# BOARD OF DIRECTORS PUBLIC MEETING
**Thursday, 4th July 2024, commencing at 11:15am**
**Lecture Theatre 2, Institute in the Park, Alder Hey**
**AGENDA**

| No. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| **PATIENT STORY (11:15am-11:30am)** | | | | | | | |
| **1.** | **24/25/106** | **11:30<br>(1 min)** | **Apologies.** | Chair | To note apologies. | **N** | For noting |
| **2.** | **24/25/107** | **11:31<br>(1 min)** | **Declarations of Interest.** | All | Board members to declare an interest in particular agenda items, if appropriate. | **R** | For noting |
| **3.** | **24/25/108** | **11:32<br>(2 min)** | **Minutes of the Previous Meeting.** | Chair | To consider and approve the minutes of the meeting held on: **6th June 2024.** | **D** | Read enclosure |
| **4.** | **24/25/109** | **11:34<br>(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.** | **24/25/110** | **11:35<br>(10 mins)** | **Chair/CEO's Update; including:**<br>• **Update on July's Strategy Board.** | Chair/<br>L. Shepherd/<br>J. Grinnell | To receive an update on key issues and discuss any queries from information items.<br>To receive an update on July's Strategy Board. | **N** | Verbal |
| **Collaborating in Communities** | | | | | | | |
| **6.** | **24/25/111** | **11:45<br>(15 mins)** | **LUFT/LWH/Alder Hey Partnership Update; including:**<br>• **Liverpool Neonatal Partnership governance update.** | L. Shepherd<br><br>A. Bass | To receive an update on the current position and confirm support for the proposed reinvigorated partnership approach.<br>To receive an update on the current position. | **D**<br><br>**N** | Read report<br><br>Verbal |
| **Operational Issues** | | | | | | | |

| 7. | 24/25/112 | 12:00<br>(40 mins) | **Evidence of our Performance:**<br>• **Integrated Performance Report for M2, 2023/24:**<br>- **Experience and Safety.**<br>- **Revolutionising Care.**<br>- **Pioneering.**<br>- **People.**<br>- **Collaborating for CYP.**<br>- **Resources.**<br>- **Divisions**<br>➢ **Gender Service (North Programme) update.**<br>• **M3 Flash Report/ Operational Overview.** | A. Bateman<br><br><br>N. Askew<br>A. Bateman<br>A. Bateman<br>M. Swindell<br>D. Jones<br>J. Grinnell<br>Divisional Directors<br>L. Cooper<br>A. Bateman | To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br><br>To receive an update on the current position.<br>To receive an update on the current position. | **A**<br><br><br><br><br><br><br><br><br><br><br>**A**<br>**A** | Read report<br><br><br><br><br><br><br><br><br><br><br>Read report<br>Read enclosure |
|---|---|---|---|---|---|---|---|
| 8. | 24/25/113 | 12:40<br>(10 mins) | **Alder Hey in the Park Campus Development Update.** | J. Halloran | To receive an update on key outstanding issues/risks and plans for mitigation. | **A** | Read report |
| **Lunch (12:50pm – 1:10pm)** | | | | | | | |
| **Unrivalled Experience** | | | | | | | |
| 9. | 24/25/114 | 13:10<br>(5 mins) | **Learning from Patient Safety Incidents.** | N. Askew | To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour. | **A** | Read report |
| 10. | 24/25/115 | 13:15<br>(5 mins) | **Mortality Report, Q4.** | A. Bass | To receive the Mortality Report for Q4. | **A** | Read report |
| 11. | 24/25/116 | 13:20<br>(5 mins) | **Use of the Mental Health Act Annual Report, 2024.** | L. Cooper | To receive the Use of the Mental Health Act Annual Report for 2023/24. | **N** | Read report |
| 12. | 24/25/117 | 13:25<br>(5 mins) | **Use of Restrictive Physical Interventions Annual Report 2023/2024.** | L. Cooper | To receive the Use of Restrictive Physical Interventions Annual Report for 2023/24. | **N** | Read report |
| 13. | 24/25/118 | 13:30<br>(5 mins) | **Safety and Quality Assurance Committee:**<br>- **Chair's Highlight** | F. Beveridge | To escalate any key risks, receive updates and note the approved minutes from the 22.5.24. | **A** | Read enclosure |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | **Report from the meeting held on the 19.6.24.**<br>- **Approved minutes from the meeting held on the 22.5.24.** | | | | |
| **Pioneering Breakthroughs** | | | | | | | |
| **14.** | **24/25/119** | **13:35 (5 mins)** | **Futures Committee:**<br>- **Chair's Highlight Report from the meeting held on the 26.6.24.**<br>- **Approved minutes from the meeting held on the 16.4.24.** | S. Arora | To escalate any key risks, receive updates and note the approved minutes from the 16.4.24. | **N** | Read enclosure |
| **Supporting our People** | | | | | | | |
| **15.** | **24/25/120** | **13:40 (10 mins)** | **People Plan Highlight Report; including:**<br>- **EDI Annual Report for 2024.** | M. Swindell<br><br>M. Swindell | To provide an update on key areas and updates from the system on the workforce.<br>To receive the 2024 EDI Annual Report. | **A**<br><br>**N** | Read report<br><br>Read report |
| **Strong Foundations (Board Assurance)** | | | | | | | |
| **16.** | **24/25/121** | **13:50 (5 mins)** | **Board of Directors Fit and Proper Persons Checks.** | E. Saunders | To receive assurance. | **A** | Read report |
| **17.** | **24/25/122** | **13:55 (5 mins)** | **Audit and Risk Committee:**<br>- **Chair's Highlight Report from the meeting held on the 20.6.24.**<br>- **Approved minutes from the meeting held on the 18.4.24.** | K Byrne | To escalate any key risks, receive updates and note the approved minutes from the 18.4.24. | **A** | Read enclosure |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **18.** | **24/25/123** | **14:00 (5 mins)** | **Finance, Transformation and Performance Committee:**<br>- **Chair's Highlight Report from the meeting held on the 24.6.24.**<br>- **Approved minutes from the meeting held on the 23.5.24.** | J. Kelly | To escalate any key risks, receive updates and note the approved minutes from the 23.5.24. | **A** | Read enclosure |
| **19.** | **24/25/124** | **14:05 (5 mins)** | **Board Assurance Framework Report.** | E. Saunders | To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed. | **A** | Read report |
| **Items for Information** | | | | | | | |
| **20.** | **24/25/125** | **14:10 (4 mins)** | **Any Other Business.** | All | To discuss any further business before the close of the meeting. | **N** | Verbal |
| **21.** | **24/25/126** | **14.14 (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, 5th September 2024, 9:00am – 2:00pm, LT4, Institute in the Park. | | | | | | | |

| **REGISTER OF TRUST SEAL** |
|---|
| The Trust seal wasn't used in June 2024 |

| **SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION** | |
|---|---|
| Financial Metrics, M2, 2024/25 | J. Grinnell |
| Register of Shareholder Interests | J. Grinnell |

**PUBLIC MEETING OF THE BOARD OF DIRECTORS**
Confirmed Minutes of the meeting held on **Thursday 6th June 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) |
| | 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) |
| | Mr. I Gilbertson | Assistant Chief Digital and Information Officer | (IG) |
| | 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) |
| **Item 24/25/74** | Ms. N. Palin | Director of Transformation and Change | (NP) |
| **Item 24/25/75** | Ms. L. Weaver-Lowe | Assoc. Director of Strategy and Partnerships | (LWL) |
| **Item 24/25/85** | Dr. J. Potier | Assoc. Director of Organisational Development | (JP) |
| **Item 24/25/85** | Ms. S. Owen | Deputy Chief People Officer | (SO) |
| **Observing** | Ms. V. Greenwood | Deputy Director of Allied Health Professionals | (VG) |
| **Apologies:** | Mrs. D. Jones | Chief Strategy and Partnerships Officer | (DJ) |
| | Ms. J. Revill | Non-Executive Director | (JR) |
| | Mrs. K. Warriner | Chief Digital and Transformation Officer | (KW) |

**Patient Story**

The Chair welcomed Sienna and her mum Kelly who had been invited to June's Board to talk about the Little Hearts at Home (LHAH) platform that is currently monitoring Sienna in her home environment. Jemma Blake (*Innovation Consultant*), David Cole (*Senior Project Advisor*) Phuoc Duong (*Consultant Paediatric Cardiologist*), and Helen Walker *(Lead Cardiac Nurse*) also joined the meeting to support Kelly.

Sienna is 8 months' old and is currently being monitored on the LHAH platform after being born with a severe cardiac condition. An overview of Sienna's journey from birth was provided to the Board by the team. Kelly advised that following surgery and a prolonged stay in hospital Sienna was able to go home with the support of the Ventricle Programme which is used for the most vulnerable patients to be looked after closely in the community by community nurses. Community nurses visited Sienna twice a week to check her oxygen levels and weight which

were then added onto the LHAH platform to ensure they were within the parameters that had been set.

Kelly explained that this helped her to settle at home with Sienna knowing that she was being monitored and it made life easier in terms of being a mum at home rather than being in hospital. When the team received an alert from the LHAH platform identifying a trend in Sienna's saturations that was below the parameters Sienna was taken to her local hospital and was eventually transferred to Alder Hey for an emergency operation following deterioration.

Kelly informed the Board that she was so glad that Sienna was taken to Alder Hey as the staff at the Trust saved Sienna's life. Kelly drew attention to the lack of communication that was provided by her local hospital at such a worrying time in terms of the plans for Sienna's care (whether she was being admitted to the local hospital or being transferred to Alder Hey). Kelly advised that the community nurses are still involved with Sienna's care following discharge from Alder Hey which has provided Kelly with assurance that she is able to make contact with a health professional if she has any concerns.

Attention was drawn to the impact that the LHAH platform has and how closely it can monitor patients whilst in a community setting. The Chair felt that it would be beneficial to make District General Hospitals aware of the benefits of the LHAH platform.

The Chair thanked Kelly and the team for sharing Sienna's story and wished Kelly and Sienna all the very best for the future.

**24/25/68 Welcome and Apologies**

The chair welcomed everyone to the meeting, in particular Veronica Greenwood who is observing today's Board and Louise Weaver-Lowe who is attending on behalf of the Chief Strategy and Partnerships Officer. The Chair noted the apologies that were received.

**24/25/69 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.

**24/25/70 Minutes of the previous meeting held on Thursday 2nd May 2024**
**Resolved:**
The minutes from the meeting held on the 2nd of May were agreed as an accurate record of the meeting.

**24/25/71 Matters Arising and Action Log**

*Matter Arising*

There were none to discuss.

*Action Log*

It was confirmed that all actions are on track.

**24/25/72 Chair's and CEO's Update**

Louise Shepherd informed the Board that there is a lot of work being undertaken to progress the Trust's Vision 2030 Strategy and to look at how care can be transformed. With regard to supporting the wider C&M system, the Children's Alliance and Beyond have brought colleagues together to think about tackling challenges collaboratively.

The Board was advised of the major pivot in the Integrated Care Board's (ICB's) strategy in terms of working collectively to address urgent care, elective recovery and resources. A formal programme structure is in the process of being established and will include 19 core programmes, one being neurodiversity due to the sheer number of patients waiting for an assessment for ADHD. It has been acknowledged that this is a national issue. The team at Alder Hey along with the ICB and Beyond are thinking of ways to raise awareness of the issues being experienced by CYP in respect to the long wait for an ADHD assessment. It was pointed out that the majority of the focus is on adults but it is vital that it is recognised that CYP also have challenges in this field.

It was reported that a proposal has been submitted to the Chief Executive of the ICB, Graham Urwin, detailing an approach for urgent care, the development of a dedicated paediatric hub in collaboration with Warrington that other hospitals can access for surgery in C&M, and the expansion of the Neurodiversity Programme across C&M. The ICB was supportive of the proposal therefore work will commence to progress this. Louise Shepherd confirmed that a report relating to the proposal will be discussed during the CMAST Leadership Board meeting on the 7.6.24.

**For noting**
The Board supported the programme approach and felt that is important to work collectively in order to progress.

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

**24/25/73 Vision 2030 Oversight**

The Board was advised that there is a general sense of progress and it was confirmed that the Trust is in deployment mode. Attention was drawn to a number of key highlights:

- The Programme Board is still in its infancy but is starting to track benefits and delivery.
- The Trust is delivering a number of tactical improvements that are showing benefits which are being monitored via the Vision 2030 programme. The programme is also making sure that the organisation is deploying its resources in the right place.
- There is to be a focus on Improving My Life Chances during July's Strategy Board and reference was made to the People agenda which is the largest programme that the Trust is looking to accelerate.

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

**24/25/74 Transformation Programme**

The Board was provided with an update on the position for year two on the Trust's journey to Vision 2030, focusing on progress from April 2024 to the end of May 2024, highlighting key developments and performance metrics. The following points were highlighted:

- The Trust is making good progress, which is evident in key deliverables and benefits, as detailed in Table 1 and 2.
- Since April 2024 new governance arrangements have been implemented, this includes the establishment of a 2030 Programme Board which reports directly to the Resources and Business Development Committee (RABD), ensuring better oversight and alignment with the organisation's long-term strategic goals.
- The Board was advised of the Clinical Summit that took place on the 19.4.24 that brought together eighty colleagues to discuss leadership and learn more about Vision 2030. The event was highly positive, fostering connections amongst colleagues and facilitating co-design of actions to support the journey to 2030. A further session is planned for October 2024 to co-design solutions and explore the ideas suggested during the summit.
- There is a Transformation efficiency target of £12.6min 2024/25 with a YTD £5.6m posted green in the efficiency plan. This is an improved position since April 2024 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 RABD during June's meeting.

**Resolved:**
The Board noted the Transformation Programme update.

**24/25/75 Cheshire and Merseyside System Wide Issues Update**

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

- CMAST CYP Alliance (C&M);
  - Providers coming together around networked health delivery. It was reported that they have met six times, but it is a challenge to get appropriate representation.
  - Resource/sustainability plan is under development.
  - Clear governance process required to ensure appropriate assurances and escalations.
  - Workstreams;
    - Elective recovery.
    - Urgent care.
    - CYP diagnostics.
    - Mental Health (inpatient).
- Liverpool Place – Key developments.
- North West Specialised Services;
  - Memorandum of Understanding (MoU) with the Royal Manchester Children's Hospital (RMCH) and Manchester University NHS FT (MFT) has been refreshed.

- Women and Children's Transformation Programme (WCTP) Board was held on the 21.5.24. Aim for gateway 2 by the end of 2024.
- The Trust is working with RMCH/MFT to support the joint work and is going to attend the WCTP Board and methodology sub-group.

- ICB CYP;
  - Recovery plan is still an emergent picture with variation in speed of adoption within different Places.
  - Intention is for each Recovery stream lead to develop a mandate for each area over the next six weeks.
  - In order to ensure CYP are effectively linked and gain the focus required, the Trust has reached out in relation to:
    - Neurodiversity (already supporting via Beyond).
    - UEC (CYP Alliance - Paediatric 111, Virtual Ward, and Elective/Dental Hubs as priorities which all link in to admission avoidance/improved acute flow).
    - All Age CHC (Beyond, DCSs and Providers already engaged in an Appropriate Places of Care workstream).

The Chair offered thanks to all those working on the various areas of work and felt that it would be a good opportunity to get Local Government involved.

Lisa Cooper offered her support on the Alliance's Mental Health workstream therefore it was agreed to have a discussion outside of the meeting.

**24/25/75.1 Action: LC/LWL**

*C&M Financial Position Update*

The Board was advised that C&M is due to resubmit its financial plans following a meeting with NHS England w/c 27.5.24. C&M were instructed to identify all actions required to deliver a position of no more than a £150m deficit, therefore requiring C&M to improve its plan by £66m.

To achieve this position targets have been allocated to each provider within the C&M system. The current understanding is that on agreeing to this plan C&M will be provided with cash backed non-recurrent income of £150m to offset its net system deficit position. The Board noted that the Trust is required to make further efficiencies.

The expected impact on the Trust in terms of the savings required for the system is a £6m surplus. This position includes a technical change associated with accounting changes for PFI schemes therefore the Trust's control total may change but trading will remain the same. It was confirmed that a further update on the changes to PFI schemes will be provided in due course.

**24/25/75.2 Action: RL**

A discussion ensued and it was agreed that the Board requires further clarity on this matter, especially in terms of risk.

**24/25/75.3 Action: RL**

**Resolved:**
The Board noted the Cheshire and Merseyside system wide issues update.

**24/25/76 Evidence of Our Performance**

*M2 Flash Report/Operational Overview*

The Board received the Flash Report for M2. An update was also provided on the Trust's 2024/25 operational priorities, as detailed in the Operational Plan progress summary.

*Integrated Performance Report for M1, 2023/24*

The Board received the Integrated Performance Report (IPR) for Month 1. An update was provided on the following areas of the IPR:

*Experience and Safety*

- 94% of inpatients and 93% of ED patients received antibiotics for sepsis management within sixty minutes. It was confirmed that figures are above target in month.
- There has been an improvement in PALS concerns being resolved within five working days. It was confirmed that figures are above target in month.
- A review of the Friends and Family Test is to be undertaken as part of Vision 2030.
- It was confirmed that metrics show an improvement in performance across the board.

*Revolutionising Care*

- *Elective Recovery* – Figures for April are strong against plan; 103% for elective and 106% for outpatients.
- ED performance achieved 87.5%, exceeding the national target of 78%.
- Virtual Ward is seeing more patients which is helping to reduce long stay patients, and more specialities are starting to realise the potential of Virtual Wards.
- There are a large number of ASD and ADHD CYP waiting over 65 weeks for diagnosis. Triaging and signposting is being undertaken by the team.
- It was reported that there are 5,761 patients wating two years for a follow up appointment. There is an ambition to reduce this to zero by the year end. A Safe Follow Up Care project is being piloted by four specialities. An evaluation of the pilots will be undertaken to determine the impact that the pilot has had.
- *Diagnostics/Endoscopy* – There is a high volume of patients waiting over six weeks. The Trust is looking to improve performance in these two areas.

*Pioneering Breakthroughs*

- *Futures* - Work is taking place on metrics to enable the Trust to report on what is being delivered. A Futures Business Case and Implementation Plan is to be submitted to the Futures Committee in June 2024 for approval.
- Alder Hey is exploring Artificial Intelligence (AI) to see if it can help reduce the administration burden for professionals; a pilot of AI generated clinic letters commences in June 2024 in some wave 1 departments.
- Two projects have been submitted to the Hartree Centre for review.

- A sustainable plan for funding has been signed off.
- It was reported that there is a national commercial opportunity for the CYP As One Platform, and attention was drawn to the potential of the Northern Institute of Child Health and Wellbeing project.
- *Charity* – Positive discussions have taken place with the Charity around growth and a constructive approach for Futures from the ground up.

*Supporting our People*

- PDR completion increased from 76% in March 2024 to 90% in April 2024. Revised guidance has been shared with managers to provide support when completing PDRs in 2025.
- Turnover continues to improve. In April 2024 the Trust achieved the revised target of 10%.
- Sickness absence is 4.8% which is below the 5% target. This is testament to the work that HR team have undertaken to address sickness absence cases.
- Workforce stability metric (*churn metric*) was reported for the first time in April 2024; 64%. This is a twelve month rolling period therefore 36% of the workforce were on the move at some point during the year. It was confirmed that a target won't be set for this measure for the first twelve months.

*Resources*

- In M1 the Trust is reporting a position of £0.2m adverse to plan (£1.2m deficit against a plan of £0.9m). This is due to undelivered CIP. The Board was advised that the Trust has had to reset the first two months of its plan and re-profile CIP.
- Overall, £6m CIP has been transacted with £3.9m in progress and a £9.1m opportunity.

Divisions

*Community and Mental Health Division*

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

It was reported that work continues to improve data reporting for Mental Health Services via MHSDS due to data quality issues impacting on submissions. The Division was advised that last year's data hadn't been submitted as a segment of data was missing. A huge piece of work was undertaken and significant progress has been made. It was agreed to have a further discussion regarding this matter outside of the meeting.

**24/25/76.1 Action: LC/IG**

**For noting**

On behalf of the Board, the Chair acknowledged the risks surrounding the ASD/ADHD service and in particular the ongoing national challenges regarding lack of access to ADHD medication which is impacting on children and young people. The Chair highlighted the importance of escalating the issues being experienced, via the ICB as well as nationally. It was reported that a risk has been included on the risk register and is reviewed on a regular basis. Work is also taking place with the Exec Team to try and address some of the issues.

*Division of Medicine*

- The transformation programme ‘Neurology at its Best’ has commenced and a ‘GP at its Best’ meeting is scheduled for w/c 10.6.24.
- *Laboratories* – There is a gap in the service due to sickness absence. The Trust has plans in place in association with Whiston Hospital, and a service review is to take place to look at an alternative way of working. The service will maintain this risk until it is able to recruit in the next couple of months.

*Division of Surgery*

- Progress is being made with recruitment; a strong candidate has applied for the Intervention Cardiology role and an appointment will be made in July for a Cardiac Consultant.
- The governance of the Division is working in terms of process and feedback and improvements are being made.

Shalni Arora queried the rise in overdue outpatient/follow-up appointments and asked as to whether this is something the Trust needs to review, taking into account the amount of work that was spent previously to reduce these figures. The Board was advised that there has been a 20% increase in urgent referrals which is impacting follow-up capacity. A Safe Follow-up Working Group has been established and the Trust is on the cusp of commencing a validation at scale pilot. The clinical team is also looking at ways to mitigate/reduce the risk as much as possible.

It was reported that the Risk Management Forum has been reviewing high risks but overdue outpatient/follow-up appointments hasn’t featured in discussions during RMF meetings. It was agreed to look into this matter.

**24/25/76.2 Action: ES**

**Resolved:**
The Board received and noted the content of the IPR for Month 1 and the Flash Report/Operational Overview for Month 2.

**24/25/77 Gender Development Service**

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:

- Of the 109 assessment appointments offered, 68 CYP have been seen within the service. It was confirmed that the service is on track to see all young people by the end of June 2024.
- All CYP on the national waiting list have been offered an assessment by mental health providers, which should take place within the 2024/25 financial year. Alder Hey as a provider of mental health services is waiting for confirmation of the figures for Sefton and Liverpool to be seen within the Trust’s CAMHS services.
- The Trust has protected staff from social media but will regroup with the Communications team to keep on top of this. It was reported that the service is continuing to receive positive feedback from families.
- *Estates* – Delays have been incurred to the renovation of the building due

water testing being undertaken.

- *CQC Registration* – The Trust is awaiting confirmation of registration from CQC. It was confirmed that staff can be based at Warrington but until confirmation is received from CQC the service is unable to see CYP on this site.
- On the 29.5.24, NHS England (NHSE) advised that the Government has Introduced emergency restrictions on the use of puberty hormones, as detailed in the letter in Appendix 1 of the report. The service has requested legal advice as there are some CYP on the caseload receiving puberty suppressants from an independent prescriber. The service is also working with its South Hub colleagues on this matter. On behalf of NHSE, the service has sent a letter to all CYP on the caseload to make them aware of this change. It was confirmed that the service has made it clear that the letter was from NHSE and not from Alder Hey.

The Board was advised that Hilary Cass is looking at the governance arrangements of the Gender Service programme and will be leading on the establishment of a provider collaborative. Work has commenced to look at a programme approach and governance arrangements for a provider collaborative and it was agreed to provide an update on the outcome of this work during September's Trust Board.

**24/25/77.1 Action: LC**

Thanks were offered to Kerry Byrne for the support provided to help the service understand its risks as well as the risks to the organisation.

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

**24/25/78 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* – it was confirmed that the construction of the Neonatal and Urgent Care Centre is progressing well.
- *Park Reinstatement* – Work is taking place to address the issue relating to complexity of the swale drainage system.
- *Gender Service* – Construction work is progressing in line with the programme and occupation is due to take place w/c 17.6.24.
- *Former Police Station Refurbishment* – Work is due to be completed by the end of June and teams are on track to move into the premises in July 2024.
- *Base Camp* – Work will be undertaken with the Social Prescribing team to provide social prescribing.
- *Good News* – The Alder Centre has won the RIBA North West Regional Award for 2024, and the Catkin Centre/Sunflower House has been named as the New Build project of the year (UK) at the Design in Mental Health Awards.

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

**24/25/79 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 1.5.24 to the 31.5.24. The following points were highlighted:

- During the reporting period, one legacy Serious Incident action plan remained open within its expected completion date.
- It was reported that the feedback from the learning reviews of two incidents was positive but at times the process was emotionally difficult to go through. It was confirmed that the reports are pending at the present time but the learning review outputs will be shared with the Board once concluded.

The Chair pointed out that a Board Development Session on PSIRF is taking place on the 5.9.24 and requested that it be divided into two parts; 1. System changes. 2. The outputs from the learning review of two incidents.

**24/25/79.1 Action: NA**

**Resolved:**
The Board noted the Learning from Patient Safety Incidents update.

**24/25/80 2023/24 Nursing Workforce Report**

The Board received the 2023/24 Nursing Workforce Report which provides assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, along with appropriate systems and processes in place to manage the demand for front line nurse staffing, particularly at times of increased pressure. The following points were highlighted:

- The Trust has taken a three phase approach to workforce development.
  - *Phase 1: Recruitment* – There have been 220 applications for 50 roles with interest being shown from all regions.
  - *Phase 2: Retention* - A Nurse Retention Lead was appointed in 2023/24 on a fixed term twelve-month contract which has led to retention rates being reduced. The Trust will continue to monitor this area of work.
  - *Phase 3: Effective Nurse Staffing/financial stability* – Work continues to review ways of reducing the use of temporary staffing, including workforce reviews and reduction of agency spend.
- There has been a focus on access to development.
- The e-roster system has been fully implemented and is being monitored across wards. 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.
- 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.
- The Board was advised that the red model has not been invoked since late 2022 which is an improvement.

Chief Nurse Nathan Askew responded to a question raised by Garth Dallas relating to the lack of progression of nursing staff from a B5 role to a B6 role.

The Chair felt that the report was positive and was pleased that Alder Hey is being recognised as a good place to work.

Nathan Askew acknowledge the work undertaken by Pauline Brown to compile the report with the support of Phil O'Connor and Cathy Wardell.

**Resolved:**
The Board received and noted the 2023/24 Nursing Workforce Report.

**24/25/81 PALS and Complaints Report, Q4**

The Board received the PALS and Complaints report for Q4 which provides 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. The following points were highlighted:

- There were 41 formal complaints received in Q4, and 139 complaints in total received within the year. This 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, appointments, and communication.
- Compliance with the 5-day target to resolve informal concerns was 78% in Q4 and an average of 82% in year. It was reported that the Division of Community and Mental Health has invested in additional resources to respond to concerns.
- A good discussion took place during a recent SQAC meeting about reducing the narrative and increasing the data in the report.

**Resolved:**
The Board received and noted the content of the PALS and Complaints report for Q4.

**24/25/82 Director of Infection Prevention and Control (DIPC) Report, Q4**

The Board received the report of the DIPC for Q4 which provides an oversight of IPC activity from the 1.1.24 to the 31.3.24. The following points were highlighted:

- The IPC team continues to perform daily "isolation walks" across all areas of the Trust to communicate to staff the appropriate IPC precautions and has developed visual graphics to identify contagious patients. It was reported that this has encouraged best practice and isolation walks will continue to be undertaken.
- Funding of ICNet has been secured with plans for implementation in the new financial year.
- The Board was advised that the biggest challenge for the department is the limited workforce due to staff absence and the priority on clinical care and safety. External advice has been commissioned to tackle issues in the service.

**Resolved:**
The Board received the DIPC report for Q4.

**24/25/83 2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement**

The Board was advised that the annual submission to NHS England North West Framework for Quality Assurance and Improvement is to confirm compliance and provide assurance as required by the Medical Directorate and Professional Standards Team. The information contained within the report reflects how the Trust manages appraisals and how it intends to support clinicians to undertake their appraisals. It was reported that the Trust's submission was reviewed externally and received positive feedback.

Kerry Byrne asked as to whether the covering report could be more specific to determine the actions that are important versus business as usual.

**24/25/83.1 Action: ABASS**

**Resolved:**
The Board received the 2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement

**24/25/84 Safety and Quality Assurance Committee**

The approved minutes from the meeting held on the 24.4.24 were submitted to the Board for information and assurance purposes.

During the meeting there was a focus on Emergency Preparedness, Resilience and Response (EPRR) from a safety perspective and it was agreed that an exercise should take place in the Autumn ahead of paperwork being completed. It was reported that a discussion has taken place on risk appetite and tolerance and there is a broad agreement that the Committee will adopt a low risk around safety and a slightly higher risk around quality. The Chair highlighted the importance of monitoring quality given the resource issue. The Committee also received the Liverpool Neonatal governance report and will continue to do so on a monthly basis.

Kerry Byrne referred to EPRR and advised that a large number of actions have been completed in the last quarter. A request has also been made for a forward plan to provide detail of when each indicator will turn green.

**Resolved:**
The Board noted the approved minutes from the meeting held on the 24.4.24.

**24/25/85 People Plan: Progress in 2023 and Next Steps for 2024 and Beyond**

The Board was provided with an update on the progress of the People Plan and advised of the next steps in the development of the People Plan for 2024 and beyond. A presentation was shared in addition to the update to allow for greater depth of detail and discussion, and to seek agreement of those next steps

It is recognised that Alder Hey is in a good position when it comes to its people; evidenced via the results from the most recent Staff Survey and the organisation's metrics. The next step is to look at how the Trust progresses from good to great

and makes people feel that it is a great place to work. A number of slides were shared that provided the following information

- How the Trust want things to be (*healthier, happier, fairer future*).
- How things are.
- The gap.
- How we want things to be for our staff;
  - High performing teams (*Brilliant Basics*).
  - Leadership (*thriving leaders' framework*).
  - Safety culture (*restorative, just and learning*).
  - Values and behaviours/staff experience and empowerment (*SLAS, EDI, FTSU).*
- How we want things to be for our CYP;
  - Working together to meet the needs of CYP.
  - Trust (*do what we say we are going to do*).
  - Safety (*safe in our care*).
  - Values and behaviours (*choice and empowerment/personalised care*)
- Good to great;
  - Thriving, learning, working differently.
  - Who we are on the inside matches who we are on the outside.
- Strategic themes/culture.
- Culture 2024/25.
- Thriving 2024/25.
- Professional Development Hub 2024/25;
  - Development of a physical *and* virtual space which provides personal and professional development advice, information and support.
  - Enable our people to build their capability and support their career progression through relevant and meaningful learning opportunities
  - Key actions for 2024/25.
- Future workforce 2024/25;
  - Inclusive and values driven recruitment.
  - People practices.
  - Talent.
  - Supporting teams.
- Questions;
  - What do you think, and how do you feel about what you've just heard?
  - What do we need to do, as Board members, to support these ambitions for our people, and our organisational culture?

Board members provided feedback following the presentation which was recorded by the team.

A number of questions were raised and responded to regarding the investment required in the future workforce thus ensuring the Trust has a workforce with the right skills to drive the organisation's ambitions/change forward, the intervention required for poor performing managers to make an effective change, the support entailed for leaders who manage fragile teams, to provide them with the confidence to address/escalate issues, and the work that will need to be undertaken with staff to help them embrace the cultural evolution of the People Plan.

The Chair felt that time needs to be set aside to think about the expected behaviours so that it can be communicated properly to gain buy in from the workforce and make people understand what it will mean for them in terms of

change and doing things differently. The Trust also needs consistency in behaviours demonstrated by leaders and middle managers. Taking this into account it was felt that it is necessary for the organisation to agree what all of this looks like and provide examples for demonstration purposes. Work also needs to be undertaken to determine what the new workforce will look like as the organisation progresses.

The Chair thanked the team for sharing the presentation with the Board which received lots of positive comments. It was pointed out that the values may need to be refreshed and leadership across the organisation needs to be by example. The Chair felt that the Board had a rich discussion following the presentation and suggested that an update on cultural evolution be provided on a six monthly basis.

**Resolved:**
The Board noted the People Plan progress in 2023 and the next steps for 2024 and beyond

**24/25/86 People and Wellbeing Committee**

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

During the meeting there was a focus on two new metrics; staff thriving and index. An update was received on Freedom To Speak Up (FTSU), the Sexual Safety Charter and Disclosure and Barring Service (DBS) checks. The Committee approved the 2023/24 EDI report, and conducted a deep dive into four of the Committee's risks incorporated on the Board Assurance Framework (BAF).

The Chair asked for the 2023/24 EDI Annual Report to be shared with the Board during July's meeting.

**24/25/86.1 Action: KMC**

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

**24/25/87 Resources and Business Development Committee (RABD)**

The approved minutes from the meeting held on the 29.4.24 were submitted to the Board for information and assurance purposes.

During May's meeting there was a focus on the position of the Committee's five key risks for 2024/25, the Capital Programme and the Efficiency Programme. Reference was made to the Benefits Transformation Programme and it was reported that a smarter way of working has been implemented which is having a positive effect. It was reported that Surgery and Medicine have undertaken a large amount of work on transformation and the other two Divisions are following suite.

**Resolved:**
The Board noted the approved minutes from the meeting held on the 29.4.24.

**24/25/88 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:

- Risks have been reviewed and the outcome of this work will be reflected as part of Vision 2030.
- A conversation is to take place with the Director of Community and Mental Health Services to discuss the risk relating to ADHD.
- A report on the outcome of the risk appetite work with the Assurance Committees will be submitted to the Board in September.

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

**24/25/89 Any Other Business**

There was none to discuss.

**24/25/90 Review of the Meeting**

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

**Date and Time of Next Meeting:** Tuesday 26th June 2024 at 4:15pm via Teams.

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

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| **Actions for 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. |
| 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 | Sep-24 | **3.7.24** - 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 | Sep-24 | **4.6.24** - This action is in progress. An update will be provided in July.<br>**3.7.24** - The Medical Director is awaiting an update on this matter therefore and update will be provided to the Board in September.<br>**ACTION TO REMAIN OPEN** |
| 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 | |
| 6.6.24 | 24/25/75.1 | Cheshire and Merseyside System Wide Issues Update | Lisa Cooper offered her support to the Alliance's Mental Health workstream therefore it was agreed to have a discussion outside of the meeting. | L. Cooper/L. Weaver-Lowe | 5.9.24 | On track Sep-24 | |
| 6.6.24 | 24/25/75.2 | Cheshire and Merseyside System Wide Issues Update | *C&M Financial Position Update* - Provide a further update on the PFI schemes. | R. Lea | 5.9.24 | On track Sep-24 | |
| 6.6.24 | 24/25/75.3 | Cheshire and Merseyside System Wide Issues Update | *C&M Financial Position Update (ICB Improvement Plan of £66m)* - Provide further clarity on the position target that has been allocated to Alder Hey and the risk that this brings. | R. Lea | 5.9.24 | On track Sep-24 | |
| 6.6.24 | 24/25/76.1 | Integrated Performance Report (M1) | *Community and Mental Health Division* - Further discussion to take place regarding the data quality issues impacting data submissions for Mental Health Services via MHSDS. | L. Cooper/ I. Gilbertson | 5.9.24 | On track Sep-24 | |
| 6.6.24 | 24/25/76.2 | Integrated Performance Report (M1) | *Division of Surgery* - Discussion on the high risk relating to overdue outpatient/follow-up appointments to take place at a future RMF. | E. Saunders | 5.9.24 | On track Sep-24 | |

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

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| 6.6.24 | 24/25/77.1 | Gender Development Service | Hilary Cass is looking at the governance arrangements of the Gender Service programme and will be leading on the establishment of a provider collaborative. Work has commenced to look at a programme approach and governance arrangements for a provider collaborative and it was agreed to provide an update on the outcome of this work during September's Trust Board. | L. Cooper | 5.9.24 | On track Sep-24 | |
| 6.6.24 | 24/25/79.1 | Learning from Patient Safety Incidents | *September's Development Session on PSIRF* - Divide the session into two parts; 1. System changes. 2. The outputs from the learning review of two incidents. | N. Askew | 5.9.24 | On track Sep-24 | |
| Actions for June 2025 | | | | | | | |
| 6.6.24 | 24/25/83.1 | 2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement | Covering report sheet to be more specific to identify actions that are important versus business as usual. | A. Bass | Jun-25 | On track Jun-25 | |
| 6.6.24 | | | | | | | |

| Status | |
|---|---|
| Overdue | |
| On Track | |
| Closed | |

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| **Closed Actions** | | | | | | | |
| 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 | Closed | **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.<br>**28.6.24** - The risk register for the new Gender Development Service has been included on July's ARC agenda. **ACTION CLOSED** |
| 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 | Closed | **3.7.24** - Global activities are being overseen by the Futures Committee. **ACTION CLOSED** |
| 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 | Closed | **28.6.24** - This item has been included on July's Board agenda. **ACTION CLOSED** |
| 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 | Closed | **3.7.24** - The Division looked into this matter and it was confirmed that the figures correct. **ACTION CLOSED** |
| 6.6.24 | 24/25/86.1 | People and Wellbeing Committee | Include the 2023/24 EDI Annual Report on July's Board agenda. | K. McKeown | 4.7.24 | Closed | **28.6.24** - This action has been addressed. **ACTION CLOSED** |

# BOARD OF DIRECTORS
**Thursday, 4th July 2024**

| | |
|---|---|
| **Paper Title:** | **LUHFT/LWH/Alder Hey Partnership Update** |
| **Report of:** | **Chief Executive of Alder Hey**<br>**Chief Executive of Liverpool Women's** |
| **Paper Prepared by:** | **Chief Executive of Alder Hey**<br>**Chief Executive of Liverpool Women's** |
| **Purpose of Paper:** | Decision ☑<br>Assurance ☐<br>Information ☐<br>Regulation ☐ |
| **Action/Decision Required:** | To note ☐<br>To approve ☑ |
| **Summary / supporting information** | The purpose of this paper is to provide a briefing as to progress made to date and to set out the direction of travel for the partnership between Alder Hey/LUHFT/LWH. |
| **Strategic Context**<br><br>**This paper links to the following:** | **Outstanding** care and experience ☐<br>**Collaborate** for children & young people ☑<br>**Revolutionise** care ☐<br>**Support** our people ☐<br>**Pioneering** breakthroughs ☐ |
| **Resource Implications:** | To be determined |

<table>
<tr><td colspan="6">Does this relate to a risk? Yes ☐ No ☐<br>If "No", is a new risk required? Yes ☐ No ☐</td></tr>
<tr><td>Risk Number</td><td colspan="4">Risk Description</td><td>Score</td></tr>
<tr><td>BAF 3.2</td><td colspan="4">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</td><td>12</td></tr>
<tr><td>Level of assurance<br>(as defined against the risk in InPhase)</td><td>☐</td><td>Fully Assured<br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice</td><td>☑</td><td>Partially Assured<br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness</td><td>☐ Not Assured<br>Evidence indicates poor effectiveness of controls</td></tr>
</table>

## 1. Executive Summary

It was agreed between the CEOs and Chairs of the organisations that there was an important partnership agenda that should be pursued and reinvigorated.

The key areas of collaboration that needed focused attention were;

- The Liverpool Neonatal Partnership.
- Women's hospital services in Liverpool Programme.
- Community Services and the Integration of PLACE agenda (*with Mersey Care*).
- Opportunities for shared Research and Innovation.

## 2. Current position

*Liverpool Neonatal Partnership*

The CEOs and Chief Medical Officer met in mid-June to agree the process by which we would review the Liverpool Neonatal Partnership progress and begin to create a clearer strategic direction for this partnership. There are four workstreams where work has been refreshed over the last 6 months and the output of this will be presented to a meeting of the two Executive Teams in mid-July. A programme director currently working with Alder Hey and with experience of national work in this area is going to present a potential strategic direction for the LNP to both Exec teams in this same meeting. From there a plan will be developed to move to a much more integrated single service approach.

*Women's hospital services in Liverpool Programme*

A clinical workshop was held in May with representation from Liverpool Women's, Alder Hey, Clatterbridge Cancer Centre and LUHFT to test and develop the final case for change for the above programme.

The case for change has been approved by the respective boards at Alder Hey, Liverpool Women's and LUHFT  with some suggested improvements..

The case for change will next be presented to the NHSE Stage one assurance process at which both CEOs for Alder Hey and LUHFT/LWH will be present.

*Community Services and Integration of PLACE*

LUHFT and Mersey Care have been working through a partnership board to align their strategy on Integrated Care in the local community. LUHFTs new strategy focuses on the need for a future integrated care partnership which Alder Hey, Mersey Care and LUHFT/LWH must try and align on. The three CEOs are meeting with the Value Circle (already engaged by LUHFT/MC) to try and understand the priorities for re-organising the local community services landscape. The key objectives of this are:

Trying to understand the current service offering in Community which has been fragmented due to pre and post Covid commissioning arrangements, procurement being targeted on individual organisations rather than partnerships and the post Covid financial regime of separate innovation pots e.g. Community Diagnostic Centres. We are still operating in a model where women's health hubs are being proposed without clarity on how children fit into the model.

It is proposed that the four organisations now map all of the community facing provision, sense check the current configurations and then collaborate on how we can integrate provision to create a better offer for our diverse community.

The first meeting of the CEOs will be in July to begin this mapping exercise and start to create a vision for what a partnership could look like in the future.

**3. Summary**

- There has been progress in several areas since the Chairs & CEOs met at the start of the year to begin to shape our partnership agenda.
- Joint work on the Women's case for change has led to multi-organisational agreement on the key issues and a clearer rationale supported by data than previously experienced.
- We agree that the LNP needs to be stronger and centred around a single service with a strategy based on excellence in partnership working. There is agreement between the two organisations on how to take this forward and an independent resource in place to support the work.
- We have reached an agreement that the four organisations (AH, LWH, LUHFT, MC) need to now create a strong partnership that can prevent isolated procurement and different commissioning strategies create fragmentation of community services and will now explore how we can formulate a partnership to deliver better family focused services together.

**4. Next Steps**

It is envisaged that there will be sufficient progress in our joint agenda to meet as two Boards in September and receive updates on these items outlined and also discuss the future shape of our joint governance to oversee this work.

**Louise Shepherd CBE**
**Chief Executive Alder Hey**

**James Sumner**
**Chief Executive LUHFT/LWH**

**28th June 2024**

# Integrated Performance Report

Published: June 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

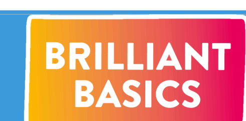
innovation

together

openness

# Contents

| | |
|---|---|
| **IPR Summary** | **Page 3** |
| **Outstanding Care and Experience** | **Page 4** |
| **Revolutionise Care** | **Page 7** |
| **Supporting Our People** | **Page 11** |
| **Pioneering Breakthroughs** | **Page 13** |
| **Collaborate for Children and Young People** | **Page 15** |
| **Financial Sustainability** | **Page 17** |
| **Risk Management** | **Page 19** |
| **Divisional Summaries -** | |
| **Community & Mental Health** | **Page 21** |
| **Medicine** | **Page 24** |
| **Surgery** | **Page 27** |
| **Research** | **Page 30** |
| **Corporate** | **Page 32** |
| **Appendix** | |
| -**Icon Definitions** | **Page 34** |
| -**Safer Staffing & Patient Quality Indicator Report** | **Page 35** |



# 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.

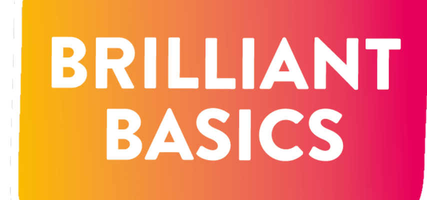
| Variation | | Assurance: Achieving Target | Assurance: Inconsistently Achieving Target | Assurance: Not Achieving Target |
|---|---|---|---|---|
| | Special Cause - Improvement | Level 1 patient safety training, ASD/ADHD triage within 12 weeks are consistently achieving target with an improving trend | Outpatients New/OPPROC per working day, PALs resolved, Never events, Severe/Fatal incidents and Staff Turnover 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, 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, IHAs, and F&F Trust/F&F ED 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:

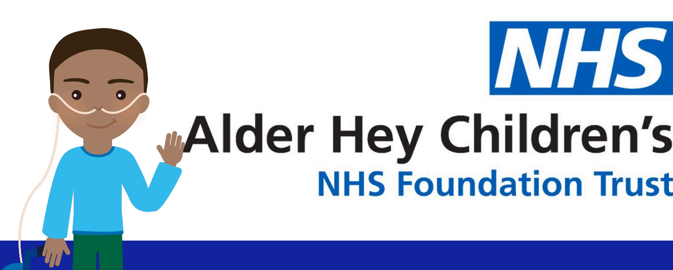
- We are consistently passing 28.6% of our metrics, with 62% of the evaluated SPC metrics achieving the target in the month of May 2024.
- We are achieving 54.8% of our metrics inconsistently.
- We are not achieving the target for 16.6% of our metrics but experiencing improvement in 2 (29%) of these 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.

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



# Integrated Performance Report | June 2024




## Outstanding Care and Experience - Safe & Caring

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

### Highlights:

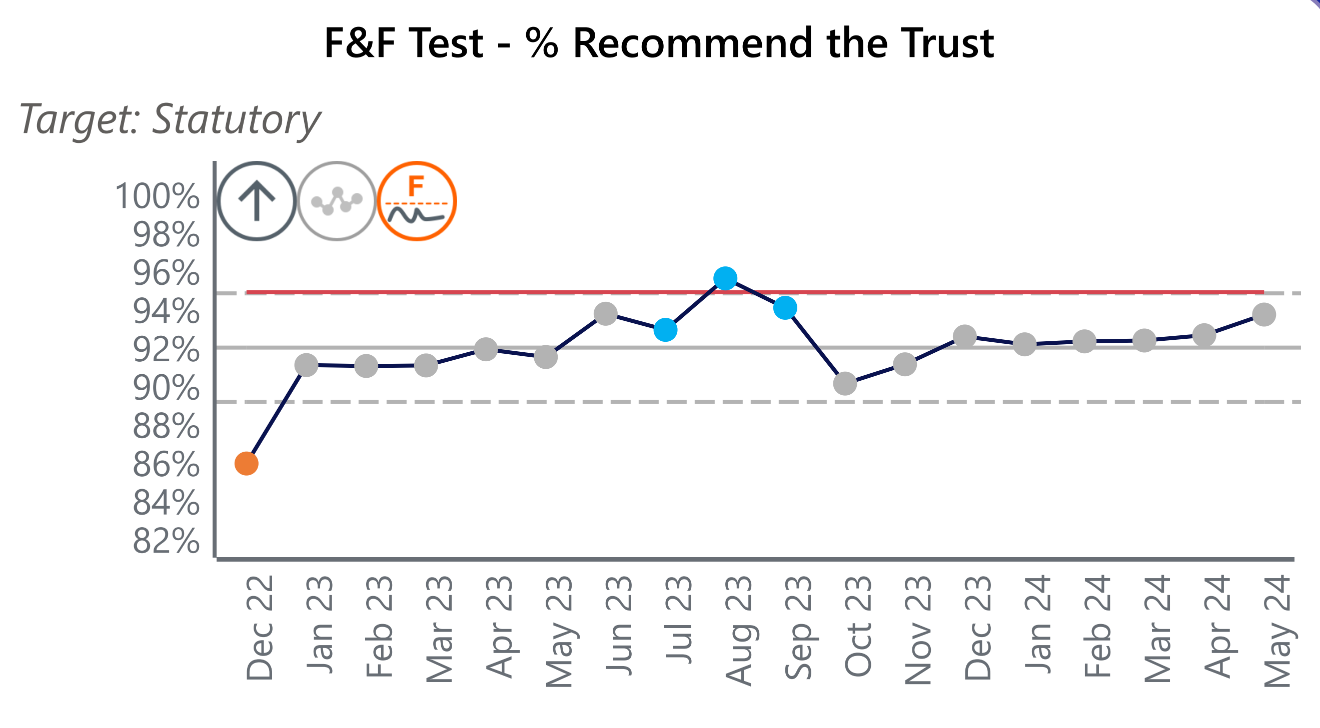
- 92% of all PALS responded to in 5 days despite the increased number of PALS received in recent months
- 93% of formal complaints responded to within 25 working days
- No hospital acquired MRSA, MSSA or C-diff infection
- Continuing upward trend in ED FFT score, with 89% of respondents satisfied in May which is the highest score in 8 months
- Very low number of Cat 2 pressure ulcers due towork by the Tissue Viability team
- Sustained improvement in ED regarding antibiotic administration for sepsis; 93% in month and 5th consecutive month of compliance over 90%

### Areas of Concern:

- Compliance in antibiotic administration on inpatient wards for sepsis was 85%; 3 out of the 4 last months below 90% compliance
- Increase in restrictive intervention reported however reporting is encouraged and in line with policy

### Forward Look (with actions)

- Divisions to review cases where antibiotics not administered within 60 minutes and identify any further learning to make improvements

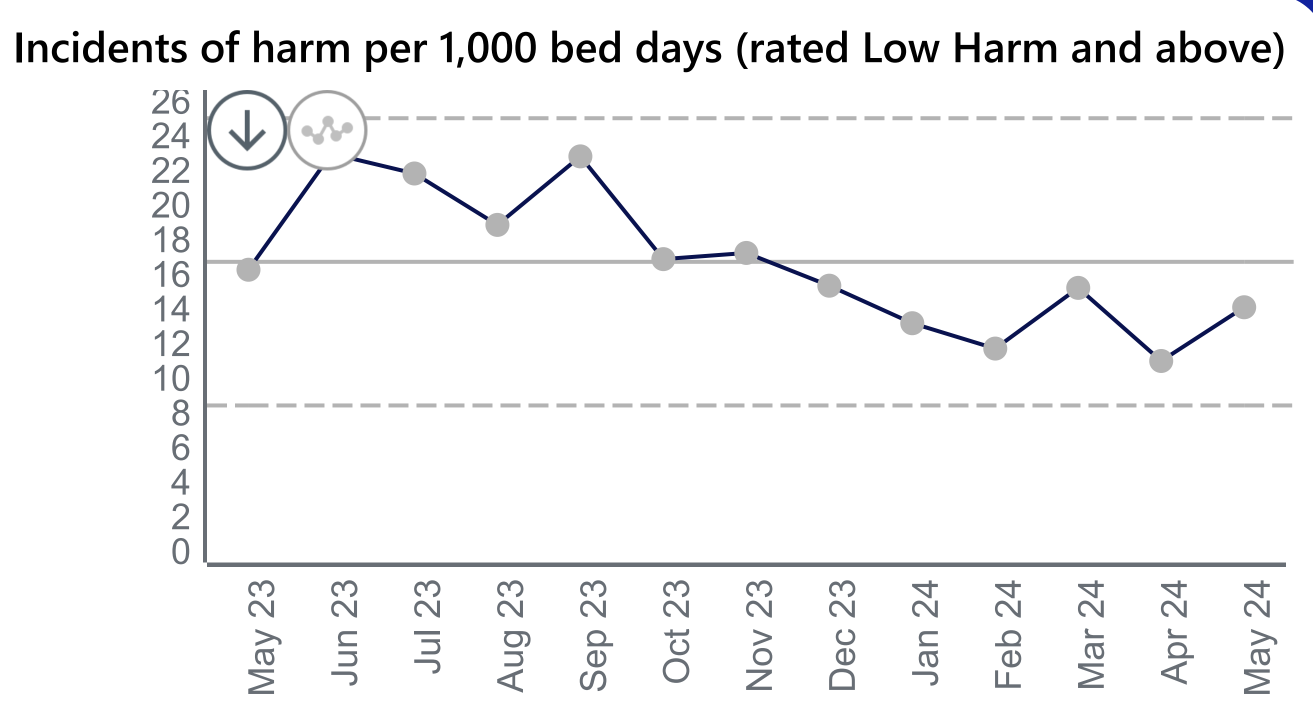



**Technical Analysis:**

Consistently not achieving the 95% target. May performance of 93.8% represents an increase from April performance of 92.8%. May 2024 performance is +2.2% compared to May 2023. This performance also represents sixth consecutive month above average of 92%.

**Actions:**

Review of FFT process in progress; 94% of respondents would recommend the Trust

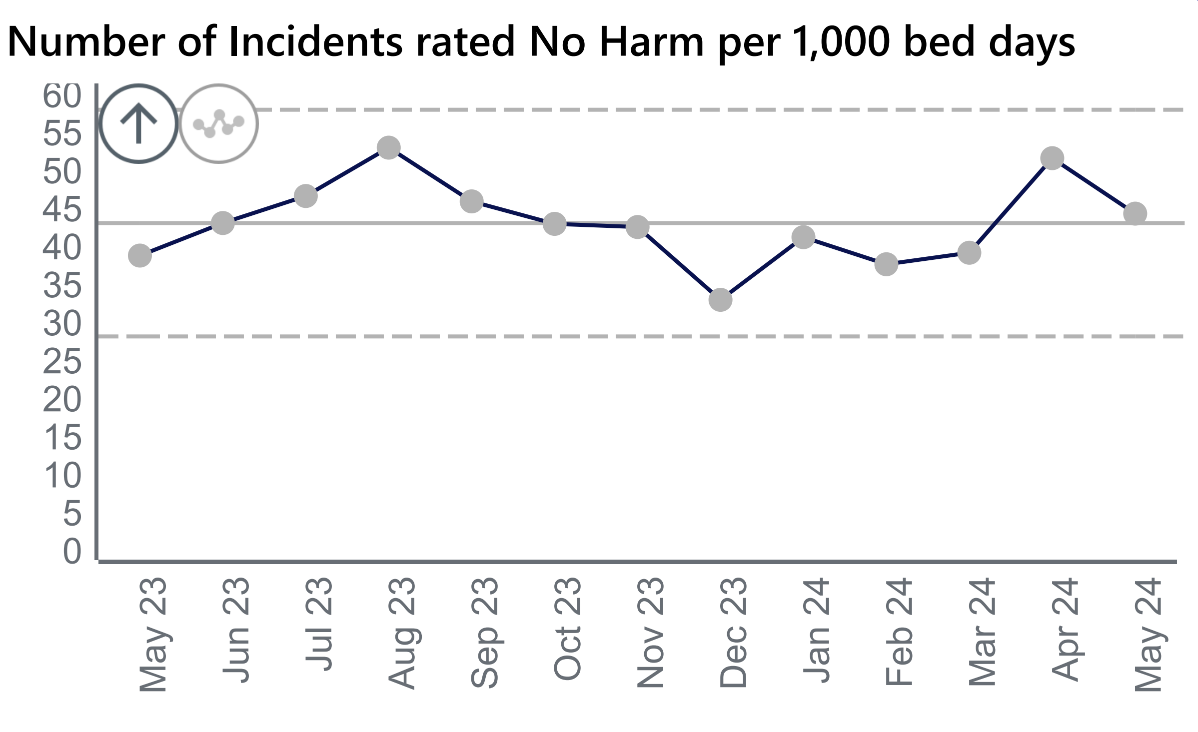



**Technical Analysis:**

Common cause variation has been observed with performance of 14 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:**

PSIRF panel now embedded where appropriate incidents are reviewed. A general downward trend in the number of incidents resulting in harm reported in the last 7 months




**Technical Analysis:**

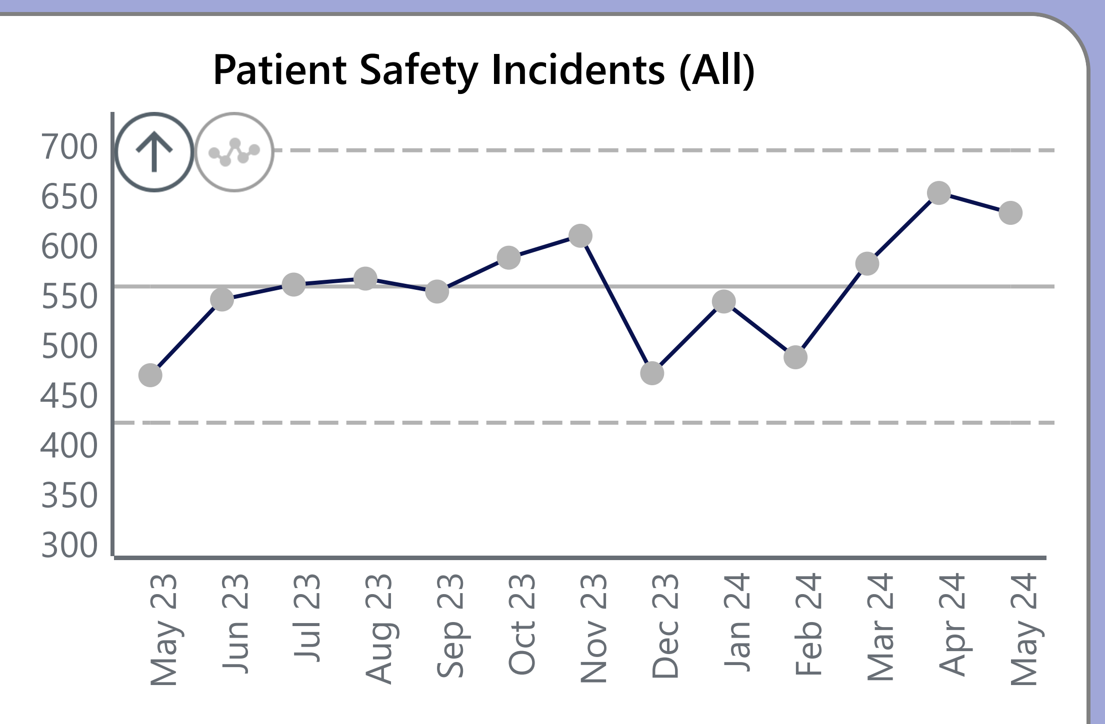
Common cause variation observed with 44 incidents of no harm per 1000 bed days. Monthly average of 43 including 38 incidents with no harm assigned due to not involving a patient directly. Incidents are now assessed on Physical and Psychological Harms. Period covers from May23 only, when new risk management system InPhase went live.

**Actions:**

General upward trend in incidents reported which have resulted in no harm; all staff encouraged to report all incidents at the weekly Patient Safety Meeting

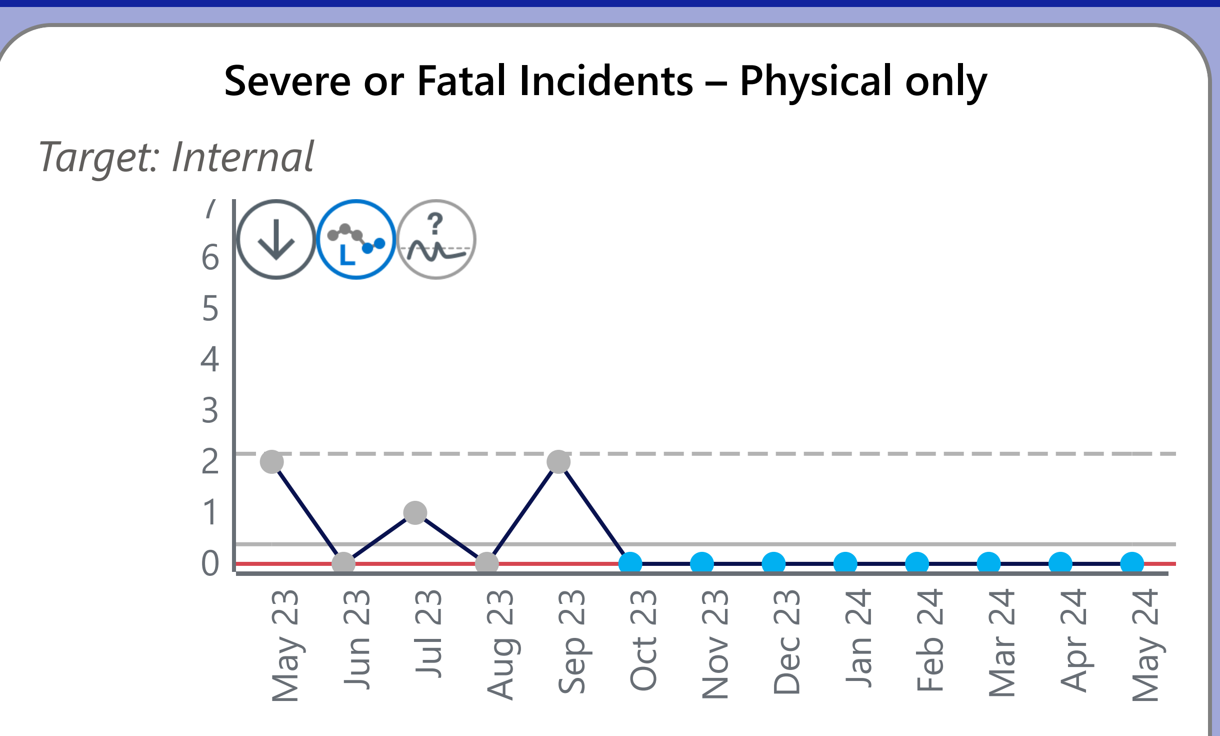
# Outstanding Care and Experience- Safe & Caring - Watch Metrics

### Patient Safety Incidents (All)



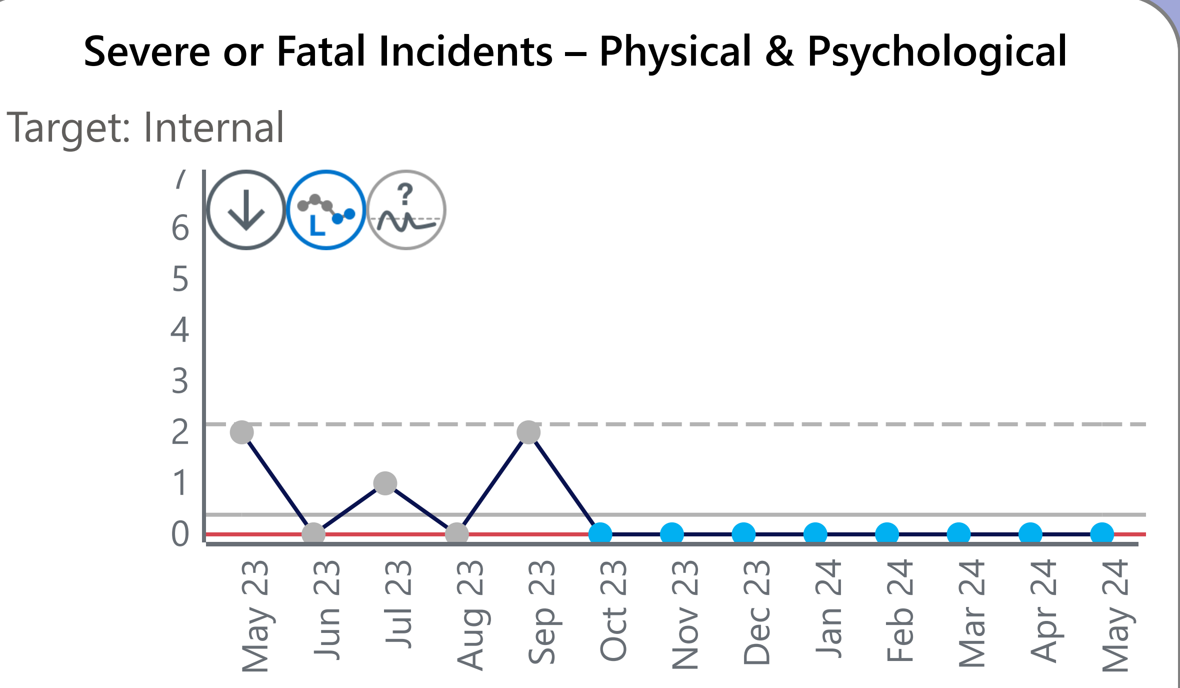
### Severe or Fatal Incidents – Physical only

*Target: Internal*

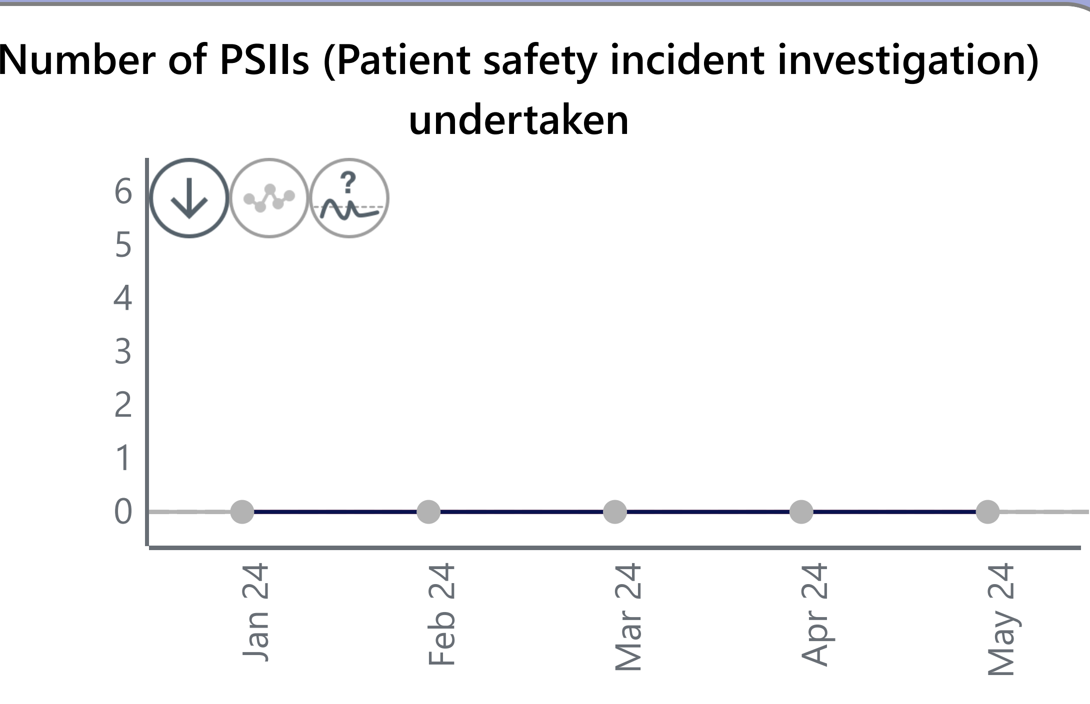


### Severe or Fatal Incidents – Physical & Psychological

Target: Internal

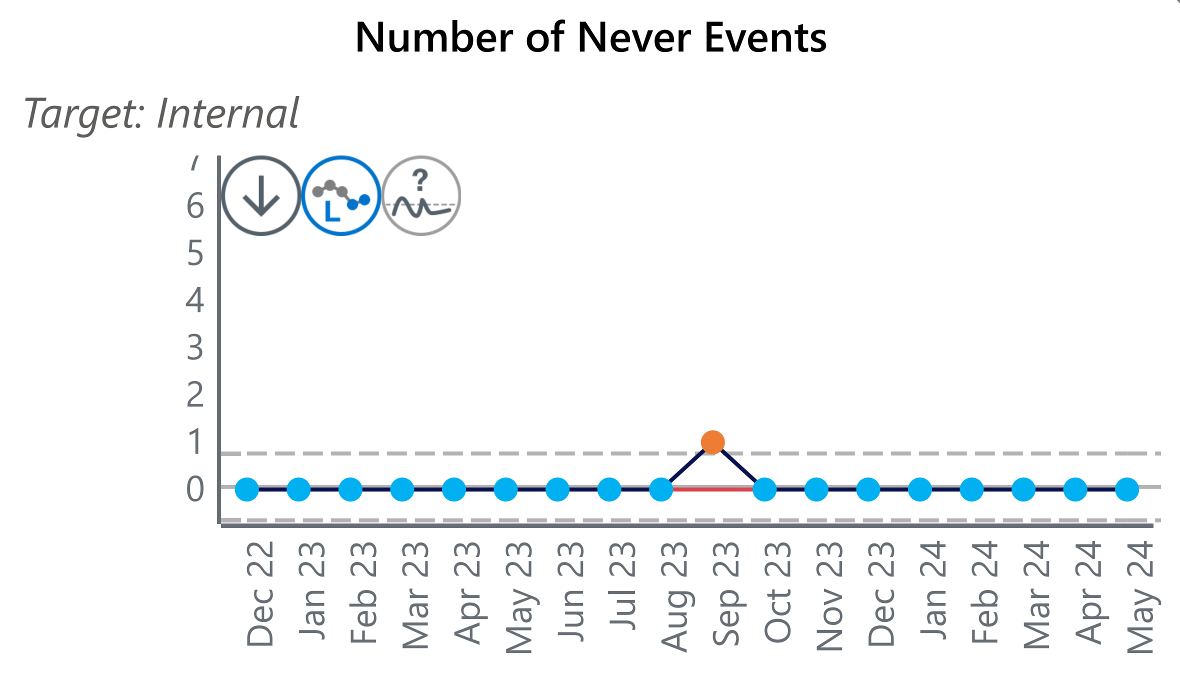


### Number of PSIIs (Patient safety incident investigation) undertaken



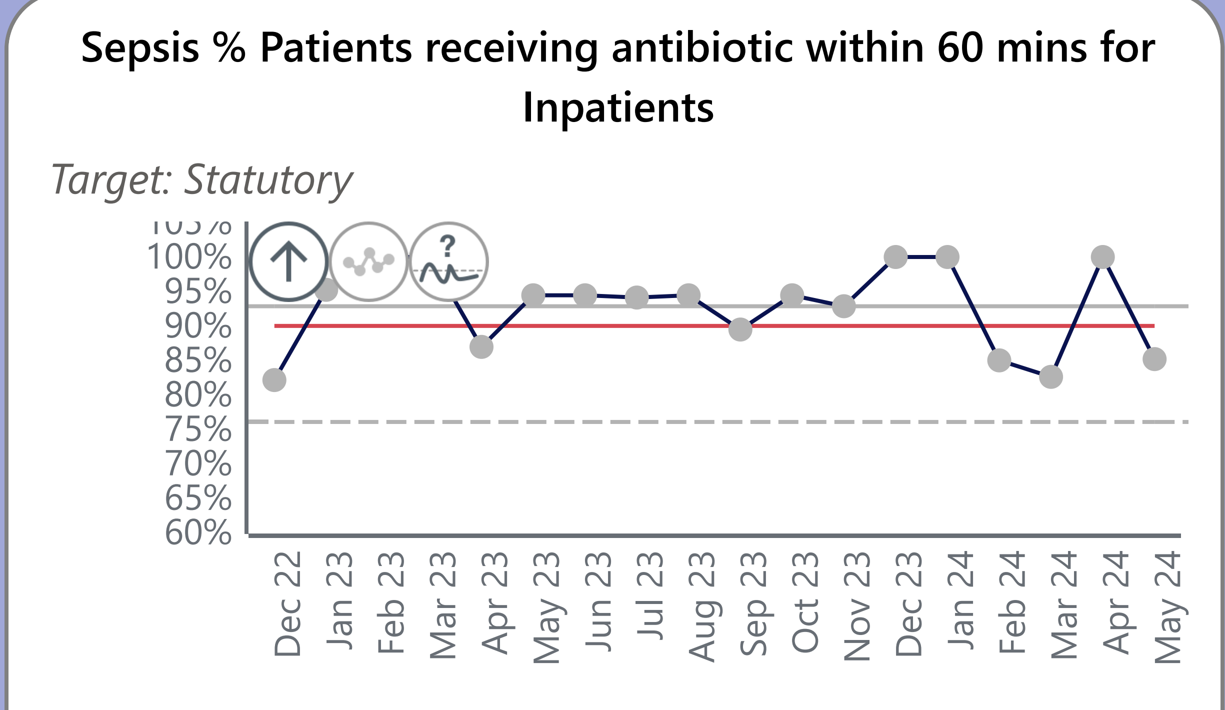
### Number of Never Events

*Target: Internal*



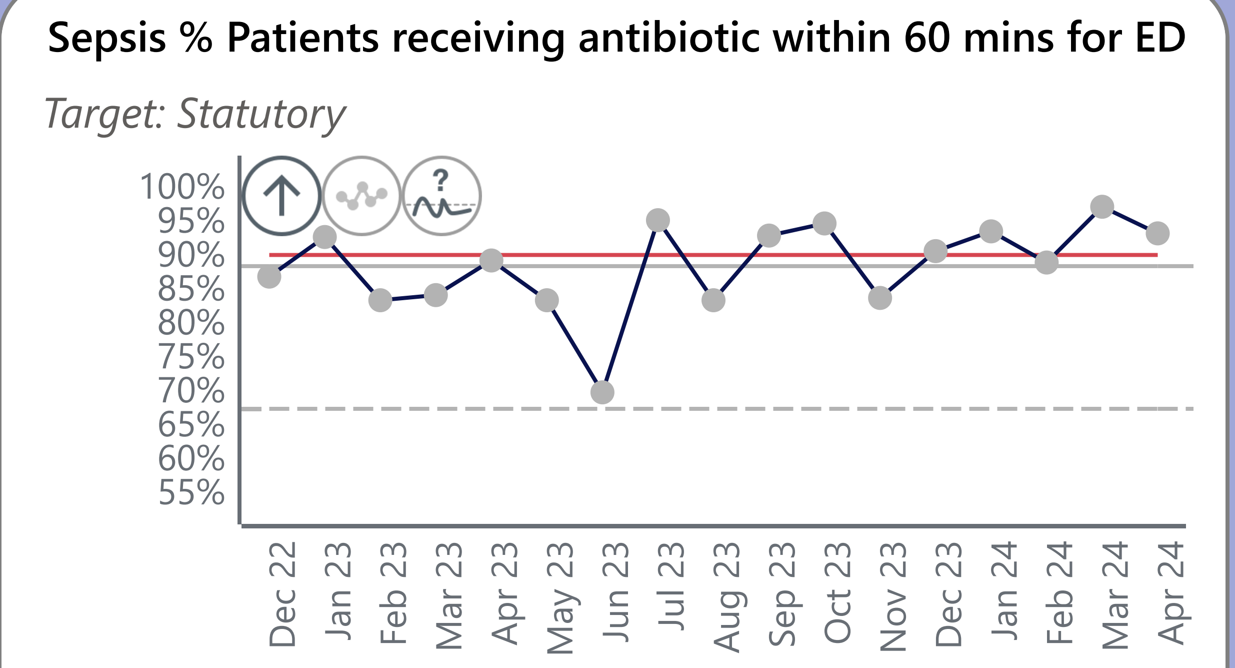
### Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

*Target: Statutory*

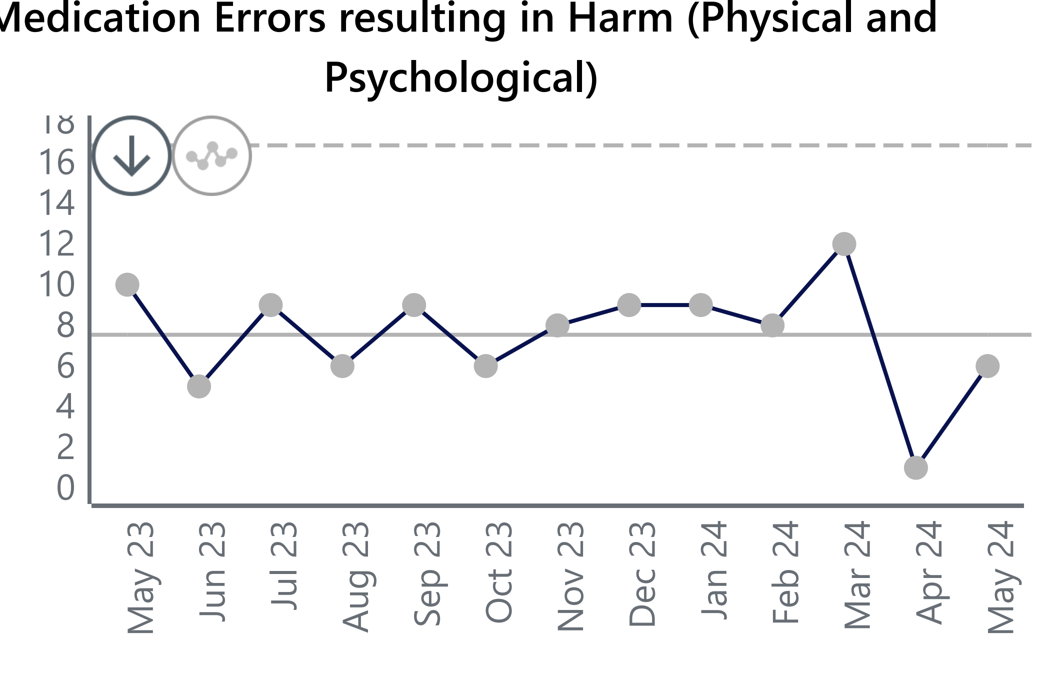


### Sepsis % Patients receiving antibiotic within 60 mins for ED

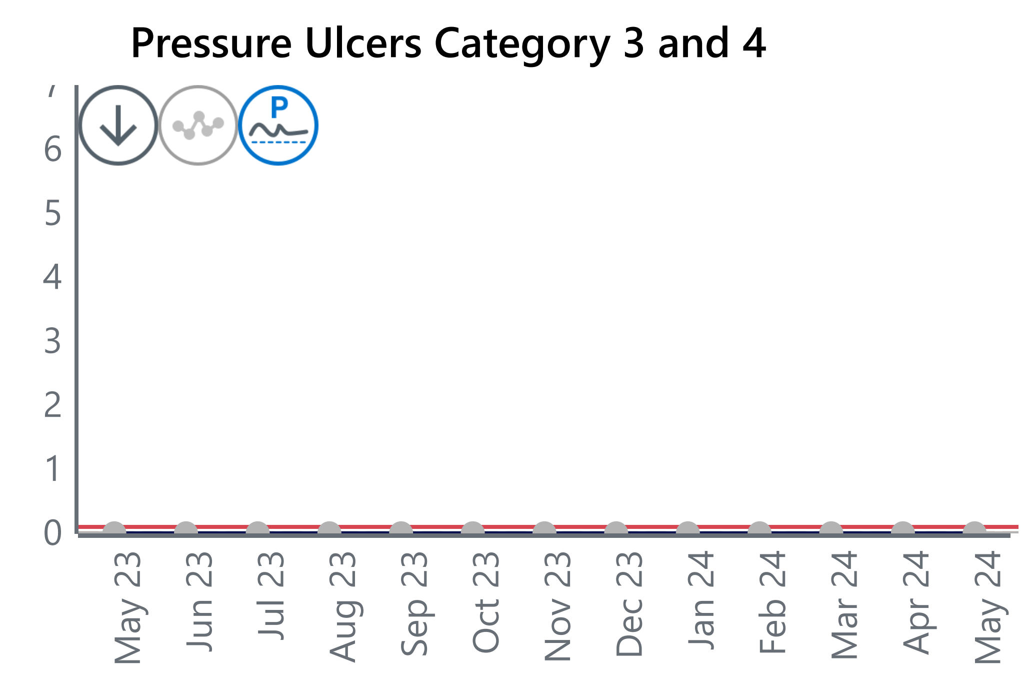
*Target: Statutory*



### Medication Errors resulting in Harm (Physical and Psychological)

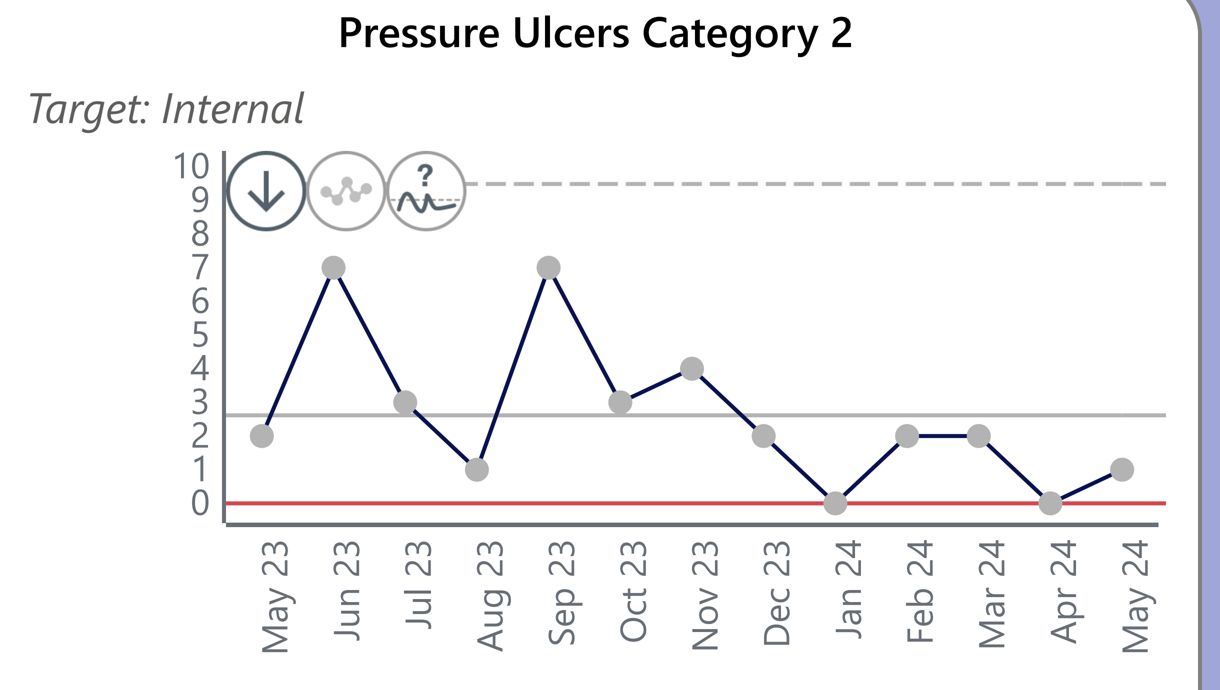


### Pressure Ulcers Category 3 and 4

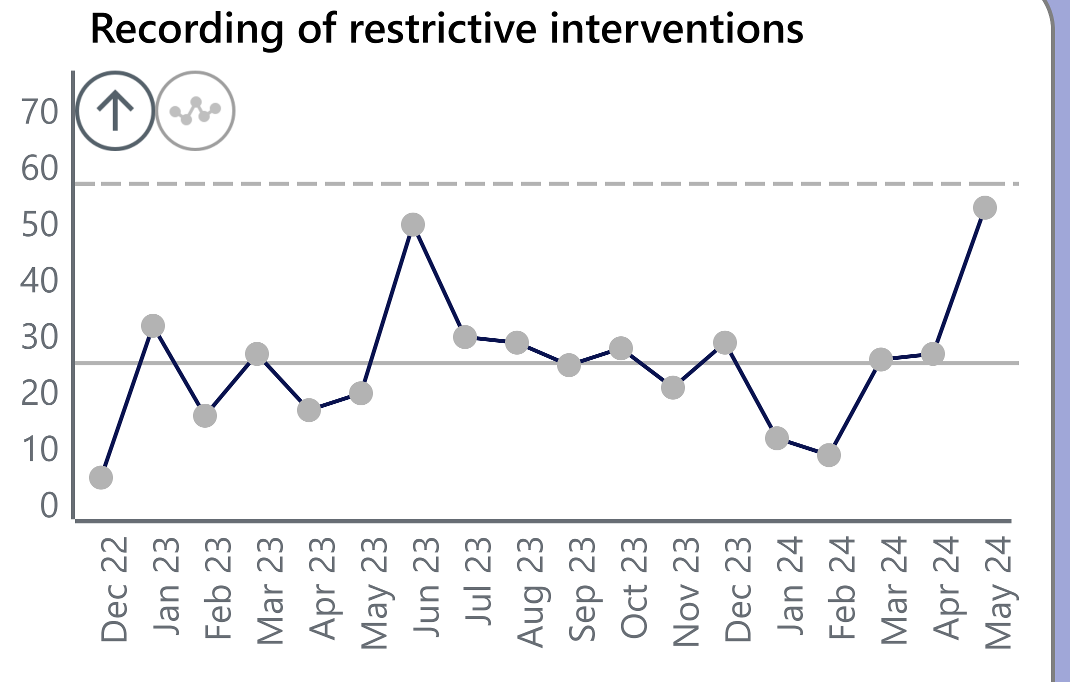


### Pressure Ulcers Category 2

*Target: Internal*

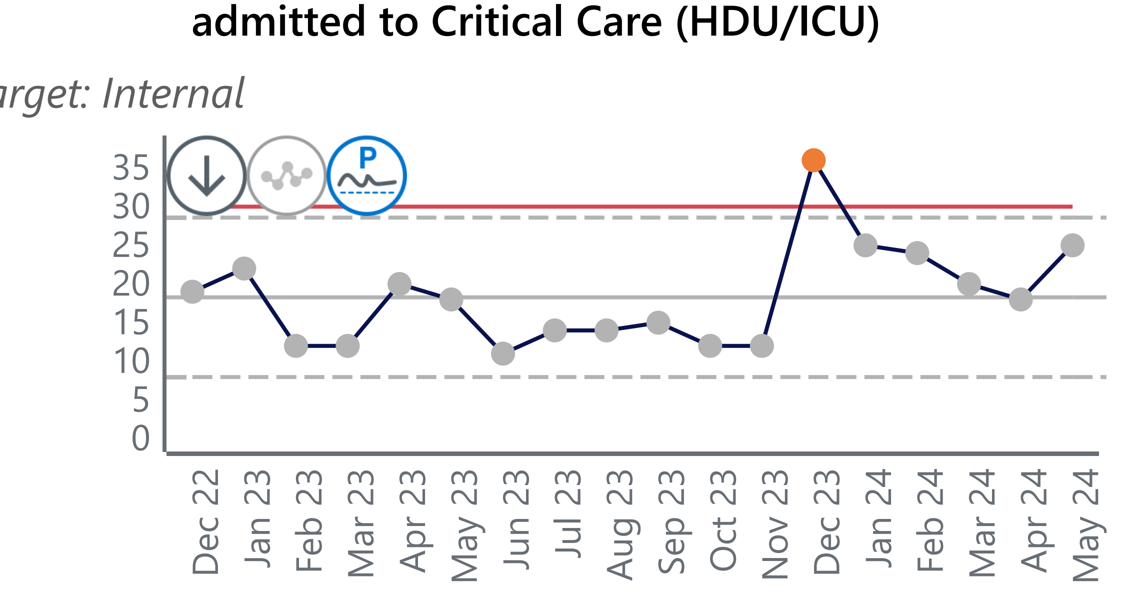


### Recording of restrictive interventions



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

*Target: Internal*

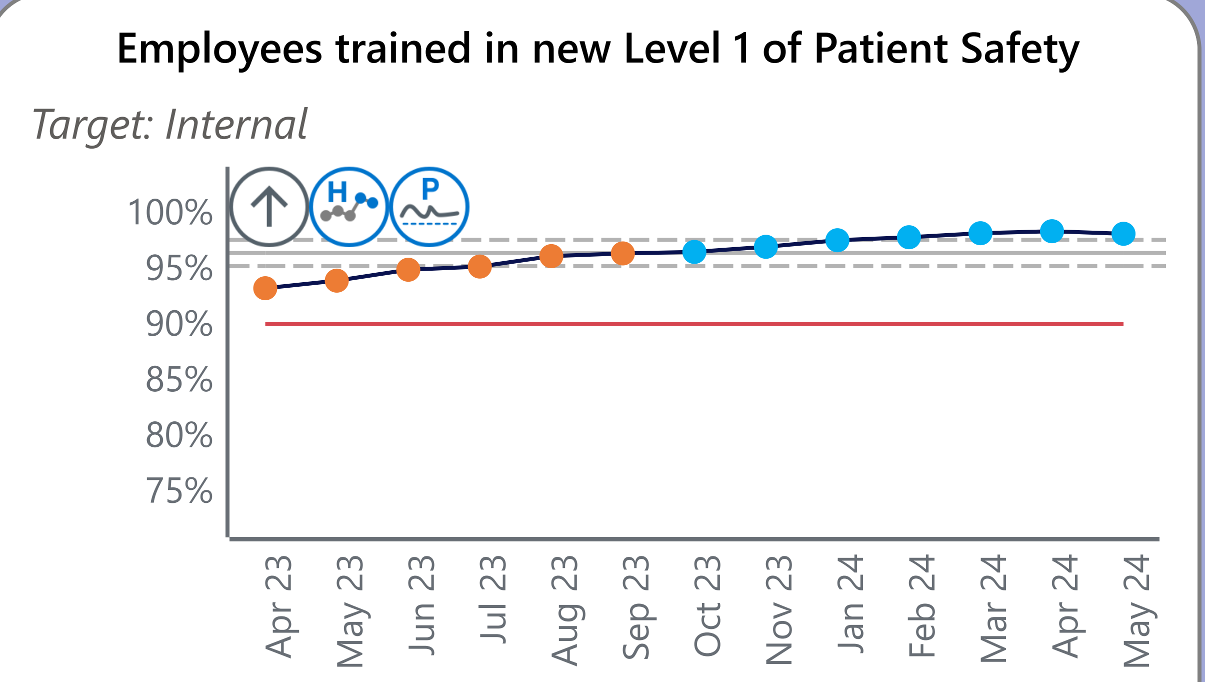


# Integrated Performance Report | June 2024

## Outstanding Care and Experience - Safe & Caring - Watch Metrics

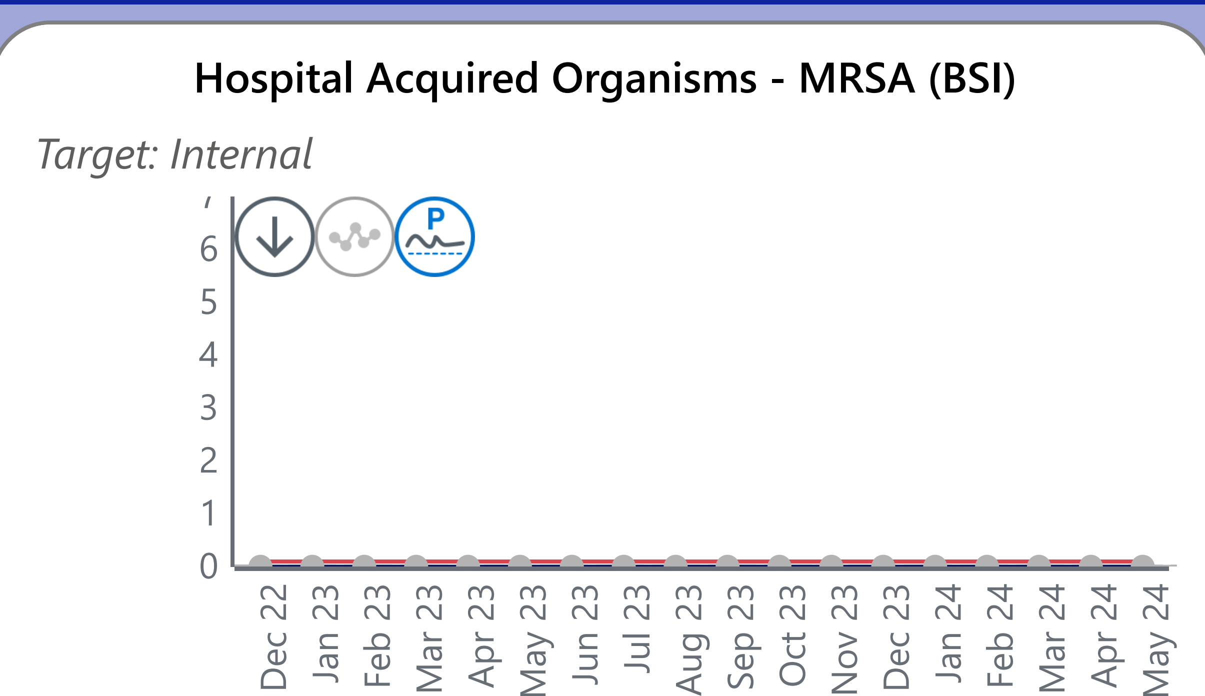
### Employees trained in new Level 1 of Patient Safety

