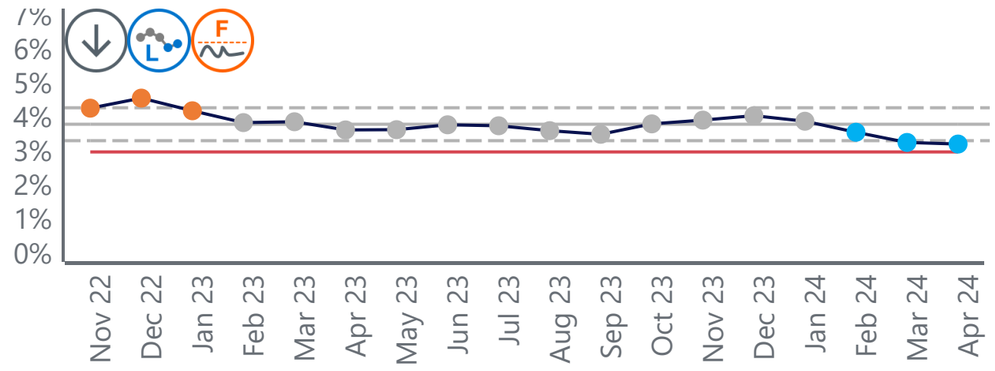
Short Term Sickness

Target: Internal



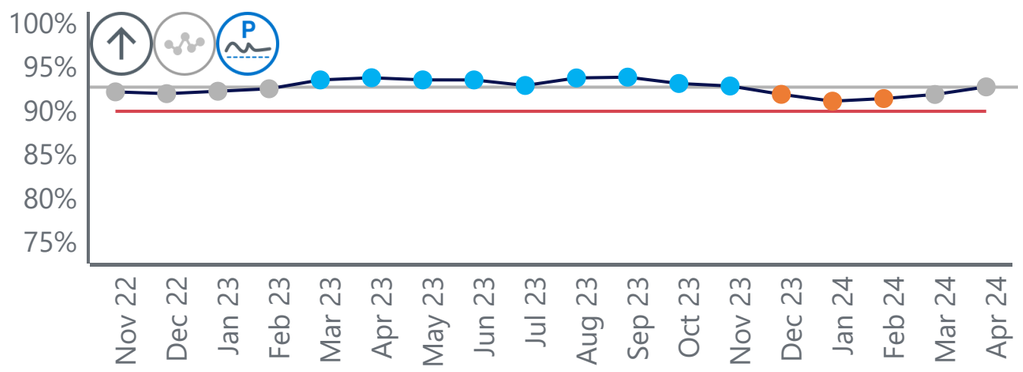
Long Term Sickness

Target: Internal



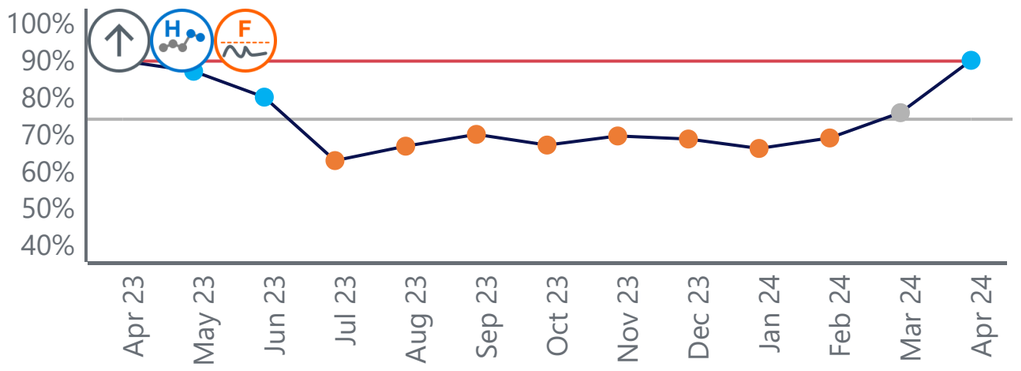
Mandatory Training

Target: Internal



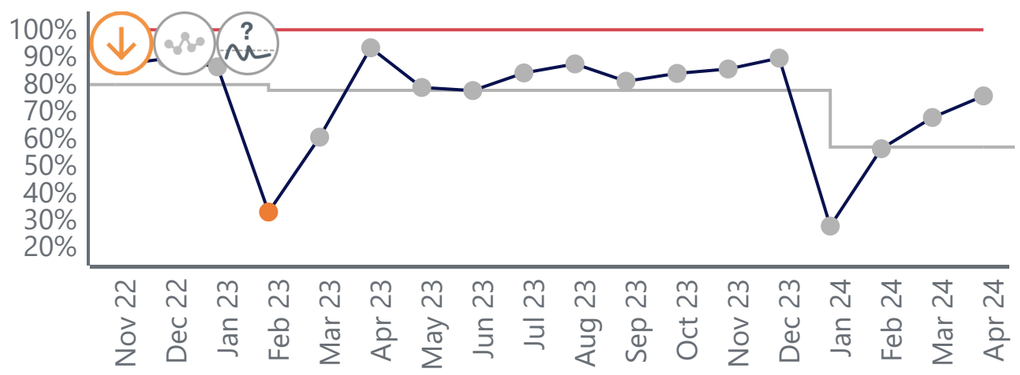
% PDRs Completed (Rolling 12 Months)

Target: Internal

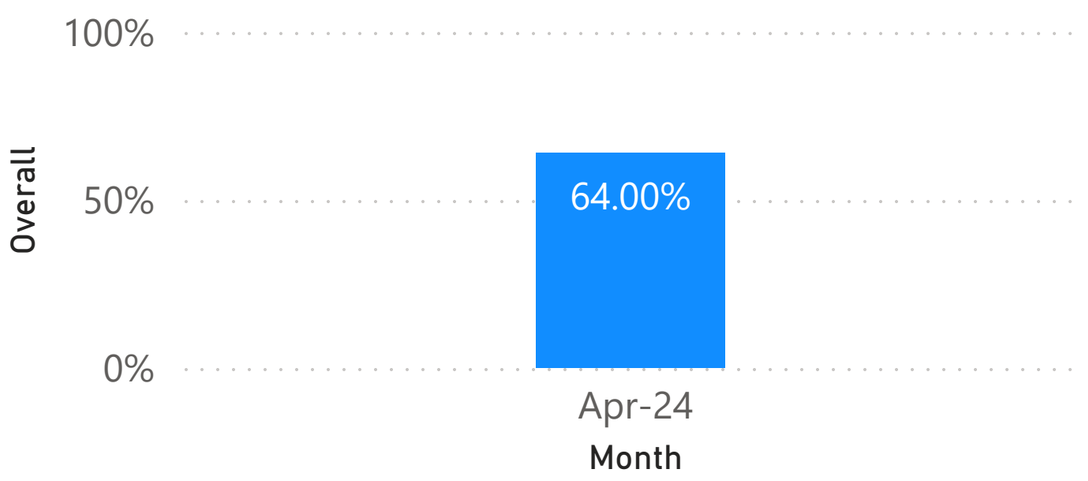


Medical Appraisal

Target: Internal

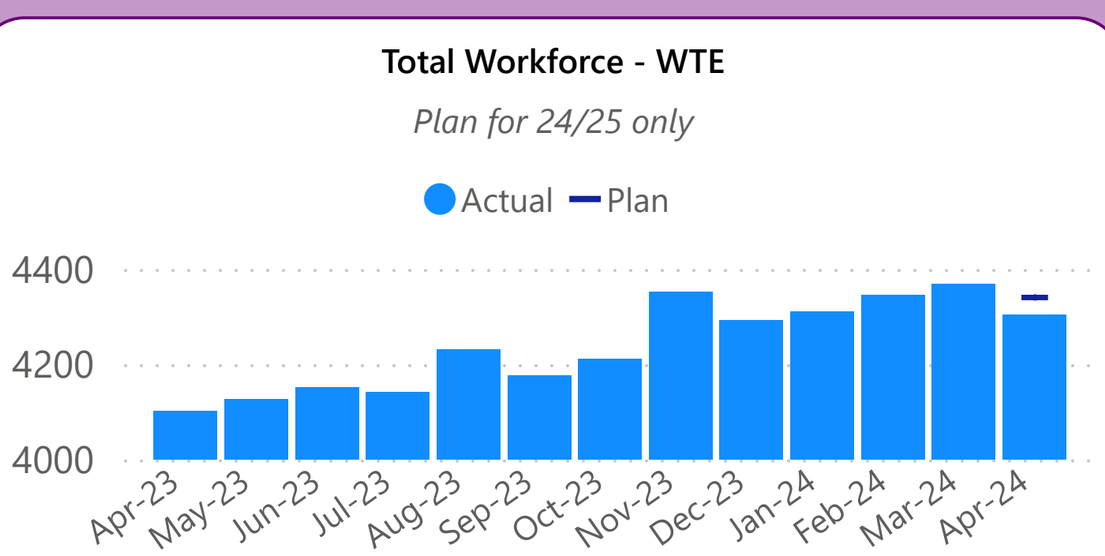


Workforce Stability



Total Workforce - WTE

Plan for 24/25 only



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Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

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

Highlights:

• Demonstration of Lyrebird (AI tool) to support clinical consultations was held on 8th May 2024. Engagement was high and departments are being identified for pilot sites.
• Stakeholder group consisting of multidisciplinary teams from across the organisation for Patient Portal is being developed to create product specification.
• Leads for the 4 pillars of the Futures Programme agreed.
• Advanced stage of developing an international hotspot in Vietnam for child health advisory services

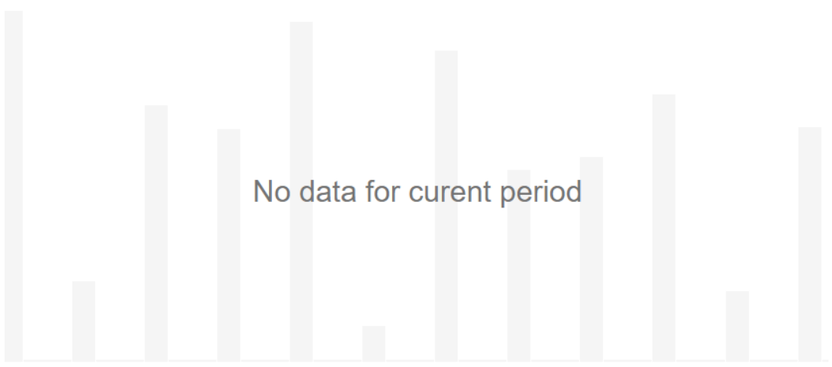
Areas of Concern:

• Initiatives are being explored and are not yet ready for implementation, thus monitoring against performance is difficult this early in the year.
• Investment and resource plan will be needed to fully realise the ambitions and objectives of the Futures strategy

Forward Look (with actions)

• In June, commence the pilot of AI-generated clinic letters in some wave 1 departments.
• Develop patient portal implementation plan
• Investment zone business case
• Northern Institute of Child Health & Wellbeing business case

Number of patients benefitting from Futures solutions or products deployed to care - In Development

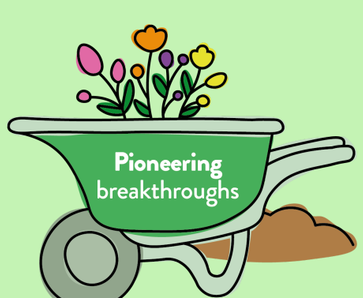


Technical Analysis:

This metric is under development

Actions:

This metric is under development and is one of the strategic driver measures for the 2030 Strategy.

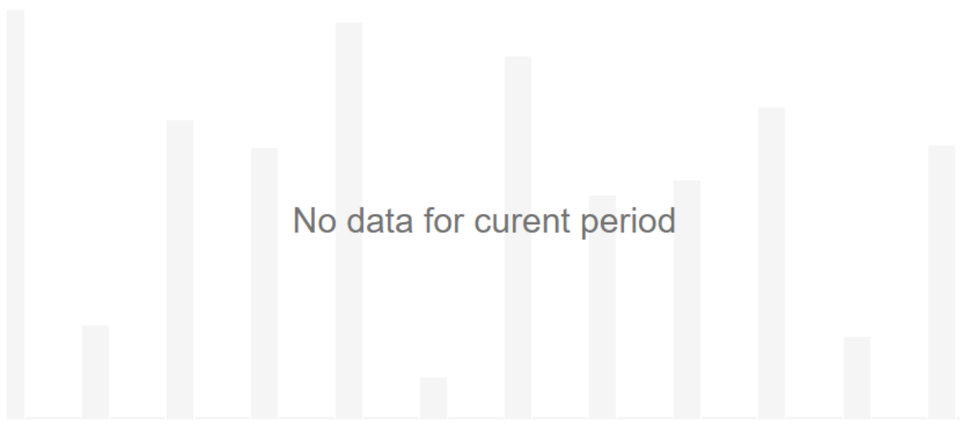


Integrated Performance Report | May 2024

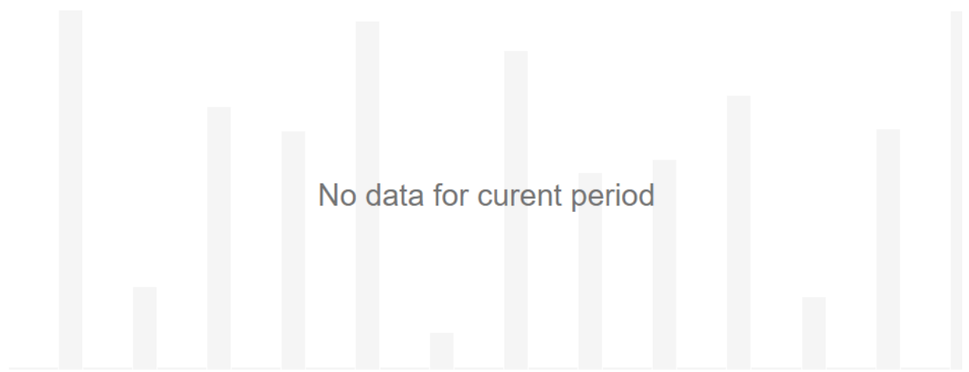
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

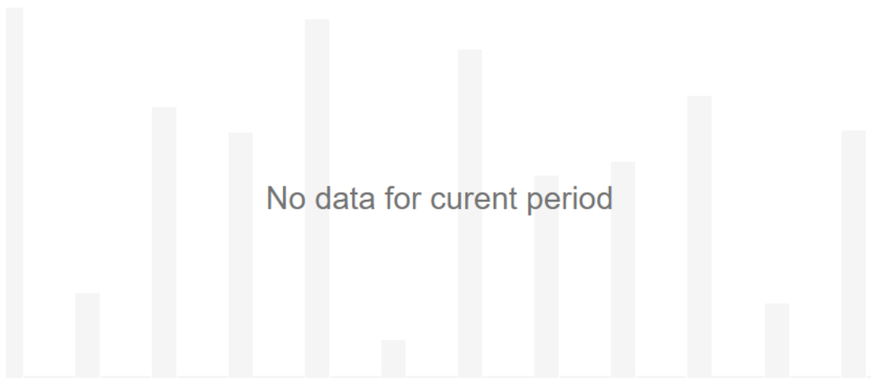
Clinical Capacity created (hours per week)- In Development



Professionals who have accessed learning through the International Academy - In Development



Number of patients accessing digital healthcare solutions delivered through Futures - In Development



Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

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

Highlights:

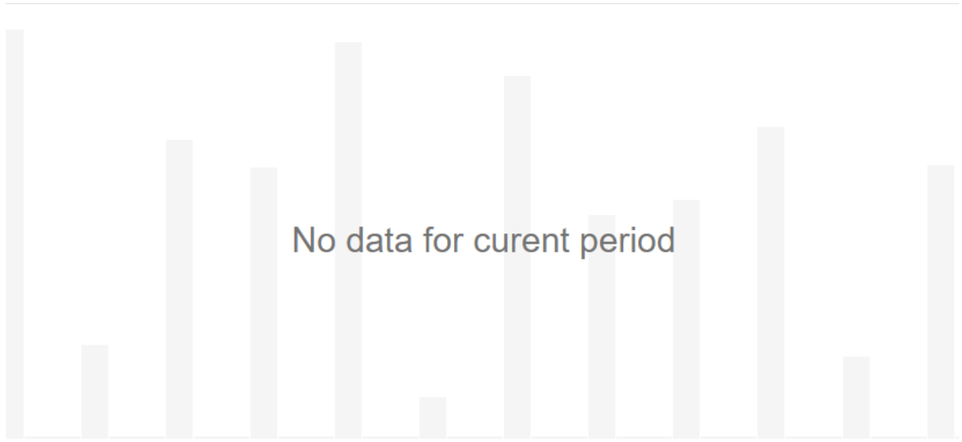
Key influencing strategies include Vision 2030, Core20PLUS5, The Health of the City 2040 (Liverpool). The Collaborating in Communities Programme has 5 workstreams – • Health Improvement and Prevention (Wellbeing Hub) – A Poverty Proofing and Social Prescribing offer for all Children, Young People and their families attending Alder Hey • Advocacy - Advocate for the CYP health needs and enable a happier, healthier, fairer future. Harness Alder Hey distinct powers to tackle children health inequalities • Greener and Clean Air Initiatives - We will lead the way in protecting our planet and create a world where children and young people can live their best lives • Creating Opportunities for CYP - Our role will be to provide and connect into wellbeing support, create supportive opportunities as an anchor institution, and play our part in the Marmot community, focusing especially on 'the best start in life' • CYP system – Reimagining the health and care system around the needs of CYPF engaging and participating in the new ways of working.

Areas of Concern:

Forward Look (with actions)

• Wellbeing Hub soft launch 1 July 2024 • Liverpool Strategic Partnership (LSP) agreement to establish a Children and Young People's Board to provide system leadership and oversight across the City

Social Value Generated - In Development



Technical Analysis:

This metric is under development

Actions:

To be reported next quarter.

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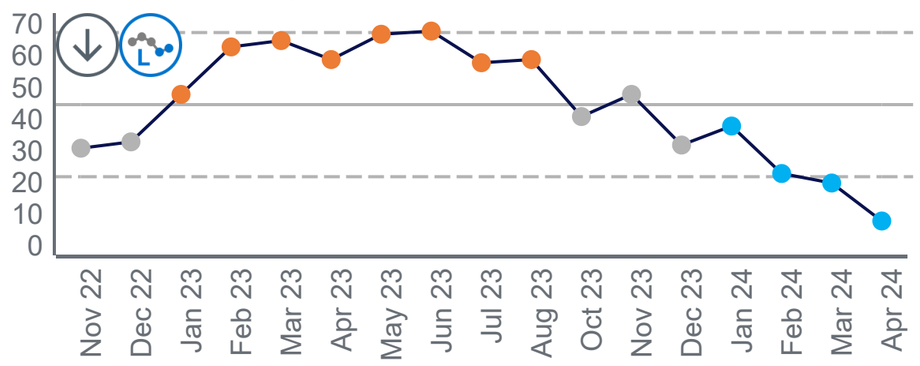
Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

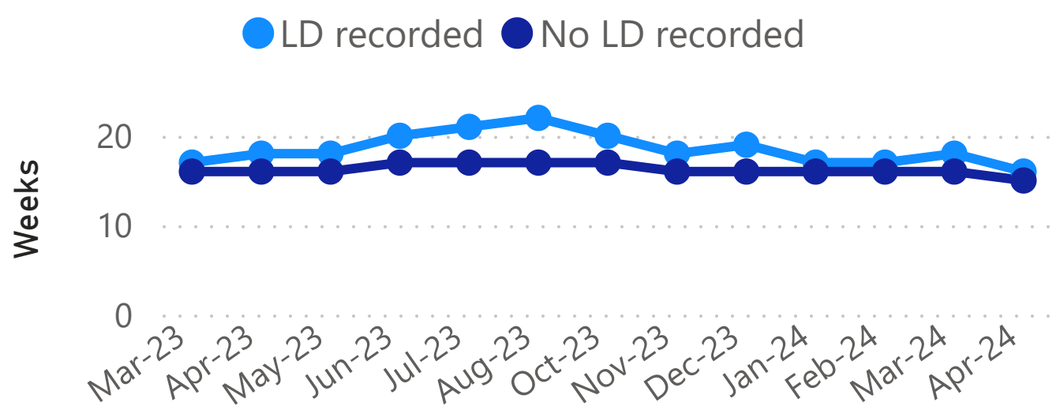
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

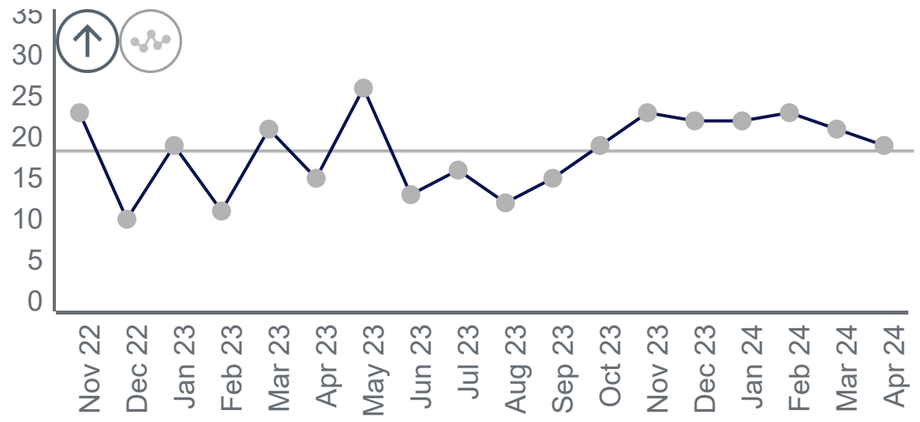


Median Waiting Time (RTT) for LD Waiters

Sept-23 Unavailable

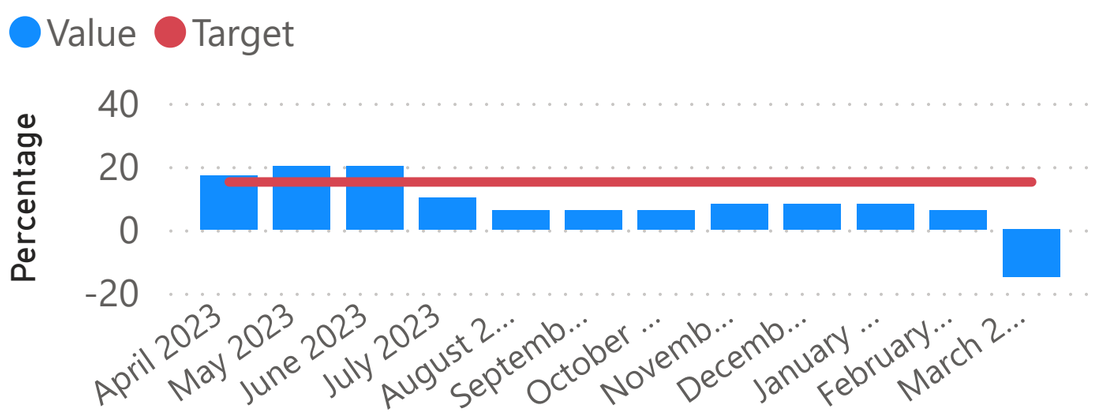


Alder Hey Community Mental Health Services : Number of CYP of BAME background referred



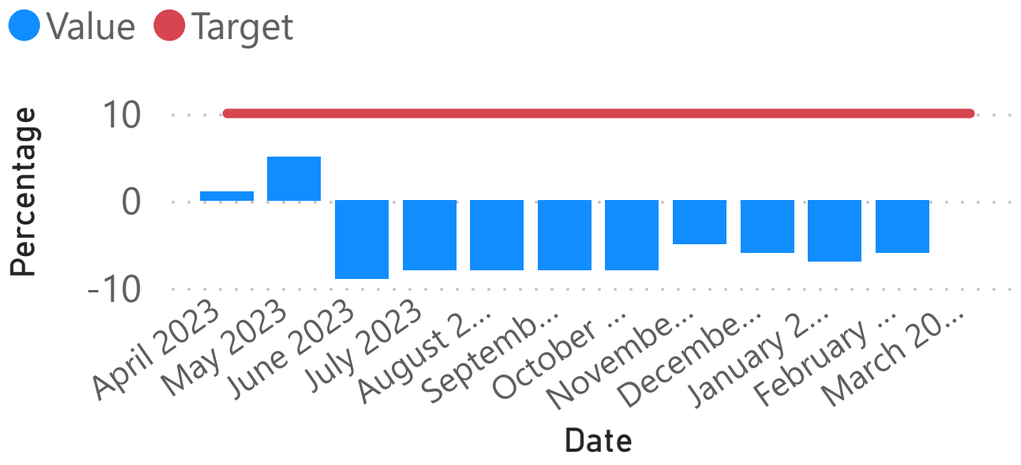
Green Plan: Reduce Carbon Footprint

Target: Internal



Green Plan: Reduce Energy Usage

Target: Internal



Green Plan: Reduce Waste

Target: Internal (50k)

Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

In April (M1), the Trust is reporting a position £0.2m adverse to plan (£1.2m deficit against a plan of £0.9m). This is due to undelivered CIP.
NB A £0.4m deficit was reported externally due to an update to CIP phasing which is not yet reflected in national plans. Forecasting to achieve £4.9m surplus subject to ERF delivery and CIP risk. CIP is £0.2m away from plan in M1. Overall, £6m CIP has been transacted with £3.9m in progress and £9.1m opportunity. On track to deliver subject to amber and red schemes. Cash has remained high in line with plan & capital is behind plan due to profiling differences.

Areas of Concern:

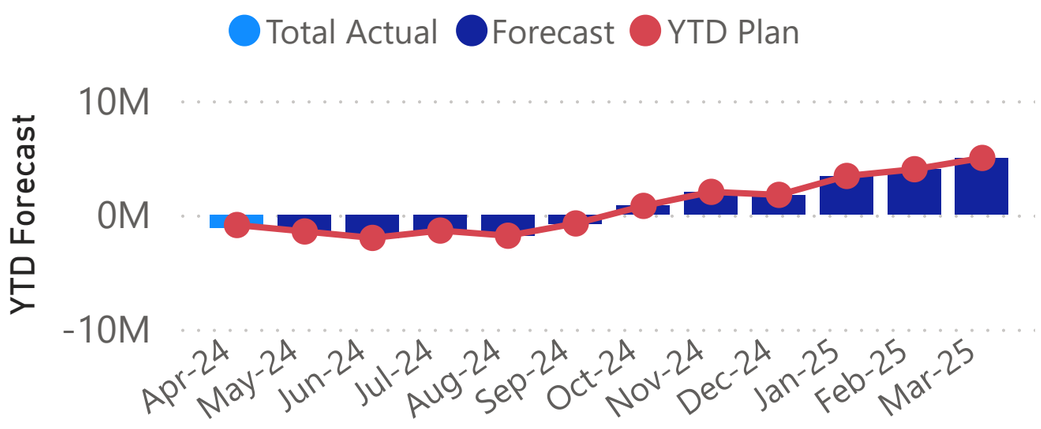
Work is ongoing to deliver full savings of £19.3m and significant progress has been made to date resulting in £6m of savings recurrently posted in M1. Forecasting to achieve £4.9m surplus which is in line with the plan set at the start of the year, so delivery of CIP is essential along with achievement of activity targets. As the wider C&M system position continues to move, Alder Hey plan figure may change to support the system in closing the current gap that remains. It is recognised that capital allocation is unlikely to be sufficient to complete all capital requirements. With this in mind a priority list has been agreed through Capital Steering

Forward Look (with actions)

Continued cost control to reach the year end position, with specific focus on non-clinical posts in line with ICB stretch target. Continued focus required on achievement of £19.3m efficiency target. Continued prioritisation of capital programme.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

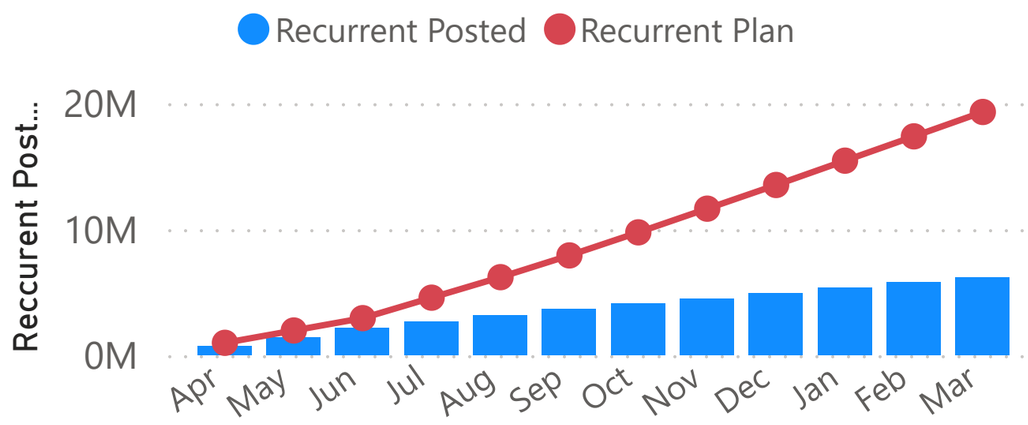
Current forecast is £4.9m surplus in line with plan set at start of the year. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through SDG meeting and divisional deep dives.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

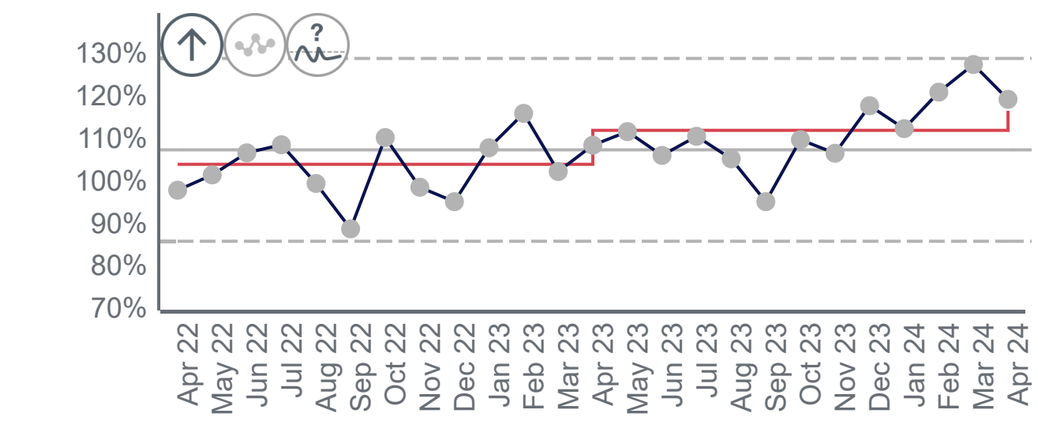
In year and recurrent CIP identified and in progress is £10m.

Actions:

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

% ERF Value (Income)

Target: Internal



Technical Analysis:

April performance estimated at 119.3%.

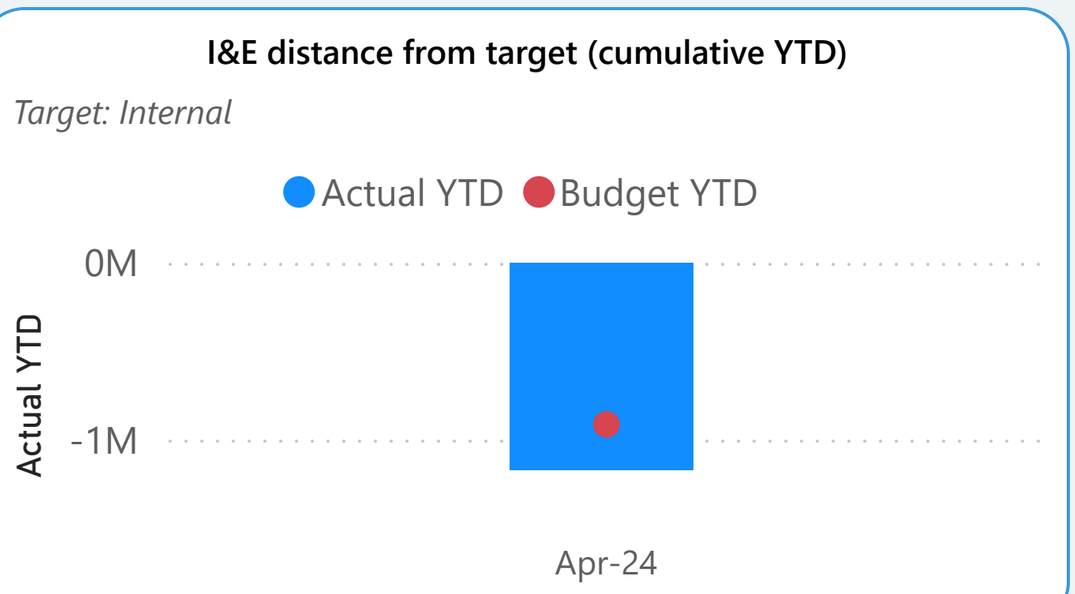
Actions:

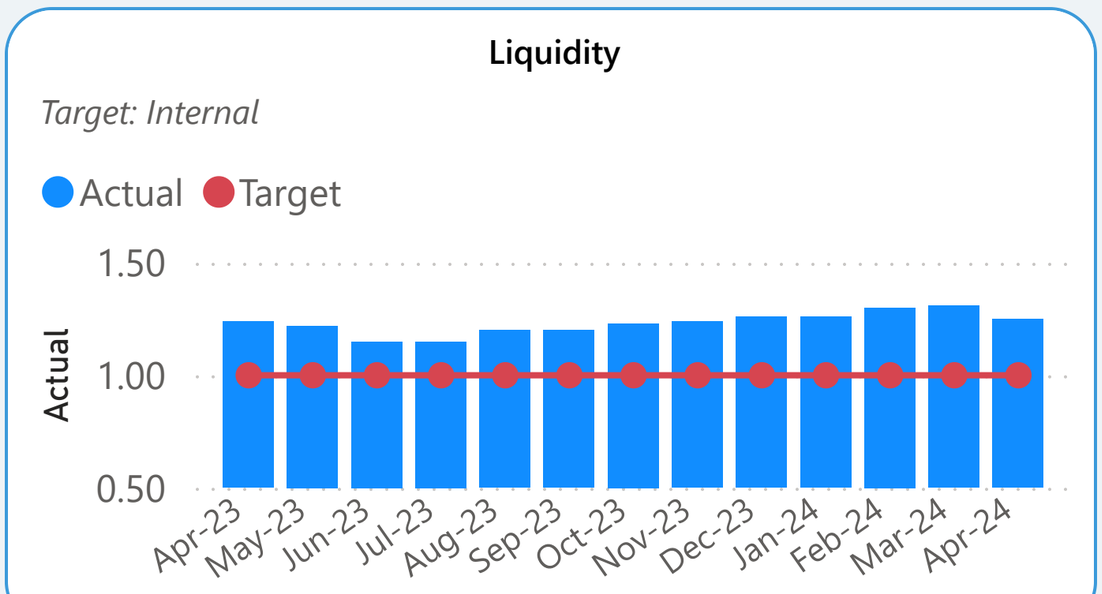
Continue to monitor those areas (at POD and speciality level) that are under performing versus plan.

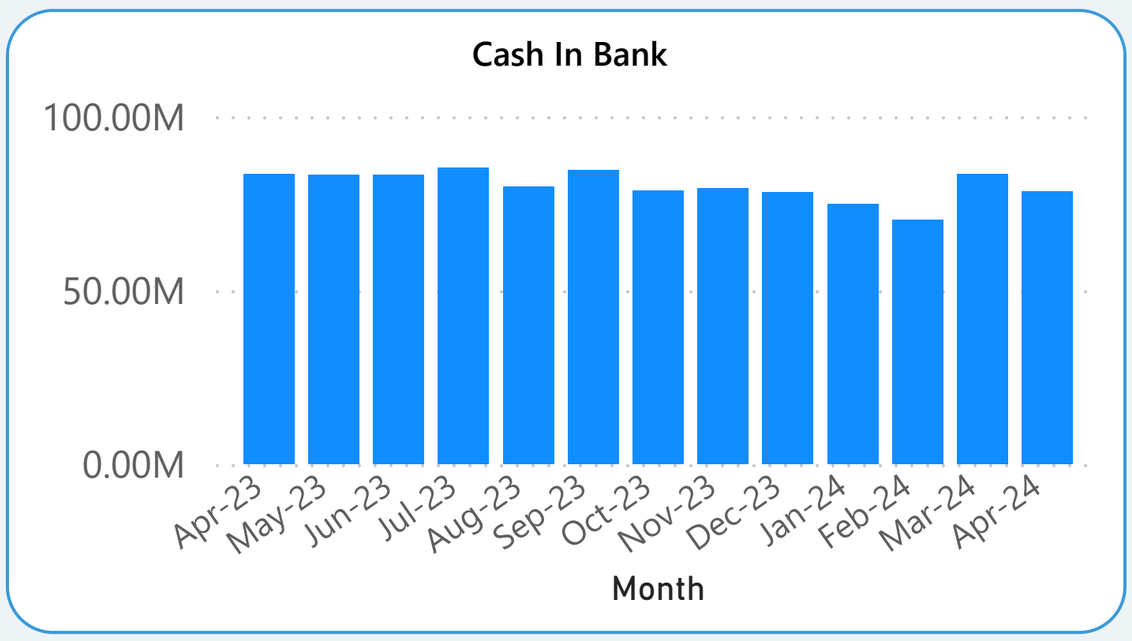
Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

Financial Sustainability: Well Led - Watch Metrics







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

- Oversight of risk reporting continues to be embedded within InPhase report functionality.
- Risk bullseye visual now incorporated in all committee risk reports
- Corporate services collaborative risk process and oversight presented at ARC

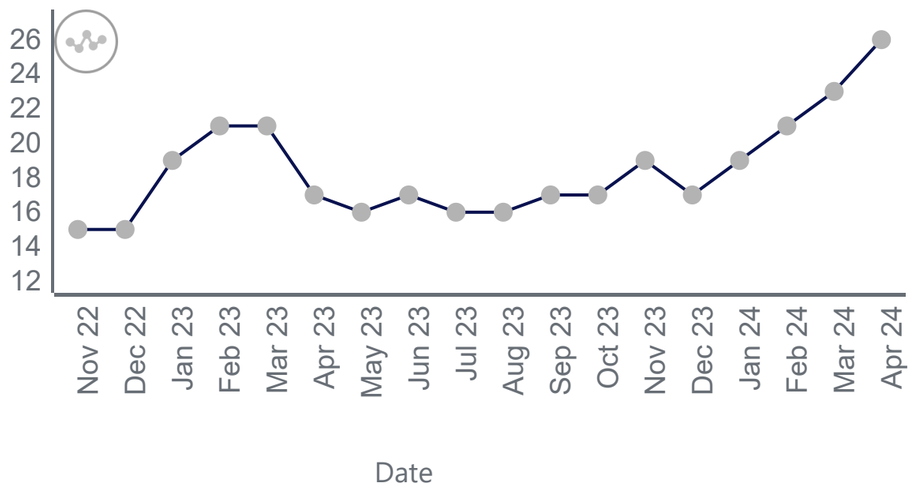
Areas of Concern:

- Risk management training cancelled due to lack of uptake
- Month on month fluctuation with updating risks despite overdue risk notification in place
- Increasing trend of high risks noted since Dec 23

Forward Look (with actions)

- Continue to oversee and escalate any overdue high risks to relevant divisional director and risk lead for immediate review and action.
- Overview of high risks continues at risk management forum

Number of High Risks (scored 15 and above)



Technical Analysis:

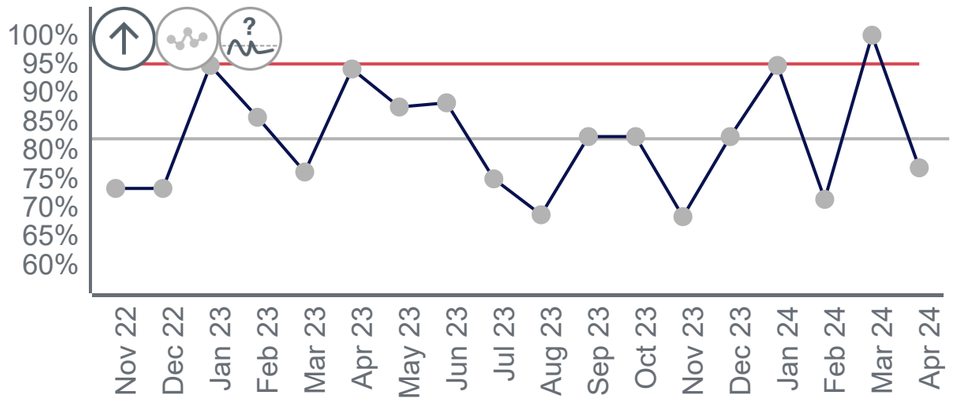
April 2024 position of 26 high risks open which is increase from 23 in March 2024.

Actions:

Total high risks = 26

% of High Risks within review date

Target: Internal



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. April 2024 performance is 77% (20/26) of risks are within expected review date.

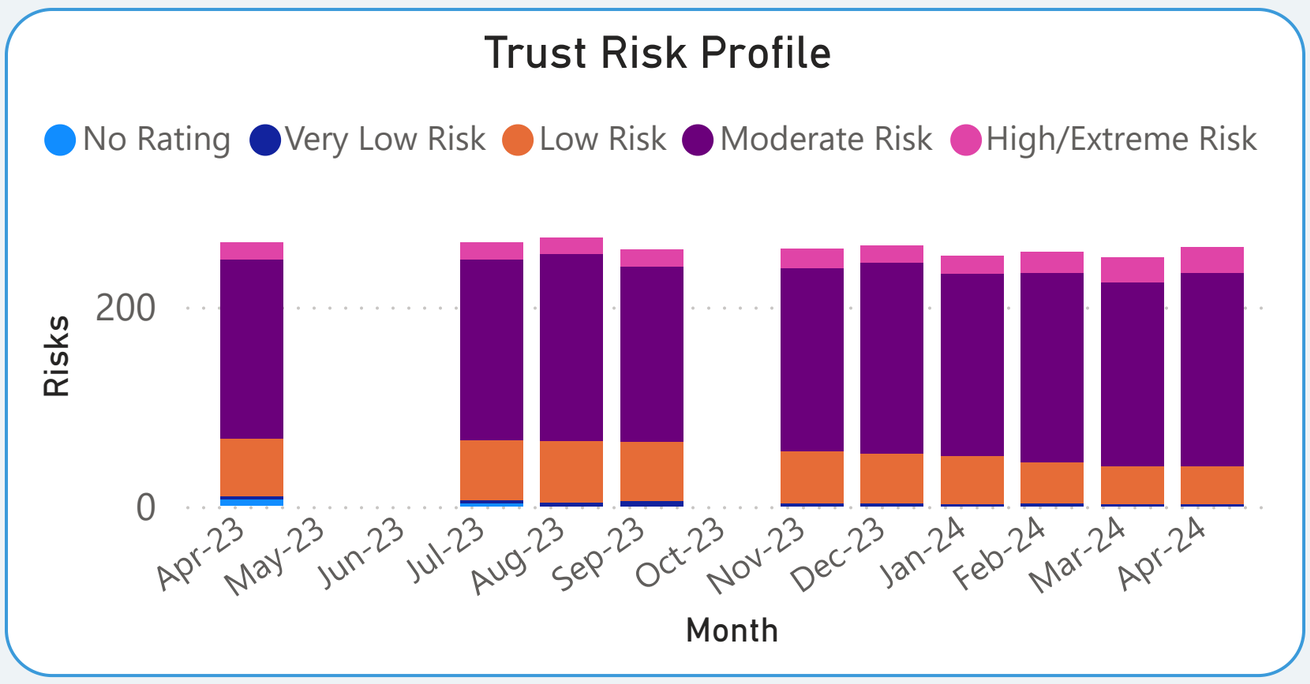
Actions:

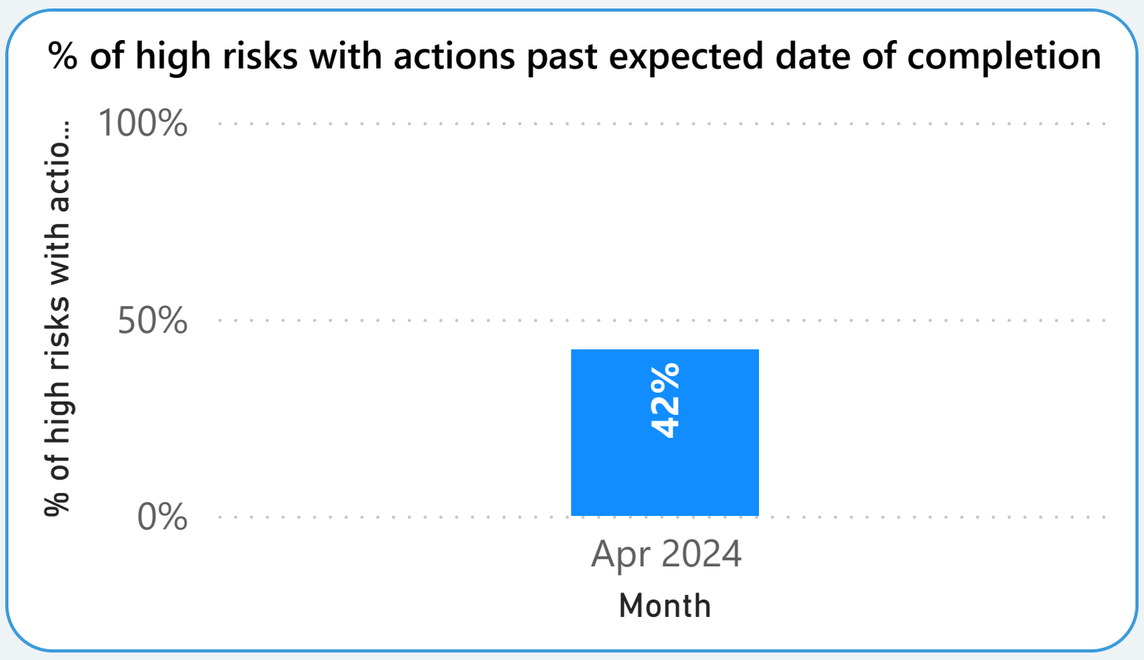
76.9% risks with expected review date. 6 overdue risks escalated to risk owner/manager for immediate update

Integrated Performance Report | May 2024

Alder Hey Children's NHS Foundation Trust

Well Led - Risk Management





Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Soft launch of NHS 111 pathway for children and young people experiencing mental health crisis.

• NHS England Gender Service North commenced and seeing young people.

• Improvement in number of PALS resolved within 5 days (80%).

• Continued increase in number of virtual ward bed days.

• Continued to meet RTT for urgent referrals to Eating Disorder Service despite significant increase in referrals (see areas of concern).

• Mandatory training levels (94%).

• Continued improvement in community dietetics RTT (81%) with reduction in average longest waiter to access service.

• Improvement in number of young people waiting to access Clinical Health Psychology – improvement in longest waiter and total numbers waiting.

• Recruitment finished for SATCo study (Community Physiotherapy) in Liverpool - 40 children recruited (Outcome measure for spinal/ posture assessment) over past 2 years.

Areas of Concern

• Eating Disorders: Significant increase in referrals in Q4 23/24 (99 referrals) compared to previous year (74 referrals Q4 22/23) and 38 referrals in April 2024 compared to 15 in April 2023. Increased assessment capacity has been identified.
• Work continues to improve data reporting for Mental Health Services via MHSDS due to data quality issues impacting on submissions.
• Waiting times to access SALT (Sefton) continue to remain high and RTT has reduced compared to previous month (55%) – significant increase in referrals since 2022/23
• CAMHS: 6 young people waiting 52+ weeks.
• Continued increase in number of young people waiting for conclusion of ASD/ADHD diagnostic pathway and continued challenges with ADHD medication shortage. Medication issues escalated to NHS England.

Forward Look (with actions)

• Task and finish group to improve Mental Health data reporting ongoing – annual data re-submitted for 2023/24, awaiting feedback (due May 2024). Expected improvement in the number of data errors in MHSDS.

• Capacity and Demand planning work ongoing for Speech and Language Therapies, including detailed review of SALT waiting times and improvement plan.

• Virtual ward GP pathway due to commence in May 2024

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

• Task and finish group to review NHS 111 Support for young people experiencing mental health crisis and mental health response vehicles – ongoing.

• WNB transport pilot ongoing, change in processes within CAMHS to improve WNB rates.

• Room utilisation: work ongoing to improve utilisation and prepare for fracture/dermatology programme of work.

• Launch of Neurodiversity transformation programme across division – first meeting held May 2024.