*Target: Internal*



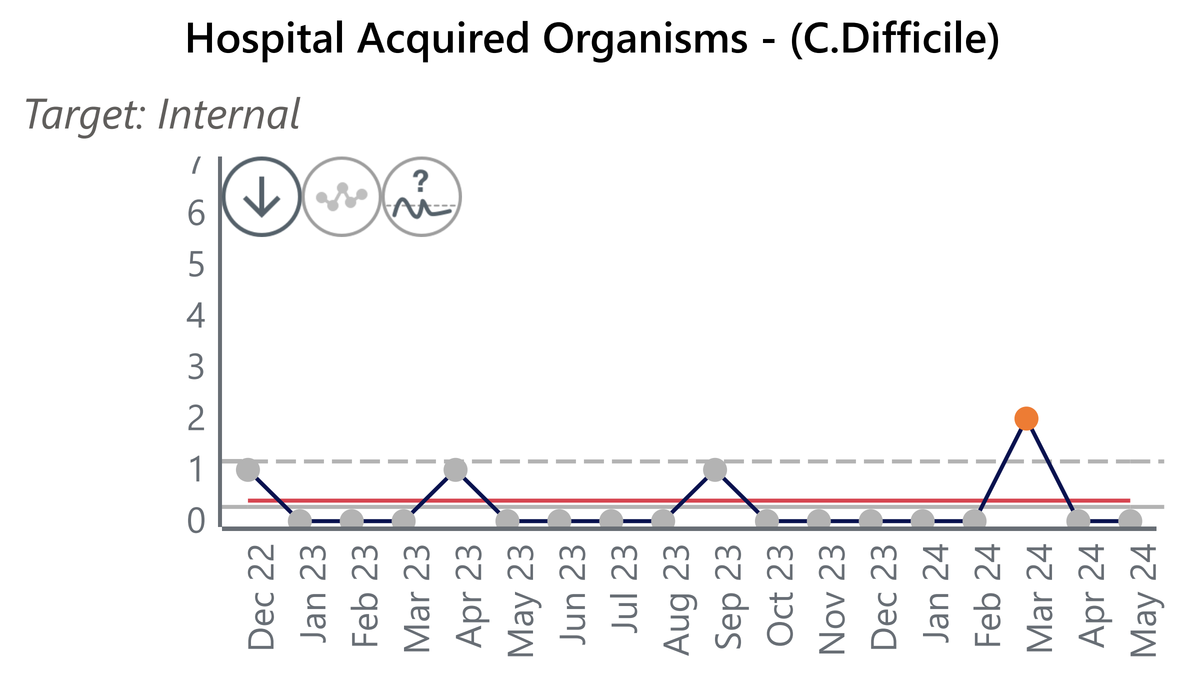
### Hospital Acquired Organisms - MRSA (BSI)

*Target: Internal*



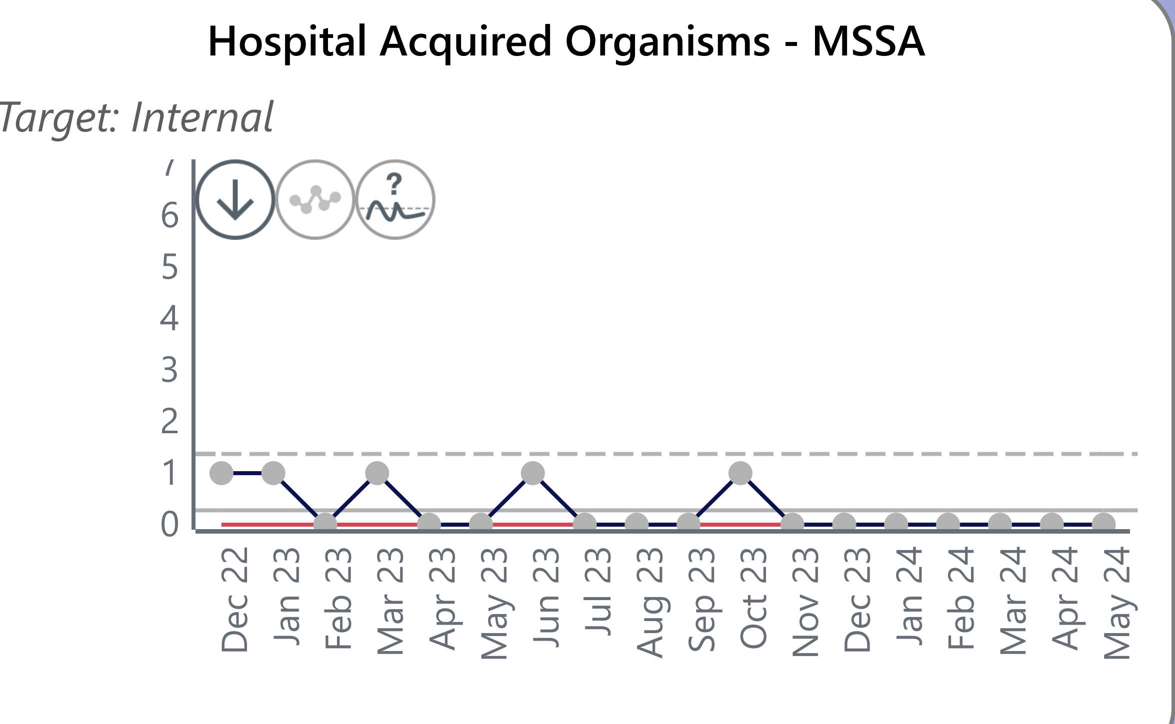
### Hospital Acquired Organisms - (C.Difficile)

*Target: Internal*



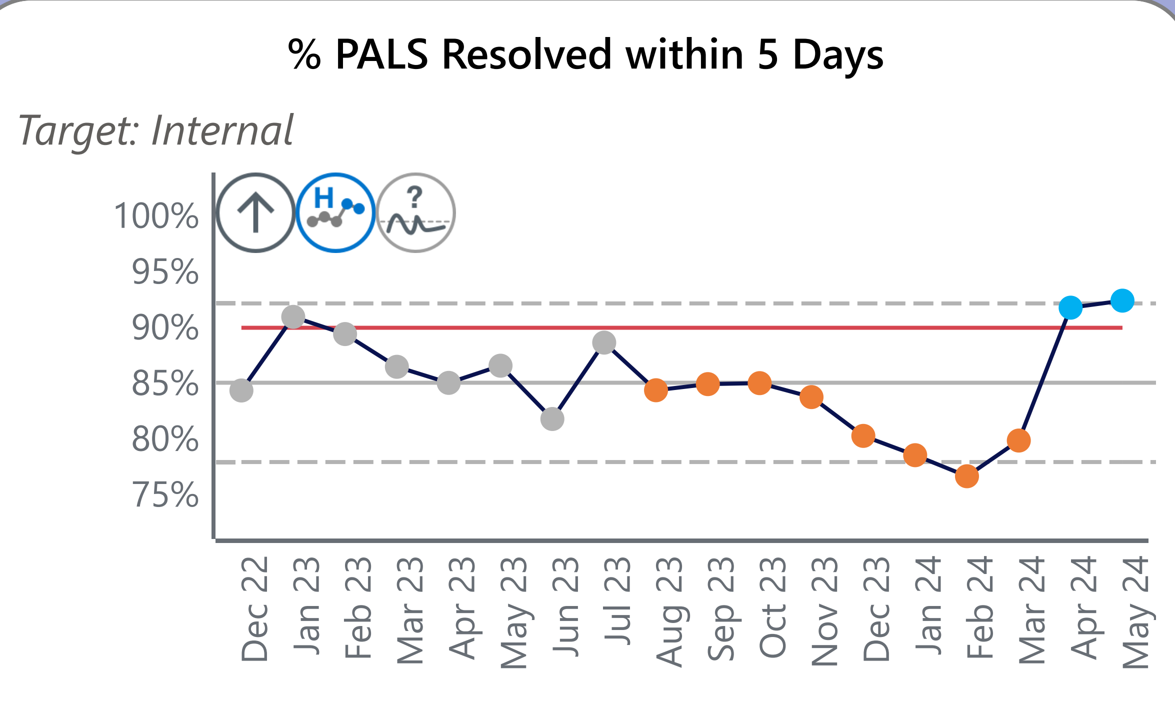
### Hospital Acquired Organisms - MSSA

*Target: Internal*



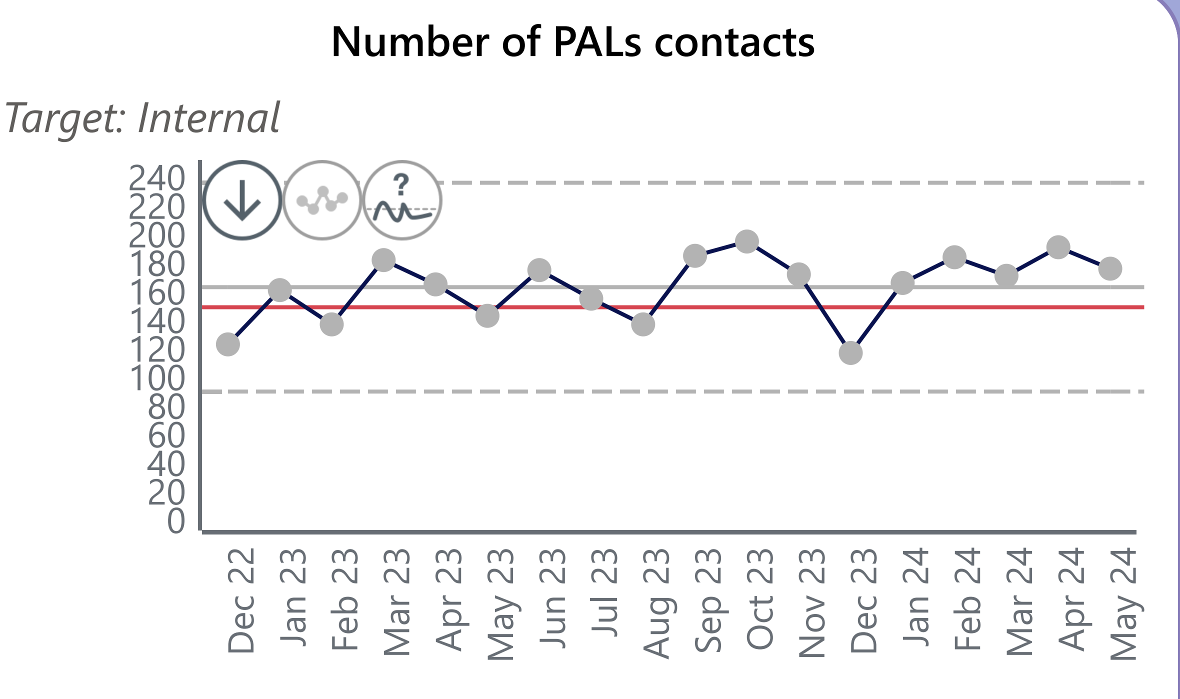
### % PALS Resolved within 5 Days

*Target: Internal*



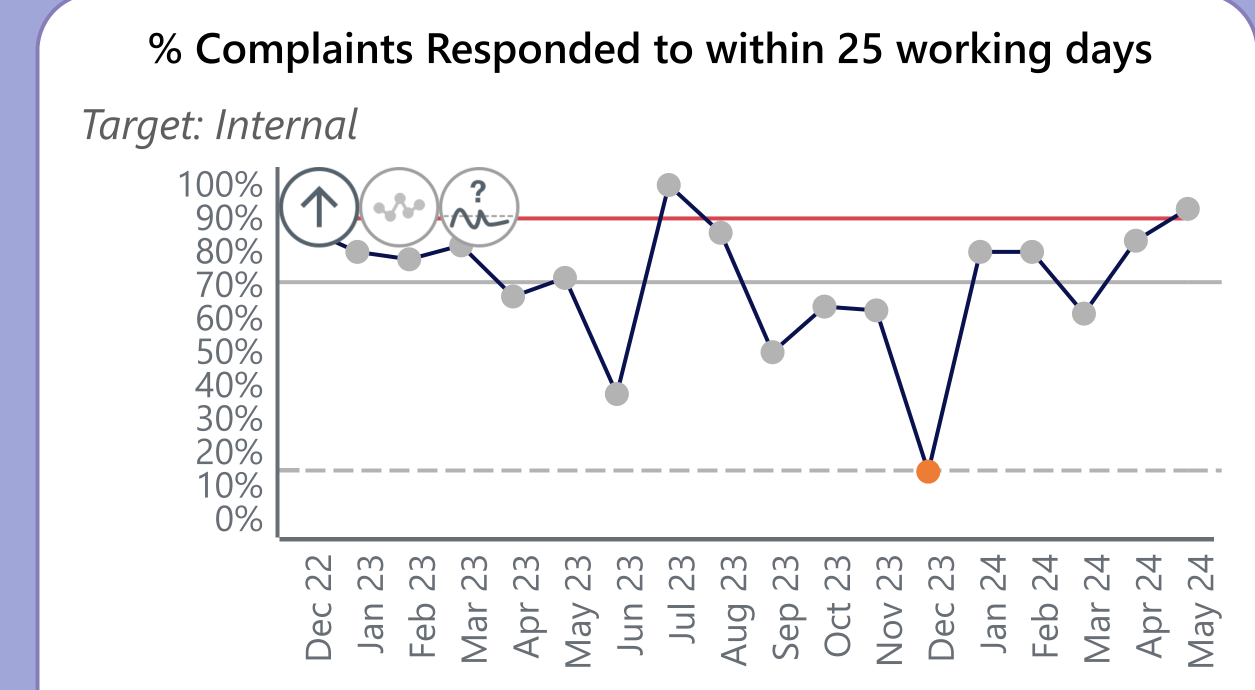
### Number of PALs contacts

*Target: Internal*



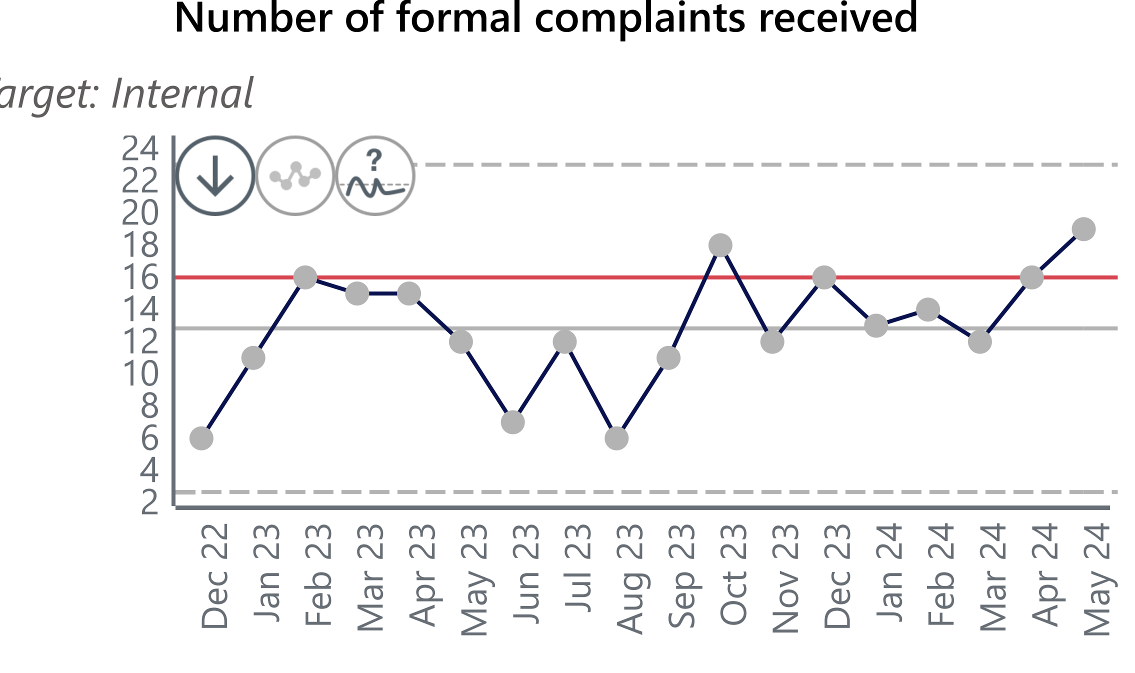
### % Complaints Responded to within 25 working days

*Target: Internal*



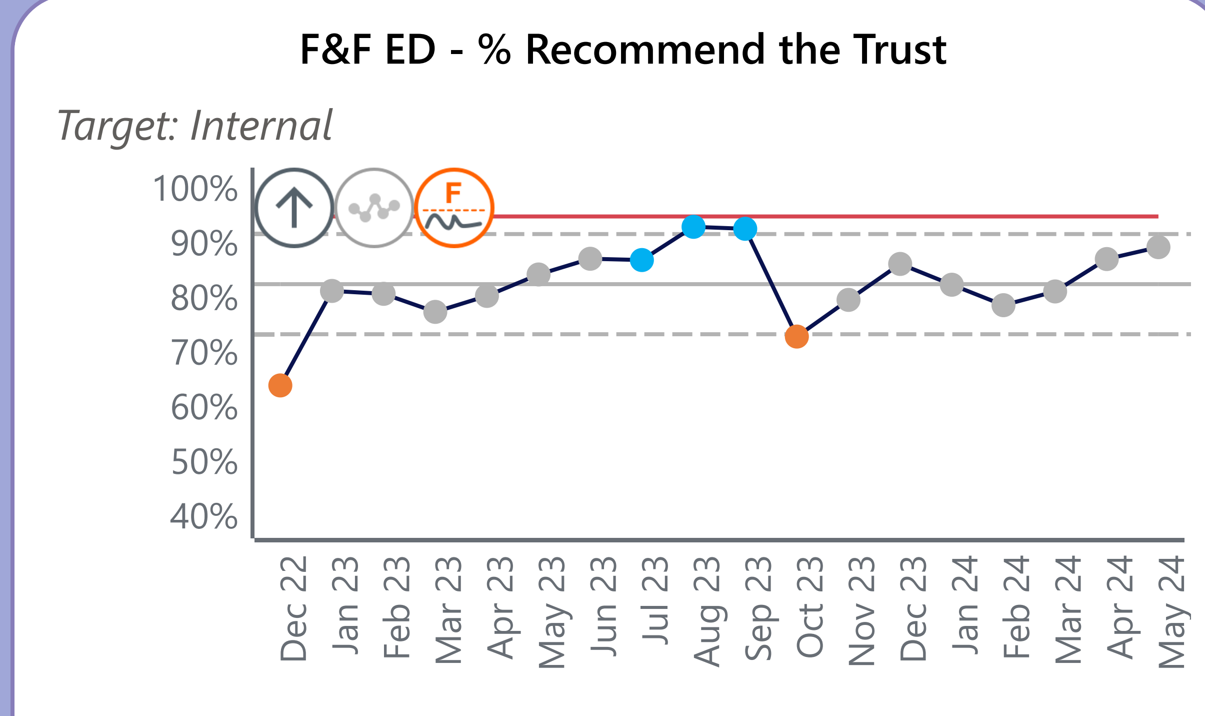
### Number of formal complaints received

*Target: Internal*



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

*Target: Internal*



# Integrated Performance Report | June 2024

## 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 86.7%, exceeding the national target of 78%
- 100% compliance remains for access to cancer services, exceeding national standard
- 720 patients waited over 52weeks for treatment against an external trajectory of 781
- Reduction in the number of CY&P waiting over 52 weeks for a CAHMS appointment
- Significant improvement in the % of IHA being completed from 20 days from referral, increasing from 27% to 76%

### Areas of Concern:

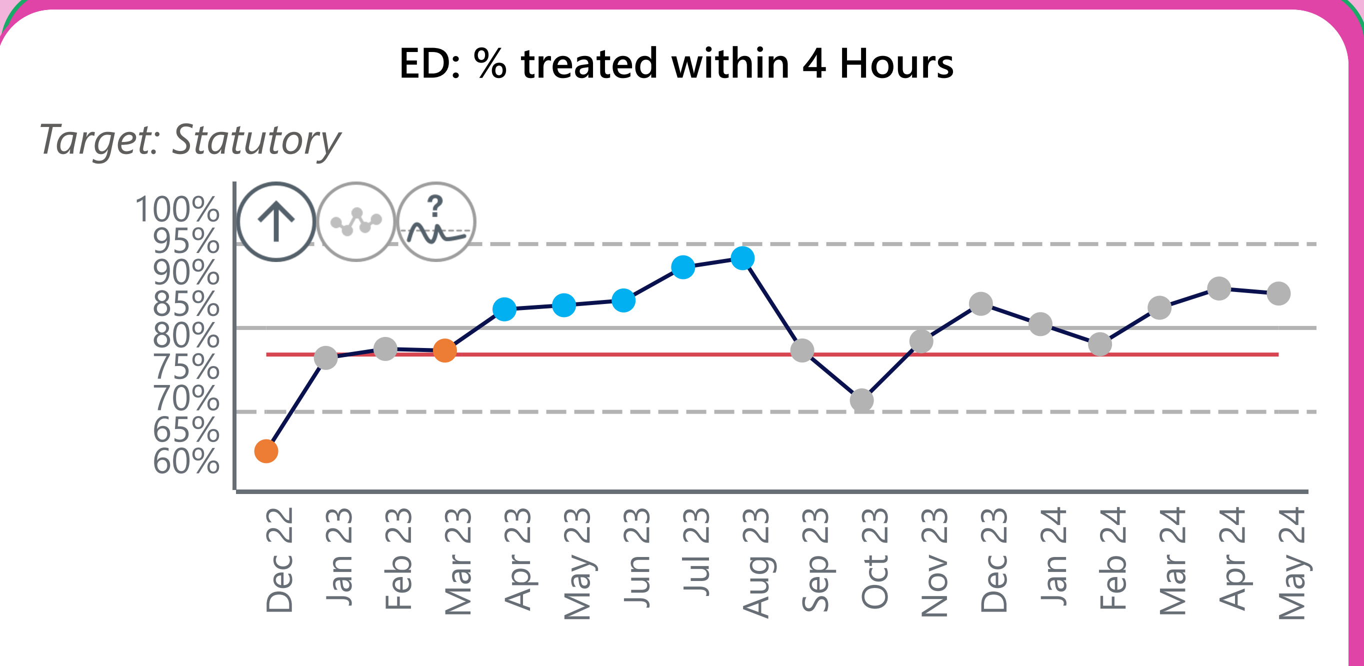
- DM01 remained at 85% for a second month, against national target of 95%
- There are 6,002 patients waiting 2 years (and longer) for their follow up. There is an ambition to reduce this to zero by year end.
- Theatre utilisation remains below the national target of 85%, achieving 77/78% for forth consecutive month
- The number of patients waiting for ASD or ADHD diagnosis continues to grow, now 2,528 patients are waiting

### Forward Look (with actions)

- Safe Follow Up Care project has expanded the scope to have oversight of all overdue follow ups, focusing on those over 2 years as a priority
- Target for working day productivity metrics to be included in the report from next month
- Productivity dashboard in development to highlight areas of opportunity for improvement
- Deep dive into sleep studies DM01 as performance has declined in month

**ED: % treated within 4 Hours**

*Target: Statutory*




**Technical Analysis:**

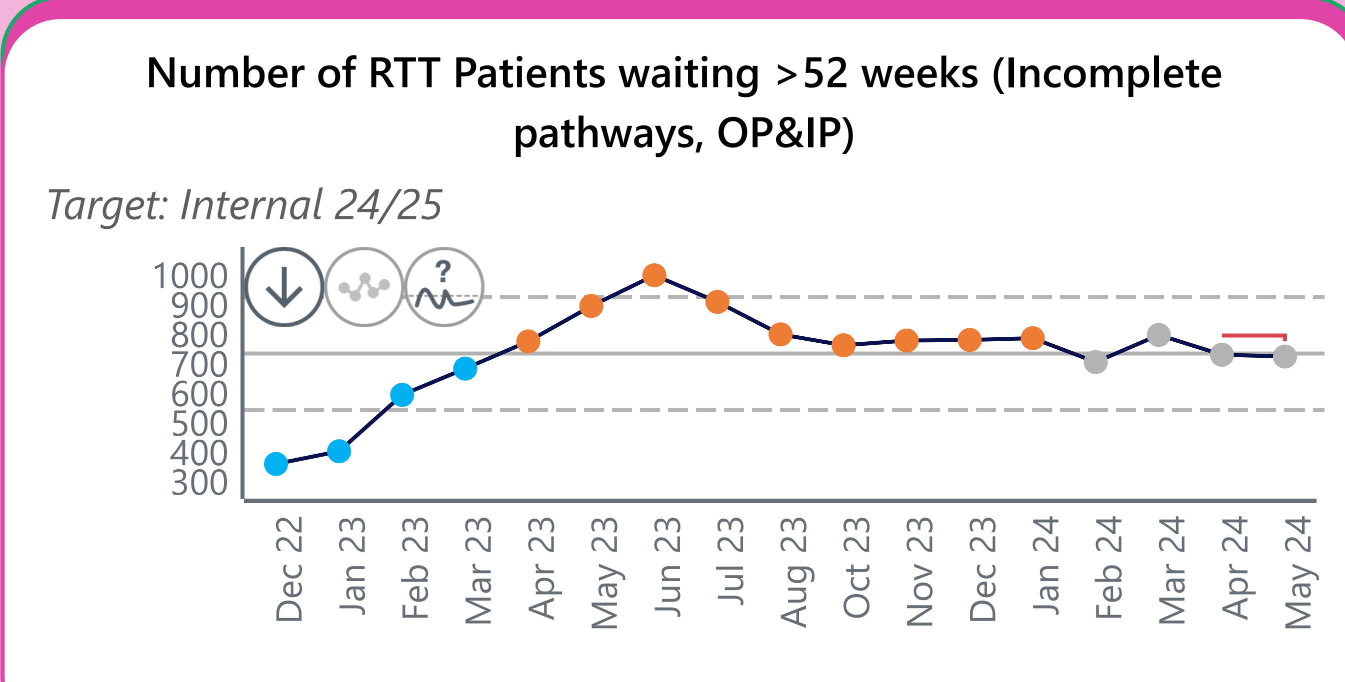
Trust is achieving the national target (>77%) in May-24. Common cause variation has been observed with performance of 86.7%. Slight reduction from Apr-24 (87.5%) however May-24 performance is +1.9% compared to May-23 (84.8%) whilst also seeing +369 extra attendances in May-24 compared to May-23.

**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 24/25*

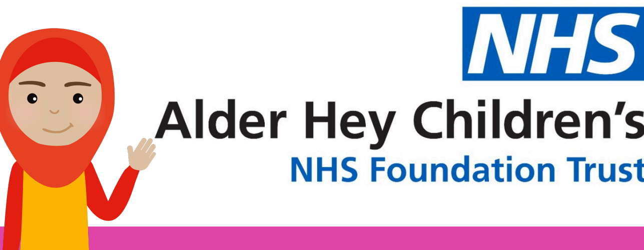



**Technical Analysis:**

Demonstrating common cause variation with number of patients waiting > 52 weeks at 724 for May 2024 against a trajectory of 781. This is a decrease from April 2024 position of 735. The top 3 services with waiters >52 weeks: Dentistry (n= 330), ENT (n=137) & Plastics (n=70). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

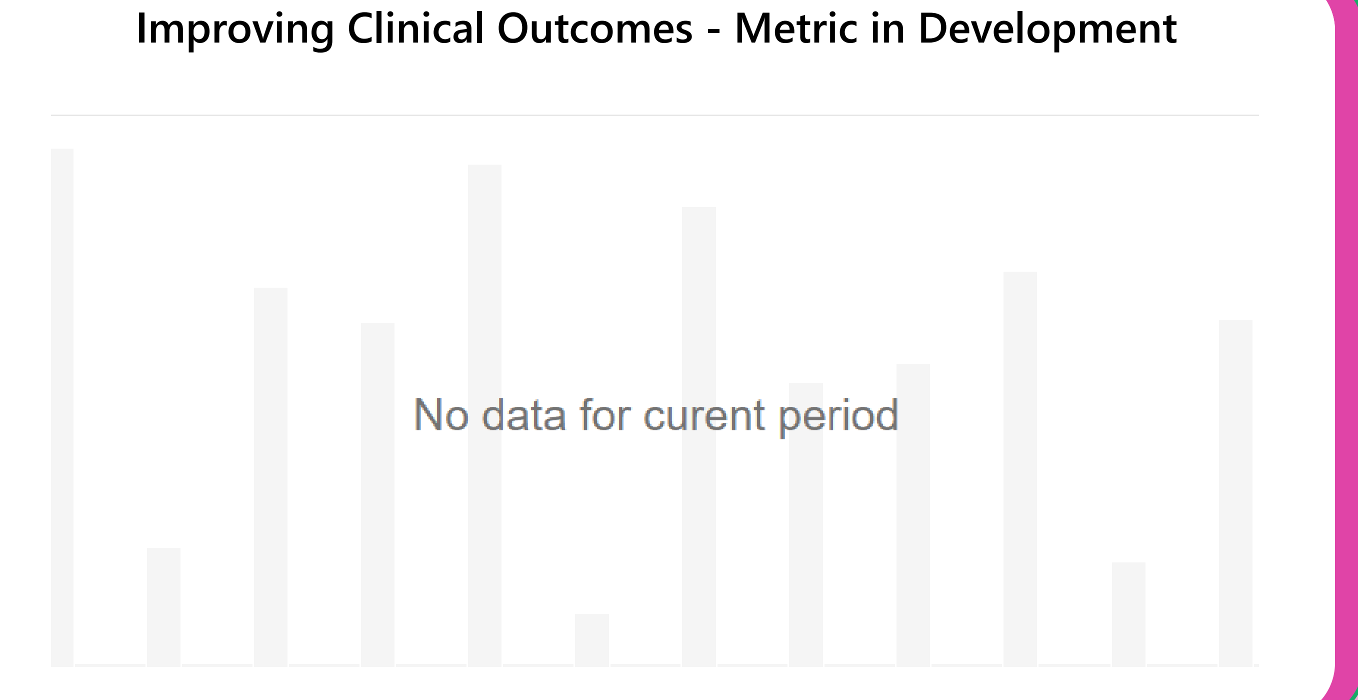
**Actions:**

A paper was presented at May Operational Delivery Board for additional capacity, awaiting external approval. Division of Surgery continues to review weekly compliance against trajectory.




# Revolutionise Care- Effective & Responsive

**Improving Clinical Outcomes - Metric in Development**



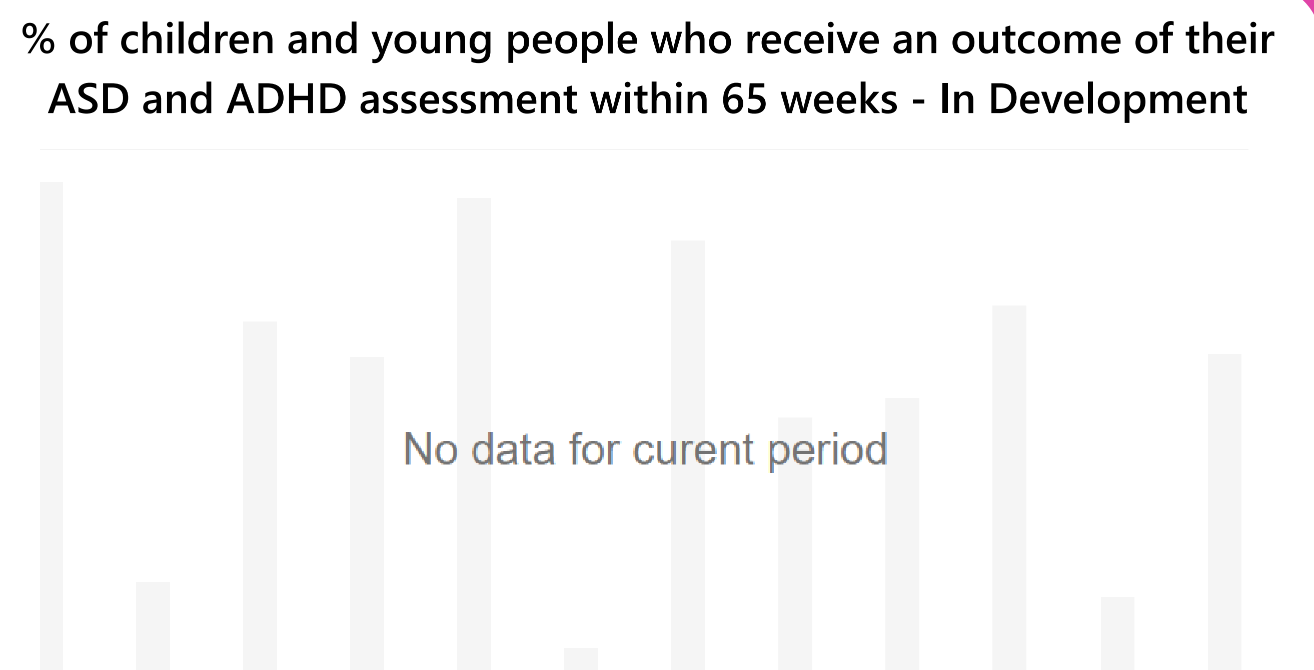

**Technical Analysis:**

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:**

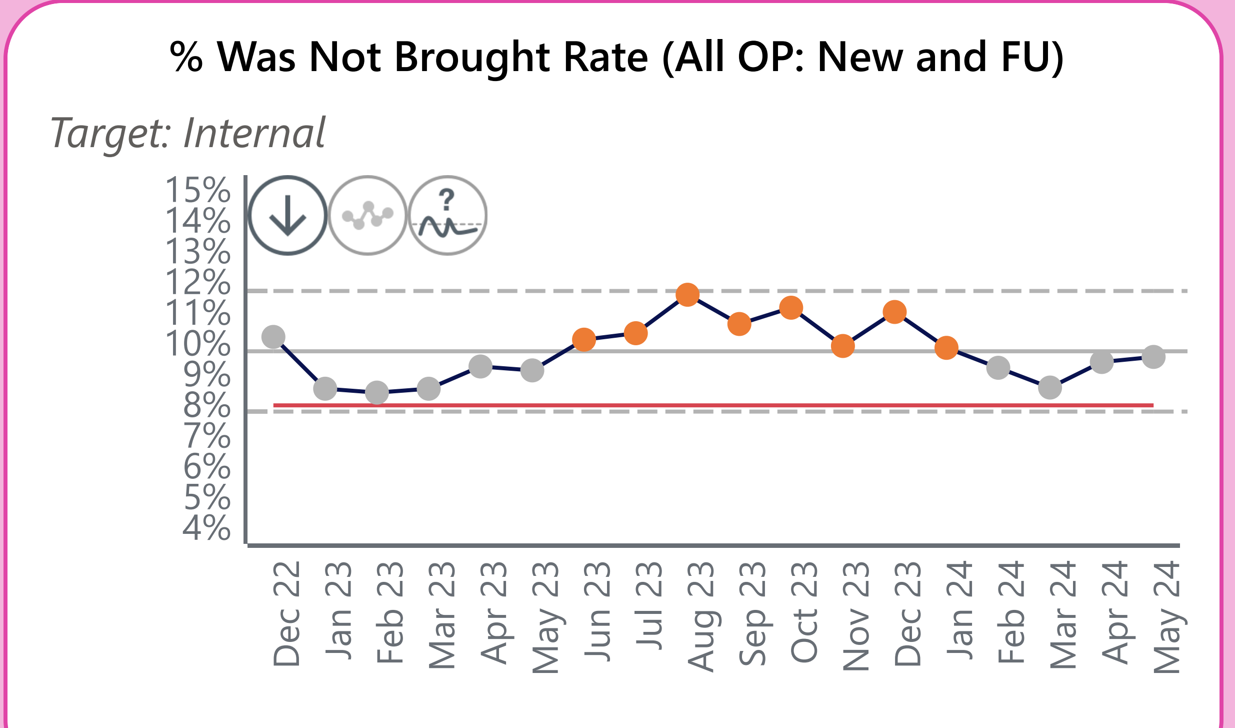
This metric is under development. The previous measure of 'Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis' is temporarily included as a watch metric on page 10 whilst the new measure is in development.

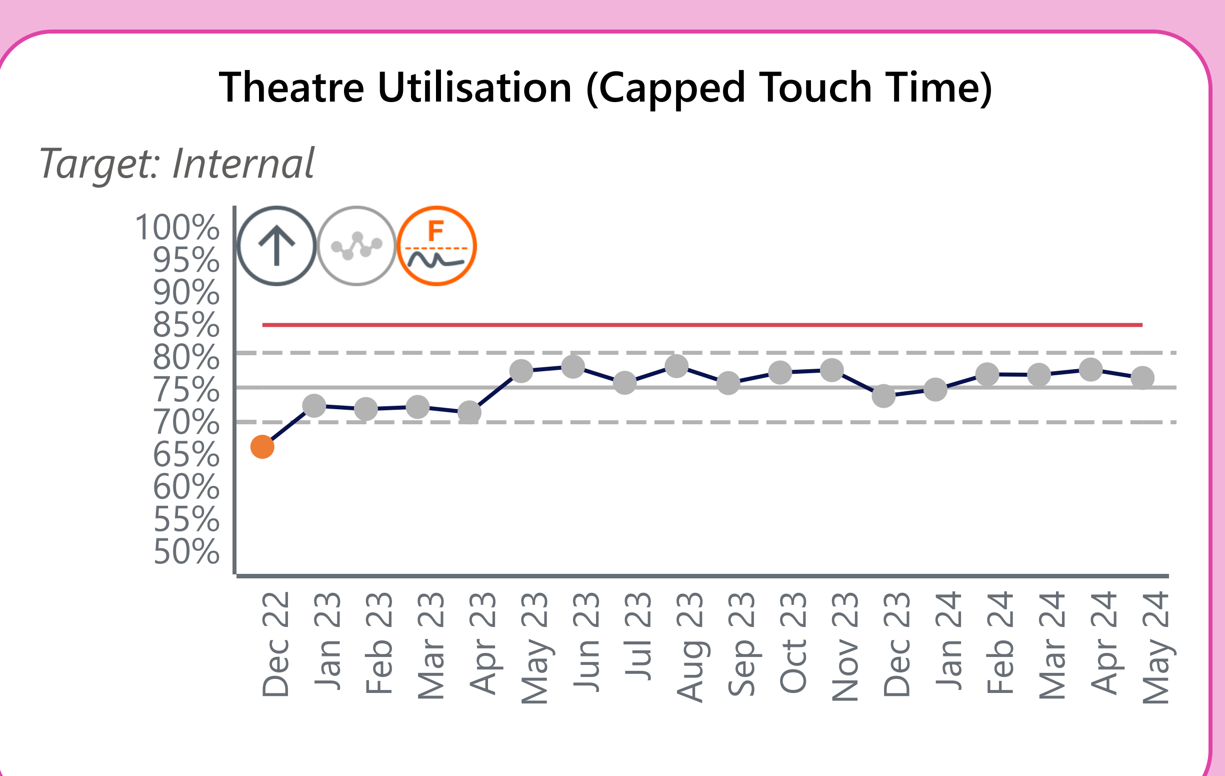
**Actions:**

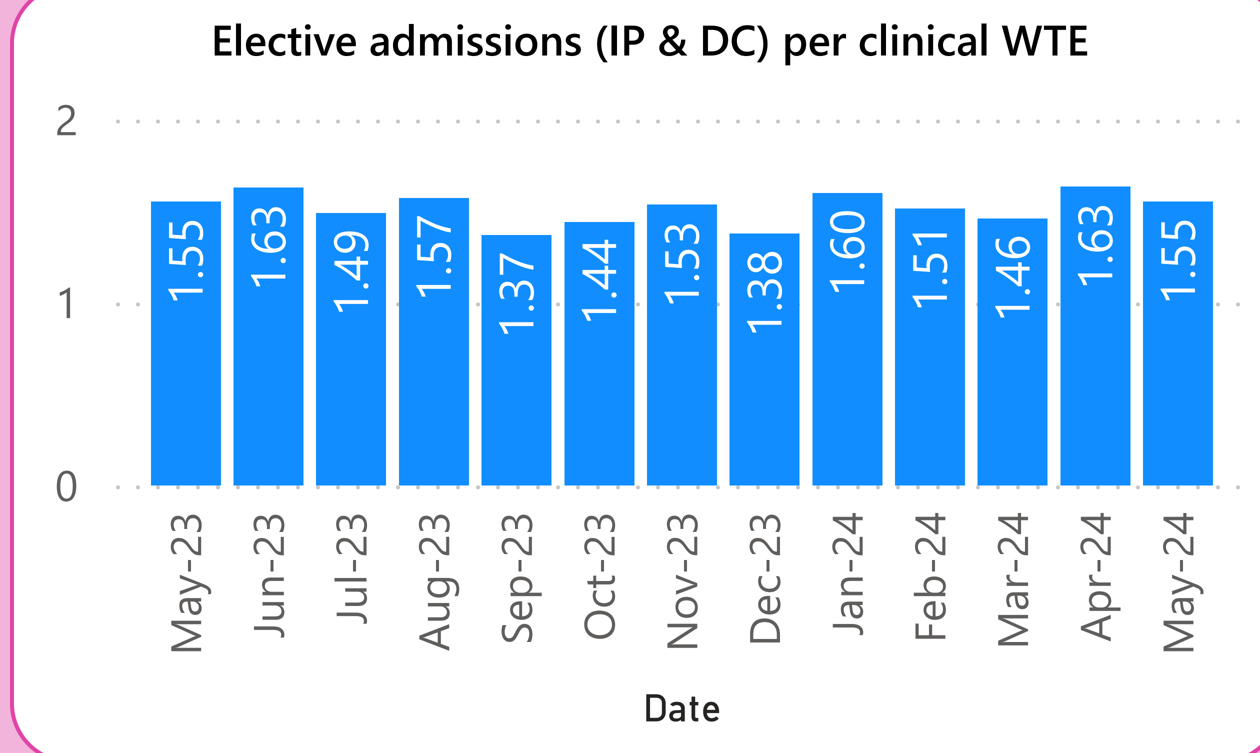
This metric is under development with the Community & Mental Health division after altering the measure from the previous "Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis"; The number waiting the end of May24 was 2,581.

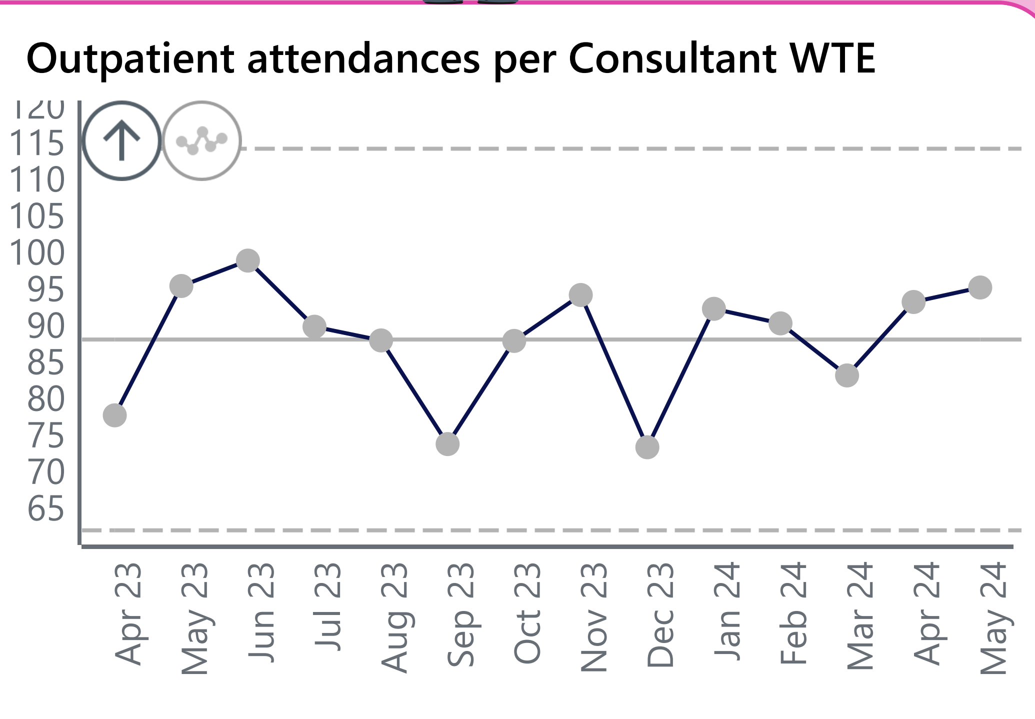
# Integrated Performance Report | June 2024

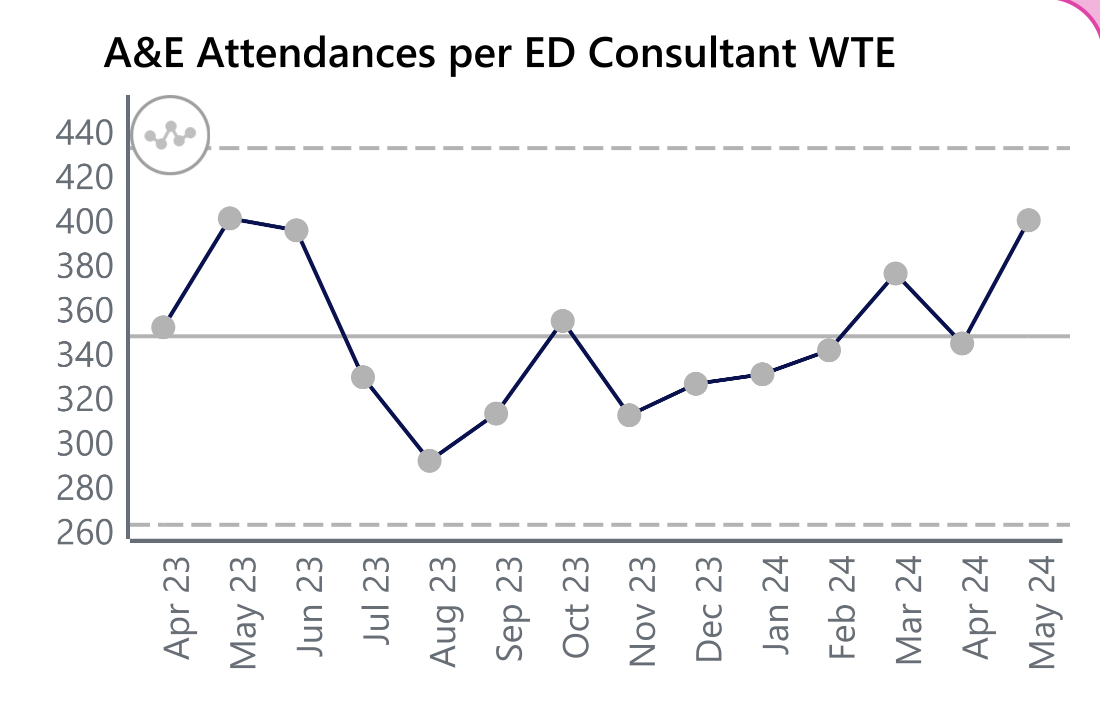
## Revolutionise Care - Effective & Responsive - Watch Metrics

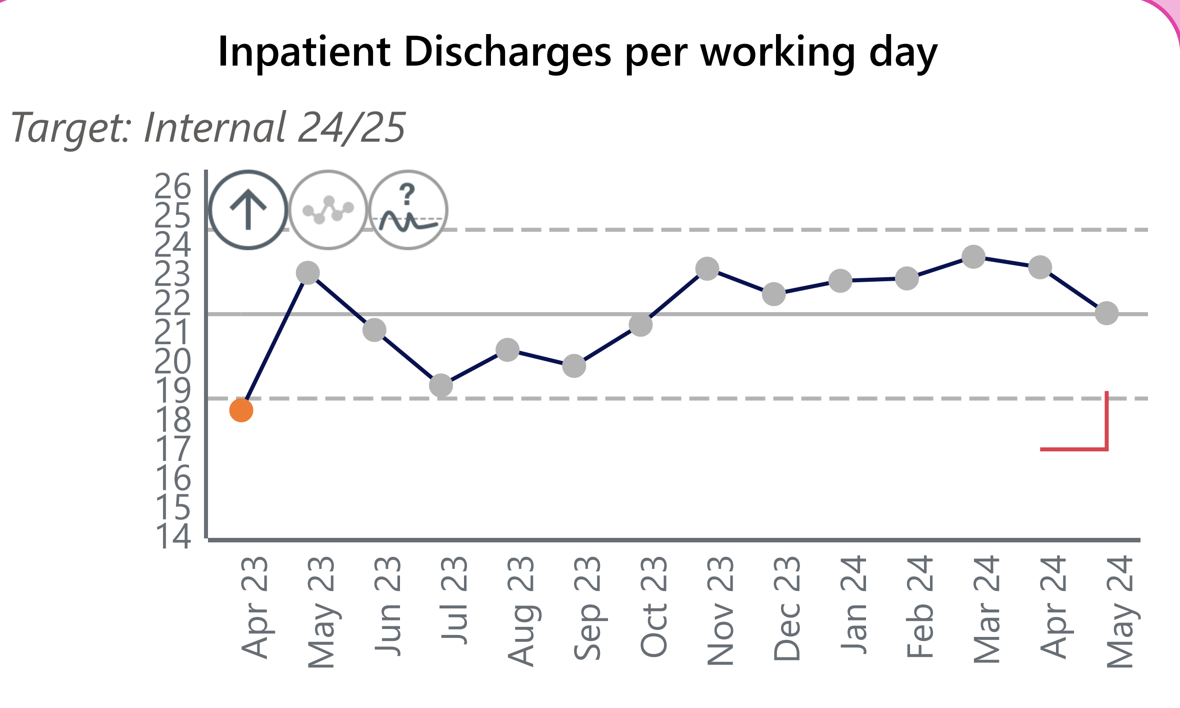


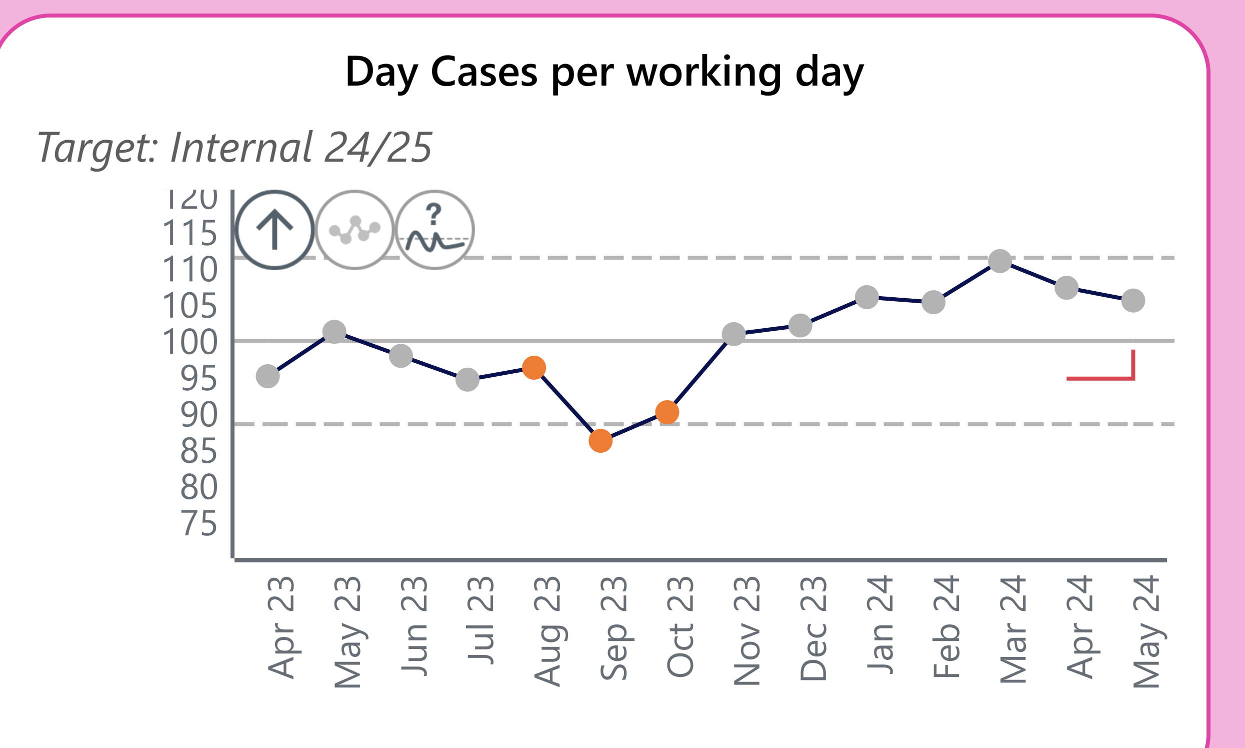



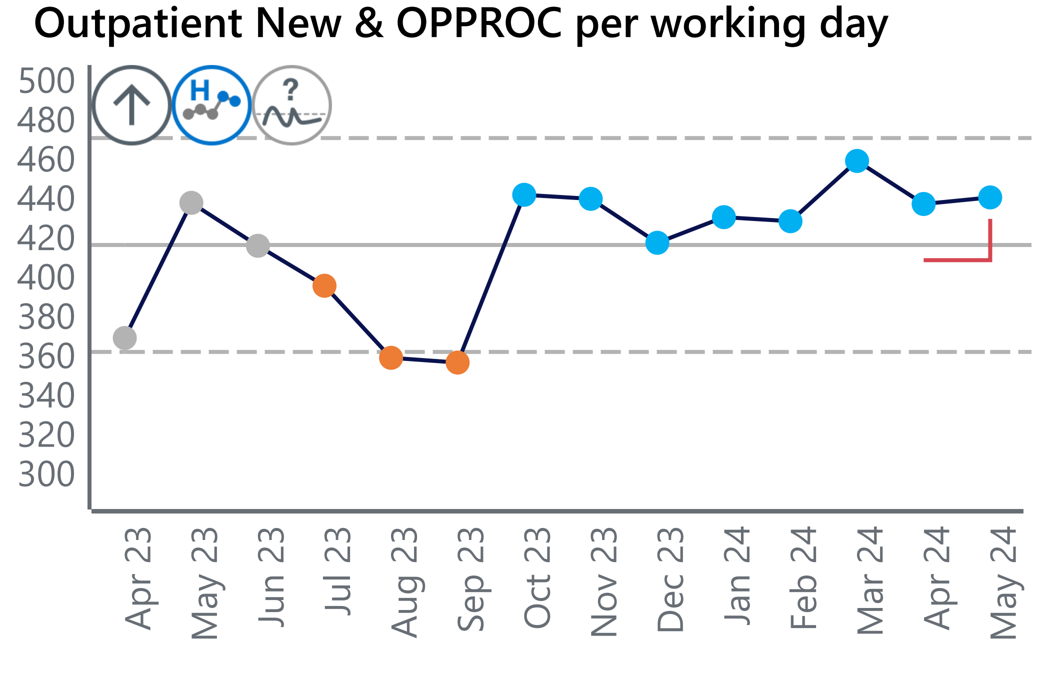



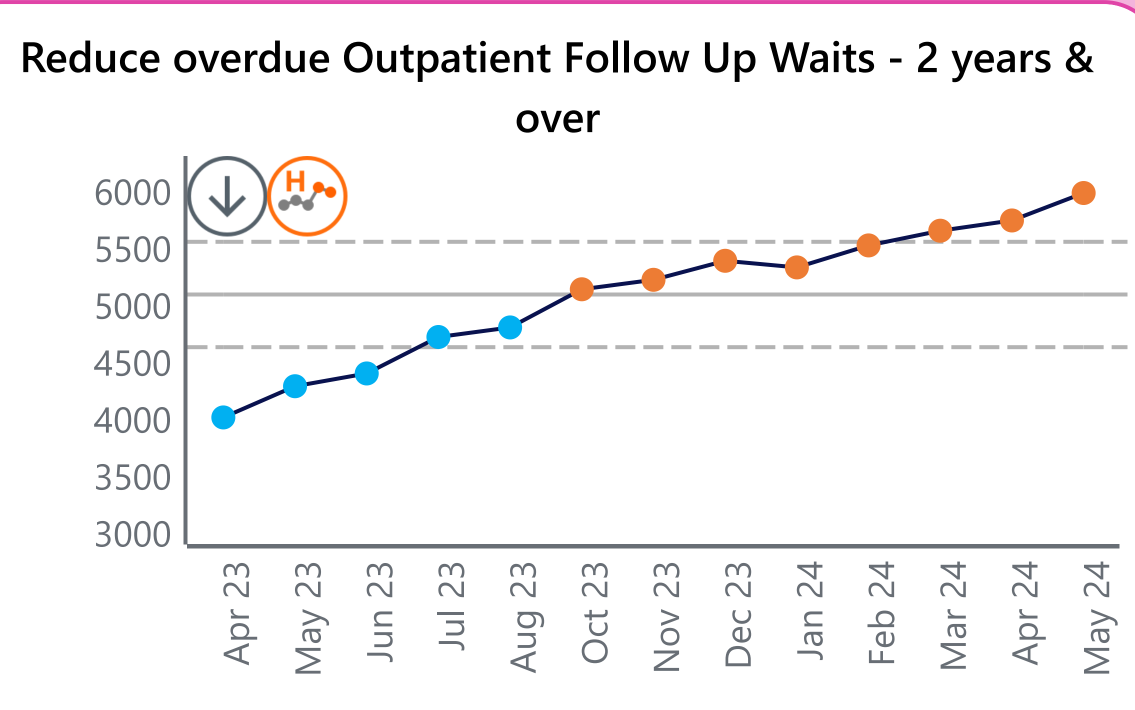



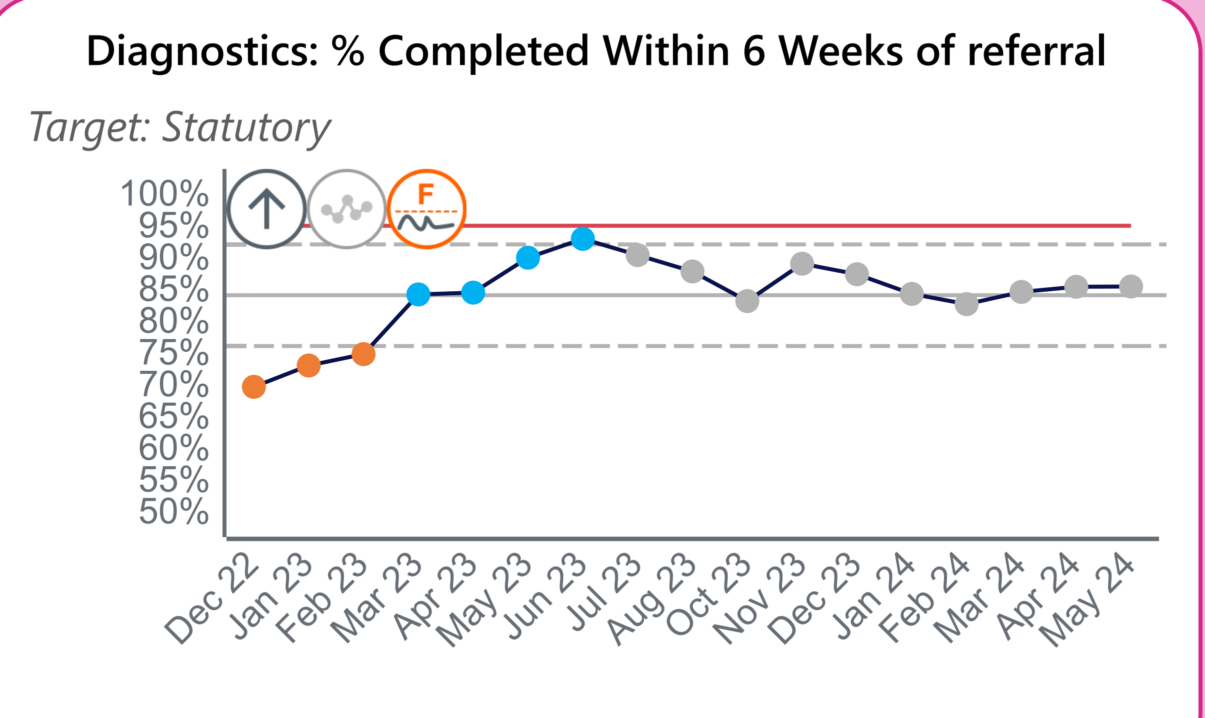



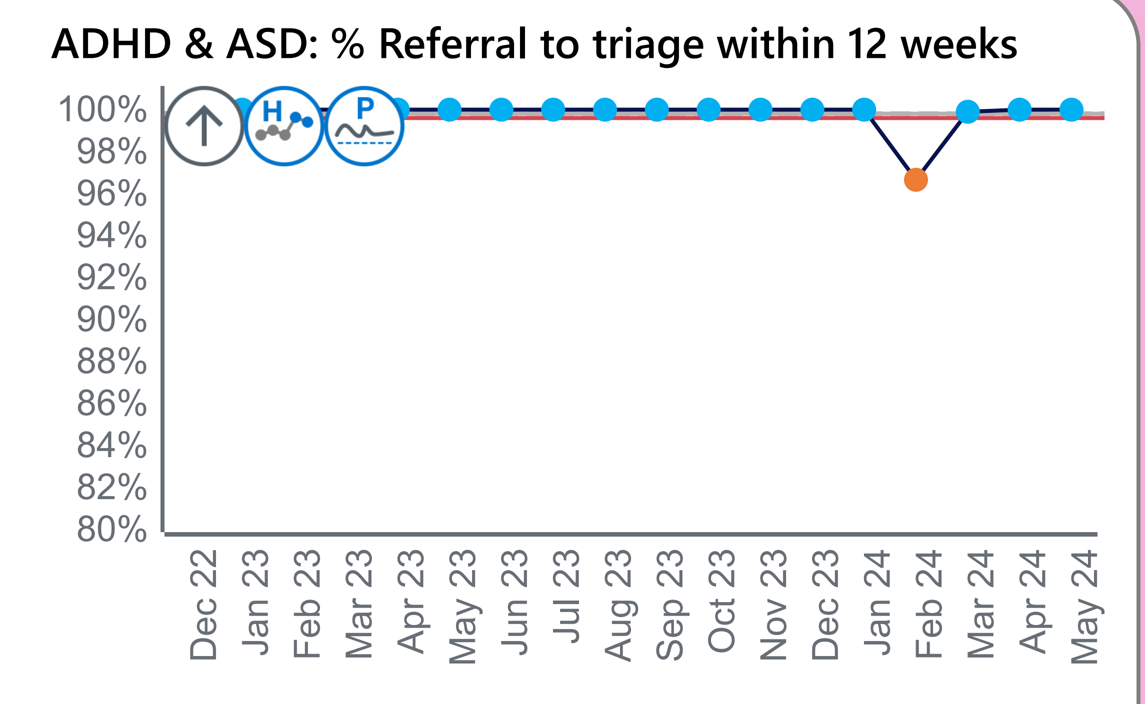



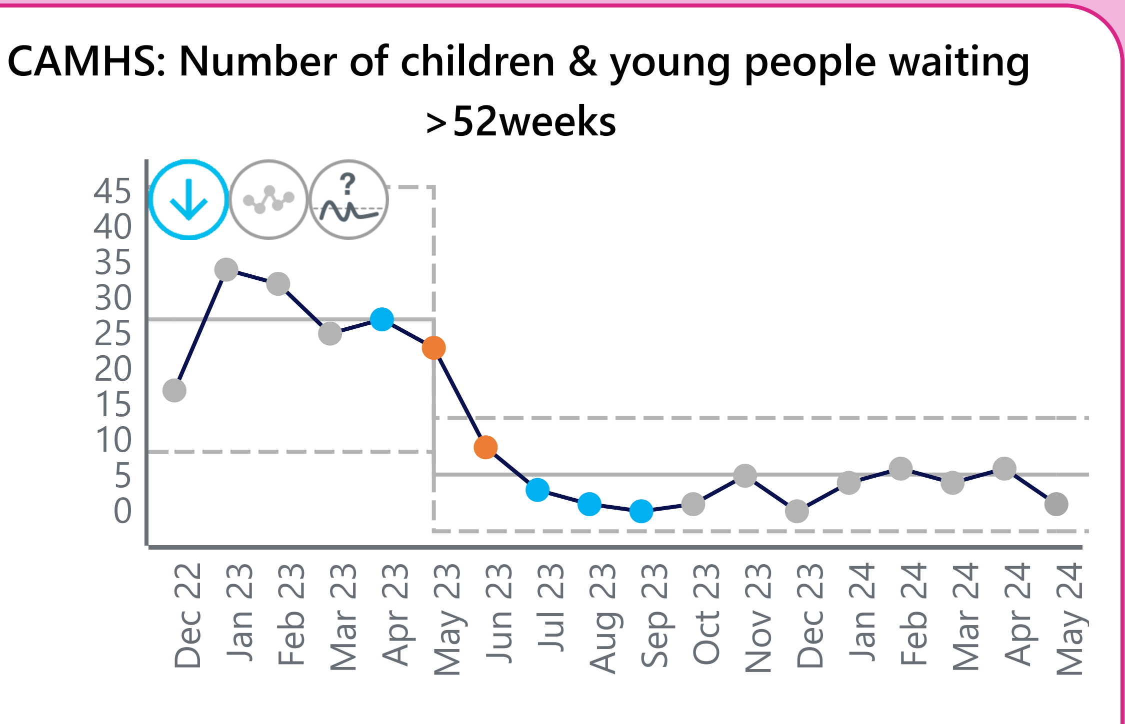



# Integrated Performance Report | June 2024

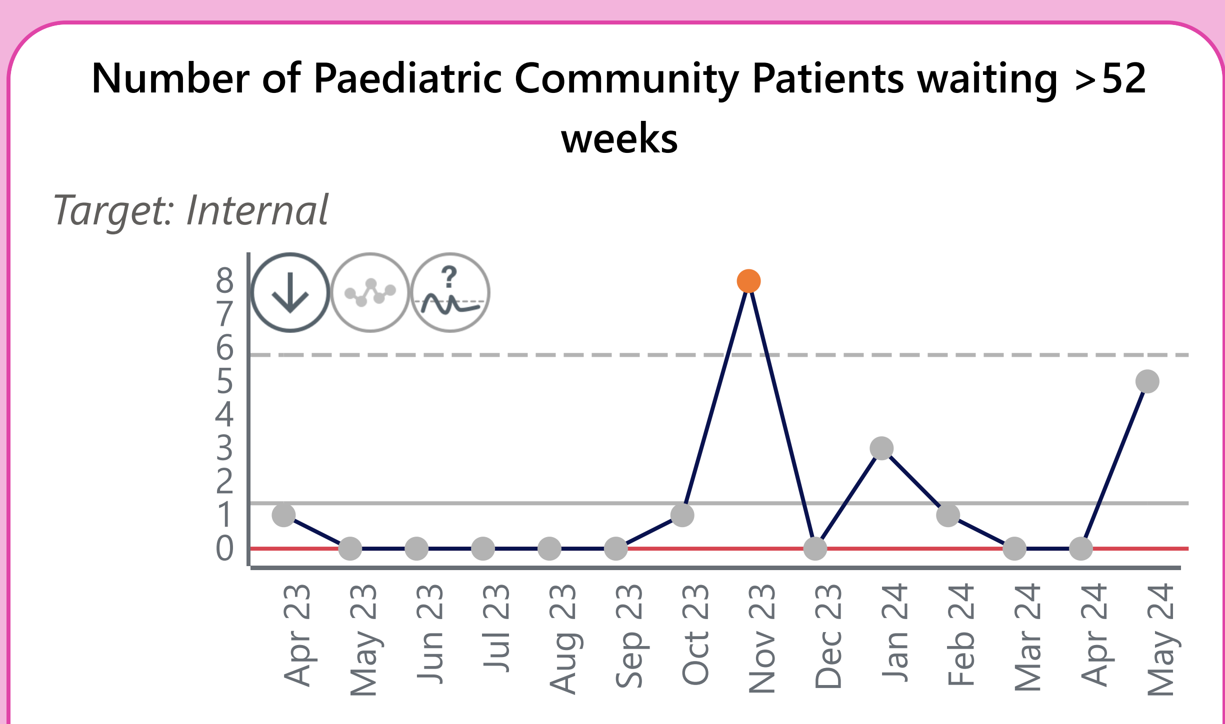
## Revolutionise Care - Effective & Responsive - Watch Metrics

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



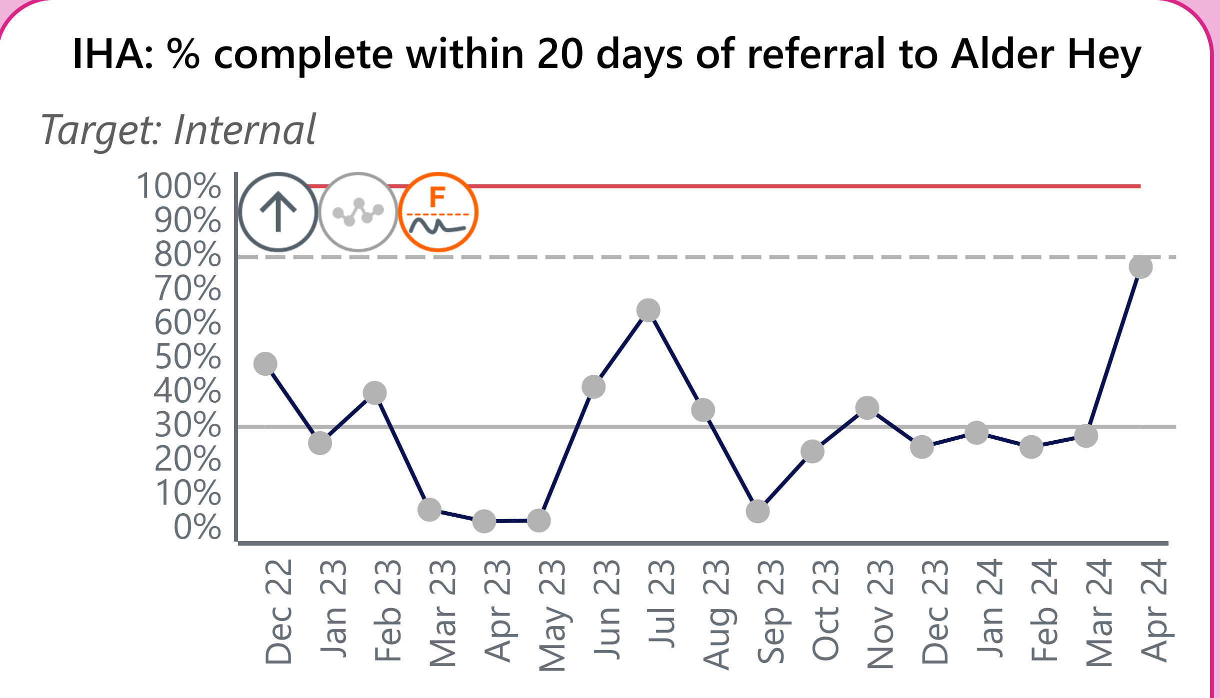
### Number of Paediatric Community Patients waiting >52 weeks

*Target: Internal*

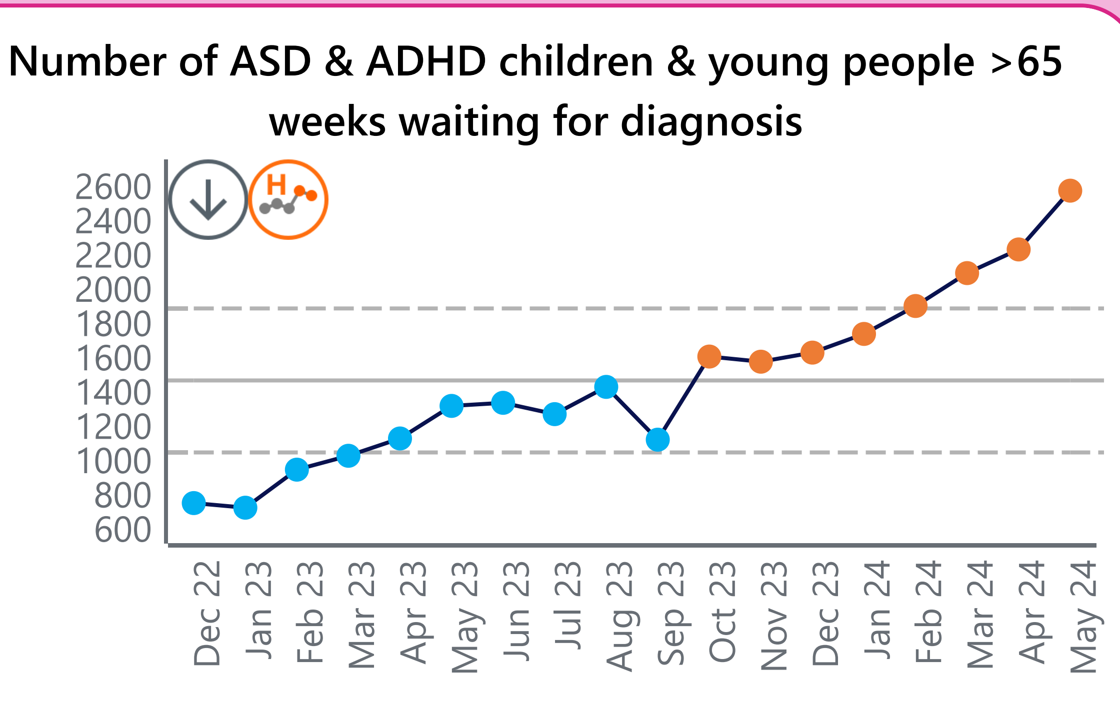


### IHA: % complete within 20 days of referral to Alder Hey

*Target: Internal*

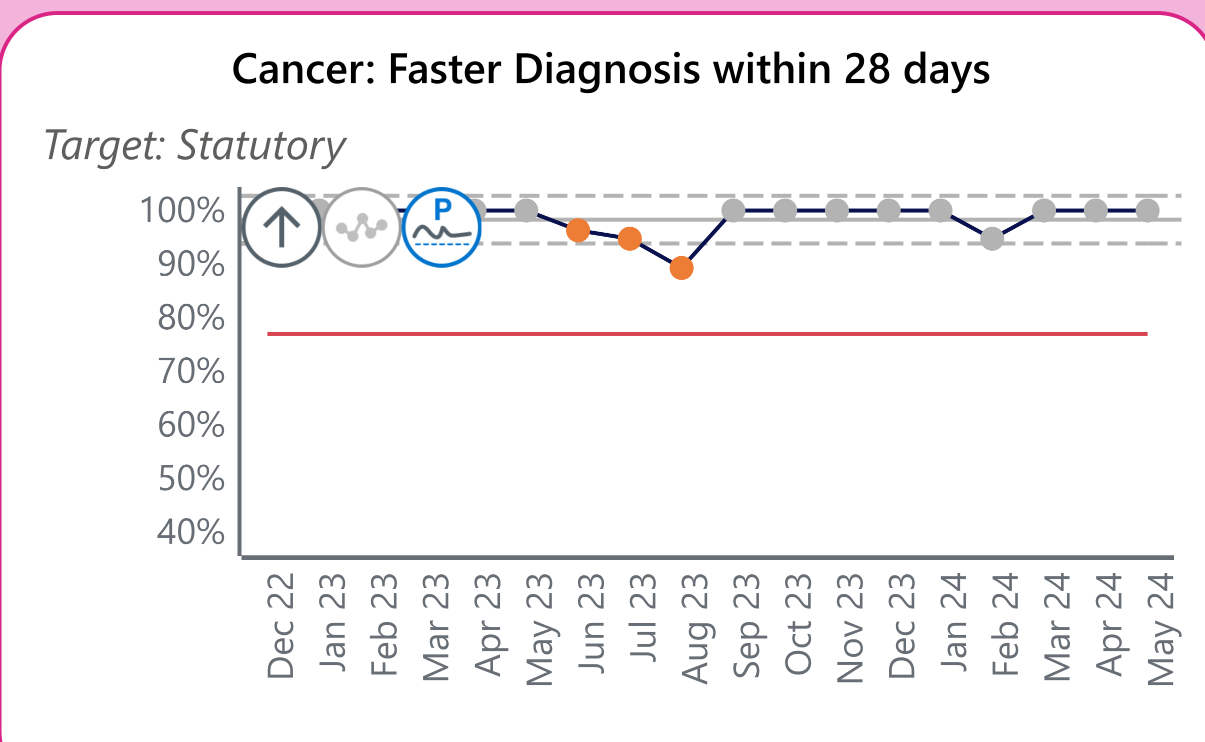


### Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



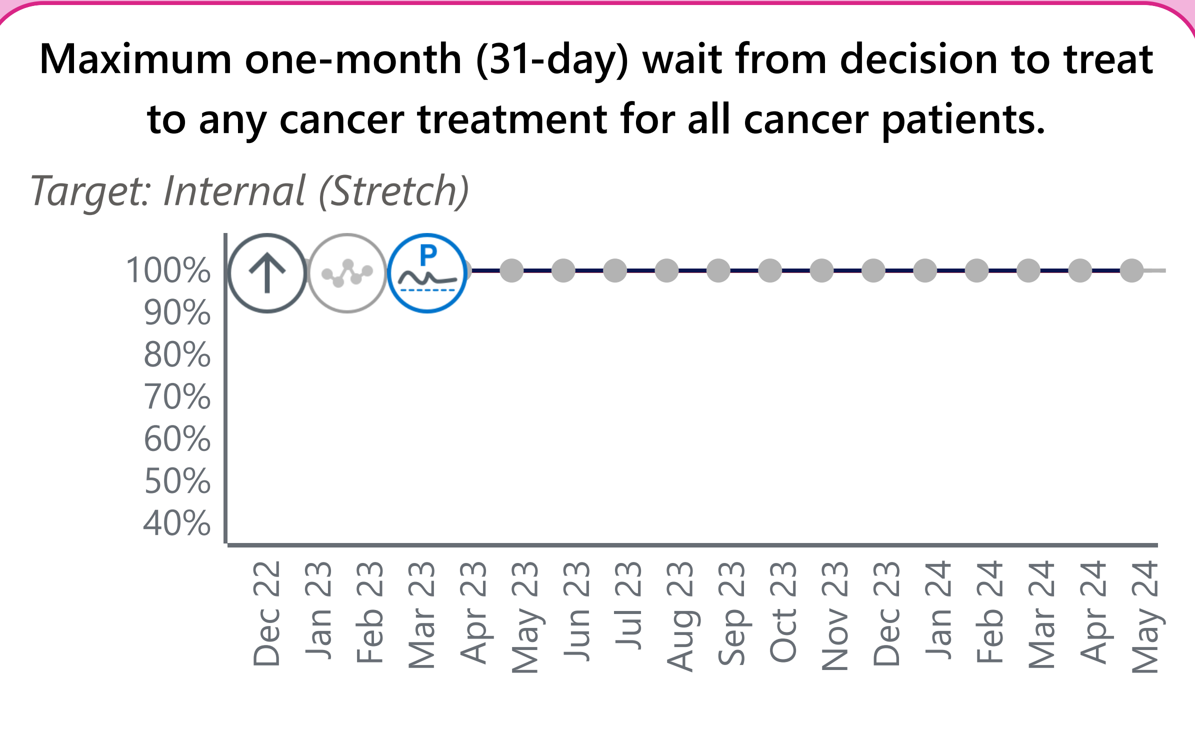
### Cancer: Faster Diagnosis within 28 days

*Target: Statutory*



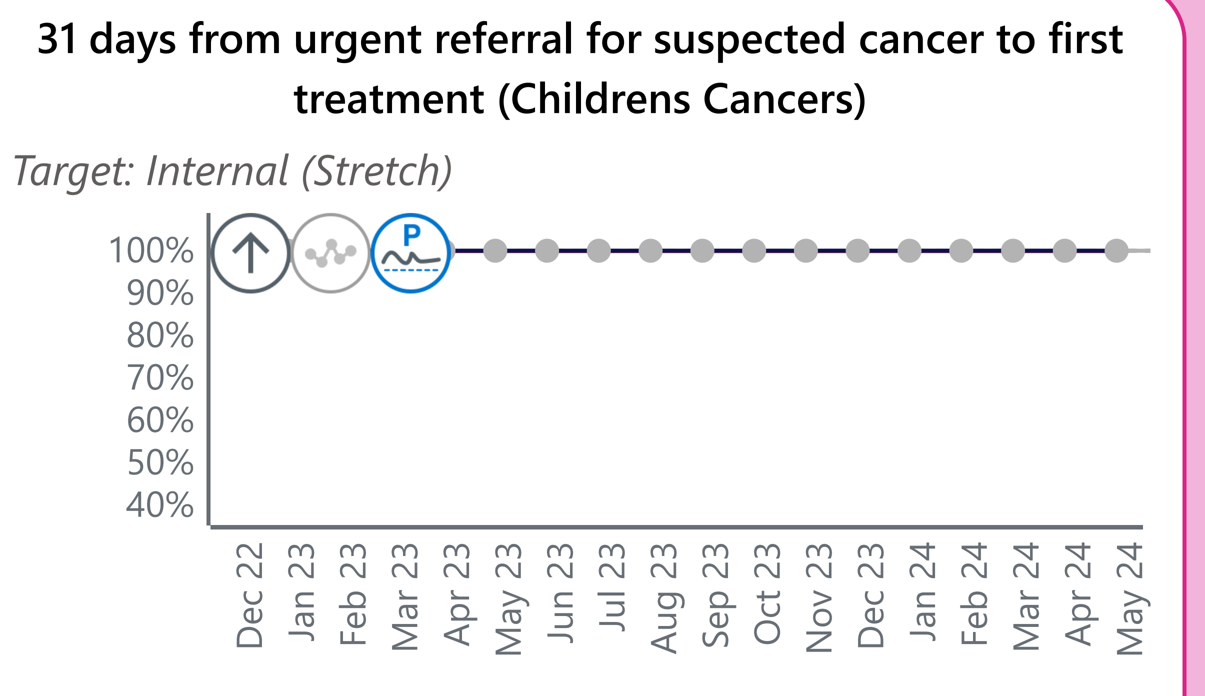
### Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

*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:**

•Mandatory training completion remains over 90%
•Turnover and sickness absence remain at or below target
•The workforce stability metric has been launched, including backdated data. 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)

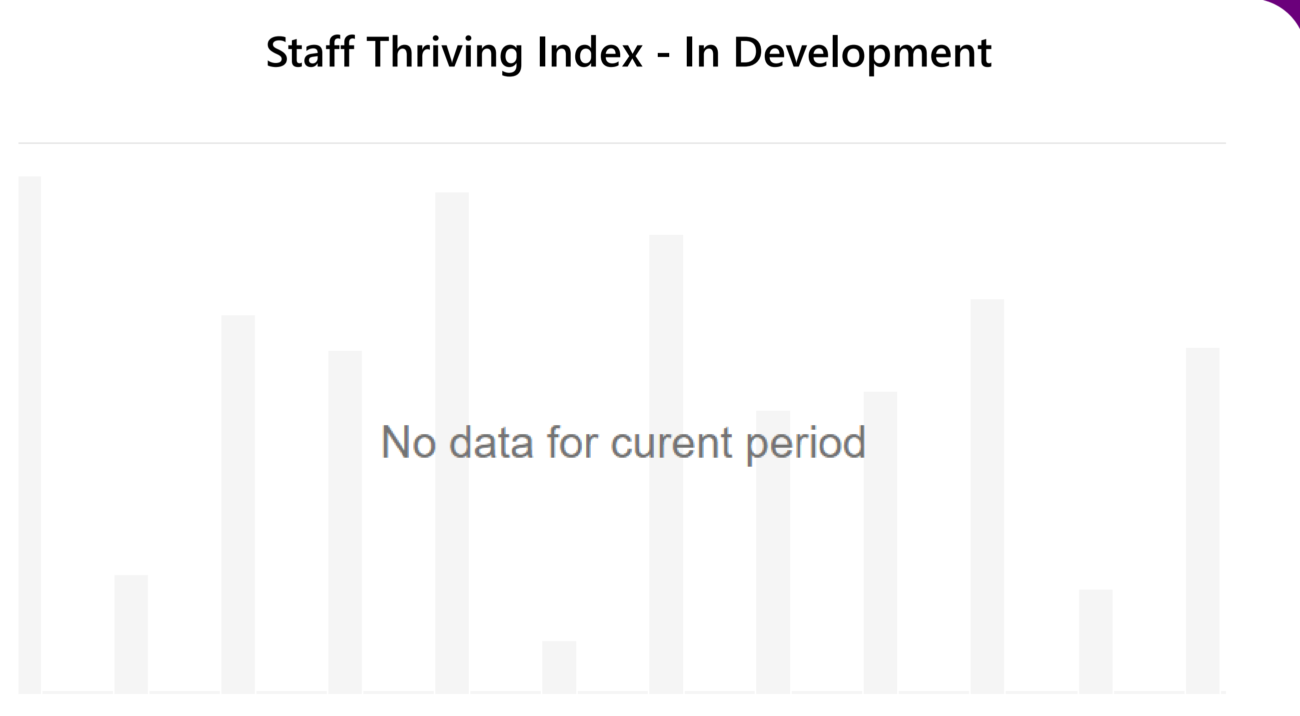
**Areas of Concern:**

•The actual total workforce in May 2024 has exceeded the plan. This means that the WTE bank and agency usage is higher than the WTE number of vacancies (bank usage has increased slightly from April to May)
•The medical appraisal rate is challenging; the position is being monitored.

**Forward Look (with actions)**

•All areas have been asked to provide a look forward, with 2024/25 PDR dates planned for the year (for non-medical colleagues) by 30th June 2024
•A managing cost and analysisng data workstream has been set up focusing on workforce spend above establishment.

**Staff Thriving Index - In Development**




**Technical Analysis:**

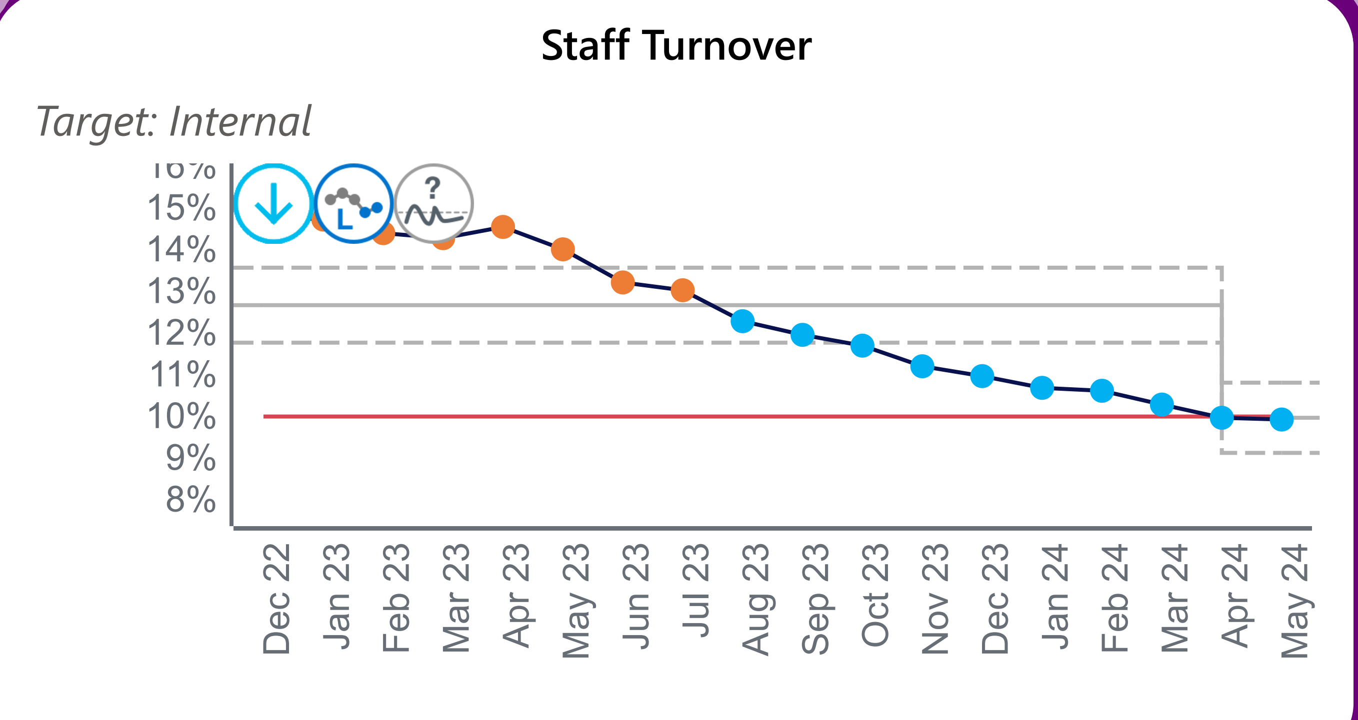
Metric in development

**Actions:**

NA – Plan for roll out in development following a successful pilot. Paper presented to People Commitee in May 2024

**Staff Turnover**

*Target: Internal*




**Technical Analysis:**

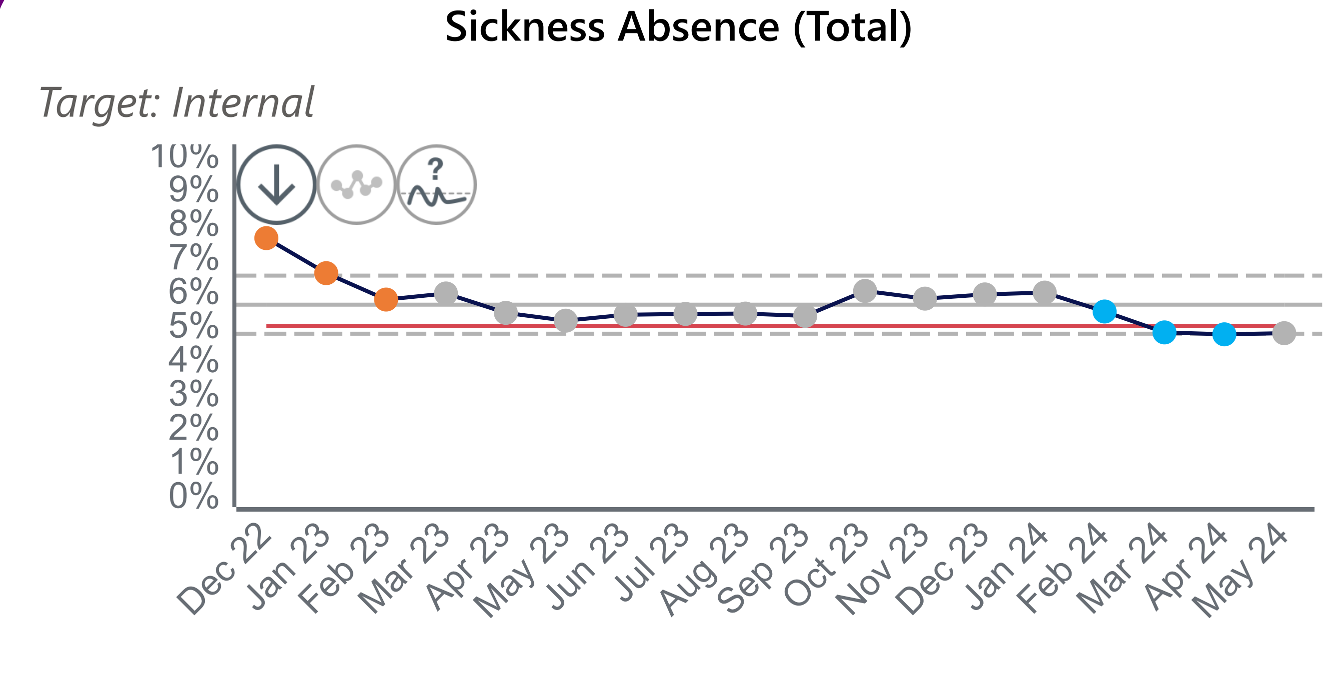
Staff Turnover continues to demonstrate special cause variation, 9.9% for May 2024 is the 14th consecutive month with a reduction

**Actions:**

Following a significant period of reduction, turnover has remained at 10% in month. Ongoing analysis and external benchmarking remain in place alongside quarterly reporting to the People Committee.

**Sickness Absence (Total)**

*Target: Internal*



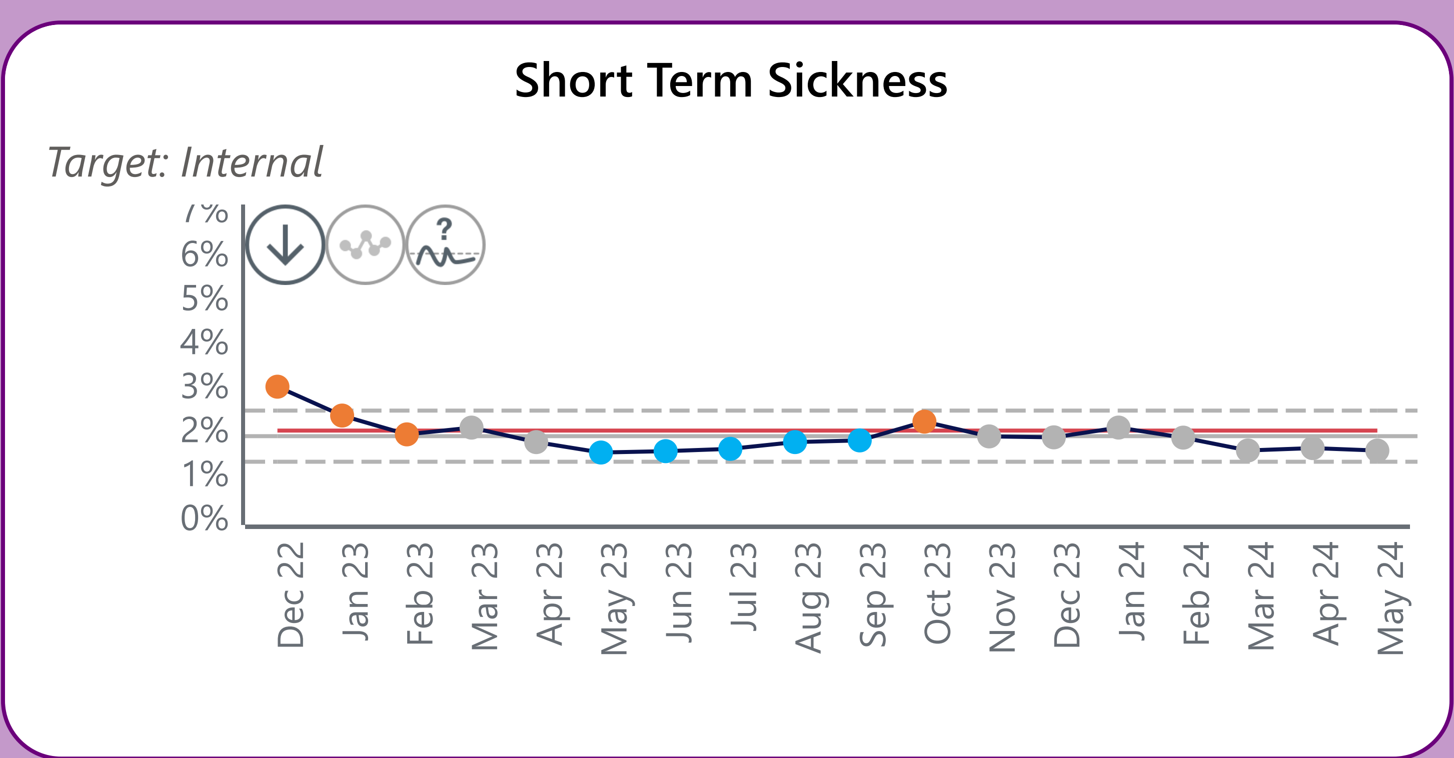

**Technical Analysis:**

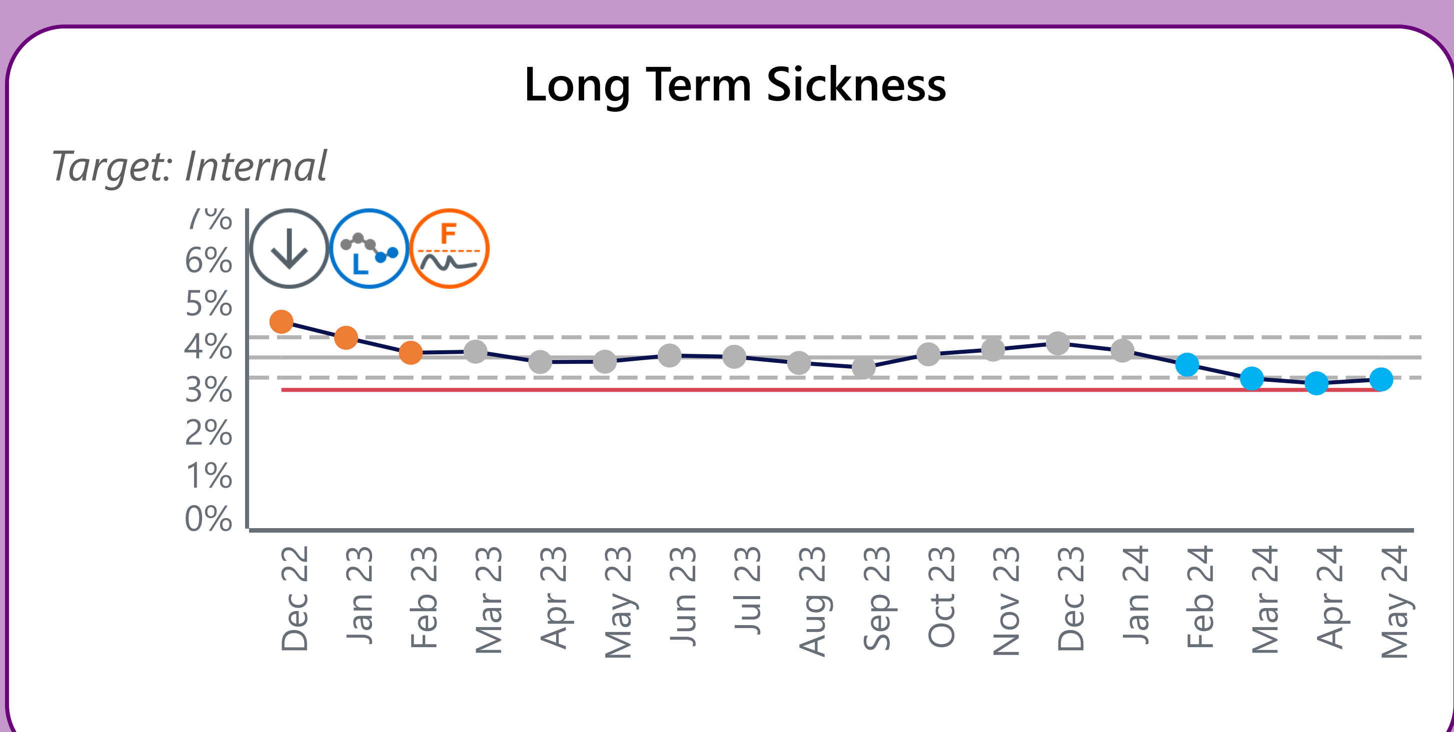
Total sickness absence in May 2024 is 4.79% which is below the 5% target. A slight increase from April 2024 at 4.75%. May 2024 performance comprises STS at 1.60% and LTS at 3.19%. Still demonstrating common cause variation, 3rd consecutive month below the target.

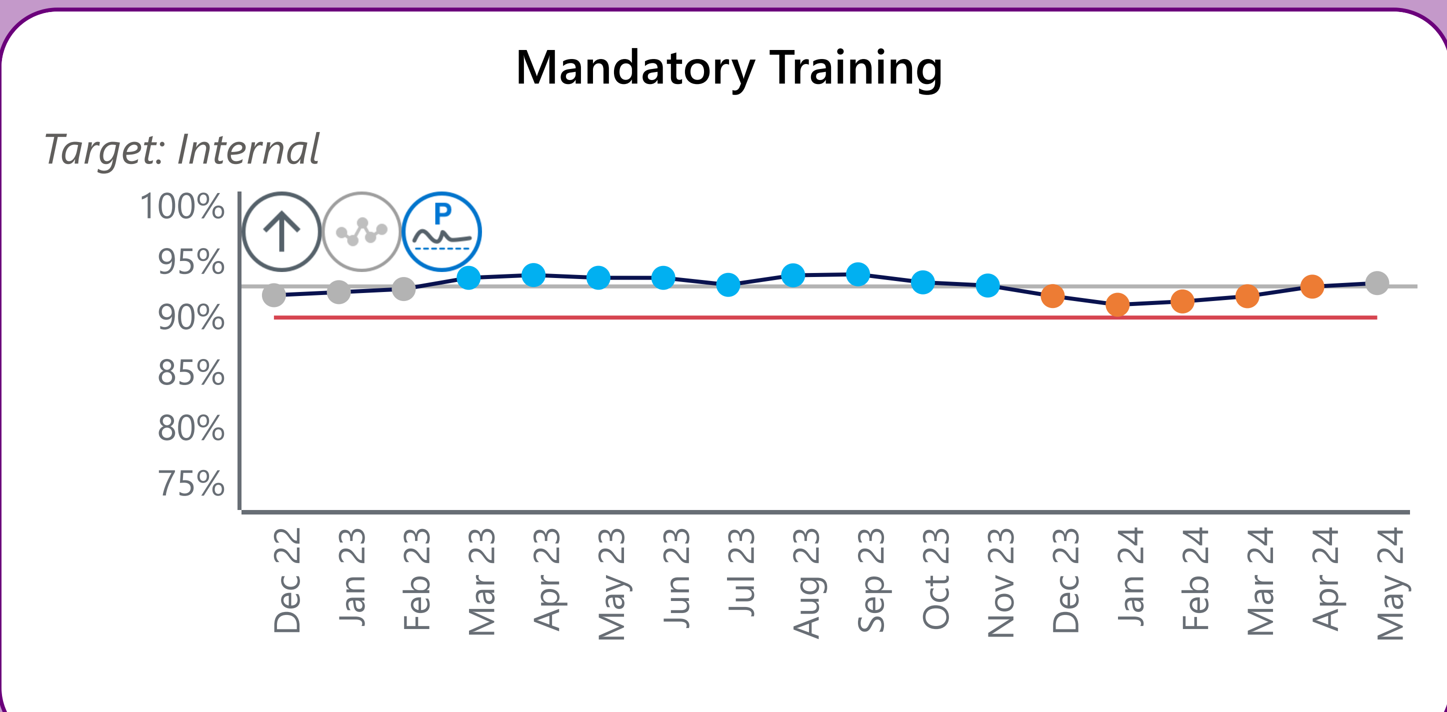
**Actions:**

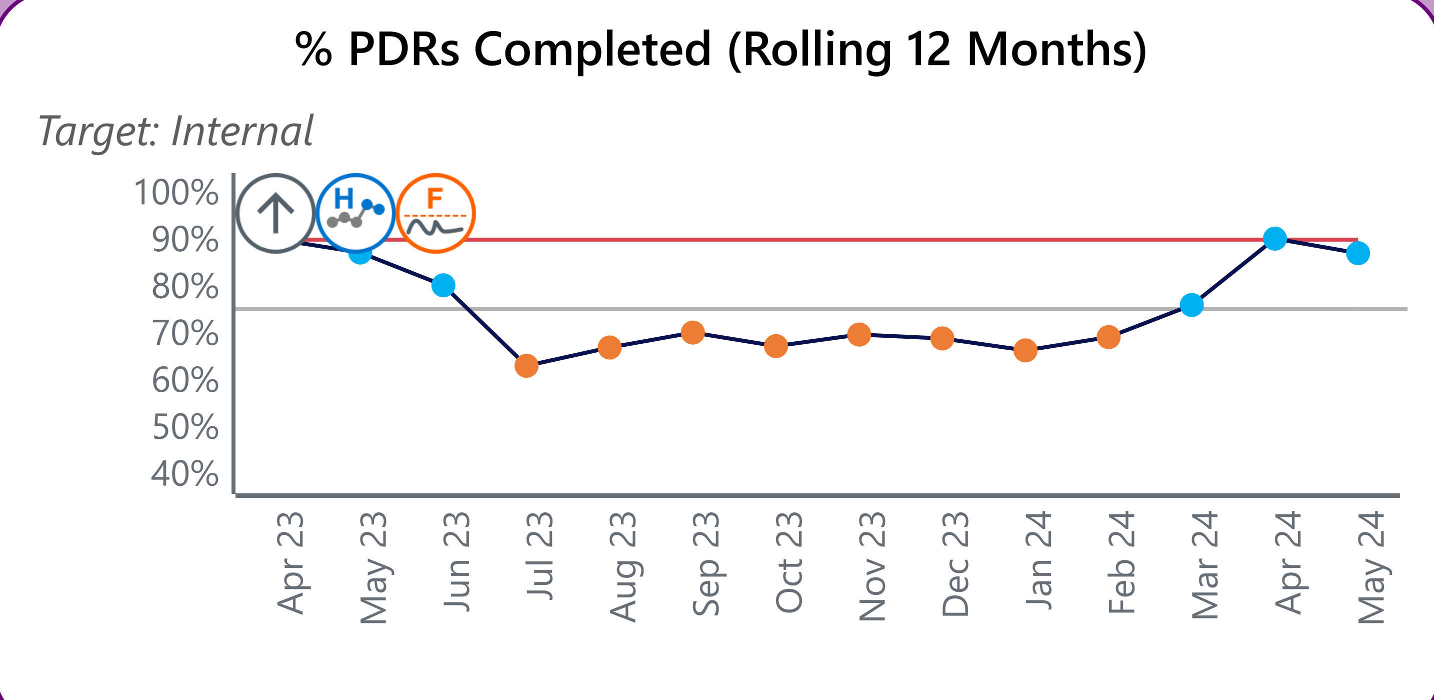
Sickness absence has remained at 4.8% in May with the following in place with discussions at divisional board, wellbeing activities, focus on long term sickness and return to work discussions

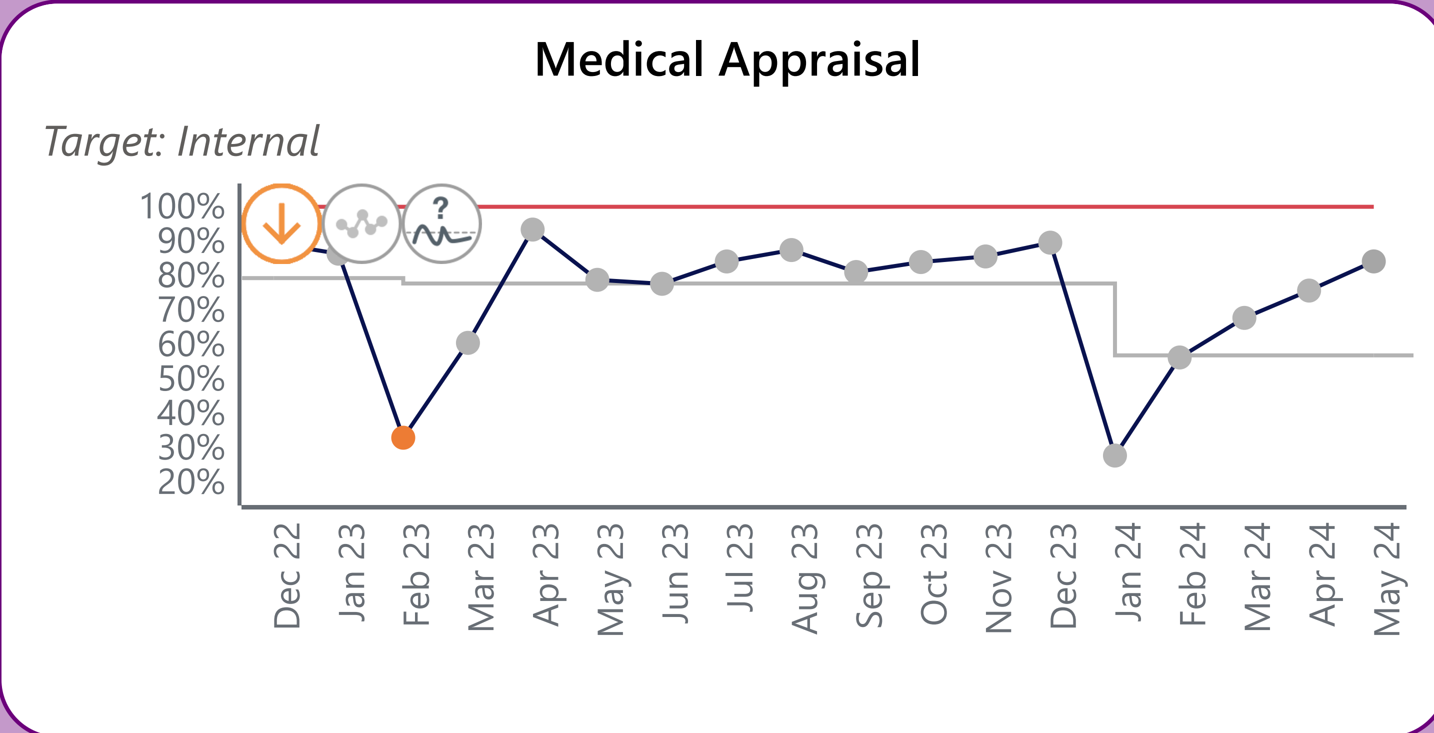
# Supporting Our People - Watch Metrics

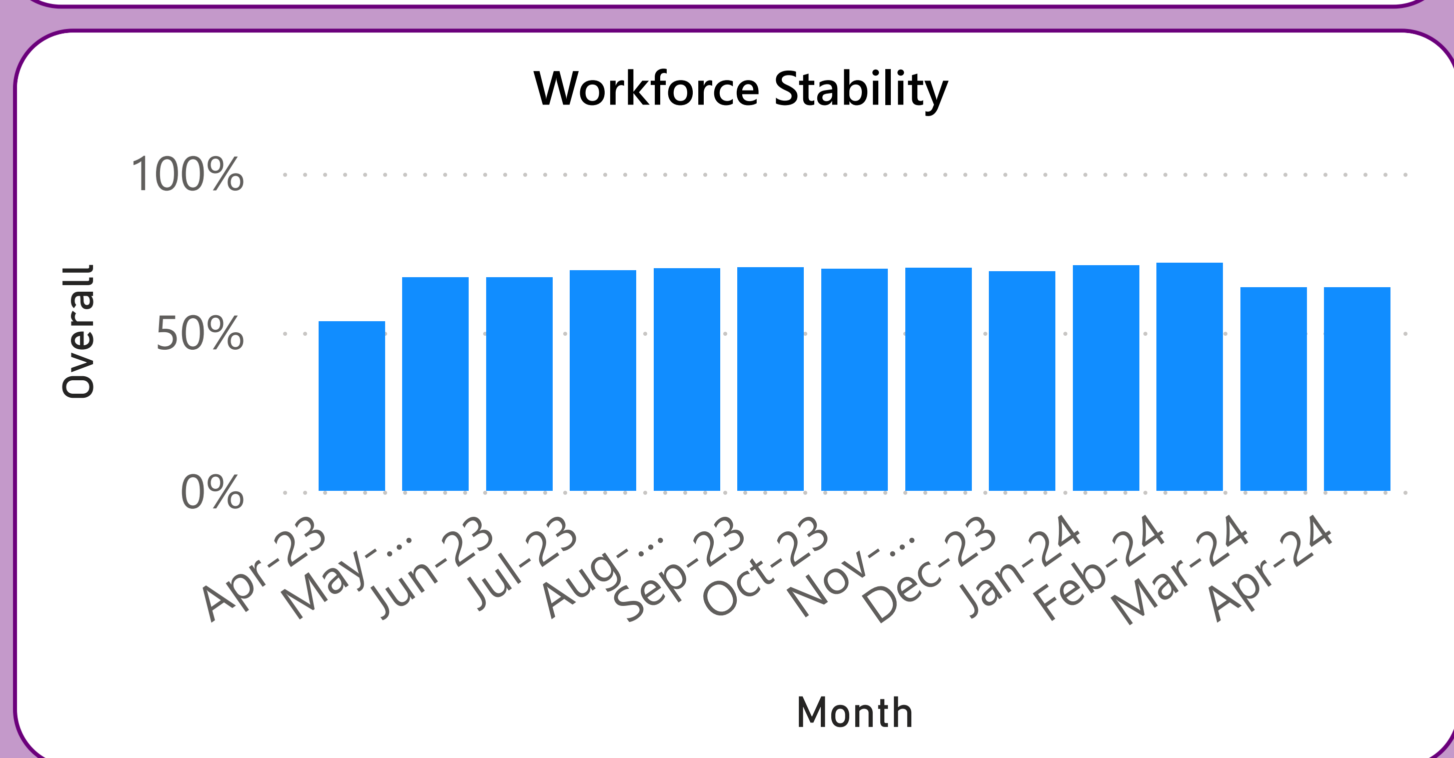


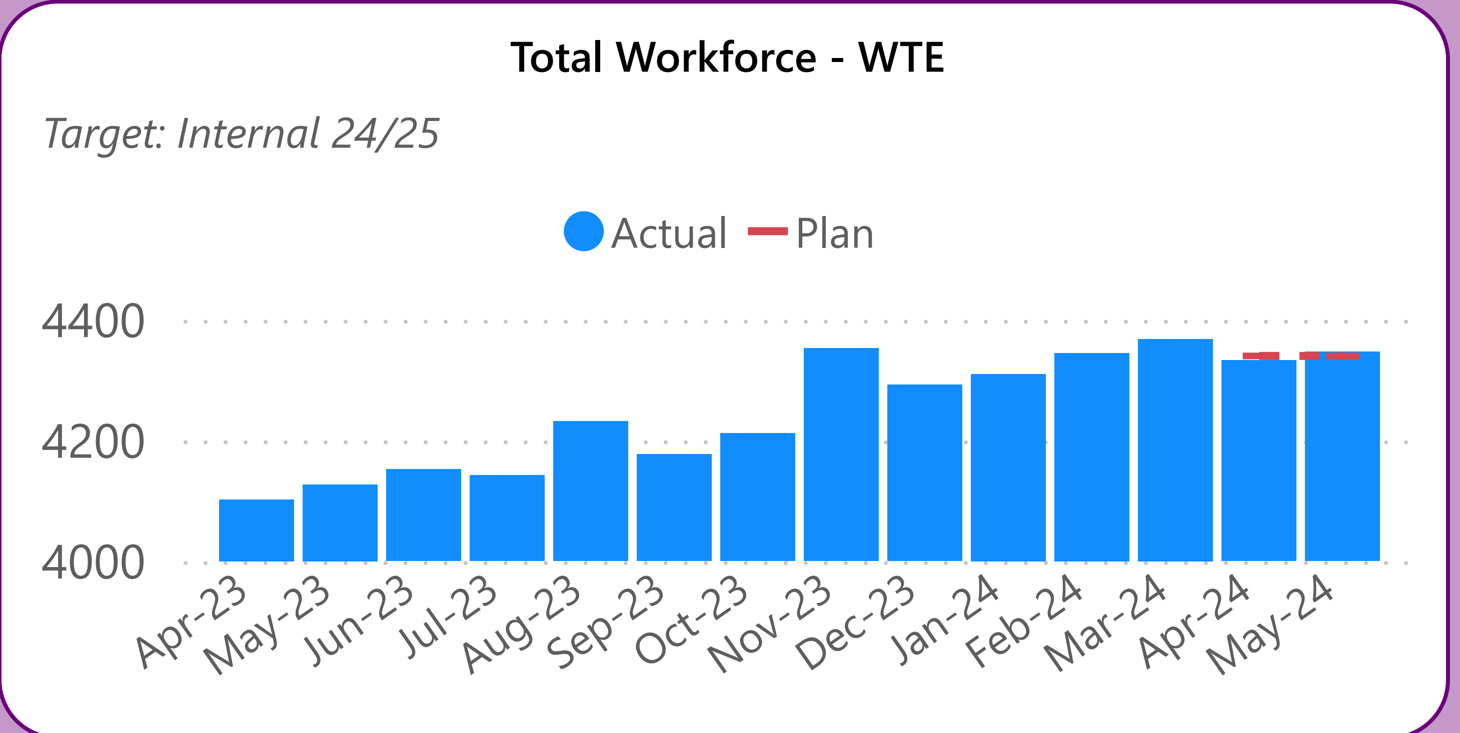



# Pioneering Breakthroughs

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

## Highlights:

- Stakeholder sessions for patient portal have been completed with internal and external peers to refine service specification.
- Engagement with company for Ambiant AI tool remains strong, with potential trial planned for end of June/start of July.

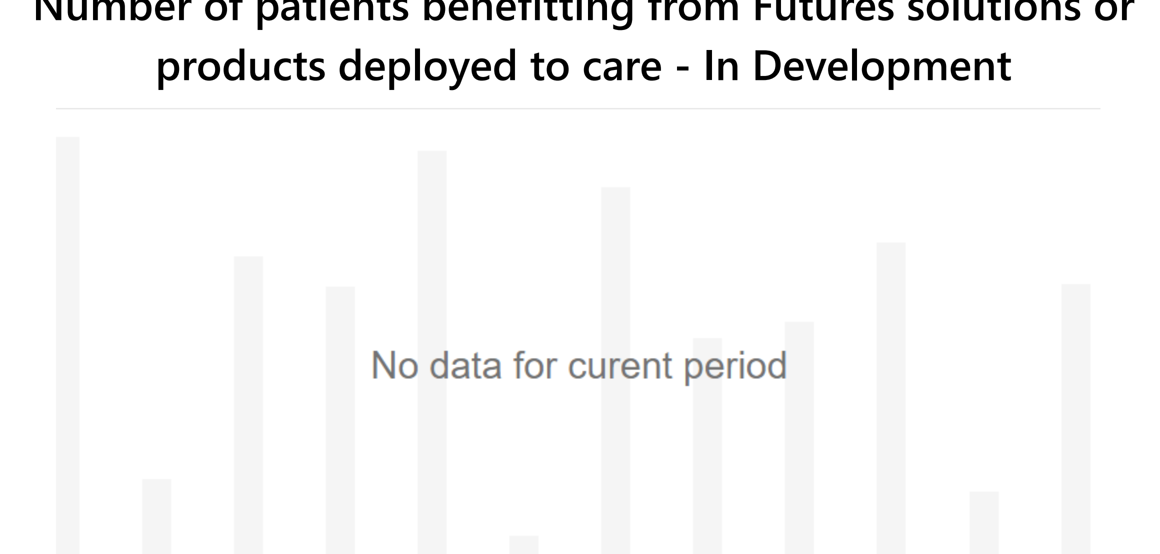
## Areas of Concern:

- Initiatives are being explored and are not yet ready for implementation, thus monitoring against performance is difficult this early in the year

## Forward Look (with actions)

- Commence pilot of AI in selected outpatient appointments.
- Develop specification for patient portal
- Finalise how metrics will be captured moving forward

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

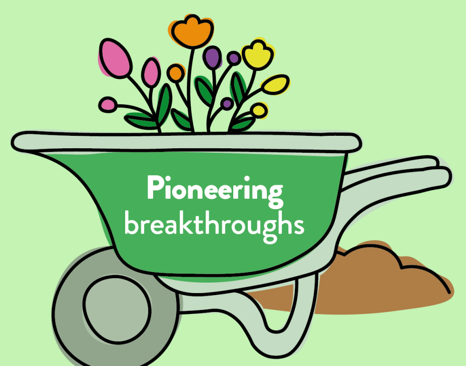



**Technical Analysis:**

This metric is under development

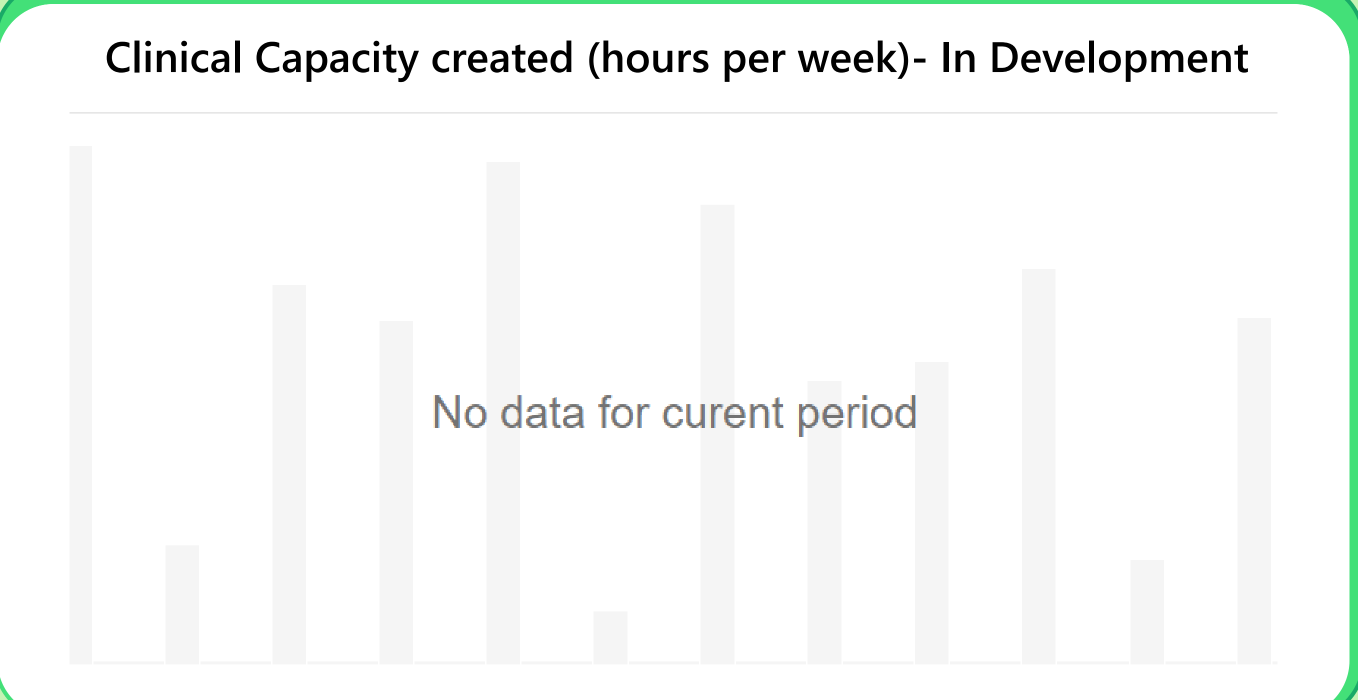
**Actions:**

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

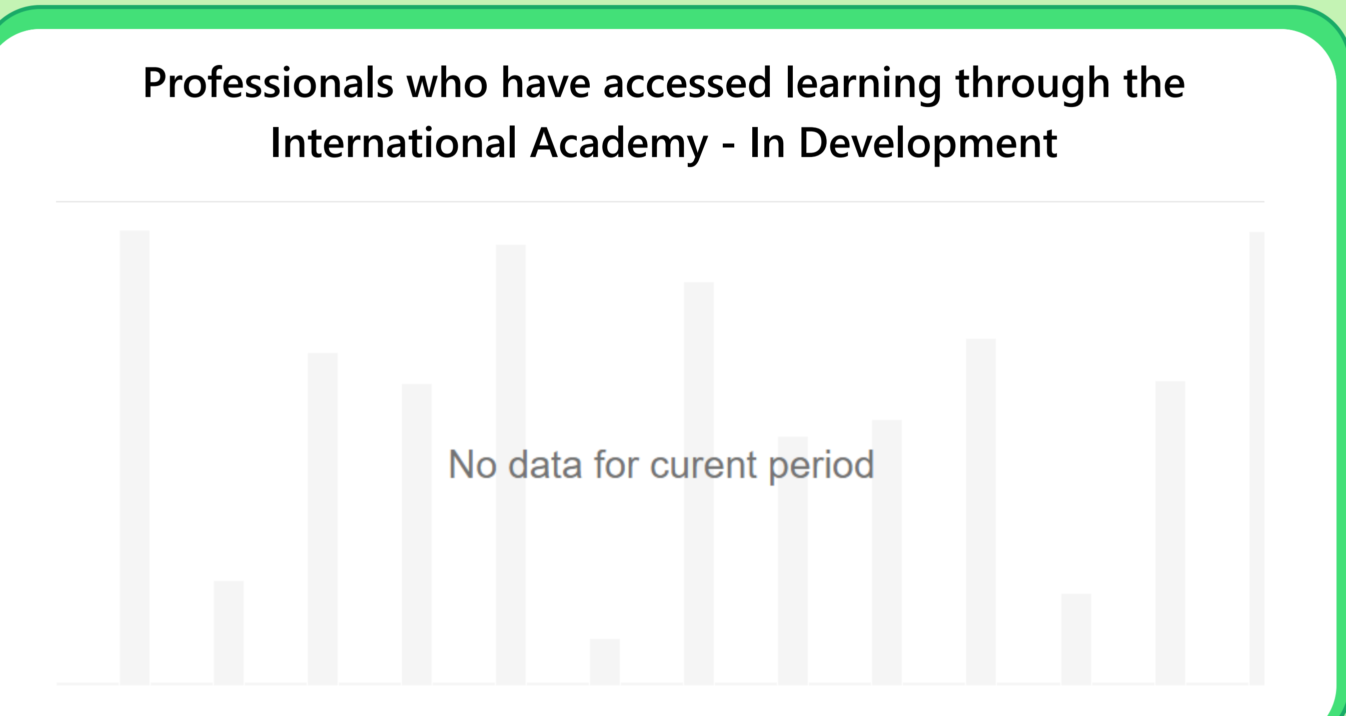


# Pioneering Breakthroughs

### Clinical Capacity created (hours per week)- In Development

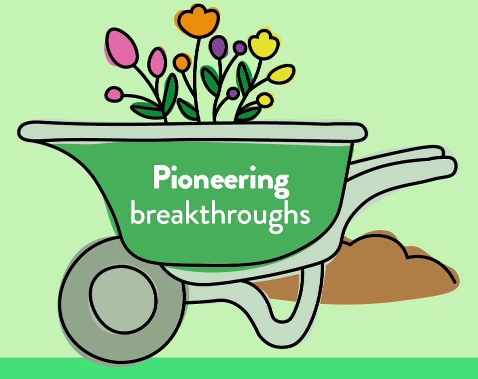



### Professionals who have accessed learning through the International Academy - In Development




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

No data for curent period



# 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:

• Health Inequalities and Prevention - Leadership: Trust's substantive Public Health Consultant (chair of HIP steering group) has been appointed • Wellbeing Hub (poverty proofing and social prescribing offer for all CYPF attending Alder Hey) soft launch 1/7/24. Service will be delivered by CAB Liverpool, Health Junction, AH PALs and Chaplaincy as a partnership. Funding provided by AH Charity (£320k) • Advocating for CYP : Funding for Advocating for CYP workstream 2024/25 agreed. Focus of campaign plan: Lung health, obesity, poverty • Creating Opportunities for Children and Young People Work experience and internship programmes underway • Care leavers projects for C&M • Project focused on arts and mental health delivered focusing on development of YP skills, and confidence through creative arts and community-based exhibition • National programme looking to establish a project to engage with CYP on matters most to them on how we tackle health and inequalities

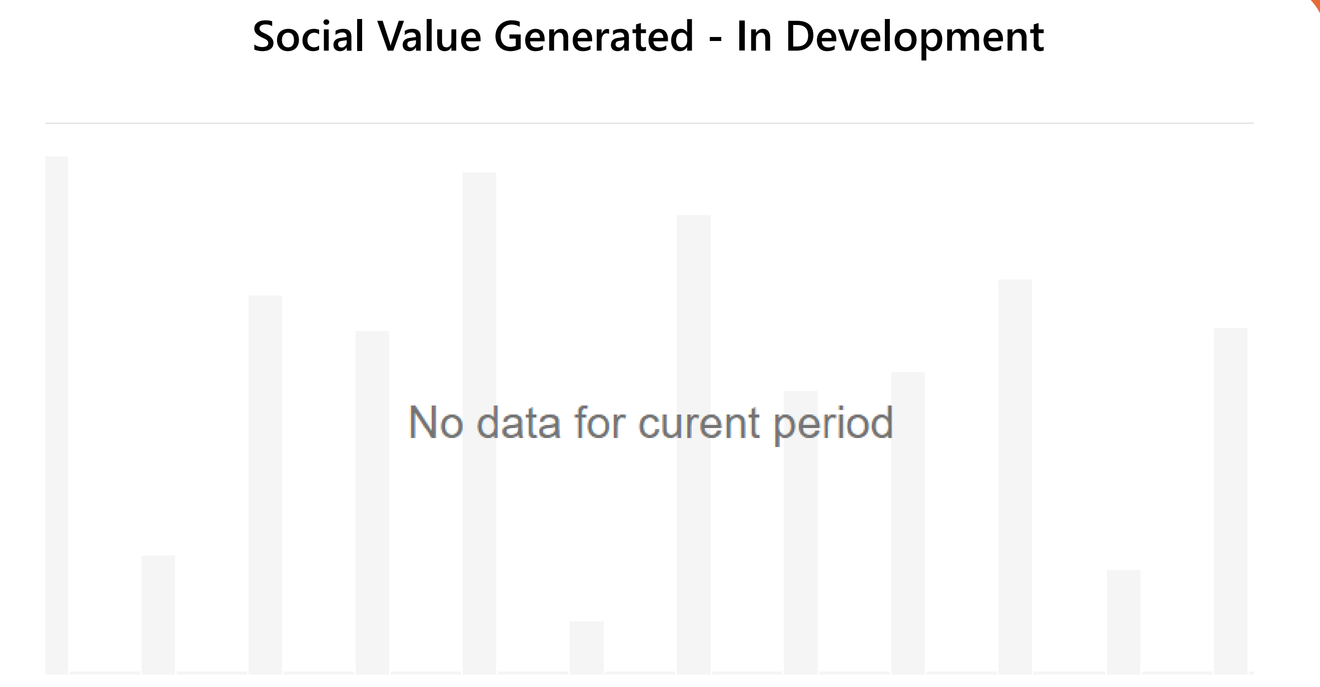
## Areas of Concern:

• Advocating for CYP – General Election called for 4th July 2024, in a pre-election period and any changes in government may mean focus amendments • Greener - Resource to take forward Greener/clean air initiatives. Workstream lead is leaving end June 24, 10 working days left in post. Individual scheme owners not confirmed to date

## Forward Look (with actions)

• September 2024 - "Improve My Life Chances" Health Inequalities & Prevention Summit which will be open to a wide audience to share the achievements, ongoing work and future plans for Health Inequalities & Prevention at Alder Hey and across the wider patch.

**Social Value Generated - In Development**



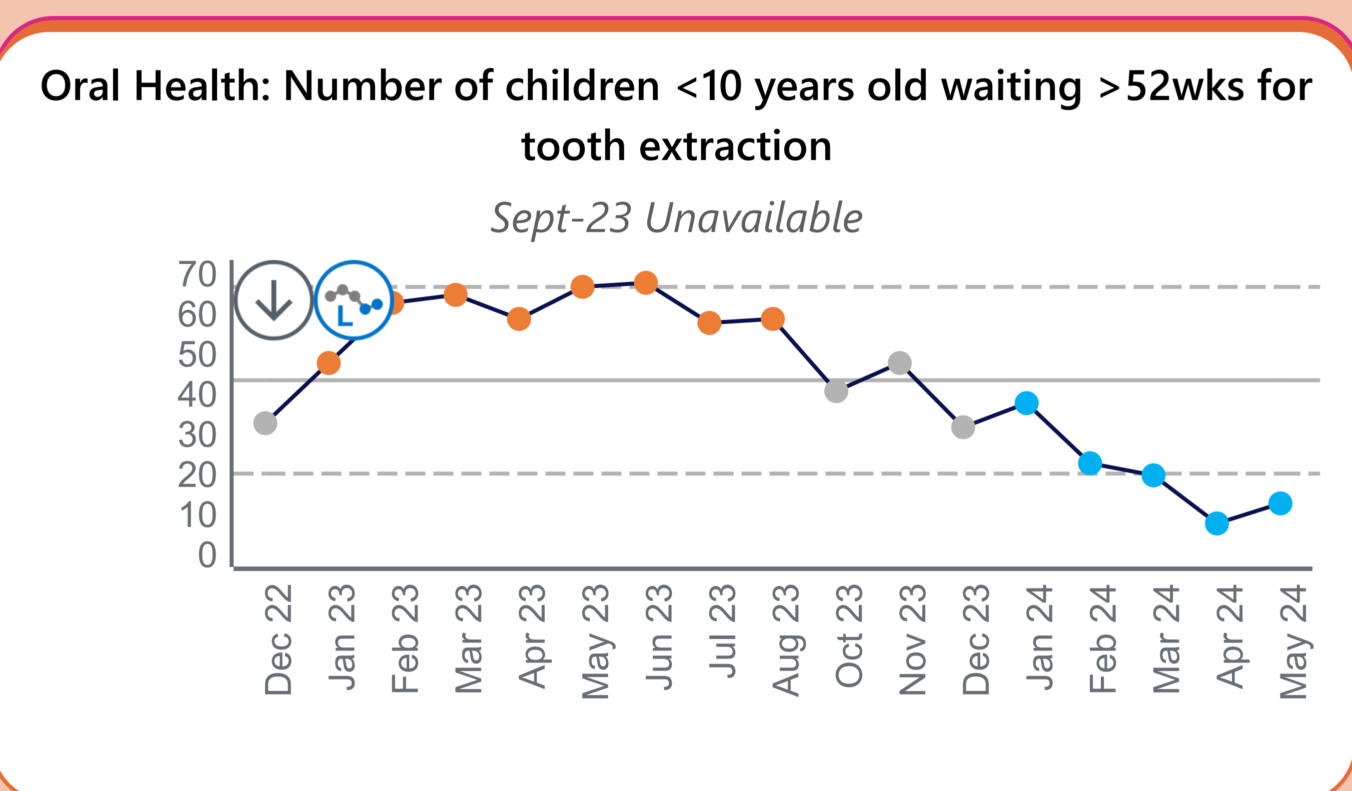

**Technical Analysis:**

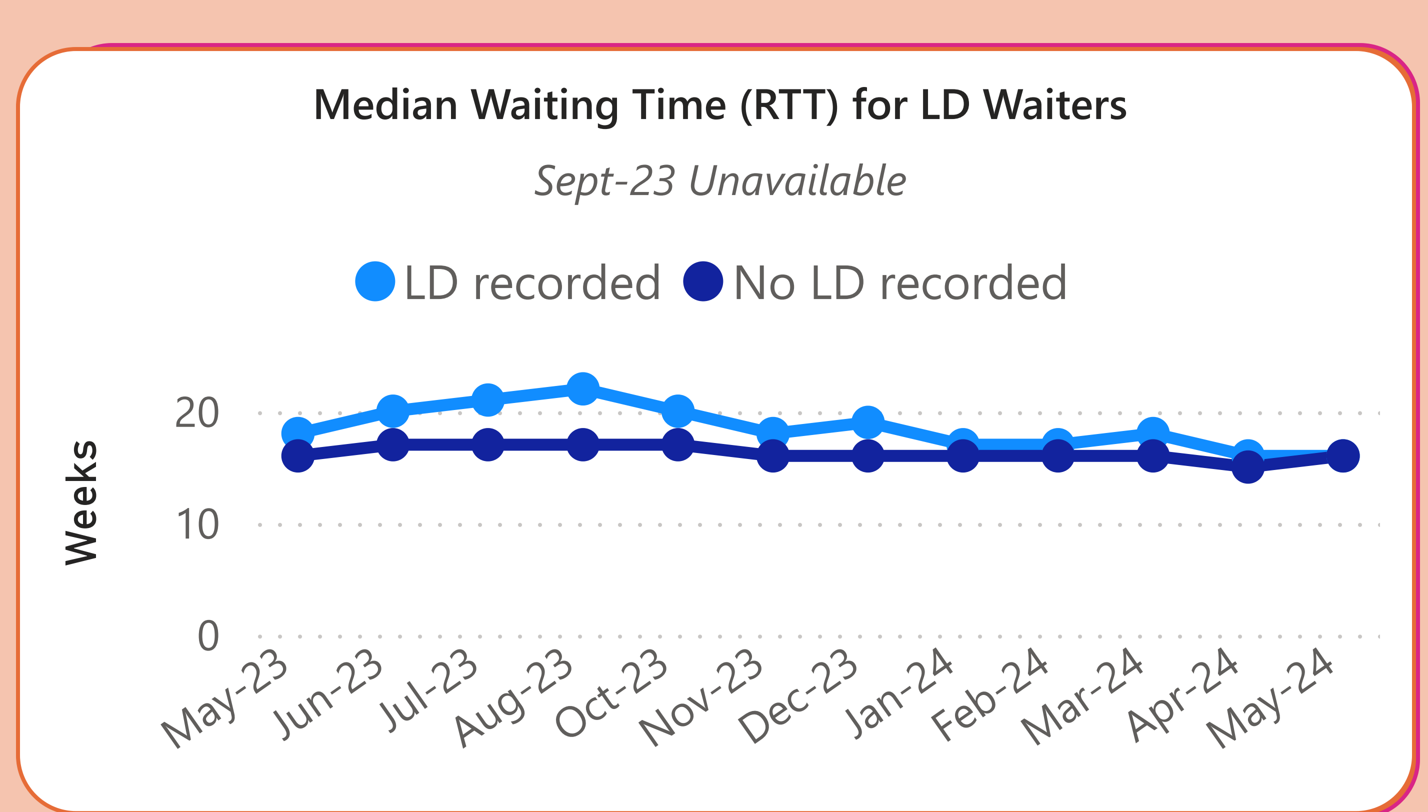
Metric in development

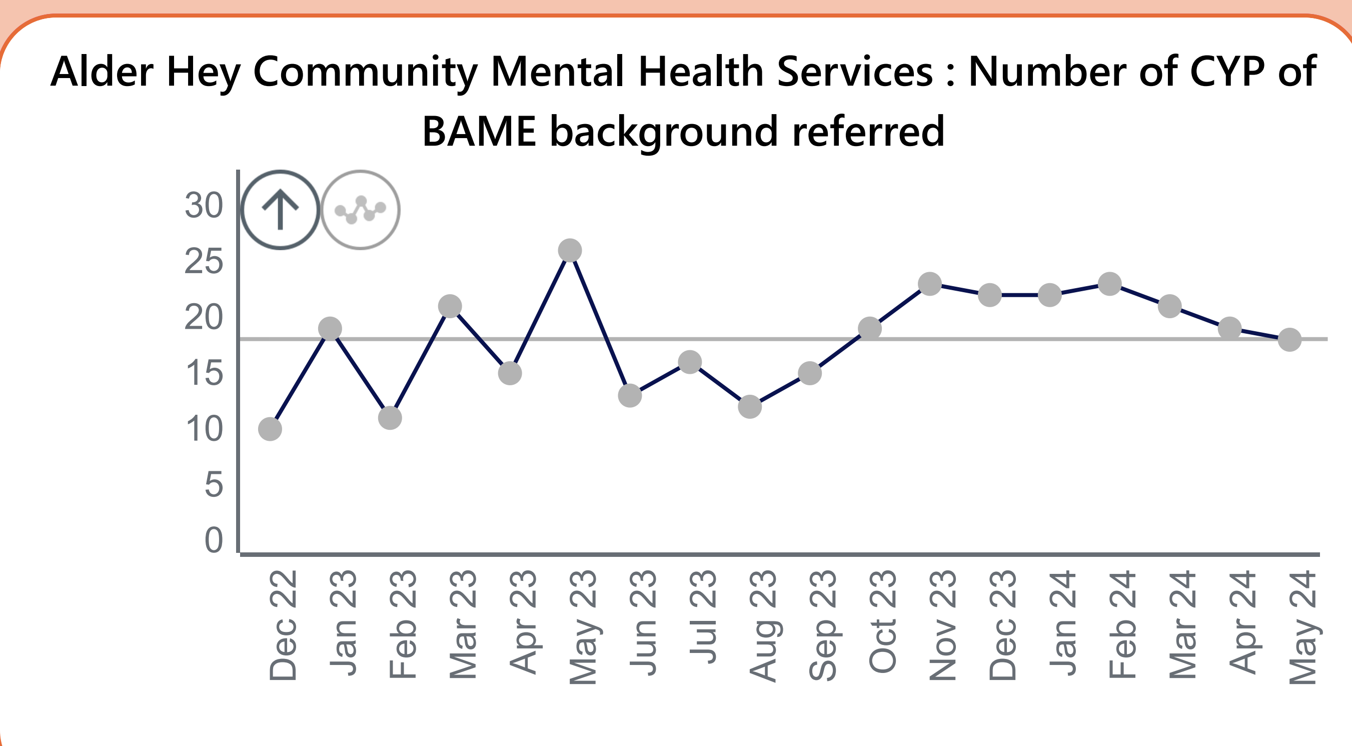
**Actions:**

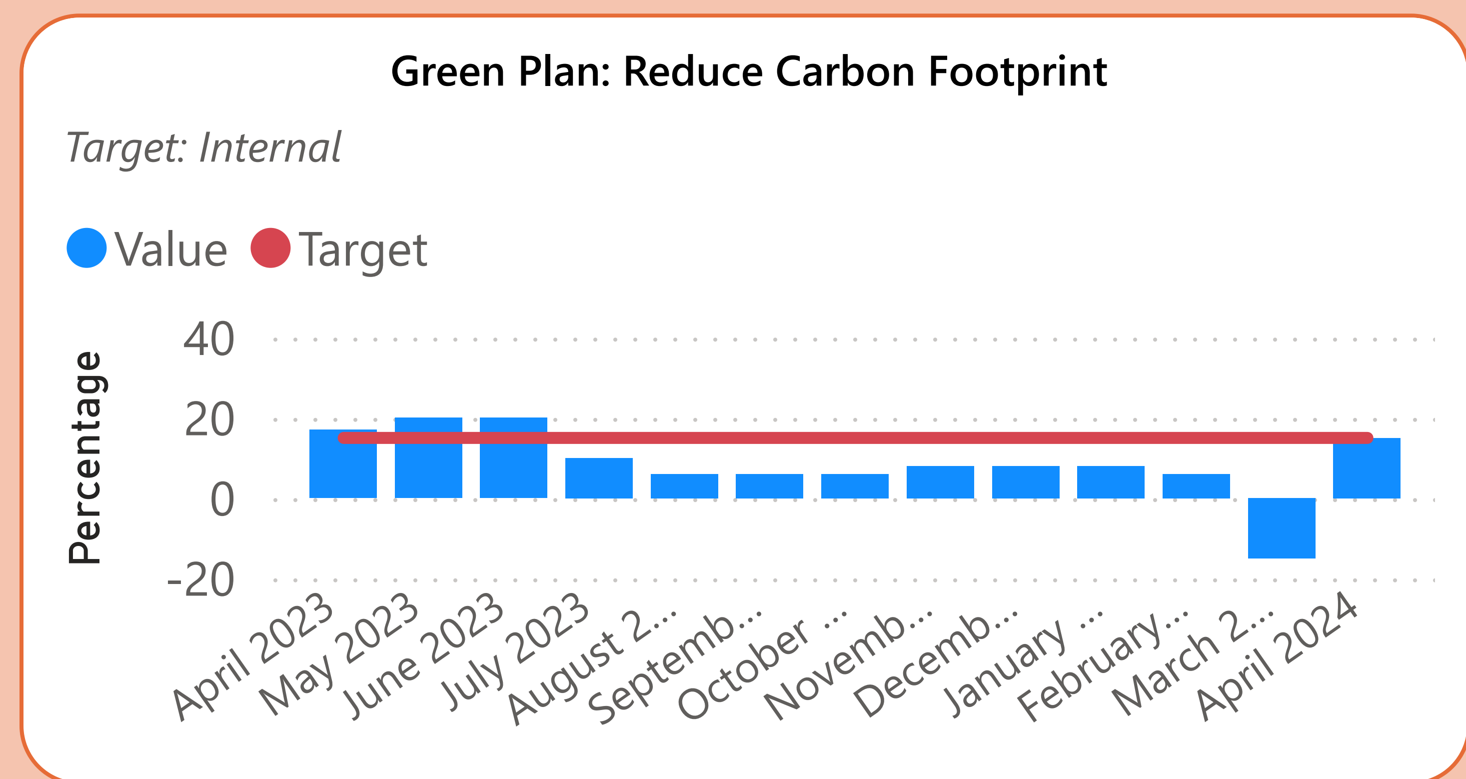
Metric in development

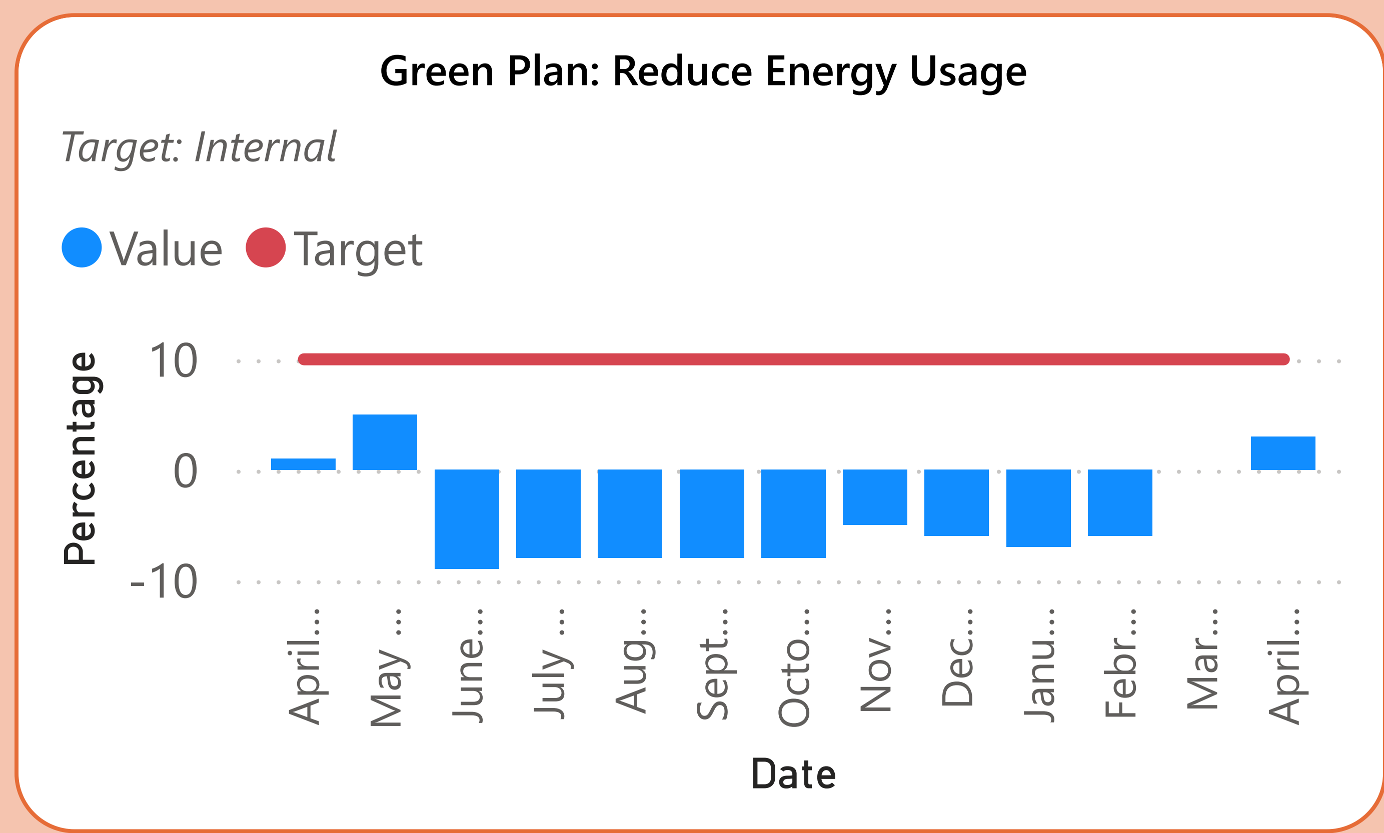
# Collaborate for CYP

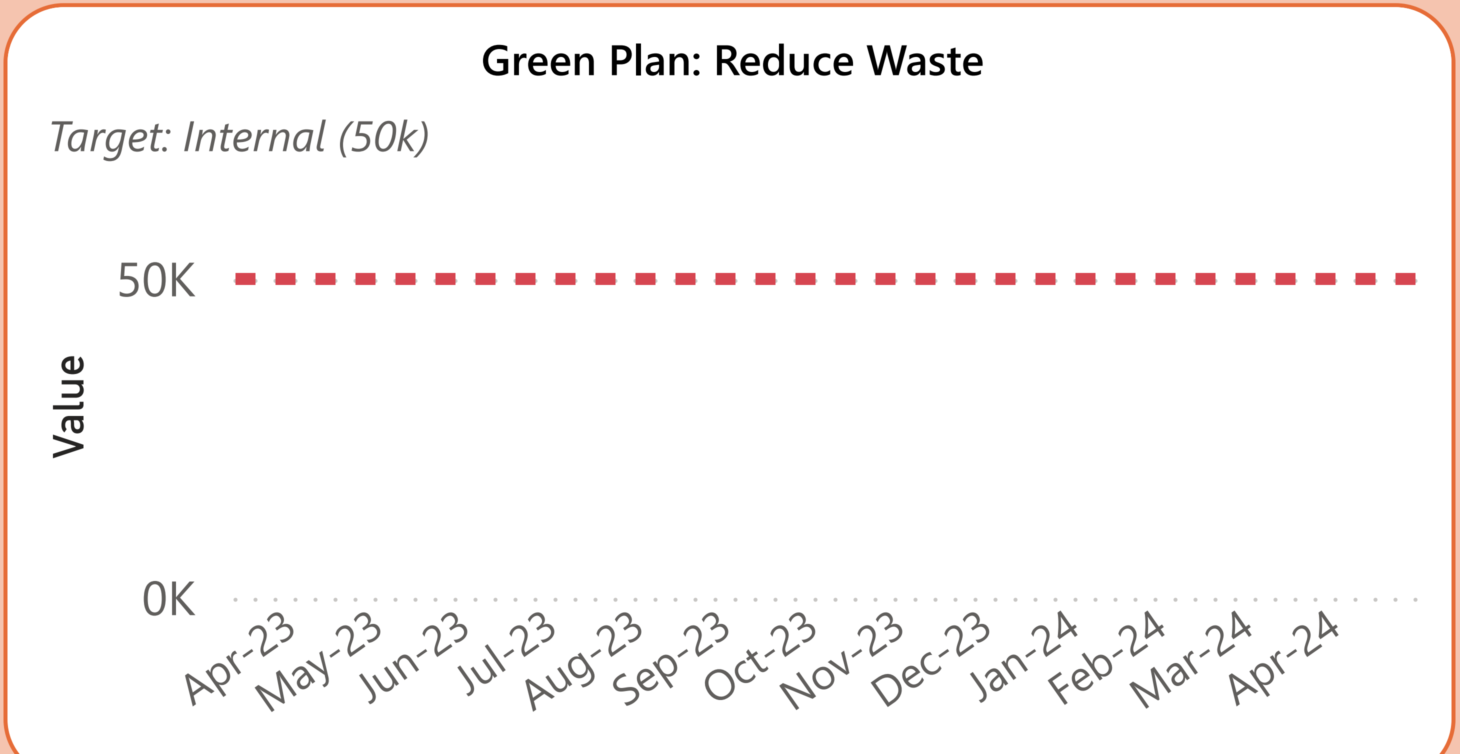


# Financial Sustainability: Well Led

**SRO: Rachel Lea, Director of Finance and Development**

## Highlights:

In May (M2), the Trust is reporting a position in line with plan (£1.8m deficit against a plan of £1.8m). This is largely due to the reprofile of CIP of £385k, following an opportunity to re-submit the plan in June. Divisional forecasts at M2 have highlighted significant challenges. Given the variance to the control total agreed with NHISE for the year, divisions have been asked to provide mitigation plans and reforecast, ahead of M3. CIP on plan in M2 largely due to reprofile of savings from Q1 to Q4. Overall, £6.5m CIP has been transacted with £5.7m in progress and £7.6m 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:

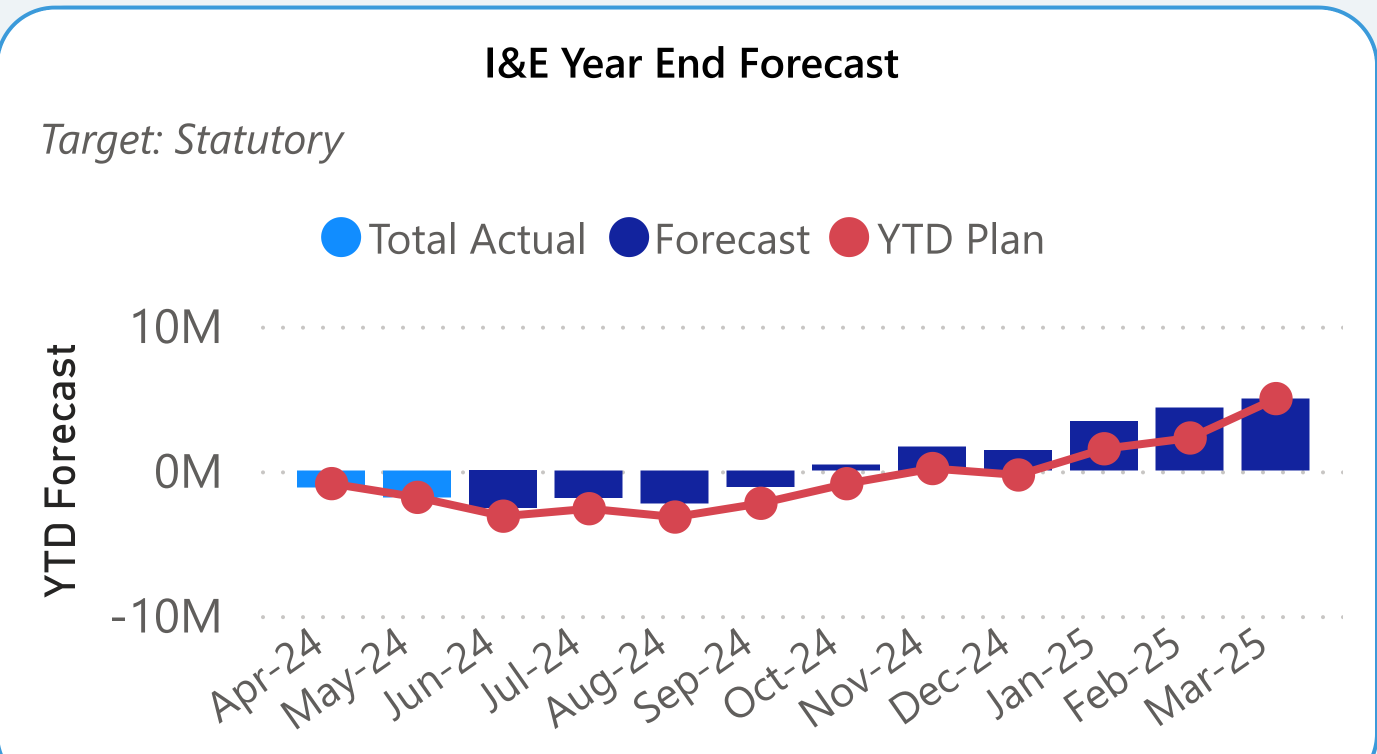
Work is ongoing to deliver full savings of £19.9m and significant progress has been made to date resulting in £6.5m of savings recurrently posted in M2. Divisional forecasts at M2 have highlighted significant financial and operational challenges. Divisions have been asked to provide mitigation plans and reforecast, ahead of M3. Planned industrial action is an emerging risk to the forecast pending clarification from NHSIE on any funding. 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 Group to manage this risk. It may be possible to add new schemes if new CDEL becomes available.

## 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 £19.9m efficiency target. Continued prioritisation of capital programme.

### I&E Year End Forecast

*Target: Statutory*




**Technical Analysis:**

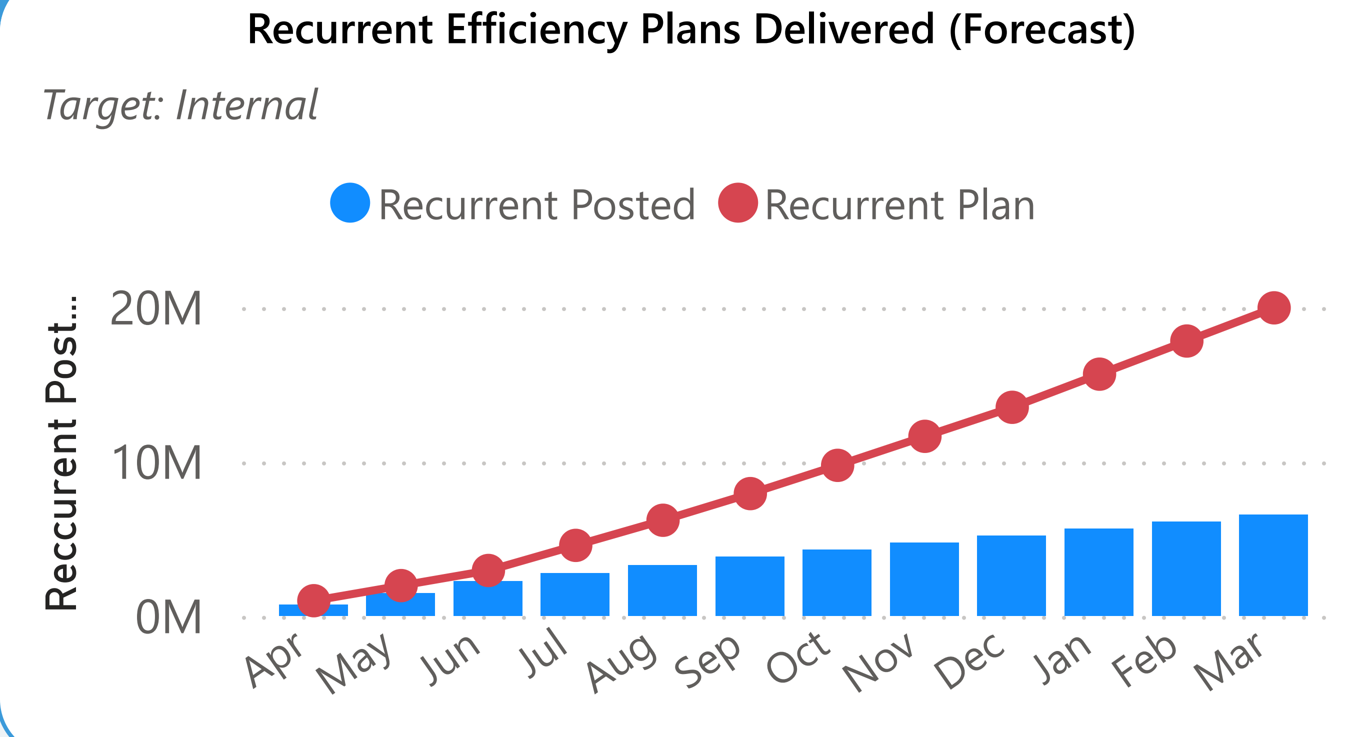
Current plan is £3.3m surplus however initial forecast has highlighted significant challenge. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

**Actions:**

Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through SDG meeting and divisional deep dives. Divisions have been asked to provide mitigation plans and reforecast, ahead of M3.

### Recurrent Efficiency Plans Delivered (Forecast)

*Target: Internal*




**Technical Analysis:**

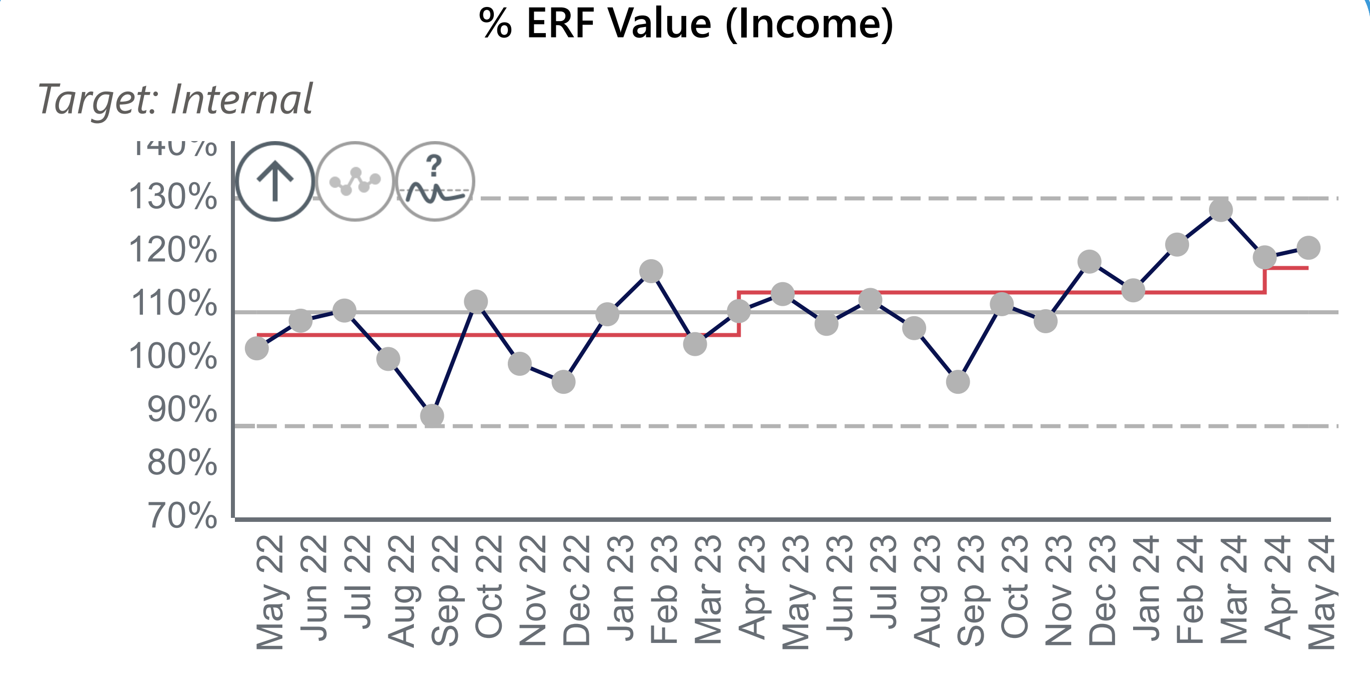
In year and recurrent CIP identified and in progress is £12.2m.

**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*



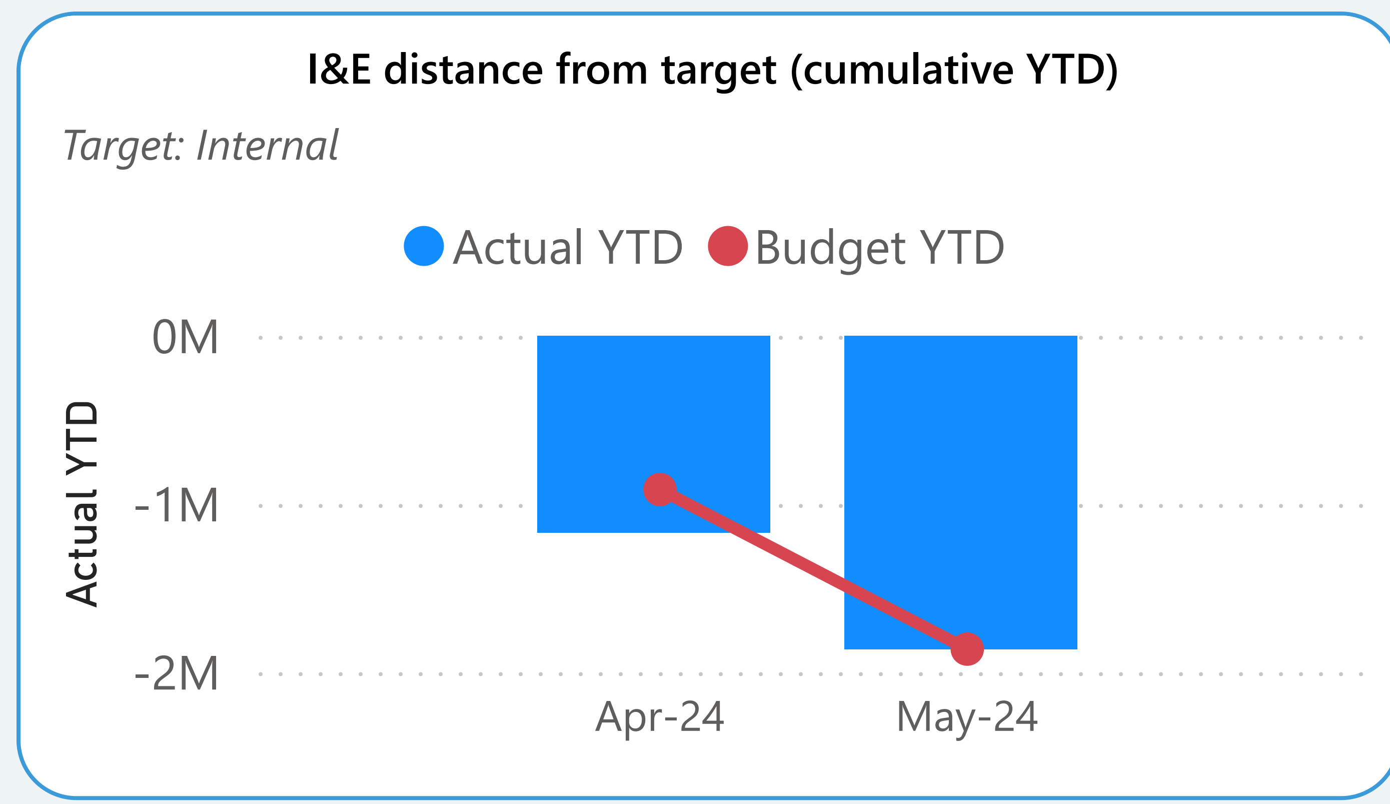

**Technical Analysis:**

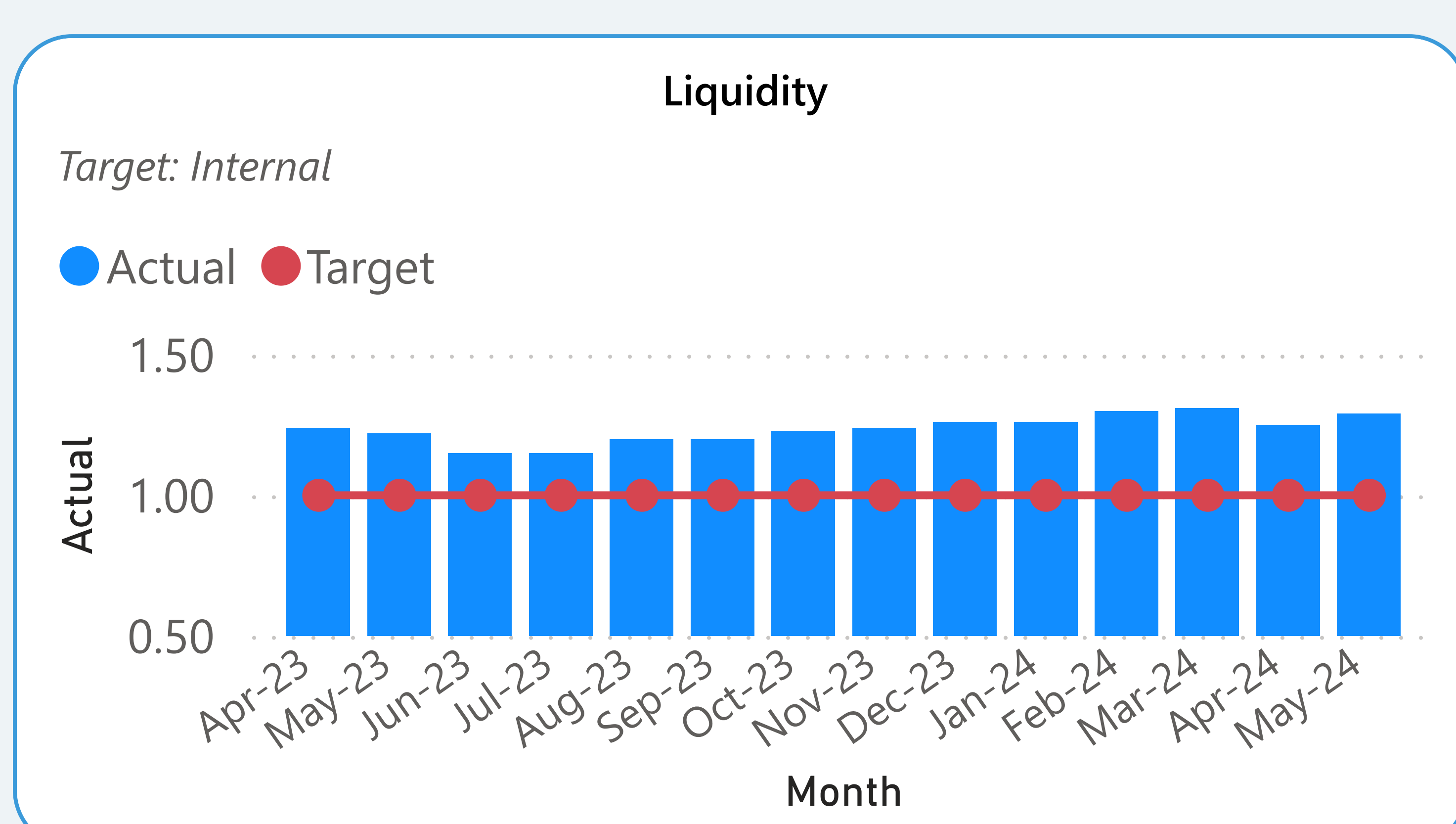
May performance estimated at 119.6%.

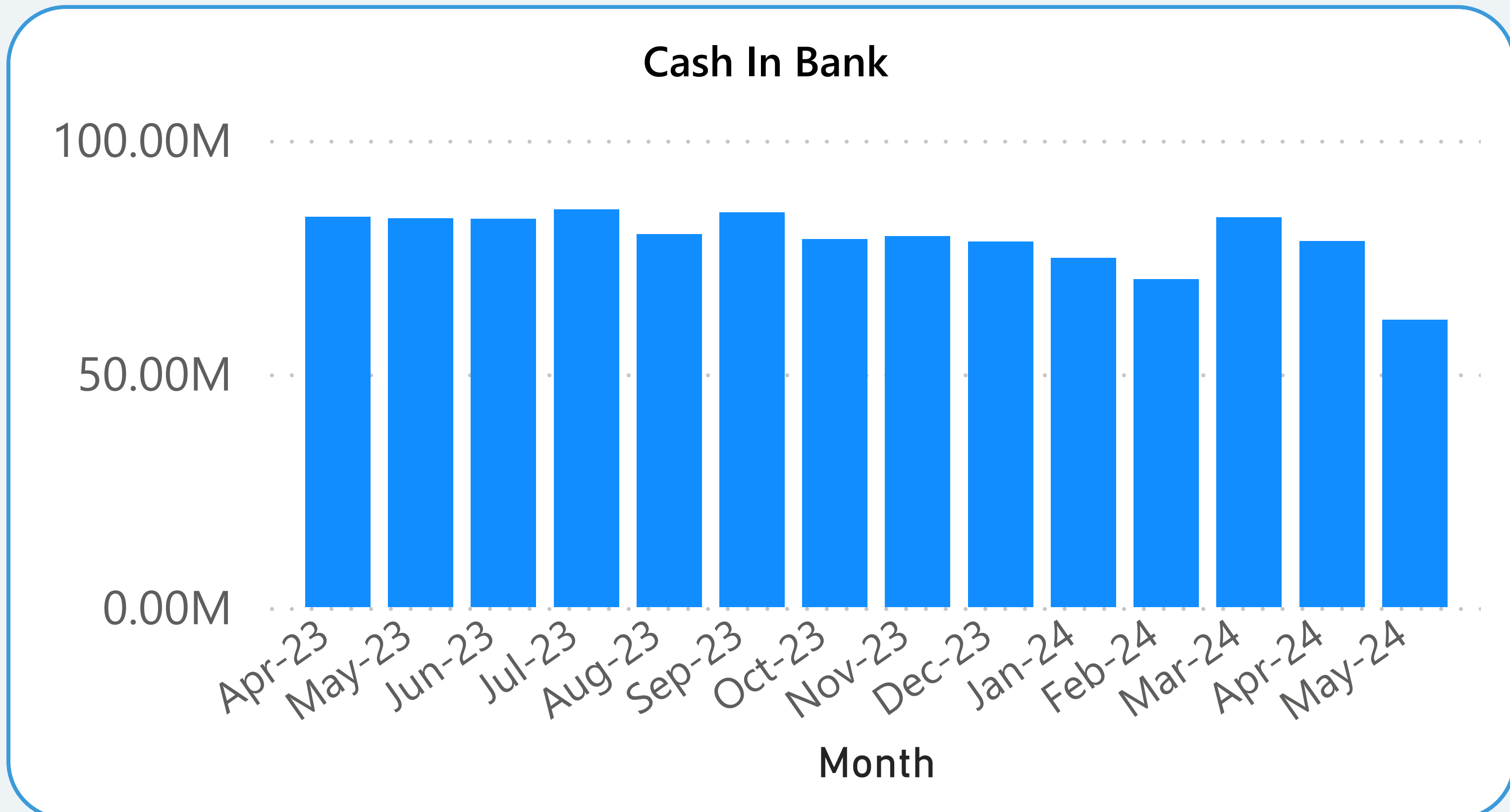
**Actions:**

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

# Financial Sustainability: Well Led - Watch Metrics



# Well Led - Risk Management

**SRO: Erica Saunders, Director of Corporate Affairs**

## Highlights:

• Oversight of risk reporting continues to be embedded within InPhase. Risk Heatmap visualisation completed and presented in all risk reports.