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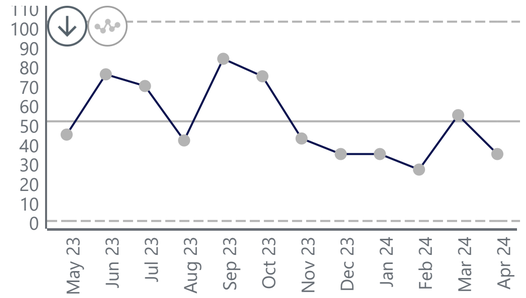
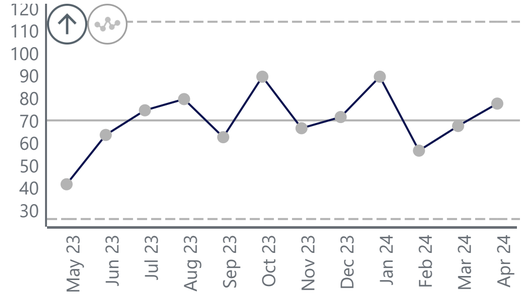
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

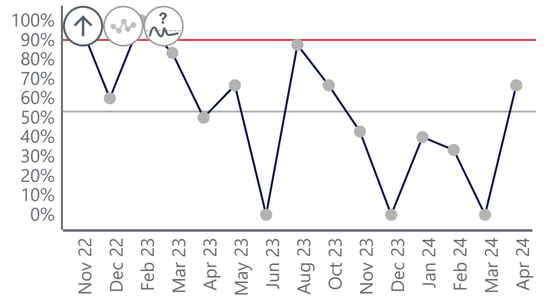
Patient Safety Incidents rated Low Harm & Above



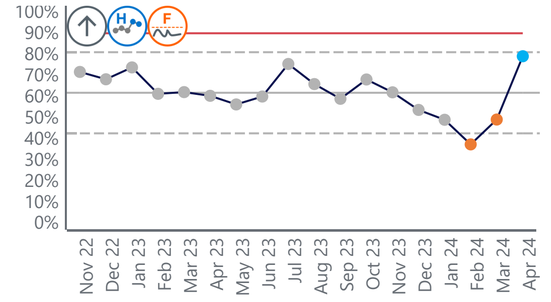
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

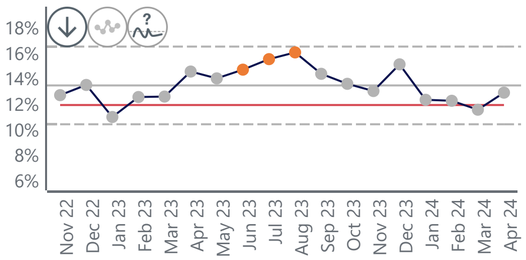


% PALS Resolved within 5 Days

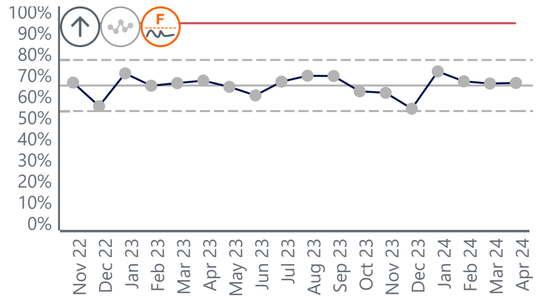


% Was Not Brought Rate (All OP: New and FU)

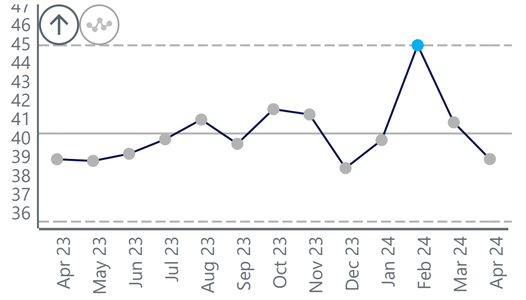
Target: Internal



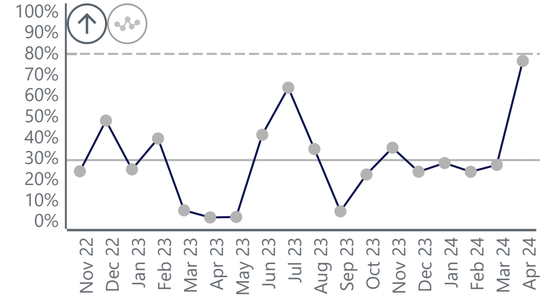
% of Clinical Letters completed within 10 Days



Outpatient New & OPPROC per working day



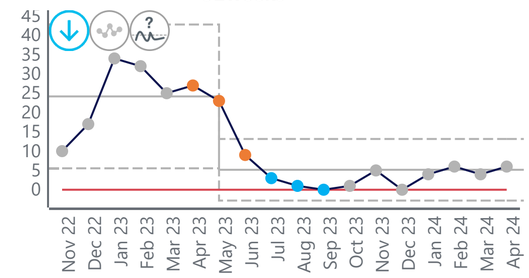
IHA: % complete within 20 days of referral to Alder Hey



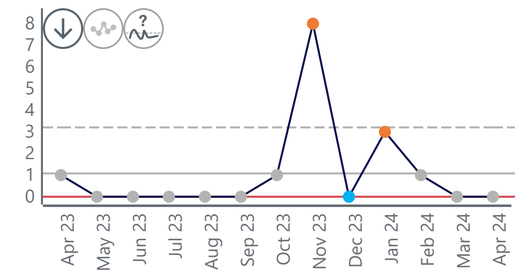
% of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks - In Development

No data for curent period

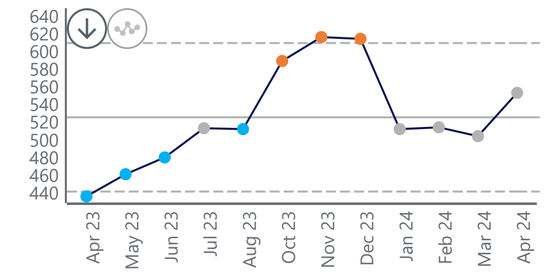
CAMHS: Number of children & young people waiting >52weeks



Number of Paediatric Community Patients waiting >52 weeks



Reduce overdue Outpatient Follow Up Waits - 2 years & over



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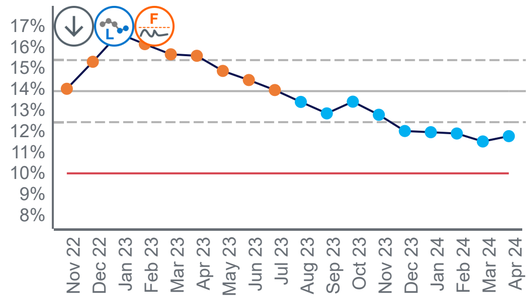
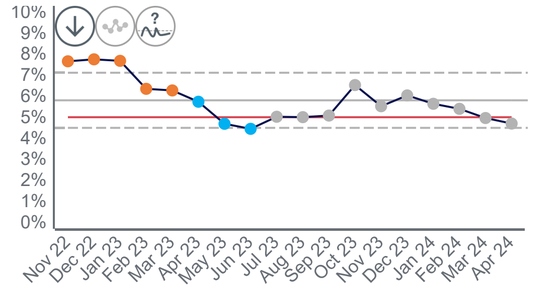
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

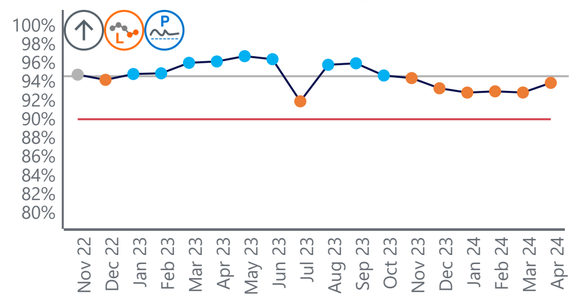
Staff Turnover



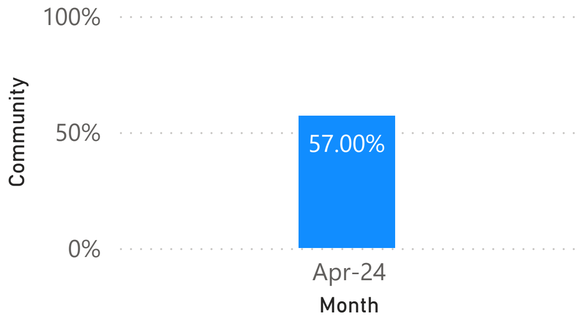
Sickness Absence (Total)



Mandatory Training



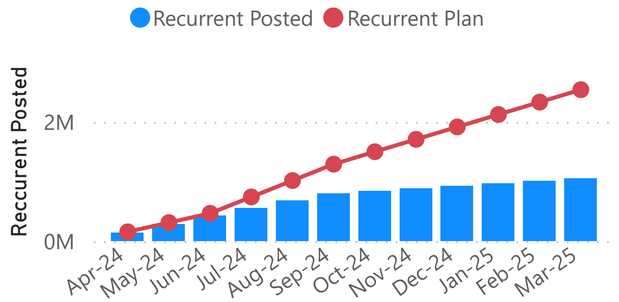
Workforce Stability



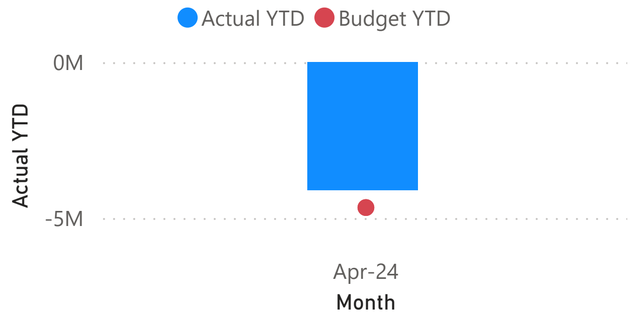
Colleague Satisfaction – Thriving Index - In Development

No data for curent period

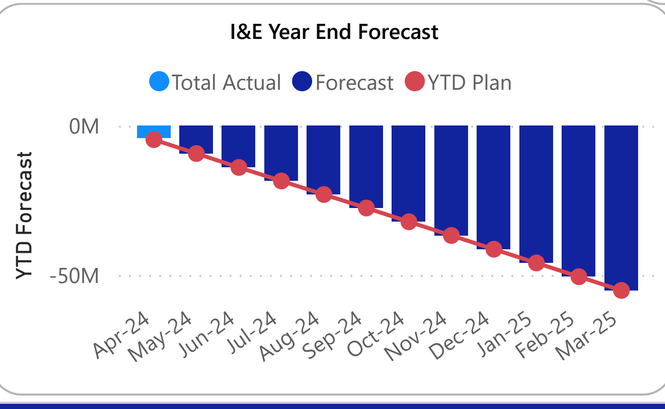
Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



I&E Year End Forecast



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

- Continue reduction in overdue outpatient waiting list
- Continued performance against 4hour target within ED
- Continued reduction in staff turnover 8%
- Further reduction in staff sickness now at 4.5%
- Increase in incidents relating to no harm associated with positive reporting culture
- 100% response rate for formal complaints for 5th consecutive month
- Slight reduction in ED sepsis compliance however remains above target at 93%
- Improved time to triage for CYP attending ED

Areas of Concern

- Slight increase in the WNB rate which we'll continue to monitor closely within month
- Increase in number of patients waiting over 52 weeks for treatment, associated with neurology
- Review of UTC utilisation following reduction below 70%
- Long term sustainability of the Interventional Radiology service under review in light of continued national workforce challenges

Forward Look (with actions)

- Focus on CYP waiting 52 weeks + ensuring all who have waited 65 weeks will receive treatment in June, 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
- Paper to be presented at ops board to improve the resilience of the current CT scanner provision
- Continued work underway to review clinic demand in the community, reviewing where clinics currently ran at Alder Hey could happen closer to home for families

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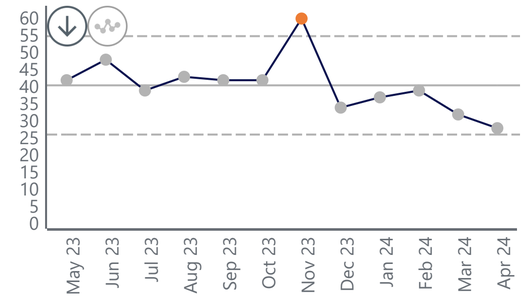
Integrated Performance Report | May 2024

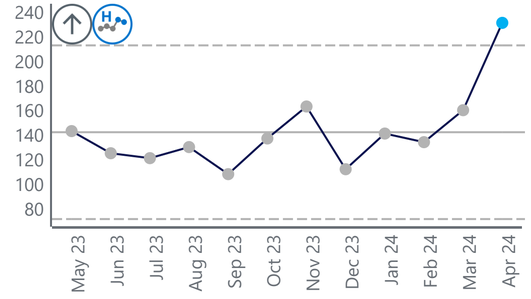
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

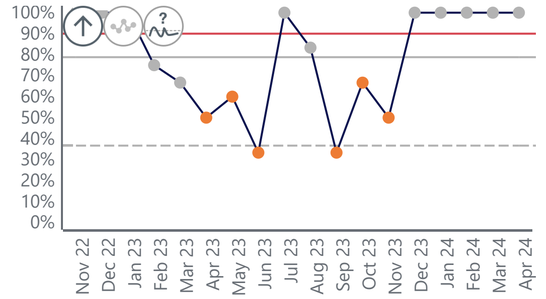
Patient Safety Incidents rated Low Harm & Above



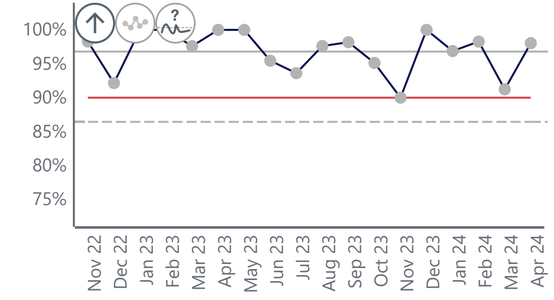
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

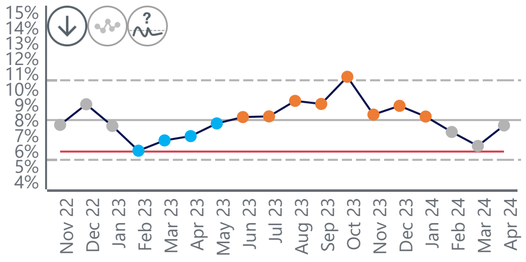


% PALS Resolved within 5 Days

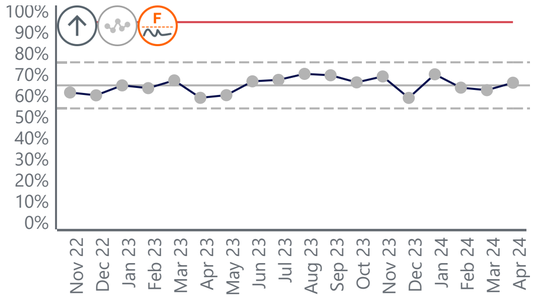


% Was Not Brought Rate (All OP: New and FU)

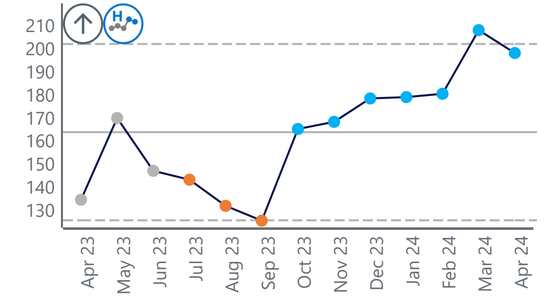
Target: Internal



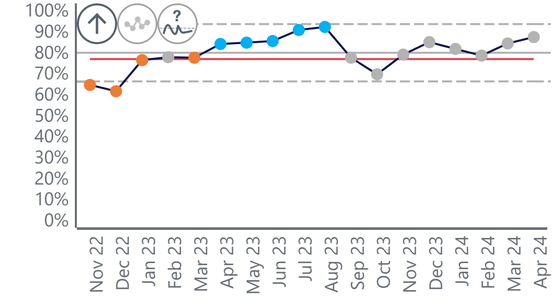
% of Clinical Letters completed within 10 Days



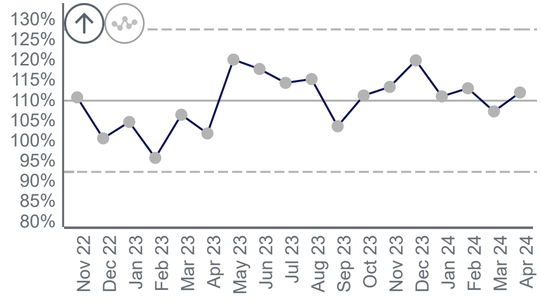
Outpatient New & OPPROC per working day



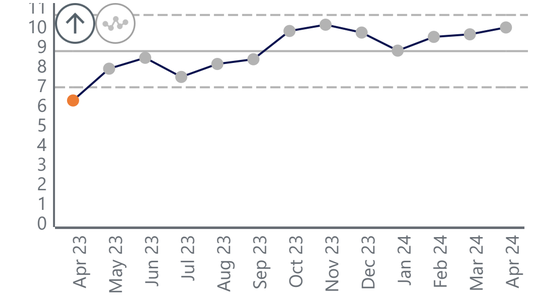
ED: % treated within 4 Hours



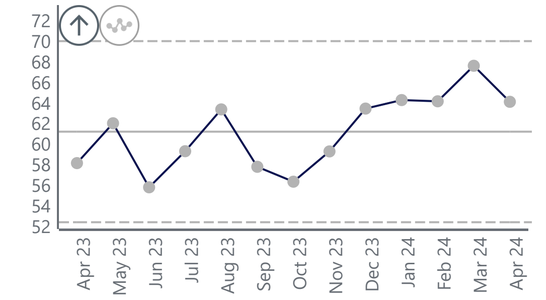
% Recovery for DC & Elec Activity Volume



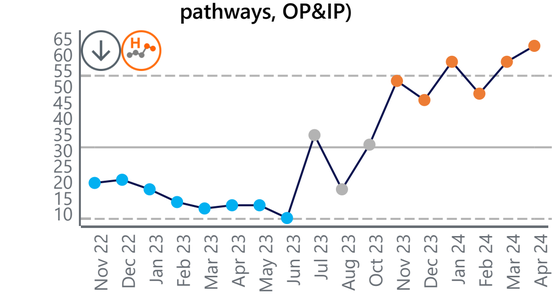
Inpatient Discharges per working day



Day Cases per working day



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



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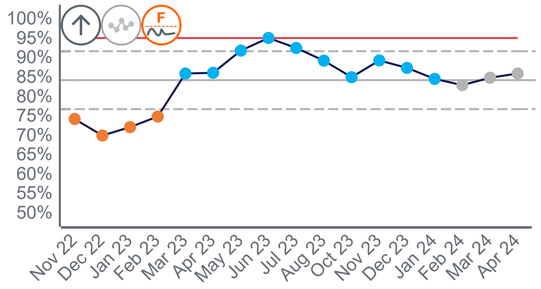
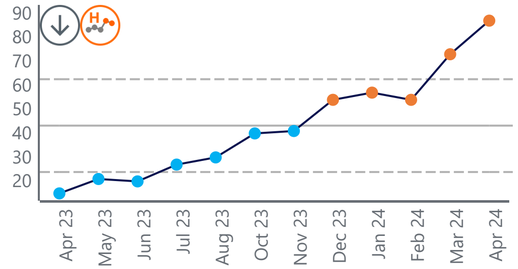
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

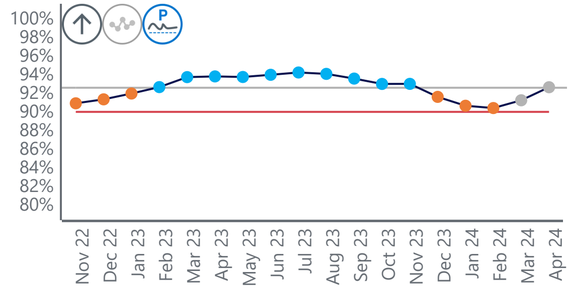
Diagnostics: % Completed Within 6 Weeks of referral



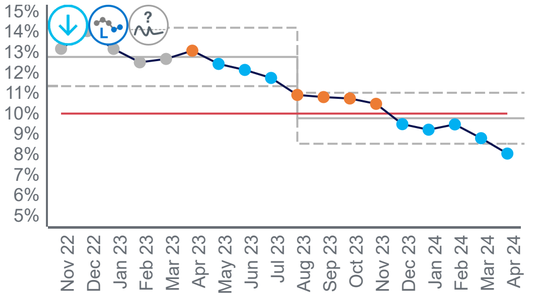
Reduce overdue Outpatient Follow Up Waits - 2 years & over



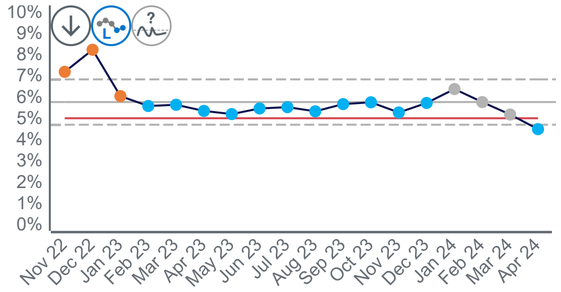
Mandatory Training



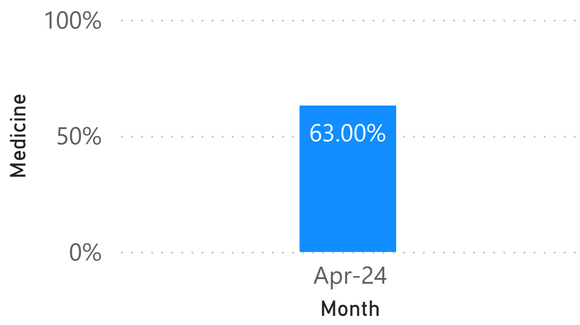
Staff Turnover



Sickness Absence (Total)



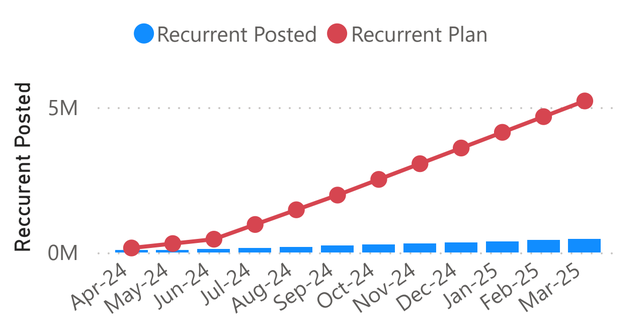
Workforce Stability



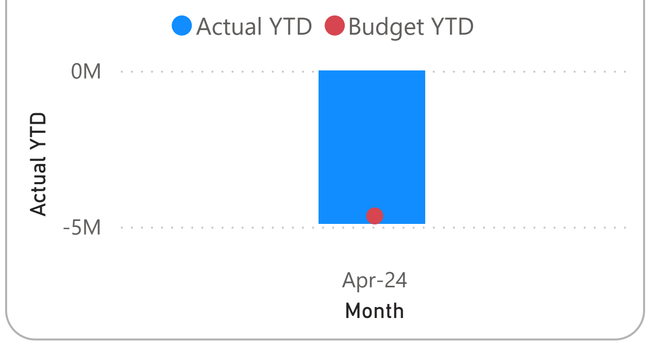
Colleague Satisfaction – Thriving Index - In Development

No data for curent period

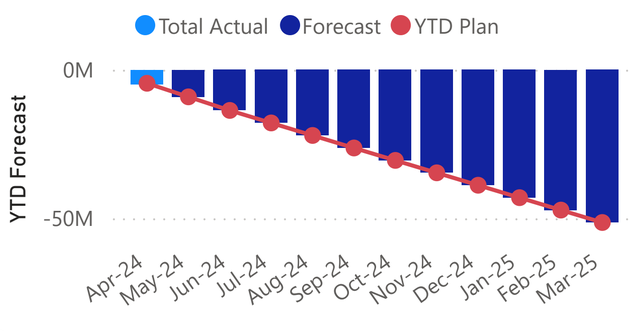
Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division - In Development

No data for curent period

Research - Number chief investigators by clinical division - In Development

No data for curent period

Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Significant increase in reporting of patient safety incidents rated no harm, showing a positive reporting culture

• Retained 100% compliance with PALS responses

• % recovery for DC & Elec activity volume saw an overperformance at 103%

• OPNEW/PROC activity volume overperformed in month with a particular increase seen within ENT, Ophthalmology & Spine

• Number of C & YP waiting over 52 weeks reduced in April although remains high

• Although total sickness absence increased in month, it is at trust target and is impacted by STS. There has been significant improvement in LTS with targeted support from HR colleagues within the division.

• Mandatory training compliance remains above trust target and has increases for the 4th consecutive month.

• Strong start to the year with CIP performance with no gaps in schemes and £3.9m delivered in recurrent schemes so far.

Areas of Concern

• % Diagnostics completed within 6 weeks remains a challenge. Area of non-compliance is Gastroscopes

• Clinical letters completed within 10 days remains static- this will undergo targeted improvement work once other areas of improvement are sustained

• Overdue outpatient follow ups 2 years and over continue to increase.

Forward Look (with actions)

• Divisional paper was supported by SDG to invest in additional capacity to support ENT & Dental to achieve 0 52 weeks by March 2025. Case pending Operational Delivery Board approval.

• Improvement work underway to improve gastroscope compliance- includes joint working with medicine to implement targeted elective lists for specific conditions

• Number of actions underway to reduce overdue 2 year follow ups including participation in external validation process. Also areas of local validation that have been completed and targeted creation of additional capacity to manage these patients is in place.

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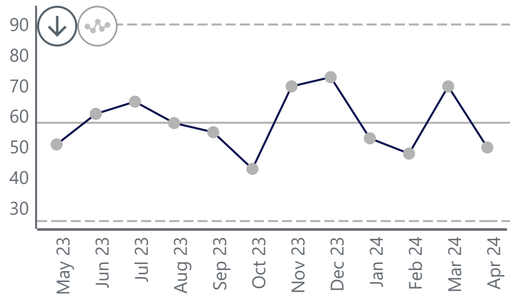
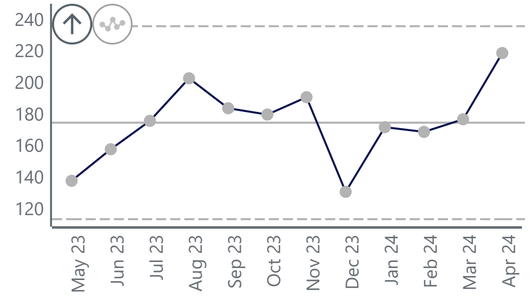
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

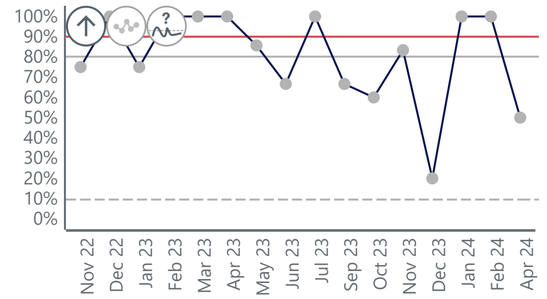
Patient Safety Incidents rated Low Harm & Above



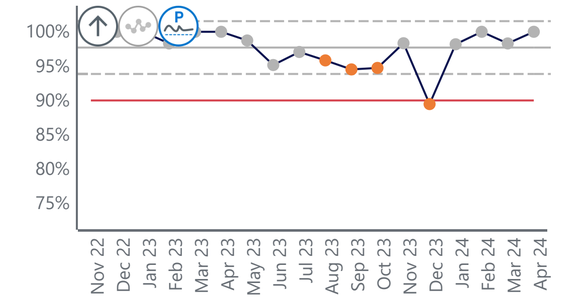
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

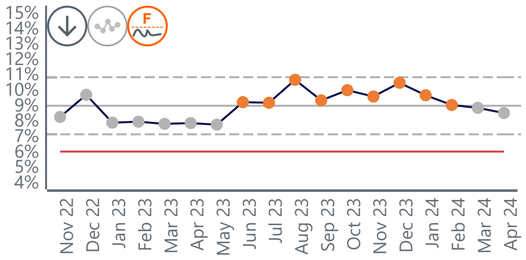


% PALS Resolved within 5 Days

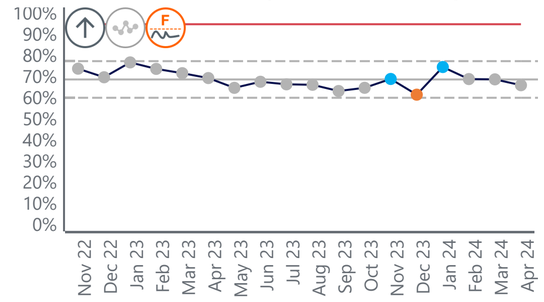


% Was Not Brought Rate (All OP: New and FU)

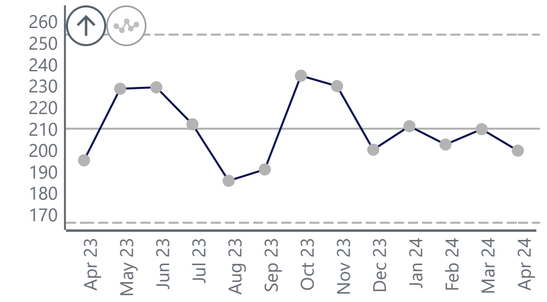
Target: Internal



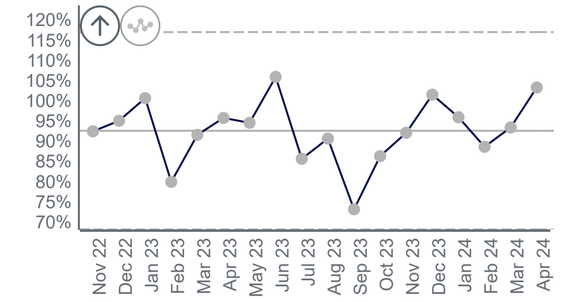
% of Clinical Letters completed within 10 Days



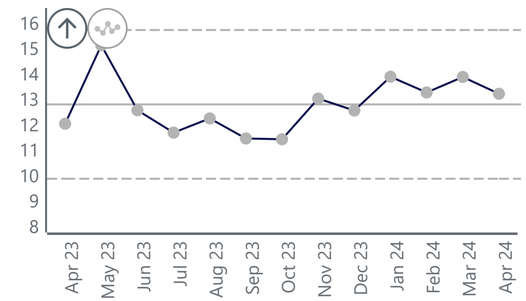
Outpatient New & OPPROC per working day



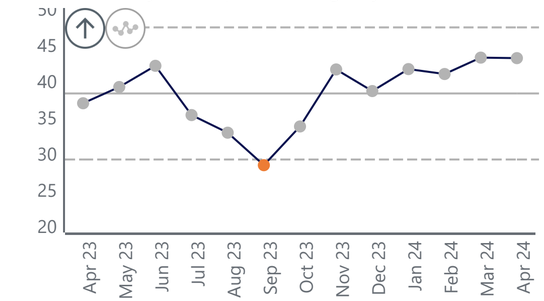
% Recovery for DC & Elec Activity Volume



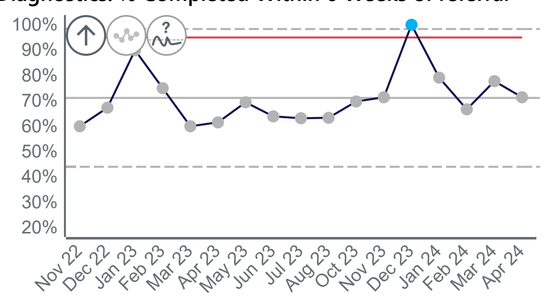
Inpatient Discharges per working day



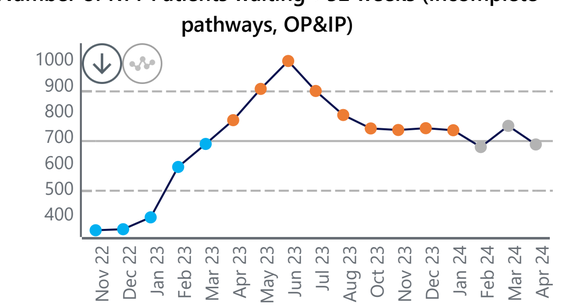
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



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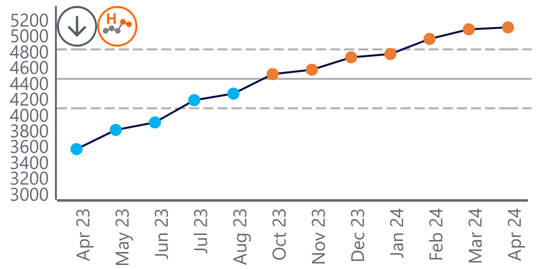
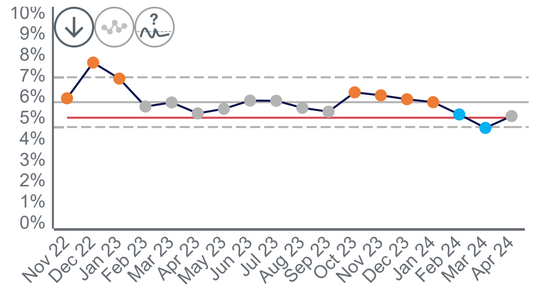
NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Surgery

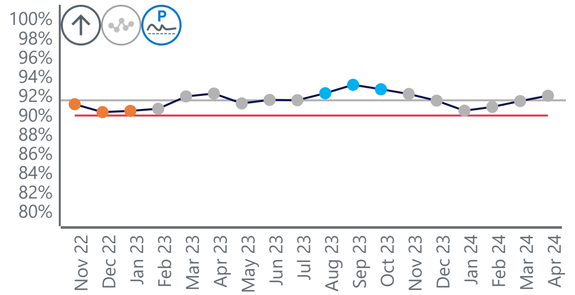
Reduce overdue Outpatient Follow Up Waits - 2 years & over



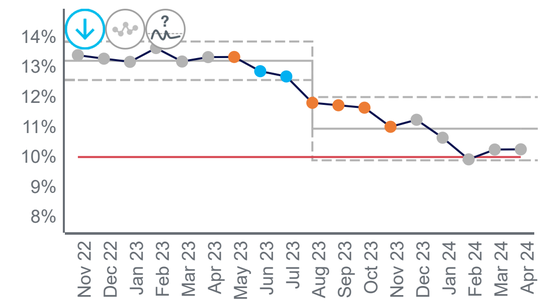
Sickness Absence (Total)



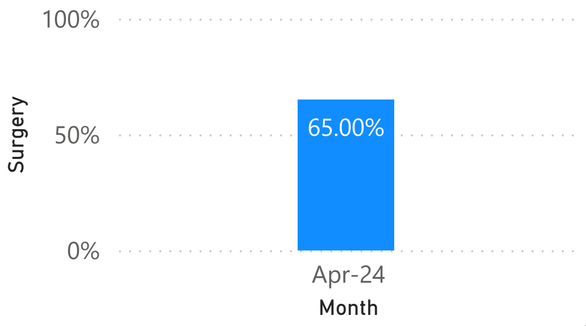
Mandatory Training



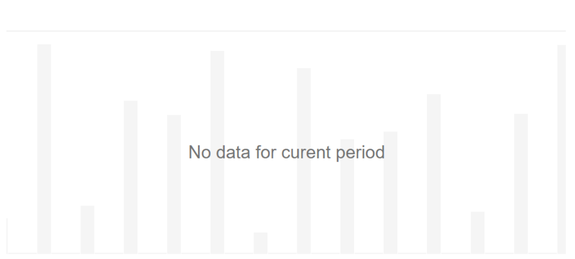
Staff Turnover



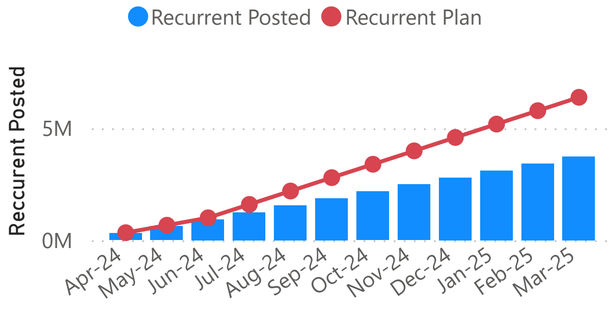
Workforce Stability



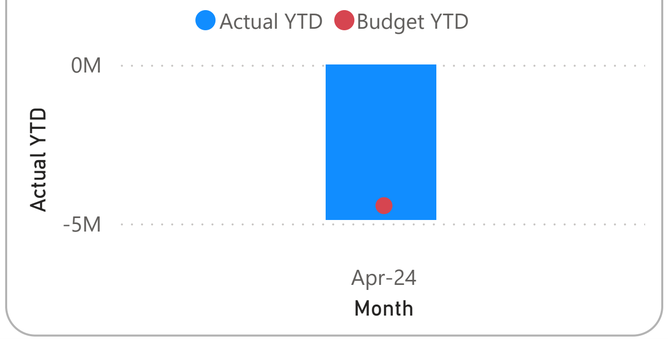
Colleague Satisfaction – Thriving Index - In Development



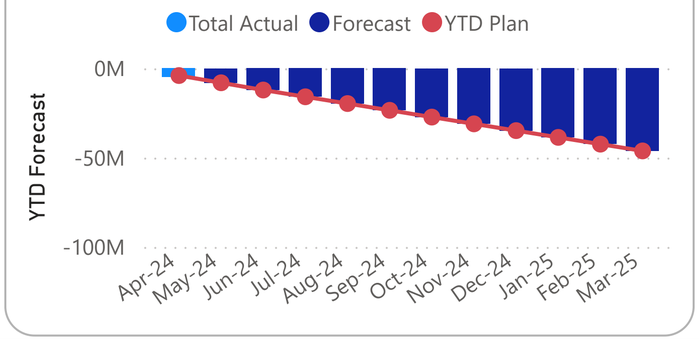
Recurrent Efficiency Plans Delivered (Forecast)



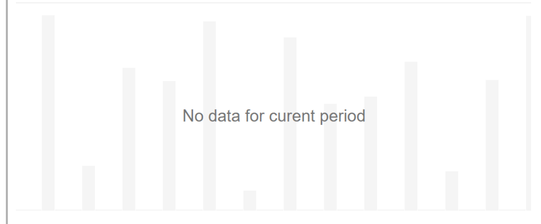
I&E distance from target (cumulative YTD)



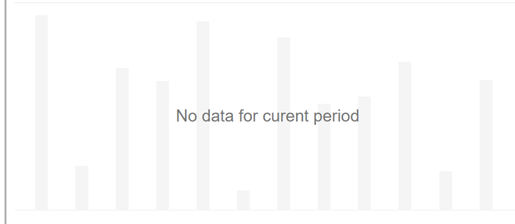
I&E Year End Forecast



Research - Number participants by clinical division - In Development



Research - Number chief investigators by clinical division - In Development



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• Successful funding awards in April include an award from the Brain Tumour Charity Quest for Cures (to Barry Pizer jointly with Aarhus University) for "Improving treatments for patients with rare embryonal and sarcomatous CNS tumours" and a successful NIHR Senior Clinical and Practitioner Research Award for Harriet Corbett to look at medical therapy for OAB in children and surgical options for BXO

• The commercial portfolio is expanding with more commercial studies currently in set up than we had open in the previous year.

• Ongoing progress with Futures collaborative working across Research, Innovation, Education and Digital.

• Workforce metrics are very positive for April with sickness dropping to 2%, turnover at 10% and mandatory training above target.

Areas of Concern

• Delays with AfC banding creating a gap in Clinical Research Facility Ops Management.

• Delays with invoicing for commercial activity due to change in approach (will be rectified in month 2)

• Support available for grants from Liverpool Joint Research Office potentially under-resourced.

Forward Look (with actions)

• Plans underway for launch of new collaboration with University of Liverpool to lead the way in child health and wellbeing (provisional date 21st June)

• NIHR grants in development for May submission (Treatment With or Without Immobilisation Study in Toddler's fracture – Shrouk Messahel and Multi-level Health Service and Delivery Research to Reduce Health Inequalities in Children with Long-Term Conditions – Ian Sinha)

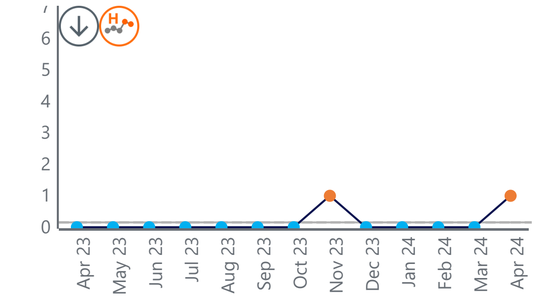
0059

Integrated Performance Report | May 2024

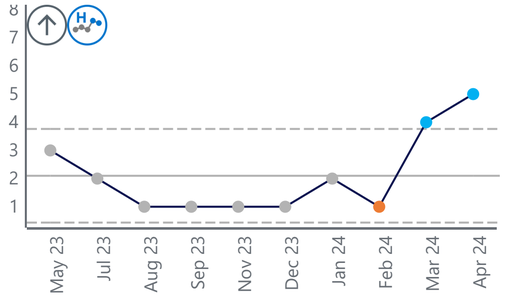
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

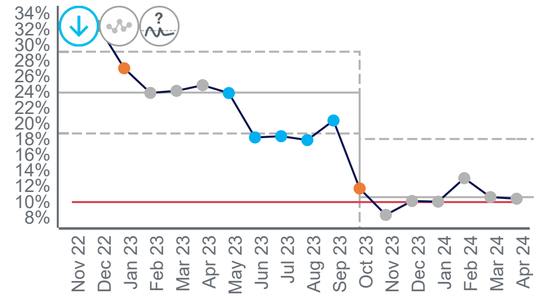
Patient Safety Incidents rated Low Harm & Above



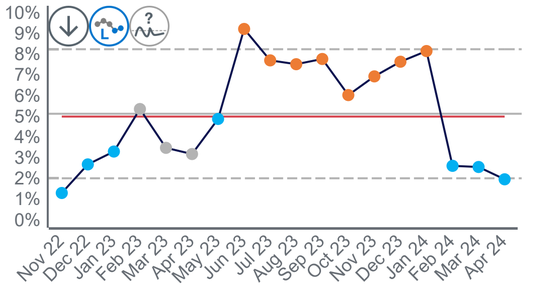
Patient Safety Incidents rated No Harm



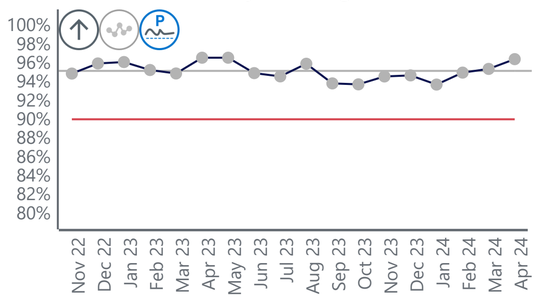
Staff Turnover



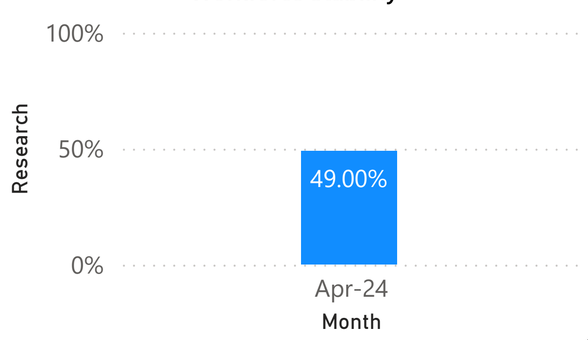
Sickness Absence (Total)



Mandatory Training



Workforce Stability



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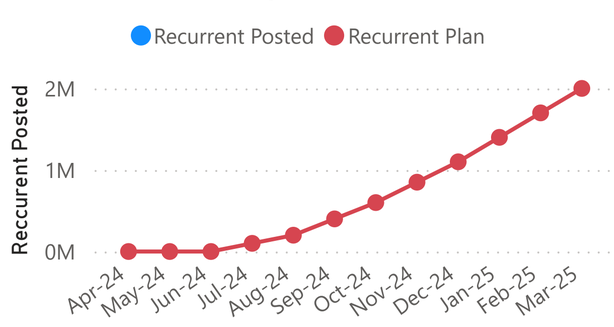
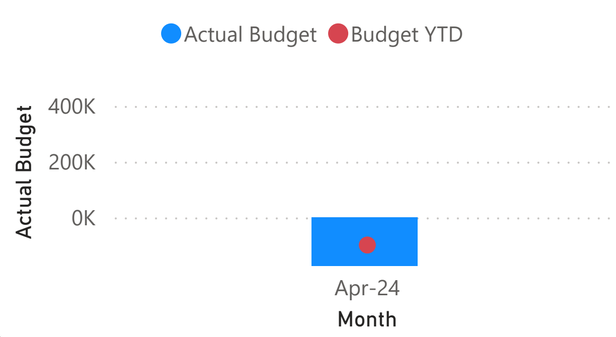
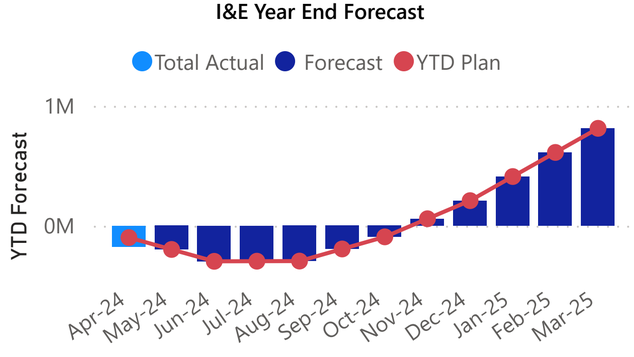


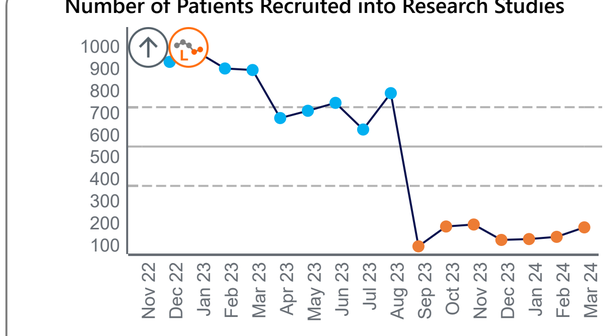
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Number of Patients Recruited into Research Studies



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

Highlights from the April 2024 Corporate Services data are:

- Mandatory training for Corporate Services remains above the 90% target at 93%.
- Staff Turnover remains steady at 11% which is below Trust target.
- Band 7 PDR completion rate currently sitting at 93%
- All PDR completion rate currently sitting at 95%
- Positive engagement in all service areas in monthly review of risks and actions required regarding any overdue risks. 93% of Corporate Risks in date as at 16th May 2024.
- Short term sickness absence has risen to 2% in-month (previously 1%). Despite remaining below Trust target (2.5%) this will remain an area of focus.
- 45% of CIP already identified and/or delivered at M01

Areas of Concern

- Return to work completion 59%
- Sickness absence 6.1% (increased from 5.6%)

Forward Look (with actions)

- Return to Work has remained the same for the past 2 months. Reports are shared with managers to highlight absences where RTWs have not been recorded therefore need to be working towards 100% compliance.
- All cases of long-term sickness absence are being managed in line with Trust Policy

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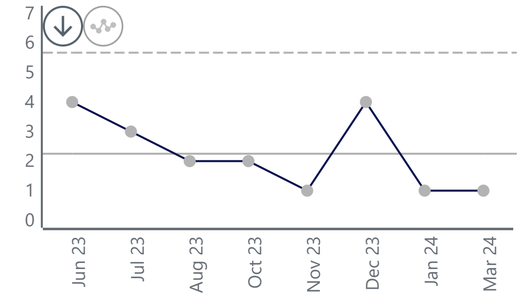
Integrated Performance Report | May 2024

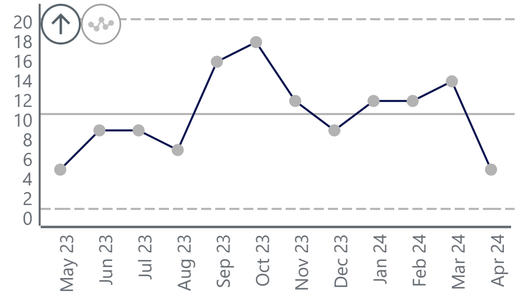
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

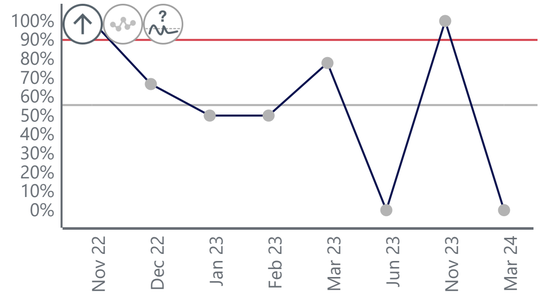
Patient Safety Incidents rated Low Harm & Above



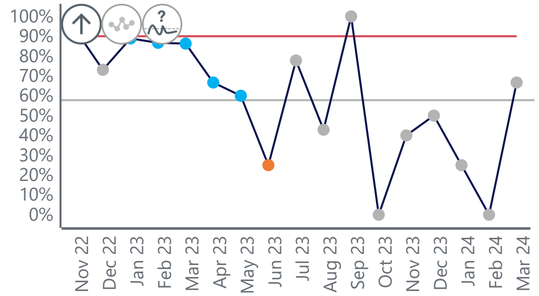
Patient Safety Incidents rated No Harm



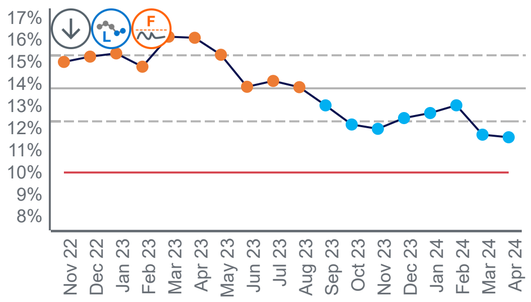
% Complaints Responded to within 25 working days



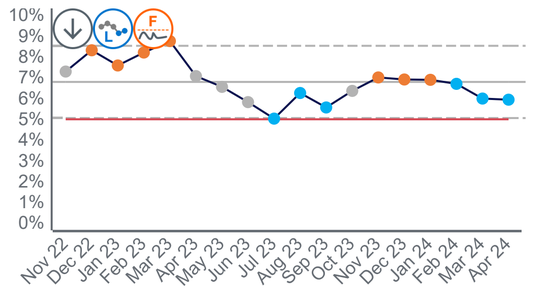
% PALS Resolved within 5 Days



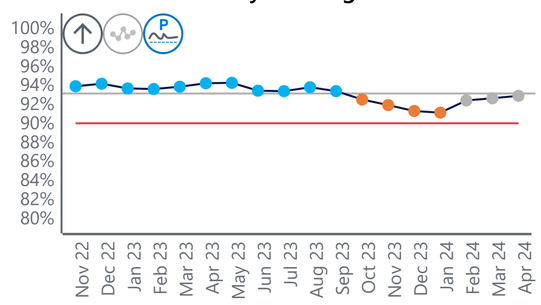
Staff Turnover



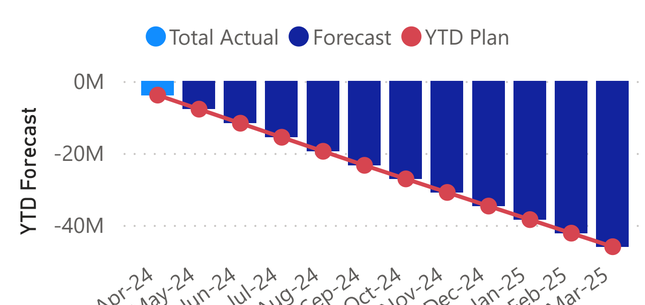
Sickness Absence (Total)



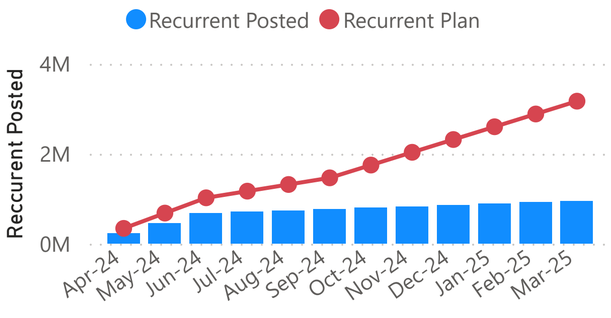
Mandatory Training



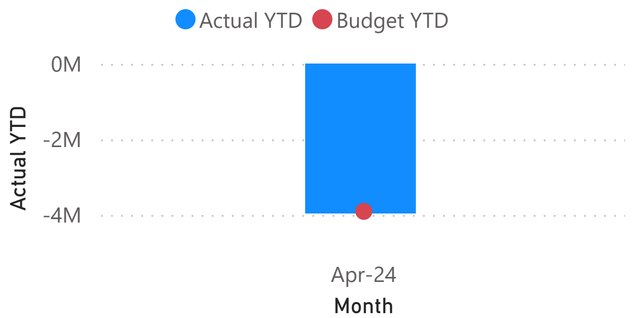
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

0063

Safe Staffing & Patient Quality Indicator Report
January 2024 Staffing, CHPPD and benchmark
May Board Paper

	Day		Night		Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate		RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of response	% Very good and good		
Burns Unit	96%	-	100%	-	121	16.5	12.69	-1.22	-7.46%	1.00	100%	0.00	0.00%	0.00	0.00%	22.01	4.04%			2	37	0	1	10	100%	0	0
HDU	81%	41%	84%	49%	311	28.9	31.64	-7.00	-9.25%	2.72	51%	0.00	0.00%	0.00	0.00%	100.57	3.93%	0.00	0.00%	16	100	0	3	1	100%	0	0
ICU	91%	80%	88%	63%	468	39.0	31.64	7.24	4.50%	2.17	52%	0.00	0.00%	0.00	0.00%	282.31	5.93%	2.00	3.23%	5	154	0	1	2	100%	0	0
Ward 1cC	86%	71%	82%	61%	474	14.1	14.9	-3.70	-6.30%	-0.70	-13%	0.00	0.00%	0.00	0.00%	42.57	2.29%	35.87	19.20%	3	68	0	15	12	100%	0	0
Ward 1cN	66%	15%	71%	-	240	13.2	15.84	1.93	5.50%	1.43	59%	0.00	0.00%	0.00	0.00%	64.92	6.27%	0.00	0.00%	5	50	1	9	2	100.00%	2	0
Ward 3A	100%	99%	99%	189%	768	11.5	10.3	-5.72	-12.00%	1.31	8%	0.00	0.00%	0.00	0.00%	188.33	11.26%	48.65	10.70%	6	51	2	18	20	100.00%	0	0
Ward 3B	73%	125%	67%	-	378	13.9	13.67	3.04	7.15%	1.56	30%	0.00	0.00%	0.00	0.00%	93.75	7.58%	28.52	24.14%	14	80	2	8	12	100%	1	0
Ward 3C	97%	95%	85%	137%	697	13.1	11.12	4.43	6.60%	4.79	48%	0.00	0.00%	0.92	16.41%	139.80	7.06%	60.96	33.56%	3	96	0	6	42	97.62%	0	0
Ward 4A	77%	58%	79%	132%	695	11.2	10.39	-1.36	-2.00%	0.80	14%	0.00	0.00%	0.00	0.00%	124.33	5.91%	6.44	4.23%	5	58	0	4	28	93%	0	0
Ward 4B	65%	83%	54%	65%	495	14.6	11.98	3.39	7.80%	2.03	5%	0.00	0.00%	0.61	1.69%	79.08	6.67%	230.06	20.37%	9	87	0	5	36	97%	1	0
Ward 4C	95%	92%	90%	104%	799	10.4	11.63	5.21	9.15%	2.62	22%	0.00	0.00%	0.00	0.00%	96.45	6.02%	44.23	15.74%	7	197	2	6	23	100.00%	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. The benchmark is based on December 2023 data.

<u>Medicine</u>

3B: Fill rate for RN's is below 80% due to a combination of short-term sickness 7.43% and 3 WTE vacancy (these were recruited to with external candidates and will commence in post over the next 3 months). HCA fill rate includes 1:1 requirement and those who support clinic as not in the baseline establishment. There was an increase in medication incidents in this reporting period.

3C: Fill rate for both RN and HCA has improved from the previous month with fill rates above 80%. The ward continues to support 4 x HCA 1:1 on a long-term basis. There was an increase in overall 1:1 for HCA's overnight not currently reflected within the baseline establishment. Risk assessments are reviewed to ensure correct supervision in place.

4B: Sickness levels continued to be monitored as there was an increase in short term sickness amongst HCA's within this period compared to the previous month. RN sickness has improved, therefore the fill rate below 80% is not reflective of requirements. The ward has undergone a remodelling and ratios of RN's required had changed, this is not currently reflected within the Healthroster. 1:1 requirements were decreased in January.

4C: Continue to see improvements in fill rate for January. The requirements for 1:1 had increased due to high numbers of EDYS admissions (7 in total).

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

Surgery

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

1C Cardiac fill rate improved from the December position, however HCA sickness remains high.

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

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

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

Critical Care

HDU: average fill rate has improved in January and similar to December had high numbers of urgent referrals to the unit.

ICU: Supernumerary staff in post within the reporting period.

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

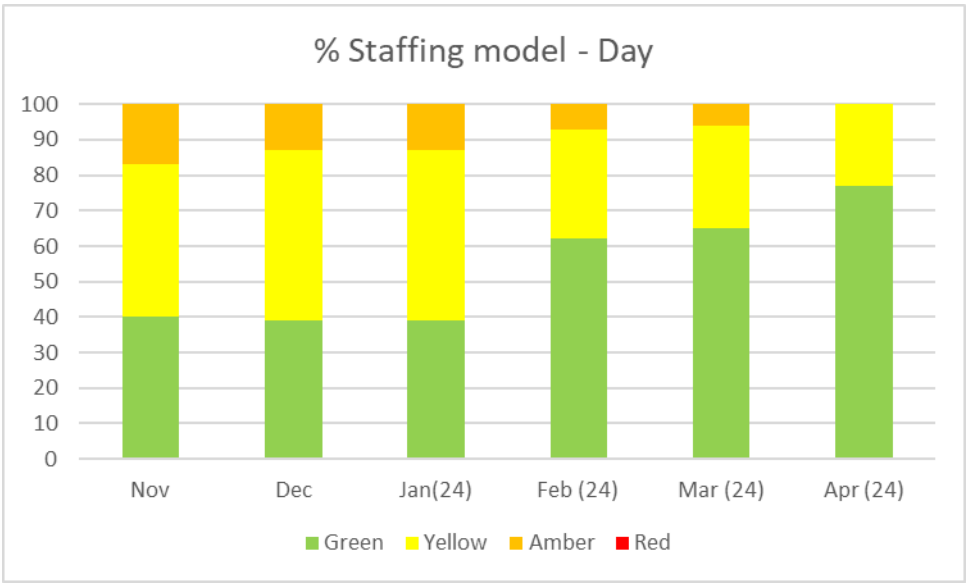
Summary

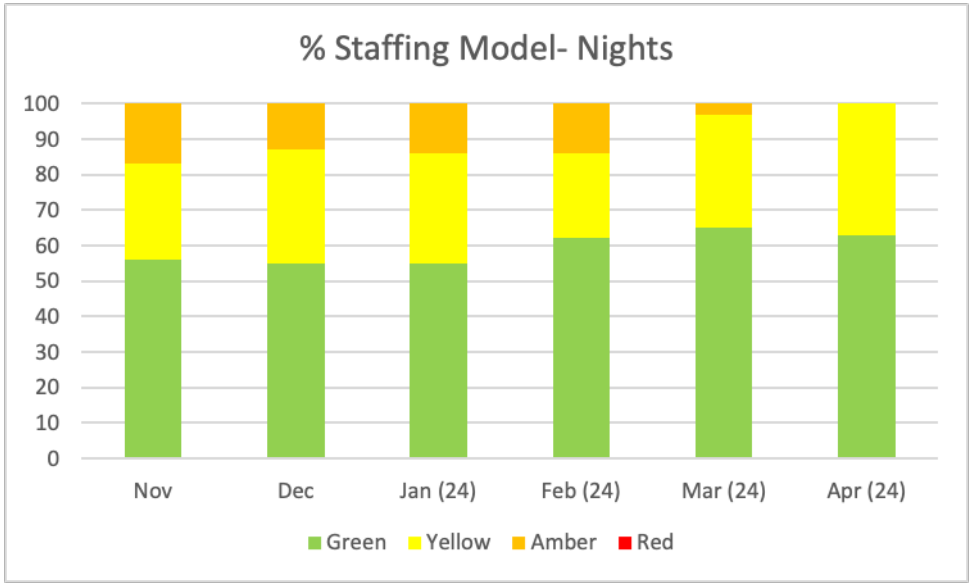
Alder Hey are above the National Benchmark in 6 of the wards/ departments (4B, 3C, 4A, 3A, burns unit and within critical care) whilst the other areas are comparable. 4C general paediatrics is lower than the National benchmark for January despite the fill rate, however this has improved from previous months.

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

Summary of Staffing models November 2023 – April 2024

Staffing RAG data has continued to show improvement with zero red shifts within the wards and departments for this reporting period. To note no amber staffing shifts were reported in April, this is the first time this has occurred within the last 6 months. A green staffing model was reported more frequently in the daytime than night rotas.





Electronic Roster KPI Report

April 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.