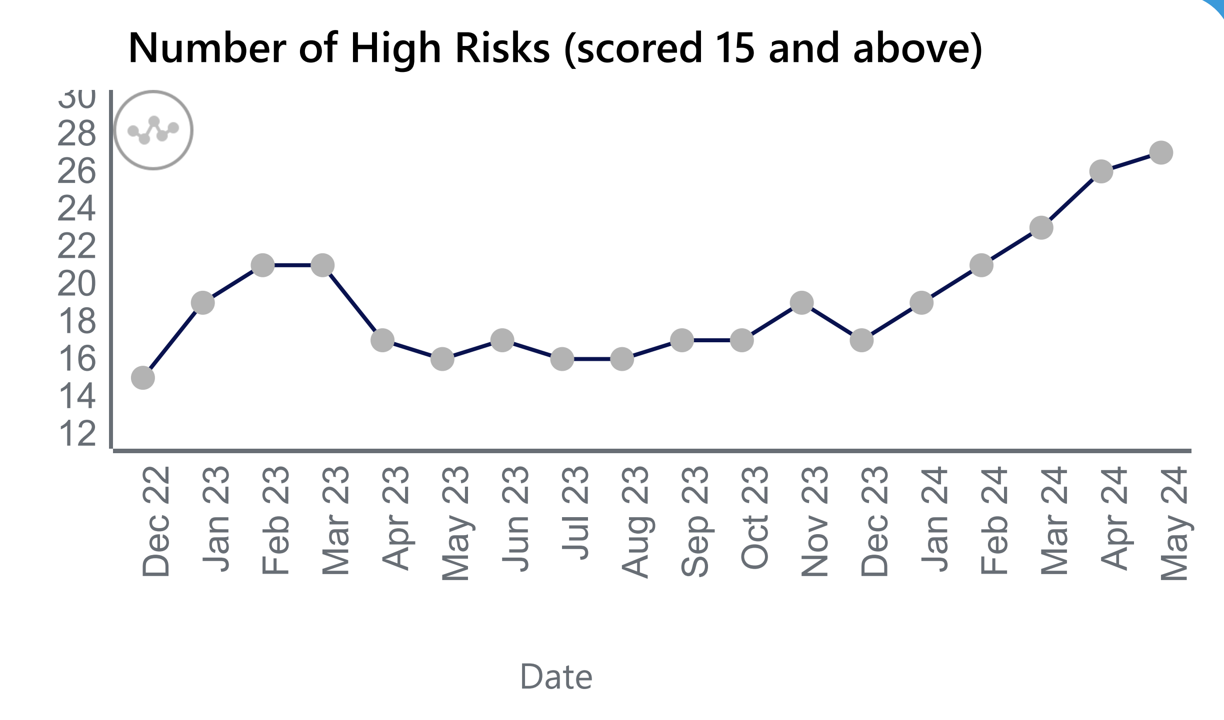
## Areas of Concern:

• Increasing trend of high risks being reported on risk register; however, there is continual movement as some high risks are downgraded and new high risks either added or risk score upgraded accordingly
• Development and delivery of Risk Management training commenced May 24 but uptake of training poor
• Inconsistencies in updating high risks by risk owners remains despite overdue risk notifications and risk oversight meetings being in place
• Despite requests/email limited involvement from all risk owners at risk oversight meetings-to be escalated at Risk management forum

## Forward Look (with actions)

• Delivery of risk management training July 24 with limited uptake
• Overview and assurance of mitigation/progression with high risks continue to be undertake as a standing agenda item at Risk Management Forum

**Number of High Risks (scored 15 and above)**




**Technical Analysis:**

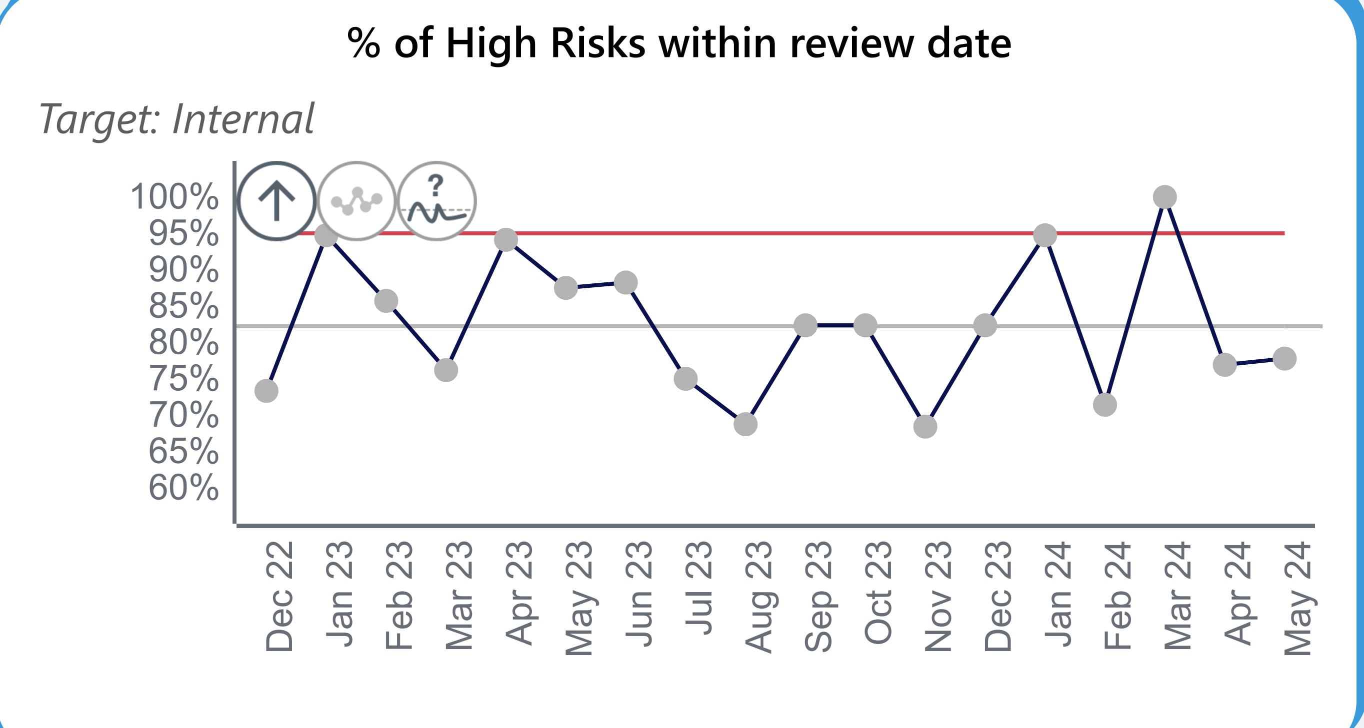
May 2024 position of 27 high risks open which is increase from 26 in April 2024.

**Actions:**

27 high risks reported in May 24 and themed as follows: Quality /Safety (12 risks) Workforce (4 risks) Compliance/regulatory (5 risks) Financial (1 risks) Quality/Effectiveness (2 risks) Reputational (2 risk) Technolgy (1 risk). This is an increase from 26 reported on Apr24

**% of High Risks within review date**

*Target: Internal*



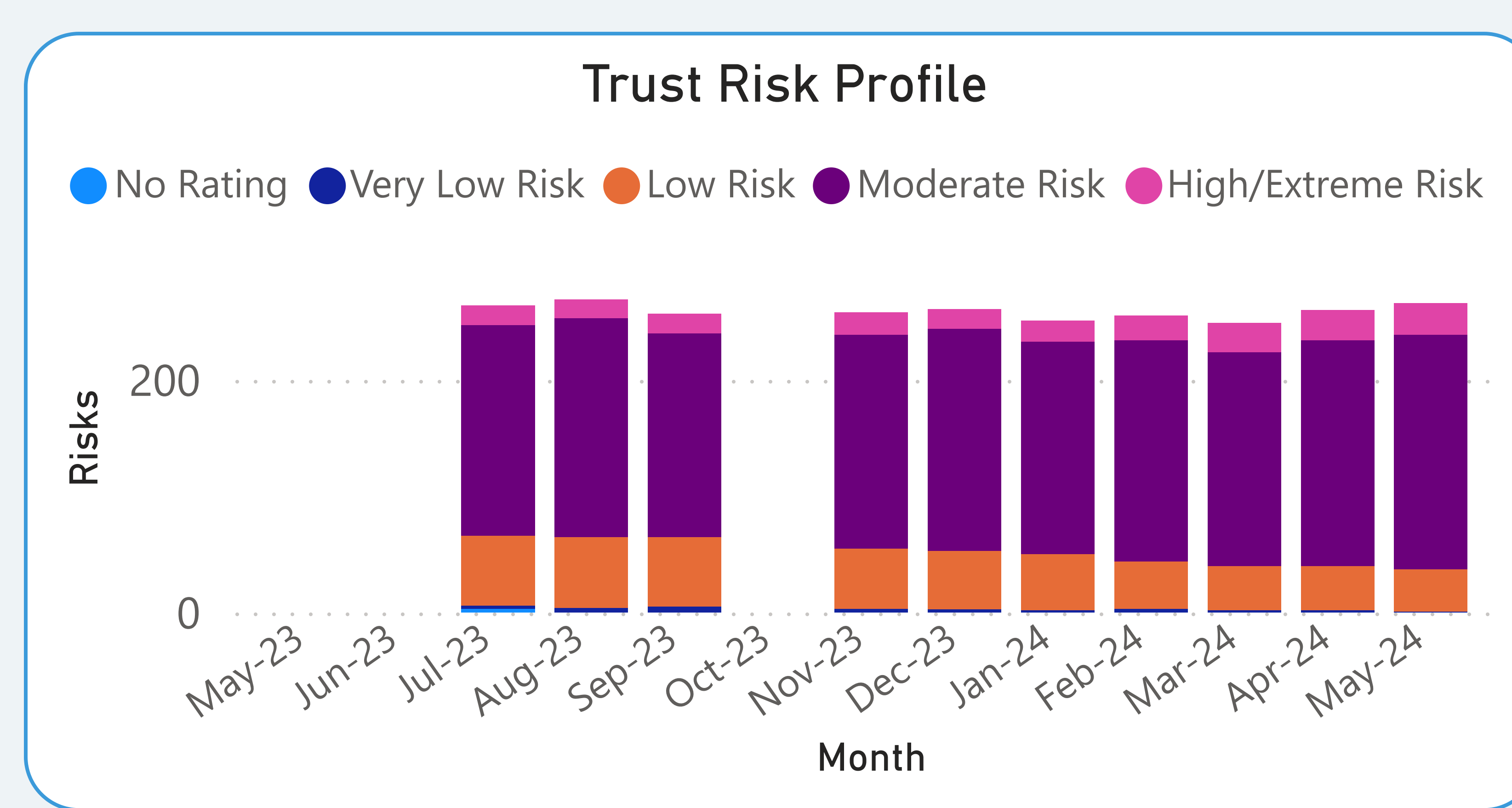

**Technical Analysis:**

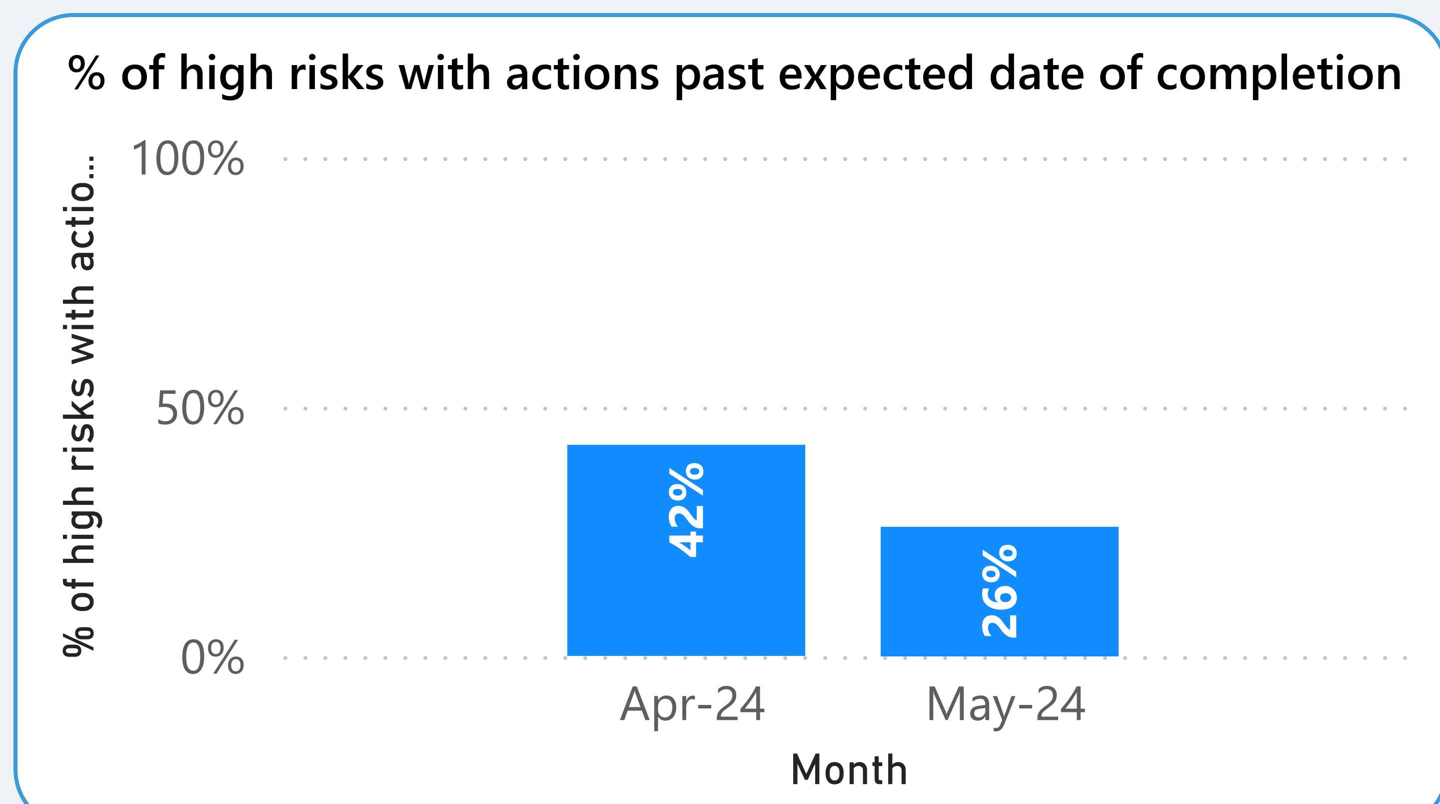
Demonstrating common cause variation and inconsistently achieving the 95% target with an average of 82% which shows significant fluctuation from month to month. May 2024 performance is 77% (21/27) of risks are within expected review date.

**Actions:**

77.8% (21/27) of high risks within review date (6 overdue) All overdue high risks continue to be escalated to risk owner for immediate action with 5/6 have since been updated.

# Well Led - Risk Management



# Divisional Performance Summary - Community & Mental Health

**SRO: Lisa Cooper, Community & Mental Health Division**

## Highlights

- Reduction in number of PALS received, and improvement in number resolved within 5 days (90%).
- Further increase in number of virtual ward bed days – highest since December 2022
- Improvement in RTT for CAMHS (67%) – highest since December 2022
- Improved RTT position for Eating Disorder Service (90%) despite increase in referrals
- Improvement in IHAs completed within 20 days of starting in care (35%) and within 20 days of referral (76%)
- Mandatory training levels (94%)
- Sickness rates remain within target (5%)
- Community Dietetics referral triage time is now in line with trust target with a continued improvement in community dietetics RTT (85%)
- 18% reduction in number of children and young people waiting over 2 years for a follow up appointment (total 442)

## Areas of Concern

- Work continues on data reporting for Mental Health Services via MHSDS due to data quality issues impacting on submissions. This has been escalated to executive team and BI team who lead this work
- Outpatient Fracture/Dermatology programme of works has been delayed until July 2024
- WNB rate across division remains stable at (13%) with highest level in CAMHS (15%). There have been reductions in the rates for ADHD and Community paediatrics which, at 8%, is the lowest it has been all year
- A number of referrals to community paediatrics (11) were not logged appropriately. All patients have now been seen and an incident logged for further review (see forward look) but did mean 6 pts had waited over 52 weeks at the end of May 2024
- Continued increase in referrals for Eating Disorder Team in May 2024
- Waiting times to access SALT (Sefton) continue to remain high. RTT has improved slightly compared to previous month (57%) – significant increase in referrals since 2021/22
- CAMHS: referral to help (first assessment) KPI remains lower than target (49% within 6 weeks of referral) – focussed work to improve wait is needed. Reduction in young people waiting 52+ weeks for treatment to start (x1)
- 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

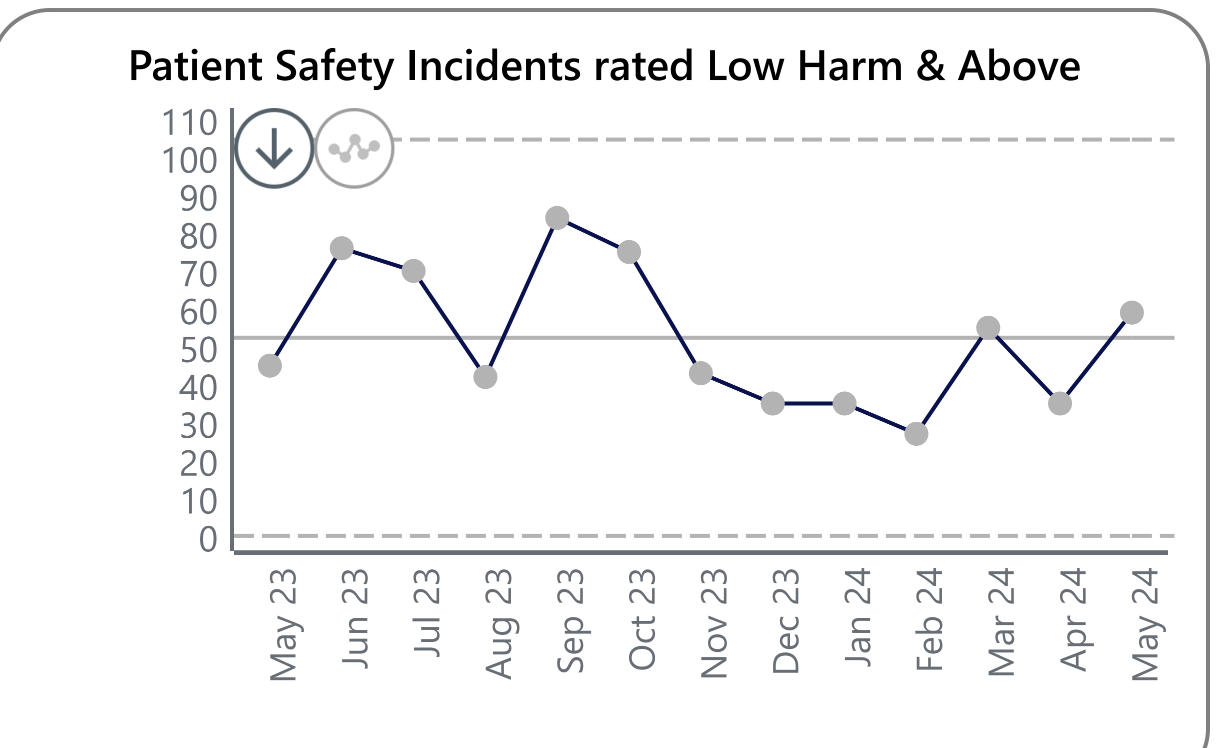
## Forward Look (with actions)

- Review of referral process for Community Paediatrics (Knowsley) referrals to streamline inline with trust processes – meeting scheduled for 12 June 2024
- Task and finish group to improve Mental Health data reporting ongoing – annual data re-submitted for 2023/24, awaiting feedback. Expected improvement in the number of data errors in MHSDS.
- Capacity and Demand planning work for Speech and Language Therapies has been completed. Work to review waiting times and improvement plan is ongoing.
- Virtual ward GP pathway due to commence on 03 June 2024. Pathway work and training has been completed throughout May.
- Room utilisation: work ongoing to improve utilisation and prepare for fracture/dermatology programme of work.

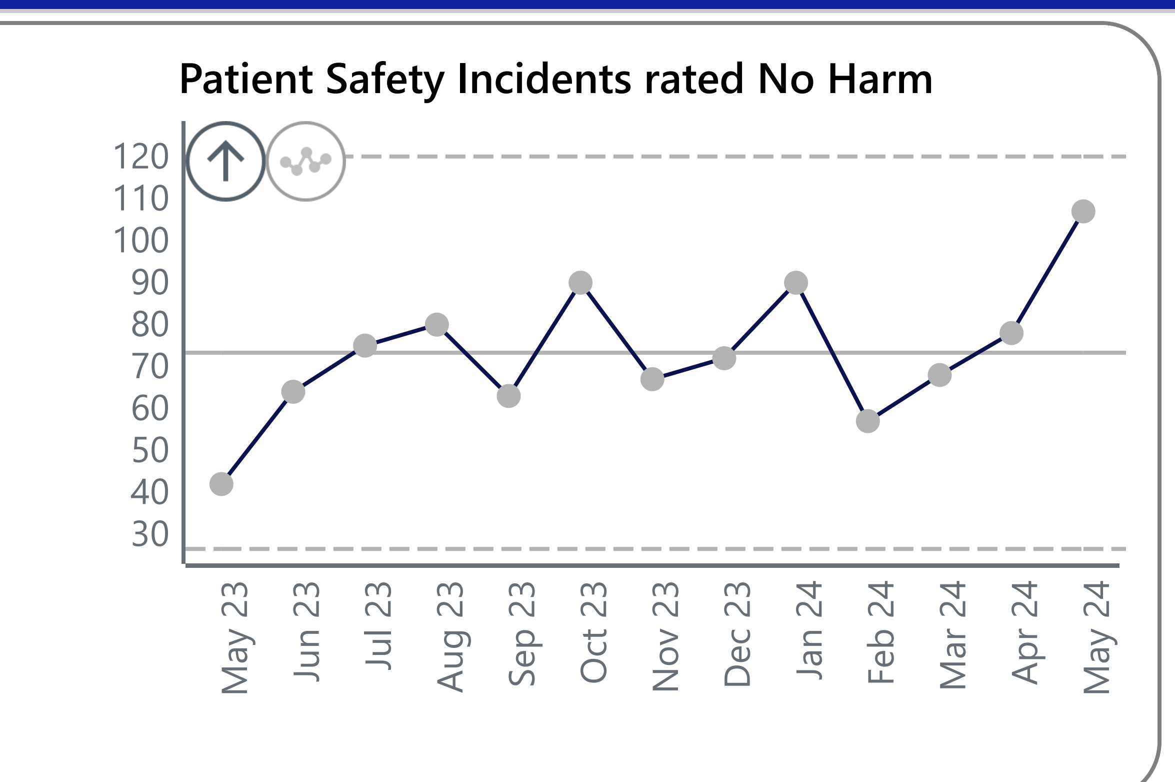
# Integrated Performance Report | June 2024

## Divisional Performance Summary - Community & Mental Health

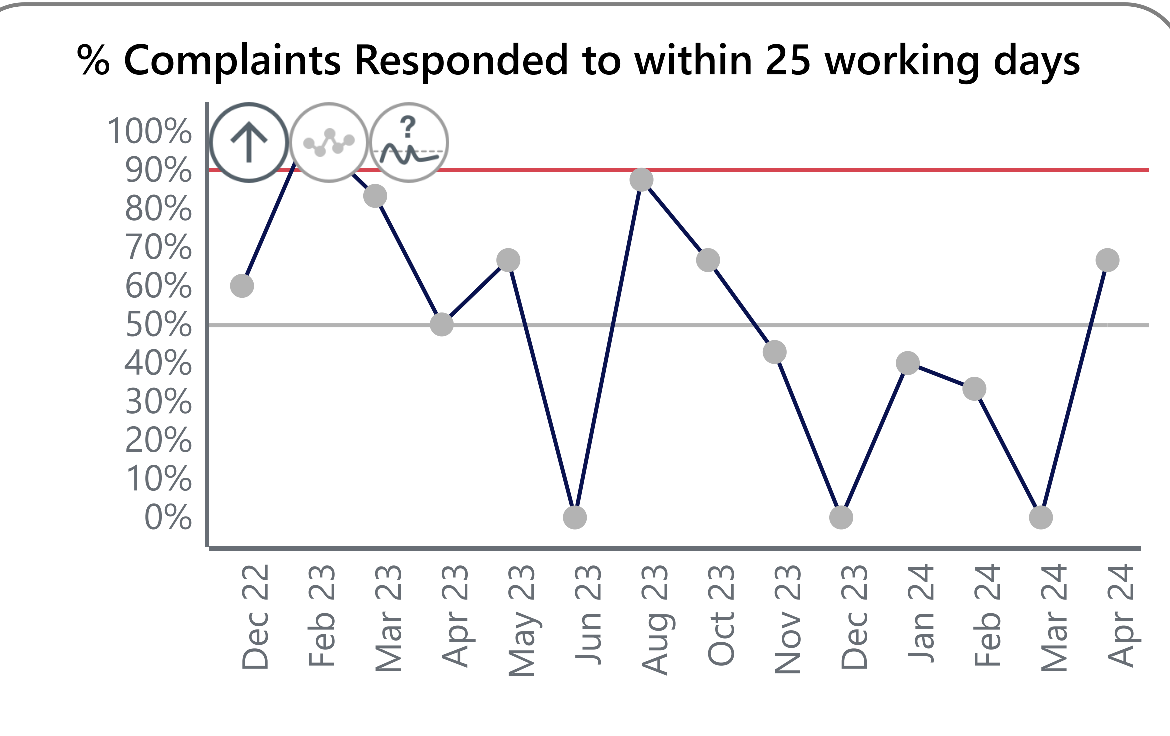
### Patient Safety Incidents rated Low Harm & Above



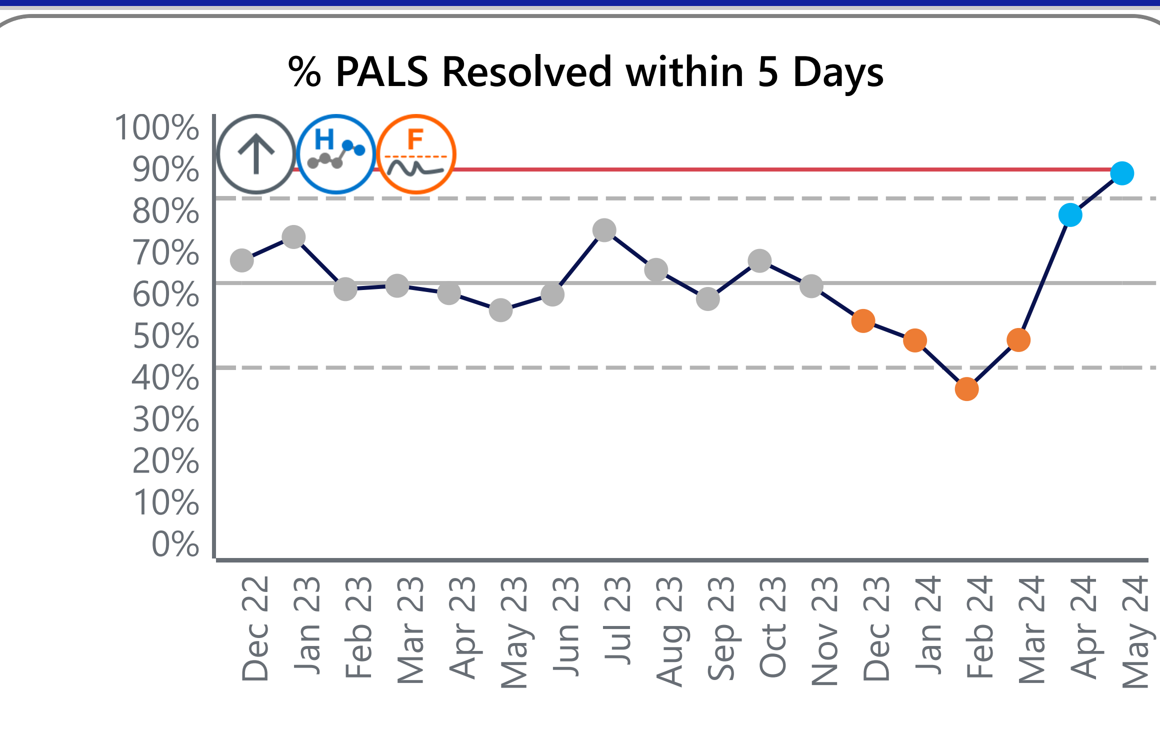
### Patient Safety Incidents rated No Harm



### % Complaints Responded to within 25 working days

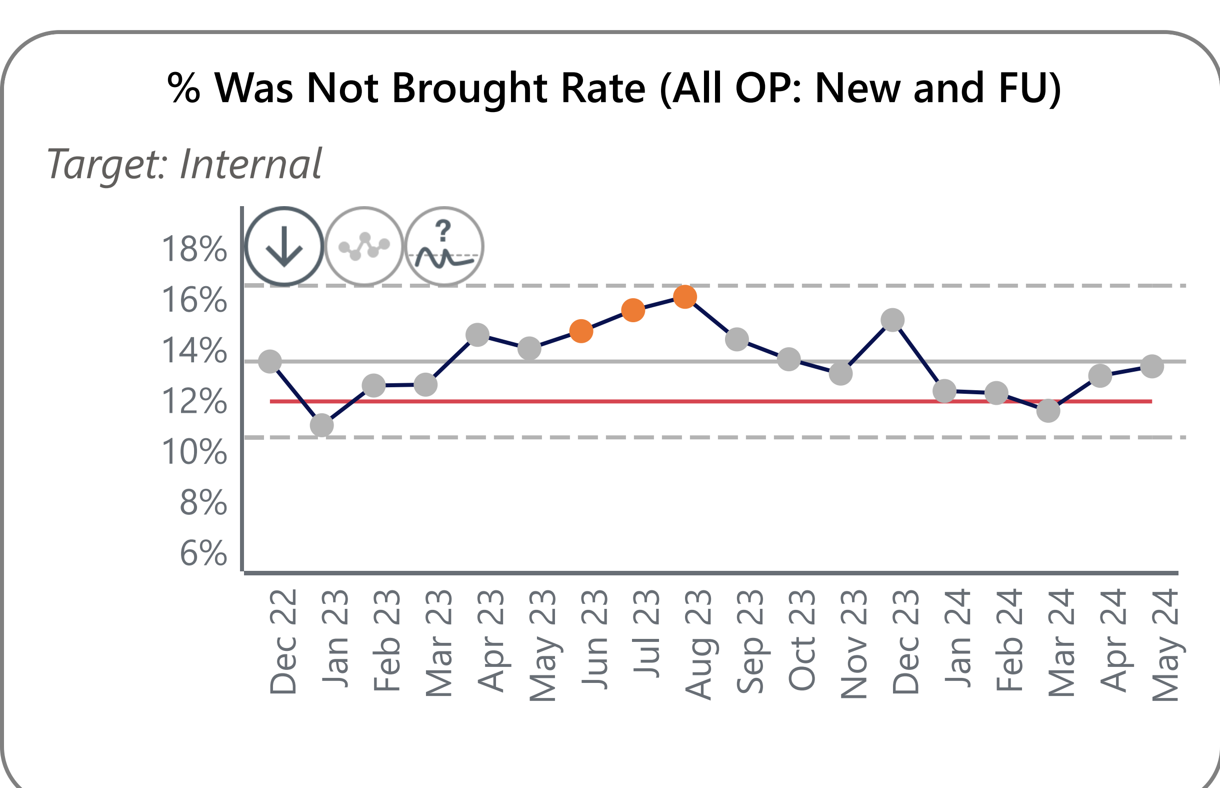


### % PALS Resolved within 5 Days

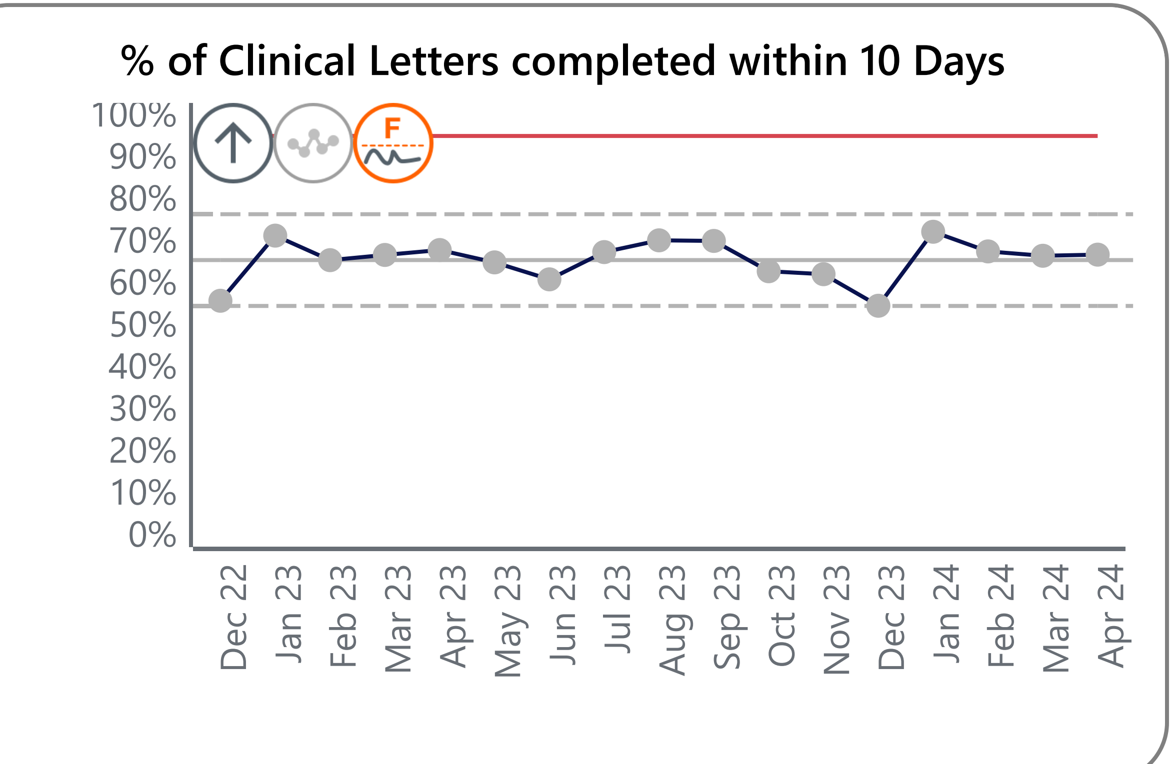


### % Was Not Brought Rate (All OP: New and FU)

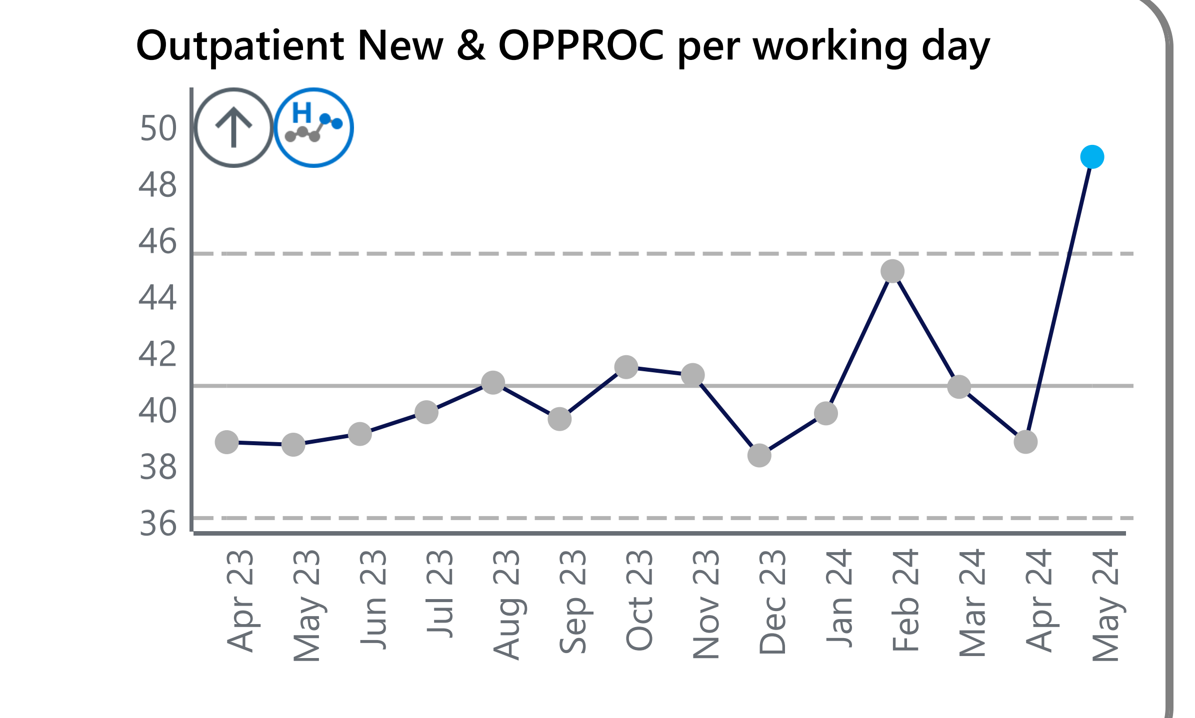
*Target: Internal*



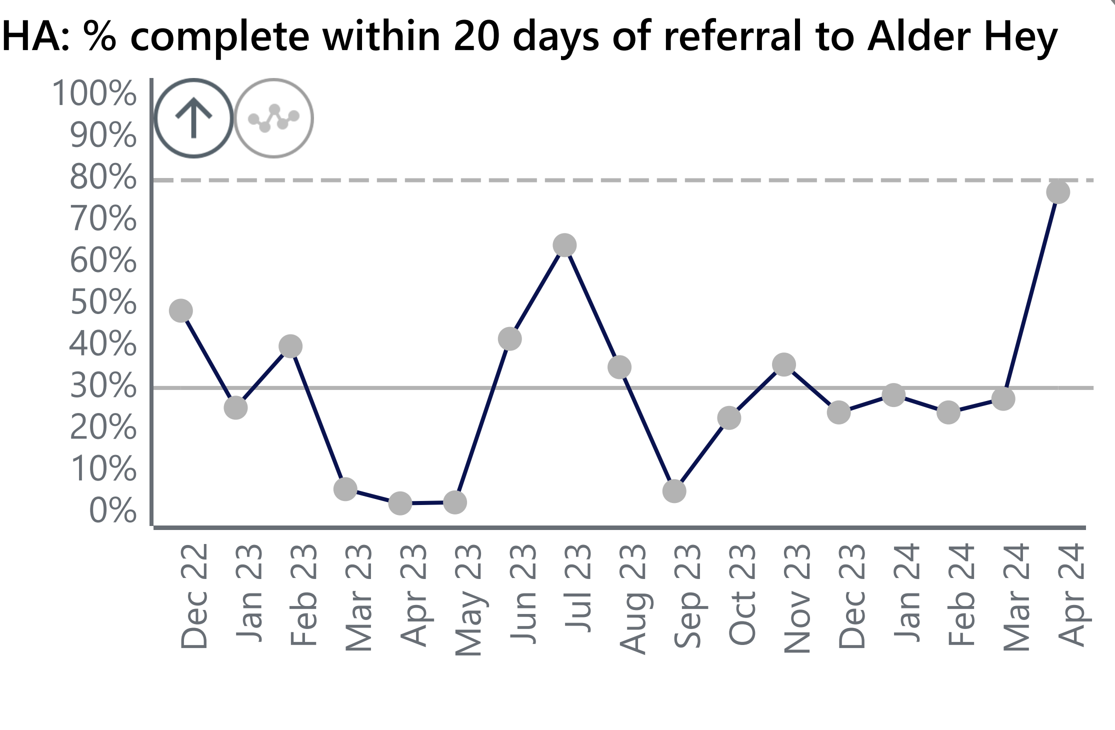
### % of Clinical Letters completed within 10 Days



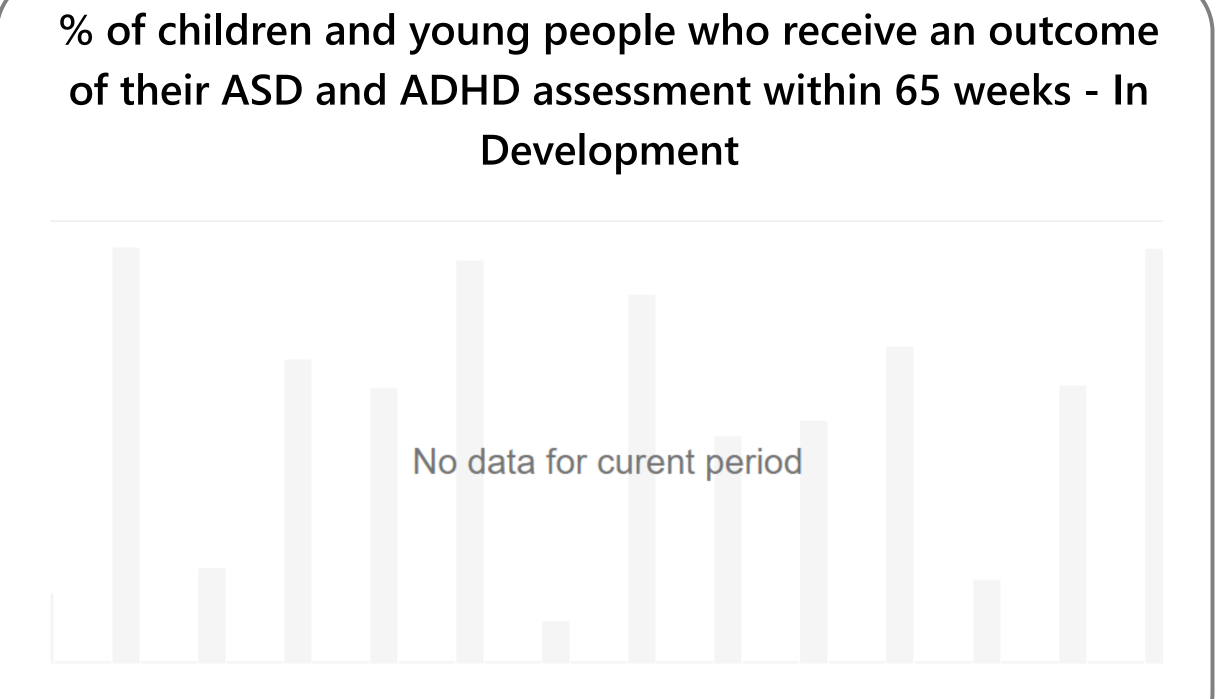
### Outpatient New & OPPROC per working day



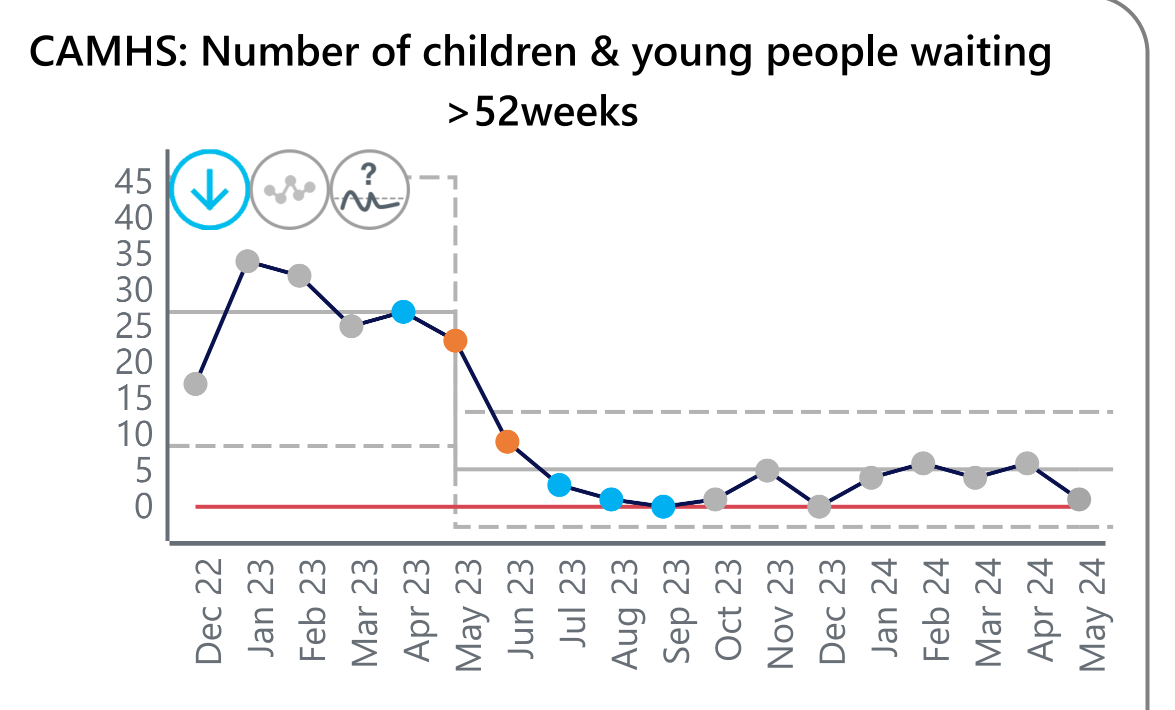
### IHA: % complete within 20 days of referral to Alder Hey



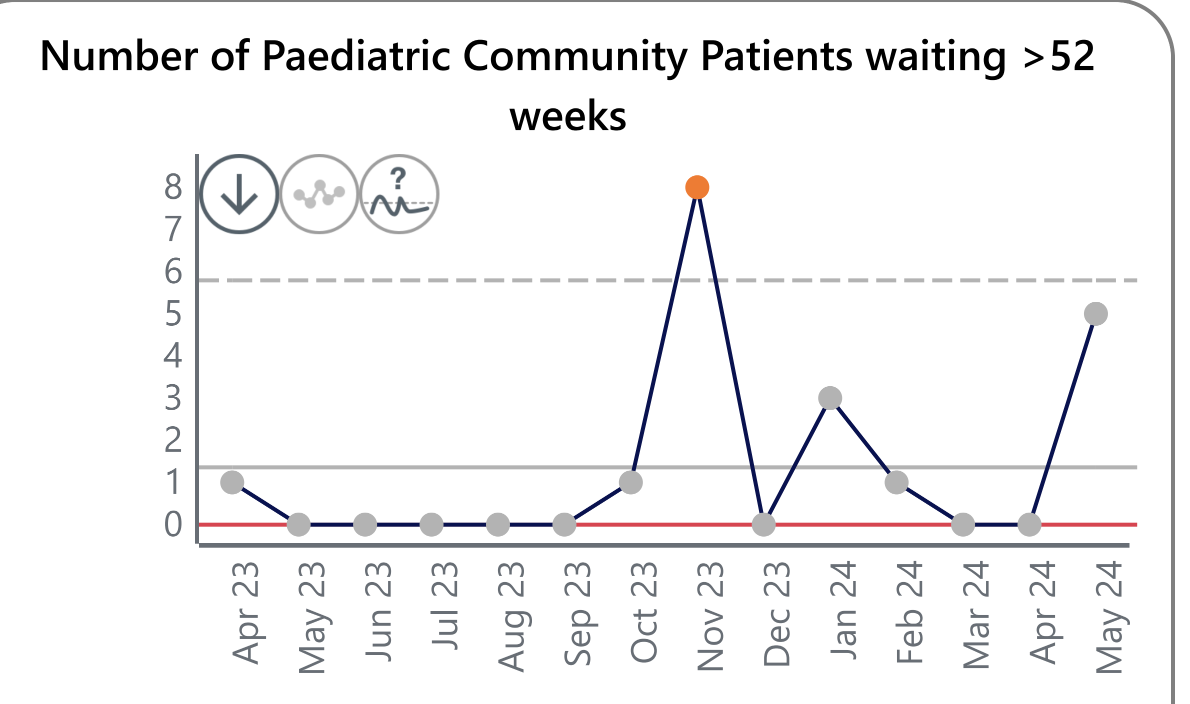
### % of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks - In Development



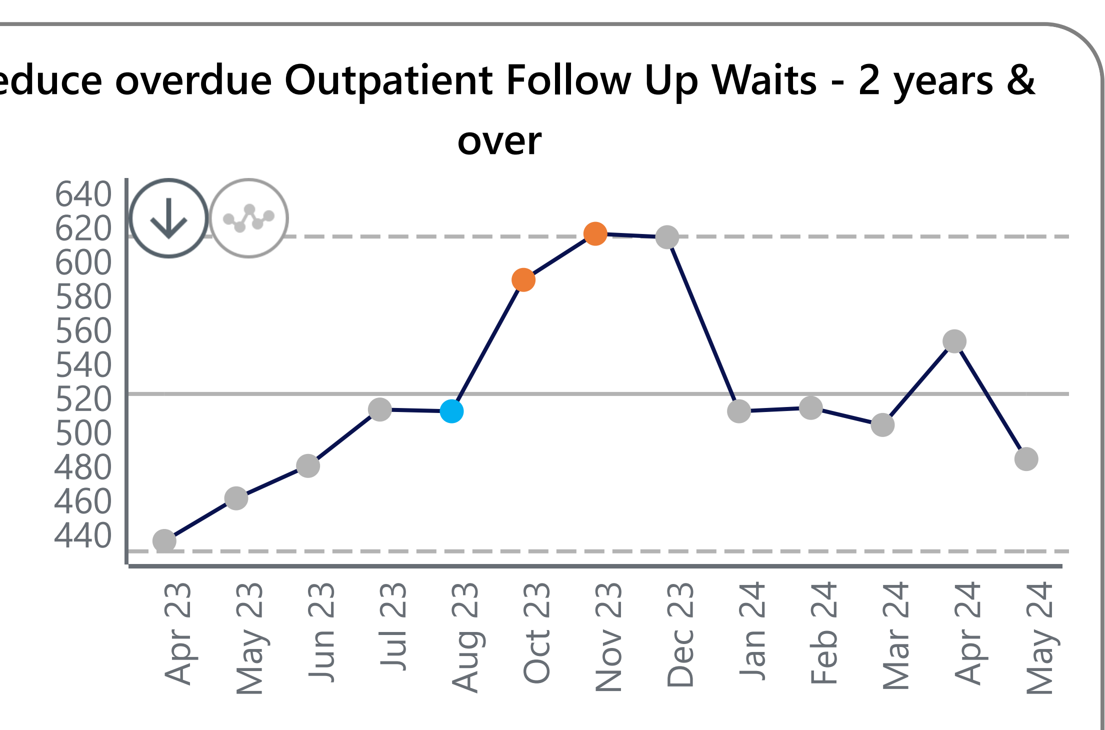

### CAMHS: Number of children & young people waiting >52weeks



### Number of Paediatric Community Patients waiting >52 weeks

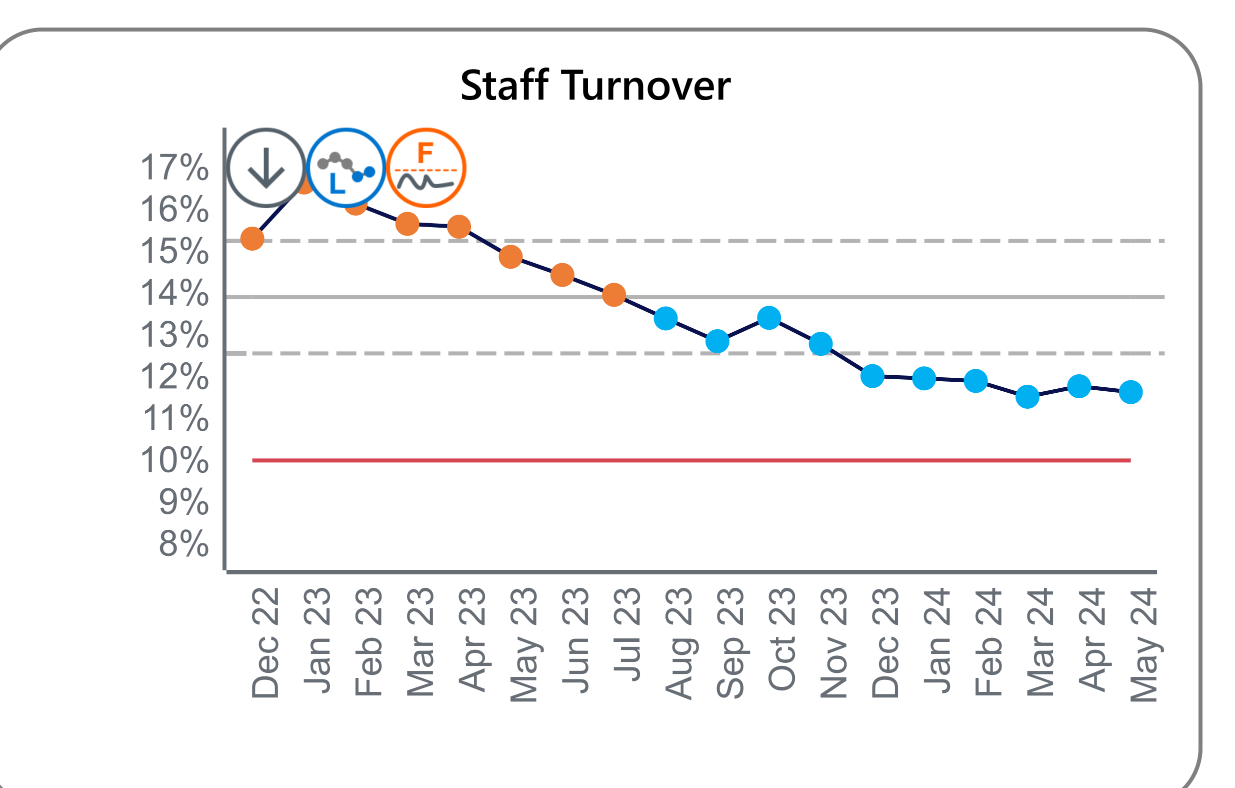


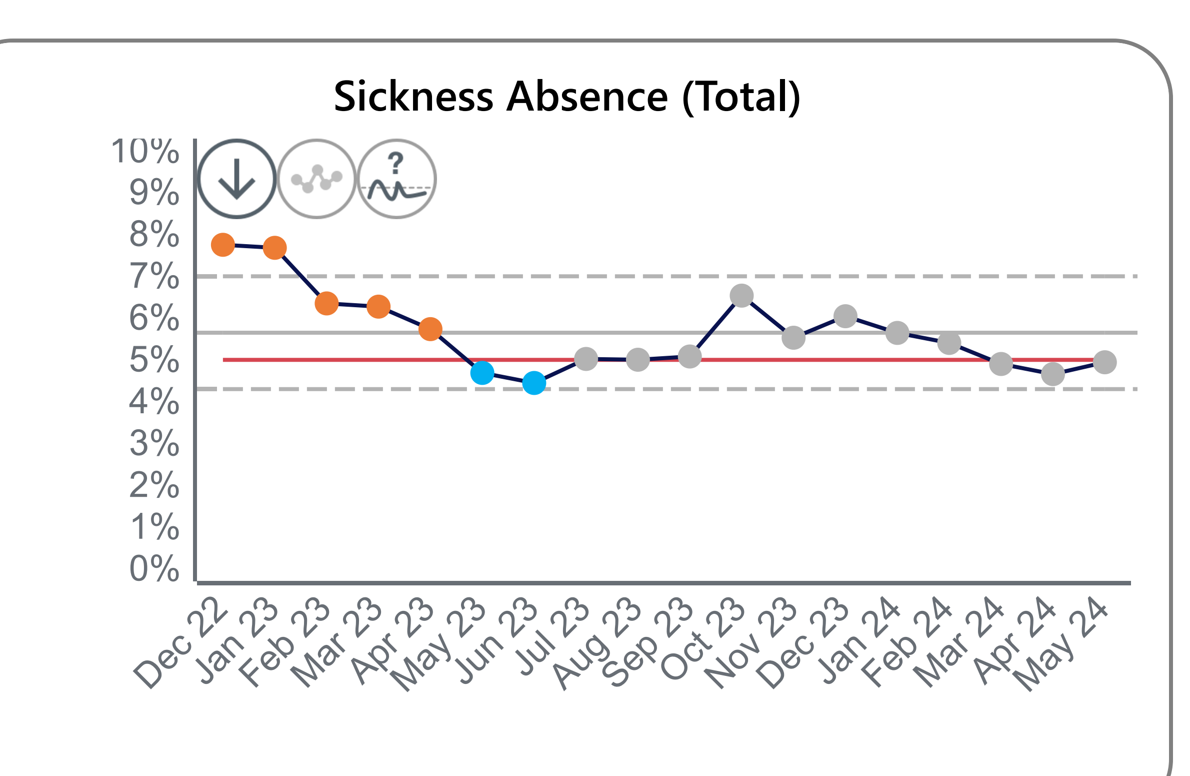
### Reduce overdue Outpatient Follow Up Waits - 2 years & over

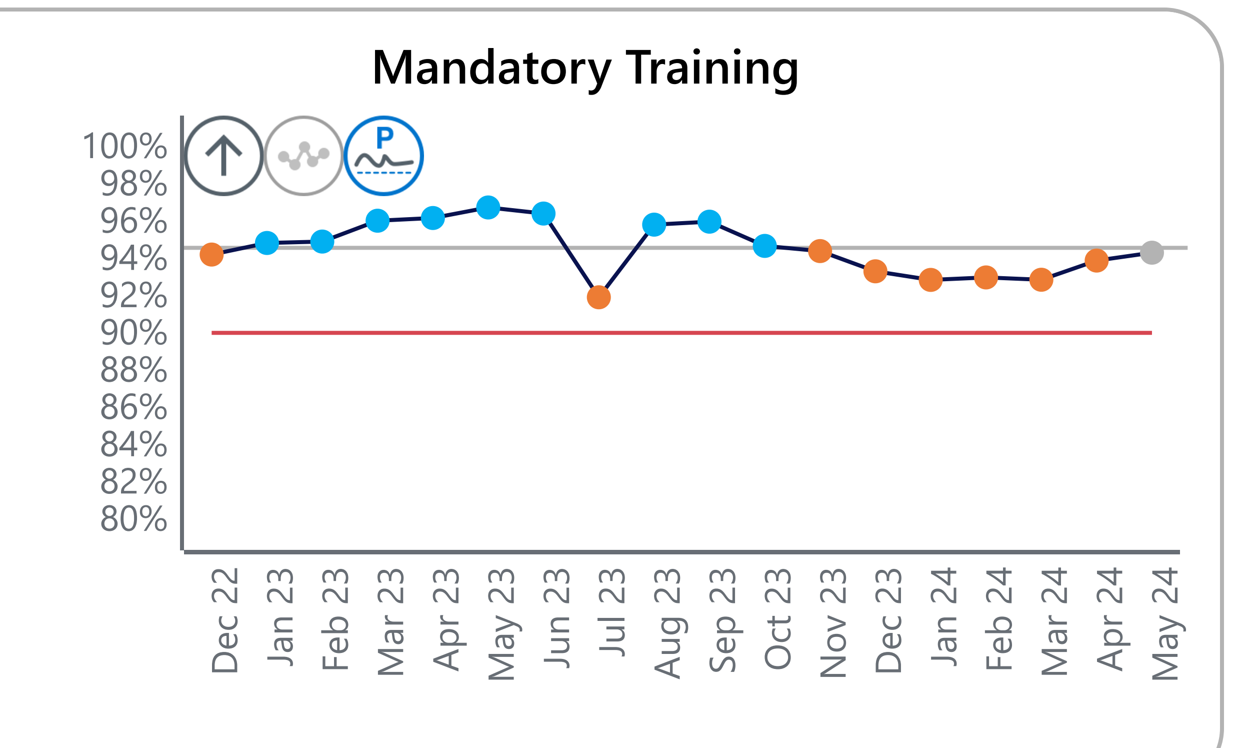


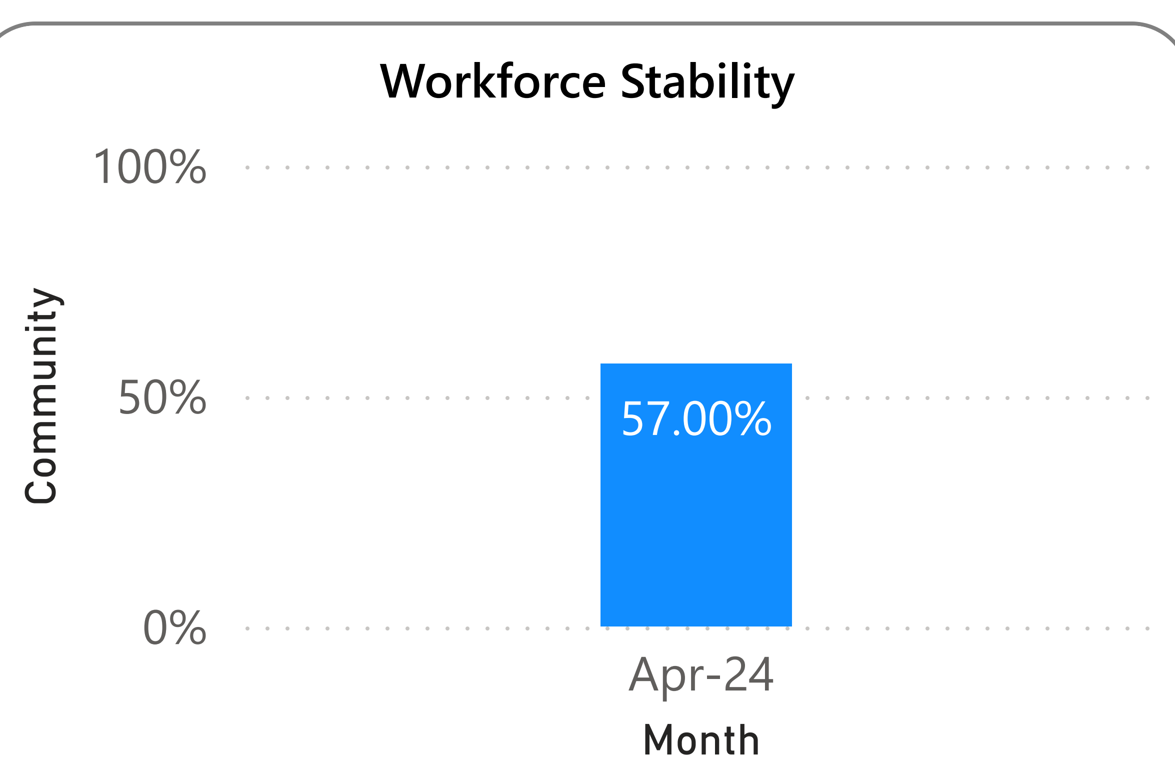
Integrated Performance Report | June 2024

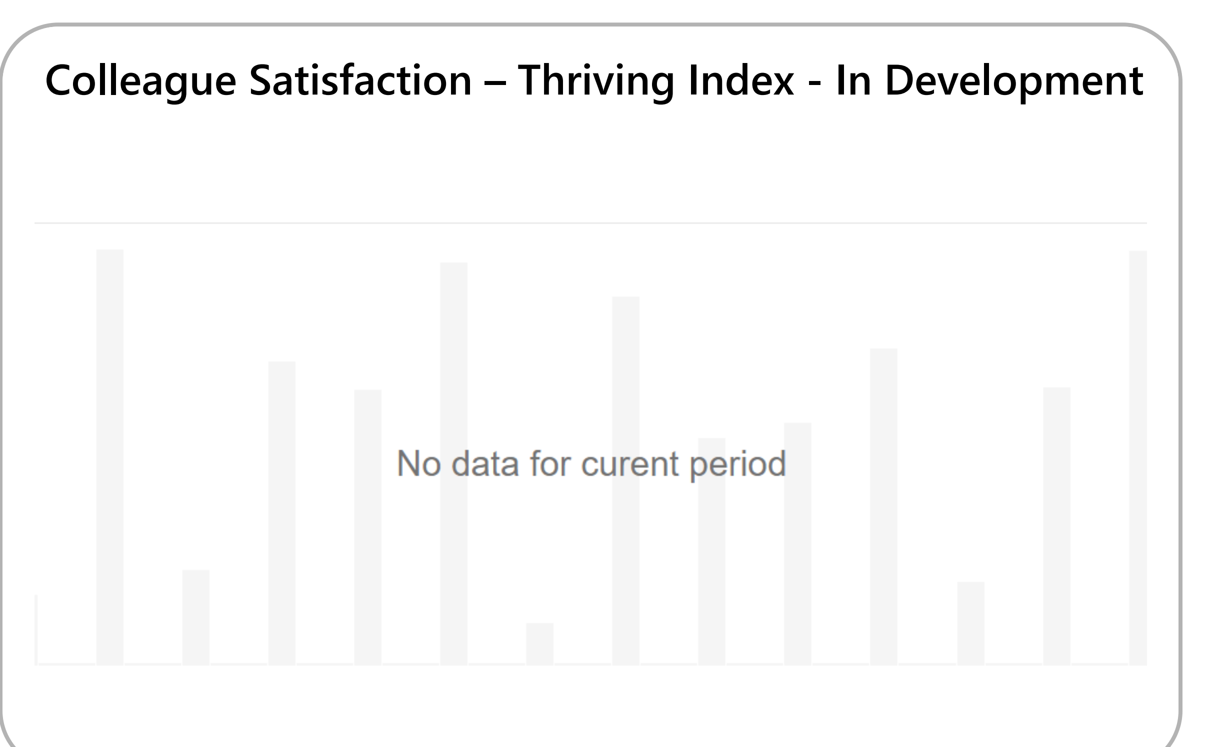
## Divisional Performance Summary - Community & Mental Health

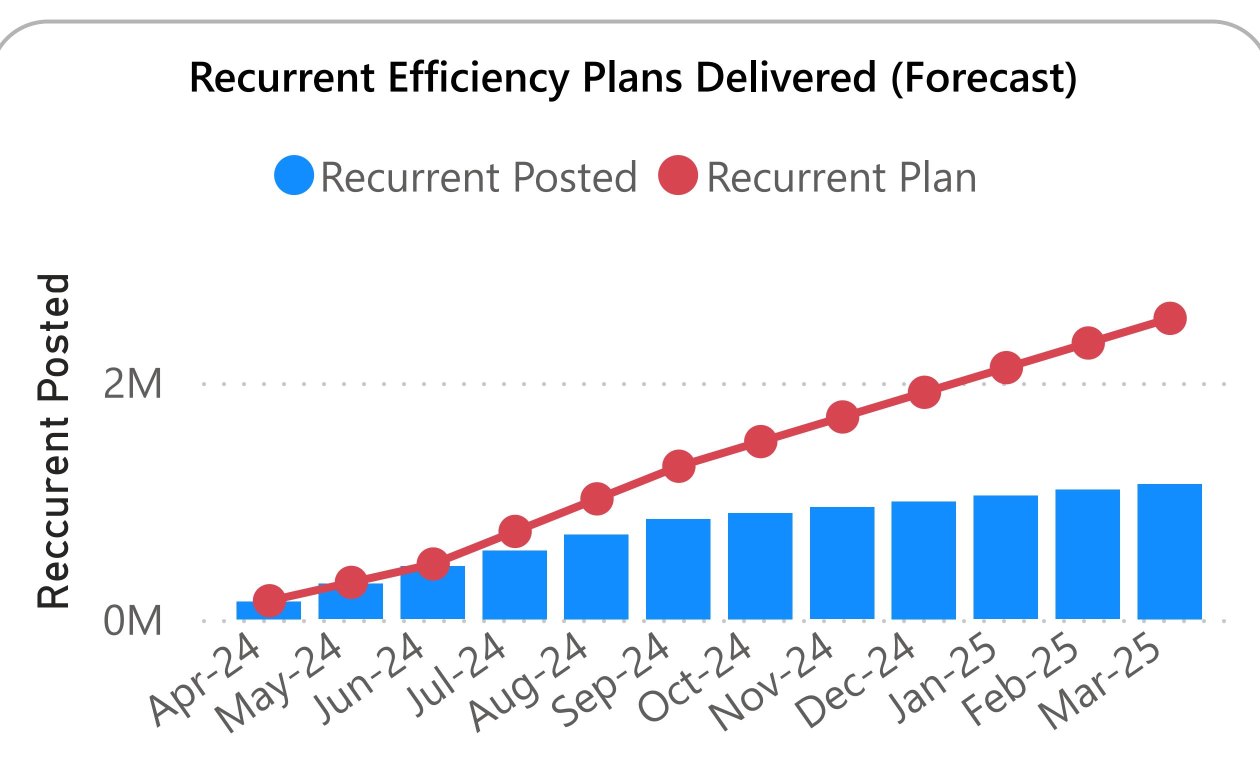


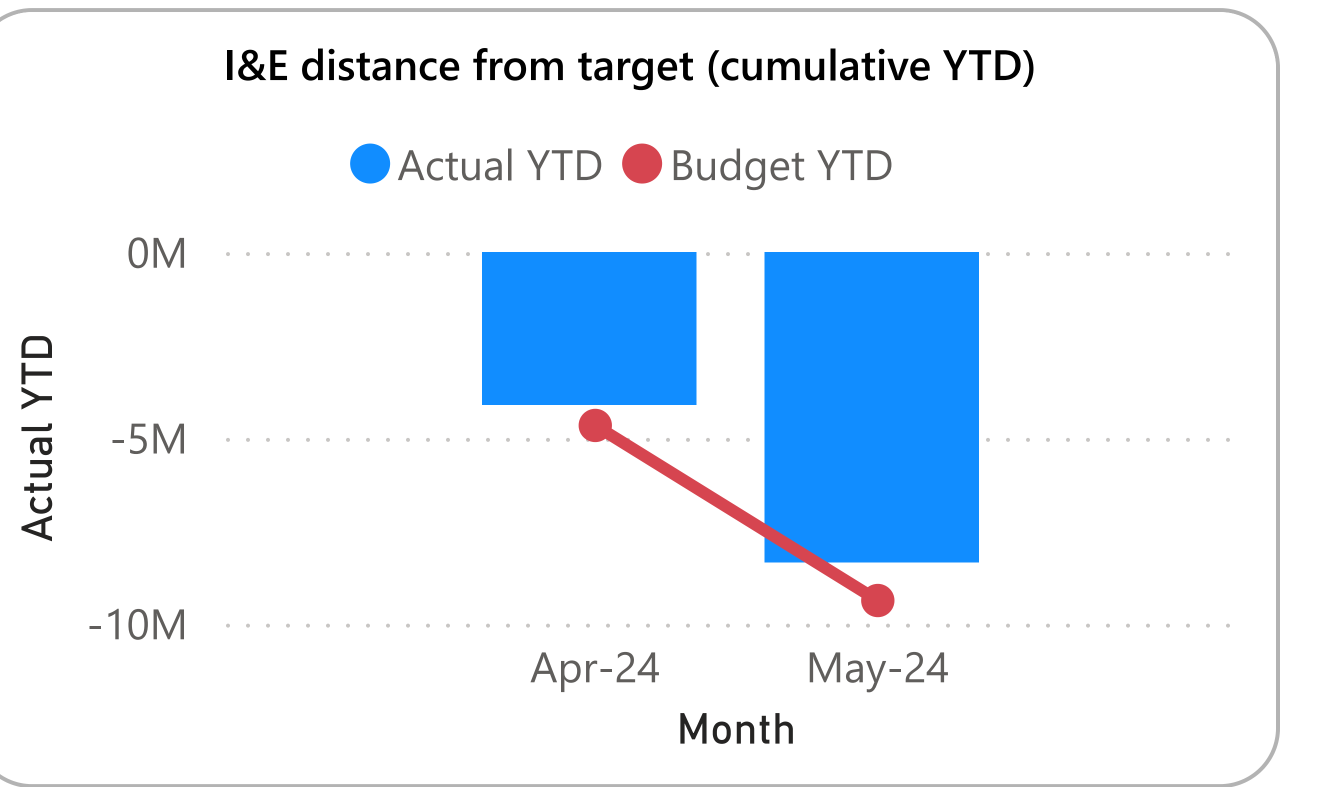



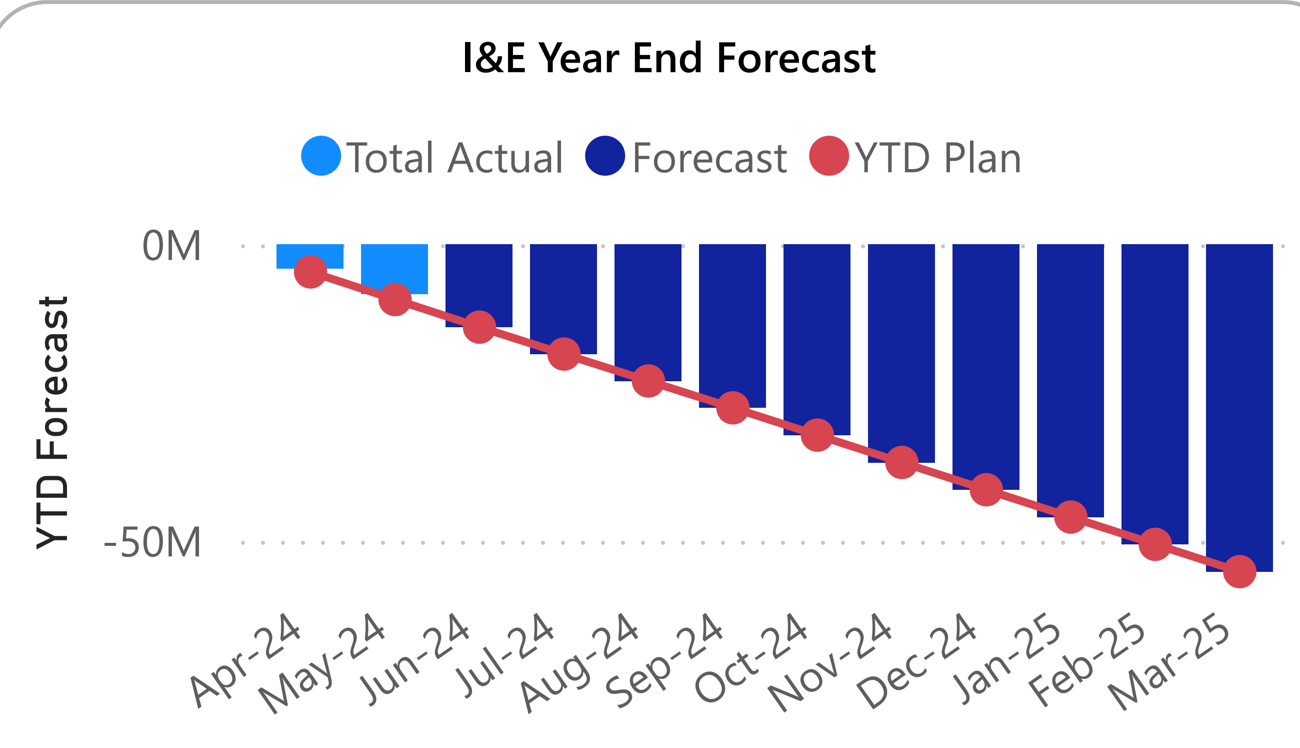



# Divisional Performance Summary - Medicine

**SRO: Urmi Das, Division of Medicine**

## Highlights

• Second consecutive month ED sepsis compliance remained above target
• 100% response rate for formal complaints for 6th consecutive month
• 100% PALS also resolved within 5 days
• Improvement seen in ED F7F test with 83% of those who completed the test recommending the service
• The division recruited to the clinical lead role for governance
• The Pathology department also recruited the only qualified consultant who passed the training course this year nationally to the team, increasing sustainability within the service
• Continued high performance against 4hour target within ED 87%
• Continued low numbers of patients who waited within ED for over 12 hours in May (4)
• Median time to triage time in ED maintained improvement and achievement of national target
• Maintained 100% cancer targets
• Increase new OP New and OPROC activity
• Continued reduction in staff turnover 8%
• Further reduction in staff sickness now at 4%
• Improvement in mandatory training compliance

## Areas of Concern

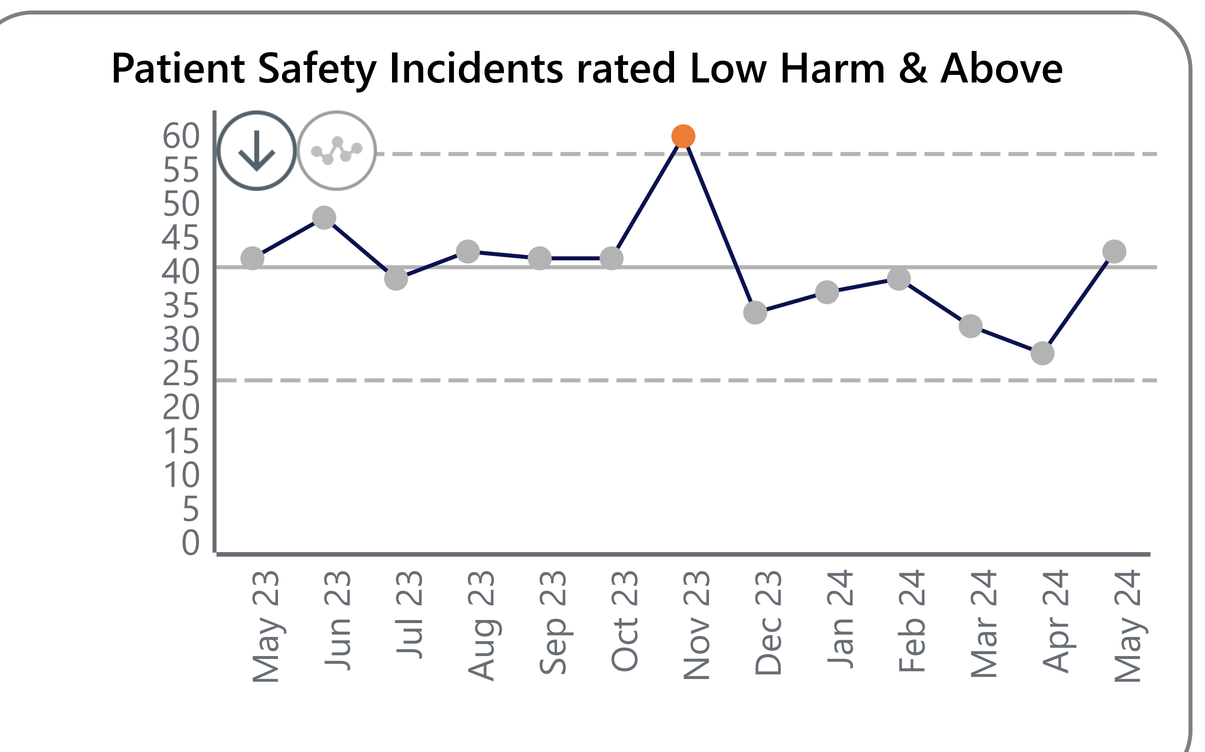
• Increase in incidents related to minor harm and above all of which have been reviewed within divisional governance. Corelating to a reduction in incidents related to no harm and near miss
• Reduction of sepsis % of patients who received antibiotics within 60 min for inpatients, all cases are under review with improvement actions in place and education and learning to be share with key team members
• Theatre utilisation continued to see further reduction, review established to ensure improvement going forward
• Increase in areas of stranded patients for May
• 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
• Overall waiting list size continues to increase

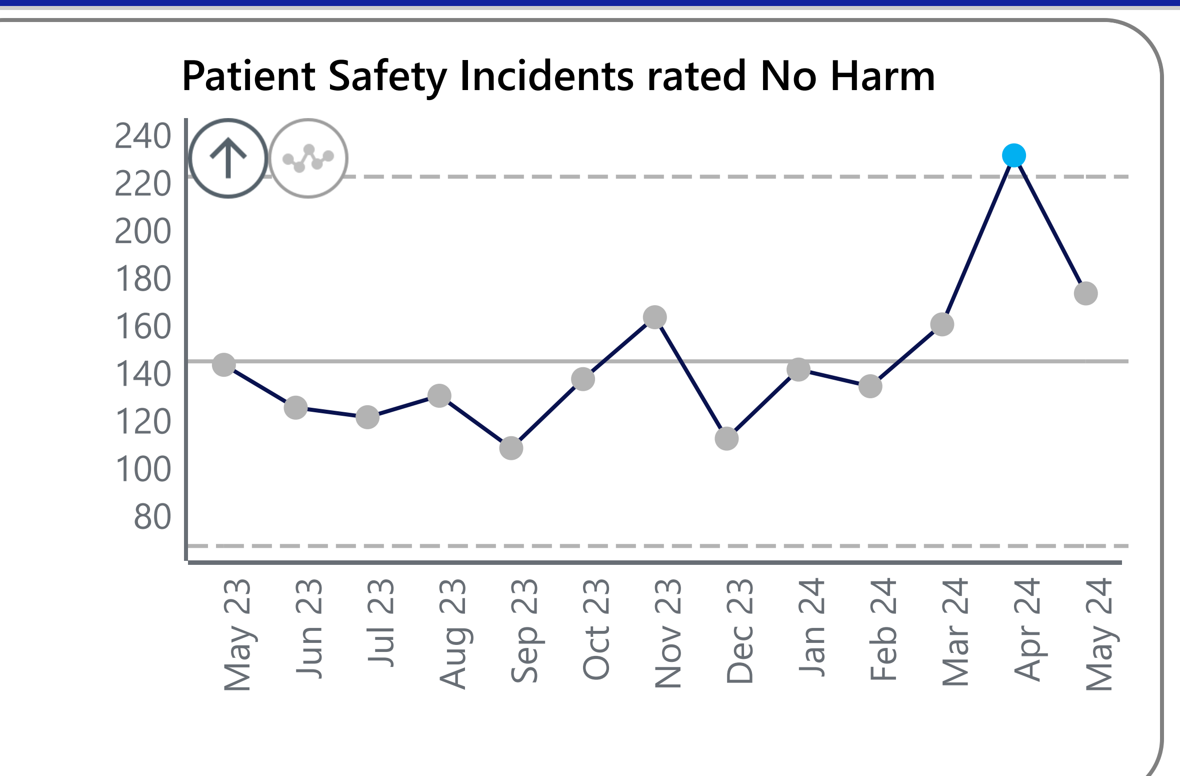
## Forward Look (with actions)

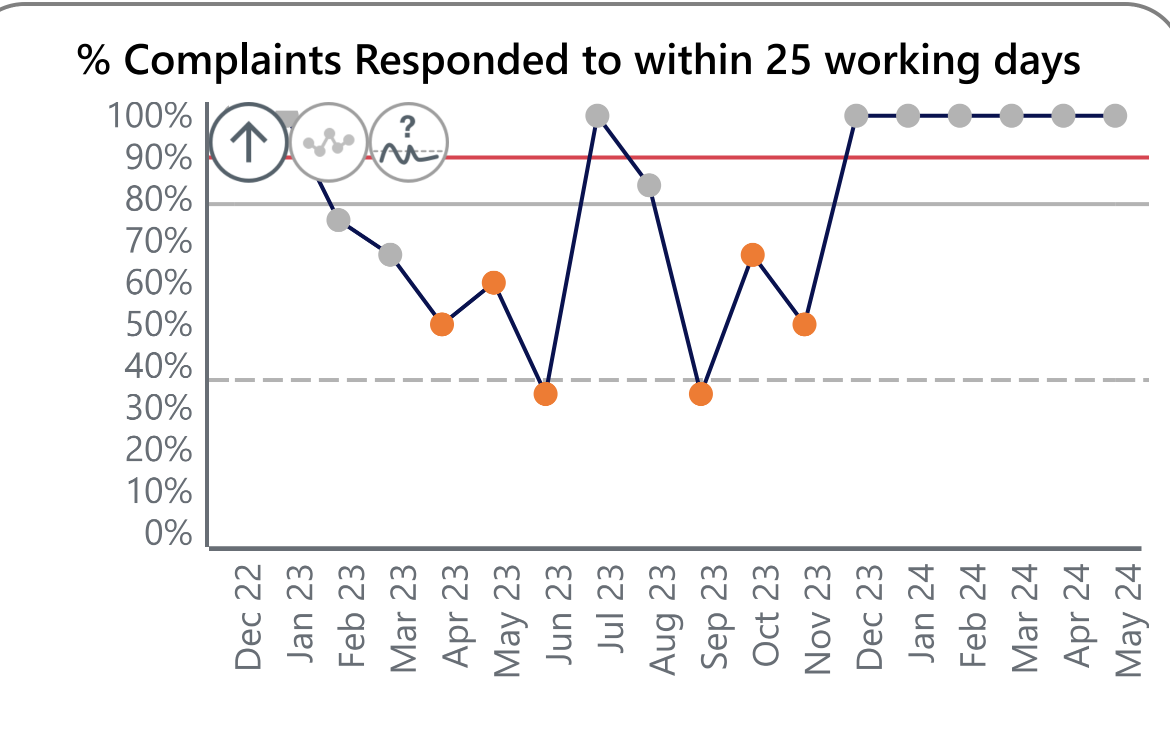
• Focus on delivering improvement for theatre touch time though scheduling and allocation process improvement
• Review of follow up waiting list with each speciality establishing an action plan to tackle long wait back log
• Continued focus on delivering CIP in a financially sustainable manner
• Focus 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

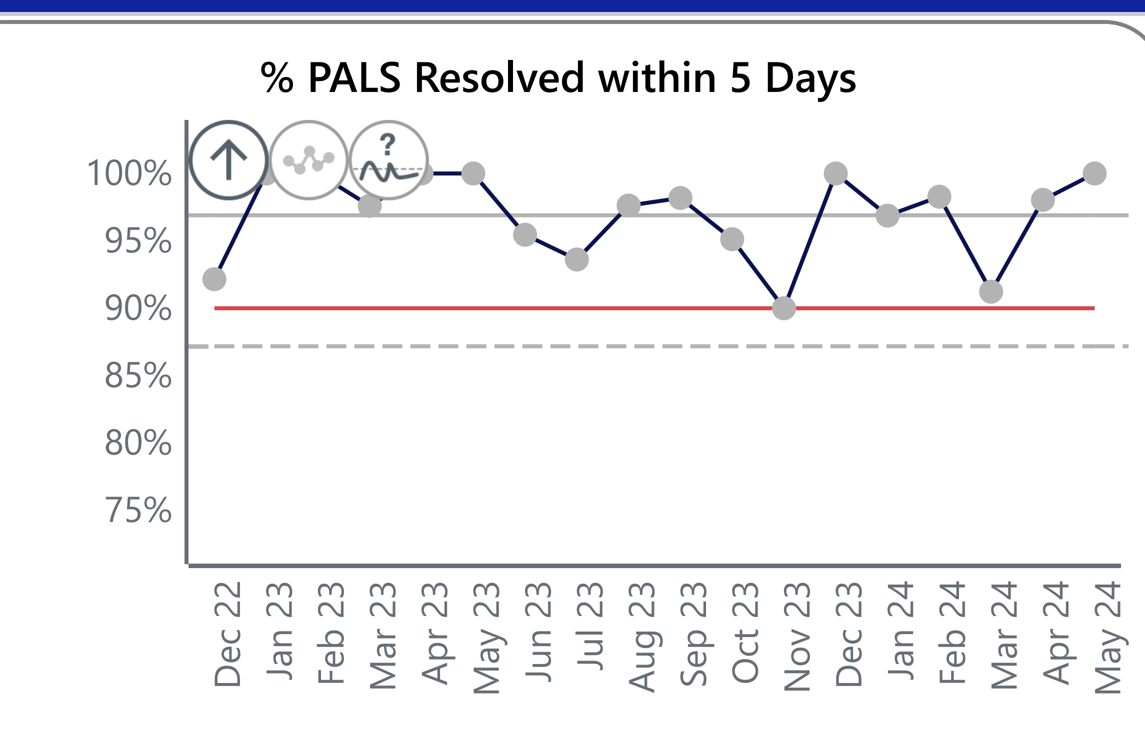
# Integrated Performance Report | June 2024

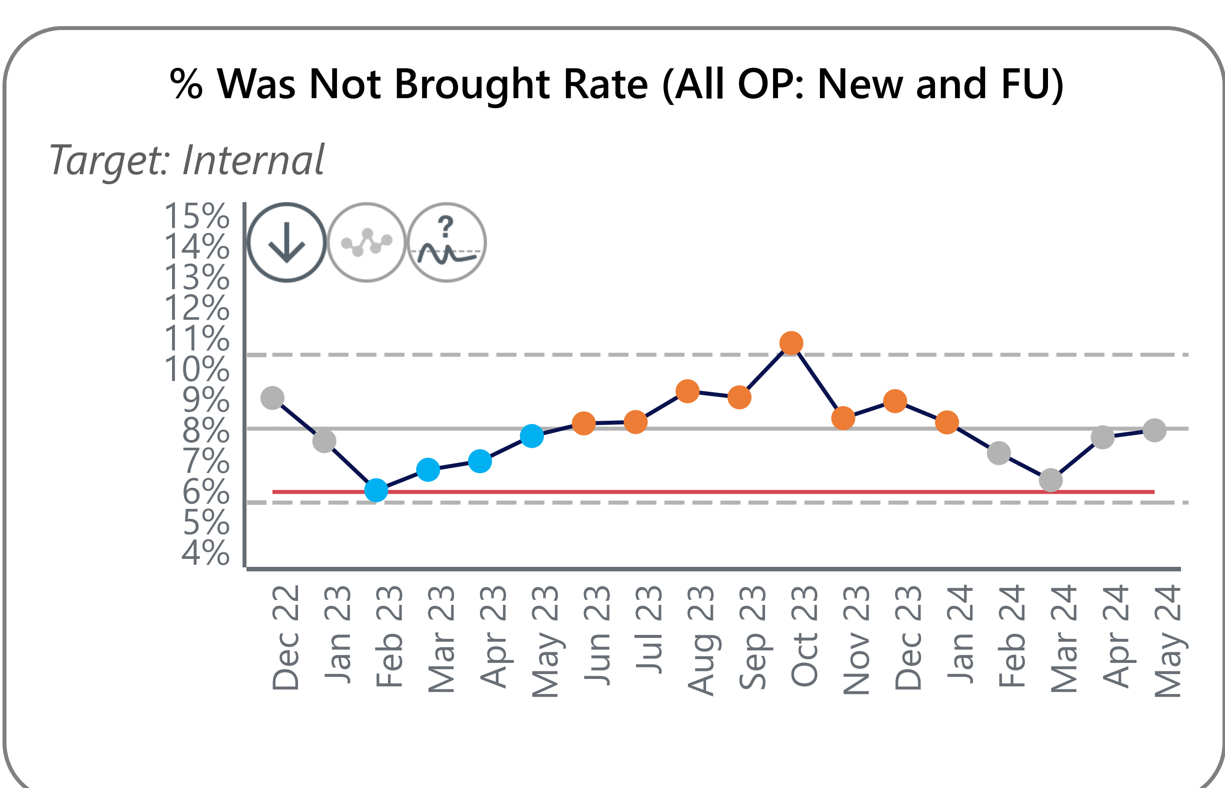
## Divisional Performance Summary - Medicine

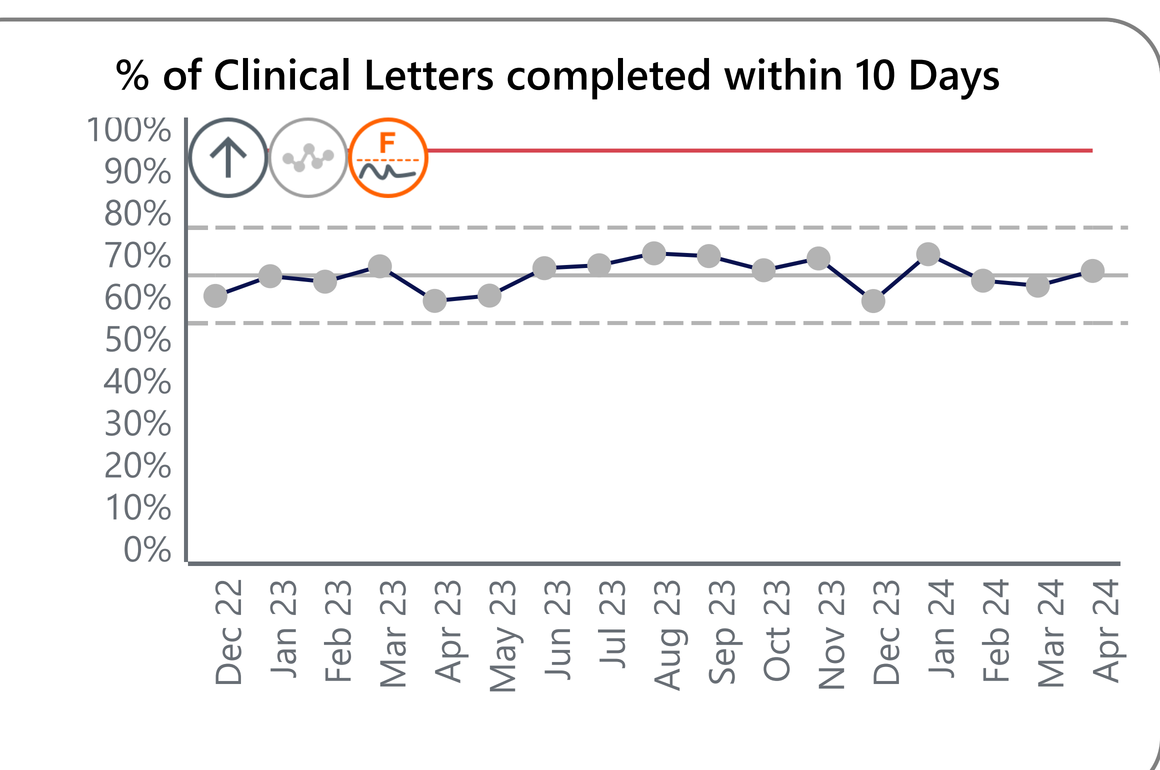


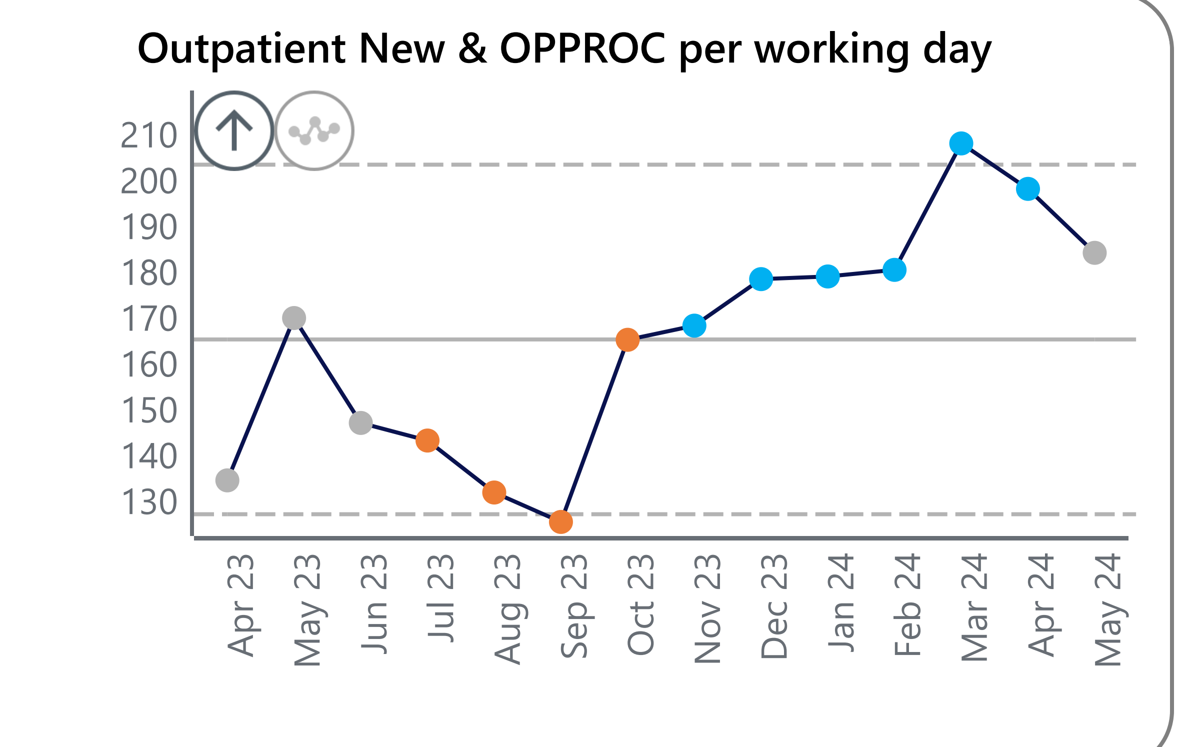



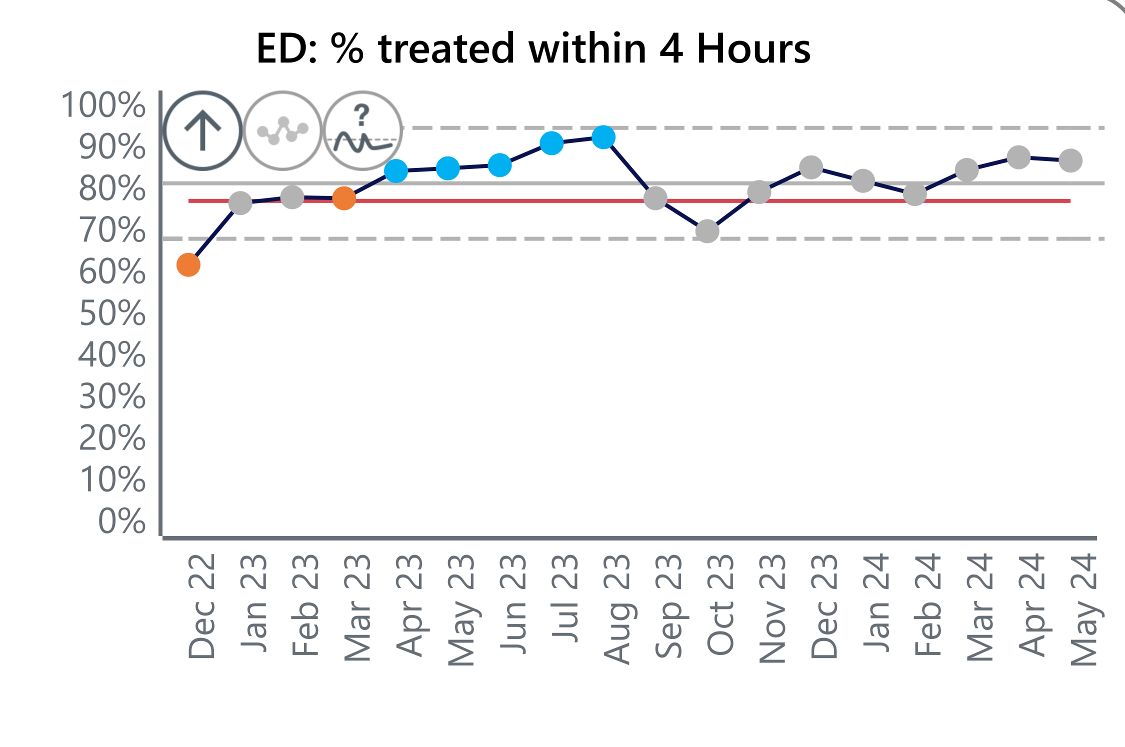



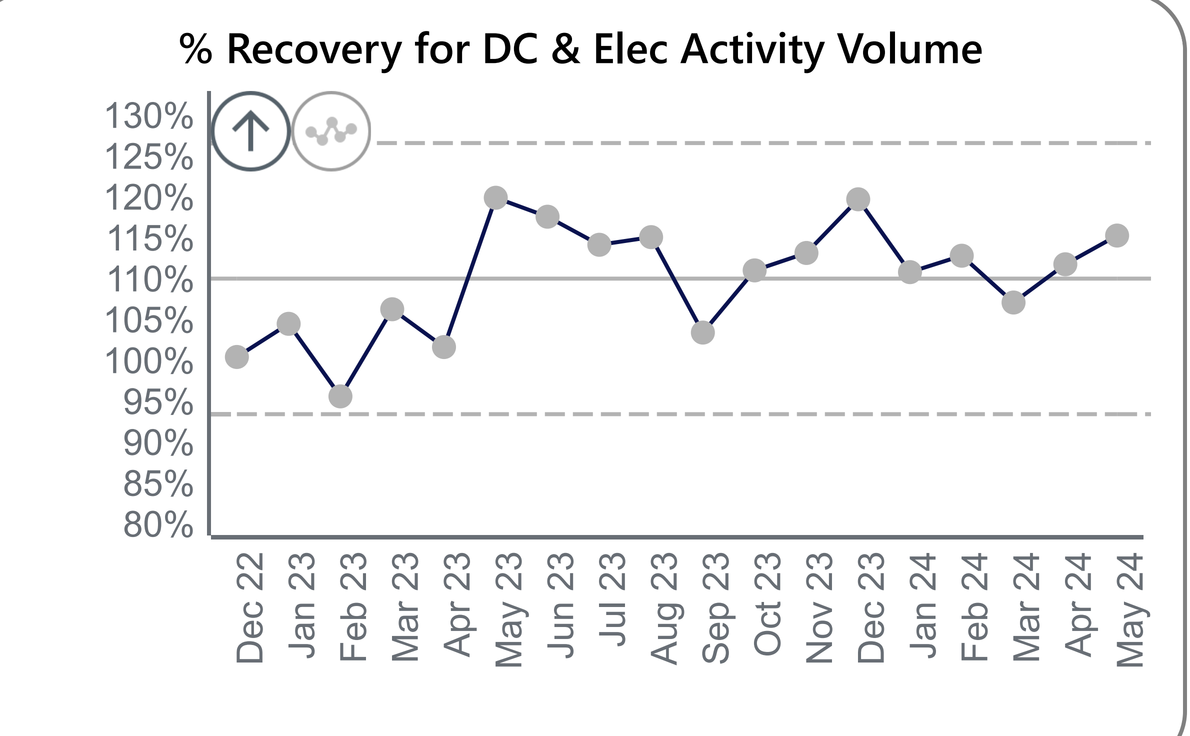



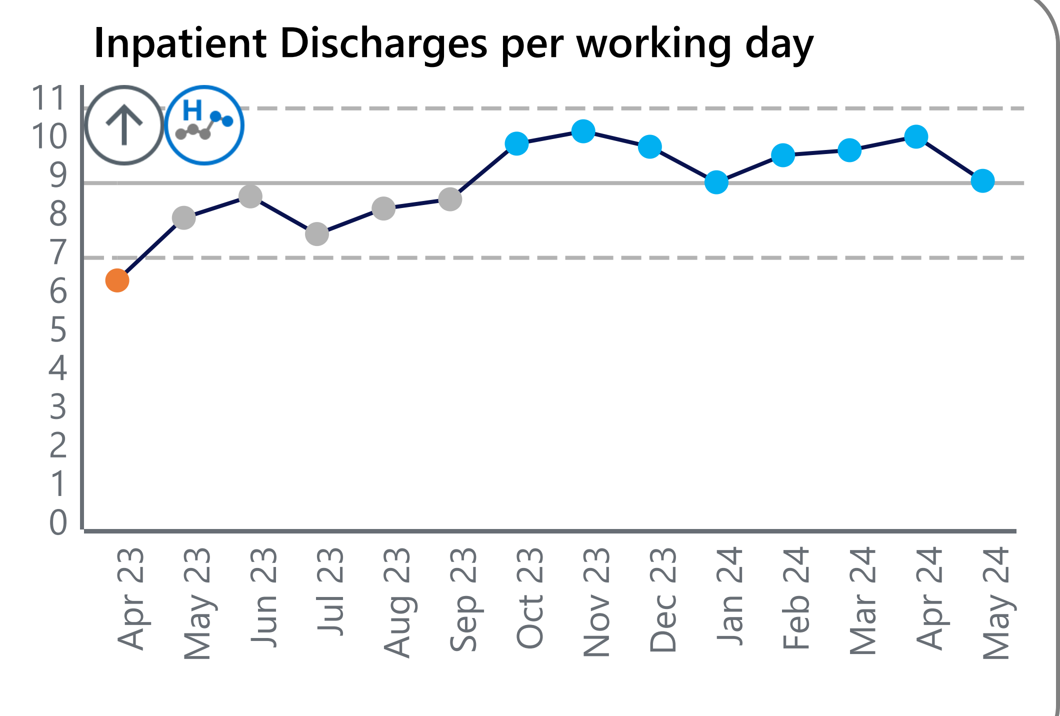



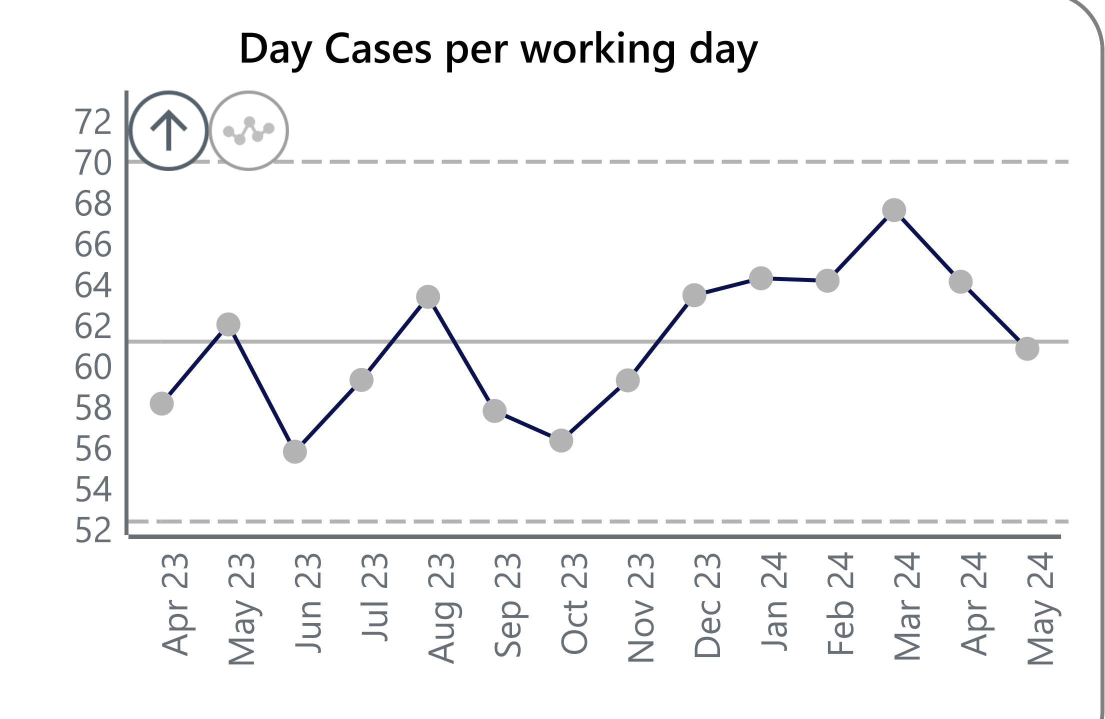



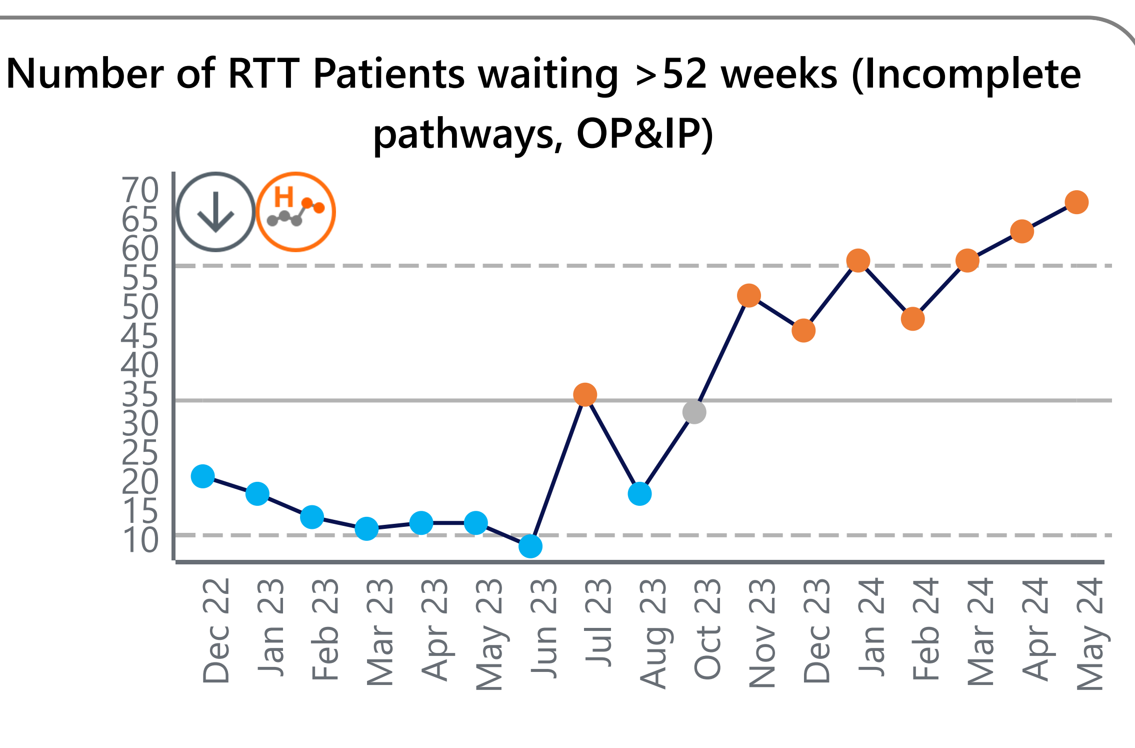



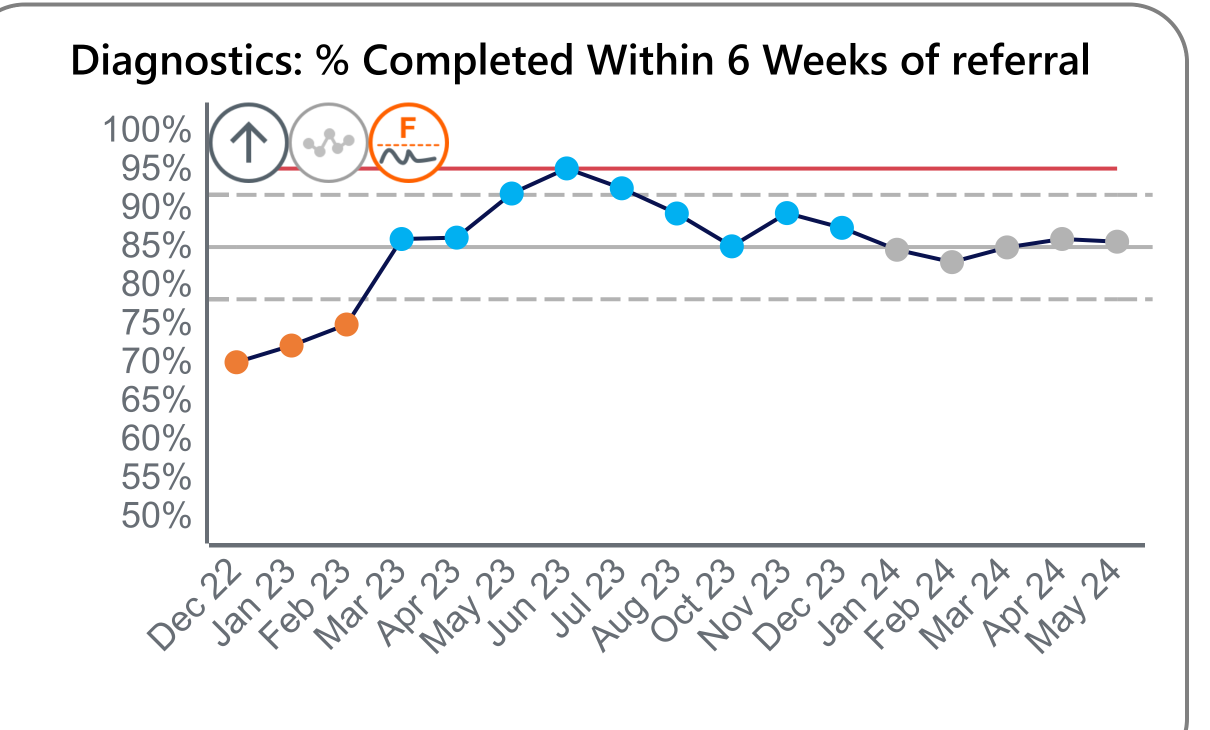



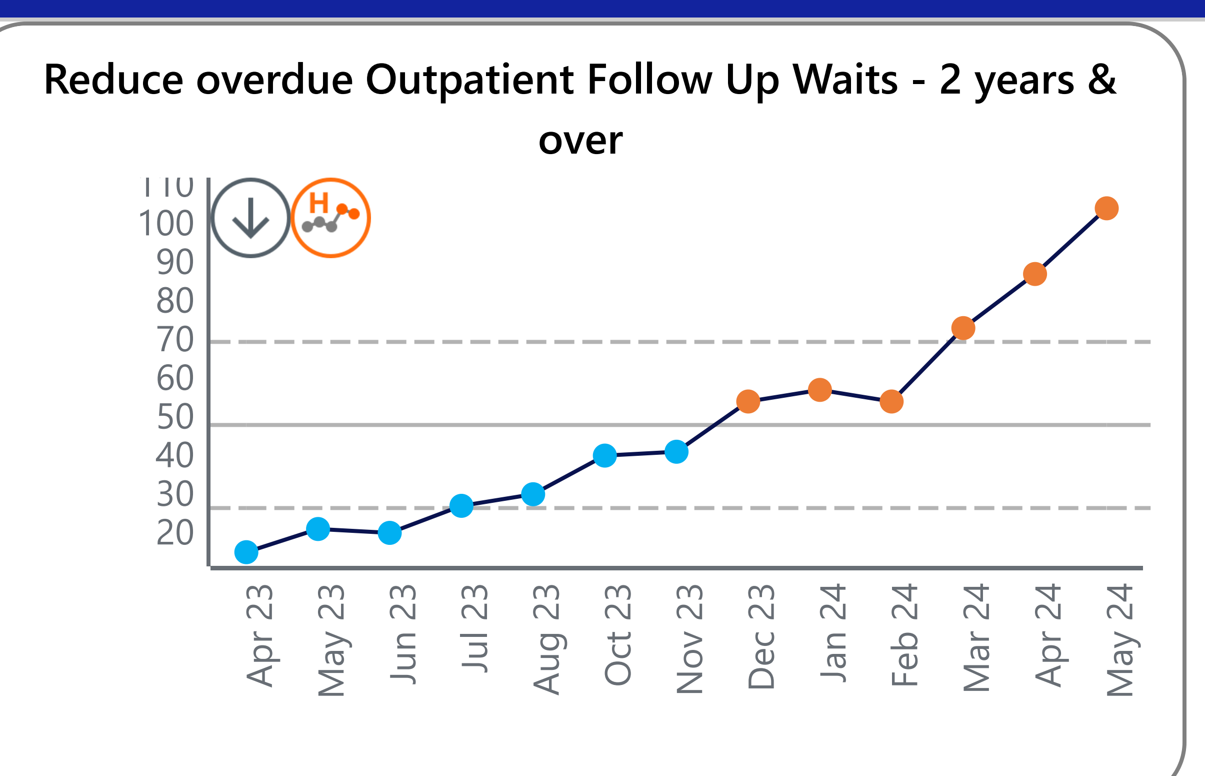



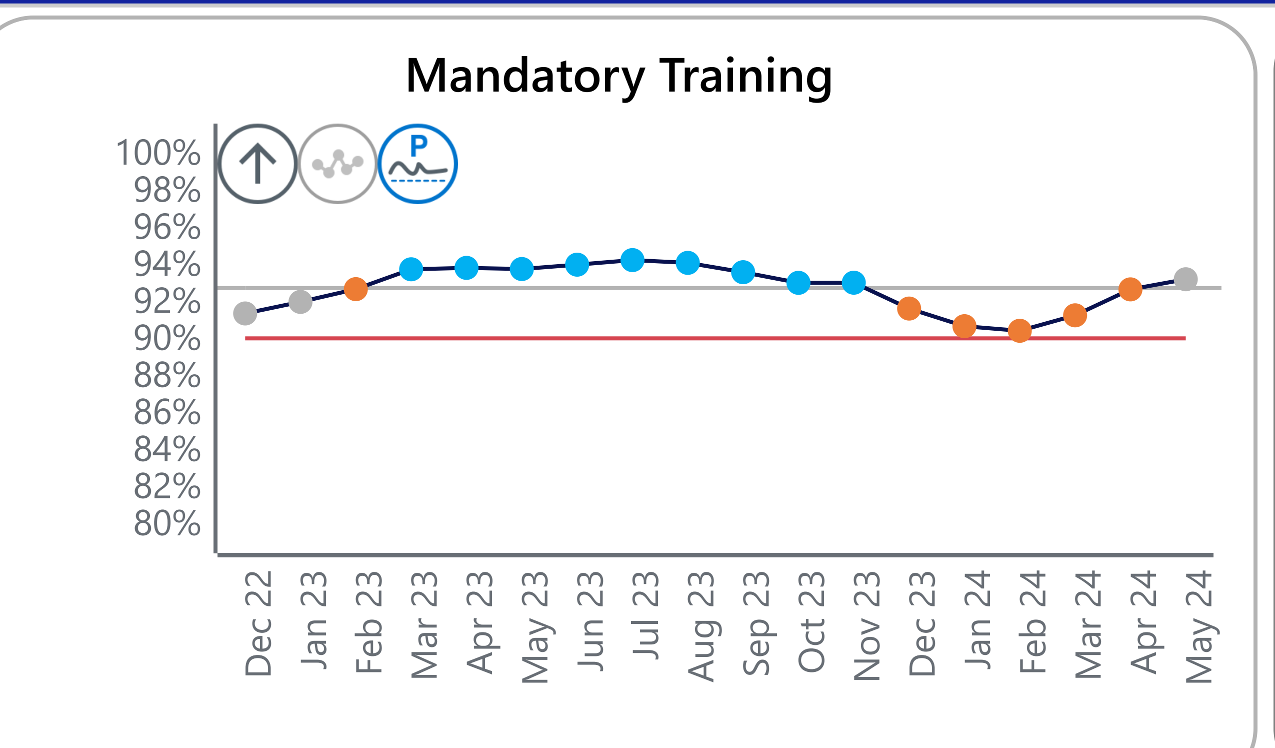



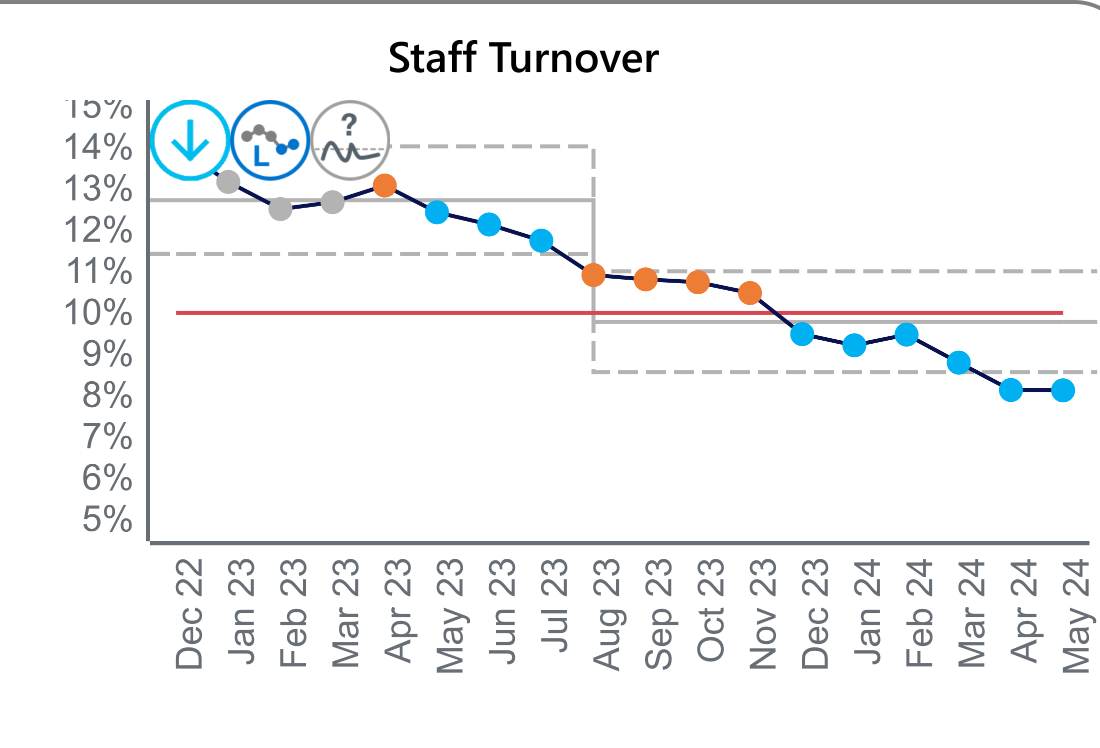
# Integrated Performance Report | June 2024

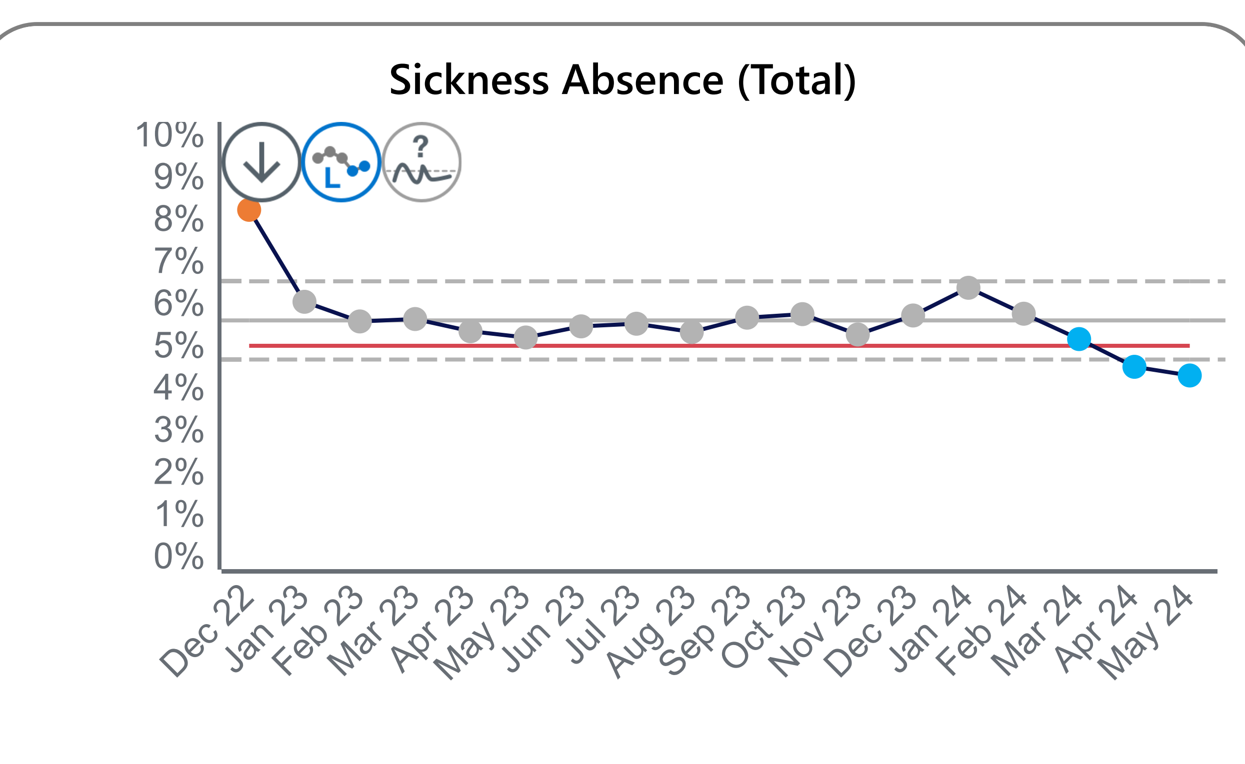
## Divisional Performance Summary - Medicine

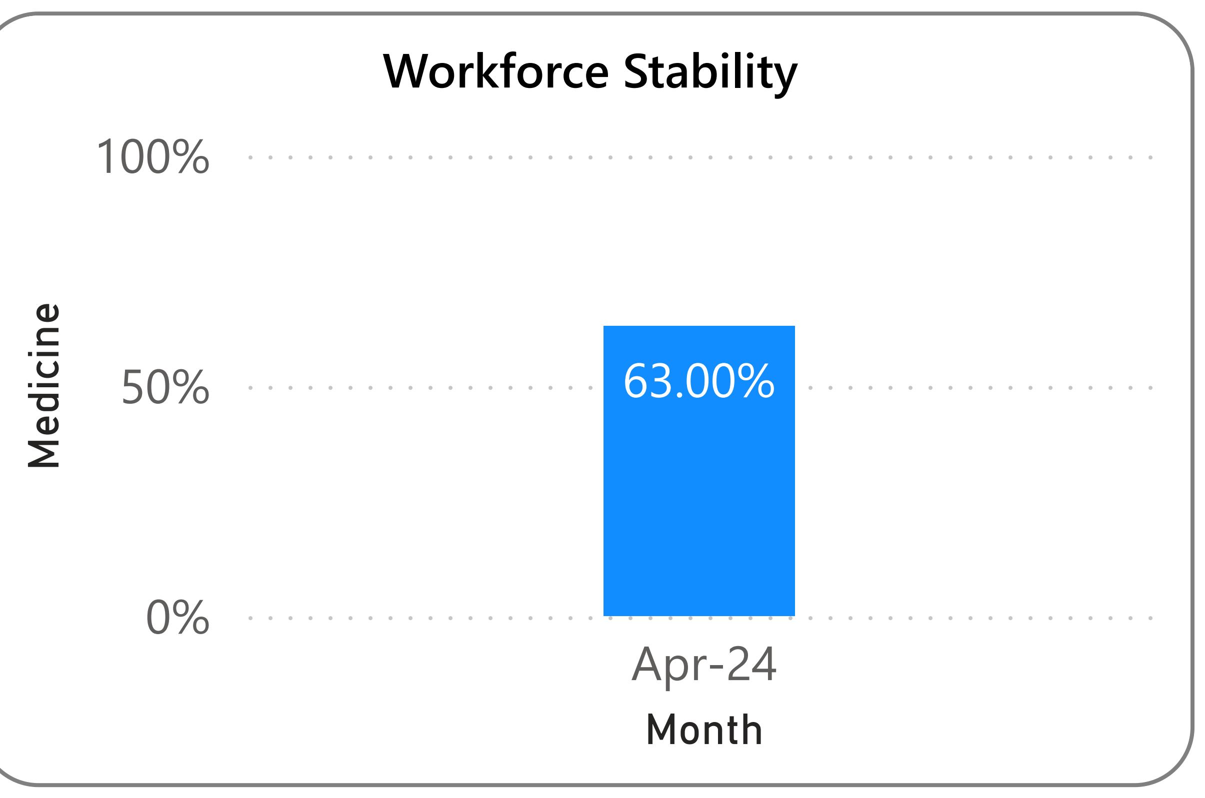


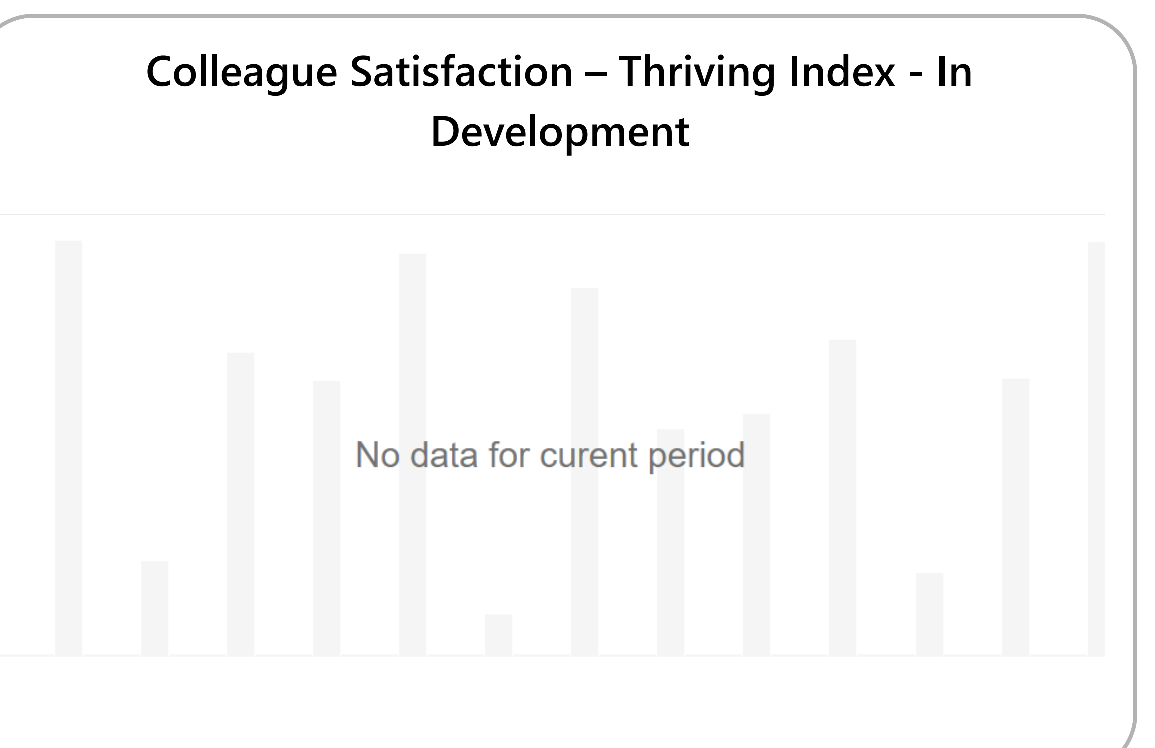



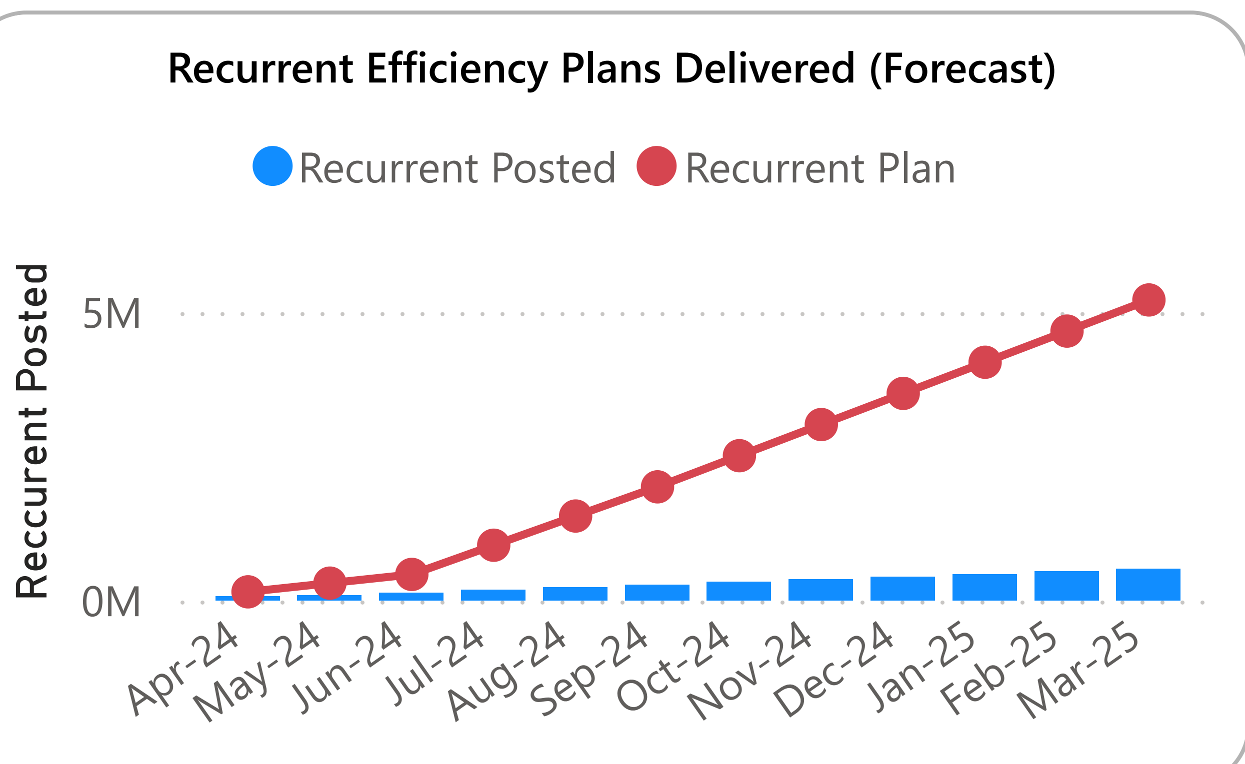



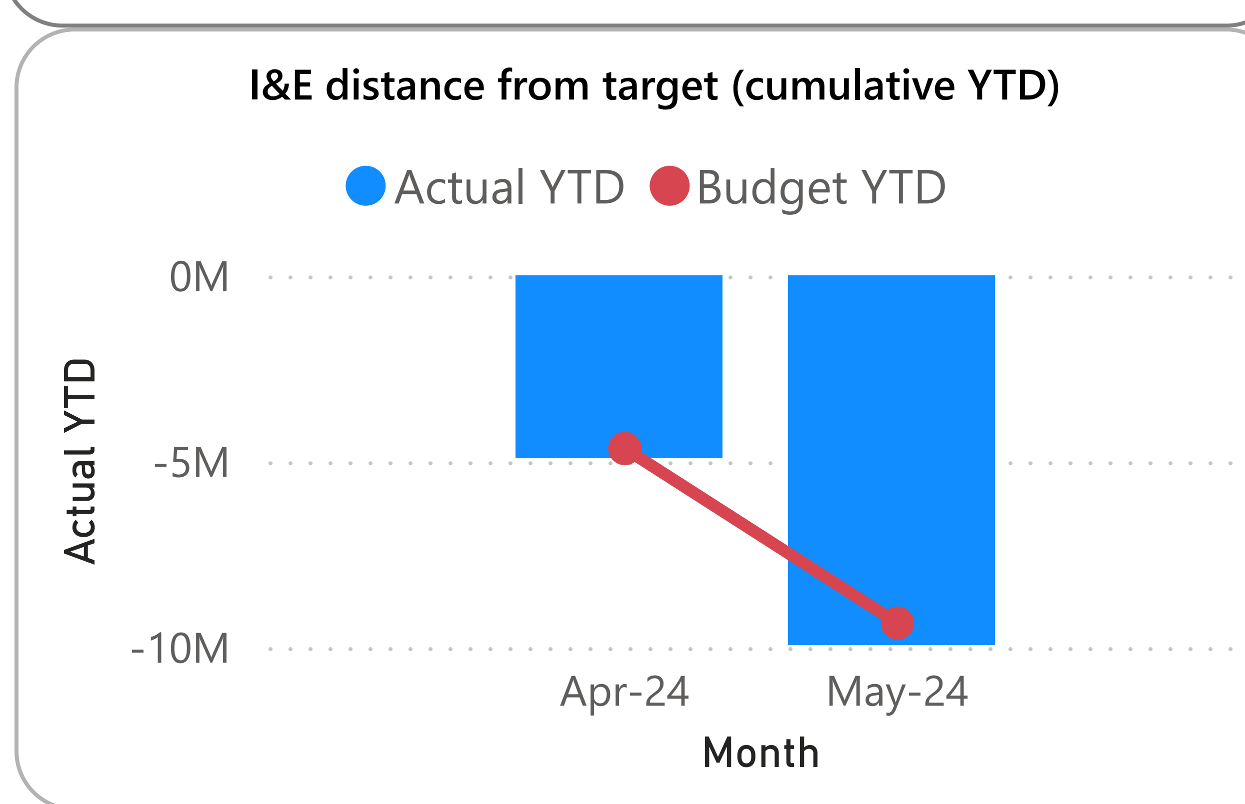



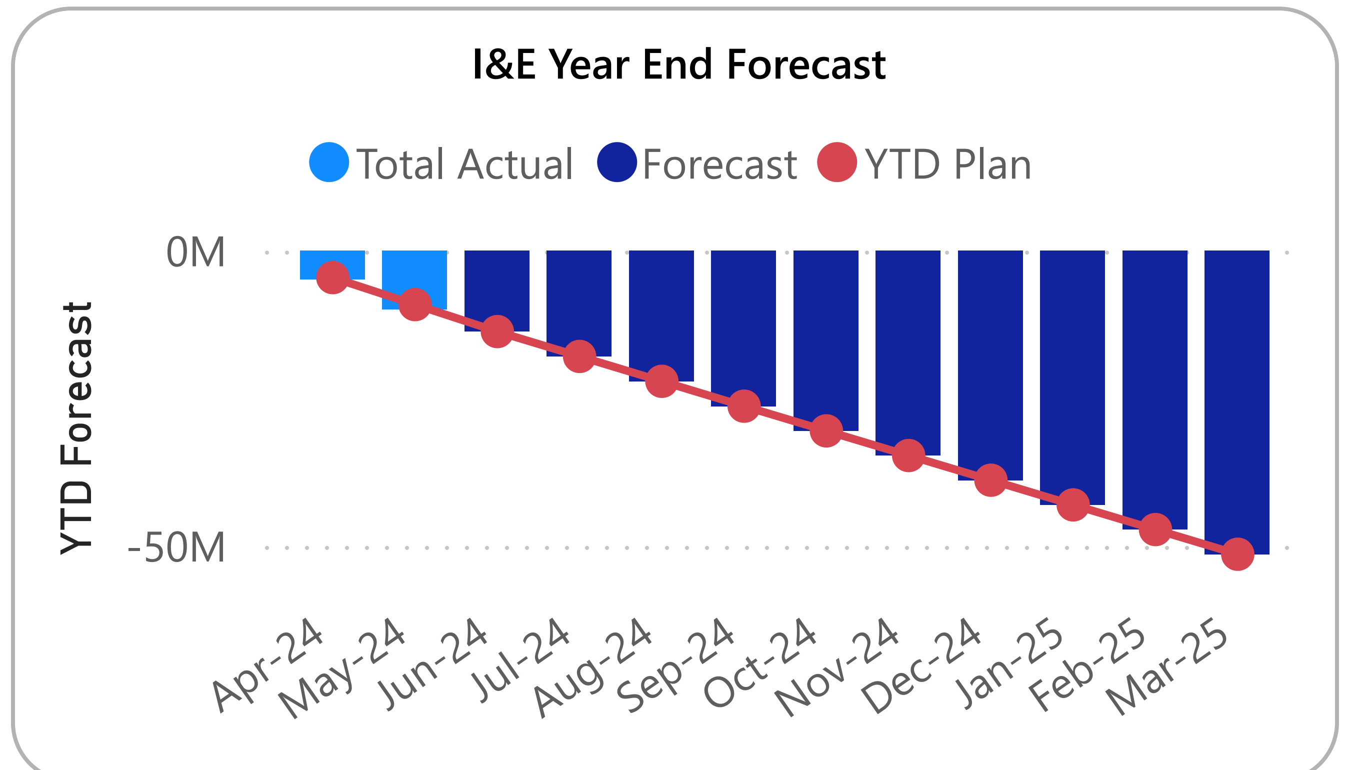



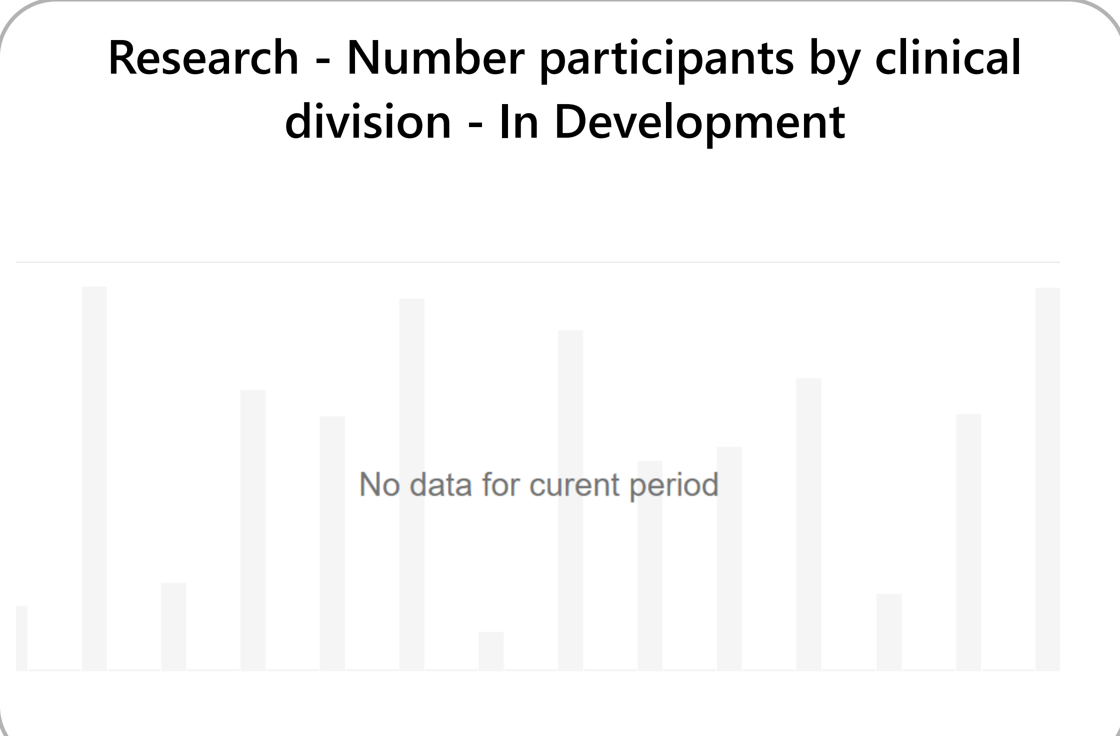



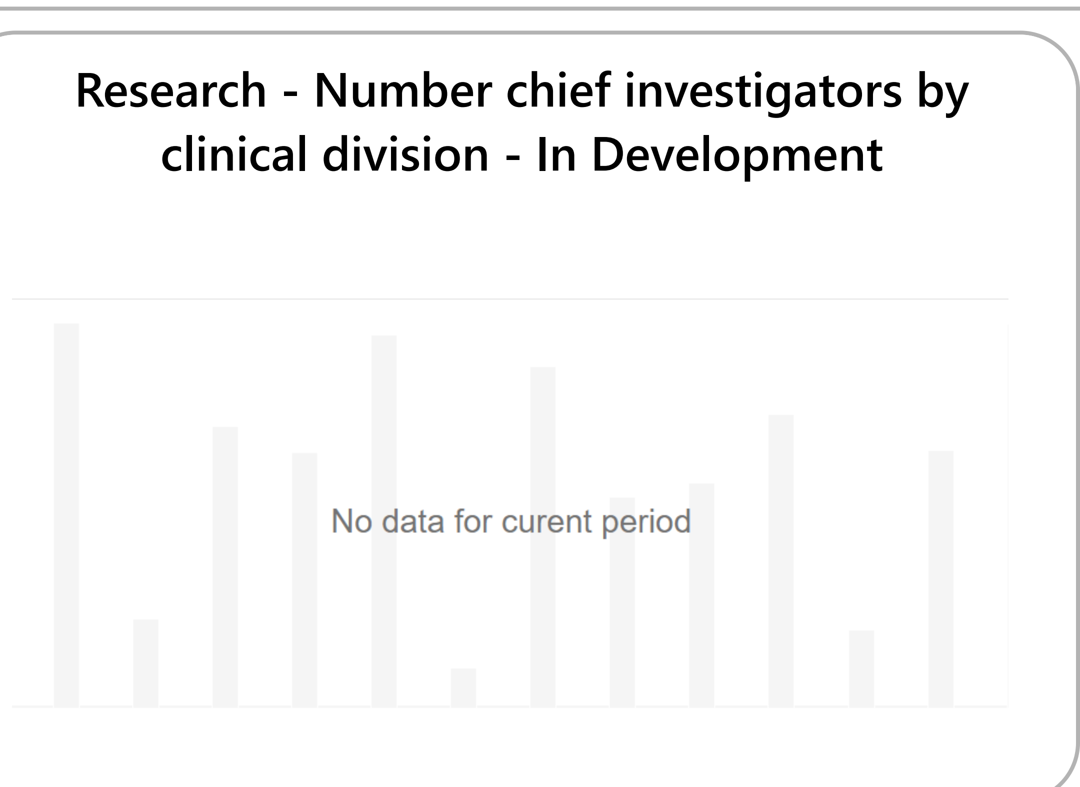



# Divisional Performance Summary - Surgery

**SRO: Benedetta Pettorini, Division of Surgical Care**

## Highlights

- Retained 100% response to PALS & achieved 100% compliance with formal complaints
- Increase in both outpatients & daycases achieved per working day
- Achieved 102% for daycase & elective recovery
- Diagnostic compliance increased at 83% although work underway to sustain delivery
- Inpatient discharges per working day declined
- Mandatory training continues to be above trust target and has increased for the 4th consecutive month
- Staff turnover rates continue to decline and are at trust target in month
- Close to achieving efficiently plans in month with majority being recurrent

## Areas of Concern

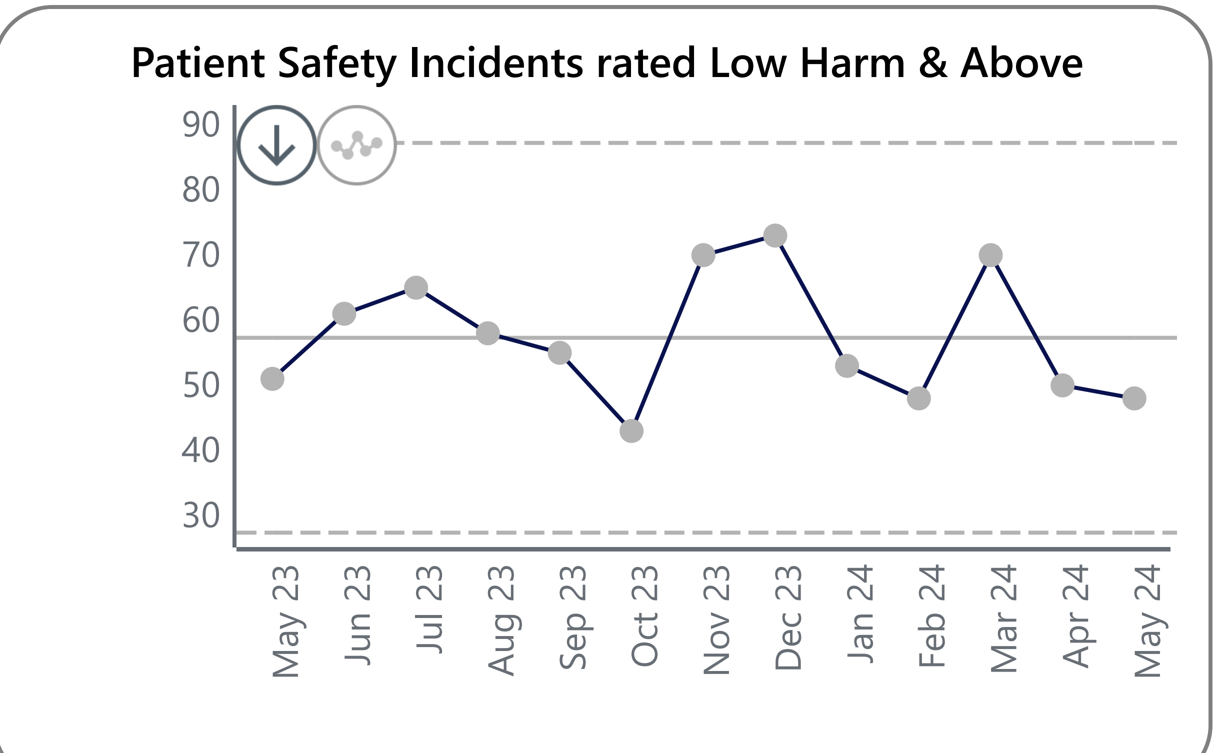
- WNB remains above target for division despite improvements in previous areas of challenge
- Although number of patients waiting over 52 weeks continued to decline for the 3rd month, still a high volume- however performing against trajectory
- Overdue follow ups continue to increase- local plans underway in some specialties but requires trust wide support around how we manage capacity issues and sustainability of access times
- Financially our forecast looks challenging with a significant issue within non-pay

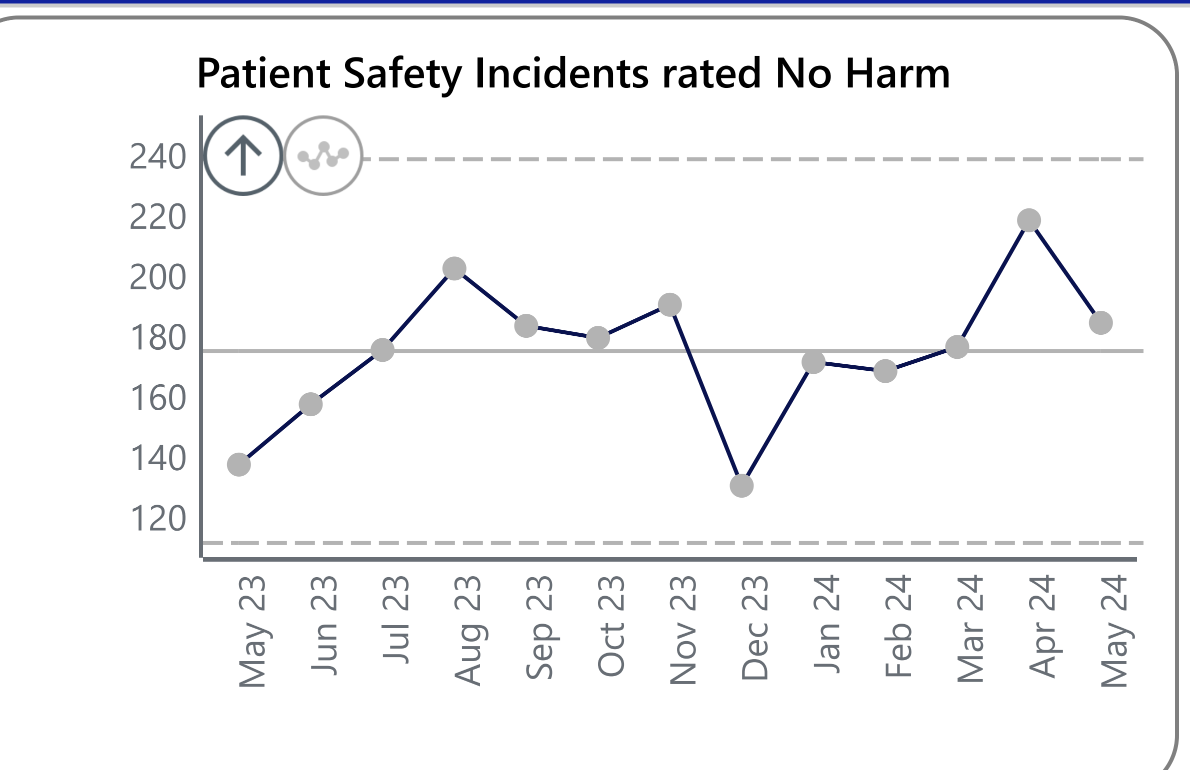
## Forward Look (with actions)

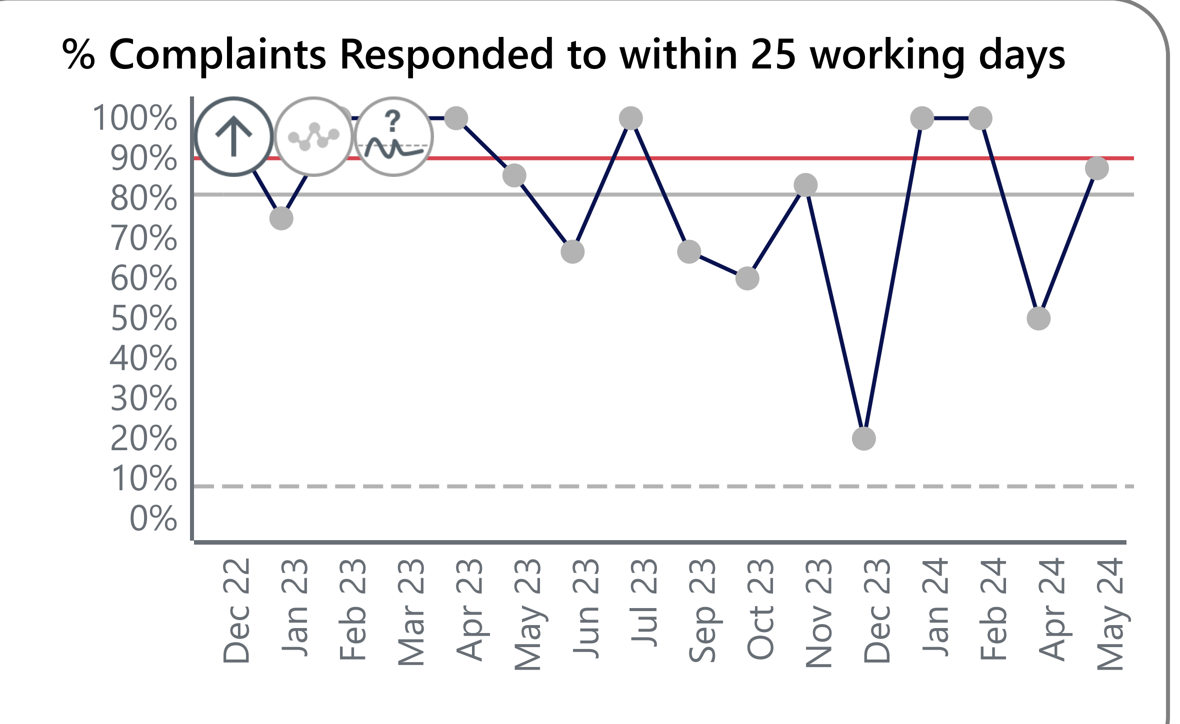
- Despite performing against activity plan, income achieved is lower in some speciality areas - deep dive underway
- Productive outpatients to focus on key improvement workstreams to include WNB
- Review of Orthotics booking & scheduling processes who have a high WNB rate
- Sickness absence remains under close monitoring and LTS remains under good management
- Ongoing actions in place at a specialty level to achieve 0 CYP waiting over 52 weeks by March 2025
- Productive theatres group underway with clear workstreams to deliver increased activity in areas of opportunity & increase theatre utilisation
- Division to review data behind discharges per day targets & review areas of opportunity
- Number of key actions in place to address non-pay challenges: clear working with procurement for theatres and wards, senior links with pharmacy to review benefits, targeted drugs savings within theatres, review of options around linking device expenditure with income

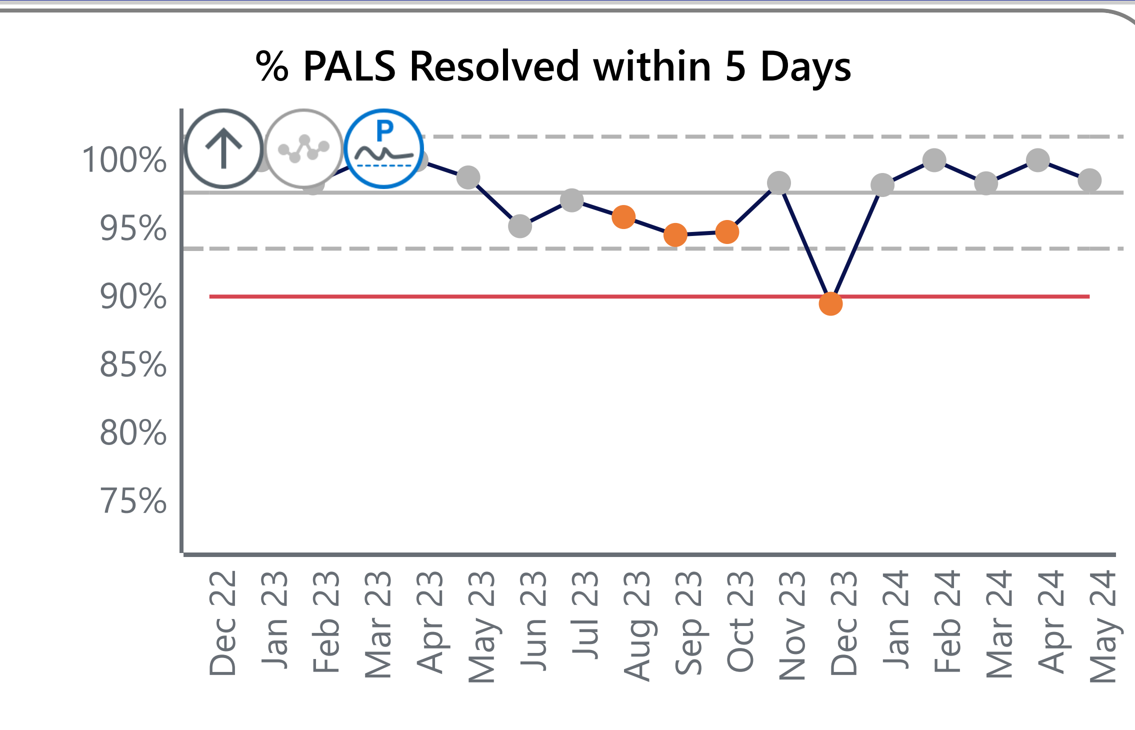
Integrated Performance Report | June 2024

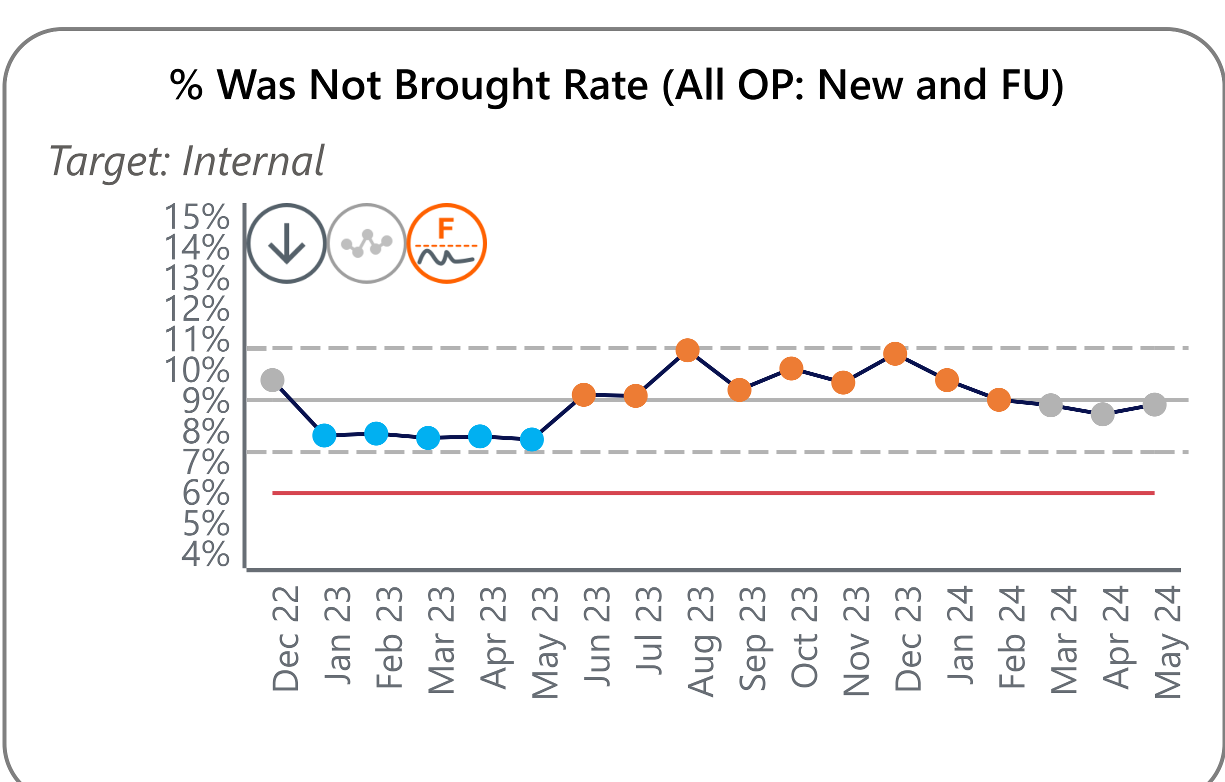
# Divisional Performance Summary - Surgery

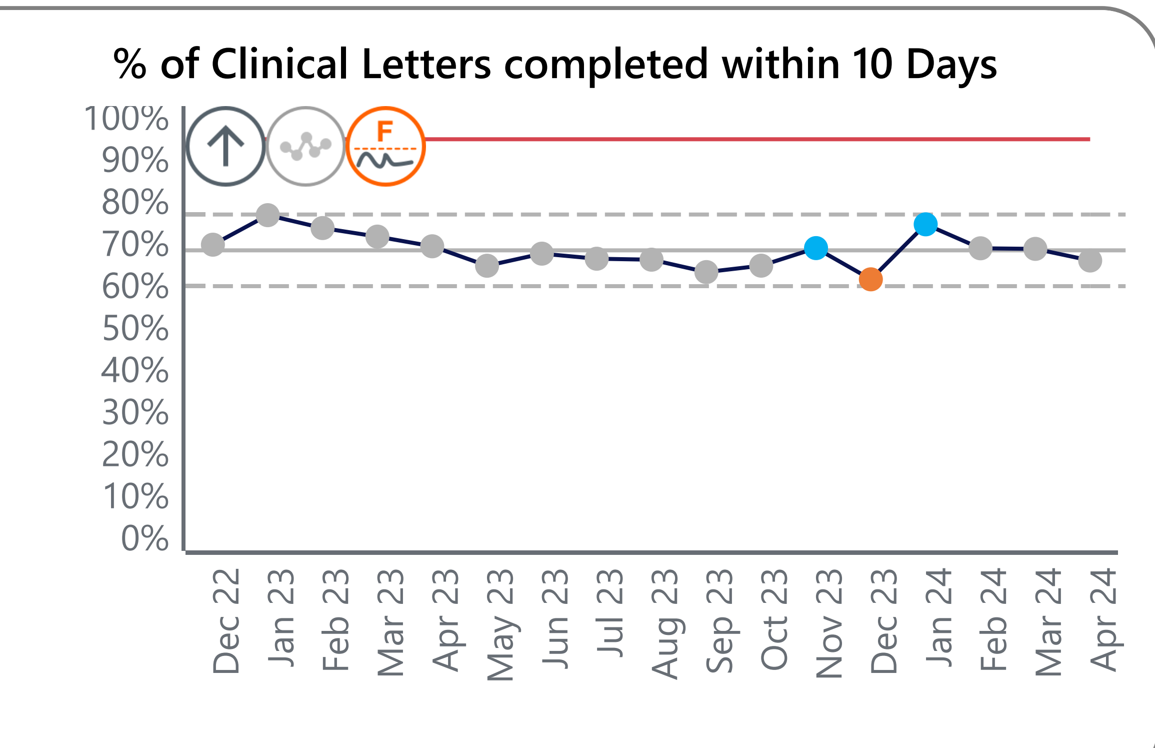


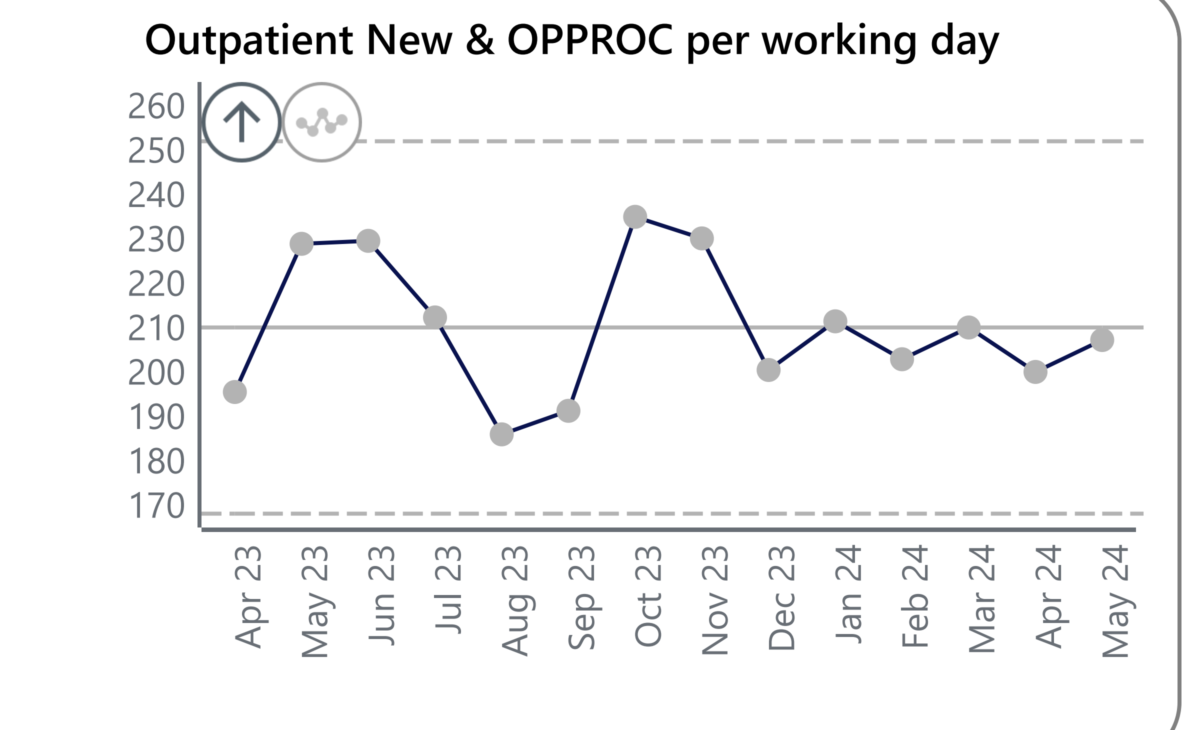



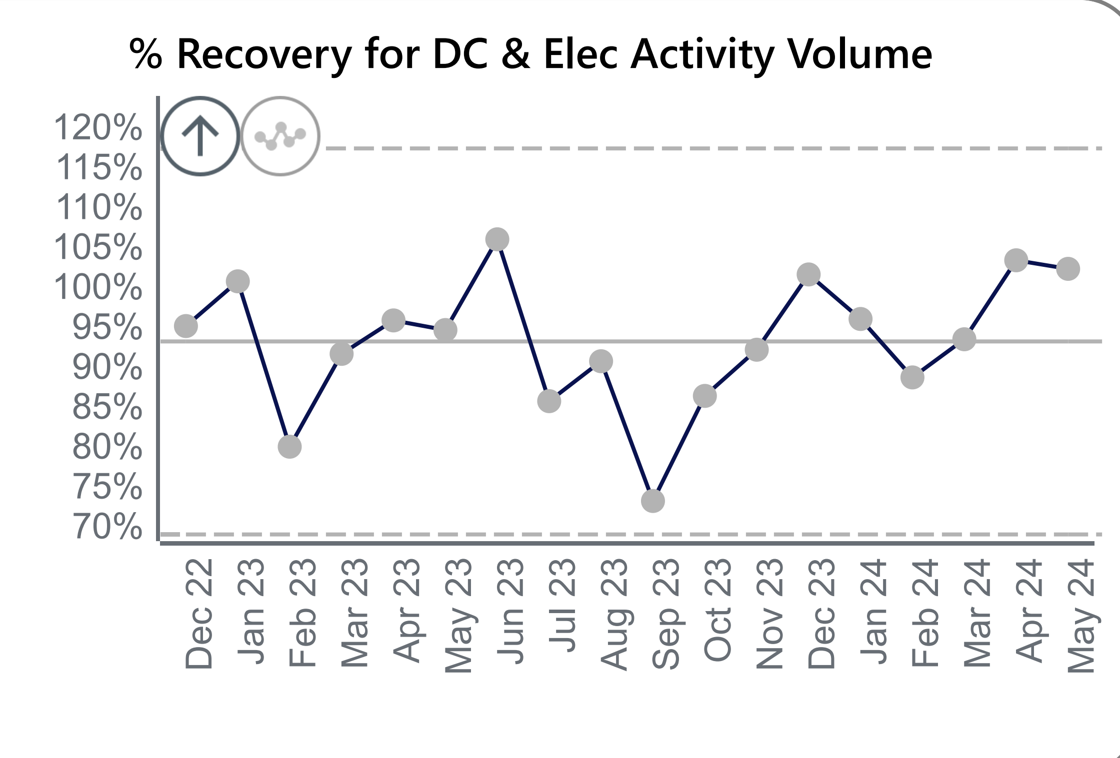



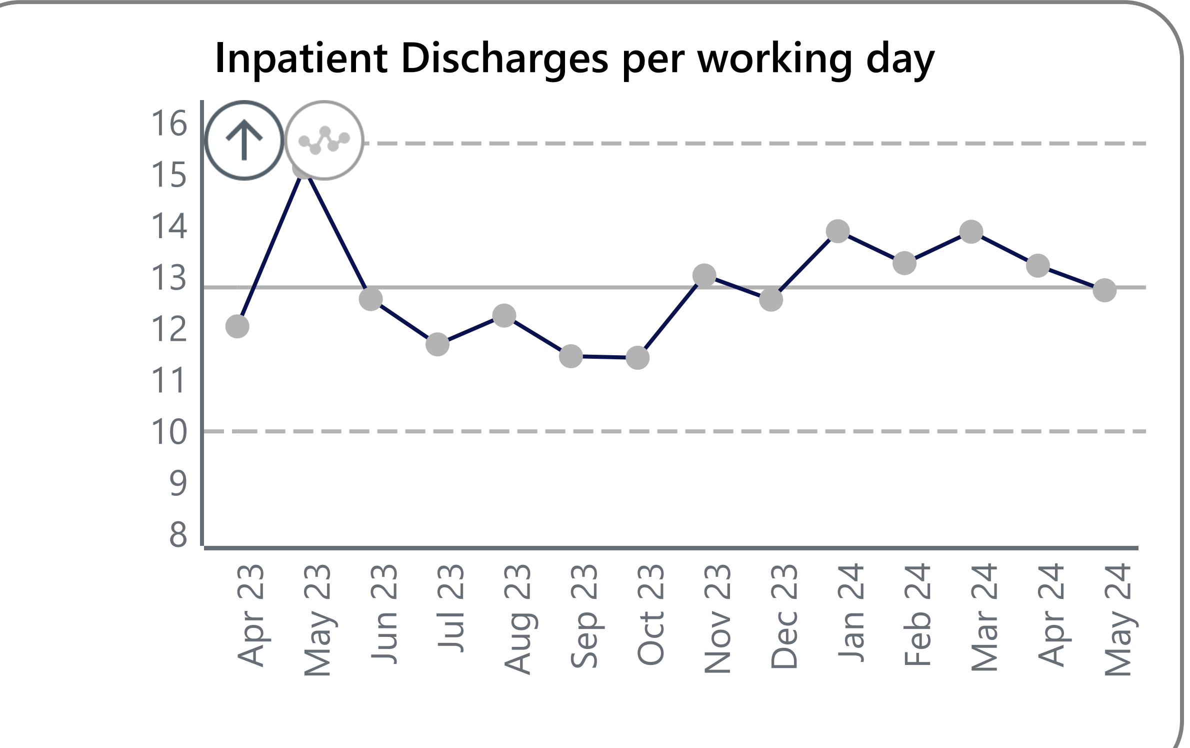



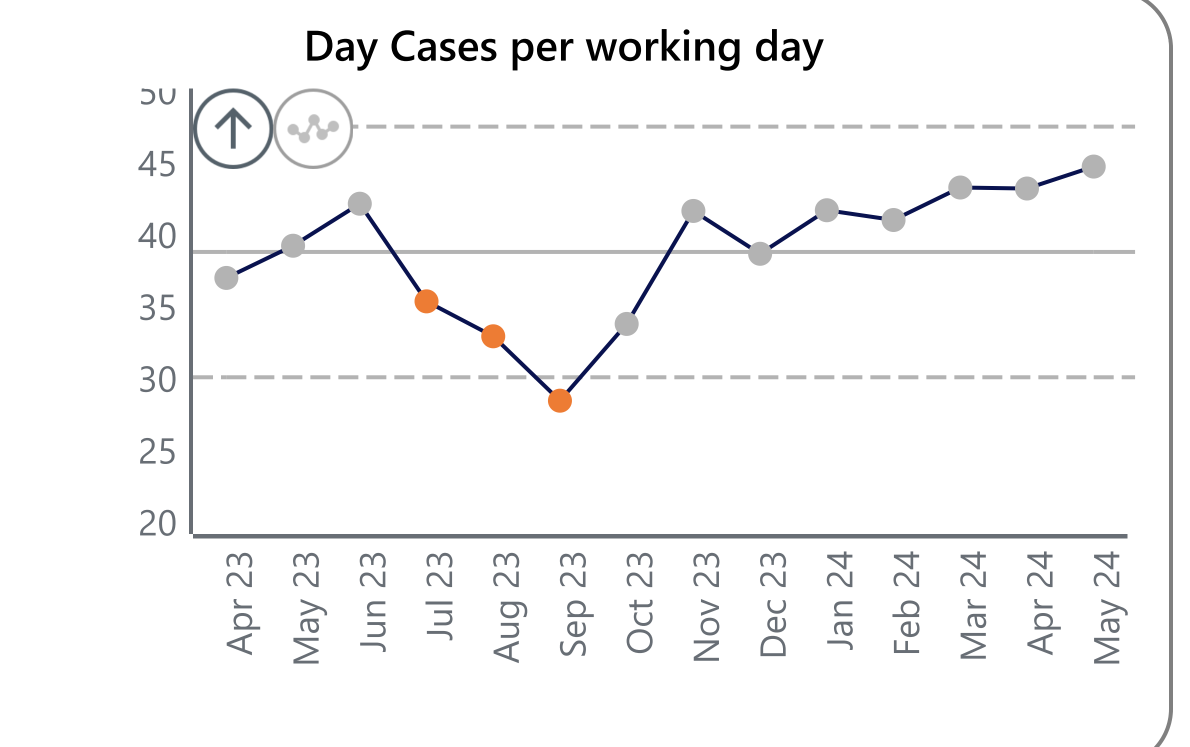



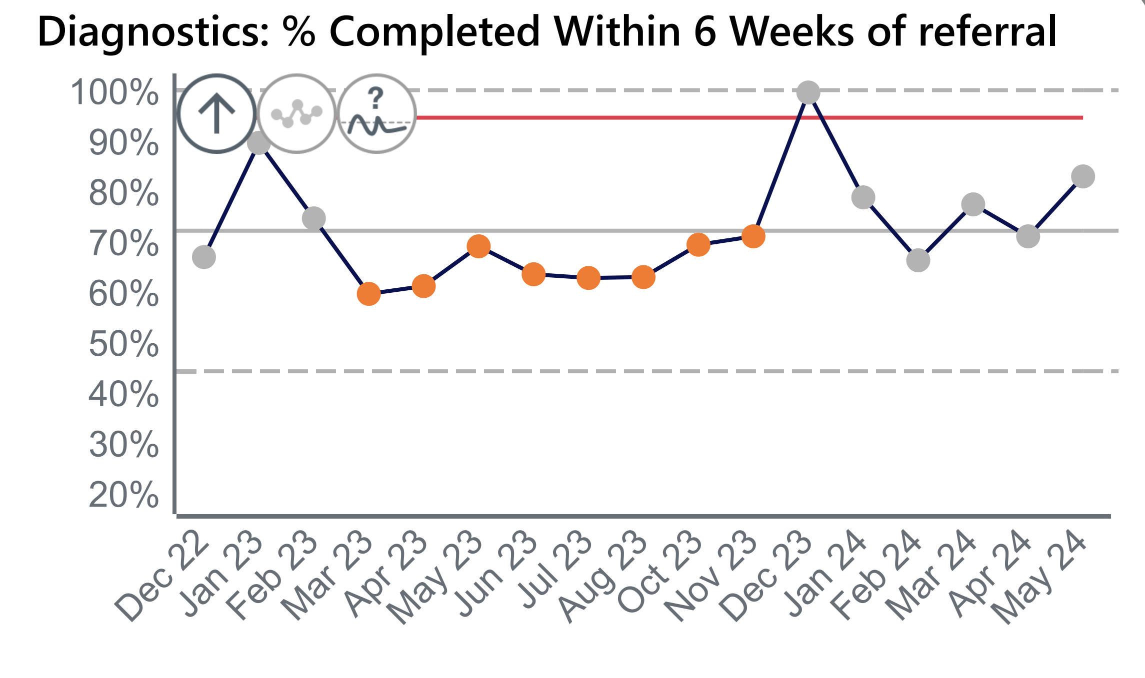



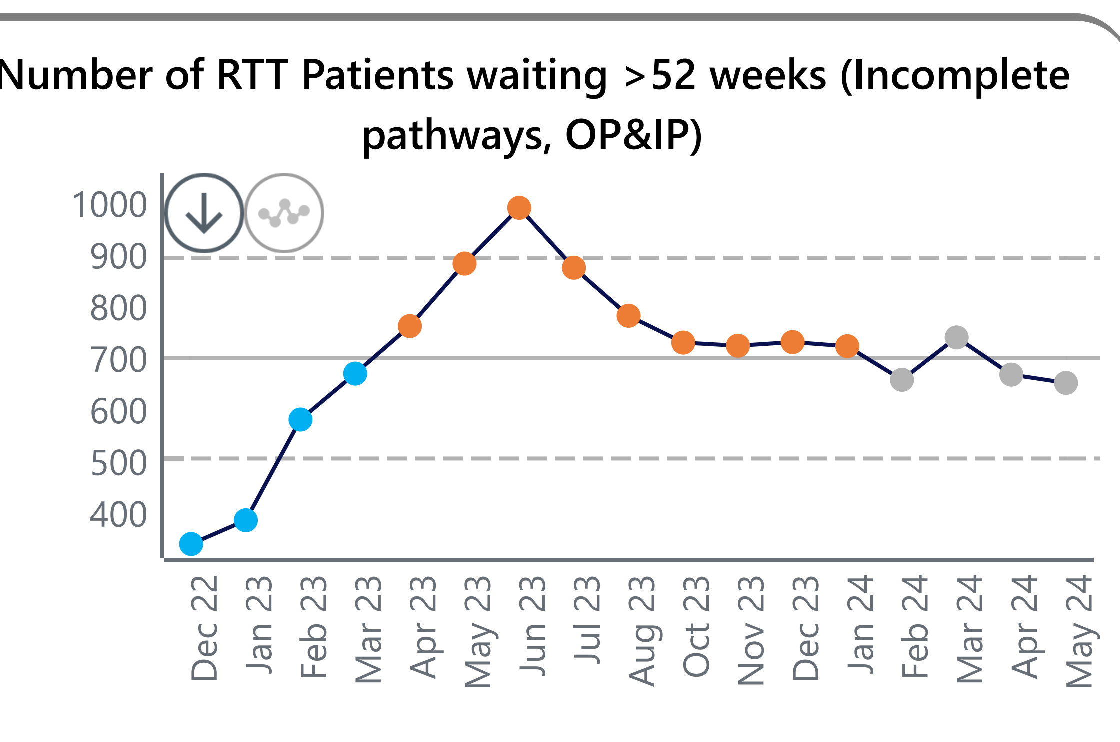



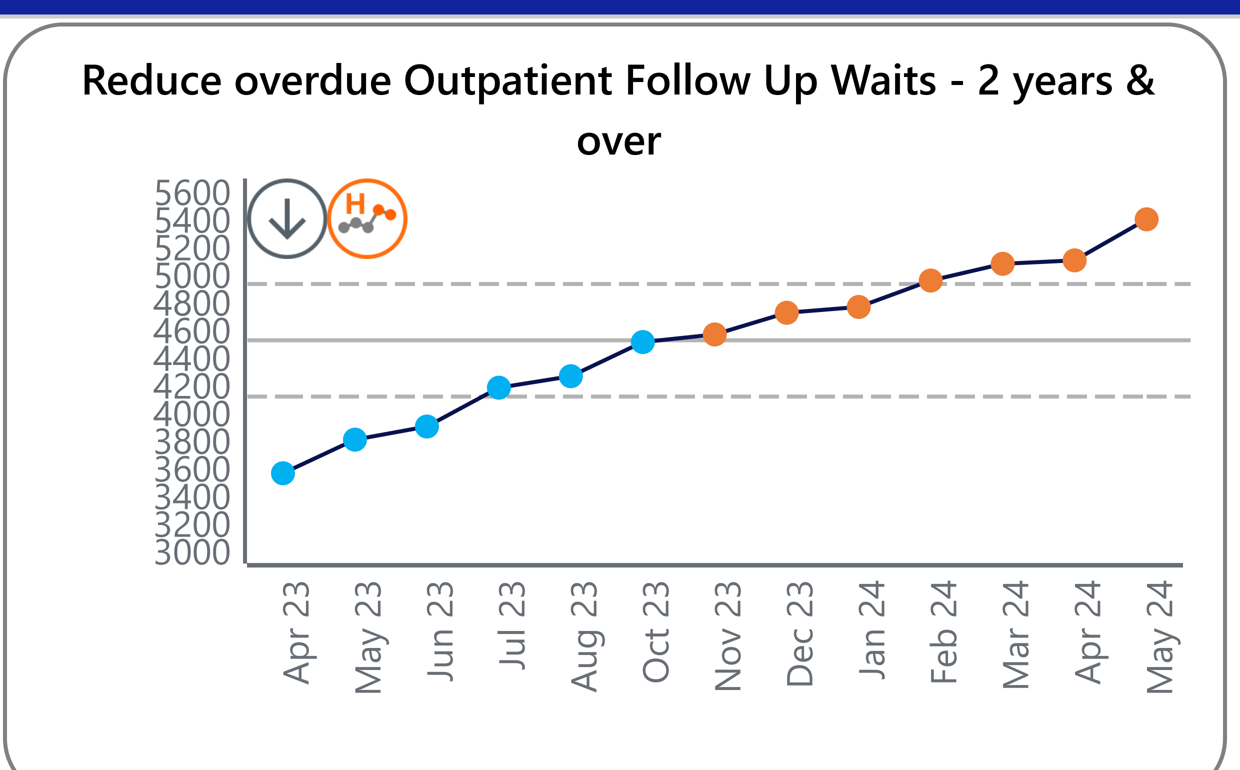



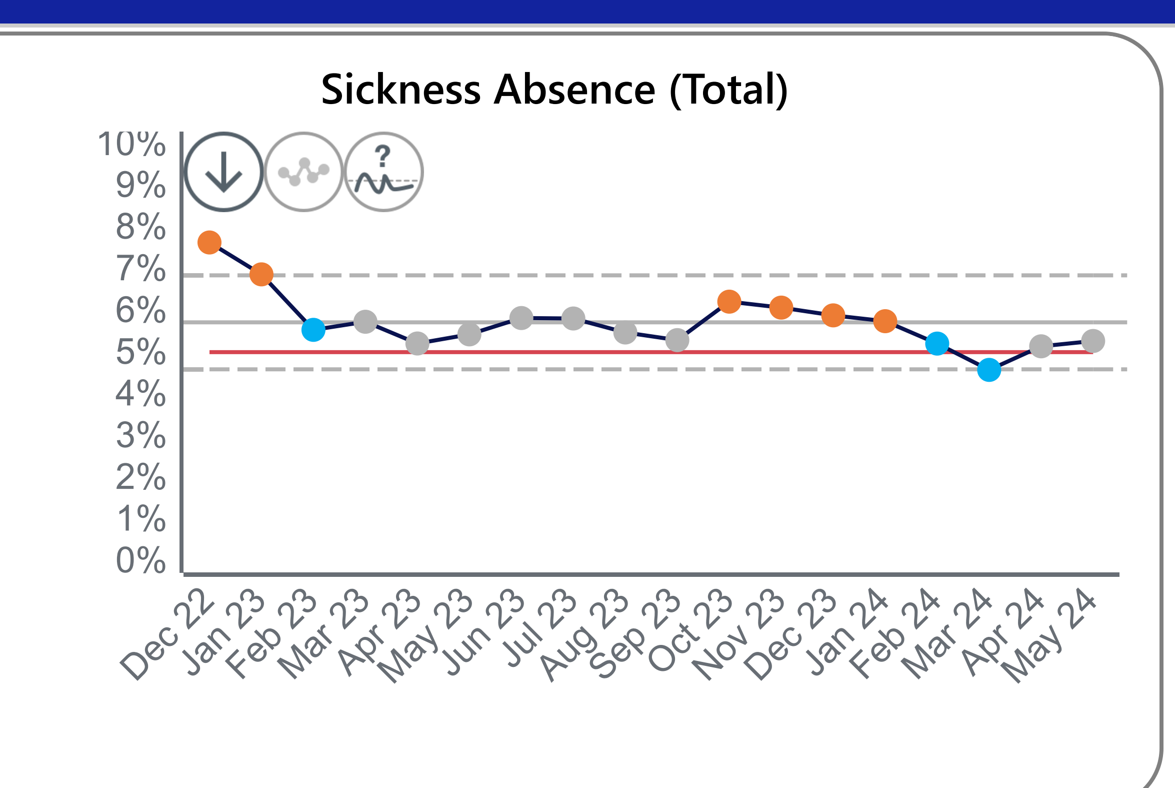



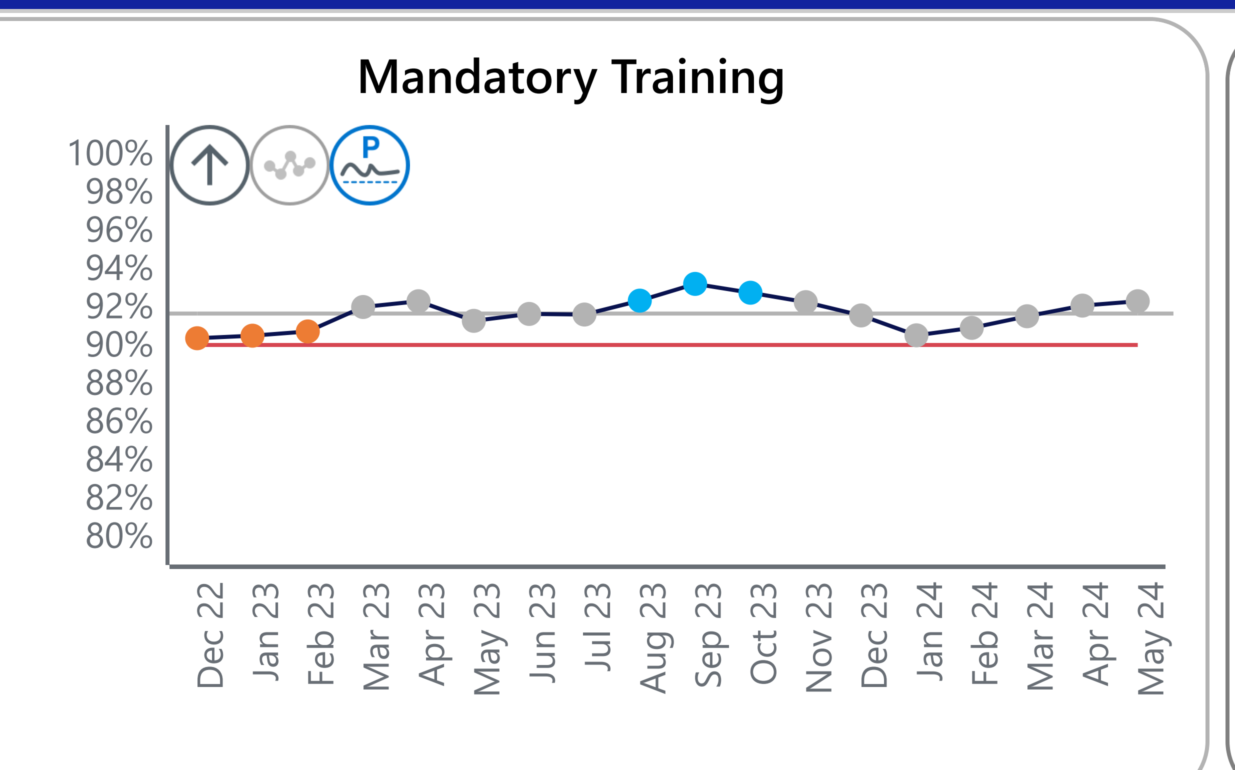



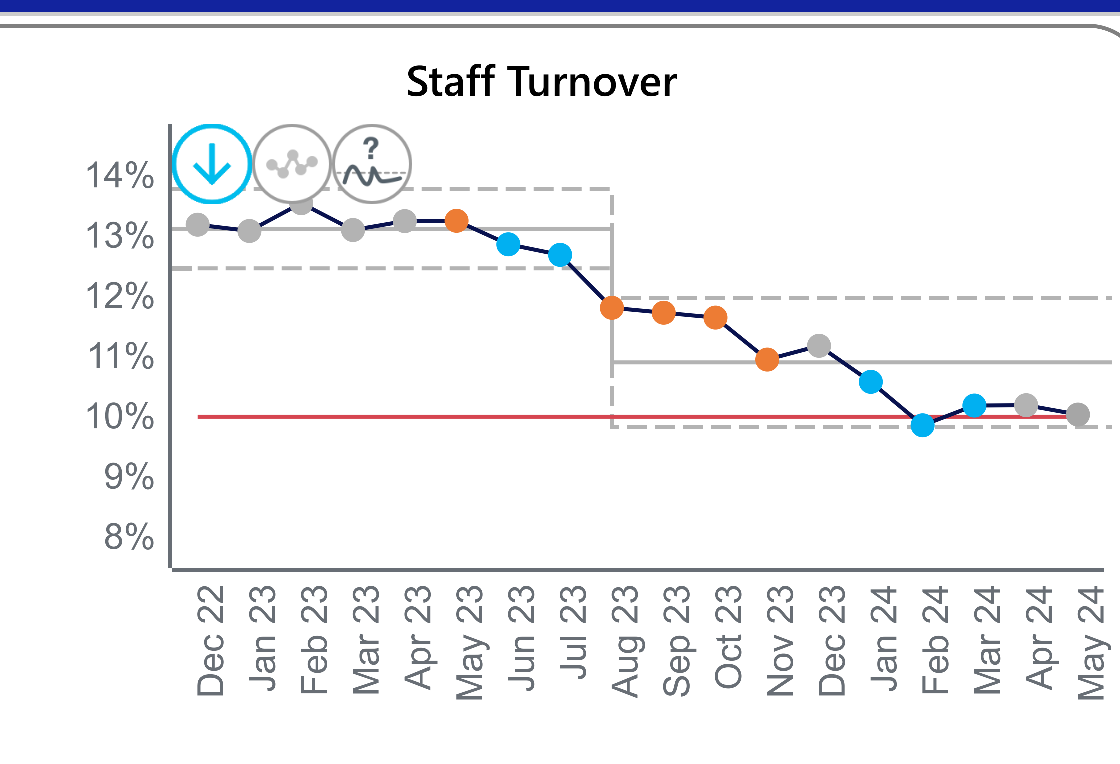
# Integrated Performance Report | June 2024