Summary Narrative

The roster team and ward managers are actively working to improve all KPI's to within target. The key elements that have been highlighted from the April KPI data are summarised below:

RosterPerform 11 Overview

KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owes)		The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shits in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days (1st April - 28th April)	% 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)	46	23.19%	80.00	492.92	0.00%	0	2	25.29%	15.63%	7.25%	0.00%	1.06%	0.00%	23.94%
Accident & Emergency - Nursing (912201)	46	41.67%	720.00	-16.88	19.25%	2218.75	2	14.39%	17.33%	4.23%	2.24%	7.70%	3.82%	36.08%
Burns Unit (915208)	41	20.52%	140.00	324.28	9.96%	237.5	22	12.57%	13.22%	5.59%	0.00%	2.40%	0.00%	24.97%
Critical Care Ward (913208)	42	31.73%	1200.00	3109.38	9.24%	1858.58	14	13.57%	12.68%	0.12%	0.52%	6.25%	4.90%	24.50%
High Dependancy Unit (HDU) (913210)	42	25.98%	640.00	483.3	16.05%	1529.5	33	17.26%	14.88%	3.78%	0.77%	8.42%	15.08%	39.92%
Medical Daycase Unit (911314)	39	23.36%	50.00	-55.55	4.45%	44	5	26.92%	17.08%	3.08%	0.00%	0.00%	0.00%	20.16%
Outpatients (916503)	41	52.37%	420.00	1240.83	16.99%	1044	22	44.49%	12.96%	0.47%	2.48%	25.66%	1.41%	42.98%
Sunflower House (912310)	12	69.66%	190.00	971.73	17.62%	581.75	24	15.45%	10.17%	0.77%	0.44%	5.16%	11.30%	39.67%
Surgical Daycase Unit (915418)	41	39.49%	85.00	422.58	7.82%	239.17	2	22.04%	10.31%	0.69%	1.60%	12.80%	0.00%	24.86%
Theatres - Cardiac & Cardiology (915405)	41	39.46%	130.00	300.75	10.69%	188.5	1	15.82%	13.72%	3.15%	8.01%	0.95%	0.00%	30.17%
Theatres - Emergency (915420)	41	34.46%	230.00	39.42	3.32%	70	0	0.52%	11.01%	2.39%	0.65%	0.00%	0.00%	18.70%
Theatres - IP Anaesthetics (915423)	41	34.96%	82.00	-30.17	7.82%	280	11	3.18%	12.95%	0.44%	1.88%	3.80%	6.10%	25.18%
Theatres - IP Porters (915435)	41	19.66%	101.00	1	7.70%	129	0	3.23%	11.04%	0.44%	0.00%	0.00%	0.00%	11.49%
Theatres - IP Recovery (915422)	41	63.51%	103.00	-29.95	9.08%	149.25	3	13.81%	8.66%	5.37%	5.12%	12.86%	0.00%	32.01%
Theatres - IP Scrub (915424)	41	19.05%	128.00	9	18.86%	294	1	11.45%	16.16%	2.12%	1.34%	9.63%	0.00%	36.11%
Theatres - Ortho & Neuro Scrub (915436)	41	35.14%	37.80	21.75	29.91%	685.25	0	9.70%	13.09%	0.70%	1.00%	16.43%	4.20%	43.31%
Theatres - SDC Anaesthetics (915429)	41	27.88%	58.40	38.92	12.72%	119	0	16.29%	25.22%	3.15%	5.08%	0.00%	0.00%	33.44%
Theatres - SDC Recovery (915430)	41	37.58%	177.30	-6.93	6.95%	90.25	6	9.55%	12.14%	6.93%	3.32%	7.93%	0.00%	30.33%
Theatres - SDC Scrub (915421)	41	40.38%	532.00	0	12.69%	408.25	24	5.97%	12.19%	0.27%	2.21%	22.30%	0.00%	36.97%
Ward 1C Cardiac (913307)	42	38.63%	361.00	1112.03	9.23%	674.2	1	5.74%	13.33%	1.65%	2.12%	5.97%	8.06%	36.06%
Ward 1C Neonatal (913310)	40	44.67%	556.00	682.5	0.23%	11.5	0	30.50%	15.31%	4.72%	0.74%	2.37%	0.00%	26.83%
Ward 3A (915309)	42	29.25%	371.00	13.97	14.05%	1118.5	49	9.84%	13.20%	3.31%	1.23%	8.43%	5.86%	33.25%
Ward 3B - Oncology (911208)	33	25.10%	555.00	3579.18	13.43%	697	32	15.90%	12.09%	5.06%	0.78%	5.88%	6.55%	36.20%
Ward 3C (911313)	39	39.31%	607.00	1932.38	18.13%	1703.5	105	24.59%	12.04%	3.91%	0.83%	7.46%	3.97%	30.81%
Ward 4A (914210)	42	21.51%	634.00	344.5	5.86%	500.5	36	17.89%	13.18%	4.81%	0.81%	6.08%	5.28%	33.30%
Ward 4B (914211)	33	33.60%	533.00	148.17	7.31%	562.5	4	28.28%	9.80%	7.29%	1.77%	11.09%	4.94%	38.64%
Ward 4C (912207)	44	29.08%	280.00	46.01	14.24%	1122.5	22	13.87%	15.70%	2.79%	0.91%	3.98%	0.38%	25.88%
Apr-24	**40**	**34.90%**	**9001.50**	**15075.09**	**11.24%**	**16556.95**	**421**	**15.86%**	**13.52%**	**3.13%**	**1.70%**	**7.19%**	**2.85%**	**30.88%**
Mar-24	**40**	**37.95%**	**9001.50**	**15714.49**	**15.80%**	**20593.58**	**325**	**17.47%**	**20.08%**	**2.26%**	**2.02%**	**7.34%**	**2.84%**	**36.23%**
Feb-24	**38**	**38.09%**	**9001.50**	**25961.77**	**15.30%**	**20805.07**	**261**	**19.43%**	**16.96%**	**2.67%**	**2.00%**	**7.33%**	**3.35%**	**34.64%**
Jan-24	**31**	**35.00%**	**9001.00**	**29114**	**13.60%**	**20742**	**409**	**21.22%**	**15.84%**	**2.08%**	**2.17%**	**8.89%**	**3.48%**	**34.06%**

Lead time has stayed at 40 days from March to April (target is 42 days) - Staff are receiving on average 40 days' notice of shifts to be worked. This is a consolidation of the previous months improvement and helps staff with their work life balance as well as assuring managers well in advance that they have the correct skill mix and staffing numbers to provide safe and effective care to their children and young people. The Roster meetings have been brought forward by 1 day to support the ward teams moving from 41 to the 42-day target. The Roster team continue to work with the Ward and Divisional leads to improve these lead times and achieve our target of 42 days right across the Trust.

Roster changes since approval is improved at 35% from 38% (target is <25%) – we have seen another improvement in month. This mainly relates to rosters now going out a week earlier and the planned sign off meetings. Again, the figure is skewed by one or two areas where there are a significant number of roster changes namely OPD, Sunflower House and Recovery. The Roster team plan to work with Managers to improve the initial roster. This work has commenced in April with significant improvements anticipated by Q2.

Net hours reduced again from 15714 from 15075 – Continued significant improvement has been made in this area. These are hours in the roster that are unaccounted for and in April this figure was improved by 700 hours. The E Roster team are working with the departmental managers to correct any

administrative errors so there is full assurance that the data reflects the true position for each area. These hours can be used in place of booking temporary staffing via NHSP.

Bank/Agency hours have fallen again in April from 20593 to 16556, and the percentage of shifts filled by temporary staff is down from 16% to 11% (target is <10%) - This figure relates to the fact that 11.24% of all shifts are identified through NHSP. Fill rates have increased in line with this, and Managers have fed back that they generally utilise their own staff so helping with patient continuity. One key factor in this will be the net hours reduction, so hours now are accounted for, meaning less vacant shifts available for bank. It is hoped that we will now see a continued significant improvement as vacancy rates are low.

Additional duties have increased from 325 to 421 (target is 0) – This month has seen a further deterioration in position. The main factor relates to 2 hot spot areas as 105 shifts have come from 3C and 49 from 3A. This is reflective of 1-1 requirements on both wards. The 3A position is reflective of additions that have been agreed to be made to the funded establishment which have yet to be reflected in the actual roster. This means the ward manager is adding shifts in for the new staff, but it is reflected as additional to the current number. This has been flagged with the Divisional leads. These 'additional duties' reflect the hours of staff booked over the funded establishment.

Unfilled roster reduced from 17.47% to 15.86% (target is <15%) Another further improvement and only just above target in this area. This could be in part due to some roster template reviews, net hours now accounted for and an increase in bank fill rates. The E Roster team continue to work with Managers to review templates.

Annual leave, other leave, and parenting leave - Annual leave down from 20% to 13.5%. Within target. Maternity and paternity leave stable at 2.85%. The figure is skewed because of high levels on 1c Cardiac, Sunflower House and HDU. Other leave down to 1.7% from 2.02%.

Sickness is down to 7.19% from 7.34% (target <5%) - continues to be above target but consistent improvements in most areas. The figure is greatly affected by Theatres, where there are smaller staffing departments identified, so percentages are affected by small numbers of staff absence. Also, OPD where staff absence is very high at 26% and also 4B at 11%.

Study leave has seen an increase from 2.26% to 3.13% (target is <2%). It was noted that allocations were significantly higher in AED and 4B.

Total unavailability is improved from 36.23% to 30.88% (target is <30%) A big improvement in month. Annual leave was within target and down from the March high, and sickness down again to 7.19%. Generally, more staff available to work the roster meaning less bank, more consistency in terms of the delivery of care and staffing assurance. This indicator covers sickness, suspension, maternity leave, study leave etc.

Progress and Challenge

Meetings continue to take place with the E Roster team and Ward and Divisional Managers, to look at the quality of rosters and make changes as necessary, that will have a direct positive impact on the KPIs. From this months' data it is apparent progress is being made consistently, with improvements in all areas apart from 2 standards. Managers continue to develop an understanding of what the data is telling them and are working towards rosters playing a key role in their workforce planning.

This report is shared with the Divisional nursing leads to share with their managers in order to improve these key workforce markers.

May 2024 Performance – Subject to change

Strategic Goals	Key Metrics	Target	Actual for May
Outstanding Care and Experience	Number of Severe or Fatal Incidents – Physical & Psychological	0 (zero)	0
	Number of PSIIs (Patient safety incident investigation) undertaken	0 (zero)	0
	Number of Never Events	0 (zero)	0
	Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	1- C diff, 1-MRSA	1 (C.Diff)
	FFT - % Recommending Trust	> 95%	93.5%
Supporting our People	Staff Turnover	*<10%*	10%
Collaborate for Children and Young People	Return Springfield Park to Liverpool City Council	Nov-23	July 2024
Revolutionise Care	ED: % treated within 4 Hours	> 77%	86.7%
	Number of RTT Patients waiting >52weeks	0 (zero)	720
	% of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks	TBC	% to have outcome within 65 weeks metric in development and the number waiting is 2,528
	Elective Recovery (Volume vs 19/20)	> 107%	108.5%
	Diagnostic Performance	> 90%	86.7%
	I&E Year End Forecast	£5.6m	£5.6m

Operational Plan Progress Summary -

Published June 2024

Strategic Goals	Progress in May 2024	Areas of challenge (Including any actions)
Outstanding Care and Experience	• First C&M Matha's rule collaborative meeting held – chaired by Alder Hey • Further improvement in L1 patient safety training • First 2 learning reviews undertaken as part of PSIRF	• Increase in 10-fold neonatal drug errors which will be reviewed. • Progressing patient safety partners which is having additional resource to support
Supporting our People	• Approved 2 new workforce measures: - Stability index and - Staff thriving index	• Team capacity, whilst recruiting to vacancies
Pioneering Breakthroughs	• Patient portal requirements review underway with stakeholders. Procurement are supporting with the next steps within the project and governance has been aligned to 2030 • AsOne design workshops for Merseycare and Cheshire roll out in progress. • LHAH Southampton PoC agreed for end of June • 2 x Projects submitted to Hartree Centre for review • Noteworthy publication - Singh A, Wade RG, Metcalfe D, **Perry DC**. Does This Infant Have a Dislocated Hip?: The Rational Clinical Examination Systematic Review. JAMA. 2024 May –	• Delays in partner payments and contracting • Team capacity and clarity on priorities • Challenges with lab support for ongoing trials and trials in set up – approach under review • Research delivery team capacity stretched due to unavoidable long terms sickness absence • First AH gene therapy trial participant forced to withdraw due to potential safety concern – follow up with family and support to find other suitable research already taken place.

	already generating international attention. • Children's Radius Acute Fracture Fixation Trial (CRAFFT) led by **Prof Dan Perry** has completed participant recruitment (with AH best recruiting site nationally) • **Paul McNamara** has secured a LifeArc and CF Trust award of £3.7m (awarded to UoL) which will generate AH research activity • **Rachel Harwood** (surgery) has secured a NIHR Academic Clinical Lecturer award to cover research salary costs.	
Revolutionise Care	• 7 developments were prioritised through Clinical Digital Design Authority for May, and 7 developments complete this month. • AlderC@re highlights include change to improve ordering blood products, PEWs change for Theatres, Coding changes for Audiology, ED ophthalmology referral process and a clear documentation for growth hormone reviews. • 720 patients waited over 52 weeks for treatment against a trajectory of 781. • A&E Performance was above trajectory with 86.7% of patients being seen within 4 hours, against an internal trajectory of 85%.	• Number of priority development requests outstanding with Meditech • Challenges ongoing around referral management within Alderc@re, options appraisal around next steps being worked through with Meditech and clinical and admin colleagues. • Number of patients waiting over 65 weeks for treatment is increasing, however performance is on track to zero patients by September 2024. • 2,528 patients are waiting for ASD or ADHD diagnosis. The ADHD medication shortage continues to affect patients following diagnosis. • 6-week diagnostic performance continues to remain below the national target of 95%, achieving 86.7% in May.

	• Early review of May's activity plan suggests an achievement of 102% against plan. This falls to 99% when reviewing elective & day case performance specifically. • Productivity dashboard is in development, incorporating metrics recommended by Revolutionising Care Programme Board.	• There are over 6000 patients waiting longer than 2 years for their follow up appointment. The Safe Waiting Follow Up Group is managing oversight of reducing this backlog. • Implied productivity metric from Model Hospital suggests that activity is costing the organisation more than 19/20. Deep dive is being reviewing by the Productivity Sprint Group.
Collaborate for Children and Young People	• **Health Inequalities** – Trust Wellbeing Hub preparing for mobilisation with Go Live date set for 1 July 2024. • **System Leadership** - Liverpool Strategic Partnership (LSP) agreement to establish a Children and Young People's Board to provide system leadership and oversight across the City. • Creating Opportunities for CYP - Social Value calculator dashboard being developed	• Need to ensure equity of provision for CYPF from Sefton and Knowsley and beyond. • •ICB Key Priorities for Liverpool identified as Urgent and Emergency Care and Liverpool Clinical Services Review. Need to continue to raise profile of children and young people's agenda in this emerging space (likely to be respiratory / NBHs / Health Inequalities / MH focus for CYP
Financial Sustainability	• £0.7m deficit in month, on plan largely due to re-profile of CIP and release of non-pay contingency reserve. • YTD deficit £1.8m with forecast to achieve plan of £5.6m surplus, subject to CIP delivery and industrial action risk. • £12m CIP identified and in progress YTD with remaining due to be posted by Q4 to achieve plan in year.	• Work ongoing to support the delivery of efficiency targets, including the work on benefits from the strategic initiatives. • Continued cost control required to reach the year end position, with specific focus on non-clinical posts in line with ICB stretch target.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 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 West)
Paper Prepared By:	Emily Gardner, Programme Director Children and Young People's Gender Service (North West)

Purpose of Paper	Decision ☐ Assurance ☒ Information ☐ Regulation ☐
Summary / Supporting information	Previous Trust Board papers (2023 & 2024)
Action required	To Approve ☐ To Note ☒
Strategic context **This paper links to the following:**	Delivery of **outstanding care** ☒ **The best people** doing their best work ☒ Sustainability through **external partnerships** ☒ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource implications	

Does this relate to a risk? Yes ☒ No ☐

Risk Number	Risk Description	Score
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	16
197	There is a risk that there is impact or disruption within the service or wider organisation in relation to legal proceedings such as a judicial review, public enquiry, or individual challenges.	16
168	There is a risk that the research proposed to support the Children and Young People's Gender Service is not on track, and the scope and eligibility for research is not clear.	12
194	There is a risk that the Gender Service is not embedded within the values of Alder Hey, does not align with organisational culture and/or is impacted by the external toxic environment surrounding the service	12

195	There is a risk that capacity of the CYP Gender Service (North West) is insufficient to meet requirements of the service's open case load and/or additional/amended requests of NHS England, which could increase or change in nature away from the agreed Year 1 Plan. Provider organisations could be put under pressure to amend service away from agreed approach to meet requests	12
198	There is a risk that there may be required additions or amends to the Gender Service (North West) which are not yet agreed or prioritised	12
196	There is a risk that the CYP Gender Service (North West) does not adhere to service delivery requirements, as required by Alder Hey via existing policies and procedures and to meet the Interim Service Specification, which the service is contracted against	9
167	Risk that the new location for the Gender Service will not be ready by the agreed date of July 2024 to start seeing patients in, following the use of interim space from April 2024	6

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 West).

2. Background

The Gender Identity Development Service (GIDS) was commissioned by NHS England and provided by Tavistock and Portman NHS Foundation Trust, for children and young people who experience difficulties in the development of their gender identity. The service closed on 31 March 2024.

In 2020, NHS England commissioned Dr Hilary Cass to review gender identity services for children and young people, because of several factors including significant increased demand; long waiting times and lack of evidence to support clinical decision making. In July 2022, in a letter to NHS England, Dr Cass recommended that the new regional centres for the re-named Gender Development Service (GDS) are led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services. Alder Hey Children's NHS FT and Royal Manchester Children's Hospital (MFT) have developed the GDS North Hub. Great Ormond Street Hospital for Children NHS FT (GOSH), Evelina London Children's Hospital (GSST) and South London and Maudsley NHS FT have formed the South Hub. Both Hubs are jointly known as the Phase 1 Providers.

The final report of the Cass Review was released on 15 April 2024 and further updates are awaited from NHS England regarding next steps, it is expected that a final service specification will now be developed.

3. Summary of progress

The service has continued to prioritise the assessment of the children and young people who transferred from the Tavistock and Portman on 01 April 2024 and is on track to provide assessment to all 109 children and young people by the end of June 2024, as agreed with NHS England. Referrals from the national waiting list will not commence until the service leadership team are assured that sufficient capacity is available. This will be reviewed when all initial assessments are complete. Receiving referrals from the national waiting list will be referred to as Phase 2 go live.

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

- Service Update
- Estates
- Workforce and Recruitment
- NHS England National Programme

4. Service Update

Assessment appointments have been offered to all 109 children and young people who transferred from the previous service provider, of which:

- 68 children and young people have been seen within the service.
- 5 young people have opted to defer their assessment into Q2 due to undertaking exams.
- 2 young people have been transferred to the London service, due to being incorrectly advised of transfer to London by the previous service.

- 1 young person has been discharged.11 children and young people have consented and been referred for an assessment by their local children and young people's mental health services, which forms part of the national offer for wraparound support for the transferring open case load. This assessment should be carried out within Q1, and the service is awaiting confirmation of receipt of these referrals from mental health providers. This assessment will supplement the service's work and ensure robust oversight and care for this group of children and young people.

All children and young people on the national waiting list have also been offered an assessment by mental health providers, which should take place within 2024/25 financial year.

As reported in the update to Trust Board in May 2024, positive feedback has been received from families regarding the service and this continues.

5. Estates

Staff working within the service continue to use interim space across Alder Hey and Manchester sites whilst renovation work continues at the premises at Warrington. Some delays have been incurred from the renovations, due to water testing taking place. Staff space is due to be available to use from 01 June 2024, with all work remaining on track for early July 2024.

6. Workforce and Recruitment

To date, the service has appointed 36.2wte staff to date, with remaining interviews to be held in June and July. NHS England have confirmed that over-recruitment to workforce establishment is supported, which the service will consider enabling additional capacity within the service.

7. NHS England National Programme

Following the publication of the Cass Review Final Report on 15 April 2024, there has not yet been any formal direction from NHS England. The service is likely to need to adapt to meet the recommendations of the Cass Review and we continue to seek clarity on next steps from NHS England.

8. Prescribing of Puberty Suppressing Hormones

On 29 May 2024, NHS England advised that the Government has introduced emergency restrictions on the use of gonadotrophin releasing hormone (GnRH) analogues used to suppress puberty as part of treating gender incongruence or gender dysphoria in children and young people who are under 18 years of age. Some of these restrictions, the ones for private prescriptions, will take effect from 3 June 2024. Further information can be found Here and in Appendix 1.

All children and young people who transferred to the new service have been sent a letter on behalf of NHS England (Appendix 2).

9. Recommendations

Trust Board is recommended to note the update from the service, particularly the positive progress around assessments and the outstanding direction from NHSE England in relation to the Cass Review.

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Appendix 1

New Government restrictions on use of

Appendix 2

Patient Letter NHSE branded v2 North So

Appendix 1

New Government restrictions on use of Puberty Suppressing Hormones (Puberty Blockers); Information for prescribers and pharmacists/dispensing doctors

The Government has introduced emergency restrictions on the use of **gonadotrophin releasing hormone (GnRH) analogues** used to suppress puberty as part of treating gender incongruence or gender dysphoria in children and young people who are under 18 years of age. Some of these restrictions, the ones for private prescriptions, will take effect from 3 June 2024.

https://www.gov.uk/government/news/new-restrictions-on-puberty-blockers

Who will the change affect most?

As a result of this new Government policy, people who are currently receiving a private prescription for GnRH analogues for any reason from a professional who is in the European Economic Area (EEA) or Switzerland, but not UK registered, will be impacted from 3 June 2024. **Pharmacies in Great Britain will no longer be able to dispense new private prescriptions, dated on or after 3 June 2024 for GnRH analogues from the EEA or Switzerland for anyone under 18 years old.**

Who will be less affected but may need advice and reassurance?

Individuals who are already receiving NHS or private prescriptions can continue to receive their prescriptions. However, they and / or their families are strongly advised to meet with their prescribing clinician to fully understand the safety risks associated with GnRH analogues when prescribed for gender incongruence or gender dysphoria. Information for patients can be found on the website for the NHS National Referral Support Service for the Children and Young People's Gender Service.

What are the specifics of the new Government Policy?

As a result of the new Government policy, it will become a **criminal offence** for a doctor, pharmacist, or any other individual in Great Britain to sell or supply these drugs to patients under the age of 18 **except in the following circumstances:**

- The child or young person is prescribed these medicines on an NHS prescription (for example, from the NHS Children and Young People's Gender Service). All NHS prescriptions and directions are outside of this ban.
- The child or young person is prescribed these medicines on a private prescription from a UK prescriber that fulfils the following criteria:
    - The prescription was dated prior to 3 June 2024; or
    - It is a repeat prescription but only when the initial prescription was written in the six months prior to 3 June 2024;
    - There are also requirements for prescriptions issued from 3 June 2024 to be marked with the person's age, annotated by the prescriber with "SLS", and in the case of prescriptions issued before that date, for the person to provide proof of identity and age.
    - The prescription is for a purpose other than the treatment of gender incongruence or gender dysphoria, or for gender incongruence/dysphoria if the patient started treatment for gender incongruence/dysphoria before 3 June 2024.

Additionally, from 26 June 2024 General Practitioners (GPs) in England will only be able to supply prescriptions for GnRH analogues in the following circumstances:

- The patient is aged 18 years or over; or
- The patient is under 18 years old, and the purpose of the prescription is for a medical condition other than gender incongruence or gender dysphoria; or
- The patient is under 18 years old and has started treatment with these medicines, and for these purposes they will be treated as having started treatment if they have been issued with a prescription for these medicines since 3 December 2023, even if they have not yet started taking the medicines.

As indicated above, new private prescriptions for GnRH analogues from a prescriber in the European Economic Area (EEA) or Switzerland who is not UK registered are banned from being supplied in Great Britain in all circumstances for patients aged under 18. For patients aged 18 or over with a prescription from an EEA or Switzerland registered prescriber, their prescription can be dispensed in Great Britain providing verification of age and identity can be shown to the dispensing pharmacist.

The effect of the order is that emergency supply under the Human Medicines Regulations 2012 is prohibited.

Further information about specific cases can be found in Appendix 1.

These changes will be reflected in the Drug Tariff from July 2024, and in dm+d this week. It will take time for these changes to be added to GP prescribing and pharmacy dispensing IT systems. Further advice will be provided on IT system changes ahead of 26 June 2024.

Support for children and young people affected by this change

Some children and young people may be concerned or distressed by changes. If they are already under the care of Childrens and Young People's (CYP) mental health provider/Child and Adolescent Mental Health Services (CAMHS) they can contact their team for advice. If they are not, their GP team will be able to assess whether further referrals for mental health support are required. Patients can also be signposted to advice on getting mental health support available at nhs.uk. Anyone in need of urgent support can contact NHS 111 and choose the mental health option (option 2) https://www.nhs.uk/nhs-services/mental-health-services/where-to-get-urgent-help-for-mental-health/

NHS England published national clinical policy on puberty suppressing hormones on 12 March 2024 alongside an evidence review which can be found here.

The General Pharmaceutical Council has published a resource for pharmacy professionals to support them in providing information, support and services to children and young people with gender incongruence or dysphoria; 'Gender identity services for children and young people: making compassionate, professional and ethical decisions' is available at: Gender identity services for children and young people: making compassionate, professional and ethical decisions (pharmacyregulation.org)

Appendix 1

ADVICE FOR PRESCRIBERS AND DISPENSERS

Puberty Suppressing Hormones			
Patient group	**Advice**	**Prescriber**	**Dispenser**
Under 18 years old and **not prescribed** GnRH analogues.	No under 18-year-old should be started on GnRH analogues to supress puberty for gender incongruence or gender dysphoria.	The initiation of GnRH analogues is not possible in the NHS specialist Children and Young People's Gender Service unless this is part of a future NIHR research study or the patient was referred to an NHS paediatric endocrinology team for assessment of suitability of GnRH analogues for gender incongruence or gender dysphoria on or before 31 March 2024. Other NHS clinicians cannot initiate a new NHS prescription from 26 June 2024. Private practitioners cannot initiate a new prescription from 3 June 2024 to patients who have not yet started treatment.	Pharmacies in Great Britain cannot dispense a new (initiation) prescription issued by a prescriber, unless the patient started treatment before the restrictions came into effect. This includes prescriptions issued in the UK, European Economic Area (EEA) or Switzerland.
Patient is under 18	Patients under 18 are strongly	If during a shared decision-making	NHS primary care prescriptions for continuation

years old and already being prescribed GnRH analogues through the **NHS** for gender incongruence or gender dysphoria.	advised to meet with their clinician to fully understand the risks of continuing taking GnRH analogues for puberty suppression. These medications can be stopped and do not need to be weaned off.	conversation considering the risks a decision is made to continue the Children and Young People Gender Service or another NHS clinician can continue to prescribe. NHS prescriptions in primary care must be marked SLS if they are issued on or after 26 June 2024.	of existing treatment marked SLS may be dispensed when the new restrictions come into force on 26 June. NHS prescriptions are not covered by the Prohibition Order.
Patient is under 18 years old and is already being prescribed GnRH analogues by a UK-registered **private** practitioner in Great Britain for gender incongruence or gender dysphoria.	Patients under 18 are strongly advised to meet with their clinician to fully understand the risks of continuing taking GnRH analogues for puberty suppression. These medications can be stopped and do not need to be weaned off.	If during a shared decision-making conversation considering the risks a decision is made to continue the private practitioner can continue to prescribe. New prescriptions must be marked SLS and include the patient's age.	Private prescriptions for continuation of existing treatment marked SLS and including the patient's age may be dispensed . Existing prescriptions, issued before 3 June 2024, can only be supplied if proof of age and identity is produced.
Patient under 18 years old and is already being prescribed GnRH analogues through a prescription from the **EEA or Switzerland** for gender incongruence	Patients under 18 are strongly advised to meet with their clinician to fully understand the risks of continuing taking GnRH analogues for puberty suppression.	If the patient wants to continue an NHS or private prescriber can continue to prescribe following a shared decision-making conversation about the risks with the patient. Prescription must be marked SLS	Prescriptions from EEA or Switzerland for GnRH analogues for puberty suppression can no longer be dispensed unless they were issued before 3 June 2024 and are still valid, and the dispenser has proof of age and identity.

or gender dysphoria.	These medications can be stopped and do not need to be weaned off.	and patient's age, if issued after 3 June 2024.	
Patient is under 18 years old and is an overseas **visitor** who has run out of their GnRH analogues for gender incongruence or gender dysphoria.	The patient may see a private practitioner, or temporarily register with a GP for advice and support.	If the patient started treatment before 3 June 2024, the private practitioner or the GP can prescribe a repeat prescription if this is within their clinical scope of practice, and they are satisfied this is urgently needed continuation therapy. Prescription must be marked SLS and have proof of age.	The patient should secure further medications from their home nation specialist if possible. However, a private prescription marked SLS from 3 June 2024, or an NHS prescription marked SLS from 26 June 2024, for continuation of treatment may be dispensed.
Patient is **18 years or older** and remains on GnRH analogues and have not started on gender affirming hormones.	Patients under 18 are strongly advised to meet with their clinician to fully understand the risks of continuing taking GnRH analogues for puberty suppression. These medications can be stopped and do not need to be weaned off.	Patients are advised to meet with their clinician so that the risks of continuation are fully understood. If after a shared decision-making conversation, the patient wishes to continue treatment the practitioner can continue NHS or private prescribing. Prescription must be marked SLS.	Prescriptions from NHS from 26 June 2024, or private prescribers from 3 June 2024, marked SLS may be dispensed. In the latter case, if it is not marked SLS, the patient may instead provide proof of age and identity. Prescriptions from the EEA or Switzerland can be dispensed if the patient is able to provide proof of age and identity. SLS cannot be used by such prescribers.
Gender Affirming Hormones (GnRH analogue prescriptions)			
Patient is under 18 years old and not yet taking	No under 18-year-old should be **initiated** on gender affirming	NHS prescribers are advised not to initiate gender affirming	NHS GnRH analogue prescriptions may not be dispensed unless marked SLS.

gender affirming hormones.	hormones by the NHS (except by Children and Young People's Gender Service in extreme circumstances).	hormones under the age of 18. Children and Young People's Gender Service will consider initiating this treatment in extreme circumstances. A private practitioner may after a shared decision-making conversation about the risks initiate prescriptions for GnRH analogues as part of gender affirmation. Prescription must be marked SLS.	Private prescriptions marked SLS may be dispensed. Prescriptions from the EEA or Switzerland for GnRH analogues cannot be dispensed.
Patient is under 18 years old and is already being prescribed GnRH analogues by the **NHS** as part of gender affirmation.	Patients are advised to continue taking GnRH analogues as part of gender affirmation. They should consult their prescriber if they wish to consider withdrawing.	Patients should have a shared decision-making conversation about risks of treatment with the CYP Gender Service or other NHS prescriber. If the patient decides to continue treatment this can be prescribed. Prescription must be marked SLS.	NHS prescriptions continuing treatment marked SLS may be dispensed.
Patient is under 18 years old and is already being prescribed GnRH analogues by a **private** practitioner in	Patients are advised to continue taking GnRH analogues as part of gender affirmation. They should consult their prescriber if	Patients should have a shared decision-making conversation about risks of treatment with their private prescriber. If the patient wishes to	Private and NHS prescriptions for continuation of treatment marked SLS may be dispensed. Prescriptions from the EEA or Switzerland for GnRH analogues cannot be dispensed.

England as part of gender affirmation.	they wish to consider withdrawing.	continue treatment the private practitioner (or an NHS prescriber, where appropriate) can continue to prescribe. Prescription must be marked SLS.	
Patient is under 18 years old and is already being prescribed GnRH analogues through a **prescription from the EEA or Switzerland** as part of gender affirmation.	This treatment should <u>not</u> be withdrawn abruptly. Patients are advised to meet with the clinician who initiated treatment for further advice and support. If that is not possible, they should meet with their GP or specialist to consider options.	Private or NHS prescribers may prescribe treatment for these patients following a shared decision-making conversation about the risks of treatment. Prescription must be marked SLS.	Prescriptions from EEA or Switzerland for GnRH analogues cannot be dispensed. NHS or private prescriptions marked SLS may be dispensed.
Patient is **under 18 years old visiting the UK** and has run out of their GnRH analogues as part of gender affirmation.	The patient may see a private practitioner, or temporarily register with a GP for advice and support.	The private or NHS prescriber can prescribe a repeat prescription if this is within their clinical scope of practice, and they are satisfied this is urgently needed continuation therapy. Prescription must be marked SLS.	The patient should secure further medications from their home nation specialist if possible. However, a private or NHS prescription for continuation of treatment may be dispensed. Prescriptions from the EEA or Switzerland for GnRH analogues cannot be dispensed.
Patient is **over 18 years old**	The patient may see a private practitioner, or	The private or NHS prescriber can prescribe a	Prescriptions from NHS prescribers marked SLS may be dispensed if the patient is

visiting the UK and has run out of their GnRH analogues as part of gender affirmation.	temporarily register with a GP for advice and support.	repeat prescription if this is within their clinical scope of practice, and they are satisfied this is urgently needed continuation therapy. Prescription must be marked SLS.	able to provide proof of age and identity. Prescriptions from private prescribers, if not marked SLS, the patient may instead provide proof of age and identity. Prescriptions from the EEA or Switzerland can be dispensed if the patient is able to provide proof of age and identity.
Prescriptions for GnRH analogues for conditions not including gender dysphoria or gender incongruence			
Patient is under 18 years old and is already being prescribed GnRH analogues for other reasons.	NHS and private patients can continue to receive prescriptions. Patients receiving a prescription from an EEA or Swiss registered prescriber are advised to seek advice from their GP or private practitioner.	NHS and private prescriptions can be issued. Both NHS and private prescriptions for GnRH analogues need to be endorsed SLS by the prescriber to demonstrate that the prescription is in accordance with the new arrangements.	Both NHS and private prescriptions endorsed SLS can be dispensed. Prescriptions from the EEA or Switzerland registered for GnRH analogues cannot be dispensed.
Patient 18 years old and over who are already being prescribed GnRH analogues for other reasons.	Patients will be able to continue to receive their prescriptions.	Both NHS and private prescriptions for GnRH analogues need to be endorsed SLS by the prescriber to demonstrate that the prescription is in accordance with the new arrangements.	Prescriptions from NHS prescribers marked SLS may be dispensed if the patient is able to provide proof of age and identity. Prescriptions from private prescribers, if not marked SLS, the patient may instead provide proof of age and identity. . Prescriptions from the EEA or Switzerland can be dispensed if the patient is able to provide proof of age and identity.

Appendix 2

Strictly Private and Confidential
To the Parent/Carer of (if 15 and under)
[YP preferred first name] [YP surname]
[YP first line address]
[YP second line address]
[YP town]
[YP County]
[YP Postcode]

Dear (Preferred Name (age 16+) or Parent/Carer of Preferred Name (age 15 and under)):

NHS England is sending this letter to everyone who is open to the *NHS Children and Young People's Gender Service*, but this information will be of most interest to children and young people, and their parents or carers, who are taking Gonadotropin-releasing hormone analogues (GnRH analogues) for gender incongruence or gender dysphoria (commonly referred to as *Puberty Blockers* or *Puberty Suppressing Hormones*).

This letter provides urgent information on the implications of new Government policy.

The Government introduced emergency restrictions on 29 May 2024 on the use of a group of medicines called GnRH analogues when they are used to suppress puberty as part of treating gender incongruence or gender dysphoria in children and young people who are under 18 years of age. Some of these restrictions will take effect from 3 June 2024.

The Government's announcement is published here:
https://www.gov.uk/government/news/new-restrictions-on-puberty-blockers

The new arrangements apply to medicines that consist of or contain buserelin, gonadorelin, goserelin, leuprorelin acetate, nafarelin, or triptorelin. This includes, but is not limited to, medicines sold under the brand names: Decapeptyl®, Gonapeptyl Depot®, Salvacyl®, Prostap®, Staladex®, Zoladex®, Synarel.

The individuals who will be most impacted are those who are currently receiving a prescription for GnRH analogues from a healthcare professional who is registered outside of the UK in the European Economic Area (EEA) or Switzerland, or who were intending to obtain such a prescription. It will also particularly impact on individuals who have not yet started on a course of treatment with GnRH analogues, depending on what the treatment is for.

If you need help

We understand that the Government's changes may cause worry and concern to some individuals and families. If it is impacting your mental health you may want to seek support. If you are under the care of an NHS mental health service, you should contact your team. If not,

you can contact your GP practice. Further advice on getting mental health support is available at https://www.nhs.uk/mental-health/children-and-young-adults/mental-health-support/

If you need support because you are waiting to be seen by an *NHS Children and Young People's Gender Service*, support options can be found on the website for the NHS Referral Management Support Service for the Children and Young People's Service.

Need urgent support?
If you need urgent support you can contact NHS 111 and choose the mental health option (option 2) https://www.nhs.uk/nhs-services/mental-health-services/where-to-get-urgent-help-for-mental-health/

Changes made by the Government

As a result of the new Government policy, from 3 June 2024 it will become a criminal offence for a pharmacist, doctor or any other individual in Great Britain to sell or supply these drugs to patients under the age of 18 **except in the following circumstances:**

- The child or young person is using an NHS prescription (for example, from the *NHS Children and Young People's Gender Service* or from an NHS GP).
- The child or young person is using a private prescription from a clinician registered in the United Kingdom that fulfils the following criteria:
    - If the prescription was dated prior to 3 June 2024, whether as a one off prescription or a repeat prescription, it can still be dispensed, whether the treatment is for gender incongruence/dysphoria or some other purpose. In practice, unless it is a repeat prescription, it will need to have been issued within the previous six months to still be valid; or
    - If the prescription is written on or after 3 June 2024, it can only be dispensed if it is written by a UK-registered doctor, nurse or pharmacist, whatever its purpose. It must be either for a purpose other than treatment for gender incongruence or, if it is for gender dysphoria/incongruence, the patient must have started treatment before 3 June 2024. In addition to those patients who have actually started treatment, patients are treated as having started treatment, whether or not they have actually taken a GnRH analogue, if they were prescribed with a GnRH analogue on or after 3 December 2023.

It will also be a criminal offence to possess these medicines, where the individual had reasonable cause to know that the medicine had been sold or supplied in breach of the ban.

Additionally, from 26 June 2024 NHS prescribers in GP practices in primary care will only be able to supply – or continue to supply - prescriptions for GnRH analogues in the following circumstances:

- The patient is aged 18 years or over; or
- The patient is 17 years or under and has started treatment with these medicines (they will be treated as having started treatment if they have been issued with a prescription for these medicines since 3 December 2023, even if they have not yet actually started to take the medicine); or
- The patient is 17 years or under and is being treated with GnRH analogues for gender incongruence or gender dysphoria by the NHS as part of a future clinical trial overseen by the National Institute for Health and Care Research; or
- The patient is 17 years or under and the purpose of the prescription is for a medical condition *other than* gender incongruence or gender dysphoria.

From 3rd June, private prescriptions of GnRH analogues from a prescriber registered in the European Economic Area (EEA) or Switzerland are banned from being supplied in Great Britain in all circumstances for patients aged under 18.

The impact of these changes

The individuals who will be most impacted by the Government policy are those under 18 years of age who are currently receiving a prescription for GnRH analogues for any reason from a healthcare professional who is registered outside of the United Kingdom in the European Economic Area (EEA) or Switzerland, or who intended to obtain such a prescription. Pharmacies in Great Britain will no longer be able to dispense new prescriptions for GnRH analogues from non-UK registered prescribers, including those in the EEA or Switzerland, for anyone aged 17 years or under. It will also particularly impact on those who have not started a course of treatment with GnRH analogues but might have started a private course of treatment with them for gender incongruence or gender dysphoria in the coming months.

Individuals who are already receiving NHS or private prescriptions from clinicians registered in the United Kingdom can continue to receive their prescriptions. However, such individuals and their families are strongly advised to meet with the prescribing clinician to fully understand the safety risks associated with GnRH analogues when prescribed for gender incongruence or gender dysphoria.

The appendix to this letter explains how the Government's changes may affect various individuals.

Buying GnRH analogues from un-regulated sources

No one should buy GnRH analogues (or any other medication) from unregulated sources such as the internet, friends or from street dealers.

From 3 June 2024 the consequences of the Government's changes will be that *possession* of GnRH analogues will become a criminal offence where the individual had reasonable cause to know that the medicine had been sold or supplied in breach of the Government's ban.

Where a child or young person is receiving GnRH analogues from unregulated sources or unregulated providers, GPs may conclude that safeguarding procedures should be explored.

Unregulated medicines can have potentially dangerous short and long term side effects; and even prescription drugs can be dangerous unless prescribed by, and managed by, an experienced and appropriately trained healthcare professional.

Yours sincerely

Professor James Palmer

National Medical Director for Specialised Services

HOW DO THE CHANGES AFFECT ME?	
• I am under 18 years of age; and • I am not yet under the care of the NHS; and • I want to start on GnRH analogues for gender incongruence or gender dysphoria	This is not possible either through the NHS or privately: • The initiation of GnRH analogues is not possible in the NHS *Children and Young People's Gender Service* unless this is part of a future clinical study. • GPs cannot initiate a new NHS prescription from 26 June 2024. • Private medical practitioners cannot initiate a new prescription from 3 June 2024 to patients who have not yet started treatment. Supply against such prescriptions will be unlawful. • Pharmacies in Great Britain cannot dispense a new UK private prescription from 3 June or a new NHS prescription from 26 June 2024, unless the patient started treatment before the restrictions came into effect. • Pharmacies in Great Britain cannot dispense any prescription for GnRH analogues from the European Economic Area (EEA) or Switzerland from 3 June 2024, unless the prescriber happens to be UK registered.
• I am under 18 years of age; and • I was referred to an NHS paediatric endocrinology team for assessment of suitability of GnRH analogues for gender incongruence or gender dysphoria on or before 31 March 2024	You may be able to start on GnRH analogues if the new NHS team responsible for your care makes a recommendation for initiation of treatment following an assessment, and if the paediatric endocrinology team related to the *NHS Children and Young People's Gender Service* agrees to initiate prescribing directly.
• I am under 18 years of age; and • I am already being prescribed GnRH analogues through the NHS for gender incongruence or gender dysphoria	You are able to continue to receive GnRH analogues. The NHS Children and Young People Gender Service and local prescribers (if they are already prescribing) can continue to prescribe; the prescription will have to be endorsed by the prescriber to demonstrate that your situation meets the new requirements. However, ***you are strongly advised to meet with your clinician so that the risks of***

	continuation / initiation are fully understood.
• I am under 18 years of age; and • I am already being prescribed GnRH analogues by a private medical practitioner, using a UK prescription, for gender incongruence or gender dysphoria	You are able to continue to receive GnRH analogues. The private medical practitioner can continue to prescribe; the prescription will have to be endorsed by the prescriber to demonstrate that your situation meets the new requirements. If the prescription was issued before 3 June 2024, you will need to provide proof of age when your medicines are dispensed if your prescription does not state your age/date of birth. However, ***you are strongly advised to meet with your clinician so that the risks of continuation / initiation are fully understood.***
• I am under 18 years of age; and • I am already being prescribed GnRH analogues through a private prescription from a healthcare professional registered in the European Economic Area (EEA) or Switzerland	You will **not** be able to receive GnRH analogues from a pharmacy in Great Britain from 3 June 2024 for a prescription issued from that date. Pharmacies in Great Britain can no longer dispense new EEA / Swiss prescriptions for GnRH analogues from 3 June 2024. You will need to stop taking GnRH analogues, unless you are newly prescribed them by a UK-registered doctor, nurse or pharmacist. These medications can be safely stopped and you do not need to be weaned off. **You are strongly advised to meet with your clinician who initiated treatment for further advice and support.** If you require psychological support, ask your GP to refer you to your local NHS mental health service for children and young people. Contact NHS 111 if you think that you are at immediate risk of psychological harm.
• I am under 18 years of age; and • I am already being prescribed GnRH analogues for a purpose other than	The changes do not affect you, except that: • NHS prescriptions are unaffected, but from 26 June 2024 the prescription will

gender incongruence or gender dysphoria	have to be endorsed by the prescriber to demonstrate that your situation meets the new requirements. • If it is a private prescription, issued before 3 June 2024, will need to provide proof of age and identity when your medicines are dispensed. • If it is a new private prescription, the prescription will have to be endorsed by the prescriber to demonstrate that your situation meets the new requirements. • If you are being prescribed by a prescriber registered in the EEA or Switzerland but not in the UK, new prescriptions will not be valid. Any new prescription will have to be written by a UK registered doctor, nurse or pharmacist. Seek advice from your GP. They may be able to prescribe for you if this is within their clinical scope of practice or they may make a referral to a relevant specialist.
• I am aged 18 years or over	The changes do not affect you. • If you are being prescribed by a UK private prescriber or a private prescriber registered in the EEA or Switzerland, you will need to provide documentary evidence of your age and identity such as your passport when your medicines are dispensed. • UK private prescribers will be able to endorse new prescriptions, issued on or after 3 June 2024, to save you the need to do this.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 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:**	**Outstanding** care and experience ☑ **Collaborative** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
Resource Implications:	None

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

Alder Hey Children's NHS Foundation Trust

Campus Development Report on the Programme for Delivery

June 2024

1. Executive Summary

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

Good progress has continued to be made to deliver projects:

2024/25 Q1 & Q2:

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

2024/25 Q3 & Q4:

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

The Development Team, with support from Estates and Health & Safety colleagues, have drafted a 5-year programme outlining proposed site completion works, enabling schemes and other infrastructure/demolition works to be considered in developing site master planning opportunities. In addition, the Team are considering the potential next phase of capital schemes to support the Trust with the journey to delivering the 2030 Strategy.

2. Key Risks

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

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	

Risk register to be developed for: Alder Park Phase 1 (EDYS/Therapies) & Elective Surgical Hub.

A number of projects continue to be affected by external resource issues which we are reliant on in order to meet delivery milestones. Most significantly, Mitie project management resources where escalation meetings remain in place to check, challenge and manage any implications.

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Park	Failure to deliver long term vision for park	BAF 3.1	12	Programme continually assessed for mitigations/improvement.
Neonatal & UCC	Affordability	Not assigned	12	Development team to identify mitigation plan for SPV/other costs. Regular, detailed reporting to RABD now in place.
SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Trust has responded to CEs and associated correspondence received. A further follow up meeting was held with the contractor 21.05.24.

3. Construction Programme Delivery Timetable (Critical Path)

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

4. Construction Programme Delivery Timetable (Associated Projects)

Project	Deliverable	2024												2025												2026+
		Jan	Feb	Ma	Apr	Ma	Jun	Jul	Aug	Sep	Oct	No	Dec	Jan	Feb	Ma	Apr	Ma	Jun	July	Aug	Sep	Oct	No	Dec	
Base Camp	Install																									
Alder Park	Phase 1 (EDYS & Therapies)																									
	Construction Phase 2 TBD (Sefton CAMHS)																									
Elective Surgical Hub	Refurbishment																									
Fracture/ Dermatology OPD	Refurbishment																									
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
Construction Programme: • Delay 3 weeks due to completion of infrastructure works and removal of asbestos is being managed within the programme. • Main construction works commenced 22.04.24. • Service diversion works are complete. • Hoarding installation to complete June '24.		Completion of main construction works. Impact on budget. Delay to unit opening. Management of noise and site access routes during peak works.	Construction completion reported as 20.10.25. On-going monitoring. Formal monthly Construction Progress meeting. On-going site management plan, including enhanced communications to patients & families.
Costs and Operational Coordination: • An update report re: increased SPV / other costs was shared 15.04.24 with RABD members. Detailed progress updates now shared monthly with RABD. • EDU/PAU decant timeline agreed: 23.08.24 (to vacate current unit). • Trust is working with Morgan Sindall Construction to look at opportunities to open the new Ground Floor as quickly as practicable. • Ground Floor shell space review meetings commenced 03.06.24 to agree final design.		Increased construction & SPV costs. Potential decant costs.	Agree EDU design and decant plan.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Trust meetings with contractor held 06.03.24, 09.04.24 & 21.05.24. An update report was shared 15.04.24 with RABD members.		Possible contract claim.	Continued oversight via RABD.

Deliverable (Catkin & Sunflower House cont/d…)	RAG	Risks/Issues	Actions/Next Steps
Sprinkler System Under-Croft Car Park: • Principal contractor to be appointed to undertake works and installation.		Fire compliance. Budget TBC.	Cost plan expected June ’24.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Executive Directors approval obtained 30.05.24 to address immediate priorities: • 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.	Full staff engagement exercise to agree final desk allocation, move dates and operational logistics. Budget and scope of works to be finalised.
Former Police Station Refurbishment: • Main contract in place, works progressing.		Operational date currently assessed as July 2024.	On-going bi-weekly senior Principals’ meeting & pre-move planning with service senior leadership team.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: Works in Progress • Sensory Garden: FOSP funded bid with LCC - Trust has offered time with our designers to draw up an initial concept. It is proposed to locate this in the former children’s playground area which has now been demolished and cleared. • Community Day – Trust liaising with LCC to arrange a community day in the summer to celebrate completion of the main park and to give the community an opportunity to discuss plans for the remaining park works.		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: • Drainage works and final seeding to the football pitches has commenced. • Turfing and seeding to the majority of the park is now complete and areas are now being opened for the community to access. • Swale drainage works have commenced in line with the revised programme. • The programme has been communicated to the public via the Trust website.		Delays in completion football pitches.	Trust discussions on-going with LCC to confirm and gather required documentation for the handover of Springfield Park to LCC.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Work ongoing in line with programme. • Appoint Construction Contractor: Spring 2024. • Start on Site: 17.06.24. • Construction Completion: 16.12.24.		Timely appointment of a construction contractor. Delay to completion, impact on operational running of the services. Mitie PM resources.	Regular meetings. Close monitoring of critical risks. Capacity management plan to accommodate patient activity during works.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

Deliverable	RAG	Risks/Issues	Actions/Next Steps
High level programme to be fully agreed – 5-year proposed plan developed. • Phase 1 scope of works to be agreed. • Phase 2&3 to be reviewed as part of the development of site master planning options.		Trust has identified a mitigation to satisfy 278 (traffic calming) requirements. Budget TBC.	Site Master Planning refresh shared with Executive Directors 30.05.24. Discussion with Trust Board 06.06.24.

Elective Surgical Day Case

Deliverable	RAG	Risks/Issues	Actions/Next Steps
An initial workshop was held 30.05.24 by Mitie with Trust key stakeholders to discuss priority works/brief: • Dependencies & phasing. • Potential small works. • Programme of works. • Next Steps. A briefing will be shared with RABD 24.06.24.		Programme, available budget. Mitie PM resources.	Concept design June '24 TBC. Indicative costs June '24 TBC.

Gender Development Services (GDS) – Estates Solution

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction works progressing in line with programme. Furniture in place (phase 1 – first floor). Main works complete on first floor. Snags to doors and to satisfy fire compliance (evacuation route) will be completed during Trust commissioning time, ahead of occupation. Phase 1 Partial Possession handover scheduled for w/c 10.06.24.		Programme, unforeseen costs. Water test results. Building Control sign off.	Delivery schedule and move plan IN PLACE. Water chlorination & testing by 14.06.24. Occupation from w/c 17 June.

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

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Contractor appointed. Works currently being reviewed with specialist suppliers/advisors. Executive Directors have approved the move of Speech & Language Therapy services from Netherton Health Centre to the second floor.		Programme, available budget.	Consultation and staff move plan. 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 6 June 2024.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	Learning from Patient Safety Incidents 1st-31st May 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	The purpose of this report is to provide the Trust Board with a summary of activity and system wide learning following the transition to Patient Safety Incident Response Framework (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:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care **Support** our people **Pioneering** breakthroughs	☑ ☑ ☐ ☑ ☐
Resource Implications:		

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

1. Purpose

The purpose of this paper is to 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 May 2024.

2. Background

On 1st January 2024, the Trust transitioned from the National Serious Incident Framework (SI) (NHS England 2015) to PSIRF in line with national requirements. PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm.

3. Local context

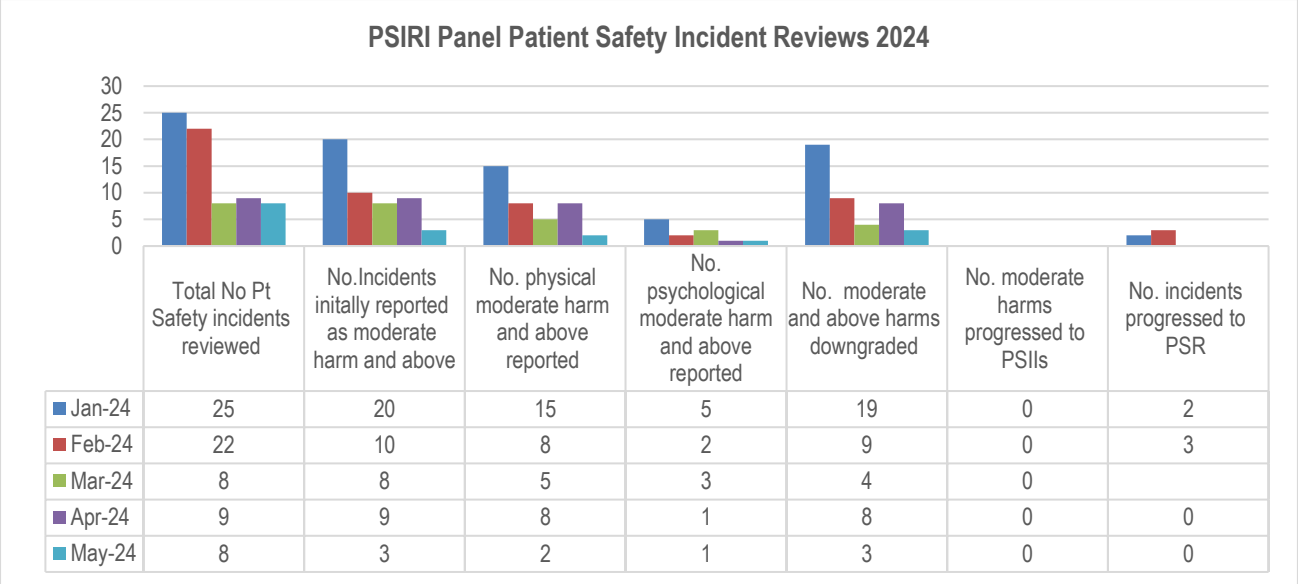
PSIRF replaces the methodology of root cause analysis with a systems-based patient safety incident investigation (PSII) approach or more locally a Patient Safety Response (PSR).

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.

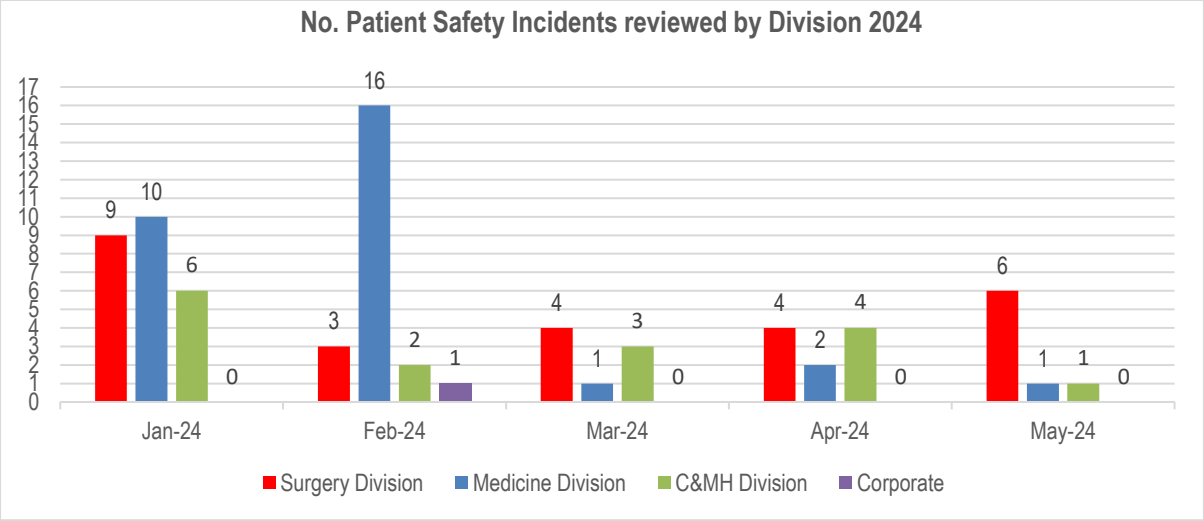
Table 1 below notes the number of patient safety incidents reviewed at PSIRI panel throughout May 2024. Table 2 notes the number of patient safety incidents presented and reviewed by division.