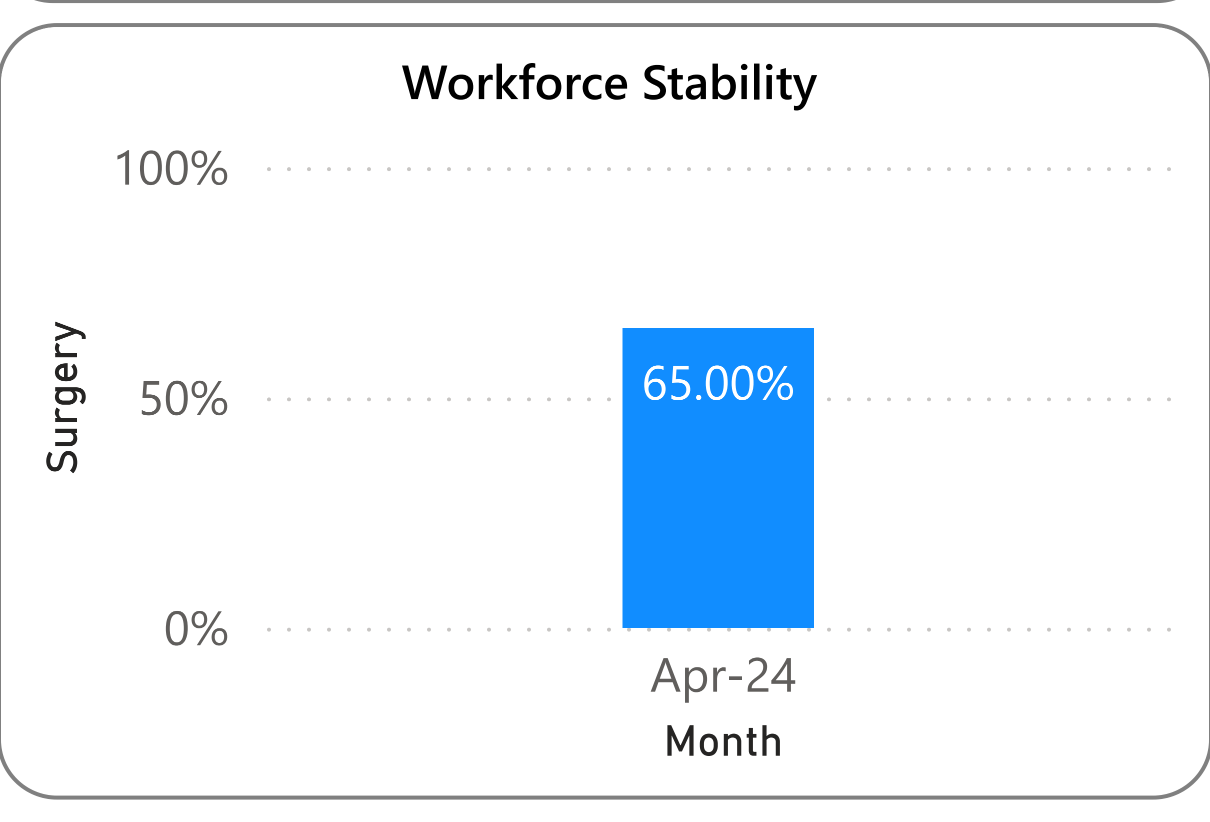
## Divisional Performance Summary - Surgery

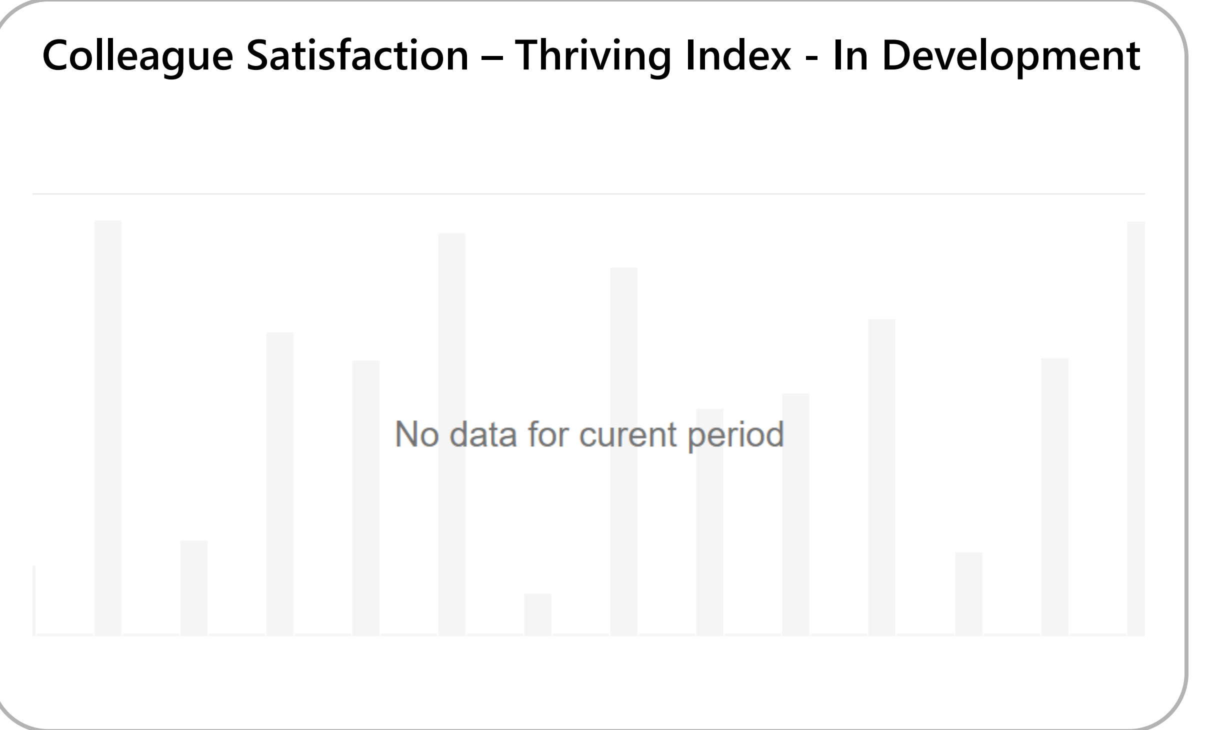


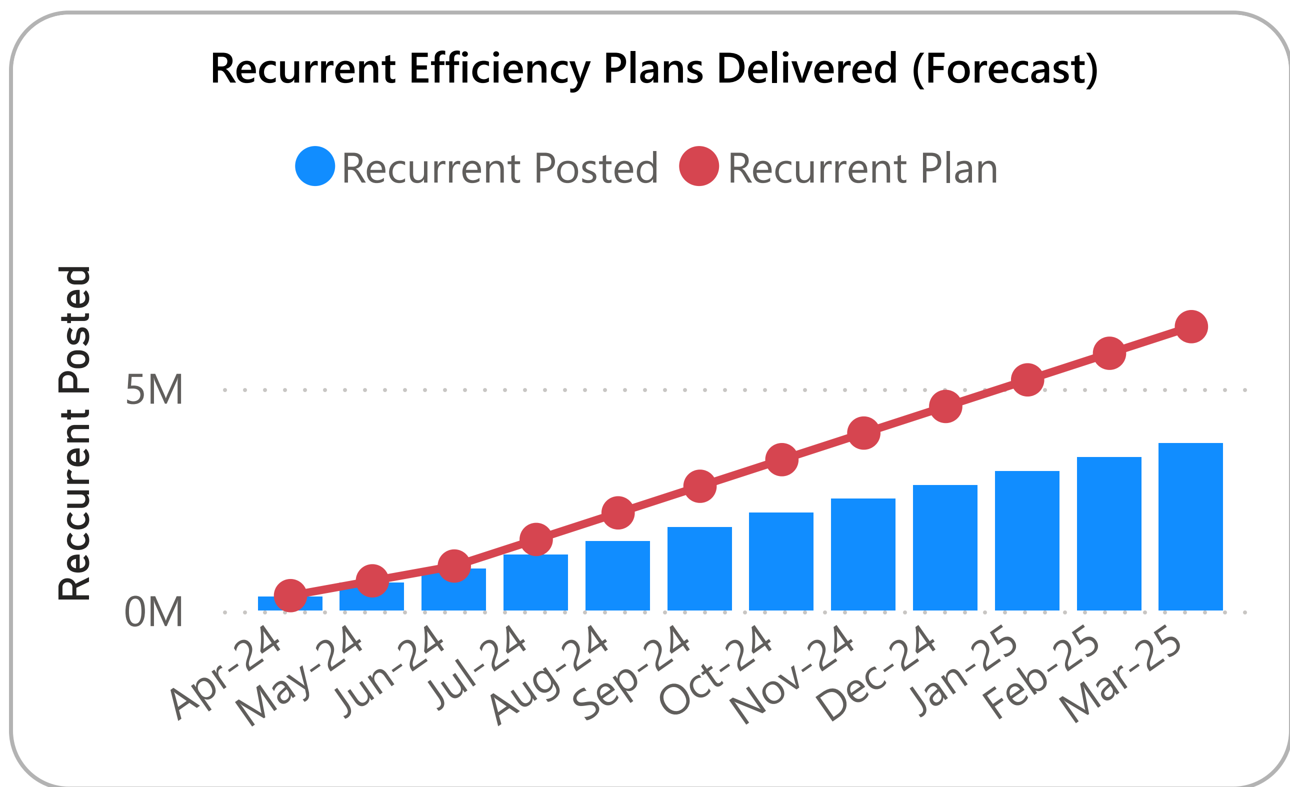



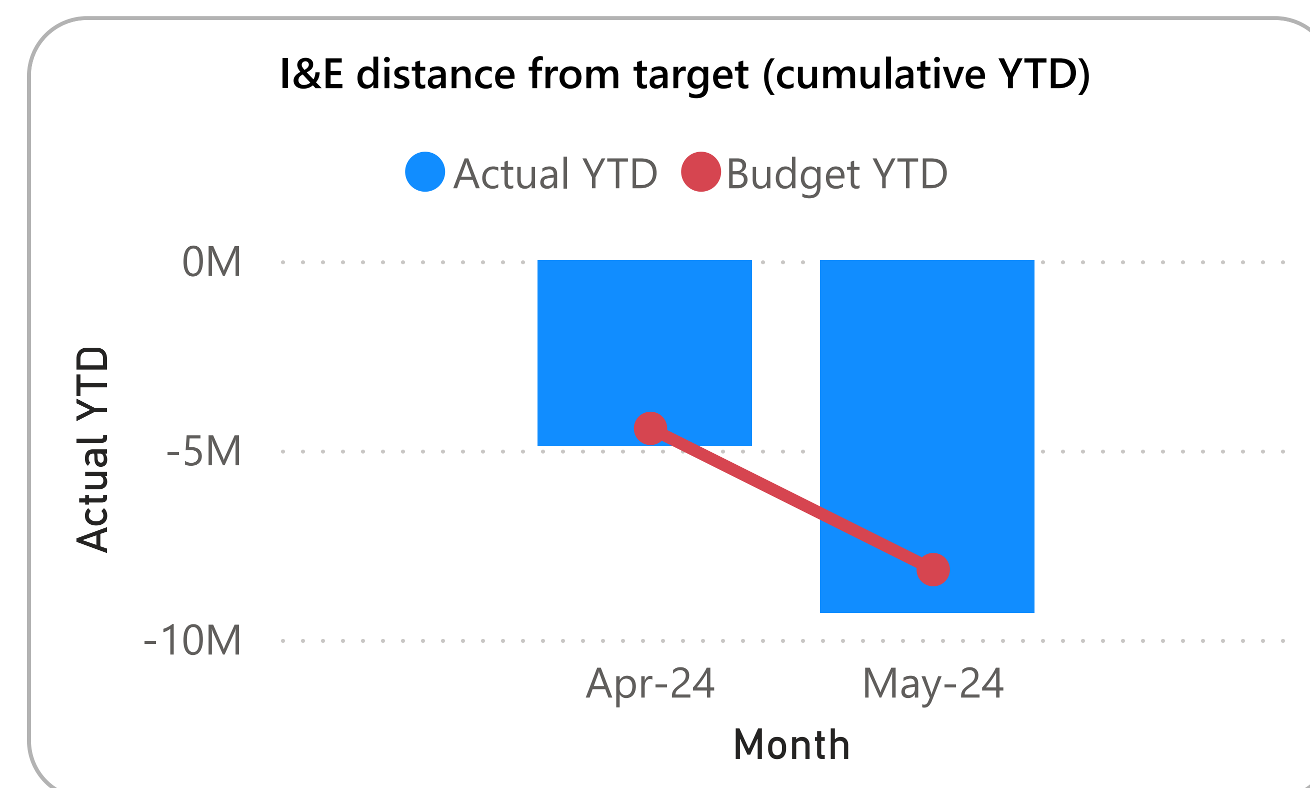



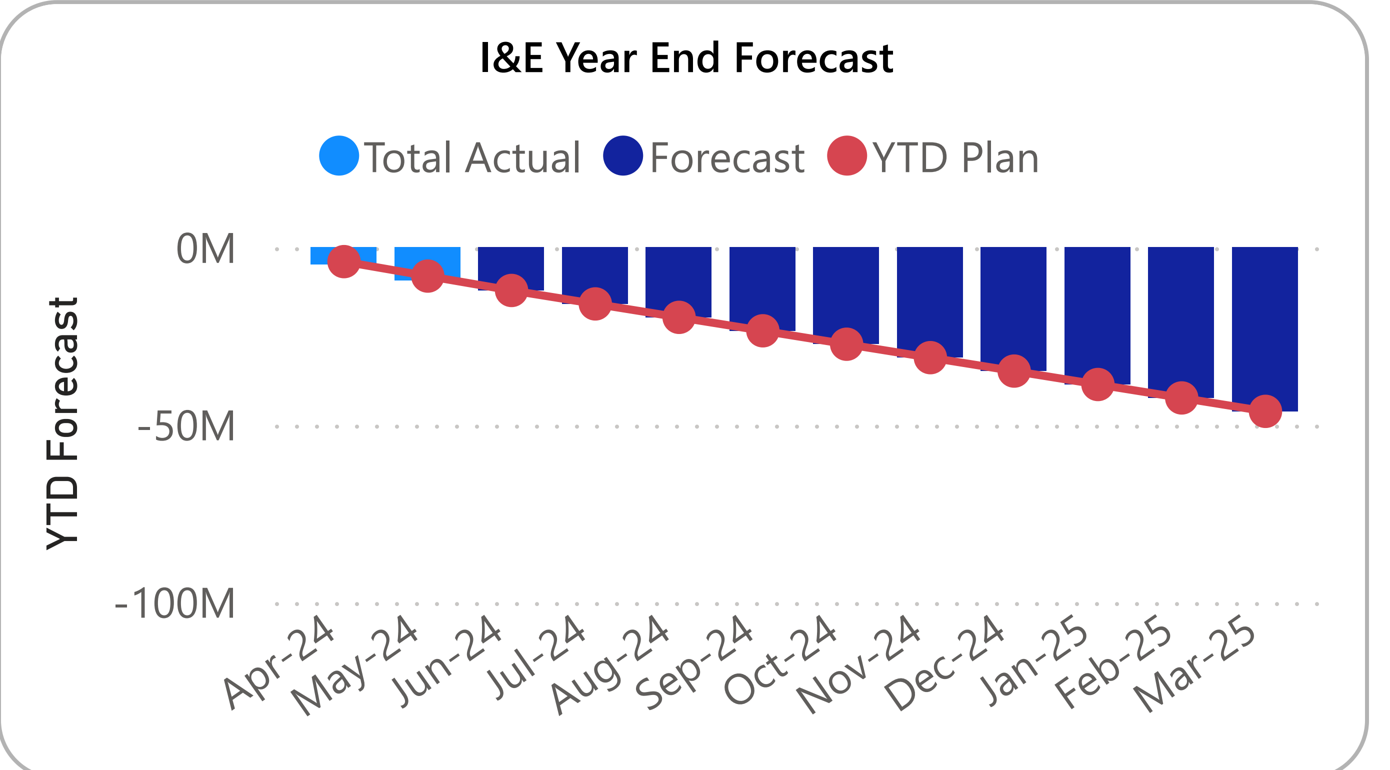



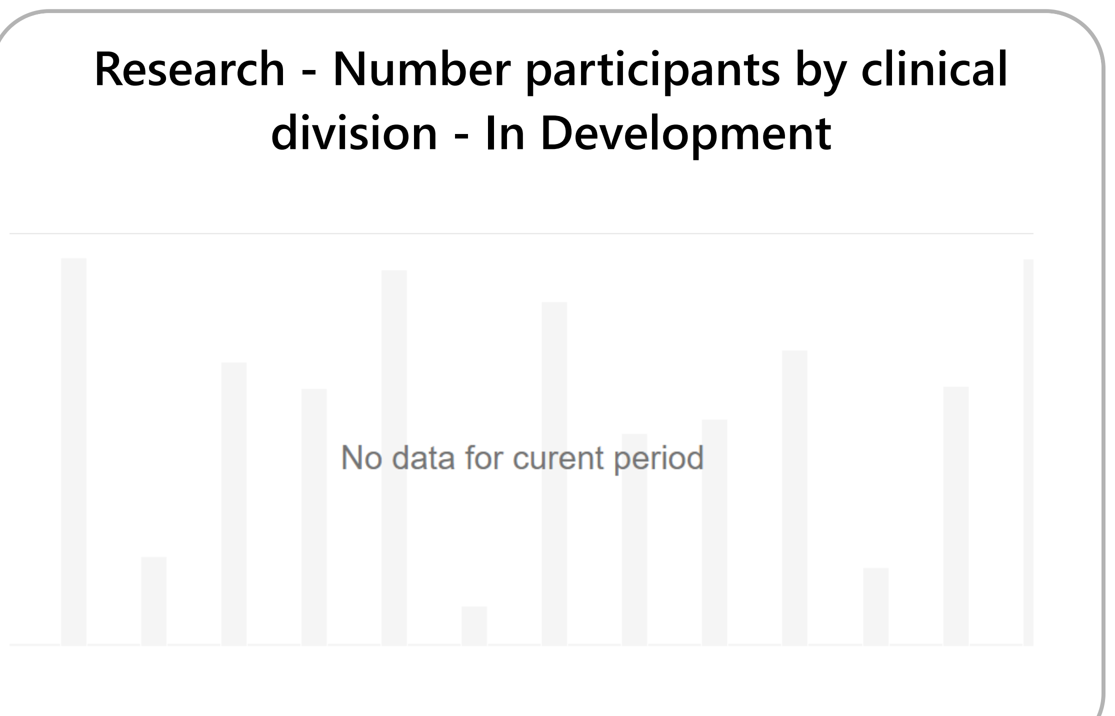



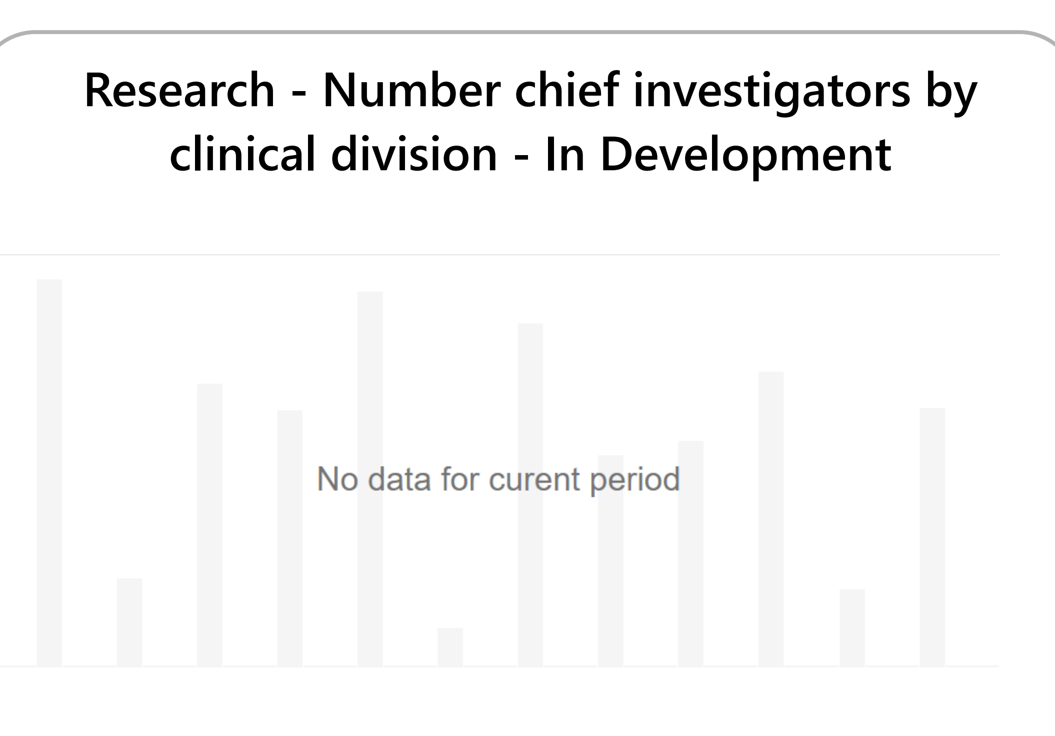



# Divisional Performance Summary - Research

**SRO: John Chester, Director of Research and Innovation**

### Highlights

• 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 – 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.

### Areas of Concern

• Challenges with lab support capacity for ongoing trials and trials in set up – approach under review

• Research delivery team capacity stretched due to unavoidable long term 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.

• Workforce metrics have deteriorated slightly in month but remain below or close to target

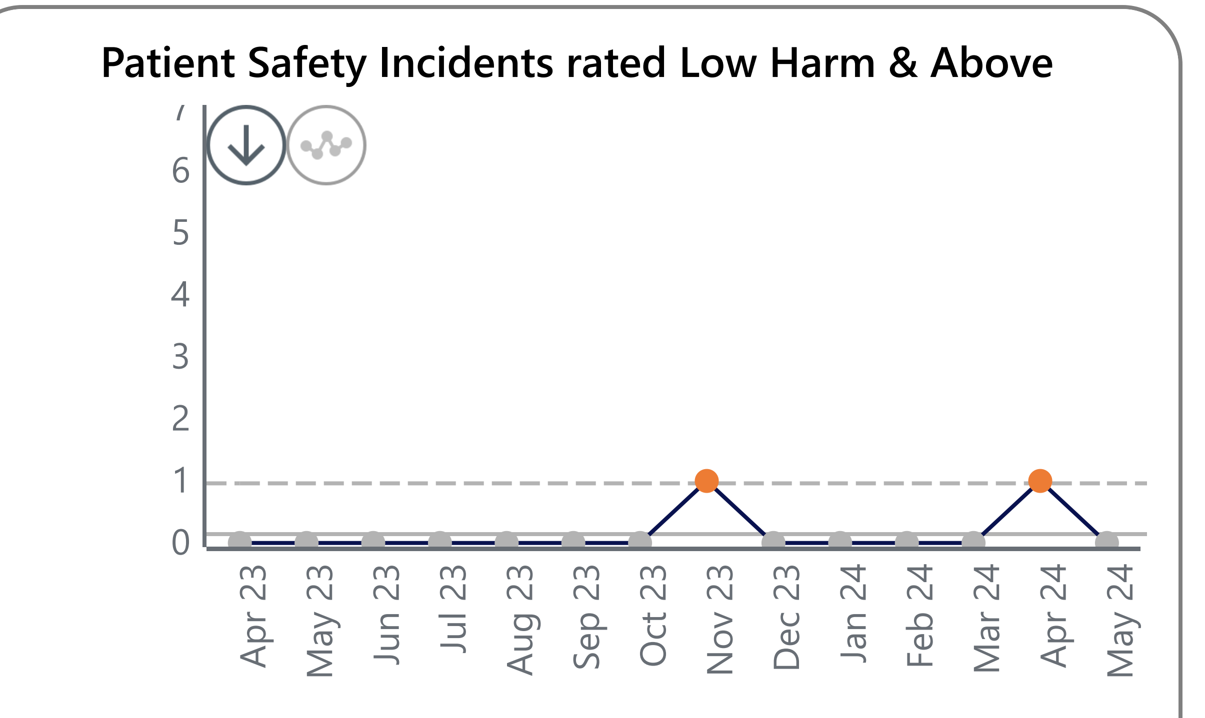
### Forward Look (with actions)

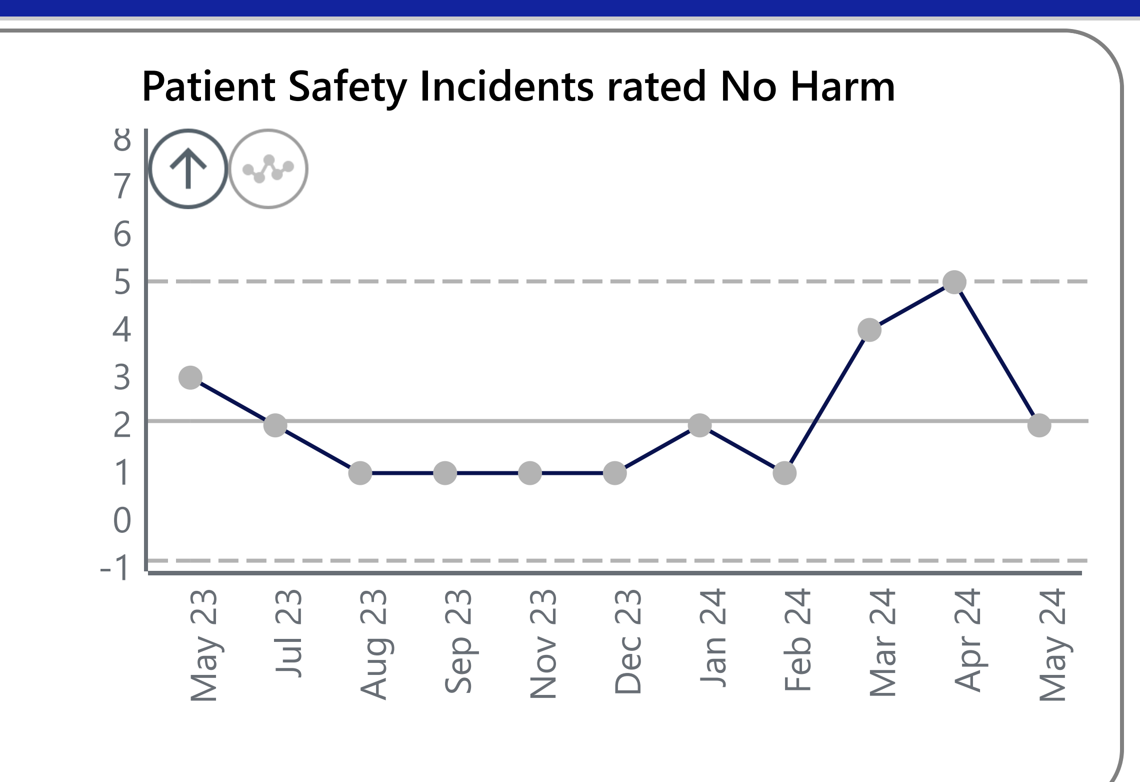
• CRD Improvement and Wellbeing Day planned for 25th June (including big conversation)

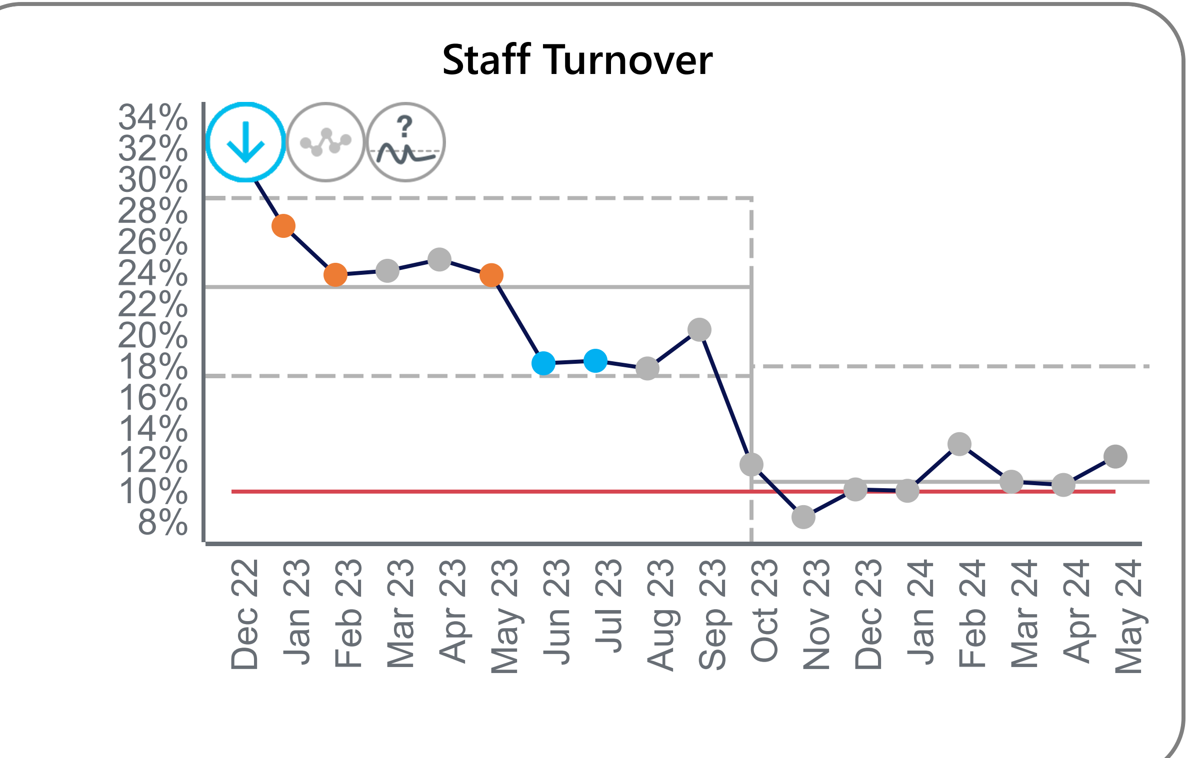
• Applications in progress for NIHR Incubator to build research capacity and develop research careers (AH led) and NIHR Commercial Research Delivery Centre (LUHFT led with AH as paediatric lead) - deadlines June/July

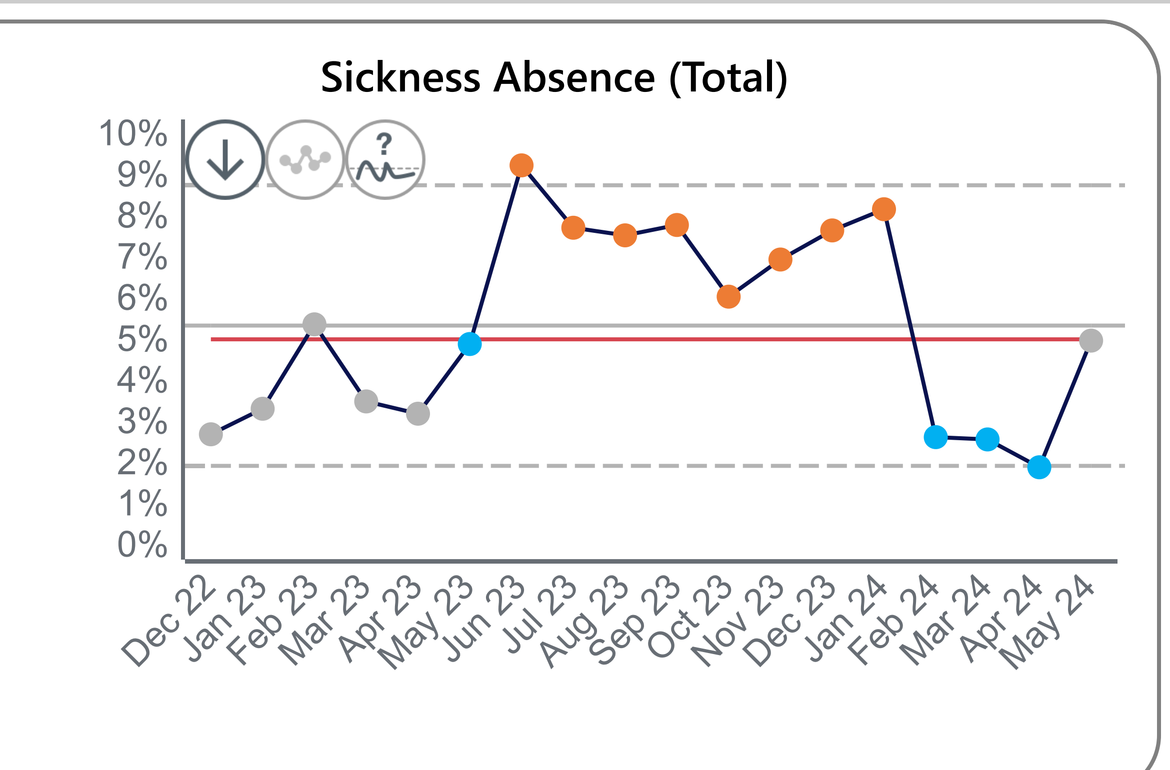
# Integrated Performance Report | June 2024

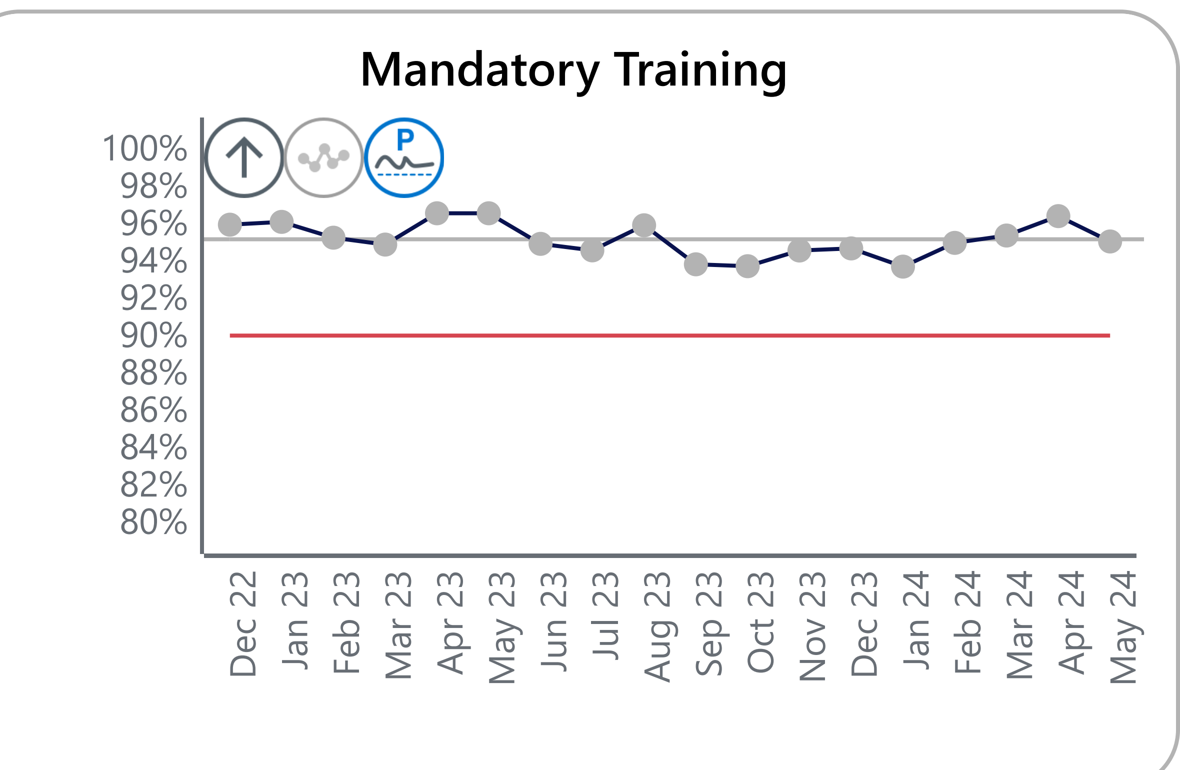
## Divisional Performance Summary - Clinical Research

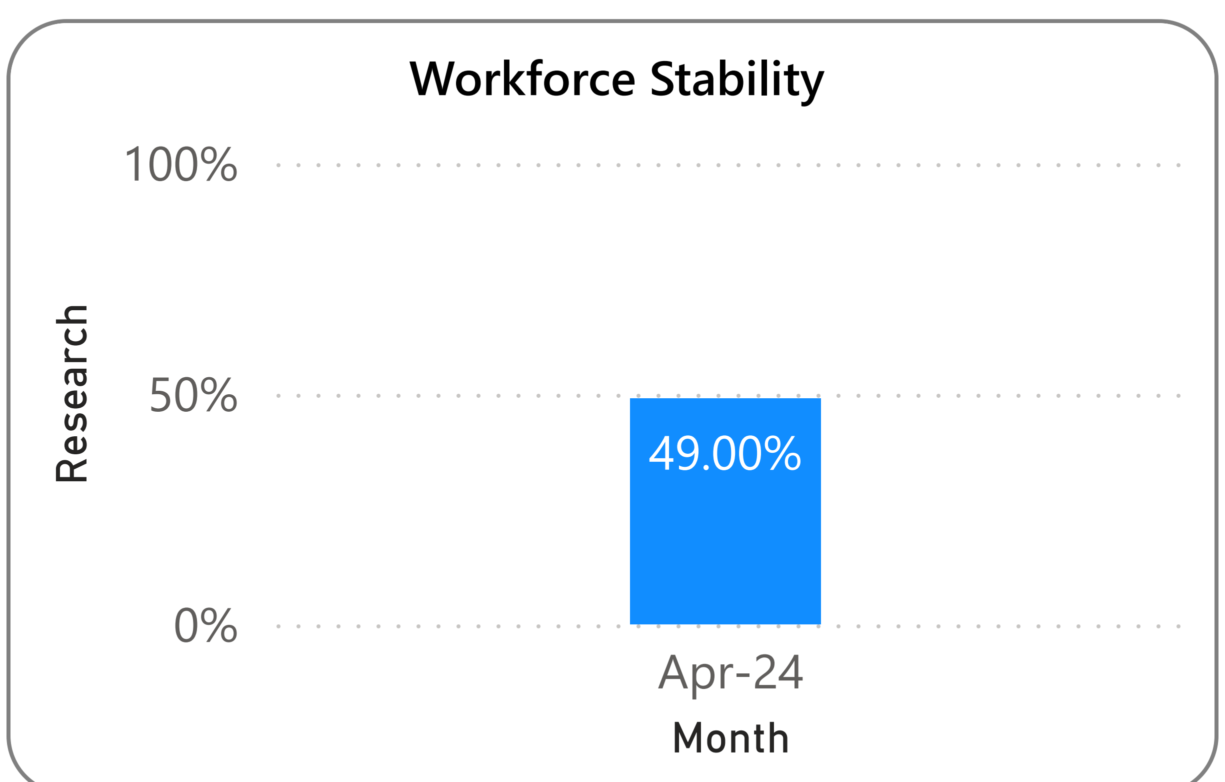


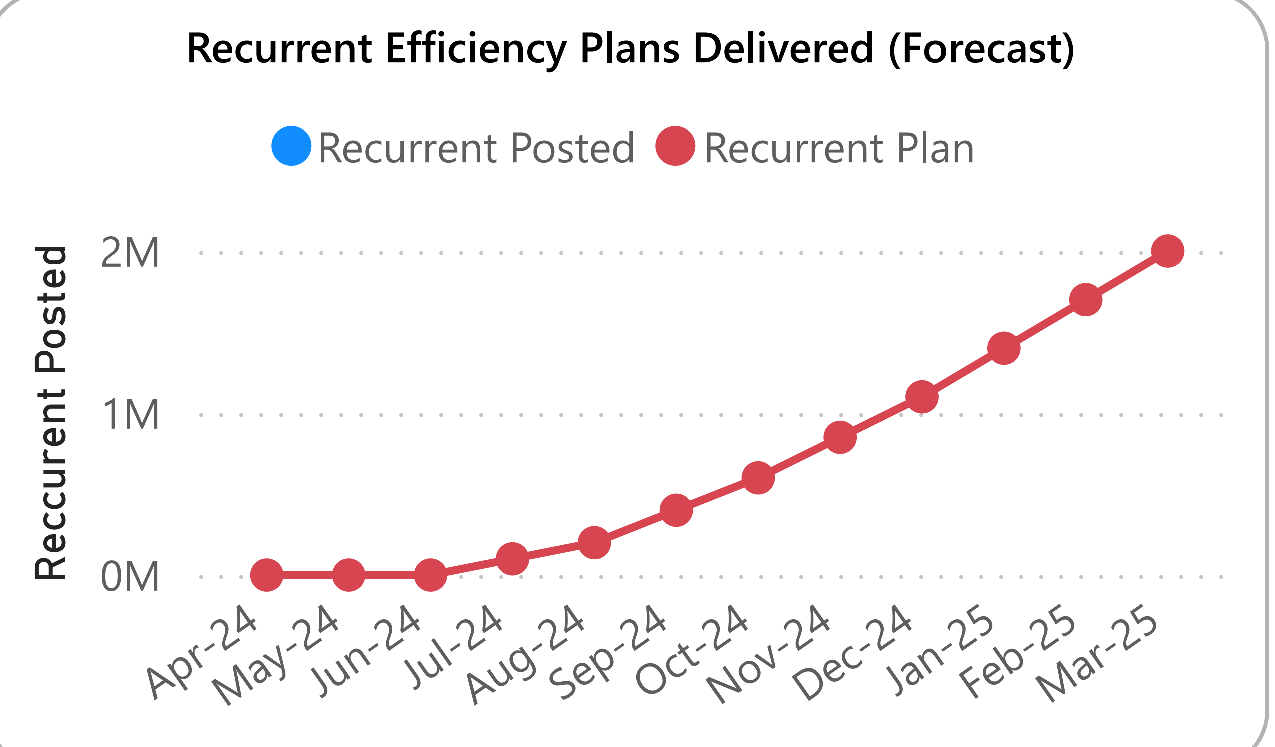



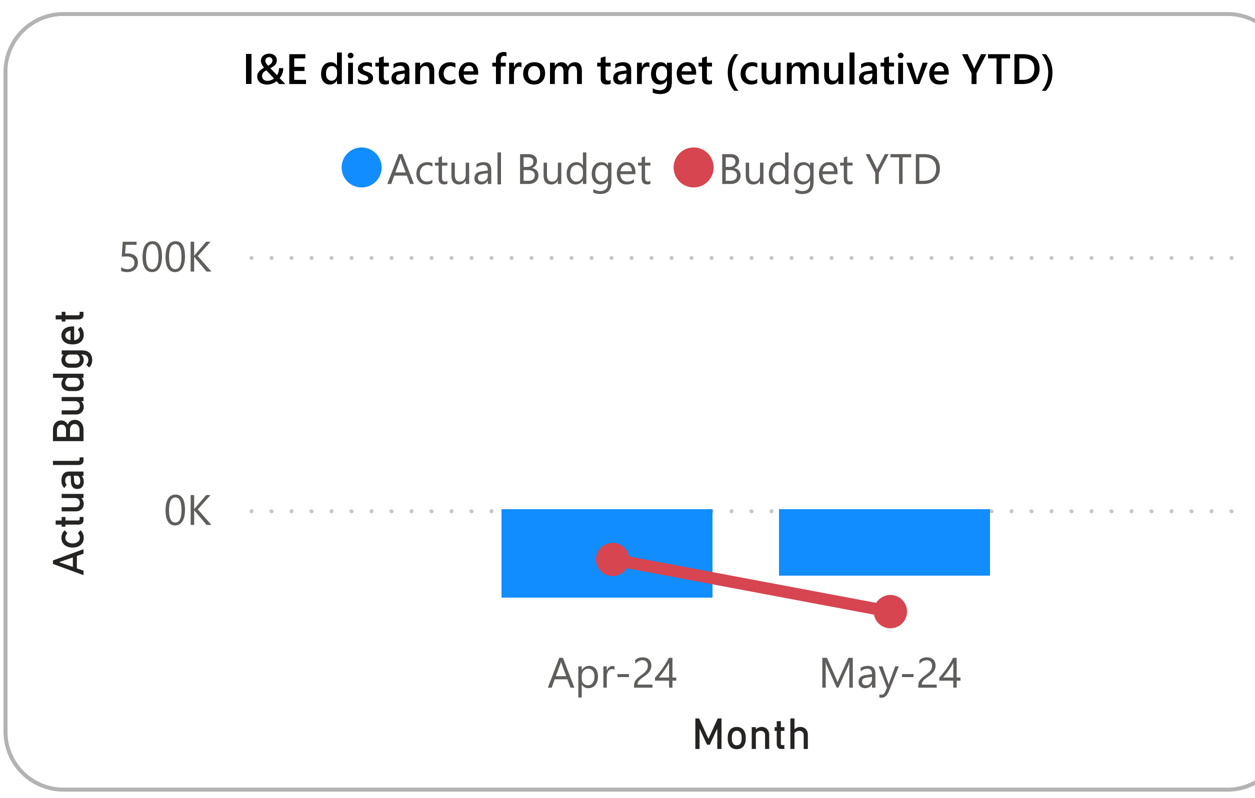



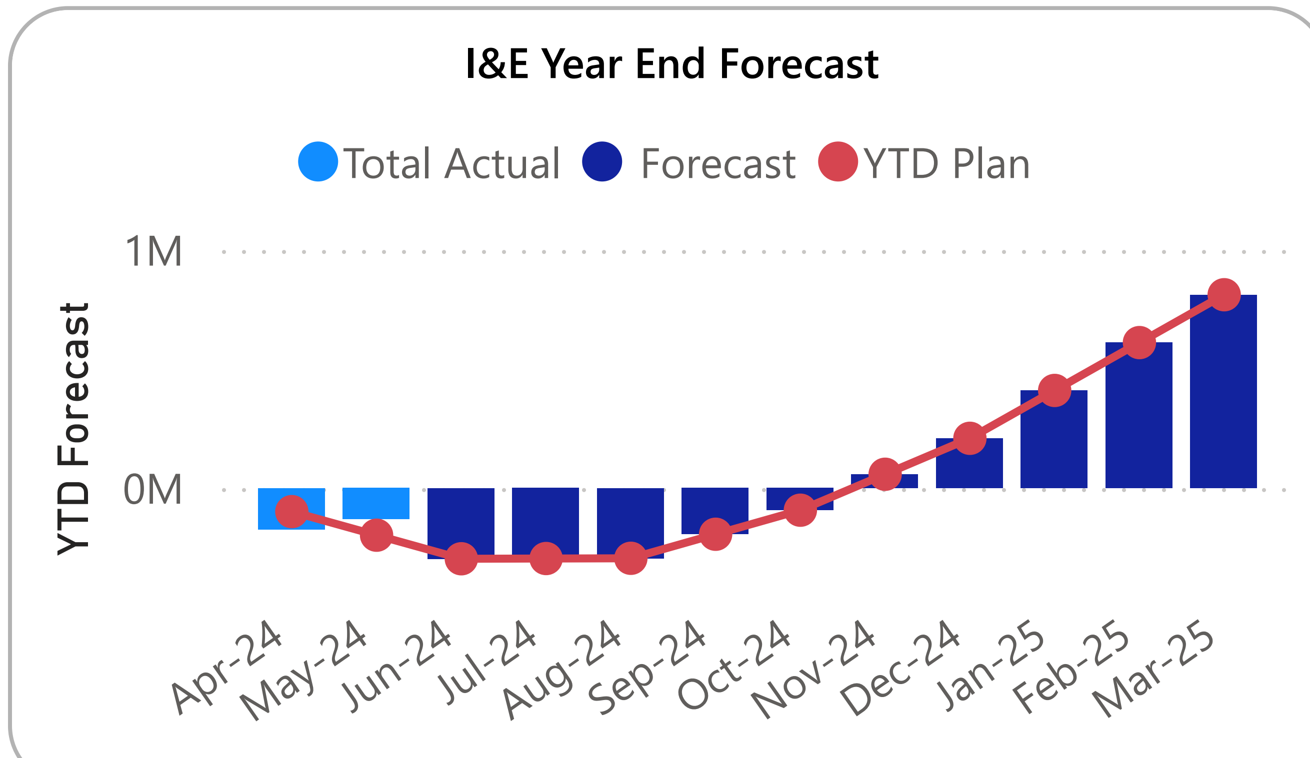



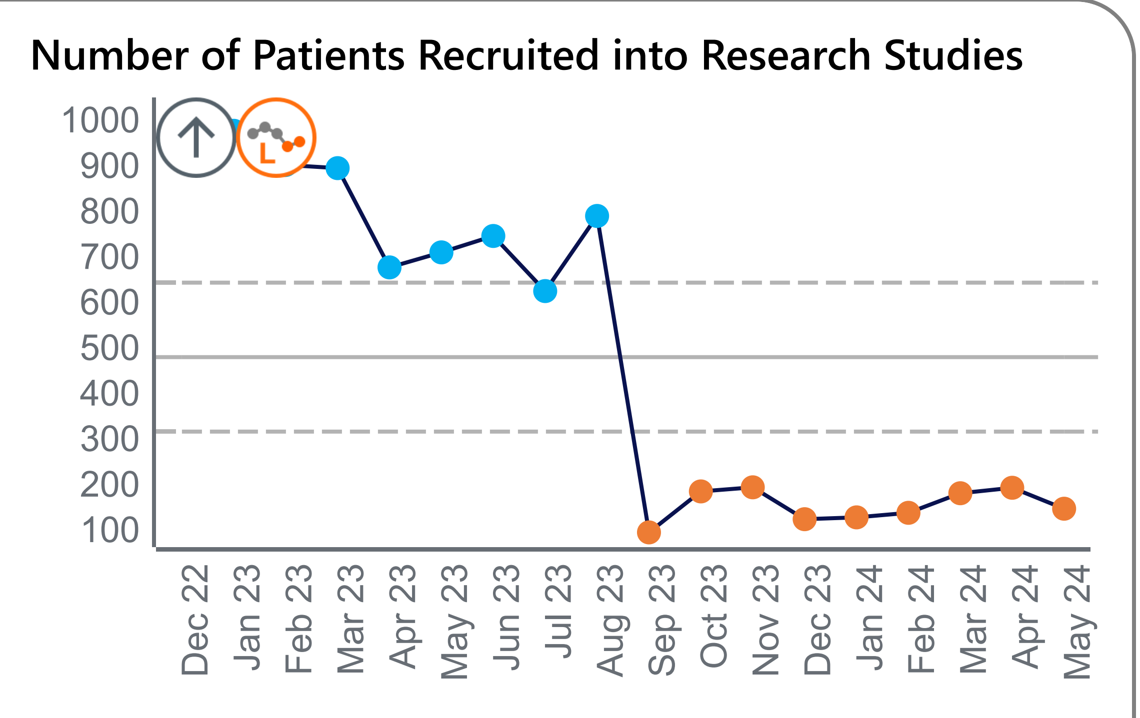



# Divisional Performance Summary - Corporate

**SRO: Erica Saunders, Director of Corporate Affairs**

## Highlights

• Mandatory training for Corporate Services remains above the 90% target at 93%.

• Band 7 PDR completion rate currently sitting at 91%.

• All PDR completion rate currently sitting at 90%.

• 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 13th June 2024.

• Short term sickness absence remains below target at 2% in-month

• Income on plan at M02

• 70% of CIP already identified and/or delivered at M02

## Areas of Concern

• Return to Work compliance is currently sitting at 56%

• Staff Turnover has increased to above Trust target 12%.

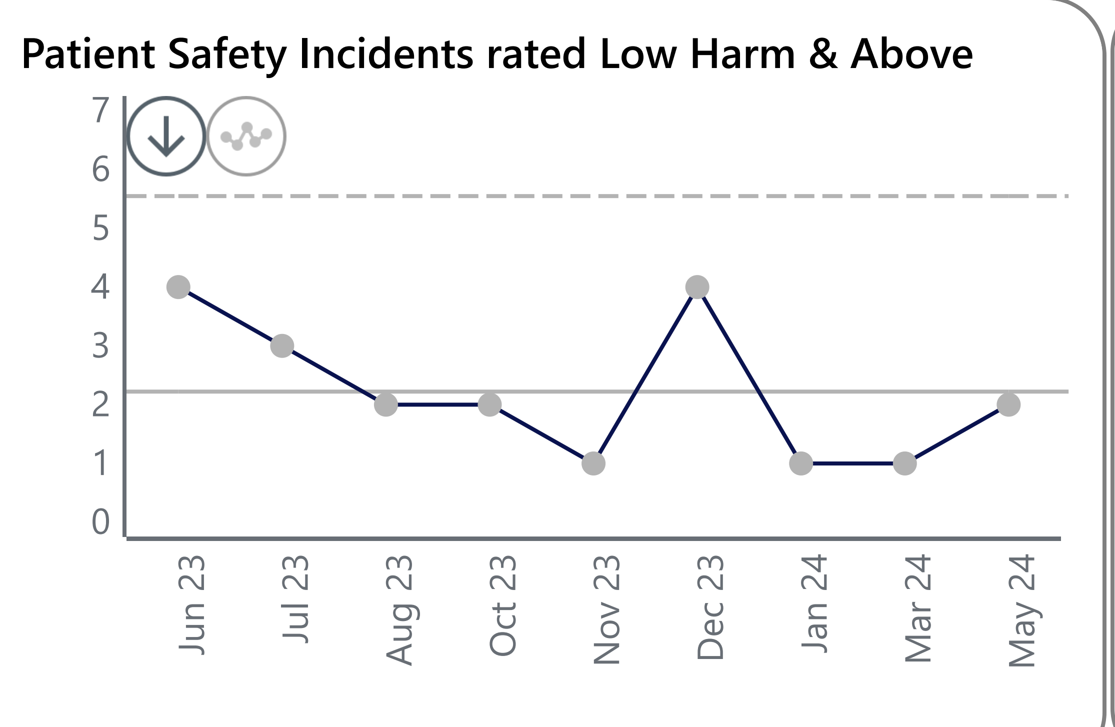
## Forward Look (with actions)

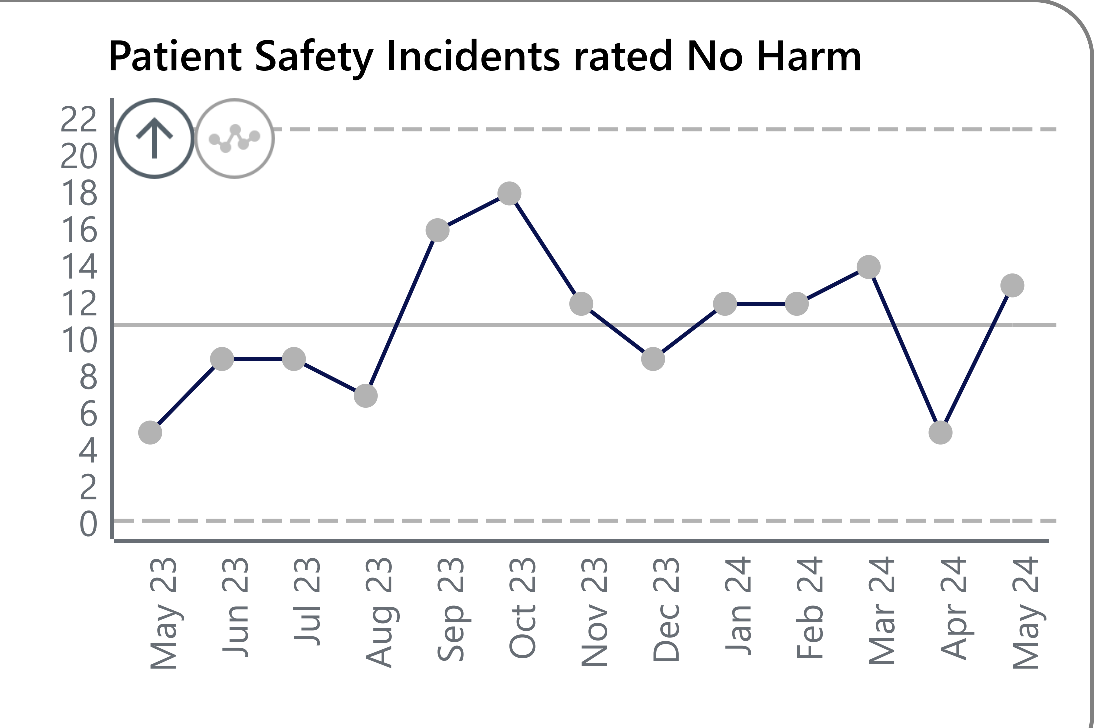
• Return to work compliance has been a specific area of focus and work is ongoing to increase compliance to meet Trust target.

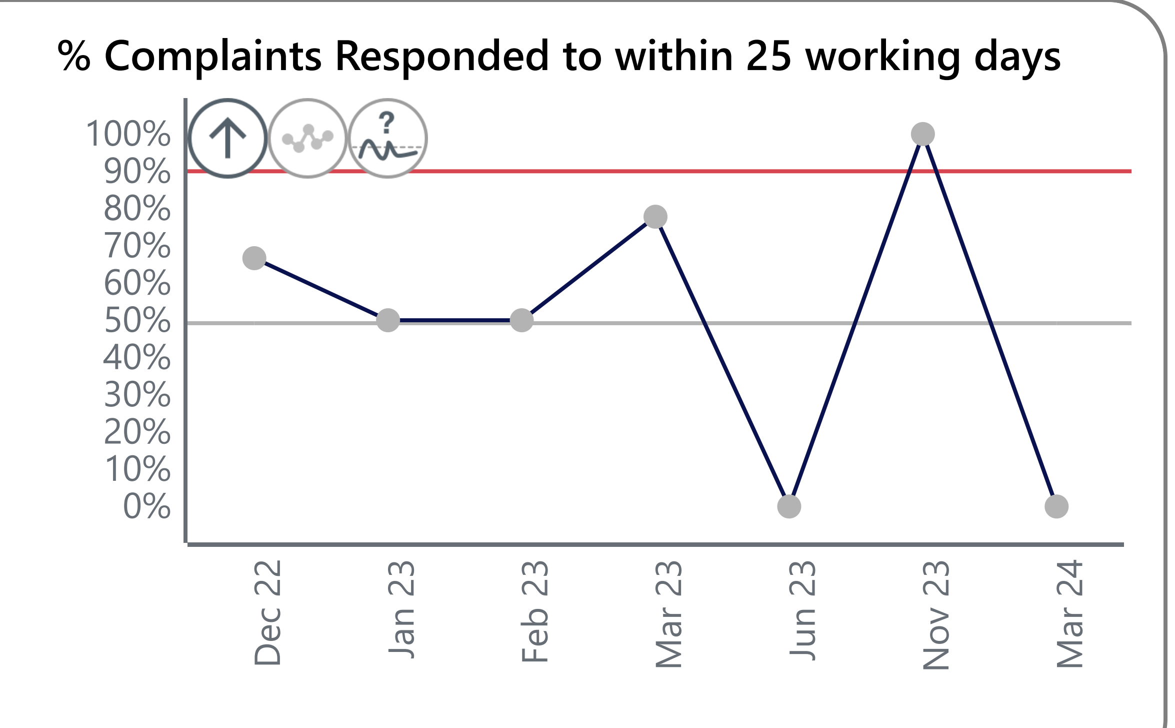
• Return to work interviews should be held as soon as possible following the end of an absence. Weekly reports are shared with managers to highlight absences where RTWs have not been recorded.

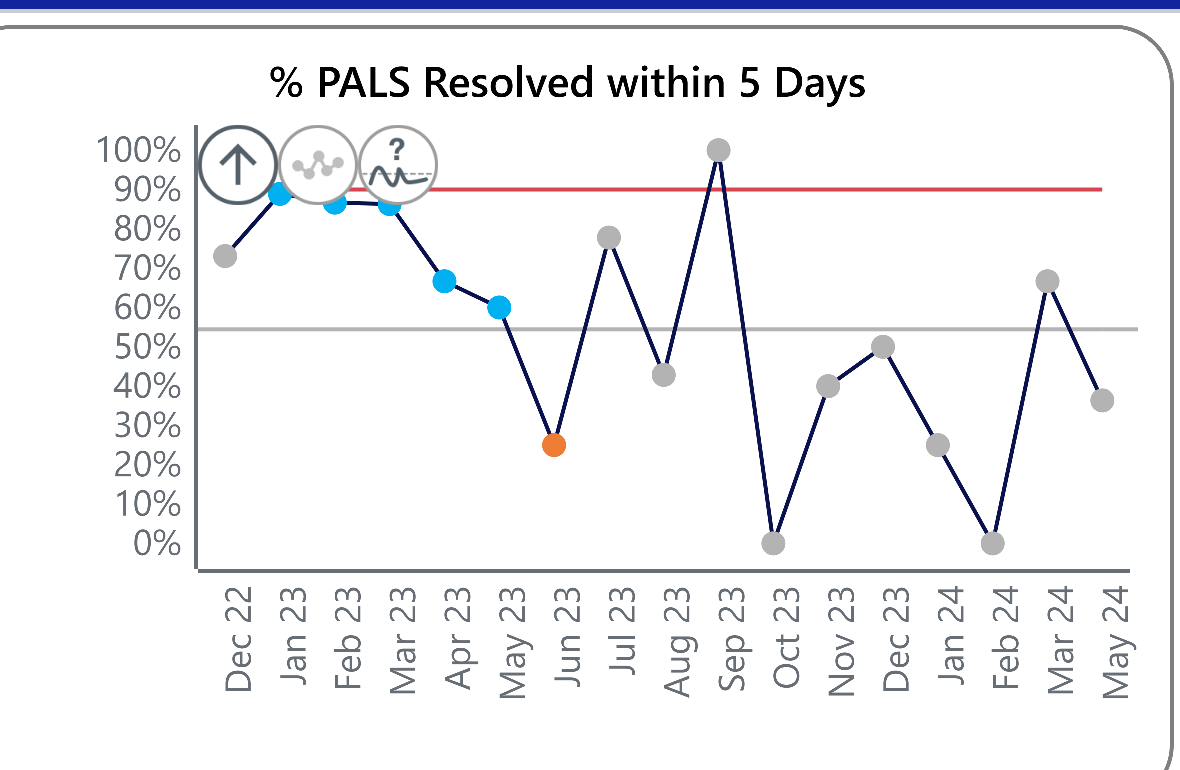
# Integrated Performance Report | June 2024

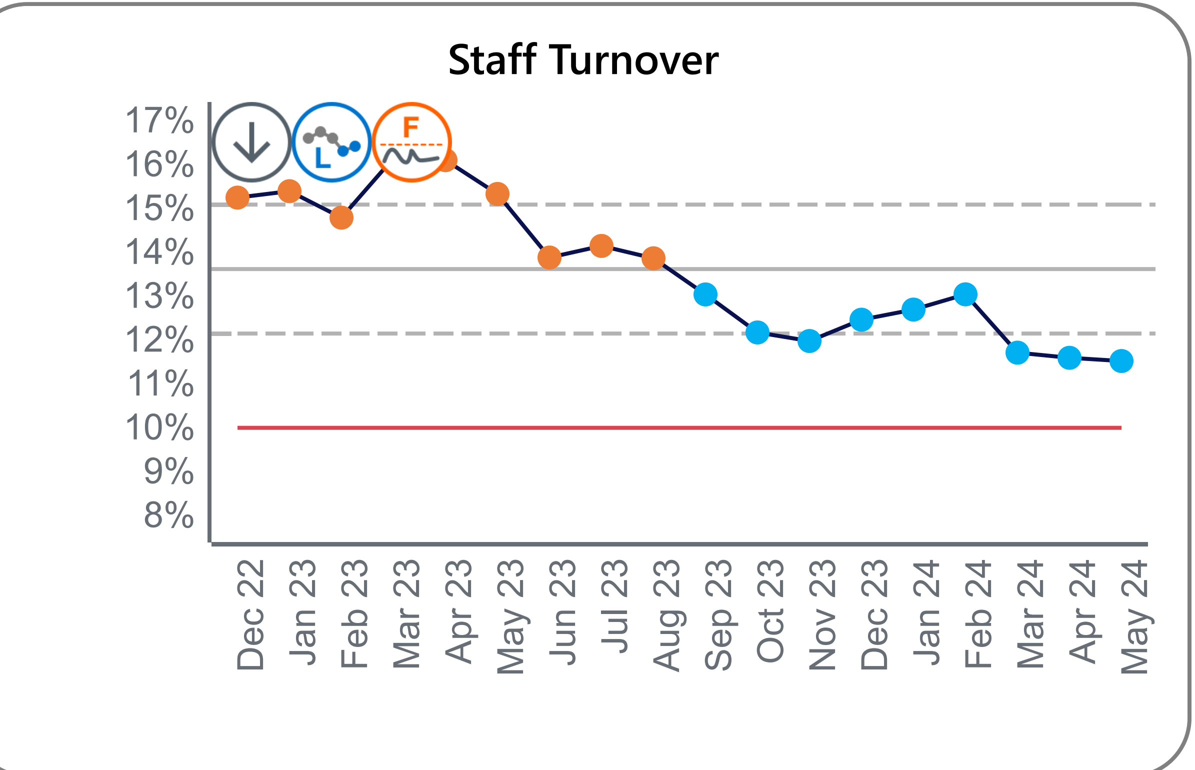
## Divisional Performance Summary - Corporate

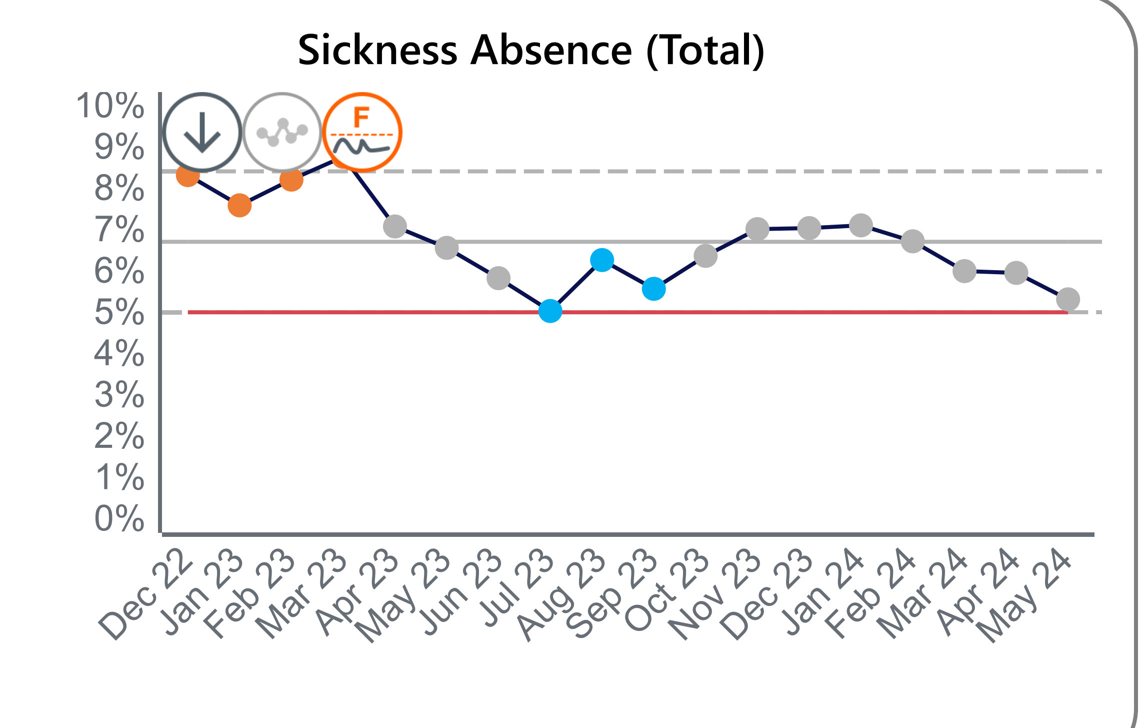


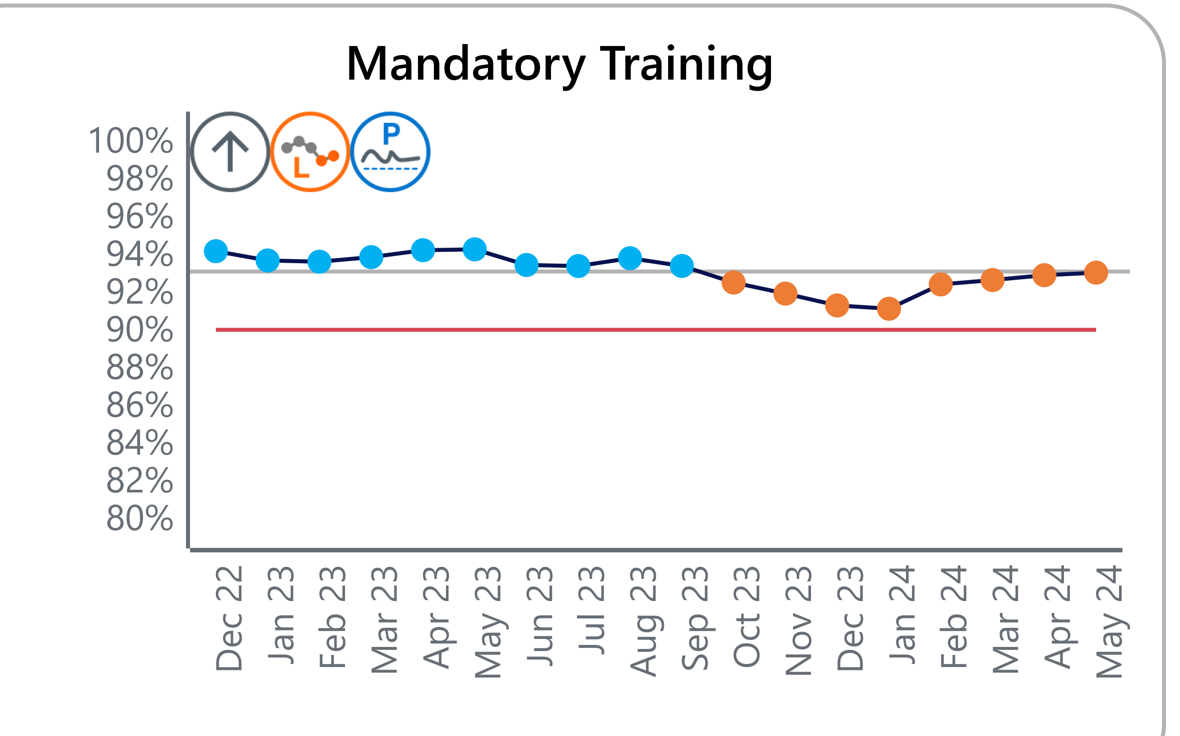



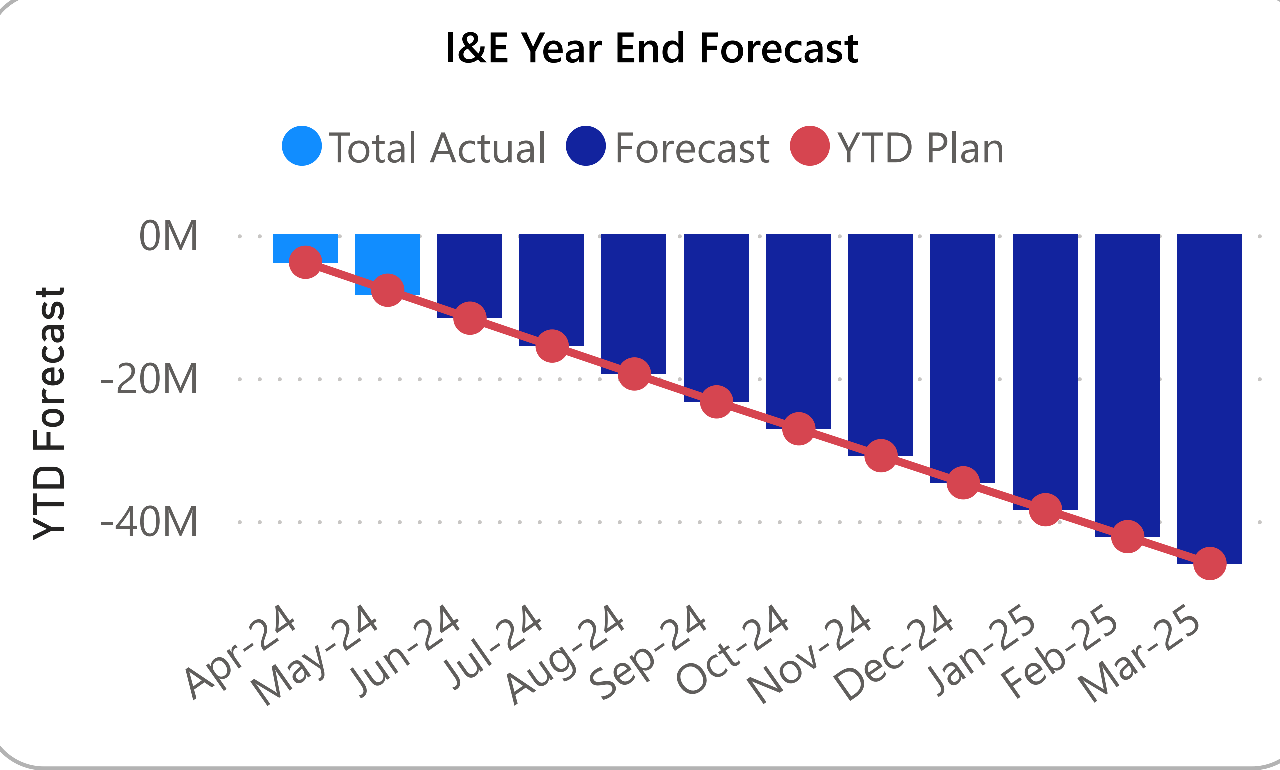



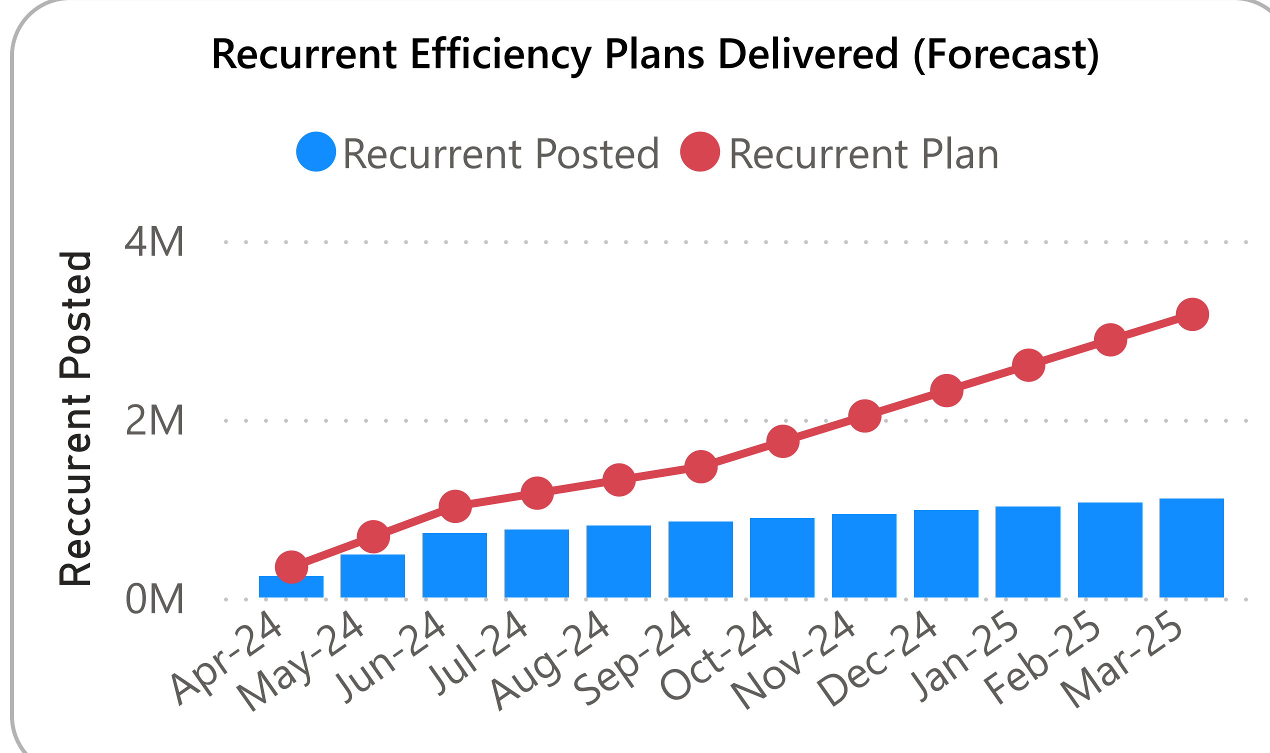



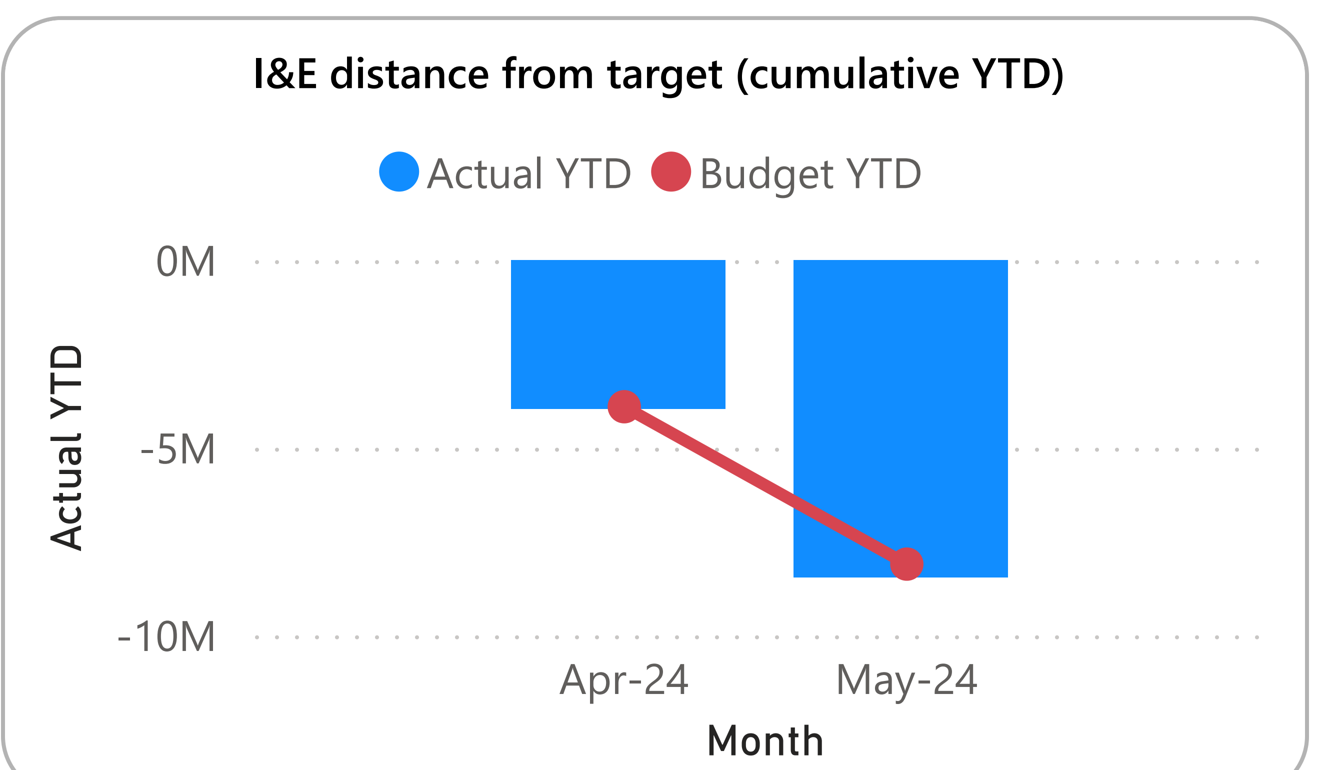



## Icon Definitions

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

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

### XmR chart

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

### Process limits

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

### Special cause variation & common cause variation

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

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

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

# Safe Staffing & Patient Quality Indicator Report
# February 2024 Staffing, CHPPD and benchmark
# June 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% | | 131 | 14.2 | 14.18 | -0.30 | -1.80% | 1.00 | 100% | 0.00 | 0.00% | 0.00 | 0.00% | 22.56 | 4.58% | | | 0 | 37 | 0 | 1 | 4 | 100% | 0 | 0 |
| HDU | 79% | 38% | 78% | 43% | 253 | 31.4 | 30.22 | -8.92 | -11.80% | 2.72 | 51% | 0.00 | 0.00% | 0.00 | 0.00% | 198.03 | 8.09% | 0.00 | 0.00% | 8 | 108 | 0 | 3 | 3 | 100% | 0 | 0 |
| ICU | 87% | 70% | 85% | 46% | 562 | 29.1 | 30.22 | -1.91 | -1.20% | 2.17 | 52% | 0.00 | 0.00% | 0.00 | 0.00% | 237.42 | 5.05% | 2.00 | 3.45% | 8 | 162 | 0 | 1 | 4 | 25% | 0 | 0 |
| Ward 1cC | 91% | 93% | 89% | 80% | 419 | 16.3 | 16.35 | -3.08 | -5.30% | -0.70 | -13% | 0.77 | 1.28% | 0.00 | 0.00% | 46.43 | 2.67% | 49.60 | 28.38% | 3 | 71 | 1 | 16 | 17 | 94% | 0 | 0 |
| Ward 1cN | 64% | 15% | 74% | | 190 | 15.8 | 15.8 | -0.07 | -0.20% | 1.43 | 59% | 1.00 | 2.70% | 0.00 | 0.00% | 73.33 | 7.08% | 0.00 | 0.00% | 6 | 56 | 0 | 9 | 2 | 100.00% | 1 | 0 |
| Ward 3A | 97% | 87% | 98% | 216% | 750 | 11.0 | 10.48 | -5.72 | -11.90% | 1.47 | 9% | 0.00 | 0.00% | 0.00 | 0.00% | 128.00 | 8.18% | 45.57 | 10.81% | 7 | 58 | 0 | 18 | 25 | 92.00% | 3 | 0 |
| Ward 3B | 74% | 108% | 67% | | 320 | 15.7 | 15.7 | 1.24 | 2.90% | 1.56 | 30% | 0.00 | 0.00% | 0.00 | 0.00% | 46.92 | 3.94% | 26.68 | 24.73% | 8 | 80 | 0 | 8 | 11 | 100% | 1 | 0 |
| Ward 3C | 96% | 107% | 82% | 151% | 678 | 12.7 | 12.66 | 4.43 | 6.50% | 4.79 | 48% | 0.00 | 0.00% | 0.00 | 0.00% | 159.75 | 8.58% | 19.01 | 12.74% | 6 | 102 | 0 | 6 | 18 | 100.00% | 0 | 0 |
| Ward 4A | 84% | 73% | 84% | 66% | 818 | 9.4 | 10.21 | -4.20 | -6.30% | 0.80 | 14% | 0.00 | 0.00% | 0.00 | 0.00% | 79.80 | 3.90% | 1.84 | 1.29% | 0 | 58 | 0 | 4 | 39 | 97% | 0 | 0 |
| Ward 4B | 59% | 86% | 63% | 65% | 515 | 12.9 | 11.2 | 2.62 | 6.00% | 2.72 | 7% | 0.00 | 0.00% | 0.61 | 1.72% | 66.24 | 5.85% | 153.95 | 14.90% | 9 | 96 | 1 | 6 | 12 | 92% | 2 | 1 |
| Ward 4C | 94% | 97% | 87% | 119% | 743 | 10.4 | 11.92 | 3.41 | 6.00% | 2.62 | 22% | 0.92 | 1.72% | 0.00 | 0.00% | 68.05 | 4.43% | 25.85 | 9.61% | 6 | 203 | 0 | 6 | 49 | 97.96% | 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 for CHPPD is based on February 2024 data from the model hospital, RAG rated for compliance.

Medicine

3B: Fill rate for RN's is below 80% due to a combination of short-term sickness, vacancy (these were recruited to with external candidates and will commence in post over the next 3 months). Despite this no staffing incidents were reported and there was a decrease in medication incidents overall. HCA fill rate includes 1:1 requirement and those who support clinic as not in the baseline establishment.

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, risk assessments are in place and reviewed on a weekly basis and MDTs to progress to discharge are attended by ward discharge coordinator, manager, and matron. There was an increase in overall 1:1 for HCA's overnight not currently reflected within the baseline establishment.

4B: Sickness levels continued to be monitored as there was an increase in short term sickness amongst HCA's in February, particularly on those who work night duty predominantly. 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.

4C: Continue to see improvements in fill rate for February. Patients with an eating disorder (EDYS) are the main patient group requiring 1:1 supervision

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 has significantly improved compared to December and January, due to a decrease in RN sickness, 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 February (long term patient), therefore contributing to the overfill on that line and will continue over the next few months.

Ward 4A : HCA fill rate below 80% due to vacancy

Critical Care

HDU: average fill rate has decreased slightly in February mainly impacted by acuity as they received 49 urgent referrals in this month.

ICU: Supernumerary staff in post within the reporting period.

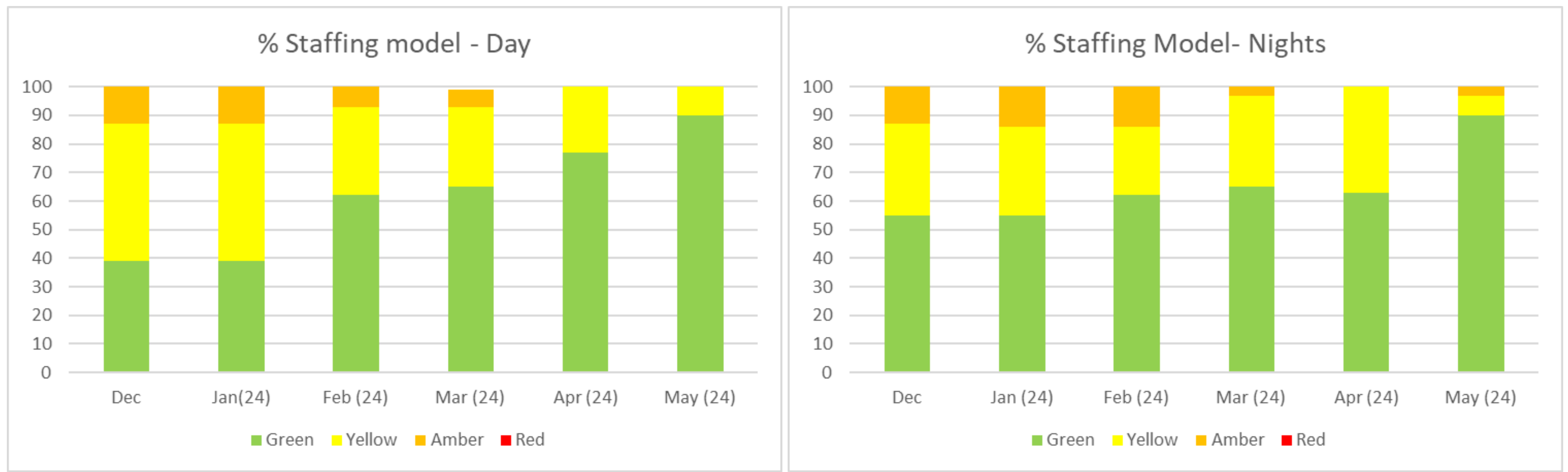
Summary

Alder Hey are below the National Benchmark for CHPPD in 3 wards/departments for February 2024 (4A,4C and critical care) whilst the other areas are either comparable or above this.

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 1-5. 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 consistently recorded on E-Roster – This is established on ward 3A and requires rollout to the rest of the Trust.

Summary of Staffing models December 2023 – May 2024

Staffing RAG data has continued to show improvement with zero red shifts within the wards and departments for this reporting period, this has been consistent for the past 6 months. To note no amber staffing shifts were reported in May for day shifts and only 3% of shifts on night duty were declared Amber. In addition, there is a significant increase in compliance with a green staffing model (from 77% on days and 63% on night duty to 90% on both)




**Electronic Roster KPI Report**

**May 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**

Further improvement can be seen in the May data, with confirmation of the impact of the work between the Roster team and the ward managers, with increasing areas of compliance int the table, albeit there continues to be room for improvement in one or two areas. 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 (29th April - 26th May)** | % 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) | 53 | 22.52% | 80.00 | 527.67 | 0.00% | 0 | 1 | 32.04% | 12.87% | 6.01% | 1.70% | 2.69% | 0.00% | 23.27% |
| Accident & Emergency - Nursing (912201) | 43 | 39.54% | 720.00 | 1.13 | 16.93% | 2006.42 | 1 | 12.00% | 12.43% | 3.87% | 1.82% | 7.23% | 5.45% | 31.24% |
| Burns Unit (915208) | 42 | 24.81% | 140.00 | 308.78 | 13.60% | 357 | 34 | 11.60% | 12.19% | 4.01% | 0.00% | 2.80% | 0.00% | 21.56% |
| Critical Care Ward (913208) | 42 | 19.89% | 1200.00 | 304.22 | 7.10% | 1394.5 | 6 | 13.86% | 14.14% | 0.14% | 0.42% | 5.08% | 4.02% | 23.80% |
| High Dependancy Unit (HDU) (913210) | 42 | 31.51% | 640.00 | 502.95 | 13.62% | 1248.5 | 34 | 19.64% | 13.86% | 3.84% | 0.55% | 9.10% | 9.15% | 36.56% |
| Medical Daycase Unit (911314) | 35 | 34.29% | 50.00 | -33.4 | 1.72% | 19 | | 15.04% | 10.82% | 2.73% | 0.00% | 0.59% | 0.00% | 14.14% |
| Outpatients (916503) | 32 | 43.42% | 420.00 | 1230.83 | 14.90% | 978.5 | 29 | 43.08% | 12.20% | 0.36% | 1.31% | 21.14% | 1.64% | 36.65% |
| Sunflower House (912310) | 6 | 20.97% | 190.00 | 203 | 19.86% | 704.5 | 38 | 17.29% | 14.09% | 0.32% | 0.97% | 2.19% | 9.63% | 36.04% |
| Surgical Daycase Unit (915418) | 23 | 34.49% | 85.00 | 231.98 | 9.01% | 281.75 | 3 | 21.93% | 15.59% | 0.00% | 5.89% | 4.72% | 0.00% | 26.20% |
| Theatres - Cardiac & Cardiology (915405) | 42 | 15.10% | 130.00 | 122.75 | 6.86% | 129 | | 7.75% | 15.15% | 2.61% | 7.72% | 1.84% | 0.00% | 27.32% |
| Theatres - Emergency (915420) | 41 | 21.45% | 230.00 | 11.92 | 3.34% | 70.75 | | 0.00% | 12.48% | 4.45% | 0.00% | 2.49% | 1.98% | 24.98% |
| Theatres - IP Anaesthetics (915423) | 42 | 16.91% | 82.00 | -6.67 | 9.05% | 335.42 | 9 | 3.73% | 10.31% | 1.30% | 2.35% | 8.45% | 6.03% | 28.43% |
| Theatres - IP Porters (915435) | 42 | 13.30% | 101.00 | -3 | 4.13% | 66.5 | 1 | 7.70% | 13.35% | 0.25% | 0.00% | 0.53% | 0.00% | 14.12% |
| Theatres - IP Recovery (915422) | 42 | 39.45% | 103.00 | -30.7 | 8.58% | 136.5 | 6 | 15.28% | 9.12% | 2.84% | 5.96% | 13.26% | 0.00% | 31.18% |
| Theatres - IP Scrub (915424) | 41 | 28.23% | 128.00 | 0.5 | 15.44% | 268.75 | 2 | 9.03% | 9.66% | 1.17% | 0.00% | 14.93% | 0.00% | 25.76% |
| Theatres - Ortho & Neuro Scrub (915436) | 41 | 32.39% | 37.80 | 16.33 | 26.44% | 623 | 14 | 10.75% | 12.38% | 2.25% | 1.69% | 12.86% | 4.54% | 39.30% |
| Theatres - SDC Anaesthetics (915429) | 42 | 17.99% | 58.40 | 35.92 | 11.60% | 87 | | 25.83% | 8.28% | 3.15% | 3.15% | 16.56% | 0.00% | 31.13% |
| Theatres - SDC Recovery (915430) | 42 | 27.75% | 177.30 | -62.77 | 11.54% | 151.75 | 12 | 4.82% | 18.17% | 1.24% | 6.61% | 8.20% | 0.00% | 34.22% |
| Theatres - SDC Scrub (915421) | 42 | 36.34% | 532.00 | 14.7 | 9.20% | 269.75 | 11 | 2.62% | 8.89% | 0.63% | 1.95% | 14.63% | 0.00% | 26.10% |
| Ward 1C Cardiac (913307) | 42 | 22.67% | 361.00 | 545.37 | 8.50% | 650.75 | 5 | 5.79% | 10.78% | 3.79% | 2.85% | 4.23% | 6.62% | 31.31% |
| Ward 1C Neonatal (913310) | 44 | 40.08% | 556.00 | 1228.5 | 0.47% | 23 | | 23.74% | 14.11% | 4.68% | 0.45% | 5.16% | 0.00% | 28.11% |
| Ward 3A (915309) | 42 | 29.32% | 371.00 | -46.07 | 10.80% | 813 | 19 | 9.01% | 10.58% | 3.70% | 1.23% | 10.54% | 6.64% | 34.14% |
| Ward 3B - Oncology (911208) | 46 | 30.96% | 555.00 | 1487.22 | 17.27% | 996 | 41 | 9.83% | 10.83% | 2.36% | 0.86% | 7.22% | 5.51% | 34.04% |
| Ward 3C (911313) | 46 | 34.70% | 607.00 | 1850.63 | 21.45% | 2068.25 | 136 | 23.28% | 10.98% | 2.90% | 1.60% | 9.17% | 3.96% | 31.79% |
| Ward 4A (914210) | 42 | 20.09% | 634.00 | 391.75 | 4.03% | 322 | 50 | 20.59% | 12.97% | 4.74% | 1.41% | 6.28% | 6.01% | 35.06% |
| Ward 4B (914211) | 46 | 35.32% | 533.00 | 161.48 | 7.07% | 575 | 3 | 24.40% | 9.40% | 5.54% | 0.99% | 9.89% | 5.60% | 35.37% |
| Ward 4C (912207) | 46 | 31.02% | 280.00 | 89.22 | 13.16% | 1015.93 | 13 | 4.89% | 12.79% | 3.85% | 1.21% | 4.59% | 1.50% | 26.62% |
| **May-24** | **40.3** | **28.32%** | **9001.50** | **9084.24** | **10.58%** | **15592.52** | **468** | **14.65%** | **12.16%** | **2.69%** | **1.95%** | **7.64%** | **2.90%** | **29.20%** |
| **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%** |

## Progress and Challenges

Progress continues in month in virtually all areas except additional duties and study leave. We have achieved target in two new areas, namely unfilled roster, and total unavailability, with some continued improvements in net hours, unavailable hours, and bank.

Medicine lead times improved again from 40 to 45 days so achieved target. Total unavailability improved from 30.25% to 28.07%. Most significantly, net hours reduced from 6026 to 4085, which is a great achievement and reflective of the regular roster reviews and the sign off meetings. This could be a result of the total unavailability improving from 36.45% to 30.25%. The issue of 4B and over allocation of study leave will be flagged with the senior nursing team. Additional duties have increased as highlighted mainly relating to 3C.

Surgery net hours have reduced again from 6836 to 3566, nearly a 50% reduction, and are now well within the target of 5566. Temporary staffing also reduced from 8582 hours to 7228, with a fill rate of 88%. There were no further declines in any other KPI areas in surgery in May.

Community total unavailability has improved from 41.33% to 36.35%, meaning more staff are available to deliver care to our children and young people. Lead times have reduced from 27 days to 19 days, with SFH influencing this figure with a lead time of only 6 days. The Roster team are supporting the roster review and sign off meetings will improve this figure in the coming months. Additional duties have also increased in community, from 46 to 67, and again the roster team are meeting with the leads to ensure the shifts are being used appropriately and are not being left unfilled in error.Net hours have increased from 1106 to 1433 with the majority of these being in OPD. The roster team are picking this up directly with the OPD Manager.

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 continuing to be made, with improvements in all areas, with the key challenge clearly additional duties. 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.

**BOARD OF DIRECTORS**

**Thursday, 4th July 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 ☐<br>Assurance ☒<br>Information ☐<br>Regulation ☐ |
|---|---|
| **Summary / Supporting information** | Previous Trust Board papers (2023 & 2024) |
| **Action required** | To Approve ☐<br>To Note ☒ |
| **Strategic context**<br><br>**This paper links to the following:** | Oustanding care and experience ☒<br>Collaborate for children & young people ☒<br>Revolutionise care ☒<br>Support our people ☐<br>Pioneering breakthroughs ☐ |
| **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 | 8 |

## 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 been operating for three months and has met the target to offer an assessment to all the children and young people who transferred from the previous provider.

The service continues to keep under review it's capacity to receive an allocation of children and young people from the national waiting list. It is envisaged that sufficient capacity may be available in the service from October 2024. In addition, there are approximately 8 children and young people who were due to be seen by the London service in Autum 2023 and the North West service has offered this group of children and young people an assessment.

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:

- Overall case load stands at 106 children and young people, following 1 discharge and 2 transfers to the London service.

- 158 appointments have been offered within the first 3 months of the service, this includes initial appointments and follow ups.
- 110 appointments with children and young people and their families have been conducted.
- 13% of appointments have been cancelled at very short notice by families, or not attended. This is higher than anticipated and the service are reviewing the reasons for this. The service will ensure that children and young people are supported to access the service, but a consistent approach to discharge with the London service will be implemented.
- 82 children and young people have been assessed and it should be noted all assessments are undertaken jointly by 2 experienced clinicians.
- 25 children and young people have been offered at least 1 assessment appointment but have opted to defer their assessment to a later date.

As reported in the update to Trust Board in May 2024, positive feedback continues to be received from children, young people and families regarding the service and this continues.

## 5. Estates

Staff within the service have started to be inducted into the new premises in Warrington, and it is expected that the building will be available for staff use within the next couple of weeks. The ground floor, where the main clinical space is located, has incurred an additional delay of 2 weeks. It is expected that the building will now be fully open in early August 2024. 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.

## 6. Workforce and Recruitment

To date, the service has appointed 36.8wte staff to date, with remaining interviews to be held in July and August. 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

To date there has not yet been any formal direction from NHS England, following the publication of the final Cass report, though this is expected by the end of July 2024. The service is likely to need to adapt to meet the recommendations of the Cass Review and will continue to seek clarity on next steps from NHS England. Work continues with NHS England regarding the National MDT and future provider network arrangements.

## 8. Recommendations

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

**June 2024 performance – Subject to change**

| Strategic Goals | Key Metrics | Target | Actual for June |
|---|---|---|---|
| Outstanding Care and Experience | Number of Severe or Fatal Incidents – Physical & Psychological | 0 (zero) | **1 (Being reviewed 2nd July)** |
| | 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 (MSSA)** |
| | FFT - % Recommending Trust | > 95% | **91.5%** |
| Supporting our People | Staff Turnover | *<10%* | **9.9%** |
| **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% | **83.7%** |
| | Number of RTT Patients waiting >52weeks | 0 (zero) | **747** |
| | % 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. The number waiting is 2,794.** |
| | Elective Recovery (Volume vs 19/20) | > 107% | **120%** |
| | Diagnostic Performance | > 90% | **88.7%** |
| | I&E Year End Forecast | £3.4m | **£ TBC** |

**Operational Plan Progress Summary**

Published July 2024

| Strategic Goals | Progress in June 2024 | Areas of challenge |
|---|---|---|
| **Outstanding Care and Experience** | • Significant improvement in Pals and complaints performance<br>• Soft Launch of family hub in place<br>• Working group commenced to review medication errors in neonates following an increasing trend.<br>• First learning reviews undertaken as part of PSIRF with positive feedback on approach from those involved | • Martha's Rule pilot slightly delayed but will go live in July.<br>• Experience workshop due to be held in July to set work plan for this year.<br>• Issue nationally with sepsis training package which is now resolved but has impacted training compliance |
| **Supporting our People** | • People Plan update to June board.<br>• Professional Hub A3 completed.<br>• Additional Management Essentials module launched.<br>• Workforce Stability metric in place | • Thriving staff index launch is delayed. Pilot successful. Reviewing method of distribution. |
| **Pioneering Breakthroughs** | • Stakeholder engagement for portal as part of Alder Hey Anywhere workstream to collate end user requirements has now come to a close – specification is now in progress of being written ahead of tender process.<br>• Ambient AI- Ongoing discussions to agree collaborative agreement with supplier including integration with Meditech, support to complete DPIA and data sharing agreements for trial | • Ambient AI- getting the collaboration agreement to commence the trial is taking longer than initially expected. |
| **Revolutionise Care** | • 747 patients waited over 52 weeks for treatment against a trajectory of 763.<br>• A&E Performance was above external trajectory with 83.7% of patients being seen within 4 hours, against an internal trajectory of 85%.<br>• Early review of June's activity plan suggests an achievement of 103% against plan. 97% when reviewing elective & day case performance for the month of June, whilst New Outpatient appointments and procedures is at 106%. | • Number of patients waiting over 65 weeks for treatment continues to increase. A deep dive into dental service is being carried out as this is the biggest area of risk to achieving zero patients waiting longer than 65 weeks by September 2024.<br>• 6-week diagnostic performance continues to remain below the national target of 95%, achieving 88.7% in June.<br>• The number of patients waiting longer than 2 years for their follow up appointment has risen to 6,113. |

| | | |
|---|---|---|
| | • Significant progress has been made with developing the Productivity Dashboard in June. The next step is to develop divisional specific dashboards and to incorporate external benchmarking.<br>• 7 developments were prioritised through Clinical Digital Design Authority for June, and 5 developments complete this month.<br>• AlderC@re highlights include change to track shared care of community prescribing, improvements for managing waiting list, document to audit care of wheeze patients, document for ponseti assessment and significant safety improvement for recording VTE assessments. | Joint working between Delivery Management Office, Business Intelligence and Performance teams has commenced in month in preparation for a workshop with Clinical Leads.<br>• 2,794 patients are waiting for ASD or ADHD diagnosis. The ADHD medication shortage continues to affect patients following diagnosis.<br>• Theatre utilisation remains static at around 78%. A paper on improvement plans has been requested by Divisions to be presented at July Operational Delivery Board.<br>• 2 Alderc@re developments have been delayed- one due to difficulties getting clinical/operational engagement another due to an increase in scope |
| **Collaborate for Children and Young People** | • Reducing Health Inequalities (HI) and Prevention<br>• 1. Positive reduction in waiting times for u10yrs tooth extractions (Core20&5CYP and Alder Hey HI target)<br>2. Wellbeing Hub – implementation progressing for July go live<br>3. Healthy Food – AH workstream evolving with Dentistry and Public health clinical leadership including working with partners such as WH Smith re offers onsite, and developing plans with via Obesity clinical leads for access to healthy fruit and vegetables via Complications from Excess Weight Clinics<br>4. Tobacco Control – Alder Hey are members of Liverpool City Council's Strategy development group, and AH COO leading internal work re: response to smoking onsite<br><br>• Creating Opportunities<br>1. Building capacity in the Widening Participation team with 2 new starters July 24<br>2. Continued widespread delivery of education/careers sessions e.g. Imagine my Future Programme @ St Mary's | • Net Zero / Green – programme leadership to be identified.<br>• Social Value – Needs sider scope e.g. include Procurement and other Trust Wide services – limited capacity & capability to drive. |

| | | |
|---|---|---|
| | Primary School (June) , Alder Hey Careers Fair, careers sessions in range of secondary schools<br>3. Social Value calculator being developed, pending permanent BI Dashboard (see also challenges below)<br><br>• CYP System<br>1. Persistent school absence - Membership of Liverpool Strategic Partnership North Liverpool Prototype Group focussing on persistent school absence – Alder Hey's role likely to be to support practitioner mental health training<br><br>• Advocacy<br>1. BB Partners (working on behalf of Alder Hey Charity, and AH trust) are reshaping campaign messaging considering the snap General Election – narrative of the campaign will need to be about supporting the new Government to work on the areas that matter | |
| **Financial Sustainability** | • £1.5m deficit in month, on plan with the exception of £232k in relation to industrial action.<br>• £0.4m of contingency from reserves was released in order to achieve this position ytd.<br>• YTD deficit £3.4m with forecast to be overspent against surplus plan of £3.4m by £232k due to Industrial action costs incurred in month. Forecast does not include costs of future industrial action.<br>• Achieving this forecast will be subject to CIP delivery and industrial action risk.<br>• £13.1m CIP identified and in progress YTD with remaining due to be posted by Q4 to achieve plan in year.<br>• Capital spend lower than plan ytd. | • Work ongoing to support the delivery of efficiency targets, including the work on benefits from the strategic initiatives.<br>• Continued cost control required to reach the year end position, with specific focus on non-clinical posts in line with ICB stretch target.<br>• HPL support to review non pay spend in divisions.<br>• Capital plan to be reprofiled to align with expected timing of spend, to support review and scrutiny of capital programme. |

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

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

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☑<br>Regulation ☐ |
| **Action/Decision Required:** | To note ☑<br>To approve ☐ |
| **Summary / supporting information** | The purpose of this report is to provide a Campus and Park progress update.<br>The Board is asked to confirm acceptance of the update and advise if reassurance has been provided. |
| **Strategic Context**<br><br>**This paper links to the following:** | **Outstanding** care and experience ☑<br>**Collaborative** for children & young people ☑<br>**Revolutionise** care ☑<br>**Support** our people ☑<br>**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 |

# Campus Development Report on the Programme for Delivery

## July 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 are continuing to develop a 5-year programme outlining proposed site completion works, enabling schemes and other infrastructure/demolition works and are also considering potential next phase capital schemes. Following a presentation to Trust Board 06.06.24, an informal consultation period will be undertaken with key internal and external stakeholders as a framework to developing site master planning opportunities at Alder Hey and Alder Park. To support the delivery of the 2030 Strategy and beyond, it will be important to understand the clinical model and to translate this into a Trust Estates 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 | 6 | 1 | 5 | |
| Police Station Refurb | TJ | 5 | 1 | 4 | |
| Neonatal & UCC | JOB | 18 | 3 | 15 | |
| Gender Development Services (GDS) | JVH/JG | 2 | 0 | 2 | |

Since last reported, six local risks have been closed and two new risks identified:

- Neo-Natal/SDEC – 2 risks closed (increased works for service diversions & planning for the jewels/facade) and 1 new risk identified (inflation costs medical devices).
- Police Station Refurbishment – 2 risks closed (general construction risks).
- Gender Development Service – 2 risks closed (budget pressure & planning consent for heating plant).
- Fracture / Dermatology OPD – 1 new risk opened (Mitie approvals process).

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.<br>Draft services Deed of Variation 28.06.24. |
| SF/Catkin | Contractor Compensation Events (CEs) | Not Assigned | 12 | Trust has responded to CEs and associated correspondence received.<br>Briefing presentation held 18.06.24 for Executive/Non-Executive Directors. |

## 3. Construction Programme Delivery Timetable (Critical Path)

| | | 2024 | | | | | | | | | | | | 2025 | | | | | | | | | | | | 2026+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Project** | **Deliverable** | 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)

| | | 2024 | | | | | | | | | | | | 2025 | | | | | | | | | | | | 2026+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Project** | **Deliverable** | 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:<br>• Electrical Strike 01.06.24 caused by an excavator affected the operation of some fire alarm panels in Sunflower/Catkin building.<br>• Draft services Deed of Variation (lifecycle & maintenance) to be issued 28.06.24, to be finalised August '24.<br>• Hoarding installation to complete June '24. | | Completion of main construction works.<br><br>Increased construction & SPV costs.<br><br>Delay to unit opening. | Construction completion reported as 20.10.25. On-going monitoring. Formal monthly Construction Progress meeting.<br><br>Fire alarm panels to be replaced. |
| Costs and Operational Coordination:<br>• Trust is working with Morgan Sindall Construction to look at opportunities to open the new Ground Floor as quickly as practicable.<br>• Ground Floor (GF) shell space review meetings commenced 03.06.24 to agree final design. | | Potential decant costs.<br><br>Potential budget & programme impact of GF reconfiguration changes. | Agree decant plan ED waiting and EDU.<br><br>Agree GF design. |

### Catkin & Sunflower House Building

| Deliverable | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| Finalising Contract Position:<br>• Trust meetings with contractor held 06.03.24, 09.04.24 & 21.05.24.<br>• A briefing presentation was held for Executive/Non-Executive Directors 18.06.24. to update on latest position and next steps. | | Possible contract claim. | Continued oversight via Finance Transformation & Performance Committee. |
| Sprinkler System Under-Croft Car Park:<br>• Cost quotes requested from two potential contractors, one received and one awaited. | | Fire compliance.<br><br>Budget TBC. | Cost analysis review upon receipt of both quotes. |

## Modular/Office Buildings

| Deliverable | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| Space Utilisation:<br>Executive Directors approval obtained 30.05.24 to address immediate priorities:<br>• Permanent solutions for those staff currently accommodated on a 'temporary' basis.<br>• Alternative accommodation for teams/services currently based in the Histopathology building, to allow demolition of the building.<br>• Potential increased scope: meeting rooms and storage. | Green | Potential resistance from teams to new ways of working, sharing space with other teams and re-locating.<br><br>Lack of funding for works/kit. | Full staff engagement exercise to agree final desk allocation, move dates and operational logistics.<br><br>Budget and scope of works to be finalised. |
| Former Police Station Refurbishment:<br>• Main contract in place, works progressing. | Green | Operational date currently assessed as July 2024. | On-going site meetings & pre-move planning with service senior leadership team and estates. |

## Park Reinstatement

| Deliverable | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| Community Communications: Works in Progress<br>• 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.<br>• 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. | Green | Inconsistent communications. | Continued and maintained input & communications from all key stakeholders. Quarterly newsletters and regular website updates. |
| Completion Works:<br>• Drainage works and final seeding to the football pitches has been completed.<br>• Turfing and seeding to the majority of the park is now complete and areas are now being opened for the community to access.<br>• Swale drainage works have commenced. | Amber | Finalised swale drainage solution. | Trust discussions on-going with LCC to confirm and gather required documentation for the handover of Springfield Park to LCC. |

| Deliverable (Park Reinstatement cont/d…) | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| • The path connecting the existing and new Park (near the Monument) has been finished and is open for access. | | | |

## Fracture and Dermatology Outpatients

| Deliverable | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| Work ongoing in line with programme.<br>• Start on Site: 12.08.24.<br>• Construction Completion: 06.12.24.<br><br>Although the start on site date has been delayed, a re-phasing of construction works allows for an earlier construction completion followed by 2 weeks Trust commissioning with a 'go live' date of 20.12.24. | | Delay to completion, impact on operational running of the services.<br><br>Mitie PM resources. | Regular meetings. Close monitoring of critical risks.<br><br>Capacity management plan to accommodate patient activity during works. |

## Mini Master Plan for Eaton Road Frontage / Master Site Planning

| Deliverable | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| High level programme to be fully agreed – 5-year proposed plan developed:<br>• Master Site Planning presentation to Trust Board 06.06.24.<br>• Informal 9-month key stakeholder engagement to be undertaken. | | Trust has identified a mitigation to satisfy 278 (traffic calming) requirements. Budget TBC. | Confirm site tidy and priority immediate works.<br><br>Clinical model / estates strategy to be developed. |

## 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:<br>• Dependencies & phasing.<br>• Potential small works.<br>• Programme of works. | | Programme, available budget.<br><br>Mitie PM resources. | Concept design July '24 TBC.<br>Indicative costs July '24 TBC. |

### Gender Development Services (GDS) – Estates Solution

| Deliverable | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| Main works complete on first floor. Snags to doors and to satisfy fire compliance (evacuation route) are being completed during Trust commissioning time, ahead of occupation.<br><br>Staff fire training & building orientation has been undertaken.<br><br>Water chlorination completed and test results are all clear.<br><br>Phase 1 Partial Possession handover scheduled for 28.06.24. | | Programme, unforeseen costs.<br><br>Building Control sign off. | Delivery schedule and move plan in place.<br><br>Staff occupation from w/c 1 July. |

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

| Deliverable | RAG | Risks/Issues | Actions/Next Steps |
|---|---|---|---|
| Start on site expected July '24 under LOI, enabling works and site set up.<br><br>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.<br><br>Develop Phase 2 business case.<br><br>Develop wider site master planning. |

## 6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 4 July 2024.

**BOARD OF DIRECTORS**

**Thursday, 4th July 2024**

| | |
|---|---|
| **Paper Title:** | Learning from Patient Safety Incidents 1-30 June 2024 |
| **Report of:** | Chief Nursing Officer |
| **Paper Prepared by:** | Associate Director of Nursing and Governance |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☐<br>Regulation ☑ |
| **Action/Decision Required:** | To note ☑<br>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**<br><br>**This paper links to the following:** | **Outstanding** care and experience ☑<br>**Collaborate** for children & young people ☑<br>**Revolutionise** care ☐<br>**Support** our people ☑<br>**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 1-30 June 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

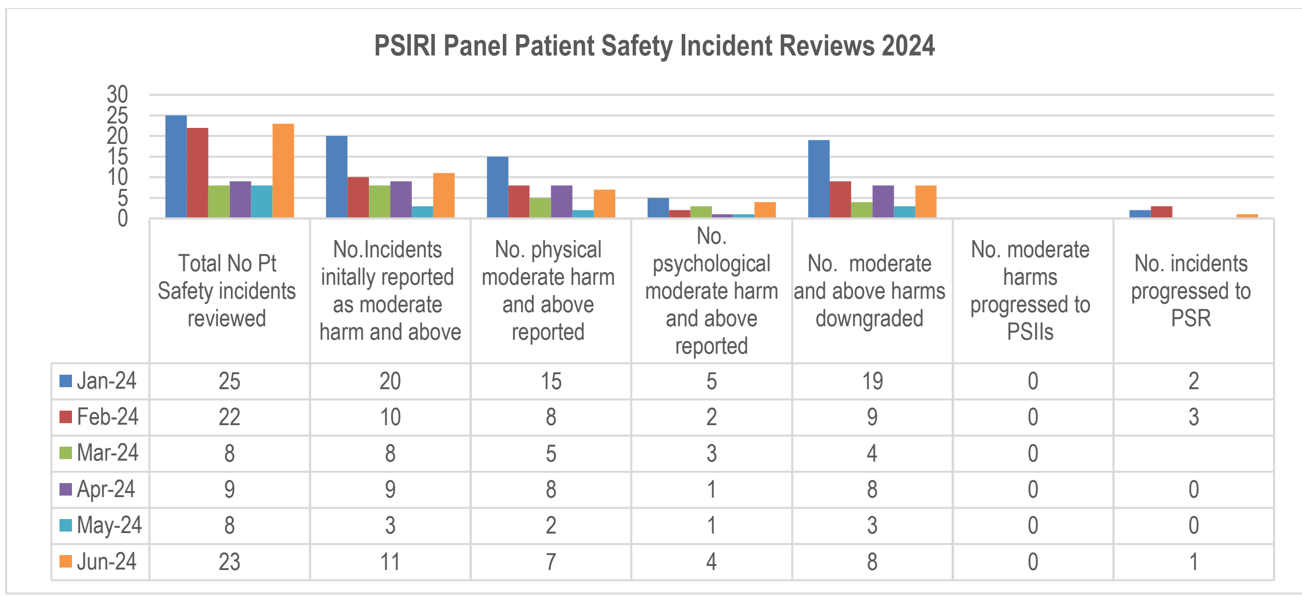
PSIRF replaces the methodology of root cause analysis with a systems-based patient safety incident investigation (PSII) approach or more locally a Patient Safety Response (PSR).

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.

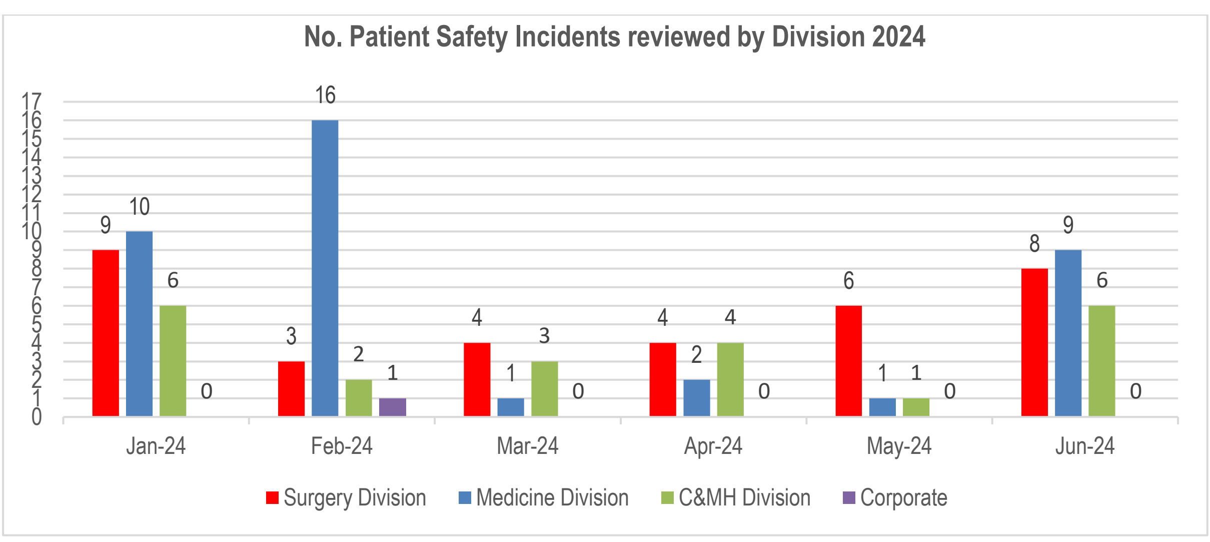
Table 1 below notes the number of patient safety incidents reviewed at PSIRI panel throughout June 2024. Table 2 notes the number of patient safety incidents presented and reviewed by division.

**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 |
| Jun-24 | 23 | 11 | 7 | 4 | 8 | 0 | 1 |

**Table 2**




A total of 23 new reported incidents were reviewed at the weekly PSIRI panel during the reporting period 1-30 June 2024, of which 11 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 8 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)

**1** PSR was commissioned for June 24 as outlined below.

#### 3.3.1

***- # 11067 Moderate physical harm (Medicine).*** *10 year old patient in early puberty. Seen in endocrine clinic 4 June 24 where it came to light patient had missed a year of treatment to prevent progression of puberty and had been lost to follow up.*

**PSIRI panel decision**. Incident initially reported as low harm. Following review was increased to moderate harm and DoC applies. Division to undertake MDT review and report back to PSIRI panel. Endocrine team to undertake look back at system to ensure no other patients have been lost to follow up and safety net OPD appointments with use of SMS text reminders.

## 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.

**4** Duty of Candour responses were required during the reporting period.

## 5. Learning from patient safety incidents

The PSIRI panel received **1** PSR from February 24 that undergone an MDT review and presented back to PSIRI panel with the following learning:

**5.1** ***- # 7991 Moderate physical harm (Surgery).*** *Neonate baby weighing 2.5kg had undergone 2 surgeries in 12 hours returned from theatre coffee ground vomiting NG on free drainage. Following surgery baby was nil by mouth (NBM) and received intravenous (IV) fluids and medications, including paracetamol (delivered through a small tube directly into the vein).*

*The IV paracetamol was prescribed on a paper chart, and the dose prescribed was for 19mgs of IV paracetamol to be given every 6 hours which equates to 7.5mgs/kg as per Trust Guideline. Baby should have received a total of 1.9 mls of paracetamol given over 20 minutes but a ten times error occurred and was given 19mls which equated to 76mgs/kg.*

*Baby prescribed and received doses of an antidote called acetylcysteine and his bloods were monitored as per the National Tox-base advice service and moved to the surgical neonatal unit for closer monitoring and observation.*

**PSIRI panel decision**: Remain at moderate physical harm, DOC applies and division to undertake MDT review. MDT Panel held on the 13 March 24. Report approved by PSIRI panel on 6 June 24.

**Learning identified** as follows:

- Standardise the storage of IV paracetamol across the trust.
- 2. Review the trust guidelines for the treatment of IV paracetamol overdose
- Discuss at the Bedside verification group the ability to scan IV paracetamol.
- Investigate the use of guard rails for intermittent infusions.

### 5.2 System learning

The PSIRI panel identified 5 incidents presented in June 24 that would benefit from linking into an existing workstreams to inform system learning as outlined in table 3 below:

**Table 3**

| Brief incident description | PSIRI Panel findings /Learning | PSIRI Panel Recommendations |
|---|---|---|
| **Medicine Division** | | |
| #11252 #11298 Patient abscension from ward 4c | Despite pilot system in place on ward 4c 2 patients were able to abscond from the ward. Both patients were found and safely returned to ward. Links to current risk 2634 (risk of absconsion) on risk register | Division to link both incidents into existing work on risk of absconsion being led by DoN and Head of Nursing Medicine |
| #11095 #11098 #11094 | Family on staff violence and aggression | Division to link incidents into existing work on zero tolerance being led by DoN. |

**5.3 Cross organisational reviews**

The divisions presented 3 incidents to PSIRI panel that had occurred at another organisations following transfer to Alder Hey. Under PSIRF the incident harm level sits with the referring organisation and the responsibility of that organisation to undertake a review and share any learning with Alder Hey. Brief details outlined below in table 4.

**Table 4**

| Brief incident description | PSIRI Panel findings /Learning | PSIRI panel decision and recommendations |
|---|---|---|
| **Surgery Division** | | |
| #11595 Patient transferred from Lancaster Hospital. Had fallen and fractured left femur on 22 June 24. Thomas splint applied in Lancaster incorrectly | In pain therefore splint removed and 4 areas of pressure damage to foot observed. TVN referral confirmed dep tissue damage Splint re-applied and patient instantly in less pain. | Incident referred to Lancaster 27 June 24 for further investigation. Moderate physical harm applies via Lancaster Hospital |
| **Community & Mental Health** | | |
| #11031 EDYS informed by community T4 team raising concerns about a young person in community with extreme weight loss. And BMI < 12. Previously under EDYS but transfer to private eating disorder clinic | Following a strategy meeting young person was admitted to Alderhey for treatment of anorexia following discharge from a private eating disorders clinic. Other concerns include the young person's review by a new private GP locally who deemed the young person fit to fly to a private eating disorder clinic on South Africa however young person did not have capacity. | ICS informed. SBAR requested from Trust for sharing with ICS corporate nursing team to disseminate across the C&M ICB to support a swift response regarding any concerns with private eating disorder clinic.<br><br>Incident referred to Private Clinic 27 June 24 for further investigation. Severe physical harm applies via Private Clinic/GP |
| #11099 Service made aware by parent of admission to Southport hospital of patient previously | Young person had been reviewed at GP practice monthly over last 3 months. No advice or referral from | ICS informed and incident referred to GP surgery and Merseycare for further investigation. |

| known to EDYS who had a current BMI of 9 and at assessment on 4 June 24 was severely compromised. | GP/Hospital had been made. Young person has lost 27kgs since discharge from EDYS in Aug 2023. The current admission to hospital was due to an overdose of paracetamol. Merseycare crisis team undertook an assessment but did not pick up on the eating disorder and link with the adult Merseycare eating disorder service, suggesting the young person could be discharged and seek a self-referral | Severe physical harm applies via GP/Merseycare |
|---|---|---|

**6. Training and Education**
**6.1 Patient Safety E-Learning**

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

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

**6.2 Bespoke Training**

Total of 20 staff completed the bespoke PSIRF Engagement and Oversight training delivered by Consequence UK against the national service specification for staff involved in learning responses and acting in Family Liaison roles (FLOs).

**7. Legacy Serious Incidents (SIs)**

All legacy SI investigations and subsequent actions have now concluded.

**8.Next Steps**

Areas of focus include the following:

- **Patient Safety Project support** -Successful recruitment of patient safety project support through the apprentice route.

- **Training**: Further roll out of PSIRF training to matrons, ward, and service managers by Heads of Nursing and AHPs and service leads with support from Associate Director of Nursing and Governance.

**9. Recommendations**

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

# BOARD OF DIRECTORS

**Thursday, 4th July**

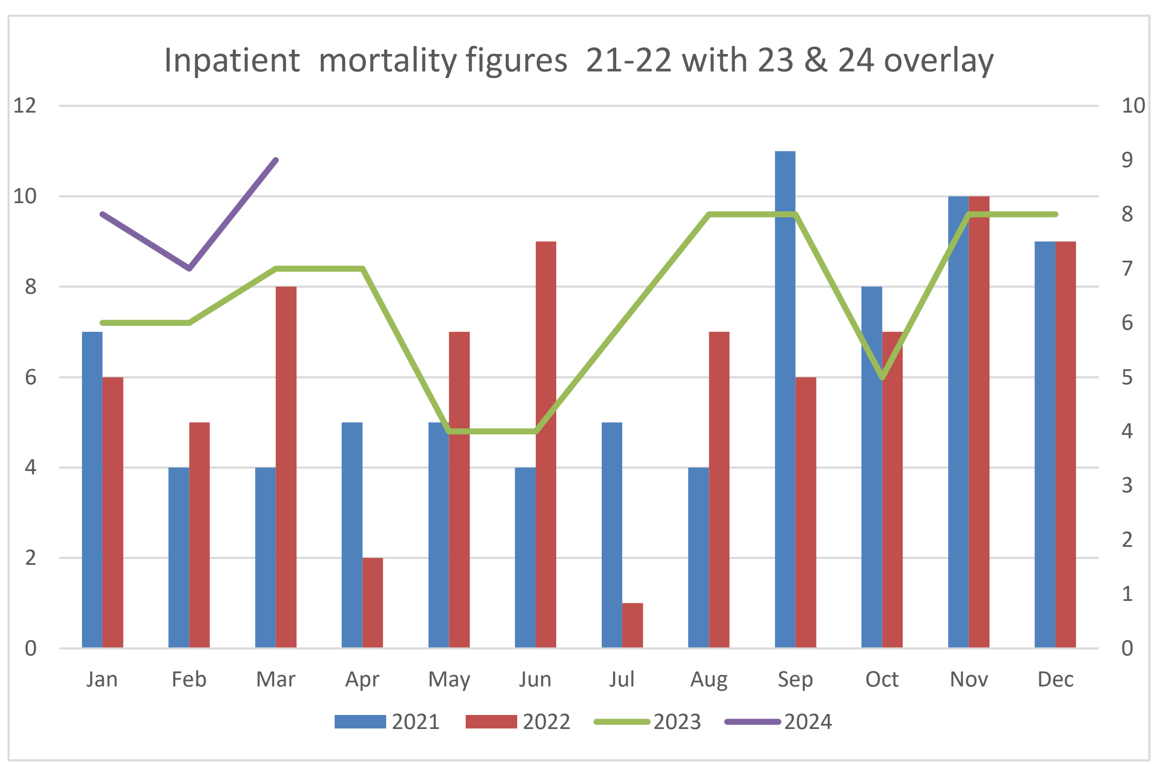
| **Paper Title:** | **MORTALITY ASSESSMENT** |
|---|---|
| **Report of:** | **Mr Bass, Medical Director.** |
| **Paper Prepared by:** | **Julie Grice, HMRG lead.** |

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

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

Section two is the Quarter 3 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved, and specifics about expected vs observed deaths.

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




This graph above denotes the number of deaths, however there is a tread that demonstrates a higher death rate than previous years. As the data from the preceding years demonstrates there are often fluctuations and the average over the year is usually similar. The group have noted that there does appear to be an increase in the number of Out of hospital cardiac arrests in recent months, this will be assessed and highlighted to the Liverpool CDOP (Child Death Overview Panel) for further investigation. Out of hospital cardiac arrest is an uncommon paediatric presentation, and the prognosis is poor.

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

1) One of the most significant recent changes is the introduction of the Medical Examiner (ME) process. The pilot for this began in AHCH in March and is a legal requirement from September 2024. The ME process at AHCH is being undertaken by the LHUFT Medical examiner team. The Trust appointed two paediatric ME's to join the team to provide the expertise to support the process. The pilot has been progressing with any issues highlighted and solved. There are a few challenges with the legislation that has now been released that will need to be resolved prior to September. The ME team, AHCH, the Coroner, and other Trusts nationally involved in the process are collaborating on a solution.

2) It was highlighted in the previous quarterly report that there was no administration support for the HMRG process due to staff leaving. This is now resolved with a new administrator starting in post by May 24. The role has been modified from previous, so it is a full-time administrative role which will support both the HMRG and CDOP (child death overview process). It is a statutory requirement that information is released to the various CDOP panels, and this has been a challenging time due to the pressures on the safeguarding team. By having one person working on both processes, it will provide consistency and continuity. It will take time to modify and improve the process but the action should result in improvement.

3) There is on-going work related to the SUDI/SUDC (Sudden unexpected death of an infant /child). The regional pathway needed to be updated but in view of recent events there has been a review of our internal procedures /pathways. When this is completed then education will be undertaken across relevant areas to support the clinical teams and families in these difficult cases.

## Current Performance of HMRG

## Summary of 2023 Deaths

| | |
|---|---|
| Number of deaths (Jan. 2023 – Dec. 2023) | 77 |
| Number of deaths reviewed | 73 |
| HMRG Primary Reviews within 4 months (standard) | 70/73 (96%) |

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

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

## Outcomes of the HMRG process 2023

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

## Potentially Avoidable Deaths

There have been four potentially avoidable deaths in the 2023 cases reviewed so far. Of these two were due to external factors which by definition were potentially avoidable. There were no issues relating to care received in AHCH. The other two cases highlighted issues in care in AHCH which could have been improved. Following duty of candour, these have been discussed with the family and multiple reviews undertaken to ensure that all possible learning is achieved and prevent a reoccurrence.

## Learning disabilities

The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 70 cases, so far reviewed in 2023, 16% were identified as having learning disabilities. In comparison, last year, 26% of the mortality cases were children /YP identified as having LD.

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

Reviewing the 11 cases identified in 2023:

1) 55% had congenital, chromosomal or genetic conditions as their primary diagnostic code.
2) 1 case coded as sepsis, but this was a community acquired infection and the child had been extremely unwell previously requiring a PICU admission with a relatively mild illness.
3) 36% were coded as death inevitable with hindsight so unfortunately the child /YP was going to die regardless of the optimum care that AHCH provided. There was no possibility of changing the outcome.
4) There was withdrawal of care in 45% when there is nothing more that could be done, and intensive support is removed.
5) In 18% the group considered the care to be ‘good practice’ which is

unusual as it is uncommon for this to be allocated as it only happens when the care is 'beyond the normal'.

There were no concerning themes or trends identified in the LD group of patients. The group continues to work closely with the LD team aiming to ensure that any learning or issues are shared, working towards the best possible care for this often complex group of patients who often unfortunately have considerable exposure to the healthcare system.

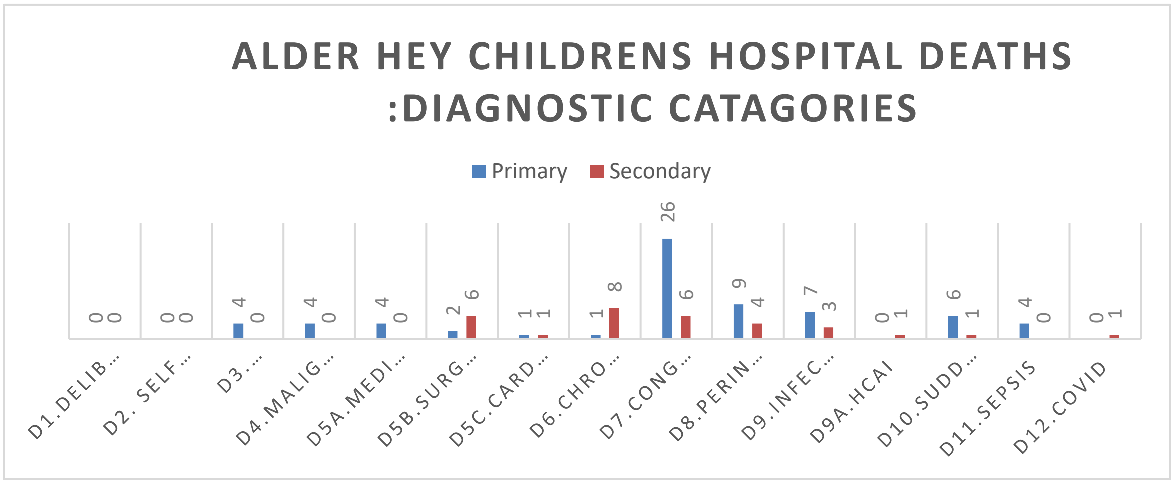
## Family

The Snowdrop (bereavement team) at Alder Hey provide an exceptional service, supporting the family for a considerable time after a patient has passed away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide. There have been an increasing number of families who are asking for a summary of the HMRG review relating to their child/YP. This is provided although done honestly it is written in a way to try and prevent additional distress.

## External Benchmarking

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

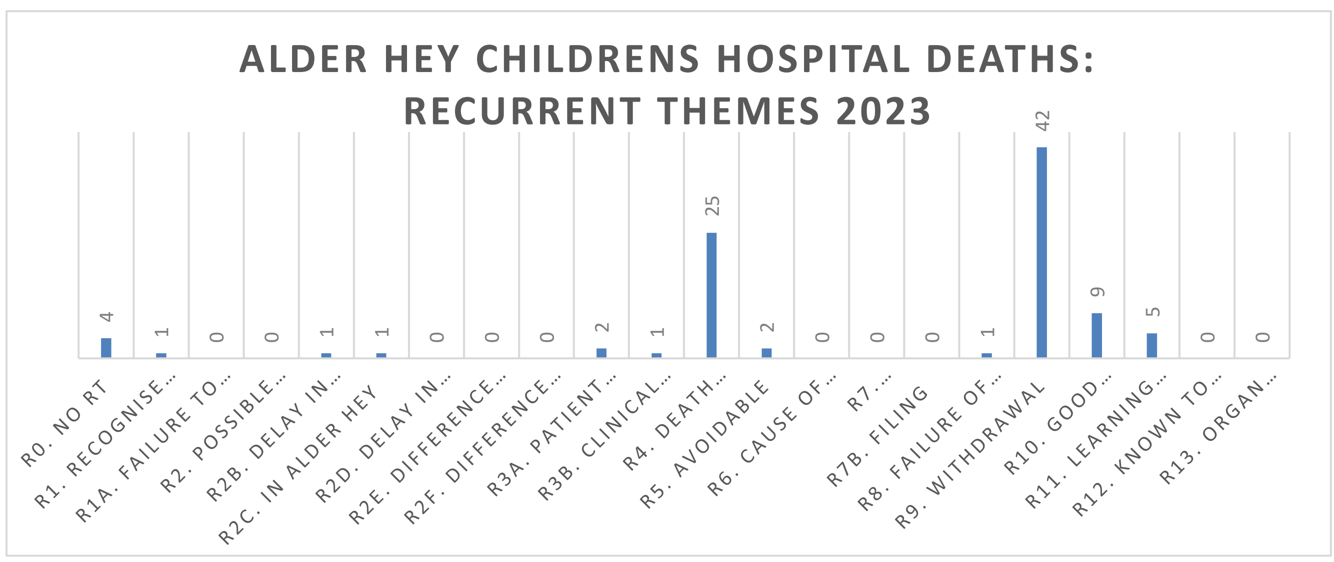
**Primary and Secondary Categories**




The cases reviewed in 2023 show that the highest diagnostic code is 'children with underlying chromosomal, genetic and congenital conditions' (37%), these are often the most complex with several issues ongoing and are the most vulnerable patients. These conditions, depending on the case, can be life limiting and often the care they have received by AHCH and their families have enabled them to live longer than anticipated.

Next, with 11 % is the diagnostic code: 'perinatal/neonatal event' which includes the extreme premature babies who often have a number of complex issues which cannot be treated. The next two codes are 'infection' and 'SUDI – Sudden unexpected death' both with around 10%. Infection is different to sepsis and SUDI's are coded as such whilst waiting for PM's /inquests although on occasions there is no clear cause.

## Recurrent Themes



The main recurrent code for 2023 was withdrawal of care (66 % of cases), which demonstrates that the intensive care team are working with families to ensure that no child/young person suffers unnecessarily when all treatment options are explored but are not suitable.

Death was concluded to be inevitable in 36%, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.

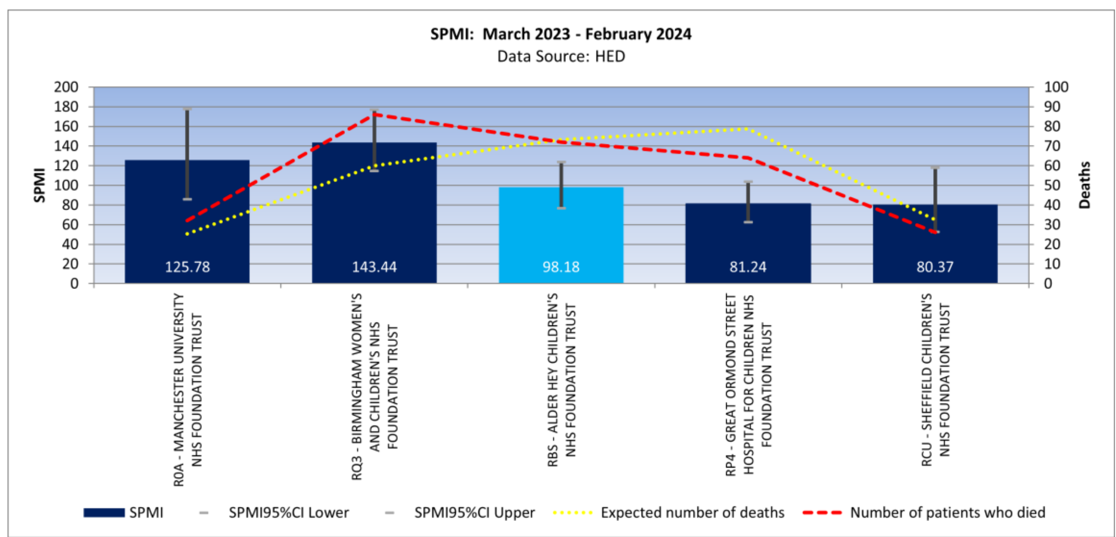
It is interesting to note that the group recorded 14 % of the cases so far in 2023 as good practice since the members tend to be very reticent at allocating this. They believe the standard of care, we as a Trust aim to achieve is extremely high. Therefore, to achieve 'good practice 'is when the team concerned has clearly gone way 'beyond the normal'.
The LD cases have been discussed in depth earlier in the report.

## Section 2: Quarter 4 Mortality Report: January 2024 – March 2024

## External Benchmarking

### Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering March 2023 to February 2024.




The chart shows that Alder Hey has performance of 70 deaths against 66 expected deaths. The caseload over the period shown by HMRG reviews that there is a very high number of cases identified as death inevitable. This suggests that the caseload over this period has been children/YP that regardless of the care provided there was no possibility of changing the outcome. This does raise the question of whether some of these cases should have been transferred and whether we are importing mortality impacting on the figures.

**-PICU**

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

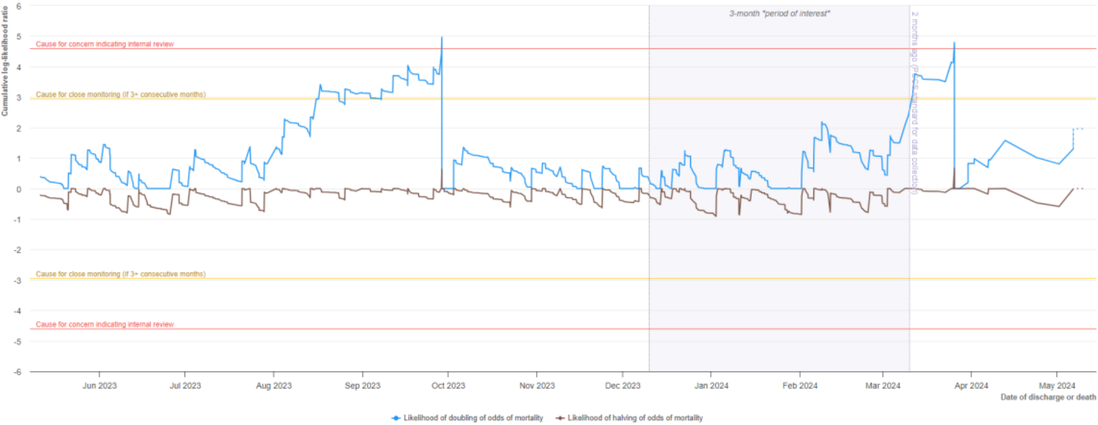
**Figure 5: Risk-adjusted Standardised Mortality Ratio (SMR) by health organisation for under 16 year olds, 2019–2021**

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

## Statistical analysis of mortality:

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

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




We noted in October 2023 the unit's risk-adjusted resetting sequential probability ratio test (RSPRT) reset point had occurred. PICAnet advised to undertake a review of cases leading up to the trigger and reset which included 14 deaths.

We completed a review which was presented to HMRG and included the following findings:

- we identified our PIM3 (paediatric index of mortality) variable reporting to be very robust, alongside the systems in place to monitor and review deaths in our unit.
- the majority of cases involved patients with either significant congenital lesions or co-morbidity that carried the potential for a negative outcome.
- the majority (12/14) were considered to be death inevitable in hindsight with little that could be done to alter the clinical course.
- these were not always apparent at presentation (i.e. when PIM3 is calculated), and highlights both the inability for PIM3 to account for particular co-morbidities, as well as evolving risk of mortality as new information is identified during the course of an ICU admission. This may especially be the case for a number of cardiac and neonatal surgical cases that are transferred in from the wider region and contribute to imported mortality.
- this is a known shortcoming of PIM3 that is currently being considered by PICAnet. We will look for further novel ways to analyse our data that may elucidate trends that would be useful to share with the wider PIC community.

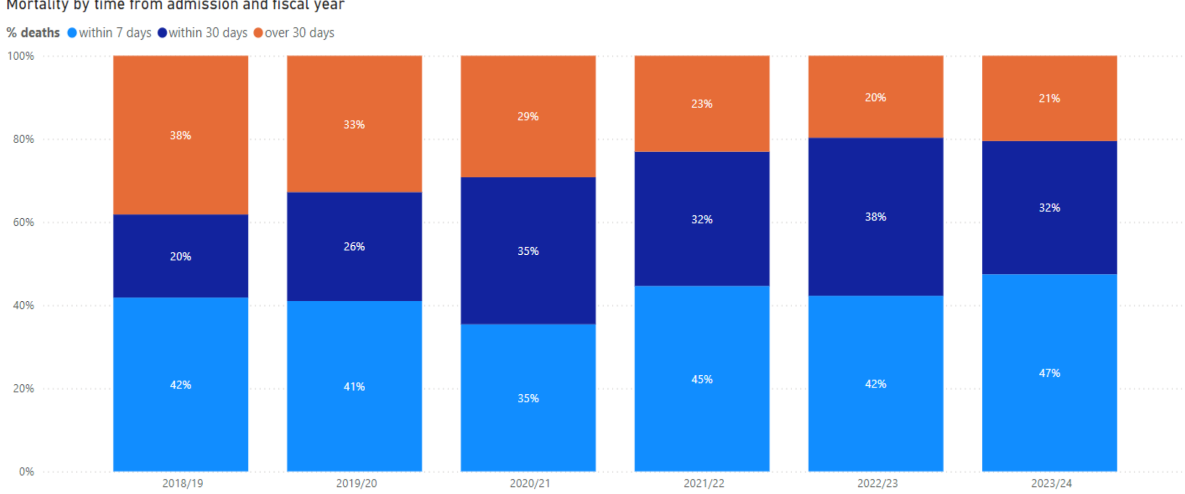
Although previous plots have appeared to 'reset' during real-time monitoring, further adjustment towards the 'period of interest' with subsequent cases has led to a gradual trend in the line away from the warning zone to remain within

the 'safe-zone'. We will continue to monitor the RSPRT closely with the line rising in March.

**Real time monitoring of mortality**

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

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




The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the financial year April 2023 – March 2024, 47% occurred within 7 days of admission, 32% occurred within 8-30 days from admission, and 21% of deaths occurred over 30 days from admission. This concurs with the points raised earlier in the report that perhaps mortality is being imported. Also, the cases that have been reviewed the percentage as death inevitable will die sooner as there is no treatment that can be offered to alter outcome.

## Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, and the 4-month target is running at an acceptable level in view of the workload and the complexity of the cases. It has been a difficult time without an administrator meaning that there has been no opportunity to undertake more in-depth reviews of themes and ensure better learning across the Trust.

Understandably, there has been a cultural change since the Letby case, and more questions are being asked across the whole process. This is correct and we need to ensure that we are being proactive rather than reactive in our response. The new administration aspect should enable this to happen and give us more capability to reach out to our external partners and improve learning in the organisation as resources will be available.
The only potentially concerning trend is the apparent increase in out of hospital arrests which we will aim to address with CDOP and assess if it is a national trend. It is also vital that we do not have children /YP transferred to the Trust where there are no real treatment options, and we are distancing them from their home support network.

The 2 potentially avoidable deaths have highlighted issues which the Trust has done its best to learn from and introduced measures to prevent reoccurrence.

**References**

**SPMI -** The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 9**

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

**PICU SMR** - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these

limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 10**

**PRAiS and VLAD charts -** The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.
The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 12**

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

| | |
|---|---|
| **Paper Title:** | Use of the Mental Health Act (1983 & 2007) Annual Report, 2023/24 |
| **Report of:** | Lisa Cooper<br>Director Community & Mental Health Services |
| **Paper Prepared by:** | Dr Andrew Kevern<br>Consultant Child & Adolescent Psychiatrist<br>Mental Health Act Lead |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | N/A |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | **Outstanding** care and experience ☑<br>**Collaborate** for children & young people ☑<br>**Revolutionise** care ☐<br>**Support** our people ☐<br>**Pioneering** breakthroughs ☐ |
| **Resource Impact:** | None identified |

| **Does this relate to a risk?** Yes ☐ No ☑<br>**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. Report Purpose

The purpose of this paper is to provide assurance to Trust Board regarding activity in relation to use of the Mental Health Act (1983 & 2007) (MHA) for the reporting period 01 April 2023 – 31 March 2024.

## 2. Introduction

There are several different legal frameworks under which Alder Hey treats children and young people aged 0-18 years, which have been determined by Statute and Case Law.

Most children with physical disorders are treated under their own consent if they are Gillick Competent, that is if they have enough intelligence and understanding of the decision to be made; or under Parental Consent if the decision is within the Scope of Parental Responsibility and if parents are believed to be acting in the best interests of the child.

The Scope of Parental Responsibility has some limitations clarified by the Mental Health Act Code of Practice and some limitations clarified by Case Law. Otherwise, there must be a decision made over whether the consent is 'a decision that a parent should reasonably be expected to make' in relation to medical care of their child.

In practice children and young people are detained under the Mental Health Act if they have a mental disorder and require hospital treatment and:

1. Require deprivation of their liberty significantly beyond age-appropriate levels of parental supervision such as the use of a seclusion room or restraint to prevent absconsion.

2. Require deprivation of their liberty and the local authority has acquired 'parental responsibility', as the local authority cannot consent to a deprivation of liberty.

3. Refuse admission and/or treatment and are Gillick competent or aged 16+.

4. Require repeated intrusive treatments such as restraint for intramuscular injections if they are extremely agitated and putting themselves and others at risk and after all alternative interventions have failed or such as requiring restraint for nasogastric feeding if they have an eating disorder.

Children and young people are detained for a period of assessment and treatment (Section 2: up to 28 days) or for a period of treatment (Section 3: up to 6 months then can be extended for up to a further 6 months, and yearly thereafter). Children and young people can challenge any of these decisions by appealing to a Mental Health Tribunal or to the Independent Associate Hospital Managers. Children and young people have access to the support of an Independent Advocate who will assist them to appeal.

Children and young people may be brought to the Emergency Department by Police under Section 136 of the Mental Health Act. The Emergency Department is a designated place of safety for those children and young people who appear, to a police officer, to be suffering from a mental disorder and to be in immediate need of care or control. Once in the Emergency Department these children and young people will

receive a mental health assessment which may result in detention under Section 2 or 3 of the Mental Health Act.

Children and young people may be detained to Alder Hey or from Alder Hey to another hospital on the recommendations of two doctors and an Approved Mental Health Practitioner (AMHP). If children and young people are being sectioned to another hospital, then the detention starts on arrival at that hospital, and they are recorded in the destination hospital's figures and not the Trust's.

Children and young people may be discharged from hospital on a Community Treatment Order (CTO) These are children and young people who have been detained on a Section 3 and the Section is put aside to allow discharge with some conditions. If those conditions are not complied with the section can be reinstated (recall for a period of assessment up to 72 hours, and then revoked if deemed appropriate).

The Mental Health Act (1983 & 2007) authorises the Trust to deprive children and young people of their liberty to assess and treat a mental disorder. The Mental Capacity Act (2005) authorises the Trust to deprive adults (>18) of their liberty to manage a physical disorder. A Family Court or Court of Protection deprivation of liberty order authorises the Trust to deprive children and young people (<18) of their liberty to manage a physical disorder or to keep them safe. All qualifying children and young people have access to Independent Mental Health Advocacy (IMHA) in line with the Mental Health Act. The provider, "Real Advocacy" is a specialist Tier 4 Mental Health Advocacy Service that works in close liaison with the Tier 4 and Paediatric Wards when children and young people are detained under the Mental Health Act.

To support both the increase in young people detained under the Mental Health Act and ensure that the legal and statutory administrative processes related to the use of the Mental Health Act are followed correctly, a service level agreement with Merseycare NHS Foundation Trust is in place. This service level agreement supports the complex administration of the Mental Health Act, facilitates the review of appropriate Trust policies, and promotes effective staff training in relation to the Mental Health Act.

## 3. Detentions under the Mental Health Act

For the reporting period 01 April 2023 – 31 March 2024, the Trust had **10** children and young people detained under a section of the Mental Health Act. This is a decrease compared to 2022/2023 when **17** children and young people were detained under a section of the Mental Health Act.

**Table 1** shows the breakdown of children and young people detained under the Mental Health Act for the reporting period compared with previous years. The sections of the Mental Health Act used are shown in **Appendix One**.

**Table 1: Annual detentions under Mental Health Act**

| Location | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 |
|---|---|---|---|---|
| Tier 4 In patient Unit | 2 | 2 | 2 | 4 |
| Paediatric Ward | 3 | 3 | 7 | 2 |
| CTO | 0 | 2 | 1 (Tier 4) | 0 |
| CTO recall | 0 | 0 | 1 | 0 |
| Section 136 | 2 | 5 | 6 | 4 |
| **Total** | **7** | **12** | **17** | **10** |

## 4. Deprivation of Liberty Order Safeguards

In relation to those aged 18 years or over, the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009, as part of the implementation of the Mental Capacity Act 2005, to ensure better legal and administrative protection for all those who may, for whatever reason, lack Capacity to consent to the care they are receiving, including where they live and how they are cared for on a day to day basis.

Prior to the Mental Capacity Act, there was a lack of clarity about how the liberty and human rights of those lacking capacity to consent to their care arrangements, including where these restricted their movement and choices, should be protected. The bulk of people whom the Act was intended to help had serious disabilities including those arising from dementia, learning disabilities and serious mental health problems.

The DoLS regime only applies to hospitals (NHS or private) and care homes (registered with CQC). In any other type of placement, deprivation of liberty can only be authorised by an order from the Court of Protection. If there is no authorisation in place, then a deprivation of liberty is unlawful.

Three factors determine deprivation of liberty under Article 5 of the European Convention on Human Rights:

1. The objective element: i.e. that the person is confined to a particular restricted place for a non-negligible period of time
2. The subjective element, i.e. that the person does not consent (or cannot, because they do not have the capacity to do so) to that confinement
3. State imputability: i.e. that the deprivation of liberty can be said to be one for which the State is responsible.

The statutory framework of the Deprivation of Liberty Safeguards (DoLS) does not apply to those under 18 years of age. For under-18s, a legal framework must be placed around the arrangement to ensure that the deprivation of liberty is lawful.

A deprivation of liberty will be lawful if warranted under statute, for example, under

- Section 25 of the Children Act 1989 (placement in secure accommodation)
- Mental Health Act 1983
- Youth remand provisions of the Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Custodial sentencing provisions of the Power of Criminal Courts (Sentencing) Act 2000

Where the deprivation of liberty is not authorised by statute, then the appropriate consent must be obtained, either from the Court of Protection or from the High Court exercising its inherent jurisdiction:

- Children/Young People Under the Age of 16 - the Mental Capacity Act 2005 does not apply to those under 16 years; therefore, application must be made for authorisation under the inherent jurisdiction of the High Court.
- Children/Young People Aged 16 and 17 - the Mental Capacity Act 2005 applies. An application must be made to the Court of Protection.

**Table 2** below shows the number of Deprivation of Liberty Order Safeguards applications made for the reporting period compared to previous years.

**Table 2: Applications for Deprivation of Liberty Order Safeguards**

| Applications | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 |
|---|---|---|---|---|
| Urgent DoLS applications | 11 | 11 | 4 | 1 |
| Standard DoLS applications | 3 | 2 | 11 | 6 |
| Court of Protection | 0 | 1 | 0 | 0 |
| **Total** | **14** | **14** | **15** | **7** |

## 5. Mental Health Act Training

Currently Mental Health Act training is required for the following areas on an annual basis: Specialist Mental Health Services, Ward 4C and Emergency Department. Training compliance for these identified areas within the Trust is shown in **Table 3** for the reporting period. All areas are compliant with the required training.

**Table 3: Mental Health Act Training Compliance**

| Service/Ward | Mental Health Act Training Compliance |
|---|---|
| Specialist Mental Health Services | 97.2% |
| Ward 4C | 100% |
| Emergency Department | 97.6% |

In addition, to annual Mental Health Act training, Merseycare provide training regarding Mental Health Act paperwork and administration to appropriate staff across the Trust as part of the service level agreement.

## 6. Care Quality Commission (CQC) Mental Health Act monitoring visit

An unannounced Care Quality Commission (CQC) Mental Health Act monitoring visit took place at Sunflower House on the 05 September 2023. The purpose of the visit

was to monitor the use of the Mental Health Act 1983 (MHA) for detained children and young people to ensure their needs are safeguarded.

On the day of the visit there were 6 children in Sunflower House, with 1 child being detained under the Mental Health Act. The review was completed by an approved CQC MHA reviewer.

Several positive inclusions are in the report relating to the environment and staff. The CQC, based on their review have concluded that they have no concerns regarding the use of the Mental Health Act and compliance with the Code of Practice in Sunflower House. No actions for the Trust were identified in the review.

## 7. Incidents

For the reporting period, **1** incident was reported in relation to use of the Mental Health Act within Sunflower House. The incident reported related to documentation for the Mental Health Act and no physical or psychological harm was sustained in relation to a child. The incident was reported to the CQC, NHS England as lead commissioners for the service and the child and family involved. A rapid learning review was undertaken which identified learning for Sunflower House which has been implemented.

## 8. Independent Mental Health Advocacy Service

An Independent Mental Health Advocate (IMHA) is a specialist advocate. The right to an IMHA was introduced in 2007 under amendments to the 1983 Mental Health Act. This gave legal rights to IMHAs which are not available to other advocates. These rights mean that IMHAs may:

- Meet qualifying children and young people in private.
- Consult with professionals concerned with the child or young person's care and treatment.
- See any records relating to the child or young person's detention, treatment, or after-care, for the purpose of providing help to the child or young person and where the child or young person consents.
- Request access to records where the child or young person lacks capacity to consent, if accessing the records is necessary to carry out the functions as an IMHA.

IMHA services are independent, confidential, and free of charge to the child or young person and whilst they do not have to accept help from an IMHA they can change their mind at any time, as such this service should be promoted to children and young people detained under the Mental Health Act. Alder Hey commissions "Real Advocacy" to provide advocacy support to children and young people detained under the Mental Health Act within the Tier 4 Childrens Inpatient Unit and acute paediatric wards.

For the reporting period there were **12** children and young people referred for advocacy support from the Trust's Tier 4 Childrens Inpatient Unit and **3** children and young people referred from Ward 4C.

Issues discussed with children and young people who required advocacy support included:

- CPA/IMAR Support
- Views on care plan
- CETR
- Discharge request
- CSC Reassessment
- MHA Rights
- Home leave
- Medication
- Diagnosis
- Review of restrictive practice including young person's views
- Meeting with interpreter
- Responses to questions from Hospital Social Worker
- Access and liaison with Solicitor
- Family contact
- Discharge from MHA framework

In addition, the Advocacy Service liaised closely between the clinical teams on Ward 4C, Eating Disorders Team and the Mental Health Act office (Merseycare) to ensure that young people detained to the acute paediatric ward have timely access to an IMHA and that in the event of an appeal this is processed swiftly. The Advocacy Service has also provided training to Ward 4C and Sunflower House staff on the role of advocacy and will continue to provide this on a quarterly basis.

There were no safeguarding incidents requiring involvement from the Advocacy Service during the reporting period and no formal complaints or concerns raised from the children and young people referred to the service. There were no complaints or compliments raised regarding the Advocacy provider during the reporting period.

## 9. Next Steps

The Trust Board are asked to note the contents of this report and be assured that the Trust has in place robust arrangements to deliver the appropriate requirements of the Mental Health Act (1983 & 2007) and is responsive to the needs of children and young people for whom this applies.

## Appendix One: Definitions of sections of the Mental Health Act

| Section of Mental Health Act | Definition |
|---|---|
| Section 2 | The criteria for detention under Section 2 of the Mental Health Act 1983 (2007), is if a person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment and possibly medical treatment for a limited period of up to 28 days. The initial assessment for detention will be completed by 2 doctors and an Approved Mental Health Practitioner (AMHP). This section can only be extended if an application is made to the county court on specified grounds for a Nearest Relative to be displaced and / or an acting nearest relative to be appointed (s.29(4)) or if the patient has been AWOL and returned to the hospital before the section expires. Otherwise, a further assessment will take place for a Section 3 if treatment is still required and is not available in the community. |
| Section 3 | The criteria for detention under Section 3 of the MHA is if a person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital. Alternative means of treatment must have been considered prior to the decision of detaining in hospital. The section is valid for up to 6 months and can be renewed by the Responsible Clinician (RC) for up to a further 6 months. After this, it can be renewed for a period of up to 12 months at a time however the RC has the power to discharge at any time. |
| Section 136 | Section 136 is an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety and for detention there to allow for a MHA assessment. Alder Hey Emergency Department is a designated place of safety for children. |
| Community Treatment Order (CTO) | The purpose of a CTO is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs. |

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

| **Paper Title:** | Use of Restrictive Physical Interventions Annual Report 2023/2024 |
|---|---|
| **Report of:** | Lisa Cooper, Director Community & Mental Health Services |
| **Paper Prepared by:** | Dr Joann Kiernan, Consultant Nurse Learning Disabilities<br>Andrea O'Donnell, Consultant Nurse Mental Health<br>Jacqui Pointon, Associate Chief Nurse Community & Mental Health Division<br>Tony Maguire, Specialist Nurse/CALM Trainer<br>Dr. Jenny Craske, Clinical Nurse Specialist, Pain & Sedation Service |

| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☐<br>Regulation ☐ |
|---|---|
| **Action/Decision Required:** | To note ☐<br>To approve ☑ |
| **Summary / supporting information** | |
| **Strategic Context**<br><br>**This paper links to the following:** | **Outstanding** care and experience ☑<br>**Collaborate** for children & young people ☐<br>**Revolutionise** care ☐<br>**Support** our people ☑<br>**Pioneering** breakthroughs ☐ |
| **Resource Implications:** | Ongoing resource required to support training |

**Does this relate to a risk?** Yes ☑ No ☐

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

| **Risk Number** | **Risk Description** | **Score** |
|---|---|---|
| *2800 | A child may be harmed in the process of holding them to complete an intervention across the Trust. | 9 |

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

## 1. Report Purpose



The purpose of this report is to:

- Provide assurance to Trust Board of activity in relation to the use of restrictive physical interventions across the Trust for the reporting period 01 April 2023 – 31 March 2024.
- Identify areas for improvement and actions for the Trust to take to support children and young people to access care safely.

## 2. Background

The identified Executive Lead for the Trust is the Chief Nurse who is supported to discharge these duties via the Director of Community and Mental Health Services.

Children and young people receiving assessment and treatment from Alder Hey either within the Specialist Mental Health Services; acute hospital services (inpatient and outpatient) or wider community, may require the use of restrictive physical intervention or clinical holding. A safe and therapeutic culture should be provided for all children and young people receiving care and treatment including those who may present with additional sensory/behavioural challenges and are detained under the Mental Health Act (1983).

Alder Hey has in place robust policy guidance updated and published in 2023 – Overarching restrictive practices policy for use with children and young people (C73) which is further supported in the Trust's Tier 4 Childrens Inpatient Unit by (MH2), which clearly recognises that therapeutic environments are most effective for promoting both physical and emotional wellness in line with best practice.

Restrictive physical intervention has increasingly replaced the term 'physical restraint'. This is any method which involves some degree of direct force to try and limit or restrict movement (Restraint Reduction Network, 2019 and updated July 2021 - Restraint Reduction Network Training Standards 2021).

[The intervention] should be necessary, proportionate, justifiable, and only used to prevent serious harm. Any use of planned or unplanned restrictive physical intervention should be carried out using the least restrictive interventions and for the minimum amount of time. The physical restriction or barriers which prevent a child or

young person leaving, harming themselves, or causing serious damage to property

are also included in the term restrictive physical intervention.

Clinical holding is a form of restrictive physical intervention and is using limited force to hold a child or young person still. It may be a method of helping children or young people, with their permission, to manage a health care procedure quickly or effectively. Clinical holding has been distinguished within restrictive physical intervention by the degree of force used, the intention of the hold and the agreement of the child (Bray et al., 2014), but should still be considered a restrictive physical intervention.

During 2023, work in this area has continued to progress across the Trust with the implementation of the Informed Consent for Clinical Holding for Planned Procedures leaflet and of the Minimising Fear and Anxiety in Children Undergoing Diagnostic and Therapeutic Procedures policy (Minimising Fear and Anxiety in Children Undergoing Diagnostic and Therapeutic Procedures.docx (sharepoint.com) (updated October 2023). Further to this, the Trust's pain study days continue to include signposting to guidelines and discussing the principles of restrictive physical interventions. Work on documentation of clinical holding is ongoing with the expanse team.

For those children and young people who are being cared for under the Mental Health Act (1983), there is specific statutory guidance on different forms of restrictive intervention (and considerations for their use) detailed in the Mental Health Act: Code of Practice (2015). This was updated in October 2017 and included further guidance on implementing changes to police powers and places of safety provisions. In addition, when providing care to young people aged over 16 years, staff should be aware of their professional obligations relating to the Mental Capacity Act (2005).

There are a number of publications regarding the use of restrictive interventions and clinical holding with children and young people (Mental Health Units (Use of Force) Act 2018 - GOV.UK (www.gov.uk) update 2021, Quality statement 10: Review of restrictive interventions | Learning disability: behaviour that challenges | Quality standards | NICE RCN Guidance; DHSC), all of which clearly articulate the need for organisations to have a proactive approach to reducing the use of restrictive interventions but also to ensure that staff are appropriately trained and that there is a positive, transparent and collaborative culture when reporting on the use of restrictive interventions and clinical holding.

Current complicating factors have arisen in relation to differences in training needs

and requirements for T4 Inpatient mental health unit, separate to the acute paediatric setting. This has required an alternative provider on a trial basis and a thorough review of this is underway to determine appropriate next steps.

During 2024, the training provision will be reviewed and defined, with the long-term objective being to reduce, as far as possible, the use of external agencies to support children and young people with complex additional needs.

### 3. Data regarding restrictive physical interventions

For the reporting period 01 April 2023 – 31 March 2024, the Trust reported **302** incidents regarding the use of restrictive physical interventions of children and young people accessing services at Alder Hey. This is a significant increase in the number **(199)** reported 2022/23 and the number **(152)** reported during 2021/2022.

**Table 1** below shows the recorded incidents involving restrictive physical interventions or clinical holding reported across the Trust per division for 2023/24 compared with previous years.

**Table 1: Recorded incidents involving restrictive physical interventions**

| Division | Restraint | | | | Clinical holding | | | |
|---|---|---|---|---|---|---|---|---|
| | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
| Medical | 44 | 30 | 76 | 16 | 1 | 4 | 14 | 14 |
| Surgical | 5 | 23 | 19 | 6 | 2 | 4 | 9 | 3 |
| Community & Mental Health | 34 | 88 | 68 | 261 | 80 | 3 | 13 | 2 |
| **Total** | **83** | **141** | **163** | **284** | **83** | **11** | **36** | **18** |

Whilst the decrease in reporting of incidents relating to the use of restraint within the medical and surgical wards may be attributed to the reduction in children and young people being admitted to the acute paediatric wards who have complex and challenging behaviour and the work between the Trust's Crisis Care Service and

Emergency Department, the reduction in the reporting of clinical holding incidents

requires further review and work. During 2024/25, this will continue to be monitored and developed to maintain the governance of this type of intervention and explore the development of approved practical clinical holding techniques and training provision regarding this area.

The increased reporting of incidents for the Trust's Tier 4 Inpatient Unit relate to 4 highly complex children requiring planned restrictive physical interventions to provide safe care and treatment under section 3 of the Mental Health Act for significant periods.

The reporting of the use of restrictive interventions reflects the continuing work undertaken across the Trust to support appropriate recording; awareness raising of the use of restrictive practice; training related to Positive Support, bespoke awareness training sessions for departments e.g., Theatres, Outpatients and Phlebotomy and the CALM physical intervention training alongside the targeted work undertaken through the recently established (January 2024) Mental Health Acute Liaison Team (MHALT) regarding basic communication with children & young people with behavioural and/or mental health presentations and consideration of reasonable adjustments in the acute environment.

Further improvements regarding the reporting of restrictive physical interventions and clinical holding have been made to the Trust's incident reporting system, this included incorporating reporting in line with The Use of Force Act (2018) requirements.

All incidents should be reported within a maximum of 24 hours and both staff and children and young people provided with debriefs following the use of restrictive interventions. A debrief model has been defined by the Restraint Reduction Network and is embedded within the Trust's Restrictive Interventions policy. During 2024/25 an audit of incidents relating to the completion of the debrief in relation to incidents over the last 12 months will be undertaken and relevant learning and actions identified.

## 4. Data regarding restrictive intervention incidents reporting harm

For the reporting period 01 April 2023 – 31 March 2024, **zero** moderate or serious harm incidents were reported regarding the use of restrictive physical intervention and clinical holding in relation to children, young people, staff, or others (parent/carer/visitor).

A total of **132** incidents involving low harm were reported **(Table 2)** which is an increase from 2022/23 **(19)** and demonstrates improved incident reporting overall. On review, it was noted that of the **47** reported as harm to a child/young person **9** were directly linked to the RPI procedure the remainder were due to the reason why the RPI was carried out e.g harm to self. There are **78** reports of low harm to staff during the RPI procedure.

**Table 2: Incidents reporting physical harm 2023/24**

| Division | Total Number Incidents | Harm to child/young person | Harm to staff | Harm to other |
|---|---|---|---|---|
| Medicine | 7 | 2 | 4 | 1 |
| Surgery | 6 | 0 | 5 | 1 |
| Community & Mental Health | 119 | 45* | 69 | 5 |
| **Total** | **132** | **47** | **78** | **7** |

The Trust continues to provide support and assistance to children, young people and staff who are harmed following the use of restrictive physical intervention or clinical holding.  This includes reflective practice, debrief sessions and access to Health Psychology support. In addition, a new Mental Health Acute Liaison Team (MHALT) has been established early 2024 and are currently scoping and developing the service for the acute site. This is alongside the established LD/ASD Liaison team.  Supporting children, young people and staff is paramount within this area of work to develop robust and transparent responses to need.

Currently staff harm is often recorded in the narrative of the incident making it difficult to track and audit. An action for 2024 is to review the reporting of staff harm and include a section on the InPhase form to support accurate reporting and follow up.

## 5. Staff Training

Education and training are central to promoting and supporting change. Staff who may be required to use positive behaviour support, restrictive physical interventions or clinical holding must have specialised training (including bank staff and security), with

the focus on training being avoiding the use of, and alternatives to, restrictive physical interventions.