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	8	5	3	4	0	
Apr-24	9	9	8	1	8	0	0
May-24	8	3	2	1	3	0	0

Table 2



A total of 8 new reported incidents were reviewed at the weekly PSIRI panel during the reporting period 1st -31st May 2024, of which 3 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 3 incidents based on incident findings and use of the NHS England harm grading criteria .

3.2 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)

0 PSRs were commissioned for May 24

3.4 System learning

Delivery of 2 comprehensive patient safety learning reviews have commenced to understand context and inform system thinking and learning:

- Multidisciplinary learning event held in April 24 regarding Ward 4c safeguarding incident.
- Restorative learning event held May 24 with key staff involved in the care of a patient on PICU following elective craniofacial surgery). Family vacate commissioned to be the conduit between trust and family in supporting this restorative process and system learning.

Learning review outputs will be shared with Board once concluded.

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.

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

5. Training and Education

5.1 Patient Safety E-Learning

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

E-Learning Modules	%Compliance
Level 1a Essentials for Patient Safety (All staff)	**98.3%**
Level 1b: Essentials of patient safety for boards and senior leadership teams	**100%**

5.2 Bespoke Training

Delivery of bespoke Engagement and Oversight training by Consequence UK for all staff involved in learning responses and acting in Family Liaison roles (FLOs).

Development of suite of methodology templates for use across the trust:

- After Action review tool
- Account of involvement
- Memory capture

Pilot session on human factors delivered for PCIU. Debrief for team leaders concluded.

6. Legacy Serious Incidents (SIs)

All legacy SI investigations have now concluded (Appendix 1). Oversight of the action plans are being monitored by the Divisions.

7. Next Steps

Areas of focus include the following:

- **Patient Safety Investigators**-Successful interview and appointment of 2 Patient Safety Investigators. Pending start date from HR

- **Training**: Consequence UK delivering learning response training (completion June 2024)

8. Recommendations

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

Appendix 1 Legacy SI action plans: During the reporting period (1st – 31st May 2024), **1** legacy SI action plan remained open within its expected completion date.

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 8 actions completed.	31/01/2024	30/06/2024	4
2023/17791	15/09/2023	21/09/2023	Never Event – Wrong implant / prosthesis used.	9 All actions completed.	01/05/2024		0

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Report of:	Chief Nurse
Paper Prepared By:	Director of Nursing and Deputy Director of Nursing
Subject/Title:	Nursing Workforce Report 2023/2024
Background Papers:	• Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Hard Truths: The Journey to Putting Patients First: Department of Health, 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Quality Network for Community CAMHS Standards for Services: Royal College of Psychiatrists, 2020 • Safer Staffing: A Guide to Care Contact Time: NHS England 2014 • Single Oversight Framework: NHS Improvement September 2016 • Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals: Department of Health and Social Care, February 2016 • Standards of Proficiency for Registered Nurses: Nursing and Midwifery Council, May 2018 • Developing Workforce Standards: Supporting providers to deliver high quality care through safe and effective staffing: NHSI, 2018 • Stepping Forward to 2020/21: The mental health workforce plan for England: Health Education England, July 2017

	• NMC Emergency Standards: NHSE January 2021 • Winter 2021 preparedness: Nursing and midwifery safer staffing: NHSE/I November 2021 • Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals: NHSE, September 2021 • Ockenden report - Final: Department of Health and Social Care, March 2022 • NHS Long Term Workforce Plan, June 2023
Purpose of Paper:	This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing, particularly at times of increased pressure. To inform the Board of Directors of nursing workforce activity and progress in 2023/24 and proposed workforce improvements in 2024/25
Action/Decision Required:	The Board of Directors are asked to approve the following: The content of the report and assurance that appropriate information is being provided to meet national and local requirements. • The information on safe staffing and the impact on quality of care • Recommendations
Summary/Supporting Information	• Annual staffing report
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Provider of 1st choice • Deliver clinical excellence
Resource Impact:	none

Does this relate to a risk? Yes ☐ No x☐

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

Executive summary

The aim of this paper is to provide assurance to the Trust Board of Directors that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff.

Since the previous annual Nurse Staffing report for 2022/23, the senior nurse / AHP leadership team have continued to work on the recommendations that were agreed. This report contains an updated position with regard to the nursing workforce and makes further recommendations for continued improvement.

The recruitment action plan has continued in order to provide safe staffing levels. Alder Hey has demonstrated continued success in this highly competitive regional and national market, and of the 106 employment offers that were made for Band 5 recruitment, only 9 did not move through to full recruitment and commence in post. This represents a reduction in attrition rate from 30% to 8.5% following the introduction of the revised recruitment pathway.

From May 2023 the Trust has successfully recruited 97 nurses via the national recruitment route plus 38 internationally educated registered nurses, 135 band 5 nurses in total. We also recruited 7 RNDA's, who were our own HCSW who had been through the apprentice programme to RN. 63.7 WTE RN's left the organisation in the last year. This is significantly less than last year's total of 135 (reduction of 50%). In terms of our non-registered workforce, we have seen 43 new starters and 25 leave the organisation. The final cohort of international nurses arrived in December 2023. The focus across all bands remains retention of our workforce.

The Trust successfully recruited to other key senior nursing leadership posts in 2022/23, including the appointment to the Professor of Child Health post, driving our clinical academic and research work.

In year, nursing vacancy rates continue to be below 2%, which is significantly lower than the national average of 10% as reported by NHSE. As of March 31st, 2024, the Trust had 0 vacancy for RNs, with a positive variance of 14.49 wte over our funded establishment. Staffing pressures are therefore largely due to staff availability to work due to sickness absence and maternity/paternity leave, and other absences reasons. Further tables regarding recruitment, leaver and HR staffing data are referenced in Appendices 4 and 5.

The Trust's mandated monthly submission of staffing levels to the NHS website was 79% for RNs and over 90% for non-registered nurses. This is an -improved position from 2022/23, with just 4C an outlier. This referenced in Appendix 1.

Staffing RAG data has continued to show improvement with zero red shifts within the wards and departments for Q3 and Q4 2023/24. The Trust benchmarked positively with comparator organisations for Care Hours per Patient Day (CHPPD). The Trust utilised temporary staffing where possible to address staffing pressures. Where the Red model was invoked, in line with the escalation process, this was immediately escalated to the Chief Nurse.

The Trust as part of its People Plan work is focussed on retaining its nursing workforce and a Nurse retention lead was appointed in 2023/.24 on a fixed term twelve-month contract.

A review against the RCN standards was repeated in 23/24 which has demonstrated continued improved compliance, with all core standards now rated as compliant.

The senior nurse / AHP leadership team continued to implement the comprehensive Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025 and a Workforce sub-group continues to deliver on the associated implementation plan, Chaired by the Deputy Director of Nursing. Significant progress has been achieved with regard to the action plan, with full implementation expected by March 2025.

The strategy has a clear vision to:

- Be a national leading centre in the training, education, and recruitment of paediatric nursing and HCSW's.
- Diversify recruitment strategies to be more representative of the population we serve.
- Ensure that staff have clear opportunities to develop, grow and progress in the organisation.
- Develop to embrace new roles and transition to a sustainable model for the future.
- Have clear structure for advanced and enhanced roles; services will be developed around the needs of children, young people, and their families, and will clearly align to the service needed to provide their care as part of the 2030 vision.

The report details proposed workforce improvements in 2024/25 and continued implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025

Contents

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1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care delivered by the right staff, in the right place, with the right skills, and to ensure we have a resilient, resourced, well trained nursing and HCSW workforce to deliver this.

This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing.

This report will outline the national guidance and regulatory requirements related to nurse staffing, a summary of achievements in 2023/24, compliance with workforce standards, and detail the workforce pressures and challenges experienced in year.

The report details proposed workforce improvements in 2024/25 which include continued implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025.

2. National context and regulation

There are a number of tools available to determine safe staffing levels. The tools currently used at Alder Hey are Royal College of Nursing standards nurse to patient ratio, skill mix review, patient acuity and dependency assessment through the SCAMP Safer Nursing Care Tool, professional judgement, and triangulation with nurse sensitive indicators.

Specific guidance for safe staffing levels in neonatal and paediatric settings is set by the Royal College of Nursing (2013). A review of the Trust's compliance against the 16 core standards for 2022/23 can be found in Appendix 3, with the Trust now fully compliant with all 16 standards.

Additional specialised guidance for staffing in paediatric intensive care and high dependency settings is set out by the Paediatric Intensive Care Society (PICS 2015). The British Association for Perinatal Medicine lay out standards for care of neonates (BAPM, 2011). The Royal College of Psychiatrists set out CAMHS standards (RCP, 2020).

In November 2017, the National Quality Board (NQB) published improvement tools specifically for the care of children and neonates: Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care (NQB 2017). The improvement resources are based on the NQB's expectations of safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in place the right place at the right time.

In September 2021, NHSE published staffing guidance regarding the anticipated surge in Respiratory Syncytial Virus (RSV) in the paediatric population (Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals). In addition, in November 2021 NHSE/I published the Winter 2021 preparedness: Nursing and midwifery safer staffing document to assess winter and surge readiness which was reported to the Trust Board in December 2021.

A specific workforce statement is provided in the annual governance statement which is monitored by NHSE. Implementing the recommendations and strong, effective governance, provides Trust Board assurance that workforce decisions promote patient safety and comply with the Care Quality Commission's (CQC) fundamental standards, NHSI compliance and the Board's statutory duties.

In line with Department of Health Hard Truths Commitments (2013), all Trusts are required to submit monthly staffing data. The Trust is compliant with submitting data to the public through NHS website and on the Alder Hey website (Appendix 1)

In March 2022, the Department of Health and Social Care published the Ockenden report; the outcome of an independent review of the maternity services provided by an NHS Trust. NHSE have set out that in reviewing the report, Trust Boards must take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars. Two of the four key pillars directly related to the front-line nursing workforce are:

1. Safe staffing levels
2. A well-trained workforce

The Trust has devised and fully completed a comprehensive action plan to address the recommendations that directly and indirectly apply to Alder Hey.

In June 2023, The Long-term Workforce Plan was published setting out an ambitious plan to recruit 170,000 more nurses to support safer staffing. The model proposes to train, retain, and reform the workforce to ensure the NHS has the right number of staff with the right skills and competencies in the right place to deliver safe, effective patient care within an affordable budget.

3. Summary of achievements

The overall impact of the success of the nursing workforce strategy, including a reduction in vacancies, development opportunities, retention strategy and other initiatives to support safe nurse staffing is as follows:

3.1: Recruitment

i. 135 wte Band 5 nursing staff recruited in 2023/24 including 38 international nurses Plus an additional 7 RN degree apprentice graduates.
ii. 9 from 106 wte nurses being offered a post at Alder Hey failed to commence in post.
iii. Vacancy rate less than 2%, at many points in the year it was 0.
iv. A responsive recruitment culture with evidence of strong partnership between senior nurses and human resource staff, notably working together on successful national recruitment days, plus, a comprehensive induction and preceptorship programme for new nursing staff.
v. A continuance of our 'one stop' recruitment event in 2023/4, with all candidates being interviewed on the same day and if successful their recruitment team and admin appointment confirmed at the same time. This is completed across a whole day with morning and afternoon interviews following successful medication assessments. The process is completed in partnership with our divisional nursing teams and our recruitment team.

vi. Recruitment strategy partnership working with Higher Education Institutes to attract potential student nurses from diverse backgrounds and wider work to engage with the student workforce to provide a clear offer to encourage their choice for Alder Hey to be their preferred work option.

vii. Successful completion of our international recruitment programme with an additional 38 wte nurses recruited and supported by our PEF team.

viii. Continued work on our Health Care Support Worker (HCSW) programme to achieve the NHSE zero vacancy target. Further funding being used to deliver the HCSW Care. Certificate for our substantive staff and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is HCA vacancy.

ix. Successful recruitment of 38.93 wte HCSW's and the ongoing implementation of our Care Support Worker direct programme as part of our career pathway for our Health Care Support Workers

x. The successful completion of 9 of our HCSW to Registered Nurses via the Degree Apprenticeship programme (RNDA).

xi. The successful ongoing support of 7 internal Nurse Associate and Assistant Practitioners to the RNDA 2-year programme.

xii. Further investment in the PEF workforce team to support the delivery of our workforce and education programmes.

xiii. Our preceptorship framework has recently been internally reviewed and updated, and we have been awarded the interim quality mark (IQM) from NHSE. The framework enables regular engagement with a PNA, group and individual restorative clinical supervision.

3.2: Safe staffing levels

i. The daily 'safer staffing' meeting is fully operational and embedded. It has been led by the Heads of Nursing with other senior nursing support and information feeds into both the Bed and Daily Safety meetings.

ii. Matrons for Surgery and Medicine are allocated responsibility to oversee safe staffing for their divisions on a daily basis and ensure robust plans are in place.

iii. The 'Red, Amber and Green' staffing model was utilised at times of pressure in line with escalation process; this was particularly required during the periods of seasonal pressures.

iv. Positive comparison against benchmarking data comparing Care Hours per Patient Day (CHPPD) with the national benchmark. This is referenced in Appendix 2.

v. Monthly Safer Staffing report is produced and monitored through Trust Board.

3.3: Strong and effective leadership

i. Comprehensive 5-year workforce strategy devised in 2021 with associated implementation plan with delivery ongoing and has a clear vision to: Continue to be a national leading centre in the training, education, and of paediatric nurses and HCSW's. Continued to work through the implementation plan, reporting progress into workforce subgroup and senior leadership team.

ii. Continued to diversify our recruitment strategies to be more representative of the population we serve.

iii. Development and recruitment to a new role of Nursing Retention Lead to support a reduction in leaver rates through development of nurse retention programmes.
iv. Opportunities for staff to develop, grow and progress in the organisation.
v. Continued to develop our workforce teams and implement our strategy, to embrace new roles and transition to a sustainable model for the future.
vi. Developed a clear structure for advanced and enhanced roles; services will continue to be developed around the needs of children, young people, and their families, and will clearly align to the service needed to provide their care and to Vision 2030.
vii. Continued review of the Matron and Heads of Nursing structure, with additional leadership roles implemented this year.
viii. Successful recruitment to the Professor of Child Health role.
ix. Internal promotion to Band 7 Ward Manager positions and Band 6 Ward Sister/Charge Nurse positions.
x. Safer Staffing Huddle chaired by a senior nurse.
xi. Involvement in the regional Band 6 'Task and Finish Group' to develop a robust and consistent Band 6 development programme.
xii. Continued establishment of the competency development programme.
xiii. Implementation of the Band 5 development programme
xiv. Continued roll out of the Band 2-3 organisational change process for our HCSW.

3.4: Educational developments

i. Review of our Nursing preceptorship framework to align with new national guidance and ensure post pandemic requirements are being met.
ii. Rotation pathway continues for all newly qualified nurses; facilitates the development of a wider skill set; access to a wider experience in medical, surgical and specialist fields.
iii. Embedded the Band 5 development framework, which offers clear guidance through the initial first 2 years post recruitment identifying the range of learning available and expected.
iv. Implementation of the major trauma competencies across the organisation.
v. Successful bid awarded from Health Education England via the RePAIR process to enable the production of resources to support ongoing recruitment and retention projects.
vi. Practice-based learning packages have been developed to support an increased number of learners and reviewed the diversity of learning opportunities the organisation can offer.
vii. Ongoing partnership working with our HEI partners to ensure full utilisation of existing placement capacity and the opening of new placement opportunities linked to research and management.
viii. Devised a full student engagement programme with annual engagement days for all nursing students focusing on key skill development and enhanced knowledge building.
ix. Implementation of a quarterly learner forum which provides a learning hour and listening hour for multi-professional learners within the organisation.
x. Ongoing support of our 9 students on the Registered Nurse Degree Apprenticeship (RNDA 4) who are progressing well.
xi. Ongoing support of our 8 internal Nurse Associate/Assistant Practitioners on the Register Nurse Degree Apprenticeship (RNDA 2) due to complete in January 2024.

xii. Full implementation of the Supportive Coaching in Practice (SCiP) model to support our learners onsite. Now sharing this development via national events and regional groups.
xiii. Supported 24 nursing staff to undertake the Professional Nurse Advocate (PNA) training with 10 now successfully completed.
xiv. Ongoing support of PNA forum and the overall PNA organisational strategy to ensure full utilisation of this role to support the nursing workforce.
xv. Fully embedded the Practice Education Recognition Certificate (PERC) adjusted recruitment pathway. This enables those student nurses who demonstrate consistent exceptional practice to be identified and successfully recruited. Ward / Departmental Managers are able to offer a recruitment opportunity for final year students to their area in recognition of exceptional practice.
xvi. Continued to support senior nurses and aspiring nurse leaders to undertake the MSc programme in leadership enabling staff to gain the necessary skills and competencies to successfully fulfil senior nurse roles. Maintained and supported 3 senior nurses per year to participate.
xvii. Practice Education Facilitators and Clinical Practice Educators continue to address organisational education requirements and provide a streamlined approach to a wide variety of staff development opportunities.

3.5: Quality metrics

i. Continued monitoring of different aspects of practice using the Tendable Audit Tool across all the wards.
ii. The Ward Accreditation programme has been further developed to include additional departments, with 23 wards and departments included in the programme.
iii. The ward accreditation measures have been mapped across to reflect the CQC self-assessment framework and all assessments are now carried out using this tool, with the scoring reflective of the CQC assessment framework. All areas have successfully currently achieved either gold or silver awards or Good via CQC scoring matrix.
iv. E-roster system fully in place and monitored across wards, with KPI's reviewed updated and performance monitored. Weekly sign off meetings with the Divisional nursing teams is starting to reap some benefits with improvements in a number of KPIs, namely lead times, unavailable hours and leave.
v. Local challenge boards continue to monitor staffing at Divisional level providing information for recruitment events. They also provide assurance around key performance indicators reporting into Trust wide committees.
vi. Patient Safety Meetings continue to provide assurance around our safety culture.
vii. Acuity review with associated SOP developed.
viii. Process of Quality Ward Rounds continues to evolve, with a range of quality topics reviewed. Involvement from the CYP has been a significant benefit to the process. Associated action plans are monitored via Divisional Governance committees. The quality rounds are undertaken by the senior nursing team and provide visibility and drive improvement work across all areas.
ix. CNIO supporting digitally enabled quality improvements and solutions.
x. Monthly Safer Staffing report provides an update on quality metrics.

3.6: Retention

i. The Internal Transfer Process (ITP) offers existing Alder Hey band 5 nurses the opportunity the relocate within the organisation. The ITP creates a framework for band 5 nurses to identify a new area they would prefer to work, and for us as an organisation to support these relocations were possible, without the need for formal recruitment processes.
ii. In 23/24 we saw 65.71 RNs leave the organisation which is significantly less than the 135 wte who left in 22/23. Only 9.3 HCSW left the Trust in 23/24.
iii. Retention data specific to Alder Hey is now tracked and comparable to regional and national data thus enabling targeted intervention with improvement being demonstrated. The recent data is clearly showing a reduction, specifically in Band 5 leavers.
iv. Professional Nurse Advocacy programme lead by the Retention lead continues to develop with 19 in post, delivering supervision and support to our nursing teams, specifically our new recruits. They are also involved in supporting some Quality Improvement projects.
v. Work has been undertaken to create a developmental framework for all band 5 nurses within the organisation, this is inclusive of the preceptorship period and also details the opportunities available to staff in addition to the expectations of the organisation at designated points being clear.
vi. We are currently facilitating a delivery programme of the care certificate to our existing health care support workers.
vii. All nurses are supported to complete the organisational Standards for Student Supervision and Assessment (SSSA) training enabling them to meet the Nursing and Midwifery Council (NMC) requirements to support and assess student nurses. As part of SSSA training we now also provide education in relation to the preceptor role and the introduction to coaching.

4. Hospital nurse staffing model

4.1: Ward establishments

The staffing model is fundamentally based on achieving compliance with the national requirements, patient acuity, professional judgement, and review of compliance with key quality metrics. 100% of ward establishments were reviewed across a 4-week window in 2023 and analysis fed back and escalated to the senior nurse / AHP team and the Executive team. We are now fully compliant.

Staffing models and winter planning review undertaken with each Ward Manager, Matron, Head of Nursing and Associate Chief Nurse. The establishment review was also extended to include the Divisional Human Resources Business Partner and the Financial Business Partner. Their presence and input into the review was extremely beneficial, and they provided a breakdown of all financial and HR metrics related to that ward / department. This improved methodology will continue for the 2024 establishment reviews scheduled for a 3-week period in June 2024.

4.2: Safer staffing levels

Trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System and publish this data at ward level; the Trust is compliant with submitting data.

The Trust produces a monthly Safe Staffing and Patient Quality Indicator Report to provide a summary of overall Nursing and HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Data can be compared and benchmarked with CHPPD figures from comparative wards enabling investigation to understand any significant variation and to make sure the right staff are being used in the right way in the right numbers. CHPPD includes total staff time spent on direct patient care including clinical time such as preparing medicines, documentation, and safeguarding.

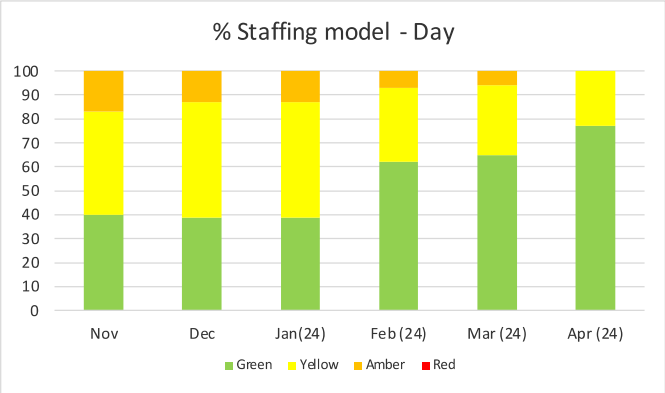
The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift. A monthly ward fill rate of 80% and over is considered acceptable nationally. Fill rates for 20232/24 demonstrated that the average overall staffing level was 85% for the year as shown in Appendix 1. Broken down further we find the overall RN reported staffing levels are at an average of 79%, with the HCA fill rate was 91%.

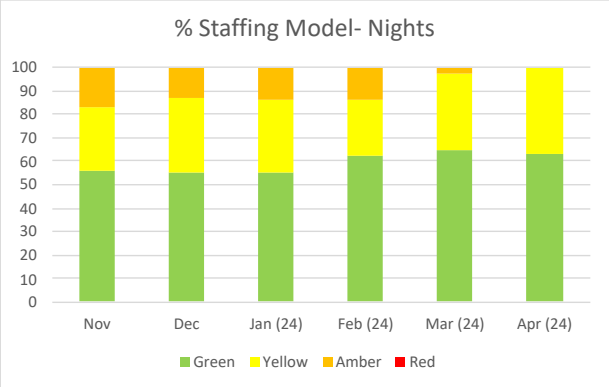
Appendix 2 shows the CHPPD benchmarking data by ward for 2023/24. An analysis of the CHPPD benchmarking demonstrates that the Trust provides a similar or slightly higher than average care by patient hours. The benchmarking data used for HDU is the same comparator as for PICU therefore it is appropriate that this figure is lower. The Burns Unit compares higher than the national benchmark in the earlier part of the year, however that is because the Trust has included the day case clinic staffing within the reported figures. This has been amended in Q4 and is reflected in the data. The only area that does not meet the national benchmark is Ward 4C which has failed to meet this benchmark between October 23 and March 24. This position hasn't changed from 22/23 although significant recruitment has occurred in early 2024 and this position will be monitored and reviewed as part of the annual establishment review. It is expected that the increase in the funded establishment will have a positive impact on CHPPD.

Safer Staffing meetings were held twice per day Chaired by a Divisional Associate Chief Nurse or Head of Nursing where plans were made for the day and night in line with the Standard Operating Procedure (Nurse Staffing Escalation Ward and Departmental Optimal and Minimum Staffing Levels: The overall staffing status (Green; Yellow; Amber; Red) was escalated to the Daily Operational meeting and to the Chief Nurse in line with the escalation process. The red model has not been invoked since late 2022.

A breakdown of the status of day and night shifts in year is shown in the graphs below which shows there has been no escalation to red status in this reporting period. The data also demonstrates the effective management across the 24-hour period with staffing comparative on day and night shifts in line with activity.

0121





4.3: Compliance with RCN guidelines

To continue to monitor and improve staffing levels, a review against the RCN standards has been repeated in 2023/24 by the Director of Nursing as detailed in Appendix 3.

4.3.1: RCN Core Standards

The thermometer below demonstrates the journey of improvement against the RCN core standards since the first audit was undertaken in 2014.

July 2014	2	4	6	7	8	10	11	15	16	1	3	5	9	12	13	14
Feb 2017	2	4	6	7	8	9	10	11	12	13	15	16	1	3	5	14
Feb 2018	2	3	4	6	7	8	9	10	11	12	13	15	16	1	5	14
Mar 2019	2	3	4	5↑	6	7	8	9	10	11	12	13	15	16	1↑	14↑
Mar 2020	2	3	4	5	6	7	8	9	10	11	12↑	13↑	15	16	1	14↑
Mar 2021	2	3	4	5	6	7	8	9	10↑	11↑	12	13	15	16	14↑	1
Mar 2022	2	3	4	5	6	7	8	9	10	11	12	13	15	16	14↑	1
Mar 2023	1↑	2	3	4	5	6	7	8	9	10	11	12	13	14↑	15	16

The Trust has maintained full compliance with all standards since March 2023. A full analysis is detailed in Appendix 3.2

4..3 Workforce data Summary

Table 1 shows the March 24 total RN workforce position, taking account of a number of indicators including starters, leavers, sickness, and vacancy amongst a number of other workforce factors.

Table 1

Organisation Name	FTE	Acting Up	Active	Internal Secondment	Maternity & Adoption	Out on External Secondment - Paid	Budget FTE	Vacancy FTE	Hires 12 month rolling	Leavers 12 month rolling	Turnover 12 month rolling %	Sickness 12 month rolling %
411 Sunflower House (912310)	10.87		10.87				13.69	2.82	5.80	5.93	53.61%	5.16
411 Outpatients Level 2 (916503)	15.89		15.29		0.60		16.33	0.44	1.76	1.00	6.35%	12.00
411 Children's Community Nursing Team (912406)	14.23		14.23				12.75	-1.48	0.00	0.00	0.00%	6.93
411 Medical Daycase Unit (911314)	5.79		5.79				6.04	0.25	0.00	0.00	0.00%	1.05
411 Ward 3B Oncology (911208)	42.70		38.49	1.60	2.61		42.94	0.24	6.00	5.92	14.63%	7.15
411 Ward 3C (911313)	66.78		62.86	1.00	2.92		67.38	0.60	1.31	0.92	1.51%	6.95
411 Ward 4B (914211)	38.88	1.00	31.89	2.53	3.45		43.57	2.69	2.00	6.91	16.98%	9.21
411 Accident & Emergency (912201)	83.33		80.54	1.00	1.79		82.67	-2.66	5.00	8.25	9.99%	7.58
411 Ward 4C (912207)	52.34		52.34				56.88	4.54	10.00	11.84	22.45%	4.83
411 Burns Unit (CHP) (915208)	16.64		16.64				16.34	-0.30	1.00	0.00	0.00%	2.56
411 Ward 1C (913307)	60.99		53.97	1.48	5.53		58.44	-3.47	7.92	7.69	12.86%	3.76
411 Ward 1C Neonatal (913310)	33.64		32.64			1.00	35.21	1.57	4.00	5.15	14.83%	4.11
411 Critical Care (913204)	12.51		12.51				11.57	-0.94	0.60	0.00	0.00%	2.03
411 Critical Care Ward (913208)	158.94		150.33		8.61		160.87	1.93	16.84	16.00	10.14%	5.14
411 High Dependancy Unit (HDU) (913210)	83.40		74.81	0.31	8.28		75.66	-7.74	9.53	5.61	7.30%	6.70
411 Ward 4A (914210)	72.77		69.01		3.76		66.53	-7.24	7.53	4.15	6.01%	7.47
411 Ward 3A (915309)	54.02		50.41		3.61		48.22	-5.80	6.00	4.68	8.64%	7.30
411 Surgical Day Case Ward (915418)	16.59		16.59				16.94	0.35	1.00	0.00	0.00%	6.34
411 Theatres - Emergency (915420)	11.35		11.35				11.05	-0.30	1.59	1.00	9.00%	2.57
411 Theatres - IP Anaesthetics (915423)	1.00		1.00				2.50	1.50	0.00	0.00	0.00%	4.46
411 Theatres - IP Recovery (915422)	9.51		9.51				10.82	1.31	2.00	1.00	11.39%	11.92
411 Theatres - IP Scrub (915424)	5.40		5.40				8.28	1.88	2.00	0.00	0.00%	4.02
411 Theatres - SDC Anaesthetics (915429)	2.76		2.76				1.56	-1.20	0.00	0.00	0.00%	4.22
411 Theatres - SDC Recovery (915430)	6.83		6.83				3.33	-3.50	1.76	0.00	0.00%	3.32
	877.14	**1.00**	**826.05**	**7.92**	**41.17**	**1.00**	**869.57**	**-14.49**	**93.64**	**86.05**	**8.57%**	**5.70**

Trust has increased its placement capacity for student nurses with additional clinical placements offered at Alder Hey in 2023/24, which will ensure a strong pipeline of domestic trained nurses for the Trust to recruit from. Key additional actions include:

- Robust recruitment drive; advertising on social media as well as traditional routes such as NHS Jobs, for both registered and non-registered nurses.
- Recruitment sessions as part of our partnership with local HEI's and also offer a recruitment preparation session for any prospective candidates.
- The "One Stop Shop" recruitment day has been embedded over 5 years and has been evaluated positively by new starters.
- The Practice Education Recognition Certificate (PERC) adjusted recruitment pathway is now in place.

The senior nurse leadership team, together with HR and the BAME Task Force, recognise that our nursing staff are not representative of our local population. Only 7% of student nurses who have had placement at Alder Hey in the last 5 years are from black, Asian and minority ethnic backgrounds; the nursing workforce is also predominantly female. The senior nursing leadership team, HR and the Communications team have been working in partnership with the local HEI's to take positive action to increase the diversity of future student nurses and working to align recruitment strategies. This is a continued priority for 2024/25

4.5: Workforce developments in 2023/24

i. **CSWD programme:** Further development of our Care Support Worker Direct Programme has seen our Band 3 HCA vacancy rate reduce to near 0%. This programme allows a local workforce with limited health care experience access to clinical paediatric ward-based placements. They also attain the national care certificate and move into a substantive or bank post.

ii. **Band 5 Development programme**: This year we have revamped our offer to our new starters. A dynamic preceptorship programme helps the newly qualified nurse

transition from pre to post registrant and starts their development pathway through competency assessment and practical and experiential learning.

iii. **Band 6 Development programme:** The Trust has been part of a national pilot to develop a programme for our Band 6 ward leaders. We have been involved in the development of a set of competencies to support their development and will use the programme as part of our career pathway work.

i. **Enhanced nurse leadership:** Internal promotion and external recruitment to Ward Manager, Matron and Head of Nursing roles has occurred this year. We have also seen recruitment into leadership roles in specialty areas to drive improvement and assurance.

iv. **Professional Nurse Advocate:** Our programme continues to develop, and the group has established itself across many areas of the Trust. The work of the PNA forum continues to embed the role across the Trust. The PNA organisational strategy provides a basis to ensure full utilisation of this role to support the nursing workforce across the organisation.

v. **Response Team:** This team has continued to evolve and establish itself in 2023/24 and has achieved full staffing during the year. This group provide senior clinical support to the ward and departmental teams on a 24/7 7 day a week basis. The team also has site management responsibility out of hours and works alongside our bed management and medical teams to deliver safe and effective care. The implementation of this team has meant we have improved in RCN core standard 14 in regard to having a Band 8a on site 24/7.

vi. **International recruitment**: Our international nursing programme has continued to develop in 23/24, reaching its completion with our final set of recruits in December 2023.

4.6: Proposed workforce developments for 2021-2025

i. **Continue implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025 with focus on:**
   a. Compliance with Regulatory guidance and safe staffing.
   b. Education, Training, and routes of entry.
      i. HCA's
      ii. Degree entry student nurses
      iii. RNDA.
      iv. Associate Practitioners
      v. Nurse Associates
   c. Education and development pathways.
   d. Establishment reviews and moving to a sustainable model of care.
   e. Ensuring every ward has a supernumerary clinical co-ordinator.
   f. Mental health and learning disabilities.
   g. Extended scope and advanced practice roles.
   h. Equality, Diversity, and Inclusion.
   i. Clinical Academic Careers.

ii. **Continued focus on improving retention** led by the lead nurse for retention. This role has provided strategic oversight for the implementation of a number of key projects to support the organisational nurse retention plans. During 23/24, the data has started to show an improved retention position.

iii. **Reduce use of temporary staffing:** Continue to review ways of reducing the use of temporary staffing, including workforce reviews and reduction of agency spend.

iv. **Implement Children and Young People Safer Nursing Care Tool (SNCT):** This will replace the SCAMPS acuity and dependency tool. The SNCT is an evidence-based measurement tool which facilitates comprehensive establishment reviews as part of a triangulated approach.

v. **Improvements for the HCA/Apprentice workforce:** Ensure that the Band 2 to Band 3 HCA organisational change continues to be implemented. Ensure clear career pathways and development opportunities are available.

vi. **Career Pathway Development:** Development of a bespoke career pathway from HCA to senior nurse.

vii. **Ensuring we have nurses with the right skills to care for our increasingly complex children and young people:** TNA and skills gap analysis, competency development, review the role of the ward-based educator.

viii. **Continued focus on education through:**

a. Continued partnership working with local HEI's to ensure learner experience is positive within the organisation.
b. Redevelopment of the Standards of Student Supervision and Assessment (SSSA) training, to link with new preceptor training and a coaching conversation session.
c. Review of preceptorship framework to ensure compliance with new national guidance and also to ensure the post pandemic requirements of the nursing workforce are being met.
d. Engagement with local schools and colleges to support career choices and workplace experiences.

5. Workforce challenges

5.1: Leavers

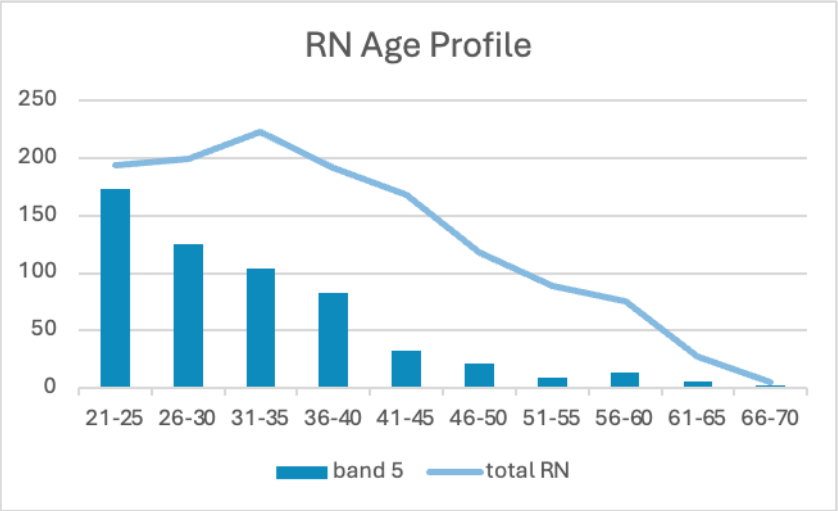
Detailed leaver data is supplied in appendix 5 – 6 and demonstrates the improved position of the Trust compared to other organisations nationally.

The main reasons for leaving have been voluntary resignation for work life balance relocation and voluntary resignation for relocation. A number of staff left the organisation citing the reason for leaving as promotion suggesting that there was a lack of opportunity for progression within Alder Hey, primarily from Band 5 to Band 6.

Leaver rates from our internationally educated nurses is very low with virtually all our nurses continuing to work at Alder Hey. There has been a significant focus on our new preceptees, and this is where we have made our biggest gains. The key interventions as part of the whole retention package including the restorative supervision, well-being support, flexible working, and professional development support.

The Trust appointed a nurse retention lead in August 2023 as a 12 month pilot. Working alongside our Quality improvement team and with our HR team to identify 3 workstreams, and reports through to the Chief Nurse and to PAWC. The retention lead will also link up with the regional and national teams and the wider Trust retention team to help deliver elements of the Trust People plan.

5.2: Age profile of RN and Band 5 nursing staff



Age profiling and the potential for retirement is an integral part of effective workforce planning, thus enabling predicted future requirements to be identified and factored into the Trust's recruitment strategy.

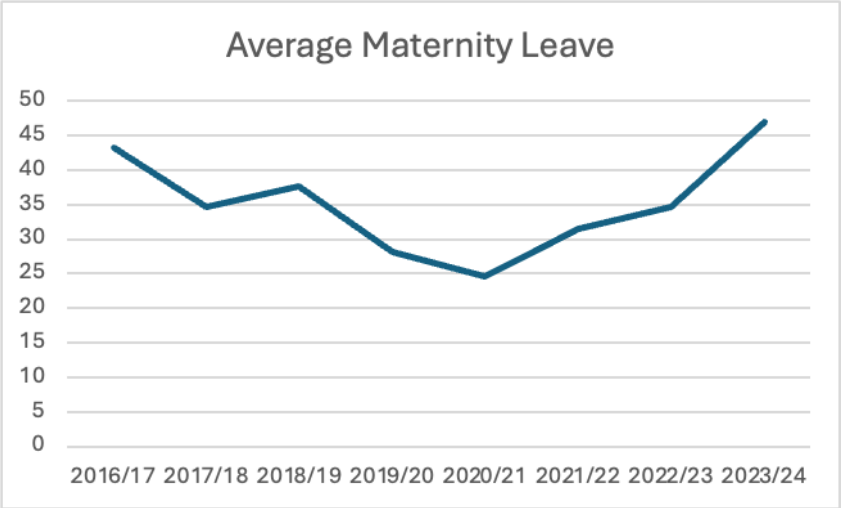
The nursing age profile in the above chart identifies 31.67 WTE (5.5%) band 5 nurses are able to retire and 196 WTE (15%) retirement risk overall within the nursing workforce.

Partial retirement options have been introduced this year and have encouraged a number of nursing staff to take their pensions but return to work.

Information relating to retirement intention is only available through staff sharing information voluntarily, therefore this poses a risk to the organisation. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years. This will take the form of 'stay interviews' which can occur anytime but mainly as part of the appraisal process. We have also been undertaking a review of the Exit interview process with our HR colleagues and this now is starting to give us much richer data.

5.3: Maternity leave

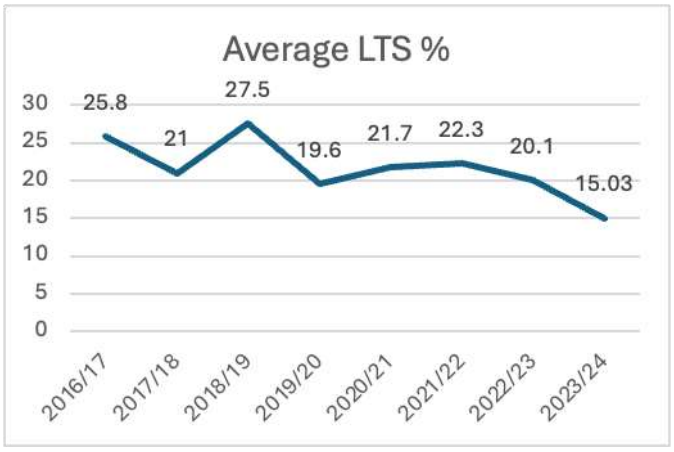
Maternity leave cover is not included within the calculated ward establishments for any of the wards. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Trust Board supported an increase to the funded "nursing pool" to 40 WTE in order to further improve resilience in providing maternity leave cover.

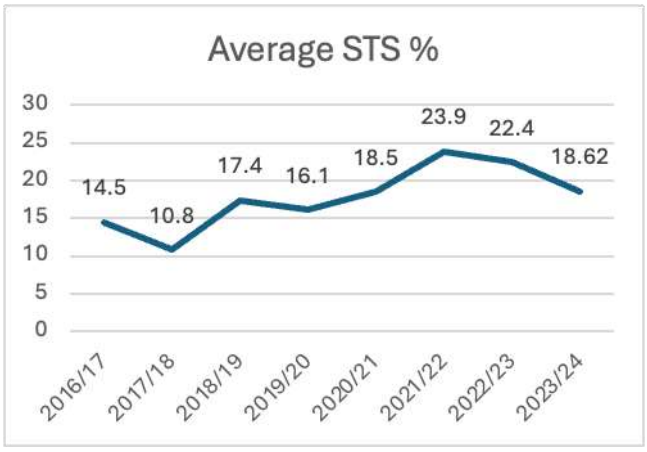


As a staffing group nursing is largely comprised of a female workforce of childbearing age. The graph above demonstrates changes in recent years with the average number of maternity leave per year, with a significant increase in the current year.

60% of maternity costs are recovered from central government across the duration of a period of maternity leave absence, the remaining 40% is the Trust's internal challenge, which is valued in the region of £480,000 per annum.

5.4: Sickness





There has been significant improvement in the average long-term sickness this year compared to previous years, reflecting the significant investment in wellbeing and other support programmes to aid staff recovery and earlier returns to work.

Short term sickness remains above the Trust target, but this year has seen an improvement compared to the previous 2 years. Ward Managers continue to work in collaboration with HR to support the physical and mental health and wellbeing of staff. Staff are signposted to SALS and referred to Occupational Health in addition to staff accessing SALS support directly.

Analysis by ward is provided in Appendix 5 for long term sickness.

5.5: Increasing patient acuity

The Trust continues to care for a significant number of patients who require 1:1 nurse to patient ratio of care outside of PICU and HDU areas. Oversight on a daily basis is provided through the Safer Staffing Meeting in line with the Standard Operating Procedure for one-to-one care (Developing Workforce Safeguards, NHSI 2018). Ward 4B model of nursing has been reviewed to consider this need.

The evidence-based Children and Young People Safer Nursing Care Tool has commenced implementation in 2023/24 with all senior nurses involved in establishment setting trained and assessed by NHSE. Patient acuity data is collected twice a year, for all inpatient areas which meet the criteria, for a total of 20 days which then informs the funded establishment for that area in line with Expectation 3 Right Staff (Developing Workforce Safeguards, NHSI 2018). It is planned to implement the Mental Health Optimal Staffing Tool (MHOST) in Sunflower House and the Emergency Department Safer Nursing Care Tool in ED following training. PICU and HDU continue to use PICS standards, Ward 1C Neonatal continues to use BAPM standards, and day case wards, Burns Unit and OPD continue to use RCN standards.

Alder Hey were involved in the NHSE led CYP SNCT study to test the proposed changes to the tool in 2 ward areas. It is hoped the national review of this tool will enable it to better reflect the range of patients which we care for.

The criteria in the current CYP SNCT tool has replaced the SCAMPS tool to enable ward staff undertake the daily acuity scoring of patients; whilst this is different to the CYP SNCT tool, which is purely for establishment setting, it does facilitate consistent criteria to assess patients against

5.6: Temporary staffing: NHSP and agency

The Chief Nurse has led a continued drive to reduce the use of bank and agency staff, however due to staffing pressures particularly linked to sickness during winter months, and 1-1 acuity demand, the requirement for NHSP has remained high in 2023//24.

Demand for Nursing bank staff decreased by 0.3% in 23/24 compared to 22/23. Bank filled hours volume increased by 8%, with an overall fill rate of 80.7% for full year 23/24. Agency use increased to 4% for the year across Theatres and Crisis Care.

Reduction of NHSP remains a priority for 2024/25 in line with the Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025.

5.7: Winter pressures / increased staffing demand

A paper published by NHSE/I in November 2021 (Winter 2021 preparedness: Nursing and Midwifery Safer Staffing), set out actions that Trusts must focus on, to ensure effective decision making and escalation processes to support safer nursing for the winter period.

This built on previous national guidance, the core fundamental principles of safe staffing, and Executive Nurse responsibilities. Trust Board have previously received assurance that plans are in place to ensure safe nurse staffing over the winter period and that plans were

connected to the wider system staffing planning, resourcing, and mutual aid. The report included a completed Assurance Framework against the four domains below set out by NHSE and identified where any improvement in systems can be made to further enhance safety and assurance.

The Assurance Framework demonstrated the policies, procedures, plans and strategies in place to support safe staffing over the winter period, including a revised model of nursing (Green, Amber and Red staffing levels), a clear nurse staffing escalation process, and a clear strategy to provide safe staffing in critical care particularly at times of increased pressure and / or surge. The Alder Hey model was reviewed, supported and approved by the Cheshire and Mersey Paediatric Network.

Actions identified in the assurance framework are incorporated in the Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025 and monitored at the Workforce meeting Chaired by the Deputy Director of Nursing.

5.8: Staffing risks and incidents reported

There were a total of 76 staffing related incidents and near misses reported in 2023/24 representing a 50% reduction on the 145 incidents in the previous year. Where staffing related incidents occur these are recorded on the Trust incident management system.

The main reported themes relate to staffing issues due to staff shortages and concerns regarding skill mix and suitably trained staff. Theatres reported the highest number of incidents, mainly relating to team availability, and work is ongoing to address any specialist skills issues and roster gaps.

Examples of action taken to address and reduce staffing incidents are as follows:

- The Safer Staffing Huddle has been embedded to ensure a clear and agreed daily staffing; appropriate redeployment of staff from other areas following assessment and review.
- Use of temporary staffing
- Weekly staffing overview meeting overseen by Associate Chief Nurse
- Weekly forward look of TCIs to plan staffing requirement.
- Clinical Educator working alongside new nurses and student nurses.

There are currently 11 open risks on the Risk Register relating to staffing with risk scores ranging from 9 to 12. All have appropriate control measures and associated actions. 4 staffing risks were closed on the Risk Register in 2023/24. An overview of the risks is shown in Appendix 6.

5.9 Ockenden report: Workforce planning and sustainability, and safe staffing

In response to the Ockenden report; the outcome of an independent review of the maternity services provided by another Trust, the Trust board approved the action plan relating to

those recommendations that directly and indirectly applied to Alder Hey. All actions relating to safe staffing levels and a well-trained workforce have been completed.

6. Recommendations

A firm foundation has been built to support ongoing workforce management and further development. The senior nursing team will continue to implement the Trust Nursing and Health Care Support Worker Workforce Plan 2021-2025. In addition, the team will continue to respond to the national picture, including emerging risks, national and local developments, and changes, and identify opportunities to transform and enable effective new ways of working.

The Trust Board of Directors are asked to support the following recommendations:

1. Implement planned developments, recruitment strategies, workforce reviews, and educational strategies in line with the Nursing and Health Care Support Worker Workforce Plan 2021-2025
2. Support the improvements and developments as detailed in this report
3. Continue to monitor and evaluate staffing levels and review safety and effectiveness.
4. Continue to work in partnership with HEI's in the evaluation and further development of new nursing and support roles including through the apprenticeship route.
5. Continue to work with HEI's to promote nursing as a career choice with people from all backgrounds and ethnic groups.
6. Continue recruitment activities to ensure low levels of nursing vacancies.

Appendix 1: Staffing availability report 20232/24

Ward Safer Staffing 2023/24	Day registered	Day HCA	Night registered	Night HCA	Overall staffing
April	68%	78%	63%	90%	75%
May	81%	87%	77%	102%	87%
June	79%	85%	76%	100%	85%
July	79%	82%	79%	91%	83%
August	77%	81%	75%	91%	81%
September	77%	84%	74%	96%	83%
October	78%	88%	76%	101%	86%
November	86%	90%	84%	93%	88%
December	82%	97%	81%	100%	90%
January	86%	67%	83%	96%	83%
February	85%	89%	83%	99%	89%
March	87%	84%	84%	99%	89%

*the above does not reflect ward occupancy and is a measure of % fill rate against roster template.

Alder Hey Children's NHS Foundation Trust

Appendix 2: Care Hours per Patient Day (CHPPD) report October 2023- March 2024

	Oct-23		Nov-23		Dec-23		Jan-24		Feb-24		Mar-24	
	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark
Burns Unit	28.9	19.43	31.9	14.73	17.1	12.69	16.5	12.69	14.2	14.18	13.6	14.18
HDU	25.4	34.24	28.2	34.24	23.9	31.64	28.9	31.64	31.4	30.22	27.2	30.22
ICU	48.8	34.24	62.1	34.24	36.4	31.64	39.0	31.64	29.1	30.22	34.9	30.22
Ward 1cC	19.4	18.64	18.6	18.64	16.4	14.9	14.1	14.9	16.3	16.35	13.4	16.35
Ward 1cN	21.0	21.18	21.2	21.18	15.8	15.84	13.2	15.84	15.8	15.8	19.4	15.8
Ward 3A	11.7	11.99	11.9	11.99	10.1	10.3	11.5	10.3	11.0	10.48	10.9	10.48
Ward 3B	15.9	15.07	16.8	15.07	13.7	13.67	13.9	13.67	15.7	15.7	11.9	15.7
Ward 3C	13.4	11.32	13.8	11.32	13.6	11.12	13.1	11.12	12.7	12.66	11.6	12.66
Ward 4A	12.5	12.03	12.1	12.03	10.6	10.39	11.2	10.39	9.4	10.21	10.6	10.21
Ward 4B	16.8	12.74	16.7	12.74	14.4	11.98	14.6	11.98	12.9	11.2	13.1	11.2
Ward 4C	10.3	11.85	11.0	12.01	9.9	11.63	10.4	11.63	10.4	11.92	10.2	11.92

No national HDU benchmark – ITU data used and HDU expected to be lower. 4c consistently lower than benchmark, to be reviewed as part of establishment review process.

Appendix 3: Compliance with RCN core standards and specific standards 2023/24

A3.1: RCN compliance by ward / department 2023/24

Standard	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Sec 5	Sec 6	Sec 7	Sec 8
1C Card																				
1C Neo																				
3A																				
3B																				
3C																				
4A																				
4B																				
4C																				
PICU																				
HDU																				
Burns																				
EDU																				
MDC																				
SDC/ SAL																				
Renal																				
Trust RAG rating	↑	=	=	=	=	=	=	=	=	=	=	=	=	↑	=	=	=	=	↑	=

Key

Green:	Compliant	**↑:**	Improved position compared to 2022/23
Amber:	Partial compliance	**↓:**	Deteriorating position compared to 2022/23
Red:	Non compliant	**=:**	Static position compared to 2022/23
Blue:	Trust agreed workforce		

Appendix 3.2: Compliance with RCN core standards 2023/24

This table provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to improve compliance:

Table 7: Core standards to be applied in services providing health care for children and young people		
Standard		**Compliance**
1	The shift supervisor in each clinical area will be supernumerary to ensure effective management, training, and supervision of staff	**Compliant↑**
	12 out of 15 areas have a supranumery clinical co-ordinator. A business case was successfully submitted in 2022 which supported the increased funding required to enable a supranumery co-ordinator on Ward 3C and Ward 4C. The Surgical Division are enacting on a recommendation from the 2022 establishment reviews to transfer funding where possible from other areas to fund a supranumery co-ordinator on Ward 3A. The remaining 2 areas are EDU and the Renal Unit. EDU is supported by the Team Leader in ED and the Renal Unit is supported by an Advanced Nurse Practitioner and Clinical Nurse Specialist. Both are small units and do not specifically require a supranumery co-ordinator. This is a significant improvement in year and with a plan in place to address the shortfall on Ward 3A it is considered that the Trust is compliant with this standard	
2	Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff	**Compliant**
	Fully compliant	
3	At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need	**Compliant**
	100% compliance with the Trust resuscitation policy for areas identified to have APLS or PLS trained staff on each shift	
4	There will be a minimum of 70:30 per cent registered to unregistered staff	**Compliant**
	Fully compliant. Where a ward looks to have high HCA ratio (for example Ward 4B), this is a deliberate workforce configuration to provide HCA 1:1 patient care and the required number of registered nurses are in place in line with RCN specific standards	
5	A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness, and study leave	**Compliant**
	The wards at Alder Hey have a funded establishment which includes a 23% uplift. The remaining 2% uplift is supported through the funding of the additional 40 WTE rotational Band 5 nurses achieving the full uplift and as such increasing the availability, resilience, and support to the front-line nursing workforce. In addition, Clinical Educator's in post.	
6	There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas	**Compliant**
	Fully compliant	
7	Nurses working with children and young people should be trained in children's nursing with additional training for specialist services or roles	**Compliant**
	Fully compliant	
8	Seventy per cent of nurses should have the specific training required for the speciality, for example, children's intensive care, children's	**Compliant**

	oncology, children's neurosurgery	
	Fully compliant. Specialist wards have locally or regionally delivered programmes to support staff development and expertise in their field as identified in their local Training Needs Analysis	
9	Support roles should be used to ensure that registered nurses are used effectively. Support roles are defined in the standards as a minimum of the following:	**Compliant**
	Supernumery Ward Manager: Fully compliant	
	Ward receptionist / ward clerk / admin support for ward staff: Fully compliant	
	Play Specialist: Fully compliant apart from PICU however they can make a referral to the Play Specialists as required which will then be reviewed and actioned appropriately.	
	Housekeeper: Fully compliant. Burns Unit access PICU / HDU housekeeper	
10	Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks	**Compliant**
	Successful bid awarded from NHSE/I to support national strategy for zero Health Care Assistant (HCA) vacancies. Funding being used to deliver the HCA Care Certificate and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is an HCA vacancy. All new Health Care Assistants signed up to NHSP undertake Advanced Clinical Skills training. All HCA's on wards have assessment of competency in assigned skills.	
11	The number of students on a shift should not exceed that agreed with the university for individual clinical areas	**Compliant**
	Fully compliant	
12	Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels	**Compliant**
	SCAMPS tool in place; plan to implement Shelford SNCT tool and MHOST tool (Tier 4) in 2023/24	
13	Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.	**Compliant**
	Ward Managers / Senior Nurses attend daily Safer Staffing Huddle to inform of ward level patient acuity and requirement for additional staff; staffing plan is agreed, implemented, and reported into the Bed Meeting. Tendable (Perfect Ward) audits, Infection Control audits and covid audits, and Ward Accreditation ratings reviewed at establishment reviews. Challenge boards monitored for each ward within Divisions and assurance regarding key performance indicators reported to CQSG, SQAC and executive performance reviews	
14	Where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24-hour period. The expectation is that this post would be at a minimum of band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification	**Compliant↑**
	The Trust is fully compliant with this standard with a Band 8a nurse on duty 24/7. Senior Nurse / AHP on Site (SNOS) commenced in February 2022. Response Team recruited and implemented which comprises of senior skilled nurses providing support to the hospital. The implementation has been a phased approach to allow for further recruitment and a consistent approach. The team consists of 6wte Band 8a	

	Senior Clinical Site Practitioners and 5.6 wte Band 7 Clinical Site practitioners.	
15	All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day	**Compliant**
	Fully compliant. Nursing and Medical staff on call	
16	Children, young people, and young adults must receive age-appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs	**Compliant**
	Appropriately trained workforce and specially designed Children's Hospital	

A3.3: Compliance with RCN specific standards 2023/24

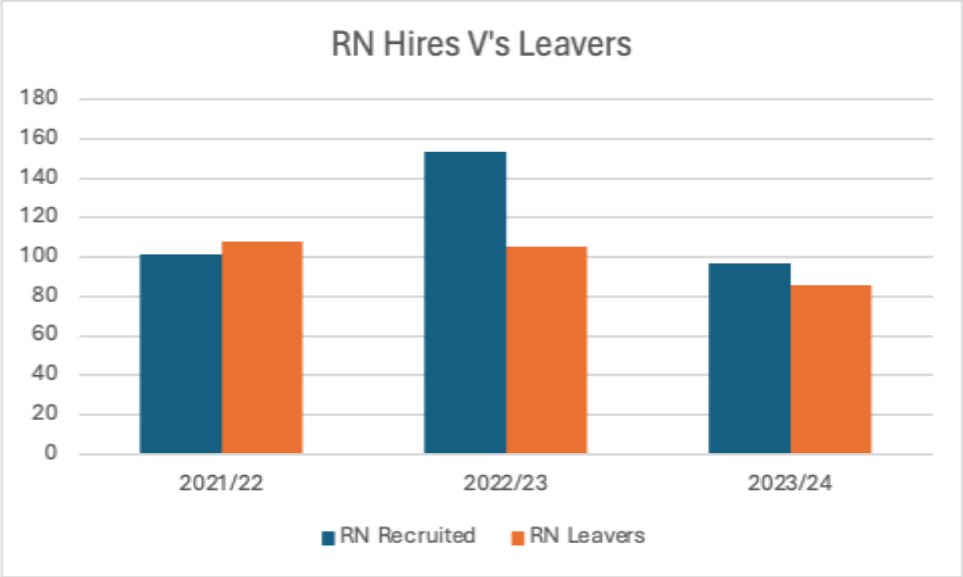
This table provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to mitigate and improve compliance:

Table 8: Staffing principles within "Defining staffing levels for children and young people's services"		
Section		**Compliance**
Section 5: Neonatal services	Bedside, deliverable hands-on care: Special care 1:4 nurse: infant High dependency care 1:2 nurse: infant Intensive care 1:1 nurse: infant	**Compliant↑**
	Fully compliant. Neonates requiring intensive care are nursed on PICU, surgical and cardiac neonates requiring high dependency care are nursed on Ward 1C. Neonates on other wards are nursed 1:3 in line with standards in Section 7 below. The Trust is part of a single neonatal service with LWH. Full establishment review taken place as part of commissioning the service and establishment increased in line with BAPM standards	
Section 6: Designated children's intensive care and children's high dependency services	PICU 6.7-7.06 WTE per bed dependent upon maternity leave included in calculation. Bedside, deliverable hands-on care: Level 1: HDU 1:2 nurse: child Level 2: PICU or HDU cubicle patient: 1:1 nurse: child Level 3: PICU: 1:1.5 nurse: patient Level 4: 2:1 PICU: nurse: patient (ECMO)	**Compliant**
	Current ratio now at 6.6 WTE per PICU bed. HDU compliant with 4.4 WTE per bed. Full nursing ECMO team established in PICU. All patients are nursed as per ratios set above unless not required for example a patient who is being transferred from PICU to a ward. HDU care provided on general HDU, Ward 4A and Ward 1C Cardiac all provide 1:2 care	
Section 7: General children's wards	Bedside, deliverable hands-on care: Children < 2 years of age 1:3 registered nurse: child, day, and night Children > 2 years of age 1:4 registered nurse: child, day, and night	**Compliant↑**
	Fully compliant following increase in establishment for ward 3C and Ward 4C	

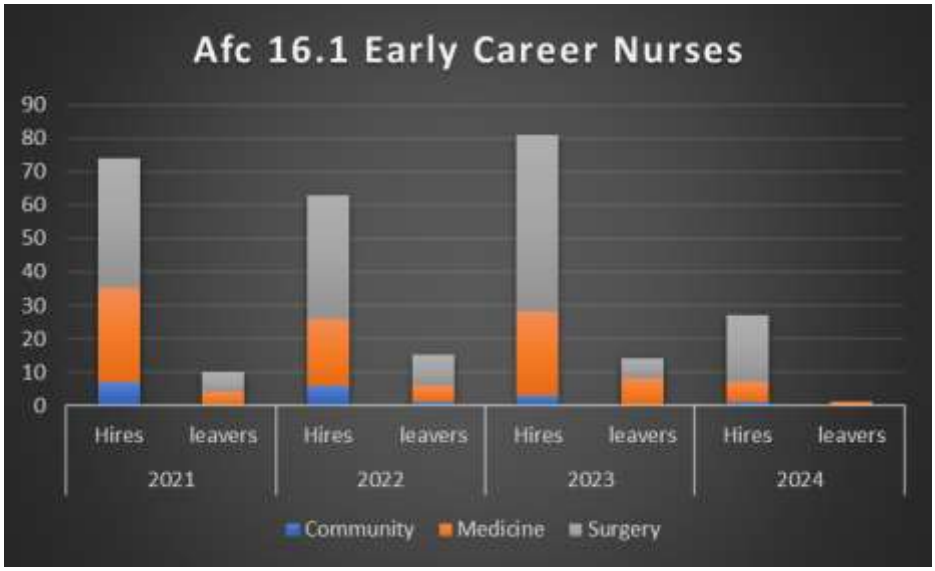
Section 8: Specialist children's wards	At least a third of patients on specialist wards (such as oncology, cardiac, neurosurgery) should be classed as requiring high dependency care, although in some ward areas this may be as high as 50 per cent. The relevant standards must be followed (1:2 registered nurse: child). The minimum standard for other children being 1:3 registered nurse: child	**Partial**
	6 out of 9 areas fully complaint; there is a case to say that almost all of the in-patient wards at Alder Hey are specialist in nature. Wards with dedicated HDU beds (Ward 1C and Ward 4A) are established for 1:2 ratio for commissioned HDU beds, and in addition Ward 4A provides 1:2 ratio for orthopaedic patients requiring a higher intensity of care. Ward 3C, Ward 4B and Ward 4C regularly have high acuity patients requiring an HCA 1:1 and this is supported and facilitated through temporary staffing as required; action in 2022/23 to review continued high acuity and either increase HCA funded establishment or create an HCA "pool". Wards are not established for 1:3 ratio for remainder of patients. Achieving compliance with this standard would require significant additional financial investment. However staffing levels and patient acuity are monitored, and appropriate action taken to ensure safe staffing at the daily Safer Staffing Huddle. Amber and Red models invoked in line with escalation process.	

Appendix 4: RN workforce data

A4.1: Hires compared to leavers



A4.2 Preceptee leavers 21/24

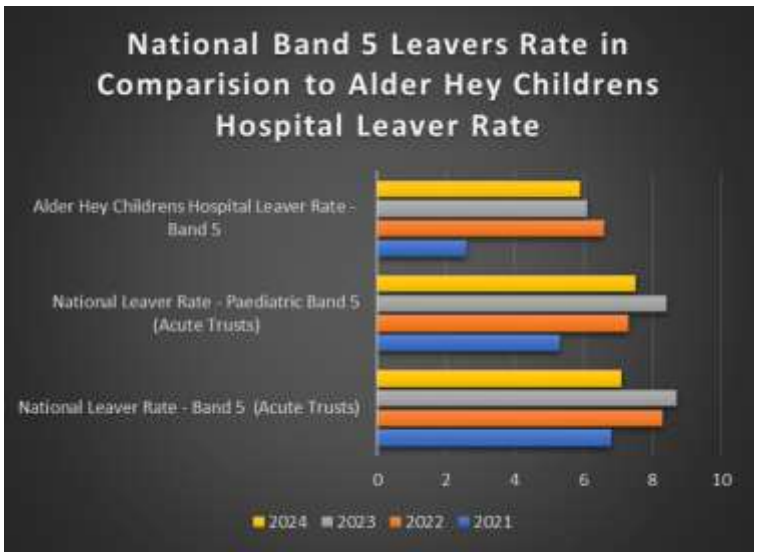


AfC 16.1 (Early Career Nurses)								
	2021		2022		2023		2024	
	Hires	leavers	Hires	leavers	Hires	leavers	Hires	leavers
Community	7	0	6	1	3	0	1	0
Medicine	28	4	20	5	25	8	6	1
Surgery	39	6	37	9	53	6	20	0

A4.3 Band 5 leavers excluding preceptees/ retirees.

Band 5 positions excluding AfC 16.1 and Retirees								
	2021		2022		2023		2024	
	Hires	leavers	Hires	leavers	Hires	leavers	Hires	leavers
Community	0	6	4	3	0	4	1	1
Medicine	6	17	6	29	4	24	3	4
Surgery	12	41	16	47	16	48	4	9

A4.4 National Band 5 Comparator leaver data



	2021	2022	2023	2024
National leaver rate- Adult Acute Trusts	6.8	8.3	8.7	7.1
National leaver rate- Paediatric Acute Trusts	5.3	7.3	8.4	7.5
Alde Hey- Band 5 leaver rate	2.6	6.2	7.2	5.3

Alder Hey Children's NHS Foundation Trust

Appendix 5: Band 5 Long term sickness by ward 23/24

LTS 23/24	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac		2.03	0.85	1.53	0.66	0.05				0.36	0.38	0.04	0.74
1C Neo									0.13	1.00	0.86		0.66
3A	1.39	1.31	2.40	2.16	1.36	1.37	0.32	0.85	1.85	2.19	1.35	1.11	1.47
3B	0.38	1.30	0.38	1.13	1.13	1.22	2.25	1.49	1.00	0.90			1.12
3C	0.48	1.40	1.63	2.69	0.73	0.38	1.36	1.47	0.83	0.37	1.63	2.60	1.30
4A	2.02	2.69	2.05	2.05	1.87	1.99	3.68	3.48	2.39	1.19	1.00	1.00	2.12
4B	4.07	2.02	4.05	1.45	1.22	1.22	2.22	2.22	2.22	1.42		0.38	2.04
4C	1.68	1.07	1.38	0.41	1.58	0.87	0.05		0.40	1.57	1.00	0.81	0.98
BU							0.76			0.38	0.35		0.50
PICU	1.37	2.55	2.93	1.27	0.78	0.75	1.78	1.08	0.13	0.94			1.36
HDU	1.73	4.91	2.87	2.41	1.46	1.45							2.47
SDC									1.00	1.00	1.79	1.00	1.20
MDC								0.26	0.26	1.33	1.57	1.58	1.00
SFH							0.97	1.24	1.69	1.06	1.58	2.08	1.44
OPD	2.51	0.58	1.42	1.39	0.48								1.27
ED / EDU	1.81	1.39	0.87	0.27	2.23	1.42		1.00	1.43	1.43	1.43	1.33	1.33
Total	17.42	21.25	20.80	16.75	13.52	10.72	13.41	13.08	13.33	15.14	12.95	11.93	
Q average	Q1: 19.83			Q2: 13.66			Q3: 13.27			Q4: 13.34			15.03

Appendix 6: Risk Register staffing risks

A6 1: Open risks 2023/24

Ref	Division	Dept	Title	Risk Score
2029	Surgery	3A	Patient safety and delivery of care on ward 3A associated with funded establishment	9
2001	Medicine	4B	Reduced availability and resources on Ward 4B to deliver staff training in invasive and non-invasive ventilation and sleep study management resulting in the cancellation or delay in admissions to Ward 4B and potential harm to patients and delay in treatment	8
2581	Medicine	Palliative	If the Paediatric Oncology Outreach Nurses don't have an adequate number of nurses, then the families we support will not receive the best quality care	9
2556	Community & MH	OPD	Inability to safely staff Catkin and Community Clinics	12
2469	Community & MH	OPD	Inability to safely staff waiting list initiative (WLI) clinics in OPD	12
2703	Community & MH	DJU	Risk of not meeting required safe staffing numbers on the Unit for all shifts	9
41	Community & MH	Learning Disability Service	Reduced staff / service capacity (LD / ASD team)	9
100	Medicine	4C	Reduction in skilled workforce on Ward 4C	9
112	Medicine	3C	Inadequate Staff Nurse skill mix on 3C	9
122	Medicine	Allergy	Lack of nursing staff within the allergy service	12
142	Community & MH	ICCNT	Community Liverpool Matron Service	9
All risks will be reviewed following the 2024/25 establishment review				

A6 2: Closed risks 2023/24

Closed risks				
Ref	**Division**	**Dept**	**Title**	**Risk Score**
2774	C&MH	ICCNT	Risk that the virtual ward may not be sustained at current levels and / or be able to expand to meet future demands	6
2693	Medicine	General Paediatrics	Patients not getting enough nursing support. Fails to meet national standards with inherent risk to reputation. Require additional resilience within the service	2
2609	Medicine	4B	There is a risk that NHSP staff, students and parents are asked to provide the oversight and / or care depending on their abilities; resulting in not all 1-1 patients receiving the level of care to reflect their acuity and meet their risk assessment	3
2334	Medicine	Medicine Division – Division Wide	There is a risk that nurse staffing on the medical wards will not be sufficient to either provide adequate care to patients or necessary capacity to meet demands	3

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	**Quarter 4 / Year End 2022/23 Complaints, PALS and Compliments report**
Report of:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

Purpose of Paper:	Decision	☐	Information	☐
	Assurance	☑	Regulation	☐
Action / Decision Required:	To note	☐	To approve	☑

Summary / supporting information

The purpose of this paper is to provide Trust Board of Directors with an update and assurance on the performance against complaints and PALS targets in Q4 and full year 2023/24, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised, and recommendations for proposed developments in 2024/25

42 formal complaints received in Q4; 1 subsequently withdrawn therefore 41 in total. 150 complaints received in full year; 11 subsequently withdrawn therefore 139 complaints in total which is a decrease from the previous year (154 in 2022/23)

The top reason for formal complaints received in Q4 and in year continues to be treatment and procedures, appointment, and communication

Compliance with the 3 working day acknowledgement for formal complaints is 94% in Q4 with an average of 95% compliance in year. Compliance with the internal Trust target of 25 working day response time is 75% in Q4 with an average of 71% in year; this is a sustained position

3 second stage complaints were received in Q4 and 15 in total in year; this equates to 12% (15 out of 125) of first stage responses that result in second stage complaints

One new referral was made to the Parliamentary & Health Service Ombudsman in Q4; no other ongoing investigations

There were 527 informal PALS concerned raised in Q4 which is consistent with the rest of the year. However there has been a continued increase in the number of informal concerns in year (1987) compared to 2022/23 (1904). The increase is understood to be partly associated with recovery following the pandemic and increased waiting

	times to time to see and treat patients. Only 5 PALS concerns escalated to become formal complaints Compliance with the 5-day target to resolve informal concerns was 78% in Q4 and an average of 82% in year. The Division of Surgery achieved 95% compliance in year and the Division of Medicine achieved 94% compliance in year; which is an excellent standard. The Division of Community & Mental health have invested in additional resource to respond to concerns and all Divisions contribute towards resolving concerns relating to corporate services. 320 compliments are recorded centrally in InPhase
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:	Increase in PALS concerns requires increased staffing resource to address; need to invest resource in addressing the themes around appointments and thus decrease the concerns raised

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

1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our service users expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate and compassionate response. Compliments, concerns and complaints are an important measure of the quality of care we deliver and are used to learn and further improve our services.

This report aims to provide assurance that the Trust is responding to patient complaints in line with its procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO).

This report provides an overview of formal complaints and informal PALS concerns received and completed between January to March 2024 (Q4) and also provides an overarching year-end report for 2023/24. The aim of the report is to provide assurance that the Trust is responding to the concerns raised by children, young people and their families in line with Trust procedures, Department of Health legislation and standards expected by the PHSO; identifying and analysing themes more widely that the Trust needs to address to make service improvements; and to highlight action taken.

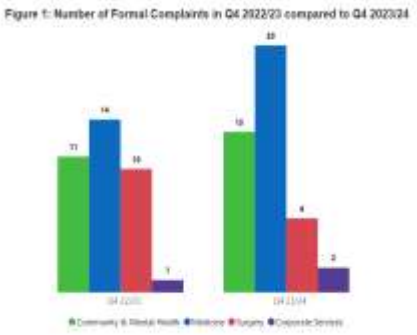
The Trust introduced a new risk management system in 2023 (InPhase). The graphs and data in this report are now provided by the Trust Business Intelligence Team exported from the InPhase system. It has taken time for the reports to be built to ensure accurate data is extracted for analysis. It should be noted that some figures in this report may be marginally different from that which were reported in previous quarters in 2023/24 following further improvements in the data extraction and reporting.

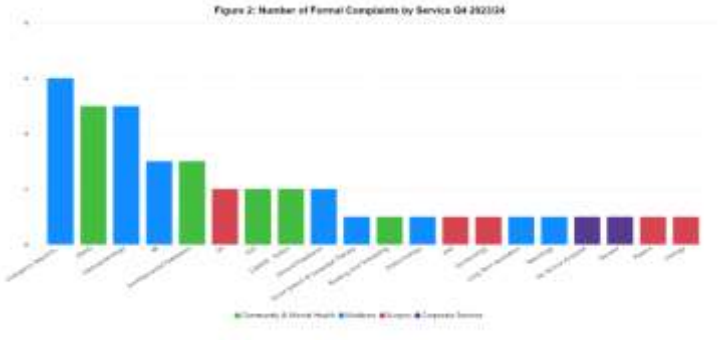
2. Formal Complaints

2.1 Number of formal complaints

2.1.1 Number of formal complaints received Q4 2022/23

42 formal complaints were received in Q4 of which 1 was subsequently withdrawn (Medical Division) resulting in a total of 41 which is consistent with Q3. This is an increase in comparison to the same reporting period last year (36 in Q4 2022/23). A comparison of Q4 with the same period last year is shown in Figure 1 (does not include withdrawn complaints); Figure 2 shows the breakdown of complaints received by service in Q4.

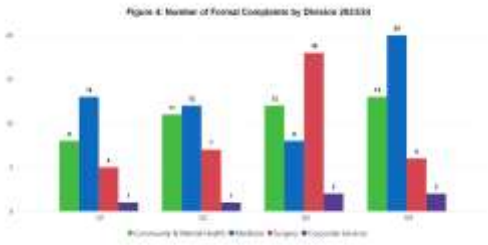


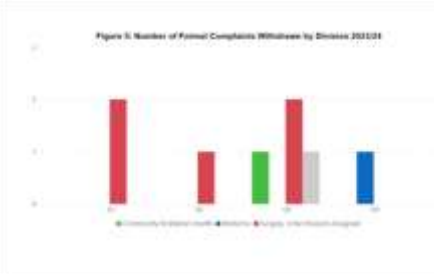


2.1.2 Number of formal complaints received in year 2023/24

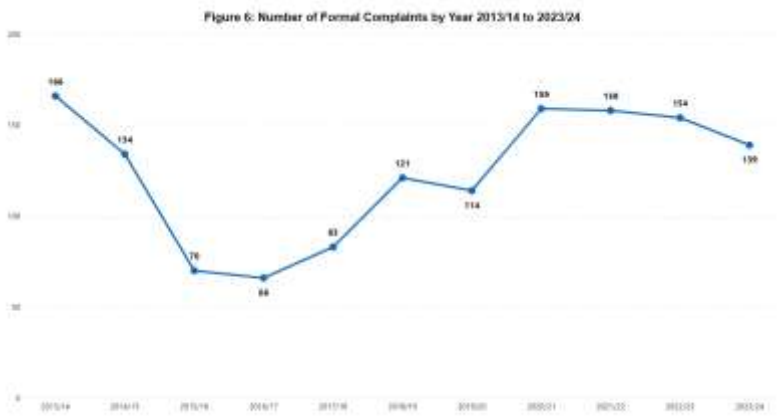
There have been 150 formal complaints received in 2023/24 however 11 have subsequently been withdrawn resulting in an adjusted total number of 139 formal complaints as shown in Table 1 and Figure 3 (not inclusive of complaints withdrawn). 5 complaints converted to a formal complaint from an informal PALS concern (2 in Medicine and 3 in Surgery) compared to 9 overall last year. Figure 4 shows the number of complaints (not inclusive of complaints withdrawn) by Quarter by Division for the full year with Figure 5 demonstrating the number of complaints withdrawn.

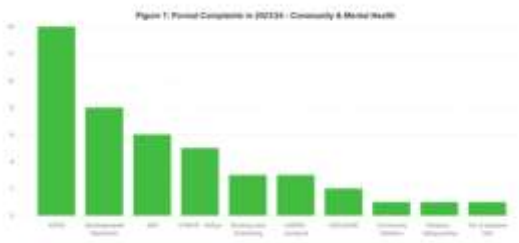
Table 1: Number of Complaints 2023/24			
Quarter	Received	Withdrawn	Actual
1	32	5	27
2	32	1	31
3	44	4	40
4	42	1	41
23/24	150	11	139

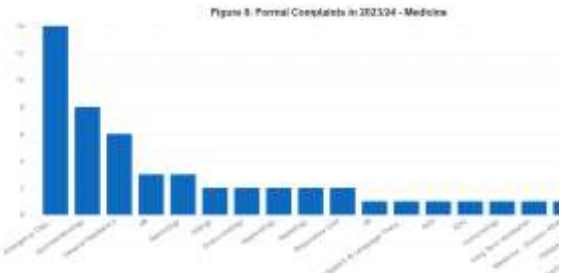


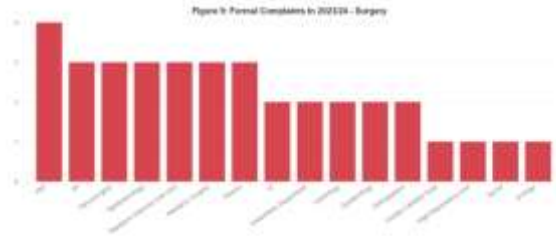


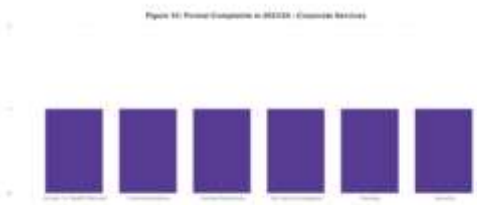
The number of formal complaints has fluctuated significantly in recent years, as shown in Figure 6. However after remaining static in the previous 3 years there has been a decrease this year which, although small, may be indicative of the improvement work undertaken by the Divisional and Corporate teams to resolve issues more quickly and informally resulting in families not feeling a need to raise a formal complaint. The period of low formal complaints between 2015-2018 may be attributed to the opening of the new hospital. Figures 7, 8, 9 and 10 show the complaints by service for each Division during 2023/24.







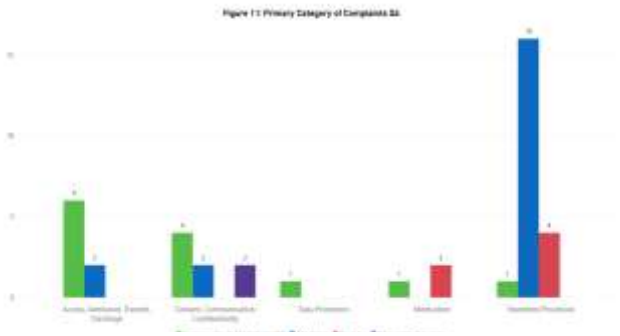


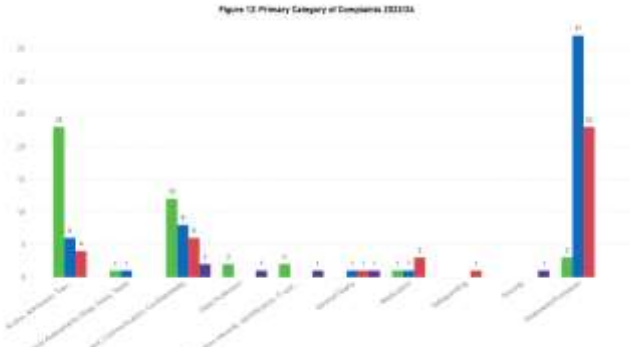


2.2 Complaints received by category Q4 2023/24 and full year 2023/24

Complaints are categorised by subject as set in the Trust InPhase complaints system. A complainant may raise several issues that the Trust must respond to, and all concerns expressed by families are categorised within the record, however the primary issue is used within this report to monitor key trends.

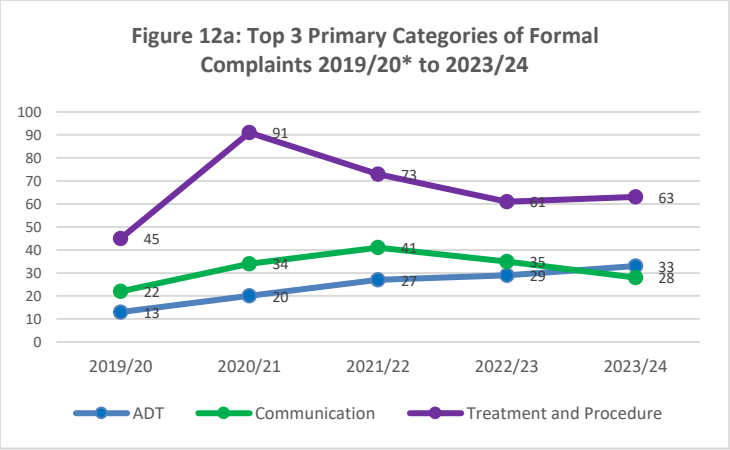
Figures 11 and 12 demonstrate that the main theme in this quarter and across the full year continues to be in relation to treatment and procedure with a total of 21 complaints (50%) in Q4, and 62 (44%) in year.





In February 2024 a deep dive into complaint themes was conducted for the previous 5 years and presented to SQAC. It is not unexpected that the main cause of concern raised in formal complaints relates to treatment and procedure given that this is the reason why children, young people and families access our services, however the deep dive provided greater insight into the main themes and issues within this category for focused improvement work at service, Divisional and Trust level. Figure 12a shows the full five year analysis demonstrating a positive decline in the number of formal complaints related to treatment and procedure and communication concerns in the last 3 years. There has been a marginal increase in

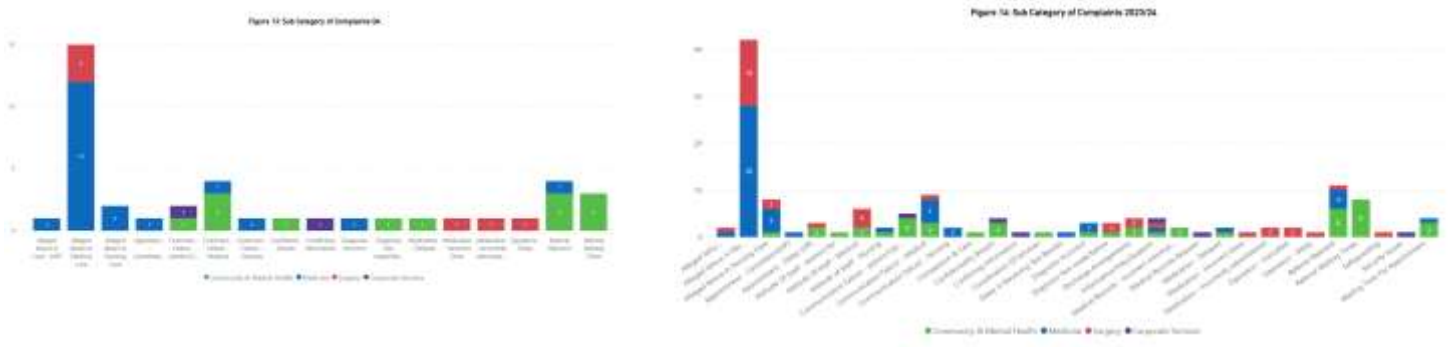
complaints relating to accessibility where data demonstrates that the majority of these concerns are raised as informal PALS concerns.

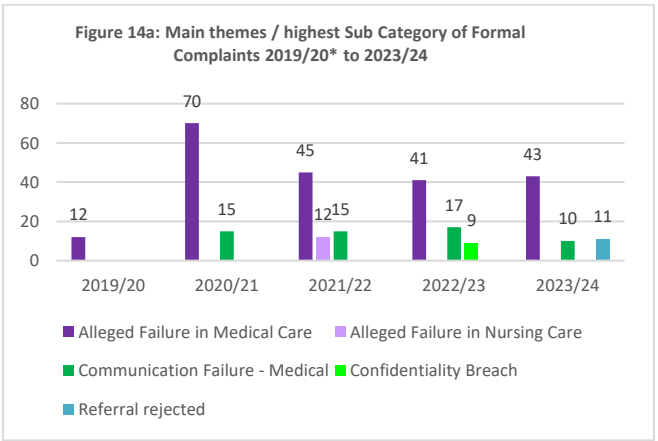


Please note: *The graph only includes data for 3 Quarters in 2019/20

Sub-category identification provides further detail regarding the primary issues raised by families. Figures 13 and 14 demonstrate that the main theme within the treatment and procedure category is in relation to alleged failure in medical care with 15 complaints (36% of all complaints) in Q4, and 43 complaints (30% of all complaints) in year.

Figure 14a shows the full five year deep dive analysis demonstrating a static position in the last 3 years relating to alleged failure of medical care.





Please note: *The graph only includes data for 3 Quarters in 2019/20

2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 National context

Current national guidance has set out that Trusts must continue to comply with NHS Complaints Regulations, however acknowledge that in some settings it may take longer to respond to a complaint and consider it currently permissible for this to go beyond the usual six month maximum time period. However, organisations should opt to operate as usual regarding the management of complaints if they are able to do so. The Trust continues to aspire to responding to complaints in line with RM6 Complaints and Concerns policy.

2.3.2 Compliance with 3-day acknowledgement 2023/24

The NHS Complaints Guidance sets out that complaints should be formally acknowledged within 3 working days; which is reflected in the Trust policy. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwatch Advocacy. The Complaints Officer may also telephone the complainant to discuss their concern further.

In Q4, 94% (40 of 42) of the formal complaints received were acknowledged within 3 working days. The two complaints not acknowledged within 3-days was due to administrative oversight.

142 of 150 (95%) complaints received in 2023/24 were acknowledged within 3 working days, demonstrating overall high compliance and sustained performance with this standard. Figure 15 shows the percentage compliance by month for 2023/24. A deep dive is underway for months where the data demonstrates performance significantly lower than expected or acceptable (March; May; August)

2.3.3 Complaints responded to and closed in Q4 and in year 2023/24

36 complaints were responded to and closed in Q4. In year, 130 complaints were responded to and closed

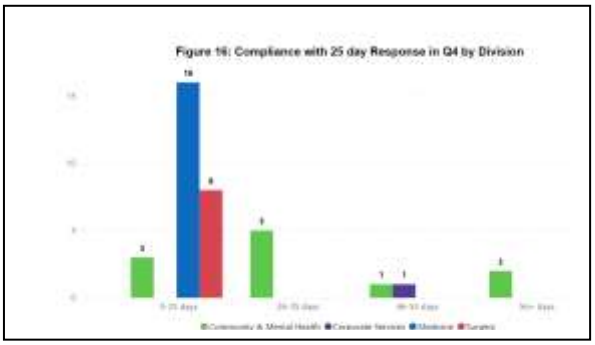
2.3.4 Compliance with 25-day response

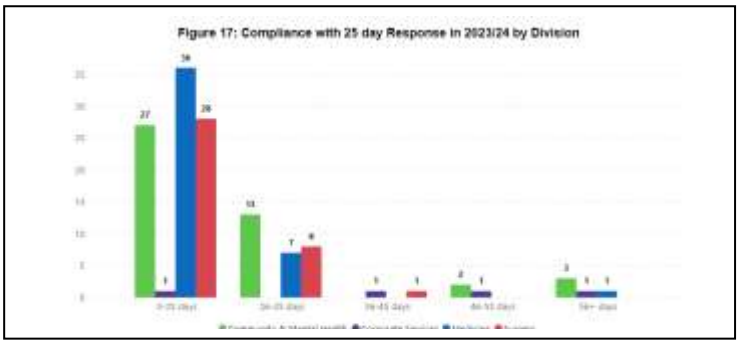
Whilst the NHS Complaints Guidance states that there is no set timeframe to respond to a formal complaint, as this is dependent on the nature of the complaint, the Trust has set an internal timeframe in the Complaints and Concerns policy to respond to formal complaints within 25 working days. Where a complaint is complex and / or multi organisational, this is discussed with the complainant to negotiate an extended timeframe with them and agree a new date for response. A meeting with appropriate Trust representatives is also offered as this can lead to a successful resolution of the concerns raised.

Figure 16 and 17 shows the compliance by month that the complaint was due to be closed in. Therefore if a complaint is closed in a month sooner than the final target response date, that complaint will not show until the following month. For example, the Division of Medicine closed a complaint in December 2023 (Q3) however this is reported on in below for Q4 as it was due for completion in January 2024. This method of data reporting changed from the Q3 2023/24 report onwards; previously, quarterly complaint reports reported on any complaint closed within the quarter irrespective of due date, however this new method of reporting is in line with the Integrated Performance Report as undertaken by the Trust's Business Intelligence team.

In Q4, 27 of 36 complaints (75%) were responded to within 25 working days as demonstrated in Figure 16. Both the Division of Medicine and the Division of Surgery achieved 100% response compliance in Q4 which is testament to the hard work and focus of the Divisions to respond to the concerns of families quickly; in the Division of Medicine this standard was achieved despite responding to the highest number of complaints. Two complaints were significantly delayed (more than 56 working days to respond); one due to complexity and one due to resource and process issues. One of these had an approved extension and no extension sought for the other.

In 2023/24, 92 of 130 complaints (71%) were responded to within 25 working days as demonstrated in Figure 17. The longest time to respond to a complaint was 82 days. Please note that within the BI data set there are 5 complaints that were due to be responded to within 2023/24 so are included in Figure 16 (36 responses) and Figure 17 (130 responses) however they have a final contact response date outside of 2023/24 and are therefore not included in Table 2 (shows 125 responses) or Figure 22 (31 responses) and Figure 23 (125 responses).





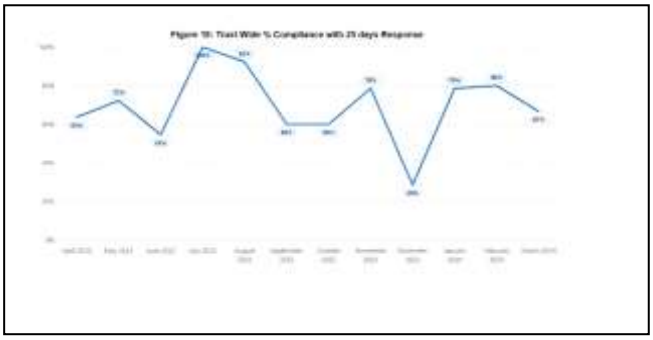
Percentage compliance is affected by the number of complaints where numbers are small, however compliance by Division in Q4 and in year is:

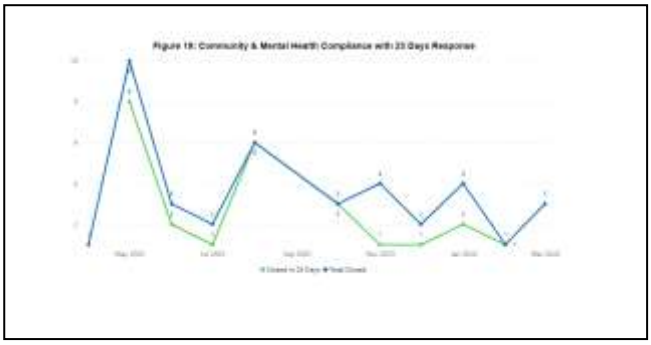
- Medicine: Q4: 100% (16 of 16 complaints closed)
  2023/24: 82% (36 of 44 complaints closed)
- Surgery: Q4: 100% (8 of 8 complaints closed)

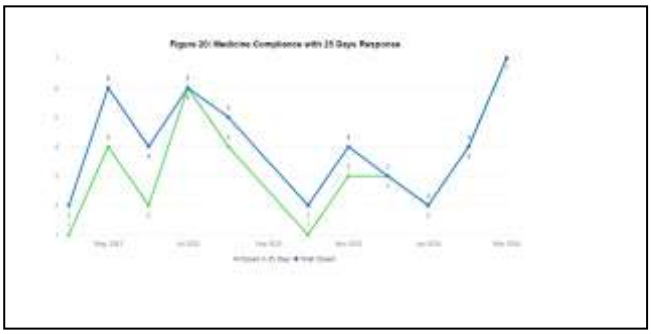
2023/24: 76% (28 of 37 complaints closed)

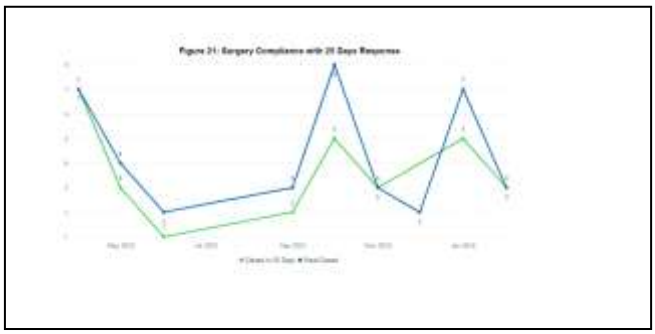
- Community & Mental Health: Q4: 27% (3 of 11 complaints closed)
  2023/24: 60% (27 of 45 complaints closed)
- Business Support: Q4: 0% (0 of 1 complaints closed)
  25% (1 of 4 complaints closed)

Figure 18 shows the Trust wide monthly percentage performance with this standard, and Figure 19-21 shows the total number closed in month and the number responded to within 25-days by Division.









NB: Where a green line does not appear in Figures 19-21 that is because the number is the same as the blue line so not visible

Whilst it is recognised that improvement work related to responding to families in a timely manner is a continued priority, there has been sustained improvement in this performance indicator from last year with an average of 71% of complaints responded to in 25 working days compared to an average of 55% two years ago; this performance has been driven in particularly by the Division of Medicine and the Division of Surgery. The improvement is testament to the hard work of all the professionals involved in the management of complaints.

2.3.5 Number of open and closed formal complaints by month

Table 2 shows there were 150 formal complaints opened in 2023/24 of which 11 were subsequently withdrawn resulting in 139 new complaints in year. The number of open complaints is inclusive of second stage complaints. 125 complaints have been closed in year (as previously reported, 5 complaints not included in Table 2 which are shown in Figure 17 as the final contact response date is outside of 2023/24). Complaints that are received in a month may not be responded to until the next month in line with the 25-day response timeframe.

Table 2: Formal Complaints received 2023/24													Cumulative to date
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Received (includes withdrawn)	15	9	8	12	9	11	17	12	15	14	16	12	**150**
Withdrawn	2	2	1	0	1	0	2	1	1	0	0	1	**11**
New complaints (adjusted from withdrawn)	13	7	7	12	8	11	15	11	14	14	16	11	**139**
Investigated, responded to and closed	10	19	9	8	11	4	14	12	7	13	8	10	**125**
Re-opened (Second stage)	0	1	3	0	1	2	1	3	1	1	1	1	**15**

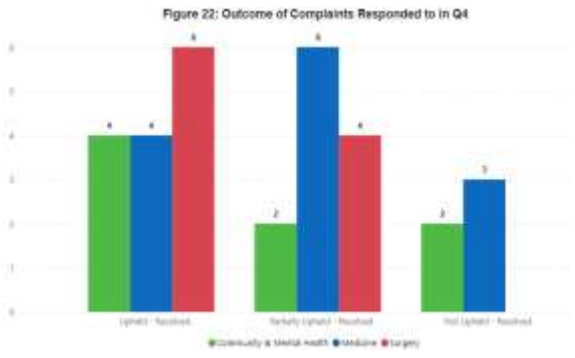
2.3.5 National complaint reporting: KO41a return

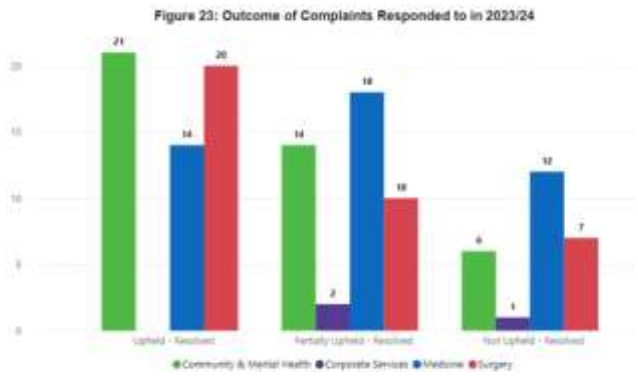
The Trust is mandated to submit data nationally regarding the status, categories and outcome of complaints on an annual basis to NHS Digital using the Hospital and Community Health Services Complaints Collection (KO41a) tool. Submission of data for 2023/24 is due between 29th April and 8th June 2024.

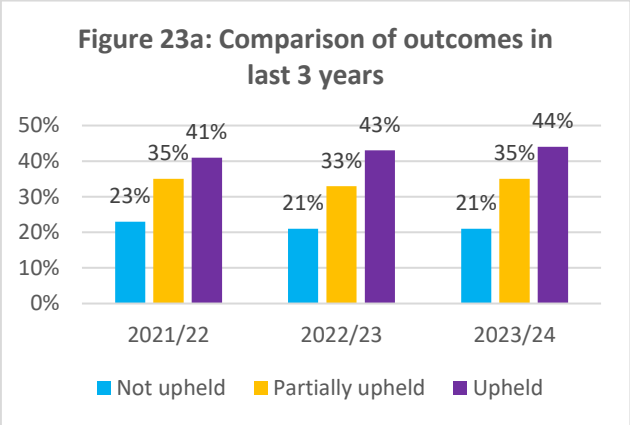
2.4 Outcome of the complaint

2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse or deputy. In Q4 5 (16%) of complaints were not upheld; 12 (39%) were partially upheld, and 14 (45%) were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether the majority of concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 22 shows the outcome of complaints by Division for Q4 and Figure 23 for 2023/24 which is consistent with the Q4 position: 26 (21%) not upheld; 44 (35%) partially upheld, and 55 (44%) fully upheld. These percentages are consistent with the previous 2 years as shown in Figure 23a







2.4.2 Second stage complaints

Second stage complaints are a rich source of valuable data and a key indicator of our performance. They can be triangulated to inform the Trust of how satisfied our families are with the quality of our response, and as an early indicator of families who may seek further resolution through the Parliamentary & Health Service Ombudsman. Second stage complaints are monitored on a monthly basis as a key performance indicator.

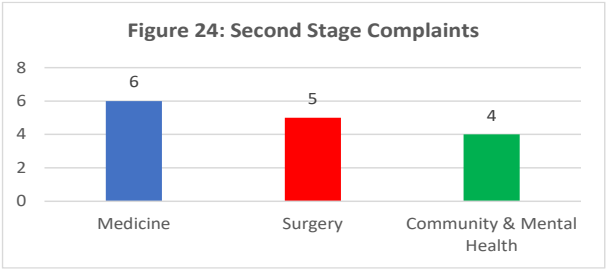
The initial response letter advises the complainant that, should they be dissatisfied with any part of the initial complaint response, or require further assistance, they should contact the Trust within 25 working days in order that the Trust can try to resolve any outstanding concerns.

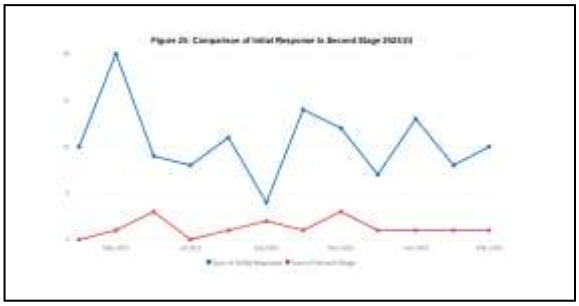
In year, 15 families informed us that they were not satisfied with the outcome of their initial complaint response: 4 received in Q1; 3 received in Q2; 5 received in Q3; 3 received in Q4. Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response. 14 cases were investigated and responded to as second stage complaints and subsequently closed and resolved to the satisfaction of the complainants; one remains open in line with 25 working days to respond.

In year 12% (15 of 125) of initial complaints progressed to a second stage complaint which is an increase in the number and percentage of second stage complaints in year compared to last year but comparable with the previous 2 years since this metric has been formally reported on as shown in Table 3. This demonstrates an overall high level of satisfaction with the quality and content of the initial complaint response, however there is a need to continue to monitor and review the reasons why families remain dissatisfied in order to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by Quarter therefore Figure 25 shows the comparison of monthly initial responses to monthly second stage complaints received.

Table 3: Second stage complaints			
Year	**Initial response**	**Second stage**	**%**
2020/21	156	25	16%
2021/22	162	24	15%
2022/23	158	13	8%
2023/24	125	15	12%





2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There was one new referral to PHSO in Q4 and the Trust were advised of the PHSO intention to commence an investigation. All documentation returned as requested. There are no other ongoing investigations and no other investigations commenced in year. This investigation rate equals 0.8% (1 of 125) of initial complaint responses and 6% (1 of 15) of second stage complaint responses

2.6 Actions and learning from complaints

It is essential that where things go wrong the Trust takes action to remedy any issues. Complaint response letters inform the individual complainant what action has or will be taken, and the Division monitor the actions through to completion. Complaints Officers include a clear breakdown of all actions in the response letter to the complainant.

Formal complaints are reviewed at the monthly Divisional Integrated Governance meetings to ensure senior divisional oversight of the current trends, to enable learning, to enable identification of specific areas of concern and any strategic actions, and ensure actions are fully disseminated, implemented and reviewed. Updates are shared by the Divisions at the Patient Experience and Engagement Group (PEEG) to ensure Trust wide learning.

Examples of improvements made to services as a result of concerns raised are:

Medical Division:

Complaint: Appointment being cancelled and not communicated to the family, resulting in the family having a wasted journey to Alder Hey
Action: Reimburse car park and petrol payments
Lesson: Short-term sickness and absence lead to cancellation of clinic appointments.

Complaint: Patient's passport not being followed

Action: To raise awareness with ward staff and the Emergency Department on the importance of reviewing the patient passport prior to any treatment
Lesson: It is important to review a patient passport, prior to any treatment being given

Complaint: The cannula process caused upset to the patient and parent, due to staff not being calm trained
Actions: Matron/Ward Manager to improve staffs' awareness on the ward, regarding calm training and who to contact out of hours for support
Invite the Learning Disability team to the General Paediatric teaching sessions to provide awareness around calm training
Lesson: Not all staff are familiar with calm training

Complaint: Several attendances to the Emergency Department; unhappy with the care received
Action: Complaint shared with the clinicians involved for reflection and their clinical supervisors informed
Lesson: Ensure results of diagnostic investigations are shared with the parents, where appropriate

Surgical Division:

Complaint: **Medication error**
Actions: Review of medication practices on SDC, review of specifics around this medication error. Head of Nursing met with Ward Manager to discuss. Conversation with Consultant regarding the importance of adhering to Alder Hey prescribing pathway
Lessons: Prescribing was not a prescribing error however consultant had deviated from Alder Hey prescribing pathway. Consultant works in 2 different Trusts and has been reminded to always follow the Alder Hey pathway when prescribing for Alder Hey patients.

Complaint: Alleged Failure in Medical Care
Actions: Administrative team reminded that all voicemails should be responded to within 48 working hours and that cover for colleagues must be provided.

Complaint: Medication Incorrectly administered.
Action: Share complaint and learning with all teams involved including ward PICU/Ward 4B/Pharmacy and medical teams.

Lessons: If patient own medication in use to ensure labels are checked against MAR. Nursing staff to confirm with parents if routine medication is prescribed once a day it is prescribed at correct time.

Complaint: Alleged Failure in Medical Care
Actions: Creation of in-house referral for fertility preserving surgery. Review of MDT functioning (Brilliant Basics team). Updating of Alder Hey fertility standard operating procedure

Community and Mental Health Division:

Complaint: Concern that false / conflicting information was given, waiting time for treatment and poor communication regarding resources available

Actions: Poor communication about process of Choice appointments - Service leaflets to be finalised to give more information to families.

Complaint: Possible data breech

Actions: 1. Standard Operating Procedure to be updated to reflect process colleagues should follow when a password pop-up appears on a child's/young person's record
2. To review who is entitled to request passwords to withhold information from a parent who holds Parental Responsibility
3. Clarify if all password requests should be followed up with a Safeguarding referral

Lessons: Ensure any referrals identified through validation or other means that have not been actioned in a timely manner after the clinic appointment with parents, are only actioned once a further contact has been made with parents to ensure consent is still fully informed.

Complaint: Delay in obtaining a prescription for medication and poor and incorrect communication with Administrator.

Actions: Share the content of the complaint anonymously with administrative staff for reflection and learning at their weekly meeting.

Lessons: 1. Making assumptions about what people know or understand can lead to errors and miscommunication
2. Communication to parents and carers needs to be clear and accurate.

Complaint: Requesting a refund on the costs of obtaining a private ADHD diagnosis

Actions: To signpost families to the correct department when it's requested to view their records.

Lesson: To make sure all admin staff know the above process

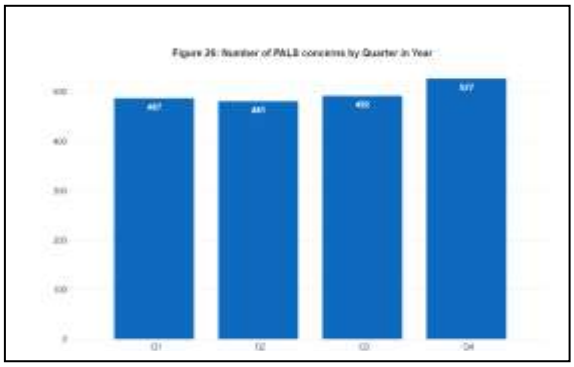
2.7 Healthwatch

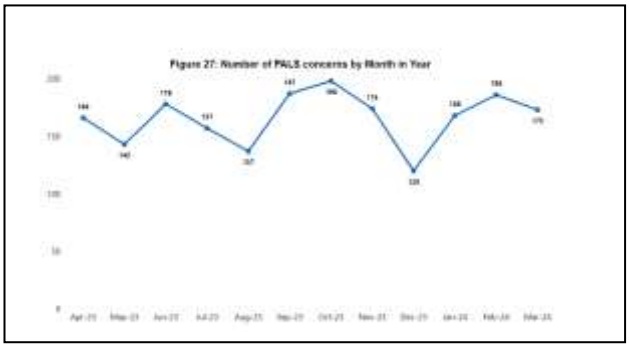
Healthwatch Liverpool and Healthwatch Sefton are key members of the PEEG and feedback any issues or concerns raised by children, young people and families. Concerns are also fed back in real time to the Patient Experience lead. Numbers are small and concerns are usually anonymous; there is a process to triangulate any concerns with concerns received by the Trust both by theme and if the complainant shares their name the Trust is able to respond directly to the individual. From June 2023, the Independent NHS Complaints Advocacy Service in Liverpool is provided by Liverpool Advocacy Hub. Healthwatch have identified that whilst the number of informal PALS concerns has increased in 2023/24 this is also a positive marker of an open and listening organisation that has clear and accessible routes for families to raise a concern.

3. PALS informal concerns

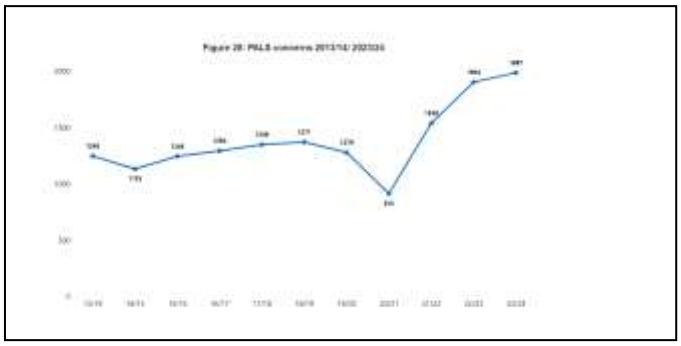
3.1 Number of informal PALS concerns received Q4 and full year 2022/23

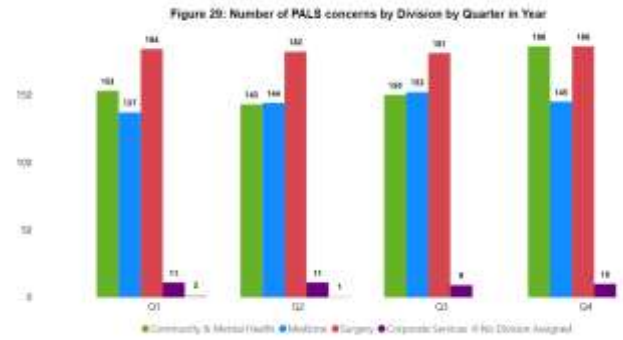
There were 527 informal concerns received during Q4; a significant increase from 492 reported in Q3 as shown in Figure 26. Figure 27 demonstrates the figure by month in year with 1987 informal PALS received. (It may be noted that the numbers may differ slightly from previous quarterly reports following data cleansing and deep dive)

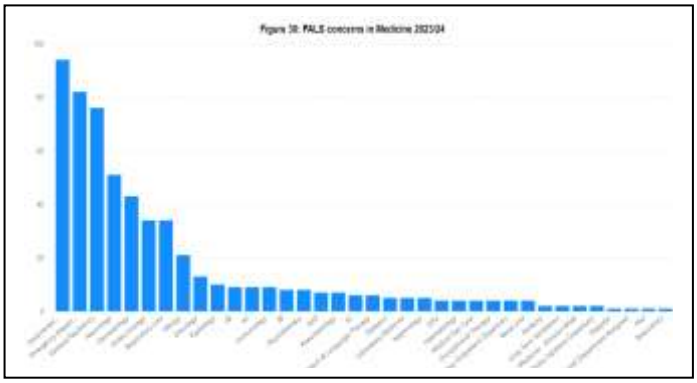


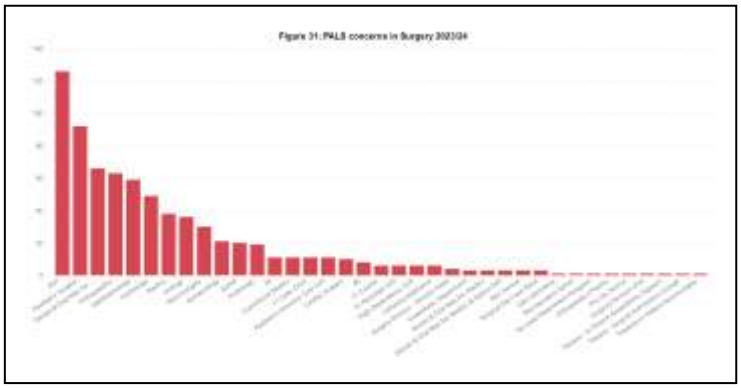


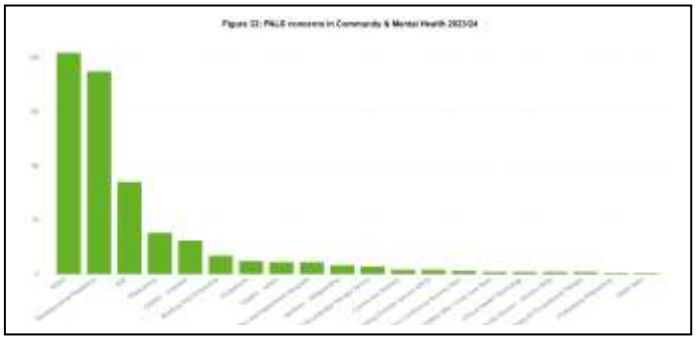
As shown in Figure 28, a total of 1987 PALS concerns raised is a continued annual increase post pandemic. The increase is understood to be partly associated with recovery following the pandemic and increased waiting times to time to see and treat patients
Figure 29 shows the breakdown of informal PALS concerns by Division by quarter and Figures 30-33 show by Divisional services

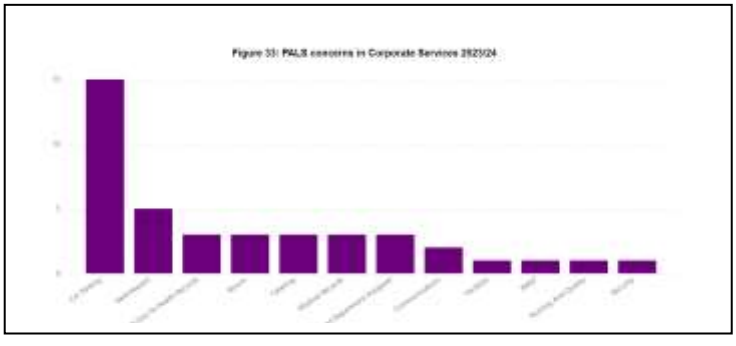












No informal PALS concerns have been received by the Clinical Research Division. The CRD have reviewed methods to collate feedback from families which best supports the needs of this patient group.

3.2 Informal PALS concerns received by category Q4 2023/24 and full year 2023/24

All informal PALS concerns are categorised by subject using the same system as formal complaints, which assists with data analysis and monitoring. The main issues raised within Q4 continue to relate to appointment waiting times, communication, and alleged failure in medical care as shown in Figure 34; this is consistent with the concerns that are raised as formal complaints and informal PALS concerns received in previous months in 2023/24 as demonstrated in Figures 35 and 36.

In February 2024 a deep dive into themes from concerns was conducted for the previous 5 years which demonstrated that the top three themes of appointment issues, communication and treatment and procedure have been consistently the highest themes as shown in Figure 36a; the deep dive provided greater insight into the main themes and issues within this category for focused improvement work at service, Divisional and Trust level.

Figure 34: Sub Categories of PALS concerns in Q4

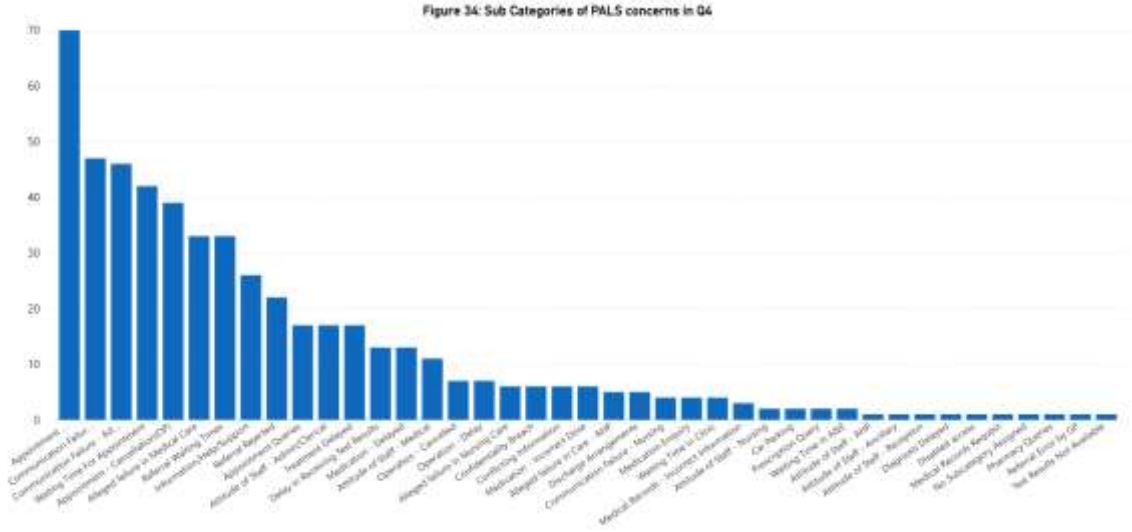
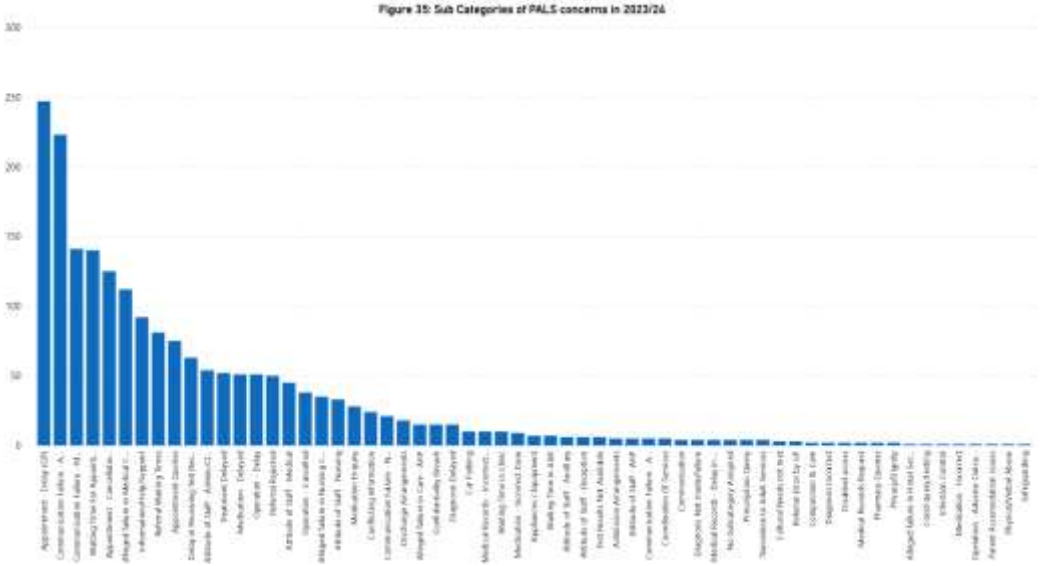
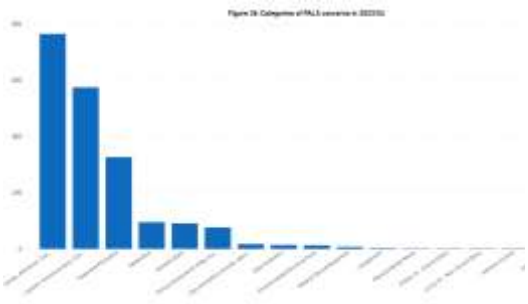
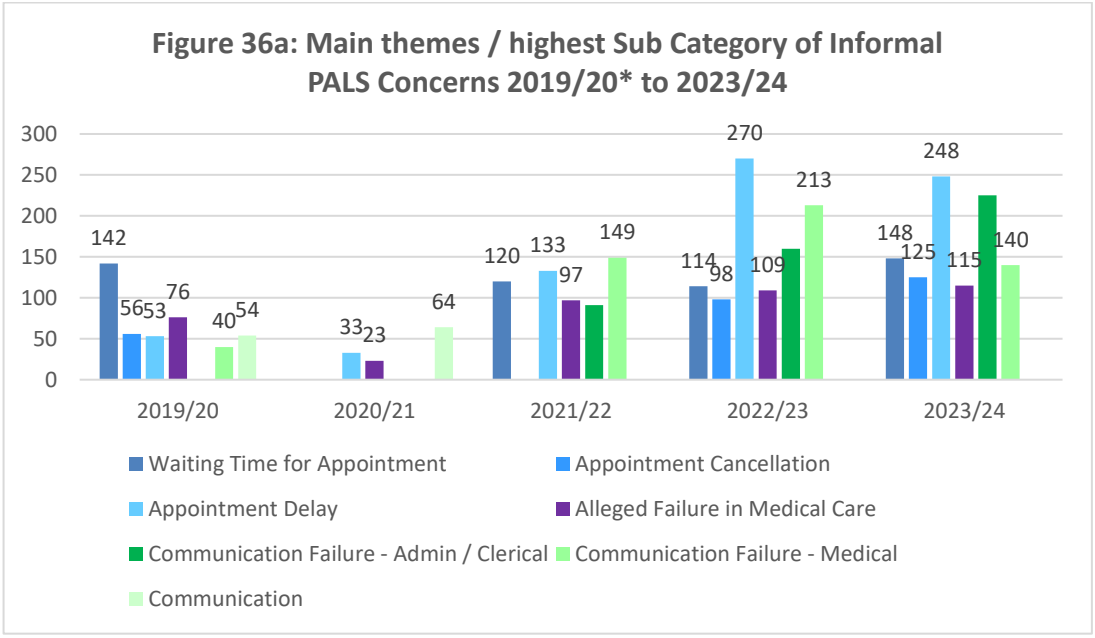


Figure 35: Sub Categories of PALS concerns in 2023/24





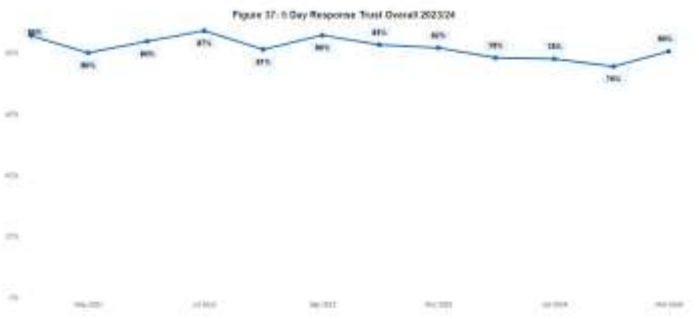


Please note: *The graph only includes data for 3 Quarters in 2019/20

3.3 Trust performance against Key Performance Indicators (KPI): compliance with 5-day response

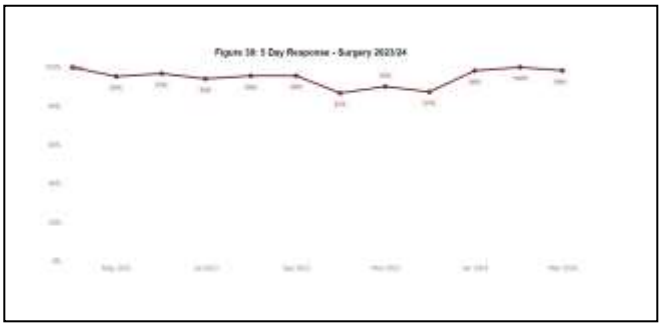
The standard to respond to informal PALS concerns is within a 5-day timeframe in order to provide a prompt resolution for children, young people and families. In Q4, 78% of PALS were resolved within 5 days. This is a sustained improvement in this standard this year as demonstrated in Figure 37 despite the increase in concerns received. This is testament to the hard work of all the teams involved and a clearly defined PALS process to work within.

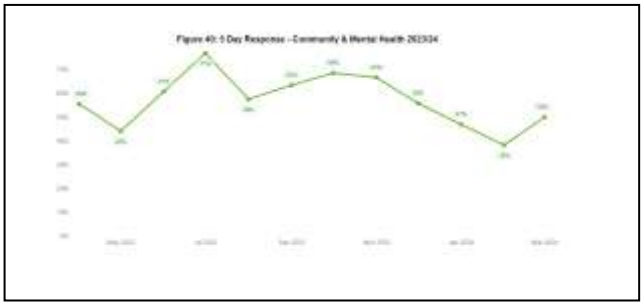
In 2023/24, 1596 of 1951 informal PALS concerns (82%) were responded to within 5 working days.

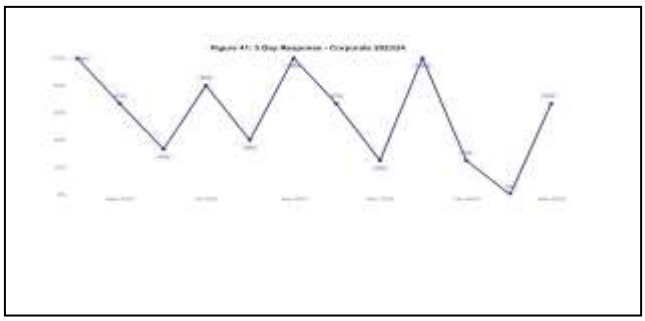


Compliance by Division in year is demonstrated in Figures 38-41 and is as follows:

- Medicine: 94% (542 of 577)
- Surgery: 95% (677 of 715)
- Community & Mental Health: 57% (354 of 619)
- Business Support: 58% (23 of 40)







Sustained improvement has been demonstrated in Division of Medicine and Division of Surgery who achieved 94% and 95% compliance respectively.

The Division of Community and Mental Health have reported high levels of PALS concentrated in Developmental Paediatrics / ADHD and ASD which has resulted in PALS exceeding the 5 working day response. A meeting has been held Chaired by the Associate Chief Nurse to look at ways to streamline, improve the process and increase compliance with the timeframe. The Division have invested in a new Support Secretary role in the Governance Team and this role will support in the processing and management of PALS. It is also reported that families often request that a PALS concern is left 'open' pending an action for example an appointment date.

Whilst the number of PALS concerns in Corporate Services is comparatively low the family with the concern should receive the same timely response therefore the process for managing these concerns has been reaffirmed with the PALS & Complaints Team

3.4 Actions and learning from informal PALS concerns

Themes and trends regarding informal PALS concerns are reviewed at the Divisional Integrated Governance meetings to ensure dissemination, learning and identification of local and strategic actions. Updates are shared by the Divisions at the Patient Experience and Engagement Group to ensure Trust wide learning.

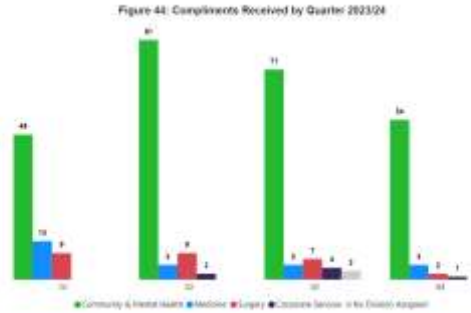
Examples of improvements made to services are:

- Significant action and learning related to concerns received regarding the national shortage of ADHD medication (on the Risk Register) that has impacted on capacity in both the Developmental Paediatrics and ADHD Teams. Regular safety huddles have taken place with key people including Pharmacy to agree actions to respond to the varying situation regarding shortages with different medications.
- An additional phone line for Developmental Paediatrics was purchased and designed due to the number of complaints received and incidents reported about how difficult it was to get through or how long family members said they had to wait, and statements that our staff were rude or unhelpful. The new system records calls so they can be reviewed, monitors how many calls are made, how long the caller waited before being answered, and how many dropped / disconnected calls there were.
- Improvements were undertaken in the Emergency Department waiting room following feedback via FFT, complaints, PALS and incidents. There was a consistent theme of poor communication as families not being kept informed of the waiting time, and poor patient experience during the wait as no refreshments available and no toys to play with. Improvements made included provision of a refreshment trolley, purchase of a tannoy system, update of the screens to ensure they display current waiting times, provision of toys in the waiting room and accessibility of sensory toys.
- The '5 Rights of Appointments' was established due to PALS concerns, appointment errors and data protection errors. The improvement work action plan developed includes training, creation of 'how to' guides, and amendments to meditech and medisec systems
- If an appointment is changed and two appointment letters have been sent out, the parent/carer will be contacted by telephone and informed of the correct day to attend. This should be documented on the system.
- An induction pack has been developed by the Division of Community and Mental Health including guidance points for staff on expectations regarding communication, values and behaviours
- Improved links between ADHD and CAMHS so that young poeople at greatest risk to themselves and others are fast tracked via consultation between the psychiatrist and the ADHD nurse led service
- Where possible when a parent has made a complaint we involve them in the improvement action- either by meeting with them to agree how we should move forward or ask them to consult on the change idea or review the final draft / action

4. Compliments in Q4

Compliments are an important measure of the quality of care, treatment and service the Trust delivers, providing powerful and valuable feedback about their experience. This feedback also provides important balance with concerns raised.

320 compliments were centrally recorded in year however it is acknowledged that the Trust receives many more compliments which have not been centrally recorded and Divisions are encouraged to submit.



Appendix I provides examples of compliments received during Q4.

5. Recommendations and proposed developments in the management of complaints and PALS

The Trust and Divisions will continue to drive improvements in response times to families for formal complaints and informal PALS concerns in 2024/25. However it is recognised that the importance of early intervention and a first contact resolution principle is key; this will ultimately lead to an increase in local concerns recorded (currently very low number reported in InPhase) with an aim to decrease informal PALS concerns and formal complaints.

i. Resource improvement of the PALS office to improve appearance, visibility, approachability and accessibility to facilitate local resolution. This is in line with the proposal for the new Wellness Hub

ii. Implement staff communication training which includes customer service training; in recognition that staff attitudes are a theme in formal complaints and informal PALS concerns

iii. Continue to work with the CYP Forum to encourage children and young people to share their concerns

iv. Divisions to review the current divisional governance process in place to ensure that going forward they consistently aggregate and triangulate the learning from formal complaints and informal PALS concerns, together with incidents, investigations, FFT and claims, to focus improvement work on what matters. Divisions to work together to adopt same and consistent approach

v. Review the digital option for aggregation and triangulation through InPhase including whether complainant is a child or young person, and protected characteristics such as ethnic background. This data would help identify any groups of individuals who are less likely to raise a concern and support the development of wider inclusive methods to report concerns

6. Conclusion

Trust Board of Directors are asked to note the content of this report and support the recommendations and proposed developments.

Appendix I: Examples of compliments Q4 2022/23

Medicine Division

Ward 4C / ED / EDU: *"My daughter was an inpatient for 6 nights. The care she received was exceptional and all staff involved in her care treated us as a family with the utmost respect and compassion"*

Ward 3C: Lovely feedback received from a family who's baby was an inpatient for 5 months. The family visited the ward with flowers and chocolates

Radiology: Mother and son said a huge thank you to the team after arriving late for an appointment. The team, including the reception staff went above and beyond to help them

Surgery Division

Ward 4A: On discharge patients parents asked me to pass on their gratitude for the excellent care that they had received. They said *"they couldn't have gotten through the night"* without it

Ophthalmology: *"After digesting the information that our newborn baby (patient name) had congenital cataracts and a rare duplicate cyst, we as first-time parents were both extremely anxious. In response to the cataracts, we were put in touch with RD and her team. From the very first phone call back in January to this day, we couldn't be more grateful for the care we've all received. RD was clear and informative about the next steps with (patient name) care and went to great lengths to answer all of our many questions and relieve some of the fear. We felt reassured by her passion and confidence in her work and also her positive and bubbly energy. Her Secretary, KF has also answered many of our anxiety fuelled phone calls and we are never made to feel a nuisance. She never fails to ask how we as parents are coping and never leaves us waiting long for a response to any of our questions either.*

(Patient name) operation was successful and he's making good progress. We visit the hospital regularly for check ups on (patient name) eyes and have been lucky enough to have the support of K also who is teaching us with great patience to put contact lenses on (patient name).

Although we will still be looked after by RD and her team for a few more years yet, we wanted to pass on our huge thanks and gratitude that we were lucky enough to be referred to her and the rest of the team!"

Cardiology: *"I trust this email finds you well. I am writing to express my profound appreciation for the exceptional care provided to my daughter, by MF to date and SK. Additionally, I wish to extend my heartfelt gratitude to MF for his unwavering commitment and recent visit to see daughter in Wigan.*

(Patient name) was diagnosed with PDA in 2023 by MF and it has been determined that her PDA is large with no sign of improvement. Drs have recommended she have surgery, and she is currently waiting for that surgery. This surgery can only take place at Alder Hey as this is the northwest facility that can undertake this surgery.

During our recent consultation on 14th March 2024, MF delivered an update on (patient name) heart condition. While her condition remains stable, it is disheartening to learn that there has been no marked improvement and her condition continues to worsen. I must commend MF for

his tireless efforts and the exemplary care he has extended to (patient name). His dedication to (patient name) well-being is truly commendable, and I believe it's essential to acknowledge his exceptional professionalism and compassion."

Community Division

Liverpool Fresh CAMHS: *"I'm hoping that you remember me otherwise this is going to be a bit awkward... It's (previous patient name), you were my CAMHS worker in 2022 and I did a course of IPT with you. I just wanted to send you a quick message to say hi & let you know how I am doing – I really hope that is OK with you! I now study Psychology at the University of Reading. I absolutely love my course and I am looking forward to my placement year where I'm hoping to be working in a mental health setting (!!!). I am now also a trainee volunteer for the crisis service Shout UK. Throughout my recovery, I have become so passionate about helping others like I was helped by professionals like you, and I'm really inspired by the prospect of turning my awful experience with depression into something good. When I look back on my time in CAMHS, I feel real gratitude for the support you gave me and just wanted to say thank you for that! If you remember, I had no people in my inner closeness circle when we were doing IPT. Even though I still sometimes struggle with relationships, I have gotten so much better at being open with the people around me. I have an amazing boyfriend who didn't run away when I told him about my mental health. I cry in front of my friends. I don't censor myself as much or try to make myself as unnoticeable as possible anymore. I can just say when I am feeling low without turning it into a joke (still guilty of that one on occasion...). Depression is something that I still struggle with daily and is a part of me that I think I will have to work on for the rest of my life, but I feel so much better and so much more supported now with the knowledge that I have the ability to open up to the people close to me. I hope all is well with you & that it's brightened up your Monday a bit to know that the work you do really does help young people. :)"*

Community Speech & Language Therapy Service: *"My son has recently finished working with Meredith for his speech. I just wanted to let you know how great Meredith has been with him. My son is 7 and from the first session she prioritised him and spoke directly to him and in a way that he could understand without being patronising (this is a great skill for kids of this ages). She quickly worked out the best way to work on the issue he was having and made all of his sessions fun but with the background learning implemented. (Patient's name) would always come out of these sessions with a smile on his face and his speech issue improving all of the time. He has now been discharged as he has improved so much so quickly and I have no doubt this is down to Meredith and the way in which she works. She is so good at her job and should be appreciated for the work she does and how she does it."*

ASD / Catkin: "*Recently was our first time visiting the Catkin Centre and we just wanted to let you know what a great experience we had and how grateful we are for that. We have visited Alder Hey several times in our daughter's 12 years and varying departments, we haven't ever had a positive experience before (apart from community appointments at Southport Centre for Health and Wellbeing which have always been good). Our daughter is autistic with a profile of Pathological Demand Avoidance, has sensory processing difficulties and is extremely anxious. In the past our visits have seen us having to visit the main hospital building and the main Outpatients department. The main hospital building and particularly the waiting room for Outpatients by the pharmacy have been a nightmare for my daughter with all the sensory input and how busy these areas are. These visits have always been stressful and caused distress*

for our daughter. However, yesterday's visit to the Catkin Centre couldn't have been more different. The fact that there is a separate, quiet car park (and free which is amazing for those of us on very tight incomes) and direct access to the department we were visiting was amazing. Then the building itself was so quiet and well laid out. The decor was friendly and inviting without being too overstimulating. The staff were friendly and helpful. For us as parents we found the whole experience seamless and that was much appreciated when arriving with a child who is highly anxious and dysregulated. Although our daughter was so anxious even she could appreciate later on in the day the more positive experience we had had. Thank you for creating this building and providing what children like mine need."

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	Infection Prevention & Control Quarterly Report Quarter 4, Jan – Mar 2024
Report of:	Infection Prevention & Control Team
Paper Prepared by:	Dr Beatriz Larru Director of Infection Prevention & Control

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

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
	See risks noted in Appendix 1 of the paper					
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Introduction

The purpose of this report is to provide the Trust Board with oversight of Infection Prevention Control (IPC) activity and reporting for the Q4 period (1st January-31st March 2024) ensuring the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

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

2. Infection Prevention & Control Department

During Q3, IPC committee received reports from the following subgroups.

2.1 Clinical Advisory Group: On 25.01.24, CAG discussed the national health incident declared due the surge in measles cases happening in West Midlands and London. The group discussed the lessons identified to support containment in secondary care and agreed with the ED representatives how to best triage, ensure IPC measures, contact tracing and protect vulnerable patients. *Action:* collaborate with the EPRR team to develop the Measles Infectious Diseases Plan & develop a new testing protocol to send measles PCR tests to LUHFT.

2.2 IPC Champions Group: On 30.01.24 and 27.02.24 the group meet to discuss the isolation and cleaning guidelines as well as the measles outbreak and recently published NHSE IPC Educational Framework. During QTR 4 we have launched the IPC champions newsletter and implemented the IPC month award. The group brought up several challenges like the lack of representation from all wards / areas in the IPC Champions Group and lack of reliable hand hygiene audit data. *Action:* Roll out of the Glove Smart Campaign in May 2024. Collaboration with the Antimicrobial Stewardship (AMS) team to comply with the IPC educational framework.

2.3 Antimicrobial Resistance Steering Group: On 18.01.24, 08.02.24 and 14.03.24 the group meet to discuss with AMR workstreams initiated to promote judicious use of antimicrobials across the Trust. The ongoing workstreams focus on 1) de-labelling penicillin allergies, 2) promote IV to PO administration of antimicrobials, 3) promote nursing role in AMS, 4) understand health inequities and antimicrobial resistance, 5) promote diagnostic stewardship by limiting unnecessary blood cultures in ICU, 6) understand behavioral change science in antibiotic prescribing and 7) surgical prophylaxis. *Action:* Codevelop a new Surgical

Prophylaxis guideline with General surgery to avoid unnecessary prologued use of antibiotics after clean-contaminated and contaminated surgeries.

2.4 Hand Hygiene Improvement Group: no meeting held in Q4 but work on going meetings with Innovation team (14.03.24) to move forward automatic methods of monitoring hand hygiene compliance to effectively promote behavioral change through auditing results.

2.5 Environmental Cleanliness Group: On 30.01.24 and 26.02.24, the discussion centred around roles and responsibilities for cleaning & decontamination of frequently used items. Action: SharePoint page developed with instructions for cleaning and decontamination of items, in accordance with the National Standards of Healthcare Cleanliness 2021. On 26.03.24 the group continued to discuss how to best implement Hospital Cleaning policy RM49 across the Trust and need for a new system for cleaning audits. Action: new electronic auditing system being procured.

2.7 High Consequences Infection Diseases (HCID Steering Group): On 18.01.24 the group meet with representation of regional EPRR leads and airborne HCID national network to provide an update on the 3C and ICU building works and the training simulation schedule planned for the Trust to became accredited as an airborne HCID centre. Action: agree on a remediation strategy for the waste management and counter-terrorism visits recommendations.

2.8 Sharp Safety Group: no meetings held in Q4 as there are still ongoing discussions with Health & Safety about appropriate leadership for this operational group.

3. Infection Prevention & Control Metrics

3.1 Bacteraemia Surveillance

3.1.1 Healthcare-associated Gram-negative Bloodstream Infections

A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA (UK Health Security Agency) is shown below in Table-1. During Q4, 5 patients had healthcare-associated Gram-negative blood stream infections. Cases were identified in surgery (2), Critical care (1), Oncology (1) and General Paediatrics (1).

The post-infection reviews (PIR) of these cases identified previous antibiotic exposure, critical illness, and significant patient comorbidities as predisposing factors, which are well known high-risk factors for Gram-negative blood stream infections.

All of these patients had central vascular catheters in place when they developed bacteraemia so the workplan to reduce Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)) across the Trust has continued during Q4, with a closer collaboration between IPC and the Microbiology laboratory to include in our PIR all significant

blood stream infections (not just those subject to mandatory UKHSA reporting such as *E. coli, Pseudomonas* or *Klebsiella*) to engage with all stakeholders in the development of the CLABSI steering group.

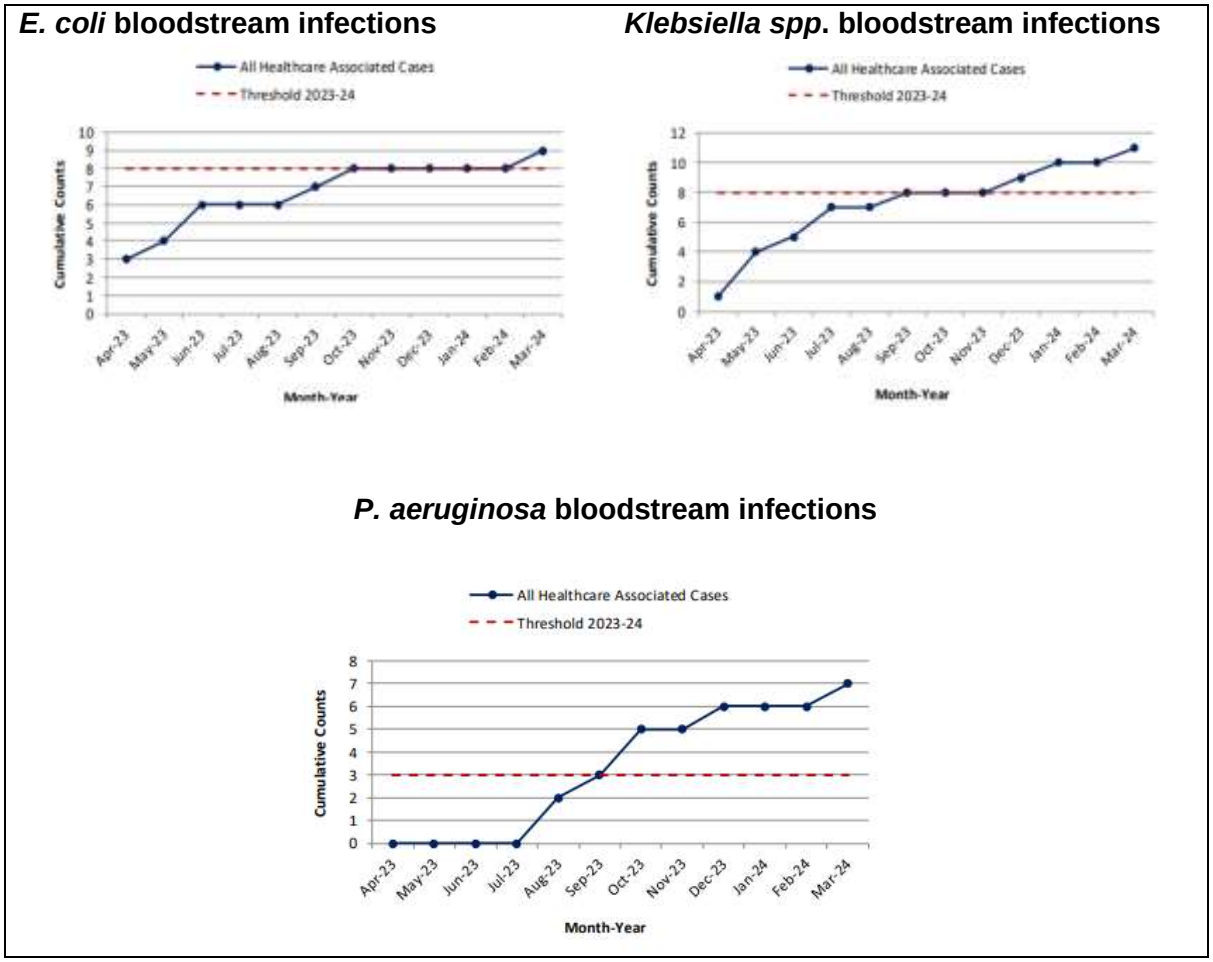
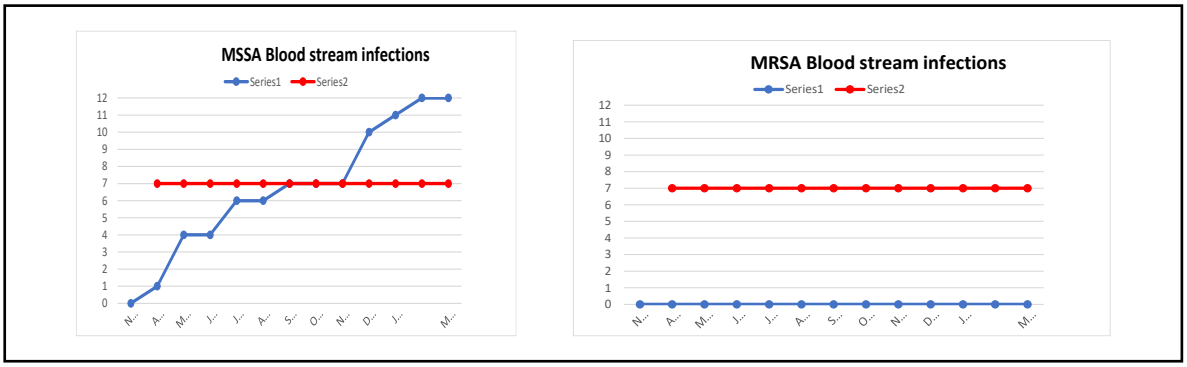


Table-1: UKHSA HAIs monthly tables for Gram-negative bloodstream infections.

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

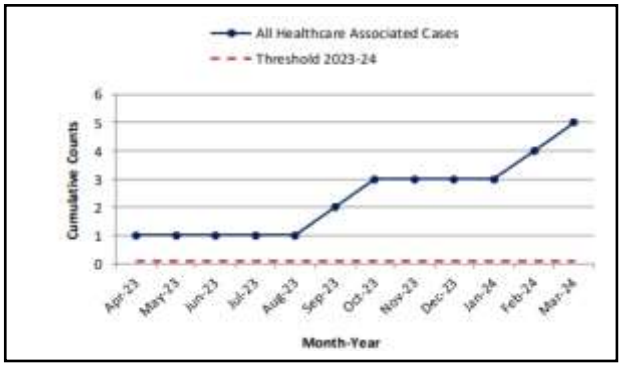
3.1.2 Healthcare-associated *Staphylococcus aureus* bloodstream infections



During Q4, 3 patients had healthcare associated MSSA blood stream infections: 1 was admitted in the cardiac ward, 1 in the neurosurgical ward and 1 in PICU.

The post-infection reviews (PIR) of 2 of these patients identified that they were colonised with *S. aureus* prior to cardiac surgery and did not underwent decolonisation treatment. While no national guidelines mandates screening for MSSA (as opposed to MRSA), most surgical site infections occur due to endogenous patient flora (*i.e.,* bacteria that colonises patients prior to the surgery and enter the body when cutting into skin). The neurosurgical team at present, are the only surgical team that include MSSA screening prior to surgery *Action:* develop a pre-screening policy that includes MSSA for cardiac surgery and orthopaedic surgery with implants, following the model used for neurosurgical patients.

3.1.3 *C. difficile* Infection



During QTR 4 there were 3 healthcare associated Clostridium difficile infections identified. Two were from Oncology and one from General surgery. PIR for the cases identified that there were no identified lapses in care, all cases were long-term/ regular hospital attenders, and all had exposure to multiple antibiotic treatment.

Since Jan24, UKHSA has alerted of a sharp increase in *C. difficile* cases across the UK, for which there is not a clear explanation. The North West is the third area worst affected.

As a response to this increase, we have recently updated our *C. difficile* policy and are working closely with the NHSE Efficiency at Scale IPC Collaboration Group.

3.2 Healthcare acquired viral infections.

3.2.1 Respiratory viral infections

During Q4, we continued to see that a large proportion out of the positive respiratory viral tests analyzed in the microbiology laboratory, were obtained on patients admitted for longer than 3 days (*i.e*., viral healthcare acquired infection). We report these rates to the ED team to ensure appropriate use of diagnostic resources across the Trust.

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

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

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

3.2.2 Gastrointestinal viral infections

During Q4, there was 1 outbreak of *Norovirus* on 3A affecting 6 patients (staff, visitors) actions were put into place and outbreak meetings held with all actions being reviewed daily in line with the Norovirus checklist. There was a cluster of Astrovirus infections (2) on 3B in March 2024.

3.3 Other Notable Infections

3.3.1 Group A *Streptococcus*

No cases of healthcare associated Group A *Streptococcus* were identified during Q4 23/24.

3.3.2 Measles

There were 3 positive measles cases reported during Q4 23/24. They were all found to be vaccine related. There was an increase in patients presenting to ED with suspected Measles requiring contact tracing (24 cases Jan-March 2024). The IPC department and DIPC closely collaborated with Liverpool City Council, NHSE and UKHSA to develop a collaborative approach to enhance MMR vaccination rates in the community and increase awareness of healthcare workers to promptly recognise measles cases.

4. Infection Prevention & Control Associated Risks

See Appendix 1 at the end of report.

5. Discussion and next steps

During Q4, the IPC department has continued to maintain their increase visibility across the Trust through daily isolation ward rounds a monthly steering group meetings despite significant staff sickness abscess in the Team with only two infection preventionist and one project coordinator actively working alongside the DIPC and deputy director of AHP for the majority of Q4. Despite this significant challenge, the IPC team was able to perform its daily activities and actively participate in the response to the measles outbreak incident in the Trust and Liverpool City Council.

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

Funding of ICNet has been secured with plans for implementation in the new financial year. Risks remain largely unchanged due staff absence and the priority on clinical care and safety.

6. Recommendations

The Trust Board is asked to note the content of this report, the actions being taken to ensure the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice and note that the IPC service continues to struggle due significant staffing challenges.

Appendix 1: Infection Prevention & Control associated Risks

Risk Number InPhase ID	Ulysses ID	Risk Description	Initial Risk score	Target risk score	Risk score Q4 23/24	Risk movement	Mitigations in place Q4
00002754	2788	Non-compliant with FIT testing for clinical staff in scope Risk transferred to the Division of medicine and Infectious Diseases on the 21.2.2024	12	2	12	⟷	Medicine Division action in Q4 are prioritising the capture of accurate data in view of commissioning as a centre to care for children with High Consequences Infectious Diseases.
00002713	2747	Inability to maintain IPC standards due to limited availability of curtains and lack of timely response to the rapid cleaning pathway Risk transferred to the Associate Chief Operating Officer, Corporate Services and Head of Facilities	9	4	9	⟷	The Business case has now been completed and awaiting approval.
00002714	2748	IPC Policies are not up to date and not reflective of current IPC practice	9	4	6	↓	The recovery plan remains in place and on track. Remaining policies are due for presentation at IPCC in May and SQAC for ratification.
00002715	2749	Lack of advanced data skills within the IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data	12	3	12	⟷	Funding secured for ICNet. Action closed. New action for the implementation of ICNet will take some months, no change to score at present until implementation commences.

00002710	2744	Non delivery of IPC standards due to insufficient IPC staffing levels	12	6	12	⟷	Significant staffing challenges remain, 2 band 6 IPC practitioners leaving mi May 2024. Lead Nurse to resume on phased return following long term absence in April 2024. Recruitment in place. Clinical oversight of remaining staff and processes by DIPC ensures safe service. Prioritization of work and streamlining of processes by DIPC and DD of AHPs (Allied Health Professionals) remains in place.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement
Report of:	GMC Appraisal and Revalidation Compliance and Assurance
Paper Prepared by:	Helen Blackburn, Appraisal and Revalidation Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☑ **Pioneering** breakthroughs ☐
Resource Implications:	N/A

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

0175						
Level of assurance (as defined against the risk in In Phase)	☑	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Remember to:

- *Keep your report risk focussed remembering the Board/Committee's strategic assurance role & core purpose.*
- *Keep reports **as short as possible** highlighting key issues.*
- *Make yourself aware of cut off points for submission of papers - late papers will not be accepted by Committee Chairs*
- *Ensure reports give a clear direction as to the required outcome e.g., approve X or decide between options A and B*

1. Executive Summary

The Annual Submission has been requested by the Medical Directorate Professional Standards team, NHSE North West. It is to provide assurance that the Trust is managing appraisals for clinicians, ensuring that they have access to appropriate resources and support. The attached report details the activity for 2023-2024 and highlights future plans.

2. Background and current state

The Appraisal and revalidation regulations have been in place since 2012. The GMC has published a revised edition of Good Medical Practice, and this will influence future appraisals, the domains have been updated to include:

- create respectful, fair and compassionate workplaces for colleagues and patients
- promote patient centred care
- tackle discrimination
- champion fair and inclusive leadership
- support continuity of care and safe delegation.

The Responsible Officer's Advisory Group, comprising of the RO, Appraisal Lead, Appraisal and Revalidation manager and Medical Staffing manager meets on a bi-

0176 monthly basis, the group reviews revalidation recommendations, ensures that the evidence provided by clinicians meets GMC requirements. Clinical staff are required to undertake an annual appraisal, the revalidation cycle is five years long. They also collect colleague and patient feedback within each cycle, to provide assurance for continued practice. The Trust purchased L2P to manage appraisals and multi-source feedback.

3. Main body of report

There are four sections contained within the report:

Section 1 – Qualitative narrative

Relates to processes and record management. We subscribe to L2P to record and manage all appraisals and multi-source feedback.

Section 2 – Metrics

Total number of appraisals completed	330
Total number of appraisals approved missed	67*
Total number of unapproved missed	5

- The clinical fellow posts fall across two appraisal years. Although they are recorded as approved missed, they are not due to be appraised until the next appraisal cycle.

Section 3 – Summary and Conclusion

A Higher HLRO meeting was held 1st June, the meeting was successful, and no issues identified, and feedback was positive. We have had a successful year and aim to review processes to ensure that they are more robust and effective to aid the appraisers and appraisees.
The implementation of coaching techniques to support appraisers has received excellent feedback.
The five appraisals that have an outcome three of these four missed the GMC permitted timeline but have been completed.
The one appraisal that is outstanding has been reviewed and an action plan has been implemented following correspondence between the Consultant and the RO.

The annual submission is for compliance and assurance as required by the Medical Directorate and Professional Standards Team. The information contained within the attached report reflects how we manage appraisals and how we intend to support clinicians to undertake their appraisals.

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Alder Hey Children's NHS Foundation Trust
What type of services does your organisation provide?	Acute

	Name	**Contact Information**
Responsible Officer	Mr Alfie Bass	Alfie.bass@alderhey.nhs.uk
Medical Director	Mr Alfie Bass	Alfie.bass@alderhey.nhs.uk
Medical Appraisal Lead	Dr Zahabiyah Bassi	Zahabiyah.Bassi@alderhey.nhs.uk
Appraisal and Revalidation Manager	Helen Blackburn	Helen.blackburn@alderhey.nhs.uk
Additional Useful Contacts	Carol Pickup	appraisallead@alderhey.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

~~**Yes**~~**/ No**

If yes, who is this with?

Organisation: **Please describe arrangements for Responsible Officer to report to the Board:** **Date of last RO report to the Board:** **Action for next year:**

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative Section
2 – Metrics
Section 3 – Summary and conclusion
Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of

Alder Hey Children's NHS FT

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	N/A
Comments:	Mr Bass continues in his role as RO
Action for next year:	N/A

1A(ii) Our organisation provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	We have a dedicated appraisal team. Consultant Appraisal Lead, Appraisal and Revalidation Manager and Administrator
Comments:	We continue to use L2P to manage the appraisals and MSF reports to support revalidation submissions.
Action for next year:	Renew the contract for L2P to ensure continuity and governance for the management of appraisals.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	To maintain an accurate record of Drs who are connected to Alder Hey.
Comments:	We use the Trust's staff in post data, new starters list, and the GMC register to manage the Dr's who have a connection to Alder Hey.
Action for next year:	To continue to monitor all Dr's associated with the Trust.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	To monitor the Medical Revalidation and Appraisal policy.
Comments:	The policy is due to be reviewed and updated before the end of July. It will be ratified by the People and Wellbeing Committee.
Action for next year:	Publish updated policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Local discussions were held with Trusts of a similar size and specialty to ascertain if a peer review could be undertaken.
Comments:	The Trusts are agreeable, and plans are underway to implement a peer review.
Action for next year:	Complete the peer review and implement outcomes from the review.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Yes, we contact all Drs who work in the Trust to ascertain the most effective way to support their needs.
Comments:	The process has been effective, however there has been some issues with some overseas Drs who are new to the NHS. We now arrange face to face meetings to offer support and provide extra appraisal training if required.
Action for next year	Continue to arrange face to face meetings and provide support.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	All Drs who had a connection to Alder Hey undertook relevant appraisals and MSF.
Comments:	All Drs are given access to L2P to manage their appraisals.
Action for next year:	Continue to use L2P and provide training updates to ensure that all appraisals meet GMC requirements.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	If appraisals are not undertaken individuals are contacted and support is provided. The ROAG meetings are used to discuss issues regarding individuals and action plans are drawn up.
Comments:	There are relatively few Drs who do not manage to complete their appraisals. When this occurs, we provide support as required. Regular meetings with the GMC Liaison officer to discuss concerns or issues.
Action for next year:	Action will be taken as required and support provided, as necessary.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	The Medical Appraisal and Revalidation policy was received by the People and Wellbeing Committee in 2021.
Comments:	The policy will be reviewed and updated for approval in July 2024.
Action for next year:	Disseminate the policy.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	We have sufficient appraisers to undertake the number of appraisals required. We also provide training for new appraisers to replace those who retire or relinquish their roles.
Comments:	The training took place May 2023, and seven new appraisers completed the course.
Action for next year:	Host another course to train appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	Two courses were held to provide appraisers with updated information, they also included a coaching session.
Comments:	The courses were well attended, they are very inter-active and give appraisers the opportunity to discuss issues that they have found during appraisals.
Action for next year:	Arrange update sessions to ensure that new information is cascaded and allow appraisers to provide feedback and network with this peer group.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	The appraisal updates are reported to the Board via the Integrated performance report.
Comments:	We send monthly updates of compliance to each division and to the clinical directors.
Action for next year:	Follow same processes.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	ROAG meetings are used to discuss recommendations and identify staff who require extra time or support before submissions are made.
Comments:	We monitor all Dr's under notice to ensure that they have the required appraisals and MSF to allow submission.
Action for next year:	ROAG meetings have been diarised and all submissions are recorded locally.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	
Comments:	We contact Drs who we are unable to submit a recommendation based upon the information that we have collated, and they have provided. We advise them of deferral time and what they need to complete before submission.
Action for next year:	Inform Drs that we have submitted their revalidation recommendation. If a deferral is to be implemented the Dr would be advised and reasons would be recorded.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	
Comments:	The Trust holds a weekly Patient Safety meeting. All divisions have robust governance infrastructure and Leads report back to Trust board. Appraisal information is sent to governance teams quarterly for action and information.
Action for next year:	

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Local Governance meetings and Maintaining High Professional Standards (MHPS) – monthly meeting. Membership includes Chief Medical Officer, Divisional Directors, Chief People Officer, Dir. Corp Affairs and HR Business Partners. All formal cases and any concerns discussed and monitored. Escalated to GMC if required.
Comments:	See above
Action for next year:	

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	
Comments:	Drs are able to access relevant information to upload to their appraisal submissions.
Action for next year:	Work with IT dept to capture information in one place for each Dr.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	.
Comments:	Maintaining High Professional Standards (MHPS) – monthly meeting. Membership includes Chief Medical Officer, Divisional Directors, Chief People Officer, Dir. Corp Affairs and HR Business Partners. All formal cases and any concerns discussed and monitored. Escalated to GMC if required. All cases have Executive and HR oversight. Formal cases have a nominated Non-Executive Director to ensure that processes are adhered to. Employees are all treated with respect and compassion in line with our Trust values and HANDLING CONCERNS ABOUT CONDUCT, PERFORMANCE & HEALTH OF MEDICAL & DENTAL STAFF POLICY.
Action for next year:	The policy will be reviewed and updated in June 2024.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type, and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	
Comments:	A quarterly report is provided to the private business section of the Board of Directors meeting detailing the latest position with regard to all employee relations issues including disciplinary cases relating to medical staff.

Action for next year:	N/A

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	The TOI requests are completed by the Revalidation Manager, shared with requesting Trust within 3 days of receipt. We communicate via email or telephone as required.
Comments:	TOI requests are escalated to the RO if concerns have been raised.
Action for next year:	Current practice will continue.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	
Comments:	There are processes in place to ensure that clinical governance concerns are managed within the Trust's policies. The ROAG group meets to review cases, the group members are the Responsible Officer, Appraisal Lead, Revalidation Manager and Medical Staffing Manager.
Action for next year:	

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports, and enquiries, and integrate these into the organisation's policies, procedures, and culture (give example(s) where possible).

Action from last year:	
Comments:	We source information from a variety of platforms, including NHSE, GMC, NHS Confederation. We also use network meetings and various journals and databases to inform changes to development requirements. Organised grand Round and regular training for updates. Regular communications are sent to all appraisers and appraisees.
Action for next year:	Deliver the new extended consultant induction programme.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	
Comments:	The People and Wellbeing Committee (PAWC) overseas the professional standards of staff within the trust.
Action for next year:	

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	
Comments:	The recruitment process is managed by the wider HR team and Clinical Directors. The processes follow national guidelines to ensure that all pre-employment checks are undertaken before employment contracts are issued.
Action for next year:	

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	
Comments:	The Trust has a dedicated organisational development team, they have developed many programmes to support staff within the Trust. They include Thriving Leaders programme to support/enable staff to perform well in their roles.

Action for next year:	Monitor numbers of staff who attend courses.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity, and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	
Comments:	We reflect the vision of the Trust through our Values. Innovation, Excellence, Openness, Respect, Together. All staff are also required to undertake EDI training.
Action for next year:	

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	
Comments:	The Trust has a values and behaviors framework it is embedded in activity and training for all staff. FTSU Guardian attends meetings within Divisions and her role and contact details are available on the Intranet.
Action for next year:	

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	
Comments:	The Trust has a robust governance process and the policy, HANDLING CONCERNS ABOUT CONDUCT, PERFORMANCE & HEALTH OF MEDICAL & DENTAL STAFF POLICY. There are various groups who meet to monitor standards.
Action for next year:	

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	
Comments:	The Trust has a strong culture of EDI and does monitor levels of parity.
Action for next year:	Liaise with HR for data collection.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher- level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	
Comments:	We have various local networks with organisations whom we benchmark our standards and intend to hold a peer review this year. We also follow guidance from HLRO.
Action for next year:	

Section 2 – metrics

Year covered by this report and statement: 1 April 24 31 March 24

All data points are in reference to this period unless stated otherwise. 2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	402

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	330
Total number of appraisals approved missed	67
Total number of unapproved missed	5

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	69
Total number of late recommendations	2
Total number of positive recommendations	56
Total number of deferrals made	15
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	22
Total number of trained case managers	5
Total number of new concerns registered	5

Total number of concerns processes completed	5

Longest duration of concerns process of those open on 31 March	11 months

Median duration of concerns processes closed	5 months
Total number of doctors excluded/suspended	2
Total number of doctors referred to GMC	1

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	87
Number of new employment checks completed before commencement of employment	87

2F – Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Higher HLRO meeting was held 1st June, the meeting was successful, and no issues identified, and feedback was very positive.
Actions still outstanding
Peer review
Current issues
To reduce the outcome three numbers by moving March appraisals to February. This will provide us with a buffer zone to ensure that all appraisals are completed before 31st March. Discussions will take place to review patient feedback and identify a better data collection method.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Move appraisals to February to ensure compliance. Renew the contract for L2P to ensure continuity and governance for the management of appraisals. Complete the peer review and implement outcomes from the review. Continue to arrange face to face meetings and provide support. Continue to use L2P and provide training updates to ensure that all appraisals meet GMC requirements. Action will be taken as required and support provided, as necessary. Host another course to train appraisers. Arrange update sessions to ensure that new information is cascaded and allow appraisers to provide feedback and network with this peer group. Work with IT dept to capture information in one place for each Dr. ROAG meetings have been diarised and all submissions are recorded locally. The policy will be reviewed and updated in June 2024.

Deliver the new extended consultant induction programme.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges, and aspirations for the coming year):
We have had a successful year and aim to tighten processes to aid the appraisers and appraisees. The implementation of coaching techniques to support appraisers has received excellent feedback. The five appraisals that have an outcome three of these four missed the GMC permitted timeline but have been completed. The one appraisal that is outstanding has been reviewed and an action plan has been implemented following correspondence between the Consultant and the RO.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body.

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	

Name:	
Role:	
Signed:	
Date:	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 6th June 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 22nd May 2024, along with the approved minutes from the 24th April 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

0198 **1. Executive Summary**

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

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

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

- SQAC received the positive Patient Safety Strategy update. SQAC was pleased to note the clear progress and good documentation on the workstreams scrutinised in month.
- SQAC received the Patient Safety Annual Report 2023/24
- SQAC received the Patient Safety Programme Board Terms of Reference and workplan for 2024/25
- SQAC received the ED monthly report, ED@ its best update
- SQAC received the EPRR quarterly update; really informative discussion were held regarding emergency preparations and resilience, with thoughtful questions, queries and responses regarding how learning is shared. **Agreed** that the Trust should undertake Major Incident exercises, without waiting until the paperwork review is complete.
- SQAC received the Board Assurance Framework
- SQAC received the Risk appetite/tolerances presentation and held a good discussion regarding the Risk appetite on key risks. SQAC agreed the proposed scheme was a good foundation, and there was broad agreement from SQAC to set a different risk appetite for safety and quality.
- SQAC received the Quarter 4: Year End 2022/24 Complaints, PALS & Compliments Report
- SQAC received the Patient & Family Quarterly Report
- SQAC received the Quarter 4: Children & Young People Engagement Leads Report
- SQAC received the Clinical Effectiveness & Outcomes Group Annual Report 2023/24
- SQAC received, NOTED and approved the Draft Quality Account
- SQAC received the CQUIN 2023/24: Quarter 4/Year End Report
- SQAC received the Liverpool Neonatal Partnership Integrated Governance Report and would continue to receive this report on a monthly basis. Good discussion was held. SQAC NOTED this new report was work in progress, and recognised that there are going to be some challenges working across two organisations with different approaches to risk and audit. A key challenge for the service is how to aligning the two approaches and create a single culture which is effective in the safety and quality domains.
- SQAC received the Divisional updates and a Deep Dive into the correlation of waiting times for Friends & Family tests
- SQAC received the Clinical Audit Annual Report 2023/24
- SQAC received the Tendable Standard Operational Procedure

4. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 24th April 2024
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Kerry Byrne	Non-Executive Director	(KB)
	Nathan Askew	Chief Nursing, AHP & Experience Officer, Chair (ACCN)	(NA)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Clare Ellis	Head of Operations – Laboratory Medicine	(CE)
	John Grinnell	Managing Director/Chief Financial Officer	(JG)
	Gerald Meehan	Non Executive Director	(GM)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RH)
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	(JP)
	Laura Rad	Head of Nursing - Research	(LR)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Paul Sanderson	Chief Pharmacist	(PS)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Office	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)

In Attendance:

24/25/05	Will Weston	Medical Services Director	(WW)
24/25/07	Kim Hewitson	Sepsis Nurse Specialist	(KH)
24/25/07	David Porter	Consultant Infection & Immunology, Sepsis Lead	(DP)
24/25/17	Dan Hawcutt	Director of Research	(DH)
24/24/19 & 20	Anthony Caseberry	Decontamination Lead	(AC)
	Natalie Palin	Director of Transformation and Change	(NP)
	Ian Gilbertson	Deputy Chief Digital and Information Officer	(IG)
	Jill Preece	Governance Manager	(JPr)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)

Apologies:	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Lisa Cooper	Divisional Director – Community & Mental Health Services	(LC)
	Bea Larru	Director, Infection Prevention & Control	(BL)

24/25/01 Welcome and Apologies

The Chair welcomed everyone to the meeting and introduced Gerald Meehan, to his first SQAC meeting. Gerald had recently joined Alder Hey as a Non-Executive Director and will be a member of SQAC. Gerald is also a Vice Chair/Non Executive Director at Wirral Community & Health Care Trust a position Gerald has held for the last 5 years.

24/25/02 Declarations of Interest

GM is a Non Executive Director/Vice Chair at Wirral Community Healthcare Trust and is also the Chair of the Improvement Board for Children's Services for Liverpool City Council, which is multi agency.

24/25/03 Minutes of the Previous Meeting

The Committee members were content to APPROVE the notes of the meeting held on 20th March 2024.

24/25/04 Matters Arising/Review of Action log

The action log was reviewed and updated.

Assurance on Key Risks

24/25/05 *Delivery of Outstanding Care*
Safe

Patient Safety Strategy update
WW presented the Patient Safety Strategy update

- Patient Safety Strategy Board had applied careful scrutiny to workstreams 6, 8, 10, 11 and 23.
- Safety metric workstream 1, the reporting of incidents had maintained the same level, there had also been a welcome and statistically significant downward trend in the incidents of harm per 1,000 bed days since December 2023.
- Negligence and litigation – the nonclinical claims infographic was completed.
- In addition to the negligence and litigation learning opportunities the Education and training workstream had made significant progress, training had been delivered in PICU, as part of the wider pilot on Civility Psychological Safety in Human Factors. Consequence UK an expert national provider of patient safety and investigatory courses had been commissioned for May and June this year, with the leads from across the organisation signing up.
- Workstream 10-Implement PSIRF - the weekly PSIRF meetings continue to review moderate harms and above, the themes are presented at the weekly Patient Safety meeting.
- There was unanimous agreement at the last Patient Safety Strategy Board to move forward with a staff safety culture workstream which recognises the interlinkage between patient safety and staff safety and would focus on Civility, psychological safety and just restorative learning and culture.
- Workstream 23 - Unacknowledged notices – MN presented a comprehensive update to SQAC at March 2024 meeting, which highlighted focussed intervention from divisional leads where required with further advances in the analysis and visibility of data.
- SQAC noted good progress made in month, and **NOTED** the key theme regarding learning across a number of workstreams in terms of the offer available to staff.

FB alluded to the 2 band 8A investigation leads and queried whether these leads would help others to undertake investigations, provide tools advice and guidance or whether they would take a lead. FB also sought clarity regarding how this is embedded culturally. WW advised that these individuals would be leading on investigations, however they would require the input from various colleagues across the organisation, especially those experts in their particular fields. WW confirmed that these two posts are currently out to advert.
FB expressed her thanks to WW for comprehensive report.

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

24/25/06 **ED MH monthly report: MH attendances and ED@its Best**
CW presented the ED MH attendances and ED@its Best update
CW advised SQAC of the revised approach of the report. The dataset had been expanded with the aim of providing an overview of three key services which contribute to the delivery of urgent and emergency care - Urgent treatment centre, Emergency Department and the Paediatric Assessment Unit.

- ED had achieved all targets within Quarter 4.
- Achieved 81.7% against the four hour target and 90% of ambulance handover times were completed within 30 minutes.
- Urgent treatment centre – during March 70% of the urgent treatment centre capacity was utilised, 30 children/young people returned to ED for further treatment (1.3%) which is extremely low. CW advised that there is a requirement for focus on improving the utilisation.
- Emergency Department – 84% of children and young people were treated, admitted or discharged within 4 hours of attendance this is 8% above the national standard.
- 4 children/young people had waited for more than 12 hours in ED, which is the lowest number since June 2023, these were children with socially complex situations.
- Median time to triage in March 2024 was 20 minutes, which is 5 minutes above the national standard of 15 minutes, colleagues had seen an increase in this over the last 3 months, there is a deep dive presently underway regarding median time to triage to establish the timeframes when the department is most challenged.

- Hotspot for improvement include Mondays and particularly Monday afternoons, and daily between 3.00-10.00. Next steps are to review how staffing is best realigned to reduce triage times and waits.
- Median time for clinical assessment in March 2024 was 89 minutes and 19 minutes higher than the national standard of 60 minutes. The heatmap clearly shows the need for improvement in the afternoon/going into the night shift. CW stated that there is a need for a full review of all staffing, particularly medical staffing, the heatmap showing a real difference between activity on a Monday and Friday in performance, with ongoing focus over the coming months.
- There had been a slight increase in friends and family test results, colleagues had anticipated this would be higher due to the reduced number of attendances in March, a deep dive into the correlation of waiting times for Friends and Family test results is being presented to SQAC at May 2024 SQAC meeting.
- 92% of Children & Young People presented within a mental health concern and were seen within crisis care, admissions had steadily declined over the last 3 month period, 2 cases related to eating disorders and 7 cases related to an overdose, with 1 patient admitted out of the area.
- PAU admission and discharge analysis was presented.

FB welcomed the new format of the report which contained informative information. FB stated that it is early days for the PAU, with more to do to understand how PAU is working. FB alluded to next steps regarding data and reporting, i.e. clarity regarding patient discharge. FB queried how colleagues would know if PAU is really adding value. FB sought clarity from CW regarding what useful further developments should be included in future reports. CW stated that the PAU information needed to be provided in greater detail. CW stated that PAU details would be provided in future reports, acknowledging FB comments with the aim of including this in the May update to SQAC. FB stated that there is a need to effectively capture the data and categorise as appropriate.

JG stated that the report is excellent, and it is evidence based. JG stated that there are potentially some flow points and a move to aligning staffing resources to provide the correct staffing.

JG alluded to what SQAC may see in the report over the coming months. CW stated that from review of the heat maps, colleagues could clearly see the busiest times when colleagues had reviewed the staffing for medical and nursing.

NA acknowledged how well the urgent care pathways are performing particularly against the national picture, and congratulated colleagues on the ongoing achievements.

FB echoed NA comments.

Resolved: SQAC received and **NOTED** the ED monthly update report: MH attendances and ED@its Best update, SQAC noted the strong ED performance and welcomed the improved report.

24/25/07 Sepsis update

DP presented the Sepsis update

- Inpatient Antibiotics <60 minutes, the Trust had maintained a level of above 90% target since 2022. There had been a decrease over the last few months, with the last quarterly figures closer to the 90% threshold. At present there is no obvious significant trend in the individual incidents, this is being reviewed to ensure that this is not a sustaining trend.
- Inpatient Antibiotics <60 minutes by month – relatively low numbers of patients that are not compliant with figures and have a significant impact on the monthly data - relate to 2 patients that do not meet the 60 minute target which may be by a few minutes and would reflect in compliance of below 90% At present this appeared to be within the variation that is seen from time to time.
- Inpatient Antibiotics <90 minute by month – over 90% of the patients were administered antibiotics within the 90 minutes which is the Trust secondary target. DP stated that in some situations individual cases are complicated and there are reasons why colleagues needed to go beyond 60 minutes to administer antibiotics.
- Delays in administration – SQAC NOTED that there are a lower number of patients with delayed administration compared to previously, less than 10 patients per category compared to 30 previously.
- There is a small reduction regarding problems regarding access, and still significant difficulties with regards to time from antibiotic prescription to administration.
- There had been a reduction with regards to issues seen previously regarding escalation and waiting for investigations.
- ED Antibiotics <60 minute -1st two consecutive quarters approximately or above 90% (89.9% in Quarter 3).

- Training compliance – there had been an improvement across all divisions since January 2024, the notable exception is Medical and Dental staff, although there had been an improvement and is substantially low point last quarter and is still 10% below currently compared to a year ago, with ongoing focus on improving compliance. DP alluded to whether there should be significant consequences should staff not undertake mandatory training.
- DP provided an update on focus over the next 6 month period

FB alluded to the Sepsis report and stated that once antibiotics had been prescribed that there isn't an electronic record that immediately issues a prompt. DP stated that it is possible to prescribe medication on meditech and for the nurses to not be aware. DP stated that he did not think there is an easy solution to this and advised that he did not think there is a practical way to include.
FB stated it would be helpful for DP and colleagues to undertake an offline discussion to address this. DP stated the importance of emphasizing this through training and highlighting the importance of communication between medical and nursing staff at induction.

Resolved: FB stated it would be helpful for DP to update SQAC within the next report regarding progress following conversations regarding this.

IG stated that he is pleased that the meetings with BI had been helpful and that the plan is well underway. IG requested DP to keep IG updated and to advise IG of any potential issues regarding any further BI support.

GM alluded to Martha's rule and sought clarity whether the Trust is involved. NA stated that the Trust is shortly due to launch a pilot for Martha's rule and that there had been a slight delay in getting this signed off. There is a Working Group who are due to meet on 1st May 2024, NA is hoping there will then be a date for implementation. NA stated that there will be a report presented to Trust Board over the coming months.

UD referred to Sepsis training and stated that meetings had taking place with the leads, UD stated that the amount of time spent following up with staff who had not undertaken mandatory training is not productive and that there needed to be stringent process in place to ensure that individuals undertake mandatory training.

FB acknowledged the sustained improvement, with some concerns regarding 1 or 2 issues and the training issues in particular with offline discussions with DP and colleagues to take place.
DP alluded to Martha's rule and stated that a distinct advantages for the Trust was not only for the patients, but also for the staff, as this would allow another route to raise concerns.

Resolved: SQAC received and **NOTED** the Sepsis update

24/25/08 **Drugs & Therapeutics Quarterly Report**

PS presented the Drugs & Therapeutics Quarterly Report
PS requested feedback from SQAC regarding the format of the report, PS expressed his thanks to WW for assistance with regards to the template for the report.

- Risk management – PS alluded to a risk relating to ward service and advised that the ward service had been transformed with groups of pharmacists and pharmacy technicians to support a cohort of wards to enable the prioritisation and identification of those patients that need to be seen first and the pharmaceutical care issues which is resulting in the metrics being met regarding medicine reconciliations and resulting in improved discharged times.
- PS advised that the Risk regarding the near patient pharmacy service (Risk 2792) was closed.
- TPN administration report is shared at Patient Safety Strategy Board, this is progressing.
- The Trust does have some medicine related Trust guidelines documents which had passed their expiry date. Approval of these Documents is managed by the Medicine Management and Optimisation Committee (MMOC).
- A Medication safety update had previously been presented to the Patient Safety Strategy Board.

PS stated that he envisaged that as the Drugs & Therapeutics Committee, CDEG, Non Medical Prescribing Committee progress that there would be increased slides demonstrating the activity of the committees in future reports.

- PS had recently been appointed to the permanent role of Chief Pharmacist, with ongoing work to ensure that the Drugs & Therapeutics committee is in place.

FB congratulated PS on his permanent appointment and stated that the report is extremely informative and welcomed further developments. FB acknowledged the guidelines requiring renewal and thanked PS for providing clarity regarding the challenges.
FB alluded to the risk relating to the availability of ASD and ADHD medication as this had been reduced. PS stated that in terms of shortages that this is still an ongoing issue. Pharmacy are supporting colleagues and patients and that this continues to have an impact on patients and clinicians.
JPo stated that colleagues continue to meet on a weekly basis with pharmacy colleagues, JPo stated that initially this was due to be resolved in January 2024, followed by April 2024, however this is anticipated to continue into the summer. Colleagues are working with the national group and have been involved in constructing national updates.
FB stated that this is currently scored at 8 and stated that it was previously scored higher. PS stated that this is due to when thinking of shortages generally colleagues are not seeing people not getting treatment, PS is moving towards removing a generic shortage risk and adding specific risks regarding specific drugs risks.
KB stated that there are a number of abbreviations within the report and stated that it would be helpful to include a glossary at the back of the report. KB requested whether the key issues within future reports could be clearly articulated.
Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Quarterly Report

Caring
Effective

24/25/09 Board Assurance Framework

ES presented the Board Assurance Framework
ES commended the Chief Pharmacist for strengthening the governance regarding pharmacy, with good additional controls in place.

ES advised that ES and NA dairies had not aligned to enable a review of the review of the 3 SQAC risks. ES alluded to the access targets and stated that this is currently rated at 20 and that given the performance achieved at year end ES is uncertain that this is the correct score, ES stated that she planned to discuss this offline with AB.

ES stated that all of the gaps that had been identified in the initial risk relating to high quality care and advised that NA and ES would need to review this in context of the 2030 strategy and the external environment as the financial landscape would have an impact on quality and safety in organisations.

ES alluded to the Mental Health risk and stated that an offline discussion would take place with ES, LC & JP to determine whether any changes are required, and the incorporation of the longstanding issues regarding ASD and ADHD would require consideration.

ES stated that an update would be provided at the May 2024 SQAC meeting regarding the risk appetite outcomes, discussions are taking place offline with leads from various assurance committees. ES alluded to the People risk which has some alignment to SQAC.

FB stated that SQAC welcomed the reviews of the strategic risks and the highly scored risks are addressed within the Divisional Reports which is the best place to review.
FB queried whether colleagues had any general questions regarding any of the risks within the Board Assurance Framework – no issues were raised.
Resolved: SQAC received and **NOTED** the Board Assurance Framework

24/25/10 Patient Experience Group Terms of Reference & workplan

NA presented the Patient Experience Group Terms of Reference and workplan

NA advised SQAC regarding the required caveat as the Trust is expecting this year to be a significant amount of change within Patient experience particularly aligning this to the 2030 vision. NA stated that there would be some organisation change, and conversations with individuals and a change in scope and remit of roles.

NA requested SQAC to Approve the Patient Experience Group Terms of Reference & Workplan for now, with a view that over the next 12 month period that there would be significant change in the remit and scope of the group in the way it reports and works.

FB alluded to its purpose and duties and stated that it wasn't entirely clear how and where children's and young people's voice would align and would be strategically prioritised. FB requested whether this could be addressed prior to SQAC finally approving.
NA confirmed that this would be incorporated as required.

Resolved: FB & NA to agree wording offline for inclusion.
Resolved: SQAC received, **NOTED** and Approved (in principle subject to NA & FB agreeing the narrative regarding voice for inclusion) Patient Experience Group Terms of Reference and workplan

24/25/11 Clinical Effectiveness and Outcomes Group Chairs Highlight report

JR presented the Clinical Effectiveness and Outcomes Group Chairs Highlight report which provided an update from the meeting held on 12th April 2024.

- At the CEOG meeting held on 12th April 2024, colleagues noted a number of challenges raised by clinical staff regarding the inability to complete the data submissions for a number of Mandated National Audits namely Epilepsy 12. The Trust is in cohort 6 which opened in December 2023 and closes in November 2024. The Trust did not submit any data for cohort 5 and there had been no submission to date for cohort 6. The Trust had received an outlier letter from the Royal College which had been escalated. Since the CEOG meeting this had been escalated to the Division and there had been a number of discussions held with the clinical lead and relevant staff to understand blockages and identify potential solutions to non compliance, this is included on the risk register with a score of 9. There are ongoing discussions with divisions taking place this week.
- CEOG noted the challenges voiced by the respiratory team regarding reporting difficulties and submitting data. JR acknowledge that a number of the data submissions are extensive, this had been escalated to the Divisions with a plan in place for the CEOG Chair to liaise with all clinical leads for all of the national mandated audits to review baseline regarding baseline, with an update to be provided to CEOG at the May 2024 CEOG meeting.
- CEOG identified an issue regarding the approver status within the document management system, limiting the ability to approve documents and policies to be uploaded in a timely manner. A task and finish group had been established, resulting in a much improved position, with oversight from CEOG.

Resolved: SQAC received and **NOTED** the Clinical Effectiveness and Outcomes Group Chairs Highlight report and **NOTED** the challenges faced by the clinical team with regards to submitting extensive data requests for National Mandated audits.

24/25/12 Transition Report

JPo presented the Transition Report
JPo advised that the data is still required to be cleansed and validated on a monthly basis. Colleagues are also reviewing the EMIS data regarding Trust wide data as the data is within different systems to understand what questions could be asked of the data which is an onerous monthly task.
JP stated that there is some data included within the report, however there is not a high level of confidence in terms of what is effecting those changes, with further work required with PW and colleagues within the BI team who are supporting to ensure a greater understanding of the data.

- JPo referred to the Transition exception register process and advised that when a person turns 18 that they may remain on the Transition exception register for a single specialism and other parts of their care is transitioned and they may no longer have access to urgent and emergency care at Alder Hey, therefore colleagues are reviewing how this is communicated to the young adult/family and also

other providers to ensure a clear message detailing where individuals can present should they have ongoing needs beyond their 18th birthday to better manage this.

- The Transition Steering group is linking in with the Genomics Steering Group with regards to the work in relation to young people at the point of transition who had been involved with genetic counselling or genetic work, with the aim of developing bespoke drop in sessions to enable individuals to better understand their condition and to think about how they have conversations with friends, families, work colleagues and health providers, colleagues are reviewing how to plan and record for these patients.
- Alder care expanse build – JP stated that the forms are still present and that the forms had to be accessed through a convoluted route, colleagues are looking to streamline this to ensure people can access more easily.
- Transition Annual conference is scheduled for 15th June 2024, this is being advertised via Eventbrite and is free to attend, the conference is well attended, with a person with lived experience who is part of the Transition Steering Group whose input is invaluable.
- Transition Steering Group meeting was held on 23rd April 2024, updates from that meeting would be included within the next Transition update.

FB stated that the Transition report is one of the few remaining reports that does not come through any other committee, and stated that consideration is required regarding the best route for this report, to ensure that the issues have real traction before being presented to SQAC.

JPo stated that the report is submitted to CEOG.
Resolved: FB stated that FB would discuss offline with NA to clarify correct alignment of reporting.
FB alluded to the successes within the Transition update, with caveats regarding the continuing difficulties regarding the data. FB referred to the extremely significant reduction of 18 year olds who are in the system and stated that if the Trust was able to perform the additional piece of work regarding the adults who are incidentally caught up in this as parents the figures would be lower still. FB acknowledged the significant progress, which was welcomed by SQAC, whilst also noting the challenges.

IG alluded to data and meditech developments and queried whether there is any additional I.T support required or whether I.T need to provide support in a different approach. JP stated that she had met with VF on 24th April 2024 and this is being prioritised. IG asked JPo to keep him updated should any additional support be required.

JR alluded to the list of audited transition coded appointments completed on doctors on rotation and linking back to the NCEPOD standard and whether this should be added to Trust wide priority audit plan.
Resolved: JR and JPo would undertake an offline discussion to discuss this further.

FB thanked JPo for ongoing support. FB confirmed that feedback would be provided to JPo with regards to what SQAC would like to receive in future regarding Transition.
Resolved: SQAC received and **NOTED** the Transition Report and welcomed the progress made.

24/25/13 Confidential Enquiries/national guidance assurance report – Quarter 4

JR presented the Confidential Enquiries/National Guidance Assurance report for Quarter 4

- The Trust participated in 5 national Confidential Enquiries.
- Recommendation and actions continue to be implemented/actioned for 4 out of 5 national report actions.
- JR had recently reported at SQAC regarding the NCEPOD Testicular Torsion study report had only just been published entitled 'Twist and Shout' which was published in February 2024 – the report findings and summary and recommendations are outlined in Appendix 1. Report had been shared at CEOG, Surgical Governance Team and the Urology teams with a request for them to undertake a baseline assessment against the key recommendations, which would be presented to CEOG at the May 2024 meeting
- An overview of the relevant key learning messages and findings from the national Perinatal Mortality review tool, learning from standardised reviews when a baby dies annual report was presented to CEOG in February 2024 and shared with the Trust HMRG lead. Alder Hey is a non maternity centre therefore the Trust is not required to undertake any PMRT reviews, however the neonatal partnership

recognise the importance of these reviews with completed PMRT reviews from maternity centres incorporating into Trust mortality process.

Next steps

- Suicide in Children and Young People Study – the reference group continues to develop its Self-Harm Reduction Suicide policy, the timeframe had been extended to June 2024 to allow the policy to be completed and ratified.
- As alluded to previously the Surgical governance team and the Surgical team had been asked to present baseline of findings against the Twist and Shout NCEPOD Testicular Torsion study.
- The Trust would continue to receive any reports that are published in year and provide a summary to SQAC.

KB stated that as participation in the confidential enquiries is mandatory and is part of the Quality Account and alluded to whether an assurance statement should be inserted into the SQAC Annual Report to provide assurance that the Trust is compliant against with NCEPOD submissions and similarly to include an assurance statement within the SQAC Annual Report for the NICE guidelines given the improvements made within the last 18 months. FB welcomed this suggestion.

FB alluded to the Twist and Shout testicular torsion report and referred to the unnecessary transfers and sought clarity whether the Trust is working with the system to understand capacity and capability of the District General Hospitals to ensure that all are aware of the correct routes.
JR stated that the Surgical Division had been requested to provide a baseline and that JP would ensure this is included in the ask.

Resolved: SQAC received and **NOTED** the progress and oversight of the Trust participation and compliance with all Confidential Enquiries/national guidance submissions for Quarter 4.
Resolved: SQAC received and **NOTED** the Confidential Enquiries/national guidance assurance report – Quarter 4.

24/25/14 Divisional Update and Deep Dive regarding eRoster KPI & CHPPD:

Division of Surgery - RP presented the Surgery Divisional update

- Success regarding the new Deep Brain Stimulator used to treat dystonia which had been placed in a patient successfully, this is a first of this type to be used in this country.
- Challenge regarding Cardiac capacity issues regarding flow for patients experienced over the last month. The division had established a daily sit rep to ensure oversight of acuity, and support flow.
- Incidents - division had seen a continued reduction in incidents and continue to monitor incidents.
- Risk register–there is 1 risk over 15 which is the BME risk relating to the capital replacement programme, there had been ongoing discussion with colleagues regarding this and there is a new Capital Board Meeting established who are due to meet in May 2024 to ensure oversight.
- The division had a high number of rapid reviews in month, they were not all moderate harms or above, they were incidents that the division felt required an extended review. The reviews were successful with relevant actions which are tracked via Inphase.
- A partnership review meeting had taken place with Liverpool Women's Foundation Trust to review a case, with good actions identified in relation to the patients pathway.
- There had been 2 MSSA cases, both cases are under review, and were within Cardiac, Duty of Candour had been shared.
- Sepsis compliance, all of the wards are above 90% compliant, with focus required for medics.
- Division had no significant breaches regarding complaints, with only 1 PALS breach due to internet issue in March 2024.

Community & MH Division – JP presented the Community & MH update

- The Children & Young People's Gender Service (North West) was launched/ went live on 1st April 2024 -109 children and young people were transferred from the previous provider.
- The division had launched the Transformation programme to bring together ASD and ADHD services into one service for neuro diversity, a programme board had been established, governance structure and workstreams identified.
- The division had the lowest was not brought rate in March for the whole of 23/24 of 11.5%, this was achieved through the use of the was not brought predictor, transport pilot and fixing the incorrect reporting where cancellations had been reported as was not brought.

- Challenges regarding leadership gaps at Sunflower House-there had been a proactive campaign to recruit maternity cover for the Ward manager this post was recruited to for a fixed period on 23rd April 2024. The new Head of Service is due to commence in post on 5th June 2024, with a new psychiatrist joining in July 2024, with wrap around support to ensure that the leadership is supported during the time of transition.
- The division are experiencing difficulties in achieving the 5 day timeframe in relations to PALS, given the complexities of the PALS issues raised which are taking longer than 5 days to address. A meeting with colleagues within the division with the largest number of PALS had taken place. The division are also planning on consulting with the Surgery and Medicine divisions to identify whether there is any shared learning to enable the Division of Community & Mental Health to enable achievement of the 5 day compliance.

GM referred to the terminology of ASD and stated that in many places now this is referred to as ASC changing from a disorder to a condition and that when GM had worked with autistic people over the years that the terminology of disorder causes some question and how language reflects thinking.
GM stated that one of the risks in the Liverpool City region had been the SEND/SEND inspections – and queried whether this has a place within this report to obtain a sense of these processes.
JP stated that there are two aspects, and that the Trust do have the SEND team within the division and that there is a Trust wide element. JP and GM agreed to discuss this offline regarding any associated risks regarding Ofsted inspections and the risks associated which had been major challenges for some areas and caused credibility of services to be questioned by parents.

GM referred to the voice of the child or young person and any service in mental health having some sense of issues for children and young people.

GM alluded to the Physician Associates not being able to undertake child protection examination and queried whether there is any action required to mitigate this as GM was not aware of this issue.

JP stated that this is a capacity issue which had been included on the risk register, the challenge regarding that the courts do not class as a valid report as the CP medical forms part of the evidence in court and courts do not see Physician Associates as credible expert witnesses, with the reports either having to be redone by doctors or counter signed, creating duplicate work. This is a national piece of work regarding the role of Physician Associates.
FB alluded to counter signing and stated that only doctors can appear in court and provide the evidence.

JP referred to the voice of child/young people and stated that the Trust work extremely closely with the Children & Young People Forum, the Chameleons, and the young people's engagement workers. Engagement is extremely active within the Division of Community & Mental Health and across the Trust. JP agreed to consider how to include updates through the divisional Patient Experience group in addition to the Trust wide Patient Experience group.
FB stated that the issue regarding terminology would be considered offline, NA would review offline and provide feedback.

Medicine – CW provided the Divisional update

- CW alluded to division working in collaboration as a teams across each of the divisions.
- Division had no patients waiting over 65 weeks in March 2024.
- Challenge regarding the CT scanner in Radiology which acts as a single point of failure, with increasing downtime.
- Incidents continue to be well managed and are reviewed daily by the senior nurses and the governance team. There had been no moderate harms for a period of 3 months. Division continue to see a reduction of % of low harm incidents from December 2023.
- Focus work continues to reduce the number of incidents open for more than 30 days with the division consistently seeing a reduction.
- Sepsis training compliance - the division are constantly improving and all wards within Medicine Division are demonstrating over 90%, with focus on medics with a 2 week plan and review.
- The division had a slight increase in pressure sores in March 2024, a further review identified 2 pressure sores, both are low grading and both had been caused by the use of splints, there had been

joint work with occupational therapy, as indicated with poor parental engagement and putting the wrong splint on, not taking the splint off and not observing it. Learning focussed on staff and parent education required to improve this.

- Division had continued focus to close complaints & PALS within the timeframe. Division had consistently achieved 100% compliance with PALS and Complaints for the last four month period.
- Risk register continues to have good oversight from the governance team and leads, with good control. There are no overdue reviews, with 6 overdue actions.
- Division continued to work with NICE and audit, resulting in high compliance in both areas.
- Focus for May 2024 is a deep dive of risks above 12.

Research Division - LR presented the Research Divisional update

- Division had great support from the play therapy team regarding a child who required gene therapy, where the bloods are absolutely vital to continue with the patient's treatment this is also linked to a challenge for the division as the play therapist is currently on long term absence, Research Divisional colleagues are working with the Play Specialist team to try and bridge the gap.
- Division continue to work with labs, a meeting had taken place earlier this week, however there is a further delay with regards to the new post as the individual is unable to commence in post until July 2024, Divisional colleagues would continue to work with the labs to open the priority trials.
- Section 7 this is a new area due to the changes to the R&I committee that some of the assurances would be directed through to SQAC. Section 7 would cover Serious adverse events, research training and any research monitoring escalations. LR confirmed that there are no issues to escalate to SQAC in month.

FB stated that it is helpful to have this information within the report

Deep Dive – into Nurse Staffing Report

NA presented the Deep Dive – Nurse Staffing report which provided information on the CHPPD metrics, comparator to national benchmarks along side the roster KPI's. The update included some of the challenges faced at Alder Hey and the next steps in improvement.

Key Areas of focus at Alder Hey

- All rosters to be finalised and issued 6 weeks in advance
- Reduce/irradicate additional duties (above establishment)
- Better planning across the year of predictable unavailability – Annual leave, study leave
- Claim back owed net hours to reduce bank spend
- Nurses shifts – given that over a year a nurse will owe 6 hours, and bank spend reduction

KB expressed her thanks to NA for providing this update, and stated that it is useful to have the boxes on the last slide and the descriptions of what they are and splitting the care hours up which would be helpful to include within the board report.

NA stated that he would review the narrative within the next report to ensure that the information is easier for the Non Executive Directors to review.

FB stated that having the KPI's would help as they would be tracked over time and would demonstrate improvements.

FB expressed her thanks to NA for the extremely informative and comprehensive update.

DH stated that the increased medication error reporting was taken as a negative, but there is generally under reporting of medication errors.

NA stated that there are slight nuances as this is not split out in teams, medication errors with harm, near miss or avoided.

Resolved SQAC received and **NOTED** the Divisional updates and the deep dive -E Roster KPI & CHPPD

24/25/15 *Well Led*
Responsive

SQAC Annual Workplan and Terms of Reference

FB Presented the SQAC Annual Workplan and Terms of Reference

SQAC **NOTED** that the SQAC Terms of Reference would be amended to include the Associate Chief Nurses as members, and would also include Laura Rad.

NA alluded to the SQAC workplan and stated that there are a number of SQAC meetings which are lengthy and requested that should any report presenters be unable to present reports assigned to them against the 24/25 SQAC workplan to notify SQAC Committee Administrator by no later than 29th April 2024 to enable the avoidance of any deferred reports.

Resolved: SQAC received, **NOTED** and APPROVED the SQAC Annual Workplan and Terms of Reference, subject to the amendments regarding the inclusion of A.C.N's and L Rad within the membership within the ToR.

Resolved: SQAC report presenters to advise SQAC Committee administrator by no later than 29.4.24 of any potential issues relating to presenters being unable to present reports against the 24/25 SQAC workplan

Resolved: SQAC Terms of Reference to be amended to include Associate Chief Nurses & Laura Rad within the membership.

24/25/16 SQAC Annual Report

FB presented the SQAC Annual Report

SQAC **NOTED** that an assurance statement would be inserted into the SQAC Annual Report within the final assurance section regarding assurance in relation to NCEPOD/National Guidance and NICE compliance issues.

KB stated it would be helpful to include a caveat in relation to assurances regarding delivering the clinical audit programme to indicate that the mandated clinical audit work programme had been delivered with the exception of Epilepsy/outstanding clinical audit, - wording to be agreed.

Resolved: Assurance statements to be inserted within the SQAC Annual report with regards to NCEPOD and NICE Compliance.

Resolved: Caveat to be included within the SQAC Annual Report with regards to delivering the Clinical Audit Programme.

Resolved: SQAC received and **NOTED** the SQAC Annual Report

24/25/17 Research Annual Report

DH presented the Research Annual Report

- A successful away day had taken place which helped to define the Clinical Research Division objectives for the year.
- Division had developed the CRD pledge and CRD charter. The pledge had a soft launch on 22nd April 2024 and refers to how the CRD work with external partners.
- CRD had commenced a process regarding round tables with departments who are research active to understand what their needs are, a round table had taken place with the CAMHS team, ITU team, Haematology and further round tables are being arranged with other departments as the year progresses.
- New partnerships had been established with GOSH, Birmingham and Sheffield, CRD colleagues had joined national infrastructures such as the NHSA, there are ongoing discussions regarding how the Liverpool City and Region research infrastructure through what is tentatively called the Northern Health Northern Institute would be set up. CRD colleagues are now members of Liverpool Health Partnership including working with the joint research office, and had restarted starting well.
- There is an initiative primarily with Alder Hey and Liverpool Women's Foundation Trust to ensure that there is a whole life course for paediatric research.
- Awards –the CRD team were reawarded a gold award for Clinical research facility for the 3rd year, which is a testament to LR and many other senior research nurses.
- DH alluded to the incident metrics and interpreting nuances, part of CRD objectives is to understand them better and that moving forward CRD want to review any serious adverse effects to ensure any learning and to ensure any proactive changes should they be required.
- Mandatory training is good, with further room to improvement.

- CRD are committed in the future to obtain more patient stories.
- Effectively there are a number of studies ongoing, DH alluded to the Crescent study, which is a difficult to recruit to study, however the Trust have half to 2/3 of all of the recruits of this study nationally, with phenomenal support.
- Responsive – DH stated that colleagues had warned previously that CRD recruitment would decrease following some of the studies such as DETECT and other studies. CRD are the second highest recruiting Trusts across the region.
- CRD had received a number of grants, this does not include the MRI scanner which is £2M which is expected in August 2024, with the aim of this being operational in the Autumn.
- CRD had submitted an annual plan that had metrics which are based on staff side work and cross working with the University and other clinical teams within the Trust.

FB stated that there is a real sense of team formation and alluded to CRD dealing with long term sickness issues.
FB stated that colleagues may have any comments or suggestions regarding what that they may want to see in future reports.
DH stated that he is hoping future reports may include more of a forward look and progress.
LR stated that CRD colleagues are proposing to provide quarterly reports which would have less content which would include recruitment data and details regarding types of studies. CRD would require some feedback as colleagues would be reviewing the previous quarter information. LR proposed that the CRD division would not submit a report in June 2024 and Quarter 1 report would be submitted in September 2024.
FB stated that SQAC are particularly interested in CRD performance against the safety and quality metrics.
UD referred to research studies and stated it would be useful to understand, outcomes, implementation and changes following studies and tracking the impact of studies. DH stated that tracking the impact is difficult, and alluded to manpower hours tracking which would be significant, given licensed in any jurisdiction and a range of outcomes.
DH alluded to the round table and stated it may be useful to gather requests on what teams are interested in receiving information on.
NA acknowledge the progress made regarding the integration and contribution to SQAC by the CRD leadership team have been able to really grasp the contribution to safety and quality.
FB echoed NA comments.

Resolved: SQAC received and **NOTED** the Research Annual Report

24/25/18 External Visits/Accreditation report

ES presented the External Visits/Accreditation report
ES made a plea to SQAC to ensure that the External Visits/Accreditation report is fully reviewed to ensure that all of the necessary information had been included and for colleagues to notify the Governance Manager should there be an additions.

ES advised that the Major trauma peer review had no actions noted.

FB stated that a number of external visits or inspections take place remotely and sought clarity whether it is clear for colleagues that these inspections or visits should be included.
ES advised that the Policy was updated to include and that ES & JP would ensure that appropriate comms are issued to remind staff.
Divisions to raise this internally through the divisional internal governance meetings.

Resolved: SQAC received and **NOTED** the External Visits/Accreditation report

24/25/19 Decontamination of Reusable Medical Devices Policy

AC presented the Decontamination of Reusable Medical Devices Policy
SQAC requested that the ratifying committee named within the policy be amended from CQSG to SQAC as CQSG committee ceased in 2023.

SQAC noted that it would be helpful for the updates/alterations within policies to be ratified by SQAC for the update/alteration narrative to be in a different colour. This would be actioned for future policies to be ratified by SQAC.
Resolved: SQAC received, **NOTED** and Ratified the Decontamination of Reusable Medical Devices Policy subject to the ratifying committee named within the policy to be amended from CQSG to SQAC.

24/25/20 **C33 – Prevention and Control of Creutzfeldt – Jakob (CJD) Disease**
AC presented C33 – Prevention and Control of Creutzfeldt – Jacob (CJD) Disease policy
SQAC requested that the ratifying committee named within the policy be amended from CQSG to SQAC as CQSG committee ceased in 2023.
Resolved: SQAC received, **NOTED** and Ratified C33 Prevention and Control of Creutzfeldt – Jacob (CJD) Disease policy

24/25/21 **Autologous Stem Cell and Bone Marrow Transplant Policy**
JR presented the Autologous Stem Cell and Bone Marrow Transplant Policy.

Resolved: SQAC received, **NOTED** and Ratified the Autologous Stem Cell and Bone Marrow Transplant Policy

24/25/22 **Any other business -** None.

24/25/23 **Review the key assurances and highlights to report to the Board.**

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

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

23/24/230 **Date and Time of Next Meeting:** 22nd May 2024 9.30 – 11.30 am via Microsoft teams

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	**The People Plan - Progress in 2023 and Next Steps for 2024 and Beyond**
Report of:	**Chief People Officer**
Paper Prepared by:	Chief People Officer

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☐
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score
2.1	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	3 x 4
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families.	3 x 3
2.3	Failure to successfully embed workforce Equality, Diversity and Inclusion across the organization.	4 x 3

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

The People Plan

Progress in 2023 and Next Steps for 2024 and Beyond

1. Purpose of the report

The purpose of this report is to provide the Board with a People Plan progress update and to highlight to the Board the next steps in the development of the People Plan for 2024 and beyond. Please note that this paper will be supported by an accompanying presentation at the June 2024 Trust Board meeting to allow for greater depth of detail and discussion, and to seek agreement of those next steps.

2. Background

As an integral part of the Trust's 2030 Vision, the People Plan was presented to Trust Board in May 2023. In partnership with Strasys, the Trust took an innovative approach to address the workforce challenges, which was how to develop a plan that addressed the immediate challenges whilst building a thriving workforce that helps improve the life chances of children and young people; a plan which also considered the diverse and specific needs of individual staff members, whilst balancing the need to develop a workforce to deliver in the new ways of working.

The objective was to use all available data, both qualitative and quantitative, from across the organisation, including performance, quality, and finance, to extract the 'human stories' in our workforce. In parallel with the development of Vision 2030, we treated our workforce as our 'population' to understand their needs, behaviours, and motivations to determine what we could do to enable an environment where they can thrive and improve care for our children and young people. This led to the work we developed on workforce segmentation to deliver more precise workforce interventions with clear benefits cases to deliver the Trust's objectives.

The plan, based around the three key themes identified for our People in Vision 2023: Thriving @ Alder Hey, Developing the Professional Development Hub and Workforce Planning, identified potential savings, efficiencies and improvements across three distinct areas; productivity, wellbeing and retention ('churn'). Trust Board supported the plan, and the associated investment into the People function which anticipated a significant return on investment.

3. Insights over the last 12 months

Using the 'Brilliant Basics' programme management methodology, the senior People Team embarked on a plan to turn the 'value propositions' identified as a result of the workforce segmentation into actions which would directly address the needs of those segments of the workforce and support the three key themes of the plan. A significant amount of learning has taken place over the last twelve months of implementing the plan which has enabled the team to further develop the thinking about the next steps for our people - **what** we should be focusing on and, more importantly, **how** we should be doing it.

a. Achievements since May 2023

There has been a significant amount of effort made by many people to implement Year 1 of the People Plan and we have achieved some amazing things in year. A snapshot of just some of the highlights from the year are below:

- The launch of an innovative approach to onboarding and induction for all new starters, with an accompanying policy framework and guidance for managers to help support newly appointed colleagues.
- The Nurse Preceptorship Lead has led the way in the development of a new approach to preceptorship for newly qualified nurses, to address the challenges of high turnover within this cohort. Turnover has decreased in year for this cohort of staff as a result.
- The development of a new 'management essentials' programme, delivering key training for both newly qualified and existing managers to assist them in managing people and their services effectively.
- A 'Thriving MDT' has been established to bring together all those involved in providing team support across the organisation to ensure intelligence is shared, efforts are pooled and teams receive the most appropriate form of support, be that via FTSU, HR, OD, an '@its best' approach or through Brilliant Basics
- The Trust celebrated Learning at Work Week in May 2024 for the first time since the pandemic, celebrating and recognising learners for their achievements, and promoting and encouraging learning opportunities for all colleagues
- The Clinical Leaders Awayday in April 2023 signalled our intent to engage with and empower our clinical leaders to be at the forefront of change and innovation. The feedback from the day was overwhelmingly positive, and a follow up session is planned for the Autumn.
- The Staff Networks have matured and developed during the last 12 months, with colleagues involved providing leadership and challenge. Achievements such as being awarded the LGBTQIA+ Navajo Charter Mark, involvement in Liverpool Pride and the roll-out of the Reasonable Adjustments Policy have all supported the inclusivity and diversity agenda.

b. Shifting the People metrics in the right direction

As a result of the collective effort of many, we have seen a significant positive shift in the People metrics across the year.

- The Trust sickness absence rate is now below 5%. This is a 1.5% reduction from the start of the 23/24 year, and 0.5% below the target set in May 2023.
- Turnover has decreased significantly to 10% from a high of 15%, exceeding the target of 13% set in May 2023.
- The 2023 survey results showed an improved picture across every theme and People Promise. In particular, the Trust had the top score in the north west (Acute and Acute and Community Trusts) for the question 'would you recommend Alder Hey as a place to work to your friends and family'. Many of the scores were 'best in class' nationally against the comparator Trusts.
- We have seen marked improvements in temporary spend and vacancy rates
- Two new metrics have been developed and will be used in 2024; a new Staff Thriving Index to measure colleague satisfaction, and a Stability Index to measure workforce movement. This is a further iteration of the 'churn' measure developed as part of the first phase of the people plan.
- By improving working lives we have made significant inroads in the cost of our workforce and that both in 23/24 and now in 24/25 this is a central plank of our benefits plan.

4. The ongoing challenges of an increasingly complex and changing working environment

When developing the People Plan in 2022/23, we considered a range of factors, outside of and within the NHS, which might affect our ability to attract, recruit, develop and retain an effective workforce. 2023/24 was, arguably, an even more challenging year for the UK workforce and these, and other challenges, will likely continue.

a. The national picture

According to the latest data from the IES[1] (May 24) the UK employment rate remains static at its lowest since 2017, while economic inactivity is at its highest in nearly a decade. Overall, there are now 900,000 more people out of work than before the pandemic, with this continuing to be explained by more people off work due to long-term health conditions, more older people out of work and fewer young people in work. This is happening despite 900,000 unfilled jobs in the economy and continued strong growth in earnings. In addition, during 2024, there were an estimated 22000 days lost because of labour disputes across the UK, some of which was due to unprecedented strike action experienced within the NHS.

Whilst inflation has decreased since 2023, the cost of living crisis remains a reality for many people. In February 2024, 46% of adults reported that their cost of living had increased (encouragingly down from 74% in March 23) due to price of food, energy bills and fuel, and around 4 in 10 adults are still expressing difficulty in paying rent, energy bills or food[2]

b. The NHS context

Workforce pressures remain and sickness remains high at 5.5% nationally, with the North West the highest region at 6.4% (as at Dec 2023). Anxiety/stress/depression or other psychiatric illness was the most reported reason for sickness, accounting for 25% of all sickness absence in Dec 23. Stress, fatigue and burnout are real issues for the service.

The increased scrutiny on the financial position for all NHS Trusts are being felt more acutely; mandates to make efficiencies in specific workforce groups, regional and external scrutiny on recruitment and vacancies, a push for collaboration and the adoption of technology, including AI, will likely see the profile of the workforce change and numbers reduce as a result.

Our ambition to provide people with fulfilling and rewarding careers at a time of such pressure and change therefore remains a significant challenge.

5. The future of the People Function

Investment into the HR and OD functions over the last 12 months has made a significant difference in the team's ability to deliver on the commitments in the People Plan and has been a game-changer in our ability to deliver real improvements. The last year has taught us that, by having all those who have a role in supporting our people working collectively together towards the same aims we can, and have, achieved more than we had hoped for. There are therefore opportunities for us to organise ourselves in a more effective way in 2024 to deliver even more for our people.

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[1] Title (employment-studies.co.uk)
[2] Public opinions and social trends, Great Britain - Office for National Statistics

In addition, in talking to colleagues across the trust over the last year we have learned that people want simplicity and a better understanding of those functions that exist to support the workforce– who we are, what we do and who we are there for. We therefore have an opportunity to present ourselves to the organisation in a different way, making it easier for our people to know who we are, and where people can go for support.

So, we will be doing a number of things to respond to the feedback we have had:

- We will be renaming the whole function 'People Services'
- HR, OD and the Academy will continue to work more closely together to better align the priorities and synergies of all of the teams working in each area.
- Each of the three senior leaders in the three areas above will be aligned to, and will lead on, the three strategic people priorities; Thriving @Alder Hey, Professional Development Hub, Future Workforce (formally Workforce Planning)
- We will move away from using 'HR' in job titles and in the department. Feedback has shown that there is a perception that 'HR' is a service for managers, and can often be associated with the 'negative' aspects of people management such as sickness management/disciplinaries etc.
- Our ambition is to establish a new physical space in the main hospital building in 2024 - 'The People Hub' - which will host a number of services which colleagues have said will help them manage their day to day working lives – such as recruitment, people services, FTSU. SALS will retain a presence on the main hospital site. We aim to supplement this by providing 'clinics' at various community sites to ensure colleagues working across the community have access to the same services as colleagues based in the main hospital site.
- We will develop an effective communication plan to ensure all colleagues are aware of the changes.

6. Next steps

We remain committed to our ambition of creating the best working environment we can for our Alder Hey people, so they can give their best to children, young people and their families. We've made real progress so far and have learned a great deal from the last 12 months which has enabled us to evolve our thinking about the next steps for our people.

In striving to do better, we have challenged ourselves by asking 'how do we go from good to great, and what are the things we will need to pay attention to, to get us there?' We think our response to this question needs to focus on the evolution of our culture, where the embedding of compassionate leadership and values-based behaviours will underpin our success, be that in the development of our patient safety culture, the provision of fulfilling careers or improved inclusivity. We intend to explore this in more detail with the Board at the June meeting.

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 20th March 2024
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director **(Chair)**	(FM)
	Adam Bateman	Chief Operating Officer	(AB)
	Garth Dallas	Non-Executive Director	(GD)
	John Kelly	Non-Executive Director	(JK)
	Jo Revill	Non-Executive Director	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS)
In attendance:	Lisa Westley	Lead Nurse for Retention	(LW)
	Jill Preece	Governance Manager	(JP)
	Jennie Williams	Head of Improvement	(JW)
	Sarah Robinson	Clinical Phycologist – CAMHS	(SR)
	Gill Foden	Head of Learning & Development	(GF)
	Phil O'Connor	Deputy Director of Nursing	(PO)
	Rachael Pennington	Associate Chief Nurse – Surgery	(RP)
	Emma Hughes	Deputy Managing Director – Innovation	(EH)
	Clair Finnigan	Operational HR Manager	(CF)
	Sarah Leo	Head of Research – Clinical Research	(SL)
	Tommy Curran	Health & Safety Risk Assessor	(TC)
	Jeanette Chamberlain	Staff Advice & Liaison Manager	(JC)
	Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
	Audrey Chindiya	Finance Manager	(AC)
	Angela Ditchfield	EDI Lead	(AD)
	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)
	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)
	Katherine Birch	Director of Alder Hey Academy	
	Rachel Greer	Associate Chief of Operations - CAMHS	
	Fiona Beveridge	Non-Executive Director	(FB)
	John Chester	Director of Research & Innovation	(JC)
	Urmi Das	Director, Division of Medicine	(UD)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	Rachel Hanger	Associate Chief Nurse – Surgery	(RH)
	Natalie Palin	Director of Transformation	(NP)
	Jason Taylor	General Manager, Research	(JT)
	Chloe Lee	Associate COO – Surgery	(CL)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
	Julie Worthington	Staff Side Chair	(JW)
	Chloe Lee	Associate COO – Surgery	(CL)
	Kathryn Allsopp	Head of Operational HR	(KA)
	Pauline Brown	Director of Nursing	(PB)

Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
John Grinnell	Managing Director	(JG)
Jacqui Pointon	Associate Chief Nurse	(JP)
Clare Shelley	Associate Director of Operational Finance	(CS)
Maisie StJohn	Service Manager	(MSt)
Adrian Hughes	Deputy Medical Director	(AH)
Lisa Cooper	Director of Community & Mental Health Services	(LC)
Neil Davies	HR Business Partner	(ND)
Jacqui Lyons-Killey	Associate Chief Nurse – Research	(JLK)

22/23/252 **Declarations of Interest**

No declarations were declared.

22/23/253 **Minutes of the previous meeting held on 22nd November 2023.**

The minutes of the last meeting were approved as an accurate record.

22/23/254 **Matters Arising and Action Log**

Action log was updated accordingly.

FM informed the Committee that Jo Revill, Non-Executive Director would be chairing part of today's committee meeting and would formally take over as Chair from May 2024 following her leaving the Trust.

22/23/255 **Annual Workplan & Terms of Reference**

The Annual Work Plan for 2024/25 was reviewed by the committee.

The Committee received the Terms of Reference 2024/25 and following discussion, agreed the following change:

- To include Raising Concerns as a standard agenda item through all meetings in support of SALS/FTSU.

FM suggested going forward to include clear guidance when presenting policies and large documents for a clear understanding of what's changed and being asked by the committee.

JR agreed with FBs comment regarding a short summary outlining decisions that need to be made and stressed the need to offer the opportunity for constructive challenge.

ES agreed with this approach and undertook to pick this up for review and discussion at the next Committee Chair's Meeting.

Action: MS/ES/JR to review.

AD requested a change to the EDI section stating *(trust is meeting its legal obligations)* and suggested to change the wording to *(in relation to the public sector equality duty)* rather than the Equality, Diversity and Inclusion as this is the goal we are working towards.

Action: MS agreed to the amendment and will make those changes as stated

to the Terms of Reference document.

Resolved: The Committee APPROVED the Terms of Reference and Work Plan for 2024/25.

22/23/256 **Monitor Progress against the People Plan**

The Committee noted the content of the current progress of The People Plan.

MS shared the progress over the last 12 months of developments reminding colleagues of the main priorities of focus:

3 big strategy themes under the people plan:
- Thriving Workforce
- Professional Development Hub
- Workforce Planning / Workforce Information

MS provided an update on the progress made since the last meeting:
- Nursing Preceptorship: Good achievement being made.
- Induction & Orientation: A new pathway will launch on 2nd April 2024 to support new starters in Alder Hey with onboarding and induction processes.
- Benefits Data: JP/DS are currently piloting and testing ideas for a staff thriving index which plans to launch in April 2024.
- Data shared at the strategy update provided helpful insight to conduct a deep dive into bank spend, sickness support by Nicola Norris, E-Roster Manager to explore ways for utilisation. Two of the Directors of Allocate, our e-roster provider have agreed to attend Alder Hey in support of our efforts to maximise usage of the system and data.
- Operational Pressures: A stock take has started to review all gaps in services for 2024/25.

MS assured the committee that progress against the strategy remains on course and all developments continue to push through with positive impacts.

Resolved: The Committee received The People Plan update and noted progress.

22/23/257 **Monitor Progress against the People Plan**
- **Divisional Metrics**

Surgery Division

The Committee received the Surgery Division metrics report (February 2024) data. RP highlighted the following:

- Sickness showed 5.2% to date. Short term is below trust target at 2% and long term sickness continues to be closely monitored.
- Turnover – the Division has done a lot of work on retention and recruitment in those high focused areas (ICU/THs) to review roles etc and continues to push improvement forward with action plans in place.
- Return to Work: Divisions continues to meet weekly; Chaired via Head of Nursing and General Managers to review compliance for improving figures.

Challenges remains relating to E-Roster and ESR data with plans in place to address and stabilise.

- PDR compliance continues to be reviewed and monitored to maintain trust position. Mangers are meeting regularly with Teams to review compliance across departments and booked in sessions – figures should improve by the next committee meeting.
- Mandatory Training shows 92% compliance and remains consistent. Safeguarding plans are in place for the rest of 2024 with colleagues booked on sessions. Sepsis did some good groundwork and continues to be reported through to SQAC.

Resolved:
The Chair acknowledged good communication and engagement displayed across the division and noted positive progress being made.

Clinical Research Division

The Committee received the Research Division metrics report (February 2024) data and noted progress to date. SL highlighted the following:

- Turnover shows a slight increase compared to last reporting data. Division remains focus on hot spot areas and continues to be monitored.
- Exit Interviews remain in place across departments and team have introduced a stay conversation as part of colleagues one to ones to ensure staff feel supported as part of their training and development.
- Sickness has reduced following winter position and remains stable.
- Return to work remains closely monitored. Challenge continue around data recording and teams are working to rectify.
- Mandatory Training remains stable and on track.
- PDR Compliance remains well managed. Data has increased from 8th March 2024 up to 90% to date and continues to improve.

KT queried the process in place for 'stay' conversations once this information was obtained. SL advised this was a new process recently set up following the divisional away day on 31st January 2024 and that initial analysis related to progression opportunities. SL added, due to clinical research being a small division, is it at times difficult for colleagues to find progression opportunities to suit their needs and Senior Leaders are exploring ways to fulfil individual goals of progression where possible. SL provided assurance to the committee that any concerns raised regarding wellbeing in the workplace would be referred to FTSU where necessary.

Innovation Update

The Committee received the Innovation metrics report (February 2024) data and noted progress to date. EH highlighted the following:

- PDR compliance remains on track and is closely monitored.

- Mandatory Training remains above trust target.
- Staff turnover saw an increase during February to 7.88% but remains under target.
- Long Term sickness continues to be stabilised and should see a positive improvement in the next reporting data metrics.
- Exit Interviews continue to be conducted to ensure staff wellbeing.

EH reminded colleagues that the innovation hub renovation was underway. In response to the potential disruption of this, check-in sessions with colleagues had been conducted and a number of SALS Pals in place within the team. Wellbeing breakfast and drop-in sessions have started and have been very much welcomed by all colleagues. Staff are also signposted to SALS when and where appropriate.

Resolved:
The Chair thanked colleagues for presenting the research and innovation information together although it was acknowledged that this could not yet be integrated into one report.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (February 2024) data and noted progress to date.

Resolved:

The Committee received and noted the contents within the report.

Medicine

The Committee received the Medicine Division metrics report (February 2024) data and noted progress to date. SC highlighted the following:

- Staff Turnover remains stable and a key area of focus within the Division.
- Exit Interviews continue to be conducted throughout the division using a new process to understand why staff are leaving Alder Hey. Following a recent deep dive, data showed 48% of staff leave the organisation within 2 years of employment. The Division is currently exploring data to identify the reasons behind the percentage and continue to monitor.
- Sickness absence currently sitting at 5.7%. Despite being slightly above Trust target, the level of sickness rate for winter months was positive for the Division of Medicine compared to last winter data.
- PDR Update: A data analysis is being reviewed following recent PDR report to ensure all areas are up to date and completed within the timeframe. A robust plan continues in place across departments supported by HRBPs to improve data.

FM commented on the deep dive into why staff are leaving Alder Hey within a two-year period and suggested all divisions adopt this analysis approach.

JR sought assurance on return to work compliance and was advised that a deep dive review at of in-month position and a historical backlog of data was being undertaken. that will exclude all historical returns and work to get an overall position to get a better sense of the background data and will continue to work with plans action in place to achieve a different approach for improved data.

Resolved:
The Committee noted the divisional metrics for the Medical Division.

Corporate

The Committee received the corporate metrics report (February 2024) data and noted progress to date. ES highlighted the following:

- The Corporate Services Collaborative (CSC) Meeting continues to meet on a monthly basis but this week the meeting was cancelled due to an annual planning event. All raising matters will be dealt with as an offline priority where appropriate.
- Long term sickness remains above trust target at 5% and is being closely monitored and managed accordingly supported by HRBP and Senior Leaders.
- Turnover was sitting at 13% and remains steady.
- PDR compliance remains a priority focus to ensure improved compliance within timelines and will be addressed at the next Corporate Services Collaborative meeting on 23/04/2024.
- Mandatory Training overall was reported at 92% but hotspot areas are a focus at CSC.

FM referred to the spike in data relating to Time to Hire. ES undertook to pick this up at the April CSC meeting for further review and understanding and will feedback to the committee at the next meeting in May 2024.

Action: ES/MS to pick up data analysis around time to hire for further review and identify any trends.

AB drew the committee's attention to the BAME workforce representation figure sitting at 6% and queried whether this was representative and proportionate and whether or not a reset was required to ensure we are measuring correctly staff from a diverse background. MS thanked AB for the comment and noted Annemarie Davies, REACH Network Chair continues to challenge on this topic to ensure representation matches the local community. MS agreed that a further review was needed in this area to ensure we are setting the right targets.

Trust Wide Metrics
The Committee received and acknowledged data report and noted progress being made across the organisation.

Resolved: Committee received and noted progress made to date from each division.

PDR Deep Dive
The committee received the PDR deep dive report and noted the contents. GF highlighted the following to the committee attention:

- PDR current window has now changed to allow more time for completion.
- Staff Survey findings reported that only 80% of colleagues advised they have a PDR on an annual basis.
- 71.2% compliance as of 15th March 2024. Actions taken to improve compliance and ensure staff have a meaningful PDR include:
    - Plan on a page
    - Pilot group within Estates & Facilities – those with similar objectives can choose to have a group PDR.
    - Weekly updates to Executive Team for assurance and oversight and continues to be reviewed and monitored monthly to ensure focus on forecasting.
    - Root and branch review of the PDR process, staff needs etc.

GD formally thanked GF for the work undertaken to date and underway.

MS aired her frustration that compliance remained below target despite the number of changes implemented and stressed the need for senior leaders to embed PDRs as business as usual.

JR asked why PDRs were not yet electronically based. GF stated that ESR was not user friendly in this regard and that a national project was underway to refresh ESR which would hopefully allow us to move forward with an electronic PDR process.
JW offered insight from the Brilliant Basics Team to apply A3 thinking to this process going forward.
SO added that RPA was also being looked at in terms of opportunities that can help us target PDR completion.

Mandatory Training Deep Dive
The committee received the Mandatory Training Deep Dive report and noted the contents. GF highlighting the following:

- Mandatory Training compliance target for the Trust is 90% with an overall reporting figure of 92.04% overall. However, hotspot areas within the figure include resuscitation, information governance, sepsis, moving and handling and safeguarding.
- Competence rate per staff member was reported as follows:
    - Green: 3035 staff members
    - Amber: 706 staff members
    - Red: 252 staff members
- Actions in place to address non-compliance are:
    - Meetings with subject leads prioritised by hotspot areas.
    - Refresh of data within ESR to capture face to face course activity.
    - Review of competency per staff required to cleanse the data.
    - Monthly communications will continue to be shared across the trust on the 1st week of the month. The Team will review that data bi-weekly to ensure all analysis is securitised.
    - GIDS Service will be incorporated in April 2024 as a required part of Mandatory Training.

- Oliver McGowan Training will be added aligned to Learning & Disability and will go live next week.

JP suggested applying a system thinking approach that requires a behaviour change to relay the importance of what mandatory training can do for staff carers and children and young peoples' lives. JP stated that some colleagues have given feedback that they do not have enough time to complete training during working hours. GF commented advising there is an amount of financial uplift for ward staff and clinicians to undertake their training where supported is provided and need to ensure all training is completed as part of their required roles.

POC referred to the uplift in the budget for completion of mandatory training, stating that he had undertaken a piece of work with the Academy in 2023 to review the increasing portfolio of mandatory training and sought assurance that this had been considered especially for specialist wards. DS advised the committee the uplift applied to wards/departments was multi-faceted and included training and education purposes, sickness absence and gaps in service and is reviewed on an annual basis on how to regularly control as an educational review. This area continues to be managed and maintained and will remain a top priority as part of our budget review.

FM reflected that the mandatory training deep dive showed good data which is making progress across the organisation and is providing good assurance for the committee's oversight.

FM asked authors to review the documentation templates in order to display a shorter summarised overview of data to reduce the number of pages for easier reading. JW commented noting Brilliant Basics will work with paper authors to streamline that data for improved submission of documents.

GD added EDI have consistent needs that should be considered as part of mandatory training and asked if this could be reviewed in line with fit for purpose perspective. GF confirmed is working closely with AD to review all content and aspects on how we will support colleagues including staff who lack learning skills and knowledge and remains a top priority.

22/23/258 **Turnover Report**

The Committee received the Turnover Report Quarter 2 and Quarter 3 and noted progress made. KJ presented the following to the committee:

<u>Quarter 2 Report</u>

- September 2023 data showed a total 13.48% with trust target of 13% compared to quarter 2 which showed a decreasing rate month on month.
- 100 Leavers were identified for Q2 showing promotion as the reason for leaving as the highest figure under admin/clerical category.
- Nursing and Midwifery showed the highest area of leavers for Q2.
- Length of service showed a 50% rate for colleagues leaving Alder Hey within a 2-year period.
- Trust Wide turnover rate by division displayed a positive turnaround and Senior Leaders continue to focus on hot spot areas.

- Benchmarking across the North West displayed by different staff groups saw a decrease in August 2023 compared to April 2023 with Medical and Dental showing an increase top end of Q3.
- Profile of Leavers will continue to be considered in line with WRES/WDES standard.
- A trial will launch within the Innovation Team to review and oversee all hot spot areas in connection to the online resignation process. Further information will be shared in due course.

KJ provided assurance that HRBP support will continue to be delivered to Managers across the organisation to help support colleagues and drive improvements to keep at trust target.

Quarter 3 Report

- Turnover rate showing in quarter 3 displays an improved position compared to quarter 2.
- Headcount showed a rate of 8.5% to date displaying an improvement across the board.
- The new Exit Questionnaire launched in February 2024. A total of 7 responses has been received to date. All compliance will continue to be monitored.

FM noted good progress and the plans in place to work and support alongside the Innovation Team and look forward to future update and progress.

GD highlighted there has been a recent data shift relating to WRES information informing the committee there has been a decrease in the number of BAME colleagues who reported had experienced assessment, bullying or abuse.

JK posed a question regarding assumptions for the final quarter of the year and how this may look. MS stated that there had been a question included in the staff survey 'are you thinking of leaving the organisation' which didn't suggest that there would be any significant movement ahead of year end and that she was hopeful of a sustained position.

JR Chaired the meeting from this point.

22/23/259 **Nurse Retention Project Update**

The Committee received the Nurse Retention Project Update initiated to support newly appointed nurses by way of a bespoke preceptorship programme. LW presented the following to the committee:

- Alder Hey was awarded the NHSE Interim Quality Mark for our Preceptorship Programme which was a huge achievement for the trust.
- Alder Hey lead a 12 month programme for newly registered nurses from starting. The new starters are supported by one on one sessions, professional nurse advocate and clinical supervision is one of the golden threads throughout this 12 months period for all preceptive nurses.

- A 6-month programme was delivered for preceptorship from October 2023 and is now in line with the national preceptorship framework which has been extended to 12 months.
- The NHSE workforce portal has been utilised to provide some benchmarking in relation to the band 5 workforce for nurses.
- Data analysis in 2023 showed an increase compared to 2021/22 data which is a huge achievement for Alder Hey.
- ESR data from 2021/22 shows that 5% of colleagues who left the trust in the first 12 months of employment. There was a slight increase in the total data for 2022 with an overall reduction of 8% to date.
- There are 2 cohorts of nurses that joined the organisation following October 2023 which shows a good thread and is having a positive impact as we move into 2024.

Financial Position

32% of the October 23 cohort had access to

one to one restorative clinical supervision. This equates to 11 members of staff who have chosen to undertake restorative clinical supervision on a regular basis and are activity retained by interventions, equating to £132k worth of saving for the organisation.

JK asked if the data takes into account the 'down time' and 'up time' of starters and leavers.

LW commented and confirmed the £12k cost is reflected in this data of upskilling new members coming into the workforce.

GD asked for assurance on what the preceptorship programme looks like in terms of culture and Alder Hey's current overall 2030 vision achievement plans. LW shared that there is an element of competency development which has recently been set to run as a pilot study aligned to vision 2030 and wellbeing support will be integrated into that workforce as part of building that resilience.

22/23/260 **Staff Survey Results 2023**

The Committee received the Staff Survey Report and noted good progress being made. MS presented the following to the committee:

- Staff Survey overall position reached 60% response rate compared to 45% nationally.

Alder Hey was rated best in class for a number of areas including recommending Alder Hey as a place for treatment, care of patients being a top priority, areas around discrimination and bullying and harassment and for the new question around whether colleagues has received any unwanted behaviour of a sexual nature.

For the question relating to recommending Alder Hey as a place to work, the Trust scored 72% placing us in the top Acute Trusts in the North West and fourth for all Trusts.

Next steps: Team continues to work closely with the BI Team on how to formulate local data packs and colleagues proceed to have meaningful conversations locally and continue to create an environment where our staff can thrive.
JR thanked the team for all hard work on pushing this which resulted in a positive outcome.

MS undertook to send the summary slides to the Committee.

Resolved:
The Committee received and acknowledged the Staff Survey Report and noted good progress being made.

22/23/261 **SALS Pals Update**

The Committee received an update on the SALS Pals project which was established in 2020 to prevent burnout, stress, and mental ill-health.

The pilot programme is supported by NHSE who funded a cohort of paid wellbeing champions to ensure all champions were recognised with a clear role description and recruitment process including in-house training for individual needs.
SR talked about the SALS/Pals model and plans to expand the service following the end of the current pilot.

Evidence that for every £1 invested there is a £5 return in terms of staff wellbeing and reduction of sickness absence rates. 101 SALS Pals were recruited within the first 2 years of the programme supporting 45% of staff.

MS noted the good level of work undertaken by the team.

JK talked about the benefits realisation and stressed the importance of including this in a business case to ensure this model continues and is endorsed by the Board.

The Committee noted the SALS Pals update.

22/23/262 **Equality, Diversity & Inclusion Board Report**

The Committee received the Equality, Diversity & Inclusion Board Report received at the March 2024 Board meeting and noted good progress being made.

GD formally thanked MS/AD for the work achieved so far on this which is making good progress.

22/23/263 **EDS22 Report**
The Committee received the EDS22 Report. AD highlighted the following to the committee:

AD introduced the EDS, which is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.
The Service section has been assessed and approved by the Safety and Clinical Quality Committee and today we are looking at workforce and leadership.

The Trusts overall score was 19.5 (out of a maximum of 33) putting us in the developing' segment. We have received good engagement with the ICB, Healthwatch and Trade Unions and our Staff Networks. An action plan has been completed and will be monitored at the EDI Steering Group.

Resolved: The committee APPROVED the EDS22 Report and noted good progress being made.

22/23/264 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

The Committee received the Board Assurance Framework for the month of February 2024. ES highlighted the following to the committee:

ES informed colleagues that work had recommenced to revisit the risk appetite and tolerance work sponsored by Non-Executive Director, Kerry Byrne. Work was also underway to reframe the risks in relation to people and workforce reflecting our 2030 Vision.

Deep dives on risks 2.1 and 2.2 had been scheduled on today's agenda, the deep dive on risk 2.3 was completed in January 2024.

Resolved: The Committee received and noted the Board Assurance Framework

22/23/265 **BAF Deep Dive (Risks 2.1 & 2.2)**

The Committee received the Board Assurance Framework Deep Dive 2.1 and 2.2 and noted the contents. MS highlighted the following to the committee:

<u>Risk 2.1 Workforce Sustainability and Development.</u>
MS reminded colleagues that this risk was in place to ensure we have the right workforce, numbers and skills to do the job.

The Committee noted there is a risk rate of 12 with a target of 4.

There are controls and mitigations in place around sustainability within the workforce with continues regularly reporting and monitoring.

Actions – mandatory training, workforce planning, talent pipelines, focussed on diversity and proportionality within the workforce.

<u>Risk 2.2 Failure to develop and sustain an organisational culture that enables staff and</u>

teams to thrive and deliver outstanding care to children and families.

JP informed colleagues that work had been undertaken to reframe this risk and help to broaden it in light of Vision 2030 and think about culture in a more rounded way.

The Committee noted there is a risk rate of 9 with a target of 4.

There is a range of controls in place resulting in a big piece of work around restorative just and learning culture that forms part of discussions at Board level in connection with thriving leadership programme for development performance. Newly established Thriving MDT Team. Assurance evidence Safety Culture as part of the Patient Safety Board. Gaps in controls continue to be worked on, including data insights from staff.

Actions to progress the gaps are within People Plan.

Next steps:
In light of the risk being revised, thought would be given to discussion at other assurance committees in relation to culture. ES undertook to reach out to other colleagues to establish their process.

Resolved: The Committee received and noted the Board Assurance Framework Deep Dive risks 2.1 and 2.2.

22/23/266 **Policies**

- **Preceptorship Policy – new policy (approved)**

  The Preceptorship Policy was introduced as a new policy to the Committee. An overview had been submitted to the Committee and assurance was provided that the Policy had previously been reviewed and approved prior to PAWC ratification.

  Resolved: The Committee Approved the Preceptorship Policy.

- **Retirement Policy**

  The Committee received the Retirement Policy which has been recently updated in accordance with the policy renewal date. An overview had been submitted to the Committee and assurance was provided that the Policy had previously been reviewed and approved prior to PAWC ratification.

  Resolved: The Committee Approved the Retirement Policy.

- **Menopause Policy**

  The Menopause Policy which introduced as a new policy to the Committee. An overview had been submitted to the Committee and assurance was provided that the Policy had previously been reviewed and approved prior to PAWC ratification.

  Resolved: The Committee Approved the Menopause Policy.

- **First Aid Policy**

  The Committee received the First Aid Policy which has been recently updated in accordance with the policy renewal date. An overview had been submitted to the Committee and assurance was provided that the Policy had previously been reviewed and approved prior to PAWC ratification.

  Resolved: The Committee Approved the First Aid Policy.

- **Health & Safety Policy – updated policy (approved)**

  The Committee received the Health & Safety Policy which has been recently updated in accordance with the policy renewal date. An overview had been submitted to the Committee and assurance was provided that the Policy had previously been reviewed and approved prior to PAWC ratification.

  Resolved: The Committee Approved the Health & Safety Policy.

The Chair acknowledged the current developments which remain ongoing and noted good progress being made.

22/23/267 **Health & Safety Committee (HSC) Minutes**

The Committee received the approved minutes of the HSC meeting held on (13th November 2023)

22/23/268 **Joint Consultative and Negotiation Committee (JCNC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on (21st February 2024)

22/23/269 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on (14th December 2023)

22/23/270 **Any Other Business**

No further business was raised.

22/23/271 **Review of Meeting – Chair's Report to Board**

Annual Workplan:

Terms of Reference:

Strategy Update:

Progress of the People Plan continues to progress forward in line with vision 2030. Good achievements being made to manage preceptorship and management Essentials with continued priority focus around the 3 big strategic themes.

Divisional Metrics:
Divisional metrics displays a very encouraged by trend particularly in staff Turnover and sickness absence.

Trust Wide Metrics:
Trust wide metrics continues to be regularly monitored in view of all hotspot areas.

PDR Deep Dive:
PDR's continue to show an improving trajectory, and GF is leading a piece of work to ensure full compliance by end April 2024.

Mandatory Training:
Mandatory Training compliance remains over the Trust target, but low in some areas but continues to drive forward in supporting Managers to improve figures.

Turnover Report:
September 2023 data showed a total 13.48% with trust target of 13% compared to quarter 2 which showed a decreasing rate month on month.

Nurse Retention Project Update:
A good forum of engagement within the preceptorship programme reached 32% who had access to one-to-one sessions and given historical supervision including group sessions. a total of £132k cost savings was achieved.

Staff Survey Results:
Staff Survey overall position reached 60% response rate. Some 'best in class' scores have been achived in the Staff Survey and overall very positive movement from 2023.

SALS PALS Update:
The new pilot programme continues to progress with support from Senior Leadership and is making good headway.

EDI Board Report:
The Committee received the report, which highlighted achievements during 23/24, and the commitment to the high impact action plan.

EDS22 Report:
Good progress made, and good examples of partnership working to development the self-assessment and associated actions plans.

BAF/Deep Dive 2.1/2.2:
Risk 2.1 risk rating 12 with a target of 4.
Risk 2.2 risk rating 9 with a target of 4.

Mitigation remains in place to review manage and maintain.

Policies for Ratification: APPROVED
Preceptorship Policy

Retirement Policy
Menopause Policy
First Aid Policy
Health & Safety Policy

The Chair noted good progress being made across all areas.

Date and Time of Next meeting
Wednesday 15th May 2024 at 2pm via MS Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Minutes of the meeting held on Monday 29th April 2024 at 13:00, Lecture Theatre 4, Institute in the park

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	(SA)
	Dame Jo Williams	Non-Executive Director	(JW)
	John Grinnell	Managing Director / CFO	(JG)
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
	Melissa Swindell	Director of HR & OD	(MS)
In attendance:	Nathan Askew	Chief Nurse	(NA)
	Sian Calderwood	Associate Chief Operating Officer – Medicine	(SC)
	Audrey Chindiya	Associate Finance Director – Operational Finance	(AC)
	Esme Evans	Business Accountant, Community & Mental Health	(EE)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Emily Kirkpatrick	Deputy Director of Finance	(EK)
	Jane Halloran	Acting Deputy Development Director	(JH)
	Emma Hughes	Acting Manging Director for Innovation	(EH)
	Hannah Grierson	Divisional Accountant – Medicine	(HG)
	Chloe Lee	Associate Chief Operating Officer – Surgery	(CL)
	Ellen Mathews	Head of Performance	(EM)
	Andy McColl	Deputy Director of Finance	(AMC)
	Graeme Montgomery	Business Accountant – Surgery	(GM)
	Natalie Palin	Associate Director Transformation	(NP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Laura Simon	Business Accountant - Medicine	(LS)
	Gary Wadeson	Associate Director Income, Costing & Commissioning	(GW)
	Amanda Graham	Executive Assistant (*minutes*)	(AG)

24/25/01 Apologies
Apologies were noted from Adam Bateman, Chief Operating Officer.

24/25/02 Minutes from the meeting held 25th March 2024
The minutes were approved as a true and accurate record.

24/25/03 Matters Arising and Action log
Updates to outstanding actions were given during the meeting.

24/25/04 Declarations of Interest
There were no declarations of interest.

24/25/05 Finance Report
Month 12 Financial Position
RL gave a brief overview of the M12 Finance report which was shared within the meeting pack, noting the position of £2m below forecast at year end. A prudent approach was taken of extrapolating the M9 position of no income and an on-plan control total position had been reached following a technical instruction adjustment for PFI. Both receivables and payables had been brought much closer to target resulting in a stronger position than previous years. The cash position was healthy

at year end, mainly due to capital project monies received but not yet spent, and a review is ongoing of available interest rates in line with the Treasury Management Policy. AN underspend had been recorded related to late-year disposals under the recommendation of auditors; this was offset by an overspend on leases which had been agreed by the ICB.

JK noted that the WTE was not listed and asked that this be included on the same basis as the ICB reporting to ensure clear visibility going forward. RL agreed, noting that this will be added to M1 with narrative once its reporting has been agreed to ensure consistency across this Committee and Workforce Committee. KW noted that this will also be in the IPR going forward. GW noted that the Divisions are showing actual figures with adjustments being actioned centrally.

Action: WTE and run rate to be included in report going forward (Audrey C)

Resolved:
RABD received and noted the M12 Finance report.

24/25/06 **Month 12 Integrated Performance Report**
EM highlighted:

Effective – ED achieved 84% against 76% nationally with 81.5% at Year End and 88% for Q1 to date. WNB reduction ongoing but more of a challenge within Community & Mental Health where work is ongoing as part of the OPD transformation and Revolutionising Care programmes.
Area of concern – theatre utilisation at 80% remains below the national target of 85%, with a workstream within the Revolutionising Care programme looking at this.

Responsive – at year end there was 1 patient over 65weeks which was a data error; Cancer volumes were maintained with 100% compliance to target; OPD has had a strong start with 129% Q1 to date.
Areas of concern - Community & Mental Health waits are a priority for 2024/25, particularly for ADHD with no diagnosis. A transformation programme has now been signed off and it is expected that more transparency of the work within pathways will give more insight to the areas of most concern. JG noted that RG & LC have been asked to look at where investment would be best targeted alongside the transparency to triangulate information. KW noted that an additional metric for ADHD Triage & Outcome from pathway can be added to the IPR to support this. EE added that work has been ongoing on the ND pathway and an update would be brought to the next meeting. JK commented that this feels like a growing pain indicative of the demand and there needs to be a more focused approach with processes in place and being followed. DJ noted that while neurodiversity is an ICB focus, no resource will go into ADHD. Place teams are being given new priorities and unexpected changes are taking place very fast with no clarity on the CYP agenda.
JG asked whether thought has gone far enough on non-clinical expenditure, the overriding message from the recent clinical leaders event was not to disempower. There is a need to develop the behaviours and drivers to think differently using technology, alternative ways of working, embracing AI. JK noted that there needs to be a look at workforce changes over the next ten years.

Action: Update on ND pathway work to be brought to next meeting (RG/EE)

EH noted that there is a real challenge to ourselves on the strategy - mapping workforce to key targets and using enablers within Futures in digital and data to

achieve the vision. KW added that creating clinical capacity and the impact of AI are within the Futures themes. JG noted that there will be increased scrutiny on workforce if the narrative isn't right. NA noted that sight must not be lost of pockets of workforce using traditional practices – this is an opportunity to revolutionise care alongside non-clinical working.

HFMA Sustainability checklist - undertake a review of this and assess where we are against this – note agreed with MIAA that this will form part of MIAA review in Q2 therefore suggest we wait for this to be complete and take back a full review but we may want to pull out any key areas.

Action: Review of HFMA sustainability Checklist to be included as part of the Q2 MIAA review. (Audrey C/ Emily K).

Optimisation
AMC presented slides detailing ongoing work on optimisation within the Trust, noting the positive work since March but adding that there is still £8m to be identified. There may be some non-recurrent slippage through Q1 with work ongoing to include recurrent. Not all workforce optimisation yet identified within Corporate. SDG will be returning in May every fortnight to keep scrutiny on this.

NP noted that staff turnover had given opportunities for £500k savings but there are concerns around delivering £1.4m. RL noted that the IQA did not yet have all data input and that this needs to be done. This was only recently shared at Operational Delivery Board and needs to go back in its next iteration. JK commented that there seems to have been a return to measuring what doesn't work, rather than by productivity measure, for example if sickness is reduced from 6% to 5%, that is 1% more workforce in the workplace. JG asked whether the granularity to look closer at department / team level detail is available.

JK noted that there may be some under-reporting of benefits achieved so could well be starting in a better position. JW added that this may take some time to pull together; JK added that the Trust need to demonstrate grip and control and be transforming at the same time; getting the balance right and changing the dialogue will likely take up to twelve months. DJ added the need for a more proactive Comms plan to respond to ICB demands and a need to put controls on the Vision 2030 work by asking "does this align to" and "how does it support delivery of" Vision 2030. RL noted that work is ongoing with the Comms team on this to gain the right balance so people will engage.

Resolved:
RABD received and noted the M12 IPR report.

24/25/07 **Surgery Division**
CL gave a brief overview of the Surgery position, noting the impact of industrial action on the adverse position of £1.2m behind after funding. Pay and Non-Pay are both behind plan, mainly due to unachieved CIP. Theatre schedule has had partial reinstatement with more to follow; a full capacity and demand review has allowed flexible sessions for HVLC and additional specialist Spine and Neurosurgery activity. A pilot of DGH partnership working is underway with Warrington to create hub capacity and an analysis of this will be brought to the next meeting.

Action: Analysis of Warrington Hub to be brought to next meeting (GM)

SA asked what the basis was of allocation of overheads and depreciation; RL replied that this was the agreed method and is based on floor space. Cost to run a service includes floor space, utilities, equipment etc. There can often be challenge on overhead costs for new developments and there is detailed information to support the numbers.

JW asked whether the hub is a benefit to Alder Hey or the system; CL replied that it is currently a pilot to Alder Hey's benefit but may well be system-wide but needs working through financially. DJ added that this is part of the CYP Alliance work where the intention is always to deliver in different ways. JK asked whether some services should be delivered away from Alder Hey, is there a better way to deliver and is there a way to define those services. DJ commented that this would be evidence for the Children's Committee Strategy. JG noted this would be not just strategic but also economic.

JG noted the improvement plan behind the Surgery position was very impressive with the ability to tease out indicators that show Surgery is doing OK and what measures there are to support that. JK noted that this is an example of what does good look like – growing activity and productivity needs to be shown. NP commented that it would be informative to see sickness / workforce data alongside to give an extra level of information and interrogation. JK noted that the improvement is evident over the last six months and by asking the right questions the data shows Futures what areas could be helped.
Actions for the year ahead were shared and will report into the Divisional Finance & Resource Group. NA noted that the data around Critical Care shows it makes a loss but it is as efficient as it can be.

Action: SLR: It was agreed further detail would be shared on apportionment/depreciation. (Gary W)

Resolved:
RABD received and noted the M12 Surgery report.

24/25/08 **Medicine Division**

SC gave a brief overview of the Medicine position, noting that following a deep dive there is now more awareness around coding and that while there were overspends on sickness and Pharmacy, overall ERF activity is £2.8m ahead of plan due to overperformance in Nephrology, Neurology and ED. The adverse YTD position is due to consultant premium costs, clinical supplies relating to activity & laboratory testing and the impact of industrial action. It was noted that there is now updated data & costings for the more expensive assets and work is ongoing to look at best utilisation and potential income generation of these either by NHS or private use. SC noted that just 5% of children attending ED accounted for 17% of the overall attendance and this will be a target for focussed intervention work going forward.

JK asked whether the Newton report would be useful for the Division to review against their performance. DJ noted that the relationships between non-elective, complex, urgent and emergency care align to the Revolutionise My Care / Futures pillar in the Vision 2030. KW noted that while there is no delivery programme for Urgent & Emergency Care, it would be good to understand the 5% shown on the slide. JG commented that this demonstrates really good work and feels transformational.

Action: Newton report to be shared with Division of Medicine (DJ)

Resolved:
RABD received and noted the M12 Medicine report.

24/25/09 **Community Division**
Update carried forward to next meeting due to time pressures – slides in meeting pack. EE noted that analysis work is ongoing, focusing on service lines and looking at the detail.

Resolved:
RABD received and noted the M12 Community & Mental Health report.

24/25/10 **Corporate Collaborative**
ES gave an update on the Corporate position, noting that there are areas within this group are not within her management. Catering and parking price increases are to be worked through; also in relation to income, the Academy are looking at income generating opportunities around collaboration work in Futures. A Trust-wide mutually agreed resignation scheme (MARS) is now open until late July and it is hoped that this will bring some movement on staffing. The Corporate Services return has given an opportunity to drill down and on review some of the granular information last year has been found to be incorrect. The Corporate Services Collaborative continues to meet monthly with a significant focus on collaborative opportunities as well as efficiencies and review of annual plans. Those services whose plans have not yet had scrutiny are due to take part in a final round shortly.

SA asked for clarity on the overspend within legal and professional fees; ES noted that this will be shared next month following a detailed review, adding that this also includes memberships to system-wide organisations not budgeted for elsewhere. RL noted that there is a figure kept in reserve for legal costs that are not budgeted.

JK noted that the WTE numbers look imbalanced with bank included in the top lines but separate in the lower lines; RL replied that only certain teams use bank & agency staff within the Corporate areas.

Action: Further work and challenge to be carried out on WTE in relation to CIP. (Andy Mc/Cristina P).

Resolved:
RABD received and noted the M12 report from Corporate Services.

24/25/11 **Workforce Analysis**
MS presented a brief overview of the recent audit and review of bank spend against sickness across the Trust, noting the reduction in sickness but increase in bank spend to cover sickness.

JK reflected on whether this was causal and noted the qualitative work to get to the granular data, MS noted that the HR team are working with Allocate to gain better understanding of the data and more informed reporting NA noted that this links with what is already known but also informs on what is not known, adding that one known example where Sickness is recorded as the reason for requiring bank staff is where it is easier to click the first line on the drop-down box, rather than seek the more accurate reason.

Resolved:
RABD received and noted the Workforce audit report.

24/25/12 **Campus Update**

JH highlighted that the paper contains details of the Neonatal costs and delivery progress to date, adding that turfing and seeding is ongoing in the Park and is expected to finish in late July. The preferred supplier for the Fracture / Dermatology work is now going through Mitie's supplier governance process.

JG noted that due to the complexity there needs to be closer scrutiny with a broader programme report.

Action: More detailed report to be prepared for next meeting and ongoing (Jayne H/Graeme M).

Resolved:
RABD noted progress to date of the Campus projects.

24/25/13 **PFI**

It was noted that nobody was available to present the PFI report which was taken as read.

Action: PFI report to be presented in person at the next meeting (GD / CG)

Resolved:
RABD received and noted the current PFI position.

24/25/14 **Board Assurance Framework**

ES gave a brief update on the latest BAF report, noting that a conversation has ben had around risk appetite and the outcome will be brought to the next meeting as there is a lot to be considered around financial environment.

Action: Risk appetite to be discussed in more detail at next meeting (ES)

Resolved:
RABD received and noted the Board Assurance Framework.

24/25/15 **2030 Programme Board – Chair's report**

NP gave a brief update, noting the revised assurance framework which has been designed to provide assurance of progress of delivery within an environment that is able to challenge and to recognise challenges to that delivery. It is expected that there will be a monthly Chair's report and a bi-monthly progress report.

Resolved:
RABD received and noted the Chair's report from the 2030 Programme Board.

24/25/16 **Annual Report**

RL noted that the Committee's Annual Report was included in the pack.

Resolved:
RABD received and noted the RABD Committee Annual Report.

24/25/17 **Terms of Reference**

RL noted that a meeting had been held with ES to discuss the Terms of Reference and changes made have now been aligned to the Workplan. The Terms of Reference will be finalised and brought to the next RABD meeting for sign-off. Details around a brand, Strategy Board and Global work are yet to be defined.

JK asked whether the papers will change at all following the change of focus for the next year; RL noted that there will be slight changes to incorporate the top four key risks on a dashboard to give a monthly update at the head of each meeting. SA asked if that would create any duplication of information; JK asked whether this would be macular against granular detail within papers; NP responded that the level of detail provided to committees will vary.

EH asked whether there will be clarity of what is contained within Futures and whether all commercial work will be within Futures; RL advised that RABD will still oversee commercial activity from a finance perspective and Futures Committee will oversee implementation of the strategy. JK confirmed that ultimately Trust Board set the budget for Futures and RABD will oversee that.

Action: Finalised Terms of Reference to be brought back for sign-off (RL/ES)
Action: Top four key risks dashboard template to be brought to next meeting (RL)

24/25/18 **Workplan**
The Committee received and noted the Workplan for 2024/25.

24/25/19 **Any Other Business**
No other business was recorded.

24/25/20 **Review of Meeting**
The Chair noted the incredible achievement of achieving financial targets in 2023/24 and acknowledged the work undertaken against the vision and strategy to deliver that performance. Improvements in workforce data are ongoing to provide richer, measurable data, with a new key risk dashboard expected next month to give clear vision of the four key risks.

Date and Time of Next Meeting: Thursday 23rd April 2024 at 1:30pm, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	**Resources and Business Development Committee – 2024/25 Key Risks (May's Position)**
Report of:	**Chair of the Resources and Business Development Committee**
Paper Prepared by:	Deputy Director of Finance

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
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

24/25 Key Risks – May Position

0243

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M1
Financial Performance including system position	Challenging 24/25 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	Month 1 position reported off plan due to efficiency savings below target. Overall C&M plan off at M1 and 24/25 plan not yet approved - £150m deficit target set by NHSIE Further stretch allocated out to providers to meet target – for AH this is £708k and largely relates to non clinical workforce reduction.	High
Capital Programme	Limited CDEL allocation in 24/25 Significant capital investment required and prioritisation required.	Medium	Capital Management Group reinstated for greater oversight in 24/25. Plan for 24/25 approved with requirement to reduce plans in areas to meet affordability within CDEL. Confirmation now received of £5m UEC incentive capital which will be used to bridge gap in funding for ground floor of NICU/PAU.	Medium
Efficiency Programme	Plan assumes delivery of £19.3m recurrent savings. Highest level set in any one year. Managing of message to organisation alongside delivery of 2030 vision.	High	Overall target increased to £19.95m, including ICB stretch target for non-clinical pay savings. M1: £11.1m in Green and Amber Forecast for M2: £12m Green and Amber Full impact of MARS will be assessed in July.	High
Benefits Realisation	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	Medium	The new framework has been launched and is being used across the 2030 Vision Programme. However, 7 out of 17 strategic-level programmes still require a benefit case inclusion. SROs have been asked to confirm their completion schedules. The 24/25 IPR includes Strategic Goals Driver measures, with 4 out of 9 in development and 2 scheduled for completion by July 2024. A single financial tracker is being used across all programmes.	Medium
Campus	Complex campus programme across multi sites.	Medium	No significant risks to report, programmes progressing in line with programme.	Medium

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2024

Paper Title:	**Board Assurance Framework Report (April 2024) and Year-end 2023/24 Report**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Monthly BAF Reports
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
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 April 2024.				As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2024/25

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 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	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	Resources and Business Development Committee
		Safety & Quality Assurance Committee
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People & Wellbeing Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People & Wellbeing Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People	Futures Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Resources and Business Development Committee

3. Summary of the BAF at 13th May 2024

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	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	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	RABD / SQAC	**3x5**	3x3
STRATIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	PAWC	3x4	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	PAWC	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	PAWC	4x3	4x1
STRATEGIC OBJECTIVE: 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	4x3	3x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	RABD	3x4	4x2
3.4 JG	Financial Environment	RABD	**4x4**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	**4x4**	3x3
STRATEGIC OBJECTIVE: Pioneering breakthroughs				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Futures	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	RABD	3x4	2x4

4. Summary of April 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  A meeting has been arranged to fully review this risk and align to the 2030 vision. The risk has been reviewed and continues as described pending the full review.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in April significantly increased above the national standard of 78%, achieving 88.5%

  Continued improvement plans are in place for Sleep Studies (sickness) and Gastro (availability of theatres) to improve the Overall DMO1 compliance, achieving 87.8%.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. The trust achieved zero 78 weeks at end of April 2024. The number of patients waiting over 65 weeks at end of April was 31. The requirement for zero 65 weeks set by NHS England has been extended to 30th September 2024. Focus on most challenged areas (Dental, ENT & Spine) will continue to meet this target with the internal aim to reach 60 weeks by end August 2024.

  Risk remains for achieving 65-week cohort regarding cancellation of agreed appointments, potential doctors strikes but these patients are being closely monitored by services.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  Weekly meetings with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved.

  The Trust is awaiting the March/April update on pipework issues.

  It was reported in April that leaks have decreased by 47% compared to 2022.

  In overall terms the leaks in 2023 amount to 4.5% of the total leaks between 2017 to 2023.

  Out-of-range water temperatures continue to be monitored and local mitigations are in place such as filters on water outlets, and later this year we will introduce a chemical dosing system across the site.

  Joint water safety workshops continue, and we are awaiting further details on the dosing system. This has been escalated several times due to the length of time Project Co are taking in resolving. The Trust is informed that progress is being made on water temperature works.

Chiller commissioning works continue positively with further works planned during May which will then bring all chillers into active use.

Works on the skylights will commence on the 15th April 2024 with all lights completed and compound struck down with landscapes re-instated by December 2024.

- ***Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (LC)***
  Review of risk and actions undertaken. Monthly review meetings with Clinical Leads and General Manager remain in place.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (MS).***
  Risk score remains unchanged - all actions remain on track.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS)***
  Risk reviewed. Actions updated. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risk reviewed, actions reviewed and on track.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed - no change to score (likelihood and impact updated to reflect further completion of park works). Risk remains a 12.
  3 out of 3 infrastructure works complete and site fully handed over to contractor.
  Other Campus activities on target for completion.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (KW).***
  The risk has been thoroughly evaluated, and the score remains unchanged, though it will continue to be reviewed in response to the financial environment and the progression of the planned transformation benefits. Our transformation programme is well-aligned with our annual plan. A specific risk has been flagged concerning our operational focus in quarters 1 and 2, driven by the necessity to achieve financial targets. There is a concern that this focus might inadvertently compromise the long-term transformational benefits. This issue will require vigilant management to ensure that immediate financial achievements do not overshadow our strategic goals for sustained improvement.

- ***Financial Environment (JG).***
  Risk reviewed and amendments made to title and impact to reflect current situation. No changes to risk score remains at 16. Actions reviewed and updated to reflect new financial year.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; no change to score in month, controls and actions reviewed./updated. Watching brief re emergent ICB controls and prioritisation.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  No change to risk score in month. Emerging Futures strategy endorsed by Futures Committee and Trust Board. Actions aligned with 5 issues causing the risk and shared between Sarah Leo and Emma Hughes.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  AlderCare Optimisation is progressing well with over 20 key developments delivered since its inception. Cyber Plans currently under review and collaboration with Clatterbridge is currently under way. Options appraisal for key Data and Analytics post to be developed in May for decision.

5. Corporate risks (15+) linked to BAF Risks (as at 29 April 2024)

There are currently 26 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.4	Dec 2017	*Apr 2023
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties	3x5	Business Support		Mar 2024	Mar 2024
2623	When the CT breaks, this causes disruption to other services who rely heavily on CT and patients receiving their treatment.	4x4	Medicine		Apr 2022	Mar 2024
178	Major Incidents disrupting the Trusts ability to maintain statutory duties	5x3	Business Support		Apr 2024	Apr 2024
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	4x4	Community	2.2	Feb 2023	*Apr 2023
169	Use of Physician Associates within the Safeguarding Services	4x4	Community		Mar 2024	Mar 2024
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	4x4	Medicine	1.2	Jul 2021	Mar 2024
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	2.2 & 3.4	Feb 2024	Feb 2024
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support	1.2, 2.1 & 2.2	Feb 2024	Feb 2024
117	Safe follow up care	4x4	Business Support	1.2, 2.1 & 2.2	Dec 2023	Dec 2023
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	4x4	Surgery	3.4	Aug 2022	Feb 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	allocated for device replacements. the remaining £4m is "at risk" and will roll over into next year's replacement budget which will then stand at £9.5m					
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4	Dec 2019	*Apr 2023
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
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		Jul 2022	*Apr 2023
91	Junior doctor staffing in general paediatrics	5x3	Medicine	2.1	Oct 2023	Oct 2023
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	2.2	Mar 2022	*Apr 2023
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	3x5	Medicine	2.1 & 2.2	Nov 2022	*Apr 2023
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	2.1 & 2.2	Jan 2020	*Apr 2023
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	Feb 2023	Mar 2024
132	Gender Service	4x4	Community	2.1	Jan 2024	Jan 2024
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	3x5	Community		May 2022	*Apr 2023
111	Anaesthetic cover out of hours	5x3	Medicine	1.2, 2.1 & 2.2	Nov 2023	Nov 2023
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)						
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.4	Jul 2021	*Apr 2023
2019	Delay in access to assessment and follow up treatment with the Community Speech and Language Therapy Service	3x5	Community	1.2	Nov 2019	Nov 2023

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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	Feb 2021	*Apr 2023
117	Safe follow up care	4x4	Business Support	1.1, 2.1 & 2.2	Dec 2023	Dec 2023
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (3x5=15)						
1524	Delayed initiation and review of ADHD medication	4x4	Community	1.1	Dec 2017	*Apr 2023
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1	Dec 2019	*Apr 2023
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2	Jul 2021	*Apr 2023
STRATEGIC OBJECTIVE: Support our people						
2.1 Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (3x4=12)						
91	Junior doctor staffing in general paediatrics	5x3	Medicine	1.1	Oct 2023	Oct 2023
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	4x4	Medicine	1.1	Jul 2021	Mar 2024
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.2	Mar 2022	*Apr 2023
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support		Feb 2024	Feb 2024
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	Nov 2022	*Apr 2023
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.2	Jan 2020	*Apr 2023
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	Feb 2023	Mar 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
132	Gender Service	4x4	Community	1.1	Jan 2024	Jan 2024
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.2	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.2	Dec 2023	Dec 2023
2.2 Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (3x3=9)						
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.1	Jan 2020	*Apr 2023
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	1.1 & 3.4	Feb 2024	Feb 2024
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support		Feb 2024	Feb 2024
2589	Inability to safely staff Catkin and Community Clinics	4x4	Community	1.1 & 2.1	Mar 2022	*Apr 2023
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.1	Nov 2022	*Apr 2023
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1	Feb 2023	*Apr 2023
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.1	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.1	Dec 2023	Dec 2023
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)						
	None					
STRATEGIC OBJECTIVE: Collaborate for children and young people						
3.1 Failure to fully realise the Trust's vision for the park and Alder Hey campus (3x4=12)						
	None					

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (3x4=12)						
	None					
3.4 Financial Environment (4x4=16)						
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		Aug 2022	Feb 2024
150	Failure to renew Abbott contract would put Biochemistry service at risk	4x4	Medicine	1.1 & 2.2	Feb 2024	Feb 2024
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
166	Gap of Innovation Chief Technical Officer (TCO)	5x3	Business Support - Innovation		Jan 2024	Jan 2024
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (3x4=12)						
	None					

* risk movement data not available pre-move to InPhase

6. Month-on-month overview of risk scores during 2023/24 (April 2023 to March 2024)

BAF Risk		2023									2024		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
STRATEGIC PILLAR: Delivery of Outstanding Care													
1.1	Inability to deliver safe and high-quality services	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5
1.3	Building and infrastructure defects that could affect quality and provision of services.	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3
1.4	Access to Children and Young People's Mental Health	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5
STRATEGIC PILLAR: The Best People doing their Best Work													
2.1	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	3x5	3x5	3x5	3x5	3x5	4x5	4x5	3x5	3x5	3x5	3x5	3x4
2.2	Employee Wellbeing	3x3	3x3	3x3	3x3	3x3	3x3	3x3					
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families								3x3	3x3	3x3	3x3	3x3
2.3	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	4x3
STRATEGIC PILLAR: Sustainability through External Partnerships													
3.1	Failure to fully realise the Trust's Vision for the Park and Campus	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4
3.2	Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships	4x3	4x3	4x3	4x3	4x3	4x3	4x3					

BAF Risk		2023									2024		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
3.2	Strategy Deployment								3x4	3x4	3x4	3x4	3x4
3.4	Financial Environment	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.	4x4	4x4	4x4	4x4	4x4	4x4	4x4					
3.5	System Working to deliver 2030 Strategy								4x4	4x4	4x4	4x4	4x4
3.6	Risk of partnership failures due to robustness of partnership governance.	3x2	3x2	3x2	3x2	3x2	3x2	CLOSED					
STRATEGIC PILLAR: Game-Changing Research and Innovation													
4.1	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..	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
4.2	Digital and Data Strategic Development and Delivery	4x4	4x4	4x4	4x4	4x4	4x4	3x4	3x4	3x4	3x4	3x4	3x4

7. Analysis of the risk ratings

It can be difficult to effectively score and update the ratings of BAF risks, because of their very nature they are often a composite of a number of lower-level risks: the risk rating score is therefore largely indicative at any point in time and any consideration of progress at the end of a year represents a direction of travel rather than an absolute score. However, the following observations can be made:

- Of the 14 risks on the BAF during the course of the year seven didn't change their risk rating
- Children and young people waiting beyond the national standard to access planned care and urgent care remains the biggest risk to the Trust currently scoring 20 (*major x almost certain)*.
- No risks increased in score during the year.
- The following risks evolved to better reflect risk to delivery of our 2030 Strategy:
    - 'Employee Wellbeing' to 'Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families'
    - 'Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships' to 'Strategy Deployment'. This meant a reduction in risk score.
    - 'ICS: New Integrated Care System NHS legislation/system architecture' to 'Risk of inability to control future in system complexity and evolving statutory environment to System Working to deliver 2030 Strategy'.
- Risk of partnership failures due to robustness of partnership governance was reduced to its target score of 6 *(moderate x unlikely)* and closed in October 2023.
- The risk relating to Digital and Data Strategic Development and Delivery reduced in score following the successful implementation of Alderc@re.

8. 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.

May 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. Robust reduction programme in the number of medication incidents and near misses 3. Impact of Industrial action in the safe delivery of care and progress against recovery 4. The CQC will move to a new oversight framework which may reduce our CQC ratings 5. The 2030 vision sees a shift to a consumer focussed experience with 5 workstreams with key deliverables for year 1, without any additional resource 6. The new models of care workstream will need to redefine the delivery of services whilst maintaining the principles of the strategy 7. Alder Care (Expanse) has been implemented across the organisation which poses risks until stabilisation.

Action	Description	May 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.

May 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	May 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

May 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	May 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

Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	
Risk Number	Strategic Objectives
1.4	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.

May 2024	
Control Description	Control Assurance Internal
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is is now being fully implemented.	Business case (attached)
Weekly performance monitoring in place for operational teams which includes: • Weekly Tuesday/Wednesday meeting with PCOs • Divisional Waiting Times Meeting each Thursday • Trust Access to Care Delivery Group each Friday This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: • Monthly contract statements • Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software

Gaps in Controls / Assurance

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to legacy waiting times and recruitment issues as a result of national workforce shortages.

Action	Description	May 2024	
		Due Date	Action Update
Continued workforce planning	Continued workforce planning including: - introduction of new roles - continued representation at C&M workforce meetings - review of all job descriptions and person spec to ensure consistency and ability to progress - development of preceptorship/development pathway	30/09/2024	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/05/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	03/04/2024	email sent to Will Calvert re. implementation phase. original request to start implementation was sent on the 19.02.24 - was advised that implementation takes around 28 days - I've emailed to chase where things are up to and will update BAF once I receive a response
Proceed with changes to CAMHS internal waiting times measures	Proceed with changes to CAMHS internal waiting times measures including: SOP/Pathway to be created Training plan for clinical and admin staff to be created and rolled out Data and reporting	31/05/2024	
Review of KPIs and Reporting Measures	Review of KPIs and reporting measures for Sefton & Liverpool place	31/05/2024	

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	
Risk Number	Strategic Objectives
2.1	The Best People Doing Their Best Work

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

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	People & Wellbeing Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation. 3. Not developing inclusive recruitment and talent management practices to improve workforce diversity

May 2024	
Control Description	Control Assurance Internal
Monthly Ops Board monitoring	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
People Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Apprenticeship Strategy implemented	Annual update to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to Board and PAWC
Nursing Workforce Report	Reports to PAWC, SQC and Board
Nurse Retention Lead	Bi-monthly reports to PAWC
Recruitment Strategy currently in development	progress to be reported PAWC
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Lack of robust talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation

Action	Description	May 2024	
		Due Date	Action Update
1. Not meeting compliance target in relation to some mandatory training topics	Process in place to monitor take up of training by topic; subject matter experts engaged in the process	31/03/2024	Work continues to monitor sickness absence through the divisions and will all of the relevant support through OH and SALS
3. Workforce Planning	3. Workforce planning across the organisation.	30/04/2024	Establishment control project close to completion before commencing the wider workforce planning project
5. Lack of a robust Trust wide Recruitment Strategy	5. Recruitment Strategy currently being developed in line with the actions set out in the NHS people plan	30/06/2023	Action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased. A Business Case has been shared with Exec Team - outcome awaited.

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	
Risk Number	Strategic Objectives
2.2	The Best People Doing Their Best Work

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

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	People & Wellbeing Committee

Description
Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision.

May 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthyl reporting to PAWC
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on Trust Intranet and accessible for staff
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2023 Staff Survey Report - main report, divisional reports and team level reports
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Thriving Leadership Programme	Strategy implementation as part of the People Plan
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at People and Wellbeing Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PAWC
Alignment of staff safety and patient safety work via developing safety culture training and developing Restorative Just & Learning culture strategy	Patient Safety Board minutes
Monthly Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Associate Director of Organisational Development and enables shared thinking about teams in need of support and joint working where indicated.	

Gaps in Controls / Assurance
- lack of embedded safety culture across the organisation - lack of understanding about a just and restorative culture approach - lack of consistent compassionate leadership - Inconsistent application of Trust values and behavioural framework - insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas - insufficient OD resource available to fully address all culture tensions and challenges when they arise

Action	Description	May 2024	
		Due Date	Action Update
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards.	30/09/2024	Staff survey data packs complete with methodology developed by BI. Work now in progress to develop a BI dashboard beginning with the staff survey results. Safety Culture data available at an organisation level and shared with Patient Safety lead. Work underway to ensure safety culture metric developed and part of overall team effectiveness dashboard. Staff Thriving Index pilot complete and index agreed with CPO. Implementation plan now in development.
Culture strategy development to include governance framework supporting culture work	Culture strategy to be developed and to include review of governance framework and reporting processes for culture work including via Patient Safety Strategy Board and People and Wellbeing Committee.	28/06/2024	Developing culture strategy to be presented and discussed at Trust Board in June.
Leadership competencies	NHSE Board level leadership competencies published with full appraisal process to follow in autumn 2024. All leader competencies to be developed based on same principles with reference to NHSE line manager competencies and other published leadership competencies.	31/10/2024	
Leadership programme review and update	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focussed review and development	30/09/2024	Strong Foundations review planned with a view to enhancing culture component. Clinical Leadership review in planning stage following Clinical Leaders away day. Plan to engage in individual listening sessions with all clinical leads in July. Insights to inform second Clinical Leads away day and to inform potential redesign of Clinical Lead roles to include consistent and robust set of leadership competencies coupled with an enhanced development and support offer.
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/07/2024	Meeting with Director of Transformation on 4th April to discuss @its Best MDT model and underpinning resource. Output to be reviewed with Head of OD. Consider next stepts in terms of building capability across HR and other supportive People functions.
Safety culture training	Safety culture training to be developed and implemented with teams to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	28/06/2024	Safety culture and human factors training pilot delivered with all PICU staff (completed March 2024). Pilot review to be arranged with Patient Safety training and leadership team to determine feasibility of and agree next steps for roll out across the organisation.
Values and behavioural framework review, update and implementation	Current values and associated behavioural framework to be reviewed in dialogue with segmented groups of staff to develop updated values and underpinning framework. Both to be embedded across the organisation with support from Brilliant Basics.	15/07/2024	

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	
Risk Number	Strategic Objectives
2.3	The Best People Doing Their Best Work

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

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	4	People & Wellbeing Committee

Description
- Failure to have a diverse and inclusive workforce which represents the local population. - Failure to take steps to become an inclusive work place where all staff feel their contribution as an individual is recognised and valued. - Failure to provide equal opportunities for career development and growth. - Non-compliance with the public sector equality duties

May 2024	
Control Description	Control Assurance Internal
Establishment of 4 x Staff Networks	All networks have appointed chairs, supported by Head of EDI. members of EDI Steering Group and report bi-monthly
Education and Training in EDI	Mandaotry EDI Training for all staff. current compl;iance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
PAWC Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PAWC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	monitored through PAWC
People Policies	People Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
NHS England Improvement Plan supported by Trust Board, and associated actions into action plan	NHSE EDI Improvement Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 3 of delivery, continues to include a focus on inclusive leadership
EDI Steering Group established - Chaired by NED	Minutes reported into PAWC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People and Wellbeing Committee
Gaps in Controls / Assurance	
Multi-factoral issues spanning training and education, sufficient EDI resources to support the agenda, cultural awareness and understanding	

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	
Risk Number	Strategic Objectives
3.1	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
		Rachel Lea

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Resource And Business Development Committee

Description
The Alder Hey long term vision for the Alder Hey Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale and in partnership with the local community and other key stakeholders as a legacy for future generations

May 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. Park Handover 3. Weather conditions causing potential delays CAMPUS: 1. Stakeholder Engagement 2. Successful realisation of the moves plan. 3. Funding availability and potential market inflation.

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

Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	
Risk Number	Strategic Objectives
3.2	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Resources and Business Development Committee

Description
Risk of failure to: - translate the 2030 Vision into operational plans and systematically execute. - deliver on the strategic ambitions to make a difference to CYP impacting on the delivery of the NHS Long Term Plan and Trust's reputation.

May 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	May 2024	
		Due Date	Action Update
2. 2030 delivery programme and plan	Trust Board signed off 23/24 multi-year April 2024. Delivery scope and plans developed for all strategic goals, required at a subject level.	31/03/2025	
3. Developing skills and capacity to deliver the Strategy 2030 (24/25)	This task has started across the individual workstreams, but given the shift that 2030 this will be continued task. New skills and capacity has been secured through the appointment of a Public Health Consultant (Started - May 24). New customer service capabilities are being developed through the roll out of customer service training in health care (April 24). The Managers Essential training which has started deliver provides a further opportunity to equip leaders/managers across Alder Hey, to support there teams to thrive (April 24).	12/12/2024	
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	

Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments.					
Risk Number			Strategic Objectives		
3.4			Strong Foundations		
CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		John Grinnell	16	12	Resource And Business Development Committee

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

May 2024	
Control Description	Control Assurance Internal
Organisation-wide financial plan.	Monitored through IPR 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 annual plan reviewed 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. Updated 5 year capital plan shared with RABD and Trust Board.
Divisional performance discussed at RABD with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through RABD 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 DOF with action plan detailing mitigation to bring back into budget.

Gaps in Controls / Assurance
1. Changing financial regime and uncertainty regarding income allocations and overall financial position of Trust. 2. Long Term tariff arrangements for complex children shows underfunding of c£3m for Alder Hey 3. Devolved specialised commissioning and uncertainty impact to specialist trusts 4. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme 5. Long Term Plan shows £3-5m shortfall against breakeven 6. Deliverability of high risk recurrent CIP programme 7. Increasing inflationary pressures outside of AH control 8. Divisional budget positions are not acheived due to emerging cost pressures and impact of Industrial Action.

Action	Description	May 2024	
		Due Date	Action Update
Changing financial regime	1. Continued annual Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2025	
Delivery of 5 year programme	4. Five Year capital plan	31/03/2025	23/24 Capital plan submitted in final plan. Due to changes in CDEL limits for the future years, further work is ongoing on the next 3 years including a review with each capital lead. This work will be complete and presented to executive team early June and reported back through 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	31/03/2025	
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	
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. Risk of lack of focus on CYP agenda in febrile system environment; leading to lack of pace, resource and investment.

May 2024	
Control Description	Control Assurance Internal
Membership of CMAST & MHLDC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST Committee in Common in place and working CMAST - CYP alliance established. MHLDC committed membership from Alder Hey and establishment of a CYP workstream.
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	Beyond Programme recurrently funded by ICS. Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board.
Impact of changing NHS finance regime, commissioning intentions (described in BAF 3.4)	See BAF 3.4 (financial environment)
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.
Joint development of new models of care on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board and Strategy Leadership Group
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings
Maintain effective existing relationships with key system leaders and regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually).
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Reporting through Strategy Board
Implementation of Vision 2030 is dependent on building capability and capacity to deliver in the new system environment. This requires both additional capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	Assessment of central team capacity along with a 24/25+ plan to address gaps to be undertaken with MD & CSPO in December 23. Linked with COO and divisions for wider capacity and capability across clinical teams.

Gaps in Controls / Assurance
1. Uncertainty over future commissioning intentions (see BAF 3.4 re finance) 2. Future delegation of Specialist Commissioned services into ICSs – shadow arrangements under definition 3. Executing the comprehensive Stakeholder Engagement Plan 4. National mandates forcing us to prioritise unexpected programmes of work 5. System finance and productivity challenges creating risk of short notice reprioritisation of system level work and resource

Action	Description	May 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.

May 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	May 2024	
		Due Date	Action Update
1. Integration of R&I activities into Futures	Completion of Research Strategy. Strategy approved by R&I Committee in Jan 24 subject to minor amendments. Amendments made and shared with new Futures Committee in April. Production of final version with design company underway.	31/03/2024	Starting
2a. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2025	
2b. Activity Levels	Review of CRD trials portfolio. Activity levels currently stable and building capacity to increase AH led research.	31/03/2025	
3a. Financial Model	Case for internal and multi-sector inward investment. Plans underway through £10m club to secure external funds for internal investment to grow through Futures	30/06/2024	
3b. Financial Model	Development of new commercial partnerships Commercial pipeline in research - multiple studies in set-up. New partnerships being explored by commercial research working group.	31/03/2025	
4. Capacity and capability	Greater engagement with and education of R&I communities Futures people pillar established, Futures programme Board to commence in May 2024	31/03/2025	
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	
5. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy. New post agreed (CRD funded) to support marketing and comms for Futures - est start date Sept 24	31/03/2025	

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	
Risk Number	Strategic Objectives
4.2	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.

May 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	May 2024	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2025	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/08/2024	Programme to commence Nov 2023
Cyber Security	Completion of Cyber Essentials Plus Collaborate with Clatterbridge to share learning and best practice	14/05/2024	
Experienced Resources	Assess workforce and develop options appraisal for impacted services	14/05/2024	