Alder Hey has provided Positive Behaviour Support (PBS) training for clinical staff since 2015 and formally embedded this into the Trust's Conflict Resolution training programme since January 2019 and this is reported monthly to line managers as part of the Trust's mandatory training matrix.

In 2020, the Trust undertook a procurement exercise to secure an appropriate "BILD/ RRN compliant training provider" to provide accredited training across the Trust. The provider selected (CALM) is part of the "BILD Association of Certified Training" and have demonstrated their training services comply with the Restraint Reduction Network Training Standards, NHS England Standard Contract and CQC regulations.

Training commenced in January 2021 and consisted of 12 hours of online learning followed by a 5-day face to face physical skills training and skills instructor training. Training was initially completed for staff on the Tier 4 Children's Inpatient Unit and a "Train the Trainer" approach was initially adopted across the Trust to ensure staff continue to receive accredited training on a regular basis and so that they can cascade training across the site. However, after completing their training staff lacked confidence to offer training and the plan has therefore been revised. Whilst Staff have continued to receive training to provide restrictive interventions, in January 2024 the Community & Mental Health Division successfully recruited a Nurse Specialist (CALM Trainer) and a Nurse consultant to review the training provided and ensure a sustainable model going forward, which recognises the different needs across the Trust.

In addition, challenges remain with training in relation to the understanding of the training offer and take up by the acute wards and departments as well as capacity for staff to be supported to attend these.

To support the additional training needs of staff within the Trust's Tier 4 Inpatient Unit the Community & Mental Health Division secured an alternative appropriate training provider. This training commenced in April 2024 and will be evaluated during 2024 to ensure it meets the needs of staff within the unit and the changing needs of the children who are receiving care within the unit.

**6. Children's Tier 4 Inpatient Unit Reduction Programme**

The Trust is fully committed to reducing the use of restrictive physical interventions across the Trust and within the Children's Tier 4 Inpatient Unit that are proportionate, appropriate and within statutory and legal frameworks. Work in this area continues and is led by Jacqui Pointon Associate Chief Nurse- Community and mental health division.

The Trust's Tier 4 Children's Inpatient Unit has embedded and continues to promote 'Safewards' in line with best practice and guidance on the use of restrictive physical interventions and is the first paediatric unit to do this fully.

## 7. Next Steps

The Trust Board are asked to note the content of this report

**Appendix 1: Recorded incidents involving restrictive physical interventions per division 2023/2024**

**Medical Division**

| Department | Number of incidents | |
|---|---|---|
| | Restraint | Clinical holding |
| Ward 4C | 13 | 10 |
| Emergency Department | 1 | 0 |
| Renal | 2 | 3 |
| Radiology | 0 | 1 |
| **Total** | **16** | **14** |

**Surgical Division**

| Department | Number of incidents | |
|---|---|---|
| | Restraint | Clinical holding |
| Ward 3A | 5 | 1 |
| Theatre – In-Patient Anesthetics Support | 0 | 1 |
| Theatre – In-Patient Cardiac Surgery | 1 | 0 |
| Theatre – In-Patient Recovery | 0 | 1 |
| **Total** | **6** | **3** |

## Community & Mental Health Division

| Department | Number of incidents | |
|---|---|---|
| | Restraint | Clinical holding |
| Tier 4 Children's Inpatient Mental Health Unit | 261 | 1 |
| Outpatients | 0 | 1 |
| **Total** | **261** | **2** |

NB: It should be noted that the increase in incidents reported via the Trust's Tier 4 Children's Inpatient Unit relate to the care provided to 4 complex presentations in children for prolonged periods:

- 1 presentation with extreme dysregulated self-harm/harm to others.
- 3 requiring Nasogastric feeding as part of their planned care when least restrictive options were ineffective.
    - 2 of the children also presented significant harm to self as result of not wanting to receive feed.
    - 1 of the children presented significant harm to themselves and staff relating to pre and post NGT feed periods.
- All children were detained under Section 3 Mental Health Act.
- The use of restrictive physical interventions are defined in the children's plan of care when least restrictive options failed.

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

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

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☐<br>Regulation ☐ |
| **Action/Decision Required:** | To note ☑<br>To approve ☐ |
| **Summary / supporting information** | This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 19th June 2024, along with the approved minutes from the 22nd May 2024 meeting. |
| **Strategic Context**<br><br>**This paper links to the following:** | **Outstanding** care and experience ☑<br>**Collaborate** for children & young people ☐<br>**Revolutionise** care ☐<br>**Support** our people ☐<br>**Pioneering** breakthroughs ☐ |
| **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 |
|---|---|---|---|---|---|---|

## 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 a 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 Quarterly IPC update with significant assurance received.
- SQAC received the Annual IPC update which provided significant assurance on Infection Prevention Control, IPC reports were extremely clear. SQAC received an update on the presence of IPC colleagues on the wards and strong attendance at Infection Prevention Forum, those aspects are working well. SQAC noted the ongoing pressures within the Infection Prevention Control team.
- SQAC received the ED monthly report: MH attendances and ED@its Best. ED continue to see high attendances, with challenges with regards to time to triage and time to clinical assessment. SQAC noted the ongoing work regarding heatmaps to address this issue. SQAC received an update on new work regarding PAU length of stay.
- SQAC received the Quarter 4 Safeguarding Report, SQAC noted the staffing pressures that the Safeguarding team had experienced. SQAC noted the focus being made on policies. SQAC noted the extremely high increase of MASH referrals into Alder Hey, SQAC agreed this would be kept under review with regards to the resources available to address this. SQAC acknowledged the good work by the team and good awareness within the Executive Team regarding the pressures that the Safeguarding team are experiencing.
- SQAC received and adopted the Merseyside Joint Agency Protocol Acute Life -Threatening Event (ALTE).
- SQAC received and adopted the Merseyside Joint Agency Protocol Sudden Unexpected Death Childhood (SUDiC) for Children aged 0 to under 18.
- SQAC received the Board Assurance Framework. SQAC noted the risks regarding Expanse referrals and the Risk with regards to ASD and ADHD regarding the availability of medication, with ongoing work with regards to this risk, with a view to having this as a stand alone Board Assurance Risk, given that the medication shortage is not going to be resolved imminently.
- SQAC received the Bi annual Aggregated Analysis Report, this was a clear report on the main themes and Trust performance in addressing and responding to the different kinds of reports, with assurance received.
- SQAC received the Quarterly Mortality Report/Mortality Annual Report with assurance received.
- SQAC received the Clinical Effectiveness & Outcomes Group Chairs Highlight Report with assurance received.
- SQAC received the Liverpool Neonatal Partnership Integrated Governance Report with relevant risks raised.

- SQAC received the Divisional updates and noted the very high risk relating to medicine/labs and noted that mitigations are in place to address this high risk, however this issue does remain a concern.
- SQAC noted the deterioration in performance regarding sepsis training within the Medicine and Surgery divisions due to the absence of training package.
- SQAC received the Deep Dive into Patients deteriorating to critical care which was extremely useful.
- SQAC received the Trust approach to the implementation of Martha's Rule. Offline discussion would be held to ensure that this receives continued attention, SQAC recognised that this would become business as usual within the general committees and that SQAC would only receive details regarding concerns in the future.
- SQAC received, Noted and ratified the Children in Care Policy

**4. Recommendations & proposed next steps**

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

# Safety and Quality Assurance Committee
# Minutes of the meeting held on Wednesday 22nd May 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) |
| | Alfie Bass | Chief Medical Officer | (ABa) |
| | Adam Bateman | Chief Operating Officer | (AB) |
| | Lisa Cooper | Divisional Director – Community & Mental Health Services | (LC) |
| | Urmi Das | Divisional Director – Medicine Division | (UD) |
| | Clare Ellis | Head of Operations – Laboratory Medicine | (CE) |
| | Gerald Meehan | Non Executive Director | (GM) |
| | Rachael Pennington | Associate Chief Nurse, Surgery Division | (RP) |
| | Jacqui Pointon | Associate Chief Nurse, Community & Mental Health Division | (JP) |
| | Laura Rad | Head of Nursing - Research | (LR) |
| | Erica Saunders | Director of Corporate Affairs | (ES) |
| | Melissa Swindell | Chief People Office | (MS) |
| | Cathy Wardell | Associate Chief Nurse – Medicine Division | (CW) |

In Attendance:

| | | | |
|---|---|---|---|
| 24/25/29/30/31 | Will Weston | Medical Services Director | (WW) |
| 24/25/33 | Jacob Gray | Emergency Preparedness, Resilience & Response Manager | (JG) |
| 24/25/43 | Jennifer Deeney | Head of Neonatal Nursing/Liverpool Neonatal Partnership | (JD) |
| 24/25/46 | Peter White | Chief Nursing Information Officer | (PW) |
| | Natalie Palin | Director of Transformation and Change | (NP) |
| | Ian Gilbertson | Deputy Chief Digital and Information Officer | (IG) |
| | Jill Preece | Governance Manager | (JPr) |
| | Linda Wain | Corporate Governance & Risk Manager | (LW) |
| | Julie Creevy | EA to Chief Medical Officer & Chief Nursing Officer (notes) | (JC) |

| | | | |
|---|---|---|---|
| **Apologies:** | Pauline Brown | Director of Nursing | (PB) |
| | John Grinnell | Managing Director/Chief Financial Officer | (JG) |
| | Bea Larru | Director, Infection Prevention & Control | (BL) |
| | Jackie Rooney | Associate Director of Nursing & Governance | (JR) |
| | Paul Sanderson | Chief Pharmacist | (PS) |

**24/25/25 Welcome and Apologies**

The Chair welcomed everyone to the meeting.

**24/25/26 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.

**24/25/27 Minutes of the Previous Meeting**

The Committee members were content to APPROVE the notes of the meeting held on 24th April 2024.

**24/25/28 Matters Arising/Review of Action log**

The action log was reviewed and updated.

*Assurance on Key Risks*

**24/25/29** *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 1, 7, 16, 17 and 21.
- Workstream 17 - Antimicrobial Resistance (AMR) – team had secured ICB input from a regional and well renowned Antimicrobial Stewardship Pharmacist on a regular basis. The workstream had also received excellent engagement from the colorectal surgeons. To compliment this colleagues had reported full compliance with the CQUIN regarding the prompt switching of intravenous to oral antibiotics.
- Workstream 21 - Total Parental Nutrition (TPN) – WW advised that the % had been updated. There had been an 8% decrease in TPN administration errors and a 45% decrease in TPN incidents causing harm over the last year, demonstrating the ongoing improvement work.
- Workstream 16 - Learning Disabilities and/or Autism – the % of appropriate referrals to the team is maintained at above 80%. There is an away day planned in May 2024 when the goals for the following year would be reviewed. The My Hospital Guide would also be rolled out imminently.
- Workstream 7 - CYP & Families as Patient Safety partners - there is still a requirement for project management support though interlinking with this workstream will be the newly appointed Patient Safety Investigator co-ordinator, and as part of their role and under the direction of the Patient Safety Investigator Leads would ensure that children, young people and families are included in investigations.
- WW advised that it had recently been agreed with Executive Team colleagues that due to the updated 2030 programme governance framework that the governance for the Patient Safety programme would only be reviewed bimonthly as opposed to monthly and that the slide would be updated for the June 2024 SQAC meeting.
- Safety Metrics – Workstream 1 – WW advised that the Trust is now measuring both physical and psychological harm in accordance with national recommendations, this is a significant improvement for the Trust and allows the Trust to understand and consider the effects of psychological harm on parr with physical harm.
- Reporting of incidents had shown an increase in trends since December 2023, for the same period the incidents of harm per 1,000 bed days shows a decreasing trend, this overarching metric for Patient Safety Strategy Board reflects the amount of work within the programme and colleagues are pleased that the efforts of the team had been recognised in the context of delivery of safe patient care.

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.

**24/25/30** **Patient Safety Annual Report**
SQAC received the Patient Safety Annual Report.

FB expressed her thanks to the Patient Safety Lead and the Patient Safety team for the ongoing work and stated that the Patient Safety Annual Report demonstrates the ongoing work and the effectiveness of the programme, with a clear strategy that had been developed and the significant shifts towards the new framework.

**Resolved:** SQAC received and **NOTED** the Patient Safety Annual Report
**Resolved:** SQAC expressed thanks to the Patient Safety Strategy Leads and team, as the Annual report demonstrates the ongoing work and the effectiveness of the programme.

**24/25/31** **Patient Safety Terms of Reference and Workplan**
WW presented the Patient Safety Terms of Reference and Workplan which demonstrated a robust framework in place.

**Resolved:** SQAC received, **NOTED** and **APPROVED** the Patient Safety Terms of Reference and workplan

**24/25/32 ED monthly report: MH attendances and ED@its best report**

CW presented the ED monthly report: MH attendances and ED@its best report

- ED maintained a high level of performance - 87.4% during the month of April 2024, this is 11% above national standards.
- Areas of focus regarding reduced utilisation in the UTC, despite reducing capacity, therefore the team are reviewing the impact. A deep dive is taking place in month with focus on increasing the utilisation.
- % of UTC attendees returning to ED had reduced in April 2024 to 3.7%, however the Was not brought rate had increased in April 2024, this is being closely reviewed with a plan for all parents and carers to receive a text containing a questionnaire regarding why the child did not attend.
- Median time to triage was 15 minutes, the national standard targets are being achieved, with a 5 minute improvement since March 2024.
- The heatmap continues to show challenges between 6pm and 10.00pm on the majority of days. There is ongoing work with brilliant basics team commencing in July 2024 to address this issue.
- Manchester triage model is being rolled out within the ED department and Alder Hey staff had been trained and are leading on this, a positive impact is envisaged over the coming months.
- There had been ongoing improvements with regards to administering antibiotics within 60 minutes, compliance in April was 93%.
- Continued analysis of PAU pathways in addition to working on the same day emergency care pathways.
- Focus on reviewing mitigations for ED/PAU move to NICU estate, working with options appraisal to be completed by June 2024.
- Colleagues are continuing to work on the format of the ED paper, with specific focus on PAU presentation.

CW stated that SQAC would see a difference within the report at the June 2024 SQAC meeting with regards to the presentation of PAU data.
FB alluded to the mitigations regarding the impact of the move and sought clarity regarding when the building work is expected to have an impact. CW stated that this would be from August and advised that there would be an impact on some services.

AB advised that it is towards the end of August when colleagues are due to vacate. AB advised that there are 3 or 4 options that are being appraised.
ABA sought clarity regarding the timeline when colleagues would be able to move back into the PAU. AB stated that it would be the end of 2025, with the need for an effective and stable arrangement for a lengthy period. The appropriate options would be presented to Operational Delivery Board or Executive Team at the end of June 2024. AB stated that colleagues are working hard to ensure sufficient capacity for winter and are also looking at a virtual offer.

**Resolved:** SQAC received and **NOTED** the ED monthly report: MH attendances and ED @its Best report and **NOTED** the key improvement actions.

**24/25/33 EPRR Quarterly update**

JG presented the EPRR Quarterly update

- Emergency Preparedness Group (EPG) continue to meet on a monthly basis.
- There had been no significant incidents reported within the last quarter, there had been CT downtime which the Trust Board and Senior Leaders are aware off, this is being monitored via EPG.
- Business continuity – an in-depth review into the Trust Divisional local Business Continuity Planning there are Business Continuity Plans across all Divisions, which are regularly used.
- Training Exercise – the Trust has had a new organisational TNA established for EPRR, currently the organisation training compliance is 93.4%, local emergency preparedness compliance is slightly lower – updates would be received within the next quarterly update.
- EPRR risks – There are 2 open risks on the Risk register both of which are scoring at 15 from a reflective position. The Trust does have Incident response plans and the Trust does have a Major Incident Plan. JG alluded to running this through the appropriate cycle, and testing and advised that once those mitigations are in place this would help reducing risks.
- 2nd risk regarding the business continuity and feeds into the divisional operational business continuity plans

- Current core Standards compliance position – The Trust is projecting 10 of the core standards completed. All had seen good improvement across the entire portfolio, however there are still some gaps which colleagues are working on. JG advised that he meets regularly with KB and NA and advised that he meets regularly with the ICB.

FB alluded to section 2.2 and the table regarding the lessons identified and stated that the incidents were relatively recent and that the actions had been identified. FB stated that in most cases that there are numerous actions which are outstanding. FB sought clarity whether these outstanding actions would have been set with a timeline, or whether they would have been set 'as and when'.
JG confirmed that all actions have an agreed timeline and advised that any outstanding actions are reported on a bi monthly basis to EPG.

FB stated that when the report displays actions outstanding within the report then it doesn't mean that the action is outside of the timeline yet. It was agreed that for future reports overdue actions would be included in the reporting table.

FB questioned why the Trust is not undertaking any exercises and requested what the issues are.
JG explained that the Trust are required to undertake one table top exercise each year. The focus currently had been on driving the improvements following the last self assessment submission. Following a discussion it was recognised that the Trust should prioritise a training and exercising plan that would be in place this year.

ABa alluded to the learning from major incidents and sought clarity whether the Trust have a plan for disseminating the learning to clinical staff.
JG advised that the share point site has been updated and includes a section for sharing the debrief and learnings from events.

ABA alluded to the need for some direct signposting for clinical teams who are involved in incidents.
FB stated that this should be addressed offline and agree how clinical teams could be signposted to information.

FB expressed her thanks to JG and EPRR colleagues for significant ongoing work.

**Resolved:** SQAC received and **NOTED** the EPRR Quarterly update

*Caring*
*Effective*

**24/25/34 Board Assurance Framework**

ES presented the Board Assurance Framework
ES alluded to page 80 of the SQAC meeting pack which detailed an analysis of the risk ratings.
ES referred to the risk appetite roadshow, which is taking place across the assurance committees, and was shared at the People & Well-being Committee on 15th May 2024. ES stated that this is work in progress and advised that discussions had taken place at Executive level which now require embedding across the organisation. This was trialled at Risk Management Forum on 21.5.24, with live examples regarding a number of risks. Ongoing work to ensure that the 2030 narrative is appropriately embedded in most of the strategic risks.
SQAC would start to see shifts coming through as the year progresses, with interesting discussions regarding how the Trust frames Patient Experience.
ES welcomed any comments or feedback - no feedback was shared.

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

**24/25/35 Risk profiling appetite/tolerances**

ES presented the Risk appetite/tolerances presentation which provided an overview of the definition of Risk appetite and tolerance, overview of the Risk thresholds, and the application of Risk Appetite.

ES advised that a small group had met to focus on the ask regarding how to ensure that the risk descriptors sitting within the tolerances are reflective of the organisation. Discussion had taken place within the group regarding whether there is scope to have a higher tolerance in certain areas than others.
ES alluded to Risk Thresholds and stated that following discussion colleagues felt it was appropriate that the Trust have no appetite to tolerate any risk that compromises patient safety.
ES referred to the quality effectiveness and stated that whilst it was not 0 that the Trust could go no higher than minimal risk appetite for risks that may compromise the delivery of outcomes for our patients, with a risk tolerance rating of 4-6.

- 120 Clinical risks on Inphase as at 26th February 2024, 102 risks are outside of the tolerance range for safety and effectiveness, 18 risks are within tolerance range for safety and effectiveness.

Next steps are to try using the terminology and using the thresholds particularly when taking the decisions to close risks & to start applying risk appetite and thresholds levels to each clinical risks within there day to day practice; Risk management hygiene at local level, and stated that Inphase can do more to assist with ensuring this is taking place as basic routine and is embedded into business as usual;

NA provided an overview of the application of Risk Appetite and advised that when colleagues had previously discussed this there had been a nuance with regards to Safety and quality as the organisation could find ourselves with a risk with a catastrophic outcome and that the likelihood had been put down to rare which is the lowest this could be reduced, and keep as an active risk to review despite all of the controls in place. It was therefore suggested that risks with a 1x5 that have all controls in place could also be closed.
ES stated that she would welcome colleagues' feedback/views.

ES alluded to the differential cycles of review. NA advised that at present all risks are reviewed on a monthly cycle and for those that require a hold the review could be extended to 3 monthly.
NA welcomed feedback from SQAC.

FB alluded to the distinction in the risk appetite between safety and quality, and that presupposes that all of the clinical risks are written in a clear format whether it is referring to safety or quality aspect of the risk. FB stated that she suspected this was not clear at present and that colleagues would need to be really clear regarding the safety aspect of the risk versus the quality aspect of the risk and this.

ES stated that colleagues had not yet agreed the 'how' and advised that colleagues often receive challenge regarding how a particular risk is described and that in due course suggested a SOP or protocol within he Risk Management Procedures

FB stated that it is correct to have no risk appetite regarding safety and this suggests a number of other consequences one of which is that it needs to be addressed urgently therefore there is a prioritisation consequence and another if there is no appetite for risk that not having the resource is not an appropriate answer, with the risk needing to be defined extremely accurately. FB stated that there is also issue regarding escalation, should an issue not be resolved within a very short period of time and whether this is escalation inside the Trust or beyond the Trust.

FB stated it would be helpful to understand the pathway that follows for issues described as a safety risk versus a quality risk regarding time, escalation path etc.

NA alluded to the first point and stated then when a risk is logged on Inphase colleagues chose a CQC domain and colleagues can extract safety information. NA stated that there could be more than one and there is a need to improve the challenge at Division and departmental level regarding accepting the risk on the register to ensure that the risk is correct and as assigned in the correct domain.
NA stated that there is a mechanism in place to keep a small financial reserve each year for patient safety critical issues and risks, with a need to review the Risk and Incident Management policy and language and how this is defined across the organisation.

NP sought clarity regarding what the long term goal of moving to this new approach is, what would be different, and what decision is anticipated to drive this forward, if reaching a point that they are appropriately defined, and being really clear regarding the 'so what' element.

KB stated that she had not been involved in those detailed discussions and stated that she is pleased regarding the level of questions and challenge, and that colleagues had not been having those discussions previously and that this this exercise is welcomed.

KB stated that on review of the heatmap on slide 4 – that all of the current risks that are included on the Risk Register by introducing these tolerances will close 18 of those risks as they are at target. KB stated that there are already target risk scores, and that these are going to replace those target risks scores, which had previously been set by individuals, and by using this Risk tolerance it sets scores consistently across the Trust which is a significant improvement.

KB referred to reporting and stated that colleagues would review whether any reporting changes need to happen, however in the short term KB envisaged that colleagues would remain with current reporting and escalation processes in place. KB stated that colleagues would see a change in the number of risks scores and colleagues would see a definite change in risks at tolerance or below tolerance. KB stated that there are always going to be risks, and the organisation is always going to have risks that are above tolerance, there are always going to be risks that colleagues struggle with, however this process provides absolutely consistency across the Trust in line with agreed appetites that the Board of Directors would sign up to and have been set as an appropriate level.

ES stated that the immediate process is for all of these to be brought together and considered by the Audit and Risk Committee and this would be presented to the September Trust Board meeting.
ES advised that there is a trajectory that once the Risk Tolerance had been presented to the Board of Directors and that the Board of Directors had signed up to the Risk Tolerance this would be cascaded through all of the assurance committees, with the Risk Management forum having the moderating function with a clear understanding from all at risk management regarding what the process is.

NA stated that this provides a springboard to relaunch training, in terms of articulation of risks, active management of risks with mitigation and review dates, understanding of tolerance and support regarding the escalation with a real focus on moving away as using the Risk Register as a valve to achieve an outcome, with appropriate scrutiny.

FB sought feedback from SQAC with regards to the principle NA had put forward regarding the possibility of risks scored at 1x5=5 (catastrophic & rare), once assured that all possible robust mitigations are in place, that those may decrease frequency of review, recognising that there is a risk that sits outside of risk appetite, and that the risk cannot be reduced any further. FB sought feedback from SQAC whether colleagues were comfortable that such risks would be reviewed less often.
NP stated that on reflection this reflects the approach taken on all of the data, focusing on what matters and using the data to drive decisions and that it is more of an evolution regarding building management system and using colleagues time and focus.
FB stated that this is correct in terms of not reviewing on a monthly basis.
FB stated that given that the broader landscape may change, and that her worry would be that it becomes a tick box exercise every 3 months and suggested a more robust review every 12 months.
NA stated that ES & NA could review this and would keep under review for 12 months.
FB stated that this had been a really useful discussion and welcomed the next iteration.

**Resolved:** SQAC received and **NOTED** the Risk appetite/tolerances update

**24/25/36** **Quarter 4/Year end 2022/23 Complaints, PALS & Compliments Report**

NA presented the Quarter 4/Year end 2022/23 Complaints, PALS & Compliments Report

- There had been a slight decrease in formal complaints from 154 in 2023 to 139.
- Top 3 reporting categories remained the same, there had been changes in the volume of the 3 main reasons, treatment and procedure remaining the same, communications had decreased.

- Compliance and performance against the three working day acknowledgement - 95%, for year 71% regarding 25 day compliance. Significant improvements were made across the Divisions in year.
- 1 referral had been made to the PHSO, which is in progress with PHSO reviewing.
- PALS had consistently remained the same regarding responsiveness despite the increased number of PALS. There had been significant improvement regarding responsiveness within Community and Mental Health Division.
- Examples of learning are included within the report.

FB welcomed the examples of learning within the report are stated it was extremely helpful to have the Quarterly and year-end report as a combined report.
KB challenged the usefulness of some of the graphs within the report and requested whether future reports, could clearly articulate the key messages.

NA stated that it is expected this report will evolve this year under the 2030 vision. This may not be in place for the Q1 report but this was planned to be addressed this year.

GM referred to the culture of how complaints are dealt with within the Trust and sought clarity whether the culture at the Trust is to deal with complaints at the lowest level possible to resolve or whether complaints are dealt with at the highest level.

NA referred to culture and stated that the Trust is starting to shape and change the culture and that parents, children and young people could lodge a complaint in any way they wish to. The Trust had been piloting whatever route that a complaint is received and making initial appropriate contact with the family for either instant resolution or resolving at the lowest possible denominator to provide an answer.
GM sought clarity whether there is a distinction in the complaints regarding how a complaint is dealt with should a complaint be regarding a clinical professional judgment or an error or mistake that something had not occurred.

NA stated that all complaints follow the same process, and that there is always someone who is independent who is appointed to investigate and review the complaint, with a level of objectivity within the divisions, all complaints are signed off and reviewed, usually by the Senior Nurse within the Division, and are reviewed by the Chief Nursing Officer prior to sign off by the Managing Director or CEO. There is a good level of objectivity and investigations is always independent regardless of reason of complaint.
FB expressed her thanks to PB for comprehensive report.

**Resolved**: SQAC received and **NOTED** the Quarter 4/Year end 2022/23 Complaints, PALS & Compliments Report and NOTED that the future reports would continue to evolve.

**24/25/37 Patient and Family Feedback Quarterly Report**

NA presented the Patient & Family Feedback Quarterly Report and advised that the report would evolve over the coming year, with a review and reset of the data collection, use and usefulness of FFT across the organisation. NA stated that the Trust had struggled since the pandemic to reach previous targets with steady and slow progress made. ED had made significant progress in month with regards to satisfaction levels.
Next steps - continue to evolve, need to review patient reported measures and patient experience outcome measures.

FB sought clarity whether NA envisaged the report changing and whether this would become a Patient Experience report or whether the Trust needed to keep a separate report.
NA stated that the Trust would aways have to have this type of report, however NA is hoping that the Patient Experience Report could be developed over the next 12 month period to be more meaningful and focus more on the experience work and append as an Appendix.

**Resolved**: SQAC received and **NOTED** the Patient and Family Feedback Quarterly Report.

**24/25/38 Quarter 4: Children & Young People Engagement Leads Report**

LC presented the Quarter 4: Children & Young People Engagement Leads Report

- Children & Young People had continued to be involved in the Gender Development service.
- Children & Young People had been involved in the Mini Mouth Matters campaign
- Work continues with the Youth bank with a partnership with NSPCC which had been progressing for 18 months, with plans to roll out nationally.
- Qualifications and life skills programme which had empowered growth and development for participating children and young people. This programme had been funded by the John Laing Charitable Trust via the Alder Hey charity who supporting the Trust in obtaining this funding.
- Children & Young People are currently planning summer activities.
- The Trust had recruited to a youth support worker to support Jess and Alex. The Trust had recruited 2 young people, one of whom had been in the Children & Young People forum and is a governor and the Trust had also recruited a young person who had recently presented to Trust Board she is a young person who had accessed services at Alder Hey from a physical health perspective and will be supporting children and young people on the acute site who are on the acute paediatric wards, as there are a number of children and young people who are admitted for a lengthy period to enable the buddy and mentoring programme to be implemented across the organisation.

FB welcomed the report which highlighted the wealth of ongoing activity of the Children & Young People. LC stated it is a model that had been shared nationally and stated that the Children &Young People are extremely empowered.

NA stated that this report is amazing and humbling regarding the achievements of the Children and Young People. NA expressed his thanks to LC regarding the employment for the Children and Young People and acknowledged the ongoing efforts of LC in supporting the Children & Young People.

**Resolved**: SQAC received and **NOTED** the Quarter 4: Children & Young People Engagement Leads Report

**24/25/39 Clinical Effectiveness and Outcomes Group Chairs Highlight Report**

LW presented the Clinical Effectiveness and Outcomes Group Chairs Highlight Report which provided a summary from the Clinical Effectiveness & Outcomes Group held on 10th May 2024

- Acknowledgement of the inaugural CEOG Annual Report 2023/24.
- Continuing improvement noted with oversight and learning from clinical audit.
- Quality Safety Audits using the Perfect Ward App SOP had been extended for a further 12 months until the module on Inphase has been developed.
- Transition Steering Group had now been added to the CEOG workplan and will report into the meeting on a quarterly basis.
- Development of a training programme for audit would be highlighted at the Clinical Audit Masterclass June 2024.

Issues to escalate to SQAC

- Discussions around the Neonatal Partnership policies on Badger, identified duplication of policies in current use and the CEOG agreed this needed to be addressed as a priority.
- Smoking Cessation service (previously a pilot) is no longer in operation within the Trust. There was a consensus at CEOG that this should now be added as a risk on the Trusts risk register. LW understanding is that the risk is currently in progress and would be added as a Trust wide medicine management risk.

FB alluded to the Neonatal partnership policies and duplication and sought clarity whether this is being address and sought clarity who would lead on addressing these issue.

JD advised that there is significant ongoing work regarding policies and guidelines and how these are harmonised across both Trusts, there is a working group which had been established which is a collaborative approach and colleagues are working through policies and guidelines to ensure that they are agreeable to both Trusts, some policies have to be facilitated to the site that they are on and there would be slight differences, both go through ratification process at both Trusts. JD stated that this is a huge piece of work and that for neonates alone that Liverpool Women's Hospital have 400 policies and guidelines, JD re-emphasised the collaborative work and stated that colleagues are welcome to join this workstream.

FB expressed her thanks to JD for her update and requested JD to provide a briefing update to I Sinha as Chair of CEOG with feedback and timescales to provide assurance to Chair of CEOG that this work is underway.
**Resolved:** JD to provide a Briefing note to Chair of CEOG

FB alluded to Smoking cessation and sought clarity whether this related to patients and families, or staff, or both. NA stated that this required offline discussion as the Trust did provide a service until recently when the non-recurrent funding ended. The future model needs to focus on where families could be signposted to for this service. NA advised that there is a public health programme to try and help children stop vaping, which would be more aligned with the focus of our work with young people.
FB stated that in terms of leadership this is within the system and inviting the system to be proactive.
NA stated that the Trust can make a real difference regarding reducing vaping in young people across the city.
JD stated that One Liverpool have an antenatal midwife and that there is a possibility that young people planning a family can get support from the midwife and can access service through the children centres in Liverpool.
KB referred to smoking cessation and stated that the main points of discussion at CEOG were regarding vaping, and the high level of vaping in Liverpool. KB agreed that this is a wider discussion and alluded to the 2030 vision regarding how the Trust advocate, influence and lobby.
KB stated that she would like to follow this through to see what the response is.
FB thanked KB for additional assurance and stated that it would be helpful for FB and GM to attend one or more of the committees to enable further insight.

**Resolved:** NA to provide an update in August 2024 regarding smoking cessation and provide indications how conversations how gone and update on how the Trust is interacting with the wider system, and what the Trust can do as an organisation with regards to smoking cessation

**Resolved:** SQAC received and **NOTED** the Clinical Effectiveness and Outcomes Group Chairs Highlight Report

**24/25/40** **Clinical Effectiveness and Outcomes Group Annual Report 2023/24**

LW presented the Clinical Effectiveness and Outcomes Group Annual Report 2023/24 and requested any feedback regarding the content and style of the Clinical Effectiveness and Outcomes Group Annual Report.

FB stated that the report is extremely helpful containing the essential detail and summarising the work over the year. FB commended CEOG for the Annual Report. No other feedback was raised.

**Resolved**: SQAC received, **NOTED** and endorsed the Clinical Effectiveness and Outcomes Group Annual Report 2023/24

**24/25/41** **Quality Account**

NA presented the Quality Account
NA expressed his thanks to colleagues who had contributed to the Quality Account and advised that it is still in draft format and is on a strict time trajectory. NA welcomed any comments or feedback from SQAC to be shared with NA by 29.5.24 for inclusion into the final version.

NA advised that the Draft Quality Account had been presented to commissioners on 17.5.24 with positive feedback received, commissioners were impressed with the ongoing innovations and the work undertaken by the Youth Forum.
FB stated that she had emailed NA with feedback recognising it was in draft, with regards to the Quality Account being edited at the end of the report with regards to acronyms and Alder Hey terminology to ensure that the Quality Account is fully accessible.

**Resolved:** SQAC received, **NOTED** and **APPOVED** in principle, SQAC committed to any amendments to be incorporated by no later than 29th May.

**24/25/42** **CQUIN 2023/24: Quarter 4 Year End Report**

NA presented the CQUIN 2023/24: Quarter 4 Year End Report which provided an update on progress at the end of Quarter 4 and year end.

- 9 CQUINs were agreed in 2023/24.

SQAC **NOTED** the good progress made in 23/24, improvements are required in relations to the Flu vaccination for frontline healthcare workers CQUIN and Supporting patients to drink, eat and mobile (DrEaM) after surgery CQUIN.

NA advised that there had been no indication that there will be any financial penalty over the year regarding non delivery of CQUINs. The Trust had been having open and honest discussions with both commissioners regarding the suitability and appropriateness of these CQUINS, particularly with regards to the DrEaM) CQUIN, as this is incredibly difficult for the Trust to monitor, which is not the same for adults.

NA stated that there are no mandatory CQUINS next year, and that CQUINS are all optional for next year. NA advised that both he and PB recommend that the Trust should not optionally undertake any CQUINS, as they require resource, and no payment is obtained as part of the programme for this financial year.

NA sought SQAC support for the Trust to not participate/ undertake any optional CQUINS for next year.

**Resolved**: SQAC received, **NOTED** the CQUIN 2023/24: Quarter 4 Year End Report and were supportive of no optional CQUINs being undertaken next year.

**24/25/43** **Liverpool Neonatal Partnership Integrated Governance Monthly update**

JD presented the Liverpool Neonatal Partnership Integrated Governance Monthly update

- Over the last month positive recruitment had taken place within the Liverpool Neonatal Partnership, with recruitment of a matron who will enhance integration, and will result in a matron on the Alder Hey site.
- Training is progressing well.
- Liverpool Women's Hospital had been re accredited FiCare and Alder Hey would hopefully receive FiCare accreditation later this year.
- 5 workstreams have been identified which will assist in the preparation to opening of the unit in 18 months time.
- JD updated SQAC that in August she is hoping to increase the medical cover on 1C neo to midnight with a twilight shift where the consultant and tier 1 and tier 2 Reg/ ANP junior doctor would be there, with an escalation plan which is due to be approved.
- Risk register – all risks had been reviewed, the Integrated Governance meeting had taken place on 21.5.24 and agreement had been reached to close many of the risks.
- Challenges regarding operationalising plans for the next 18 months. Recruitment is an issue, as is collection of data to obtain data for the neonates at Alder Hey, colleagues are collaborating with I Gilbertson regarding the data for Alder Hey.

KB alluded to the sickness figures quoted on page 6 of the report as the long term sickness is at 69.5% and short term sickness is 30.5%. This shows the split of sickness and FB requested that for future reports SQAC would want to receive the proportion of the overall staff pool.

JD advised that total sickness on the unit is just over 6% and at Liverpool Women's Hospital sickness has been just over 5%.

KB referred to the risk register and sought clarity regarding whether Alder Hey colleagues have visibility of the Risk Register and sought clarity where the risks are recorded.

JD advised that risks are recorded on Inphase and ulyssess at Liverpool Women's Hospital, risks are reported on a monthly basis at the Liverpool Neonatal Partnership Board meetings, which Trust Executives attend. JD advised that the Liverpool Neonatal Partnership Report is a new report which SQAC would receive on a monthly basis and would also be shared at Divisional Board meetings at Alder Hey and LWH and to Trust Board meetings via those routes.

KB welcomed an offline discussion with ES to discuss reporting mechanisms for Audit & Risk Committee, Risk Management Forum and Trust Board.
**Resolved:** Offline discussion to be held with ES & KB.

KB alluded to Liverpool Women's Hospital using a 5+5+5 scoring mechanism.
JD stated that LWH are moving to a new scoring system, and that colleagues would focus more on the colours of Green, Amber, Red rather than the numbers, as this provides a more even view of the position. JD stated that there is also a narrative document which reflects what the risks means for both LWH and Alder Hey and is currently being completed, there would be narrative at both sites.
KB requested KB to share Liverpool Women's Hospital scoring mechanisms.
**Resolved:** JD to share Liverpool Women's Hospital scoring mechanisms with KB.

AB stated that he is aware that the team had been working on quantitative metrics to enable numbers regarding the partnership, and alluded to the build programme, workforce development, policy harmonisation etc. AB sought clarity whether there would be a further development of this report for the June SQAC meeting to enable the report which is presented to LNP to also be shared at SQAC to ensure consistency, as there are some objective measures that would need to start emerging in the future.
JD stated that there would be two reports in the future and that this is the governance report, and there would be a project management element, which would have this focus of the workstreams, JD stated that the governance report would remain as is, and that there would be an operational report that would refer for the governance detail.
AB stated that some of the challenges that he thought may have been listed within the report are not included and stated that it is good to hear that cover is going to be extended until midnight, however there is still a discrepancy between the two sites and that AB had envisaged that this would have been included in the report as a challenge to work through to ensure the optimal safe cover. AB stated that colleagues needed to reach a position of having over 90 staff at Alder Hey to open NICU to its full capacity. JD stated that this slide was reported in RABD on 21.5.24 should have shown that after the internal moves and the current external figures recruited the overall gap is 10 WTE to be recruited prior to the opening of the unit. AB stated it would be helpful to discuss at the next LNP Board regarding how much Safety and Quality Sub Committees want to be cited on these issues, as it is a new visibility and therefore the dimensions regarding workforce and cover may be relevant within this report.

FB referred to there not being a section within this report regarding delivery of the project and whether the project is on trajectory, and whether there are any emerging issues for SQAC awareness and whether an additional section should be included for future reports. FB requested AB and JD to discuss this offline to consider, to ensure that SQAC are aware of the risks of the development of new services and what is relevant for SQAC.
JD stated that the governance report requests the clinical aspects and colleagues can add the operational issues into the report if required.
**Resolved:** Offline discussion to take place with AB and JD

GM stated that he is interested in the PSIRF section and JD's view across the partnership regarding consistent understanding of acceptable standards, what good looks like, high expectations of services and how this feels.
JD stated that it is challenging as there are two quite different approaches to PSIRF, however there is a great relationship with JR and the governance team and the team at LWH, colleagues had facilitated some good PSII, some after action reviews, with good learning. JD stated it is about sharing the learning wider than neonates and how this is cascaded more widely. JD stated that there are different priorities across both organisations. JD stated that if an incident occurs at Alder Hey then Alder Hey would lead and LWH would support and vice vesa. JD stated that there is a really robust, collaborative and transparent partnership. JD stated that it has been a journey, and colleagues are in a positive position.

GM alluded to constructive challenge and that it is accepted, and that standards need to be extremely high. JD stated that there are expectations of standards of both Truss, and that there is no fear of challenge and colleagues always do what is best for the patients and what is best for practice.

ABA stated that he had requested at the last Neonatal Partnership Board how the two PSIRF approaches would be integrated, and that ABA had requested to LWH leadership team to produce a SOP detailing how the two PSIRF approaches and how the LNP would respond to an incident, to ensure absolute clarity and ensure transparency. ABA is expecting this SOP to be presented to the next LNP Board.
FB thanked JD for her update and recognised the ongoing challenges to build a high quality service across two organisations with different ways of working, and slightly different cultures. FB advised that 1 or 2 areas had been identified that may be augmented in the future, with good discussions held regarding the two different risk frameworks and the two PSIRF framework issues, and no doubt other emerging issues in future months when people want to understand more and receive assurance that that things are aligning as appropriate. FB welcomed the next update at June 2024 meeting.

**Resolved** SQAC received and **NOTED** the Liverpool Neonatal Partnership Integrated Governance Monthly update

**24/25/44** **Divisional Update and Deep Dive regarding the correlation of waiting times for Friends and Family tests**

**Division of Surgery** - RP presented the Surgery Divisional update

- Mini mouth matters campaign which had been extremely successful and had been led by L Shuter from the Dental team.
- PDR compliance above 90%, the division have a clear plan to sustain above 90% compliance.
- Challenge regarding school entry audiology screening programme referrals – this programme was halted as referrals were not being progressed due to a lack of administration staff, temporary solution has been put in place to manage this risk, whilst obtaining a more substantive appointment.
- Sepsis compliance in month is 100%
- Training compliance had decreased to 88%, the nursing team are all above 90% and further thought required regarding how to engage and support medics to enable them to complete the training.
- The Division had no grade 2 pressure ulcers, with 3 grade 1 pressure ulcers in April 2024.
- The Division had 0 pals breaches, formal complaints are all in process and are being appropriately managed.
- 1 high risk regarding the capital replacement programme, the Capital Subgroup continues to monitor this and a newly formed Capital Steering Group had recently been created to oversee ongoing works regarding capital spend across the Trust, RP is hopefully that this Capital Steering Group can mitigate associated risk.

KB requested Community, Surgery and Research Divisions to not rebase at April but to keep 6 months of rolling data in all the different graphs within the report.

**Community & MH Division** – JP presented the Community & MH update

- ASD and ADHD referral triage is 100% within 12 weeks.
- Improvement of 5 day PALS responses from 40% in March 2024 to 80% in April 2024.
- Video had been co-produced and launched at the end of April 2024 with young people highlighting what it is like to be a young person in mainstream secondary school with Autism.
- Ongoing challenges with regards to leadership gaps in Sunflower house, the Head of Service is due to be in post on 5th June with ongoing work to keep the service safe.

GM expressed his concern regarding the Named Doctor for Safeguarding and requested an update on progress. JP stated that the Named Doctor had now been appointed, and is pending the HR usual recruitment checks and given notice etc.

**Medicine** – CW provided the Divisional update

- There had been a reduction in sickness rates, with a 1% reduction in April 2024, currently at 4% the reduction had been achieved through close monitoring and strict adherence to policies, with good working with Ward managers, leads and Human Resources, with oversight of the reasons for sickness.

- There had been a significant improvement in coding and capturing of outpatient procedures, therefore improving income generation for the division and delivery of recurrent CIP with good engagement from clinicians, particularly in Oncology and Haematology.
- Challenge regarding plans and preparations regarding the closure of PAU and EDU due to the capital estate work.
- Division continue to achieve and improve on safety metrics, Sepsis is 100% for inpatient wards, and 97.3% in ED.
- Training compliance within the wards is over 90% on every ward, the Division continue to work with medics to increase compliance with medics.
- The Division had no Grade 1-4 pressure sores in the month of April 2024.
- Incidents continue to be well managed, with low harm incidents continuing to reduce over the last 9 month period.
- There is a continued reduction in incidents open for more than 30 days.
- Focus for the month relate to a deep dive review of no harm and near miss incidents.

**Research Division** - LR presented the Research Divisional update

- LR advised that successful teamwork and extra training was provided ahead of the planned gene therapy visit. Sadly, the visit did not go ahead as planned, and advised that during the last screening tests for the individual which had resulted in the patient having to be ruled out of the study as the patient had a virus within the previous 12 month period. LR advised that the next day the Trust received notification that the sponsor advising that the study had been paused. LR stated that Alder Hey do not have any patients within the trial and that the study is now closed to recruitment, research colleagues would continue to collaborate with the sponsor to close down the study at this site
- Division have had several issues with regards to courier delays, and couriers not collecting samples (some resulting in clinical incidents as sample was not viable). This has been escalated to the courier companies and colleagues had liaised with study sponsors.
- There had been a cluster of SAE's for ASYMPTOMATIC since the time of report and that the Governance Manager had reviewed and advised that all were reported in a timely manner to the Clinical Trials unit, who were just late in reporting to the Trust, all were addressed in a timely manner.
- Friends and Family Test feedback had significantly decreased, this had been reviewed in detail and is related to average scores being given for the questions related to NIHR Patient Research Experience Survey Questions and not those linked to FFT. The Division are undertaking a review of the system to ensure that the scores created via IQVIA can be compared to FFT scores.

KB sought clarification regarding the serious adverse events and queried whether they are incorporated into the normal incident rating system.
LR stated that they are not incorporated and that internal serious adverse effects are reported to the CRD as sponsor and in relation to external serious adverse effects the Trust is only obliged to report to the sponsor. LR stated that as part of study safety objective and as part of the CRD Annual Plan LR would like CRD to have enhanced oversight, a working group is being set up to address this objective, as LR would like to reach a position to build the internal adverse effects reporting on Inphase conversations had taken place with governance team and digital colleagues. LR stated that there is a strong possibility that CRD would be able to achieve this, hoping that within the next 12 month period would be able to report serious adverse events in the same way that CRD report clinical incidents.
KB welcomed this as there is a great deal of focus with regards to learning from incidents.

**Deep Dive – into the correlation of waiting times for Friends and Family Review**
CW presented the Deep Dive
CW stated that the review had been requested to review ED FFT to identify any trends between attendance, 4 hour performance and FFT responses.

- CW stated that the FFT response rates remain stable with a slight decrease in April 2024. CW stated that this had improved, however this is only a 6% response rate
- CW alluded to the difficulty in obtaining responses when the ED is really busy, and also whilst parents are extremely stressed and worried
- Other than October 2023 FFT score was above 80% and in October 2023 colleagues seen a high number of attendees and a real decrease in satisfaction in response rates.

- Positive themes, relating to friendly staff, short waiting times for some responses, and some positive themes regarding the UTC.
- Improvement themes relating to long waits, staff communication and parking, CW alluded to busy periods in ED and how staff are able to communicate with parents during busy periods, with further work in this regard.

Recommendations

- Review FFT promotion within the department – (posters, QR codes).
- Senior nurse walk around to talk to families for feedback and encourage FFT
- Re-audit in 6 months
- CW alluded to the lack of responses and the importance of capturing the experience of these families when families had left ED, and whether it would be possible to facilitate a text after the family once the family had left ED to enable increased responses.

CW stated that the amount of questions for ED had been extended, and that this could be a real challenge for families to complete, and colleagues are going to review whether this could be reduced to enable data capturing.

FB stated that this helped SQAC to understand the current position and thanked CW for analysis.
IG alluded to improving response rates and advised that LH&C had recently transitioned to a new friends and family test and whether this may provide greater benefits for Alder Hey. IG requested if CW could ensure that digital representatives are invited to the Working group to explore any potential benefits for Alder Hey.

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

**24/25/45** **Clinical Audit Annual Report 2023/24**

LW presented the Clinical Audit Annual Report 2023/24

SQAC noted that whilst several improvements had already been made to the clinical audit process, including improved collaborative working between the Divisional Governance Leads during 2023/24, the introduction of a Trust wide CEOG ensures that there are appropriate systems and processes in place for the development and monitoring of policy, standards and compliance relating to clinical audit and NCEPOD activities. The CEOG oversight of clinical audit performance and associated learning will continue our journey of improvement throughout 2024/25, enabling the right level of assurance to be provided to ensure that continuous learning from completed audits are embedded in practice.

KB stated that the Trust is not fully compliant with the requirements for the Quality contract as there are 2 audits that the Trust had not submitted information in line with the national requirements, and that steps needed to be addressed this year to ensure that the Trust is not in a similar position next year. KB stated that one is NCEPOD, one is a national audit and one central system.
KB stated that the non-compliance with regards to epilepsy had also resulted in non-compliance within a different organisation as the external organisation rely on Alder Hey data, KB alluded to the reputational issue for Alder Hey.

**Resolved:** SQAC to receive a plan in July 2024 detailing the position of complying with obligations.

**Resolved:** SQAC received, **NOTED** and **APPROVED** the Clinical Audit Annual Report 2023/24 and welcomed a detailed update at July 2024 meeting.

**24/25/46** *Well Led*
*Responsive*

**Tendable Standard Operational Procedures**

PW presented the Tendable Standard Operational Procedure

**Resolved:** SQAC received, **NOTED** and **APPROVED** the Tendable Standard Operational Procedure.

**24/25/47 Any other business -** None.

**24/25/48 Review the key assurances and highlights to report to the Board.**

- QAC 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
- SQAC received the Patient Safety Terms of Reference and workplan
- SQAC received the ED monthly report, ED@ its best update
- SQAC received the EPRR quarterly update, really informative discussion held regarding emergency preparations and resilience, with thoughtful questions, queries and responses regarding how learning is shared and how the Trust need to undertake Major Incident exercises, whilst noting that the paperwork may not be perfect.
- SQAC received the Board Assurance Framework
- SQAC received the Risk appetite/tolerances presentation with good discussion held regarding the Risk appetite, SQAC agreed it was a good foundation, with broad agreement from SQAC having a different risk appetite to 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 was work in progress, and recognised that there are going to be some challenges regarding two different risks and aligning the two different organizations and creating a single culture.
- SQAC received the Divisional updates and a Deep Dive into the correlation of waiting times for Friends & Family tests
- SQAC received, NOTED and APPROVED the Clinical Audit Annual Report 2023/24
- SQAC received, NOTED and APPROVED the Tendable Standard Operational Procedure

**23/24/49 Date and Time of Next Meeting:** 19th June 2024 9.30 – 11.30 am via Microsoft teams

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

| | |
|---|---|
| **Paper Title:** | **Chair's Highlight Report - Futures Committee** |
| **Report of:** | **Shani Arora, Chair of the Futures Committee** |
| **Paper Prepared by:** | Chief Operating Officer |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☐<br>Information ■<br>Regulation ☐ |
| **Summary / supporting information:** | This paper provides a summary from the recent Futures Committee meeting held on the 26th of June 2024, along with the approved minutes from the 16th April 2024. |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Strategic Context**<br><br>**This paper links to the following:** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ■ |
| **Resource Implications:** | None |

## 1. Introduction

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

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

- A case study presentation was received from Professor Paul McNamara on a large funding award from Life Arc for a Cystic Fibrosis Trail finder research programme. This was a great example of discovery and pioneering breakthroughs.
- The Committee approved the final version of the Futures Strategy.
- The Committee received the business case and implementation plan for Futures and selected a preferred option for implementing Futures. The business case is to be finalised and Case tabled at Executive Directors for review and financial approval.
- Futures Financial Framework has been developed with an options appraisal of different company forms and legal entities received.
- An update was received on the Futures implementation programme, including the four pillars of discover, develop, grow and transform.
- The Committee received an update on the Investment Zone and Strasys Partnership

## 3. Positive highlights of note

Key areas of progress:

Project initiation documents completed for each Pillar.

- Discover: Plans developing for Northern Institute launch and resource request to appoint to four clinical leads for discovery
- Develop: Scoping of a Futures Fellowship Programme; embedding Futures into induction and Strong Foundations.
- Grow: Recruited bid-coordinator as part of plan to secure new investment; Investment Zone business case to be developed for September 2024
- Transform: Patent Portal specification completed and tender to commence in Q2.

## 4. Recommendations

The Board is asked to note the Chair’s Highlight report for the meeting that took place on the 26.6.24

# Futures Committee

Confirmed Minutes of the meeting held on **Tuesday 16th April 2024**

| | | | |
|---|---|---|---|
| **Present:** | Mrs. S. Arora | Non-Executive Director (Chair) | (SA) |
| | Mr. A. Bateman | Chief Operating Officer / Managing Director Futures | (AB) |
| | Dr. J. Chester | Director of Research and Innovation | (JC) |
| | Mr. G Dallas (arr. 09:55) | Non-Executive Director | (GD) |
| | Mr. J. Grinnell | Managing Director/Chief Finance Officer | (JG) |
| | Mr. J. Kelly | Non-Executive Director | (JK) |
| | Mrs. L. Shepherd | Chief Executive | (LS) |
| | Ms. K. Warriner | Chief Digital and Information Officer | (KW) |
| **In Attendance** | | | |
| | Ms. K. Birch | Academy Director | (KB) |
| | Mr. D. Cole | Senior Project Adviser | (DC) |
| | Mr. I. Hennessey | Clinical Director of Innovation | (IH) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| | Ms. E. Kirkpatrick | Finance Manager | (EK) |
| | Mrs. R. Lea | Director of Finance and Development | (RL) |
| | Ms. S. Leo | Head of Research | (SL) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| | Ms. A. Graham | Committee Administrator | (AG) |
| **Observing:** | Ms. F. Ashcroft | CEO of the Charity | (FA) |
| | Mr. G Meehan | Non-Executive Director | (GM) |
| **Apologies:** | Mr. N. Askew | Chief Nurse | (NA) |
| | Mr. A. Bass | Chief Medical Officer | (ABASS) |
| | Mr. C Beaver | Deputy Director of Communications | (CB) |
| | Mr. D. Hawcutt | Clinical Director of Research | (DH) |
| | Mrs. D Jones | Chief Strategy & Partnerships Officer | (DJ) |

**24/25/01 Welcome to the New Committee**

The Chair welcomed everyone to the first meetings of the new Futures Committee.

**24/25/02 Apologies**

The Chair noted the apologies that were received.

**24/25/03 Declarations of Interest**

There were none to declare.

**24/25/04 Minutes of the Research & Innovation Committee Meeting**

The minutes from the meeting of the Research & Innovation Committee held on held on the 18.01.2024 were agreed as an accurate record of the meeting.

**24/25/05 Matter Arising and Action Log**

*Matters Arising*

There were none to discuss.

*Action Log*

**Action 23/24/40.1** – to be transferred to Research Management Board
**Action 23/24/48.1** – to be transferred to Innovation Management Board
**Action 23/24/57.1** – the strategy has now been finalised and its implementation will be monitored through Research Management Board

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

**24/25/06 Draft Research and Innovation Committee Annual Report, 2023/24.**

The Committee received the Research & Innovation Committee Annual Report for approval.

**Note**: An updated version of the Research & Innovation Committee Annual Report has been circulated by email for virtual approval.

**24/25/07 Futures Committee Purpose and Ways of Working**

The Chair noted that the Committee presents an opportunity to make a difference and to drive implementation and deliver the Futures Strategy Whilst not being operational, Progress evaluation and monitoring will remain with this group.

The group is a place to be agile, to fail fast and make quick decisions within the terms of reference, and to consider what success will look like in twelve months' time, when the annual report is written. The meetings will be ideas-rich and paper-light, with progress updates at every meeting demonstrating achievement against the implementation plan to energize and produce solid actions and ideas going forward.

**24/25/08 Current Status of Futures Disciplines:**

**a). Research**
SL gave an update on the current position of Research, noting that their Annual Report was received for review. The Research Strategy will be shared when the draft has been signed off. A soft launch is ongoing, with the document being used to raise awareness. Financial performance was achieved; the second round of the gene therapy trial is due to take place and the second MRI scanner is due to be operational later this year. The Research team hosted a visit from GOSH as part of their work building external partnerships, tying in with the Futures objectives.

**b). Innovation**
EH gave an update on the current position of Innovation, noting that their highlight report was received for review. The team continue to work on the Innovation Strategy and support work developing the Futures Strategy. Work is ongoing on benefits realisation from Innovation. Work is also ongoing with external partners: Isla are collaborating on the remote monitoring product; Cheshire & Merseyside ICB are working with the team on the Mental Health platform, which has been sold into

two Trusts; co-creation work continues with the NICU teams on the NICU line-of-sight technology.

It was noted that this mid-point of being two years into the Innovation Strategy is an appropriate time to align and evolve into the Futures Strategy, embedding the work as business as usual (BAU).

JK noted that it seems the focus on Innovation has possibly been wrong, and it should be seen as a way to benefit Alder Hey by becoming as efficient as possible rather than as an income generator.
KW noted that in the last five years the market has changed and moved on significantly, with the pandemic impact also changing things.
LS noted that the important issue is that we do not have a commercial strategy so there is no assessment of what works where, and we are not yet there.
EH noted that partnering is critical and building relationships is key.
JC commented that there needs to be a balance of cash saving products and income generators, but primarily focused to benefit Alder Hey patients, families and staff. The benefits piece needs to be reviewed to ascertain whether the balance is at the right level rather than its current, potentially more internal shift.
SA noted that Futures is for delivering benefit ultimately to CYP, and it needs to be remembered that commercial income is to aid in delivery of the strategy and not for profit.
AB added that Futures is a shift to long term horizons, whereas patients are shorter-term. There needs to be the dexterity to do both - to deploy to care and then to sell onto other Trusts who can see the benefits being realised at Alder Hey. However, some collaborators will want to see short-term benefits, whereas NHS investment decisions can be up to 10 years.

*(09:55 GD joined the meeting)*

JG reflected on the core questions of “why are we here”, “where does the money sit”, “are we creating for today or the future” and noted that theAlder hey offer needs to be sharpened. Innovation is the place to come to try things out for staff or partners, but not to crystalise too quickly and miss opportunities.

**c). Academy**
KB gave an update on the Academy, noting that they are wrapped around development of the Futures strategy, with conversations ongoing around where the Academy sits and fits, recruitment, development, enabling learning and fast exchange of knowledge. Currently the Academy is not set up in the best format and needs further thought.; There is a clear route map in terms of the People strategy in what we want to achieve and there are great opportunities both internally and externally to create those collaborative knowledge networks but as yet the Academy is not set up for it.

JK commented that the global strategy has information about training and development but shouldn’t just be about people, it should also be about what product to globalise.
KB replied that there are conversations about the global offer – it is eminently do-able and around learning, knowledge exchange and added collaborative value but the Academy is not set up for it yet.
JC noted that ultimately the USP is clinical knowledge and expertise with our Clinical Research Fellows, but thought needs to be given to Clinical Innovation Fellows and Clinical Education Fellows.
LS asked for this ambiguity to be held for now until there is a commercial strategy to give structure and definition.

KB added that there will be test cases to use as a starting point to inform development of the global work.
AB noted that Strasys and the Global Director will be working together to lead the test work.

**d). Summary of the Year-end Position**
EK gave an update on the current financial position, noting that Innovation were broadly on budget. Research were on budget with £200k commercial income over & above forecast at year-end.
SA asked whether the budget process had been refined for 2024/25, whether Futures and BAU will have their own budgets.
EK noted that changes in the balance between internal & external will be reflected in budget terms to avoid restorative transactions

EK to discuss offline with SA and update at the next meeting following finalisation of Trust budgets for 2024/25.

**24/25/08.1** **Action: EK / SA**

KB added that the People element of the Futures strategy is to be shaped and framed by the workplan.
SA noted that there is an unanswered question around resource.
AB noted that within the Strategy appendix there is a Year 1 plan which begins to frame the support needed such as marketing function, more needs to be done but budget setting will finalise this.
KW commented that looking pragmatically the plans are good; what needs to be done pragmatically to achieve the targets but the three work areas – BAU, Transformation and Pioneering – are not clearly defined.
JG noted that more work needs to be done around having a small agile expert skillset to bring investors in and to work with partners to develop products, to ensure the way forward.
RL agreed that there needs to be a different way of capturing the investment & benefits piece, but that also note that investment may be now but benefits may not be realised for several years.
JK commented that this suggests there are two different benefit tracking processes for transformational and historic, where there should be a multi-year focus.
KW noted that there are expectations for all of the strategic goals that standard tracking methodology will be used to report into Programme Board where the overall integrated programme is held, with a multi-year benefits tracker.
SA commented that decisions need to be made quite quickly on what is BAU, transformation and pioneering, we cannot let that drift if we want to deliver this strategy successfully.
EH commented that the whole ethos of Innovation is that we can to try stuff and to fail fast, our success is built upon the ability to directly deploy into care by embracing new technology and innovative ways of working.

**Resolved:**
The Futures Committee noted the updates on the Futures Disciplines.

**24/25/09** **Case Study:**

**What success can look like – Innovation, education, collaboration with Wavelength**

The Committee received a presentation from IH on the collaboration with Wavelength and the Alder Hey Charity.

JC noted that this is a great model for sharing knowledge and generating income which is flexible.
ES commented that from a risk perspective this model is comforting as due diligence is being undertaken by Wavelength. The model appears to be one of the safest we will get.
IH added that working with the charity has its benefits as they have their own strict rules around who they will accept funding from.
SA thanked FA and commented that it is good to have a partnership together for Innovation to work with the Charity.

**Resolved:**
The Futures Committee noted the presentation on the Wavelength collaboration.

**24/25/10 Progress Update on Futures Strategy Document and Implementation Plan**

The Committee received a presentation summarising the Futures strategy document and implementation plan and the progress that has been made to date. The Committee were asked to consider four questions.

*Will the Futures strategy enable us to "Bring the future"? Correct priorities? Balance? Gaps?*
Key points:

- More balance needed
- Content there but not necessarily in correct order or balance
- Consider how the strategy evolves and where it sits within Liverpool City Region (LCR) and globally
- Internal & external audiences and partners are different – noted that Clinical Research audience less emotive
- Need to take partners on engagement journey in meaningful way
- Need to develop new ways of working with partners to deliver shared objectives – e.g. LCR public health actions
- Alignment & connection with other strategic goals & programmes within 2030 Strategy – potential for Futures to disrupt
- Quality implications particularly working with LCR
- Partnering with LCR
- Strategy needs to be in the right places to have discussions
- Do not have Commercial partnering and Communications

Outcome - emphasis on Pioneering Partnerships; Balance
Gaps - Stakeholder partnerships; Commercial strategy

*What is in and out of scope for Futures?*
Key points:

- Specification / guiding principle of BAU when established, matured & proven with handover to corporate service or division
- Some Digital Transformation areas more nuanced, some more black & white
- Need to be mindful of national and local work & not create more silos
- Test should be "Is this pioneering" – if yes, then it is Futures
- Big ideas against Transformational / BAU work
- Need clarity on measuring – value rather than just monetary
- Some projects will sit in two areas as BAU and Pioneering such as the Portal
- Will not be easy to define as Research encompasses all three areas

AB to develop guidance and decision matrix to clarify what sits where.
**24/25/10.1 Action: AB**

*Does the Investment & Growth plan look right? Income generating? Net contribution to Trust Budget?*
Key points:

- This area needs more discussion on commercial strategy
- Clarity on figures provided to Board & in Strategy needed
- Care needed when showing income in accounts – needs not to be seen as a cash cow to solve budgetary issues
- Needs to be clear narrative

*Transition from strategic planning to delivery*
Key points:

- Need to work on an implementation plan and how that happens
- Continue to track Futures, enable the Pillars to become workstreams etc
- Ensure financial plan fits
- Separate out measurements and targets – look at commercial income as a measure with a target

**Resolved:**
The Futures Committee discussed the Futures strategy document and implementation plan partnership.

**24/25/11 Integrating Academy and iDigital with Research and Innovation**

The Committee was advised that work is ongoing on the action around developing a mapping piece and that a future white board session will be held to further inform this.
KB noted the difficulties in holding things in two different "pots" while this work is evolving.
JC reminded the Committee that the rationale was to ensure all areas are considered to create a balanced framework for working together.

**Resolved:**
The Futures Committee noted the update on work around integrating the Academy and iDigital with Research and Innovation.

**24/25/12 Focus on specific objectives within the evolving Futures strategy:**

**Pillar 1: Discovery**
AB added that the suggestion of Futures MDTs has potential to produce ideas that can be pitched in the Pillars.

AB to ensure KPI dashboard reports at the next and future meetings.
**24/25/12.1 Action: AB**

**Resolved:**
The Futures Committee received an update on the Discovery Pillar of the Futures Strategy.

**24/25/13 Focus on specific objectives within the evolving Futures strategy:**

**Pillar 2: People**
EH gave a brief update. It was noted that "Little Hearts" program is about to be rolled out across Cheshire & Merseyside and is a product that could be developed further with investment, but there is concern that if it is seen as not pioneering and Innovation are removed from the program it may fail reputationally for both Alder Hey and Cheshire & Merseyside. There is a finite resource in the team being asked

to undertake the ambitious plans. A discussion was had about developing and retaining skilled and key staff.
SL noted that work is ongoing with KB and the Academy to develop initiatives for career planning from the earliest stages to benefit colleagues.
SA noted that the conversation highlights the importance of Research, Innovation and the Academy wrapping around and working together and not in silos.

**Resolved:**
The Futures Committee received an update on the People Pillar of the Futures Strategy.

**24/25/14 Focus on specific objectives within the evolving Futures strategy:**

**Pillar 3: Investment and Growth**
The Committee was provided with a summary of the Futures financial framework by EK, who noted that the key principles of the strategy are being set out for a balance between new investment streams and economies; work is ongoing on the budget plan with an aim and trajectory of financial net zero for the Trust. Real profit will be visible and re-investable via a clear framework with set principles.
RL confirmed that key principles around the desired strategy outcomes are being outlined and worked on.

EK & SL to bring the proposed framework & principles to the next meeting.
**24/25/14.1 Action: EK / SL**

**Resolved:**
The Futures Committee received an update on the Investment & Growth Pillar of the Futures Strategy.

**24/25/15 Focus on specific objectives within the evolving Futures strategy:**

**Pillar 4: Digital and Data Infrastructure**
The Committee received a brief update presentation on the Patient Portal / Alder Hey Anywhere work.
SA noted that it is good to see this work on track.
JG asked whether the hybrid option would lose the opportunity to wrap tech partners around this. A discussion was had about the finances and resources available to deliver the portal, which is seen as a key deliverable in the Futures Strategy.
KW noted that opportunities for scaled adoption are greater now than in pre-pandemic years.

KW to work on program specification, reporting and highlight report to bring to next meeting and subsequently report quarterly as a Pillar workstream..
**24/25/15.1 Action: KW**

GD asked what lessons have been learned as part of the experience.
IH noted that Children & Families should have a digital “front door” to interact with the hospital.
SA noted that it would be good to get momentum behind this and to deliver this year.
KW added that there are national expectations attached to the funding and there needs to be a plan in place to access that funding.

**Resolved:**
The Futures Committee received an update on the Digital & Data Infrastructure Pillar of the Futures Strategy.

**24/25/16 Investment Zone Update**

The Committee received an update on the Investment zone from EH, who noted that the MOU with the Department for Levelling Up has now been signed by the Liverpool City Region combined authorities and monies are now available for draw-down. The program is prioritised with Phase one projects going to the Combined Authority Board in June; Phase two projects are expected to follow in the autumn (Alder Hey is in Phase two). The template and guidance have been requested so work can begin on the business case for submission. The time is now right to bring in the Futures view on how we spend that money, to look at the economic model based on the 2030 vision and strategy. Alder Hey is the CYP flagship in the Investment Zone and there is work that can be done with UoL. The route has to be through the City Region for CYP investment. The Health & Life Sciences Cluster Board has been restarted to drive activity forward. Liverpool is applying to be European City of Technology & Innovation; there are lots of new events with private investors to look at the opportunities and products being developed. The Investment Zone prospectus – which Alder Hey are within – will be launched during Innovation Investment Week in May.
DC added that the timescales are potentially being extended from five years of funding to ten years, and to cover that extension the funding has been increased to £160m. A discussion was held on the need to work closely with LCR through their committees to understand their strategy. An explanation was received on why Alder Hey will not access Phase 1, but will bid for Phase 2 funding.

EH noted that the business case will be built over the summer for submission in the autumn. The work has been going on for two years and the outline case was "Why should LCR include Alder Hey in its plans" to resonate with the city's strategy.

EH to bring draft submission to next meeting.
**24/25/16.1 Action: EH**

**Resolved:**
The Futures Committee noted the Investment Zone update.

**24/25/17 Strasys Partnership Update**

The Committee received an update from JC on the partnership with Strasys which is progressing. The Partnership Board has a new member who is working closely with Alder Hey colleagues.

JC to invite Strasys to attend future Futures Committee meetings.
**24/25/17.1 Action: JC**

**Resolved:**
The Futures Committee noted the Strasys Partnership update.

**24/25/18 Overview of Risk Registers**

The Committee received a brief update on existing risks. JK raised a query on whether the area of potential reputational risk had now been closed down; ES replied that it was understood it had now been closed and that is due to be taken to Audit & Risk Committee with clarification from the Director of Finance & Development.

ES to seek clarification on risk closure from the Director of Finance & Development.
**24/25/18.1 Action: ES**

**Resolved:**
The Futures Committee noted the Risk Register update.

**24/25/19 Board Assurance Framework (BAF) and Risk Appetite**

The Committee received the Board Assurance Framework Report (BAF) for March 2024. ES noted that following the meeting the existing risk level and description will be refined. Risk appetite will also be considered with both internal and external context to ensure clarity around ambiguity, commercial strategy, optics around investment in the current climate and other NHS views and opportunities around descriptors and governance.
SA asked that the change in governance be picked up at agenda setting for the next meeting.

ES to include governance in next agenda setting discussion.

**24/25/19.1 Action: ES**

**Resolved:**
The Futures Committee noted the contents of the BAF report for March 2024 and the outline for refining risk level and appetite.

**24/25/20 Any Other Business**

There was no other business.

**24/25/21 Review of the meeting**

The Chair felt that the meeting was very productive with rich discussion and a lot of work ahead. It was noted that the Strategy document was very well written with its supporting implementation plan. The Chair thanked everyone for their feedback on the various agenda items discussed during the meeting and looked forward to the next meeting. It was confirmed that there was nothing to raise with other Assurance Committees.

**Date and Time of the Next Meeting:**
To be confirmed

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

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

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

**Does this relate to a risk?** Yes ☑ No ☐

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

| Risk Number | Risk Description | | | | Score |
|---|---|---|---|---|---|
| #2664<br>#16 (2.1 BAF) | Industrial strike action impacting staff availability.<br>Workforce sustainability and Development | | | | 12<br>15 |
| **Level of assurance** (as defined against the risk in InPhase) | ☐ | **Fully Assured**<br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice | ☑ | **Partially Assured**<br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | ☐ **Not Assured**<br>Evidence indicates poor effectiveness of controls |

## 1. Executive Summary

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

## 2. Current Position

### 2.1 Workforce Metrics

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

Key highlights from the workforce metric data:

**Sickness-** The sickness absence target has been reset for 2024 to 5%, which is a reduction from the 5.5% target during 2023. Short term sickness absence target is set at 2% and long-term sickness absence is set at 3%.

May's sickness absence position was 4.79% and below the new Trust target of 5%, which is the lowest rate of sickness absence in the last 19 months.

Sickness absence is largely driven by long term sickness absence at 3.19% with 1.6% Short Term sickness absence. Divisional HR Business Partners are supporting divisions to ensure that there are action plans in place to support all staff on long term sickness.

**Turnover** – The 2024 target for turnover has been reduced to 10%, compared to the turnover target of 13% in 2023.

Turnover in May was 10% acheivingTrust target. Retention initiatives are proving successful in reducing high levels of turnover.

**Personal Development Reviews (PDR's)** PDR compliance as of May 2024 was 87% slightly below Trust target of 90%.

### 2.2 Industrial Action

The British Medical Association Junior Doctors Committee (BMA JDC) announced further dates for industrial action in the NHS.

The 5 day walkout will take place in England between 7am on Thursday 27 June until 7am on Tuesday 02 July.

### 2.3 Organisational Health and Wellbeing

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

Following a baseline assessment against the NICE Wellbeing at Work guidance in 2023, Physical HWB was identified as a priority area and a task and finish

0150
group was set up. Addressing staff wellbeing following traumatic incidents has also been an area of focus leading to the development of a Debriefing Guidance and pathway, in collaboration with the EPRR lead to ensure that all staff know and have access to the opportunity for a group psychological debrief following a traumatic incident. There is also work underway as part of the new patient safety strategy to ensure that staff wellbeing is considered routinely when incidents are raised. Postvention support in the event of a suicide in the organisation, is a programme of work being led by the SALS Clinical Lead and Deputy Chief People Officer who are developing local guidance.

## 3 Conclusion and next steps

- Continuation of Divisional HR support to identify appropriate interventions needed, to support thriving teams.

# BOARD OF DIRECTORS

## Thursday, 4th July 2024

| | |
|---|---|
| **Paper Title:** | **Workforce Equality, Diversity and Inclusion Annual Report, 2024** |
| **Report of:** | **Chief People Officer** |
| **Paper Prepared by:** | Head of Equality Diversity and Inclusion |

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

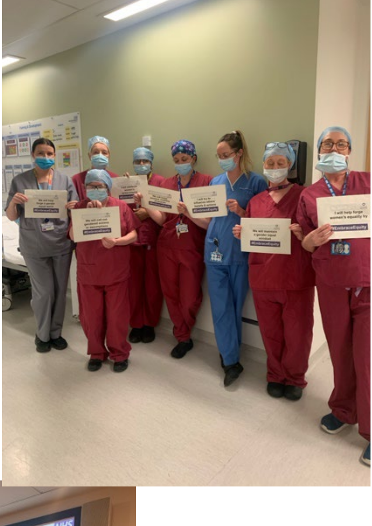
**Does this relate to a risk?** Yes ☐ No ☐

**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 |

# Workforce Equality, Diversity, and Inclusion Annual Report

# 2024



# Contents

1. Accessibility Statement
2. Introduction
3. We are Alder Hey
4. Our People
5. Our Legal Duties
6. Our Progress 2023/2024
7. Our Equality Data
8. Priorities for 2024/2025

# Accessibility Statement

Here at Alder Hey Children's NHS Foundation Trust, we want to provide information in clear and accessible ways to meet the communication needs of all our patients and staff.

To request any of our information or key documents in an alternative format including in larger print, audio or any an additional format, please access our website via the link below:

For further information contact:

General Enquiries telephone : 0151 228 4811

Website address: https://www.alderhey.nhs.uk

Follow us

## Introduction

Alder Hey Children's NHS Foundation Trust is committed to enhancing equality, diversity, and inclusion, creating a welcoming experience for all our patients, families, visitors and staff. We support a diverse workforce, recognising that everyone has different backgrounds, different views, beliefs, and different ways of working. Appreciating this diversity is key to success, helping us to provide the best possible care to our children, young people, and their families. Patient care is at the heart of everything that we do, and this is reflected in the Alder Hey values. Equality, Diversity, and Inclusion flow through all these values and are key to delivering the organisational objectives. As a public sector organisation, we recognise our role and responsibility to provide equal opportunities and advance inclusion, working to eliminate discrimination and foster good relationships as defined in the Equality Act 2010. It's not only our legal duty, but also the right thing to do and Alder Hey is committed to making a positive difference for our patients and our colleagues. We believe that everyone has a part to play in adopting a culture of inclusion and belonging and challenging inequality.
We encourage and support our people to work together, respect each other, appreciate differences, and deliver the best care to our children and young people.

This report highlights a range of initiatives undertaken throughout 2023 to embed equality, diversity, and inclusion, making it a central element of our core business. We are pleased to align our work with national plans to improve equality, diversity, and inclusion, addressing inequalities in our workforce and building an environment where staff feel valued, safe, cared for and a great place to work. We understand that we cannot make improvements without the support of our staff including our trade union representatives and staff networks who play an important role in guiding and engaging staff by raising awareness, and challenging systems, policies, practices, and behaviour. Involving our staff is critical to our success and we will continue to encourage all staff to get involved in supporting the equality, diversity, and inclusion work.

# We Are Alder Hey

Alder Hey Children's NHS Foundation Trust, located in Liverpool, UK, is one of Europe's biggest and busiest children's hospitals, we treat everything from common illnesses to highly complex and specialist conditions. Alder Hey cares for over 330,000 children, young people and their families every year. We know that a children's hospital is different and that our job is more than just treating an illness. The Trust employs a workforce of 4,115 staff who work across our community and hospital sites. As a teaching and training hospital, we provide education and training to around 900 medical and over 800 nursing and allied health professional students each year. The 330,000 children and young people we see each year are a natural reflection of the rich, diverse mix of communities and cultures in the UK. Alder Hey is an inclusive, supportive environment with warm and friendly staff. We know that being a good employer is not just about benefits and celebration. We have our values which represent all we do and how we work together with our colleagues, children, young people and their families. Our values are:

- Excellence-be part of an outstanding organisation
- Innovation-opportunity to be part of shaping the organisation
- Openness-to share and be listened to
- Respect - for each other and celebrating difference
- Together-working together to encourage inclusivity

# Our People

Alder Hey is one of Europe's biggest and busiest children's hospitals, treating everything from common illnesses to highly complex and specialist conditions. Our highly skilled staff are dedicated to putting patients at the heart of everything they do. The Trust employs over 4,115 staff who work across community and hospital services, providing care to more than 330,000 children and young people each year. We continue to work towards ensuring our staff feel valued and cared for, generating equitable opportunities and taking action to strengthen and support our workforce.

**Our Staff Networks**

We want to understand how it feels to work at Alder Hey so that we can work together with our staff to ensure they feel cared for, listened to and valued. Our fantastic developing staff networks are growing from strength to strength and have been a powerful voice and source of positive change.

- The LGBTQIA+ staff network continues to support the Head of EDI in implementing the recommendations from the Navajo assessment. The network has developed an Allyship training programme which they have delivered to the Finance team. The programme is aimed at providing staff with an understanding of Allyship and how they can actively support the staff network by becoming an Ally. The network members are also supporting the Learning and Development team to create lived experience videos which will support and complement manager training. Plans for Liverpool PRIDE which will take place in June 2024, are already underway.
- The REACH staff network continues to make positive changes and is supporting the Trust to undertake work to become an Anti-Racist organisation.
- The Armed Forces staff network is engaging with the local Armed Forces community and will be holding a series of events to mark this occasion. They are also working hard to encourage any armed forces children, young people, and their families to come together in a safe space with others from armed forces backgrounds. They continue to work with the local community cadets and will be inviting them to attend our Remembrance service later this year.

- The ACE Disabilities and Long-Term Conditions staff network continues to grow. The meetings continue to be extremely positive generating ideas to make Alder Hey a great place to work. The group have recently been working with the Head of Facilities to provide insight into the Alder Hey environment, identifying ways of improving facilities which will not only benefit our staff but also our children and young people.

**Our Staff Survey**

The results from the 2023 staff survey show some improvement in several areas. The Trust takes a zero-tolerance approach to any sort of discrimination against staff, so whilst this data is encouraging, we know we have more work to do to reduce this even further. We had a fantastic 60% response rate which is a positive increase from 54% in 2022. There was an increase in the number of staff who believe that we are compassionate and inclusive and we are above the national average which is encouraging. 71.15% of staff would recommend Alder Hey as a place to work which is 10.6% above the national average, and was the top score in the north west (acute and acute and community Trusts). Less colleagues than in 2022 reported that they had experienced discrimination, however those who reported that they had experienced this discrimination on the grounds of their ethnic background rose markedly from 19.5% in 2022 to 30.7% in 2023. This increase can also be seen nationally. Discrimination on the grounds of other protected characteristics such as disability, age and gender all decreased. This will be an area of focus for the Trust, in particular, we will work with the REACH network to better understand and reduce racism; implementing the North West BAME Assembly Anti-Racist Framework will be key to this. Both the WRES and the WDES use data from the staff survey to inform the Trust position, and both saw marginal improvements in the scores from 2022 to 2023.

## Our Legal Duties

The principles of Equality, Diversity, and Inclusion are integral to all that we do at Alder Hey and we want to ensure that we are all working to a consistent standard and that equality is considered when implementing new and amended services, and workforce

practices. Under the Equality Act 2010 all public sector organisations, which include NHS, have a duty to meet the requirements of the Public Sector Equality Duty.

Under the General Public Sector Equality Duty
we will have due regard to the need to:

eliminate unlawful behaviour, including discrimination, harassment and victimisation

advance equality of opportunities between people who have protected characteristics and those who do not

foster good relations between people who have protected characteristics and those who do not

The Public Sector Equality Specific Duty requires Alder Hey to:

publish equality information including how we are meeting the general duty

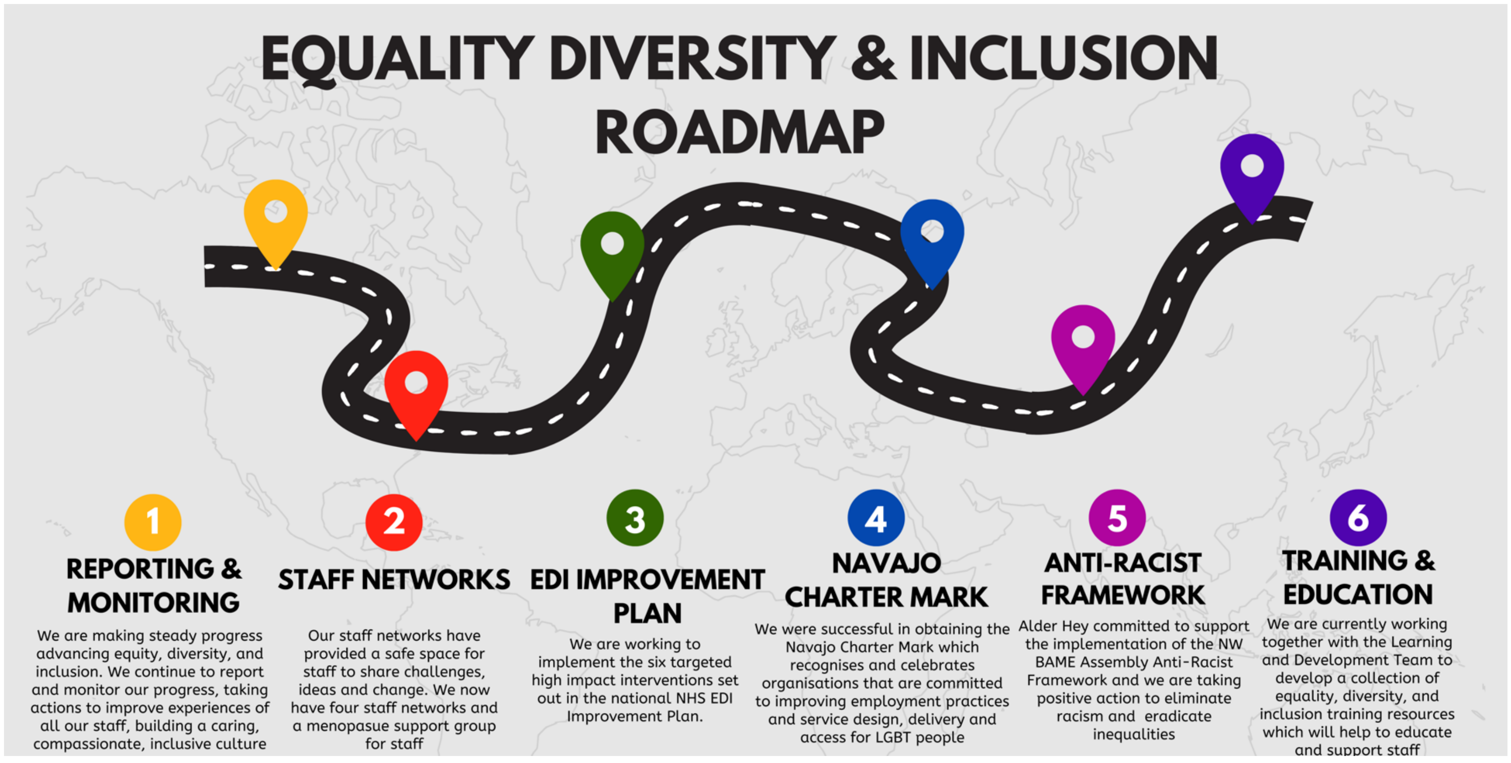
establish and publish one or more equality objectives

publish the Gender Pay Gap information annually

## Progress 2023/2024

The EDI Steering Group has been the forum for overseeing the development of the action plans in relation to all EDI frameworks and in addition, has been driving a number

of other improvements. We have made significant progress over the last 12 months and the road map illustrates the start of our journey and some of the achievements we have made over the past 12 months. We will continue to work hard to support and implement initiatives that will positively impact the working lives of our workforce, making Alder Hey a great place to work.




## Key Achievements for 2023/2024

- Established and developed four staff networks
- Staff Network developed and delivered 'Ally' training
- Been awarded the Navajo Charter Mark. The Navajo Merseyside & Cheshire LGBTIQA+ Charter Mark is an equality mark sponsored by In-Trust Merseyside and supported by the LGBTIQA+ Community networks across Merseyside– a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA+ people in Merseyside

- Alder Hey and its network members took part in another fantastic Liverpool Pride event in Summer 2023
- Working alongside HR, successfully launched the Reasonable Adjustments Policy
- Developed a suite of resources to support managers
- Produced excellent communication campaigns from all of the networks, including Black History Month, Disability History Month, LGBTQIA+ History Month and delivery of a moving Remembrance Day service in the Atrium In November 2023.
- Achieved the Armed Forces Covenant Silver Employer Recognition Scheme (ERS) award in 2023
- Accreditation with the Veterans Covenant Healthcare Alliance (VCHA)

## Our Equality Data

### Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is a tool designed for identifying key differences, referred to as 'indicators', between our white and ethnic minority staff experience of the workplace. Our aim is to close any gaps by tackling discrimination, promoting a positive culture, and valuing all staff. By supporting our staff and improving their experiences, we will have a positive impact on patient care. An environment that values, supports and commends the diversity of its workforce will result in staff that feel included, delivering high quality patient care and improved health outcomes for everyone.
We are pleased to note that Alder Hey has made improvements in two out of the nine indicators of race equality and remain static in one:

- Increase in the percentage of BME staff employed at Alder Hey Children's NHS Foundation Trust
- Static in the likelihood of white applicants being appointed compared to ethnic minority applicants
- Decrease in the number of BME staff who have experienced harassment, bullying or abuse from staff

Several actions have been taken over the last twelve months that will have attributed to the above improvements, these include:

- Supporting the development and growth of the new REACH staff network
- Appointment of Head of Equality, Diversity, and Inclusion
- Communications regarding celebration days and events
- Supporting recruitment to reduce inequality in the recruitment processes
- Promote Learning and Development opportunities for BME staff

In response to the WRES data and with the support and involvement of the REACH staff network, we have developed a WRES action plan. We will work together to make improvements against the themes identified as concerns. Where possible, we will link our actions to the NHS Equality, Diversity, and Inclusion Improvement Framework to ensure we our activities are robust, align, and work towards improving the experience of our staff.

## Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is an NHS wide standard which allows NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan. Year on year comparison enables us to show progress against the indicators of disability equality.

We are pleased to note that we have made improvements in 4 out of the 10 indicators of disability equality:

- There is an increase in staff working at Alder Hey Children’s NHS Foundation Trust who have declared a disability
- There has been a positive decrease in the relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff

- There has been a slight decrease in the percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months
- The percentage of staff saying that they or a colleague reported harassment, bullying or abuse has increased over the past 12 months

Several actions have been taken in the last 12 months that may well have contributed to the above improvements, these include:

- Developing, supporting, and growing the ACE, Disabilities and Long-Term Conditions staff network
- Working alongside the communications team to raise awareness of the staff network and disabilities
- Launch of the Reasonable Adjustments Policy
- Development of resources to support managers

In response to the WDES data and with the support and involvement of the ACE staff network, we have developed a WDES action plan. We will continue to work together to make improvements against the themes identified as concerns.

## The Gender Pay Gap

The gender pay gap is a measure of the difference between men's and women's average earnings across the organisation. As an NHS employer with more than 250 employees Alder Hey publish statutory calculations on its pay gap every year. The Gender Pay Gap report provides context to help us identify and understand the causes of any gaps, allowing us to develop, and monitor solutions that are targeted, innovative, and supportive. The gender pay gap shows the difference in average pay between all men and women in our organisation. It is different to equal pay, which examines the pay differences between men and women who carry out the same or similar jobs, or work of equal value. The data presented in this report as of March 2024 shows:

Mean gender pay gap – 27%
Median gender pay gap- 19%

Despite this pay gap, we are confident that this is not a result of paying men and women differently for the same or equivalent job roles. The reasons for a gender pay gap are often multi-factorial; terms and conditions, length of service, gender-mix, pension and flexible working arrangements will all have an impact on the overall gender pay gap results. Our long-term goal is to attain gender balance across our workforce, especially at the more senior levels within the trust. This will make a significant contribution to the reduction in gender pay gaps and gender occupational segregation across some of our staff groups. We have initiated a range of activities over the past 12 months which support closing the gender pay gap and support our ambition for Alder Hey to be the best place to work, attracting, retaining, valuing, and supporting our people:

- Well-established Menopause Support Group which has been well received. This group continues to grow offering a safe space to share experiences and support each other.
- Working with our Equality Staff Networks we have actively promoted leadership opportunities for our female staff
- We have continued to promote and support flexible working arrangements

## Equality Delivery System 2022 (EDS22)

The NHS Equality Delivery System (EDS) for the NHS was launched in 2011. The main purpose of the EDS was, and remains, to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED). A review of the EDS2 was undertaken to incorporate system changes and take account of the new system architecture. Through collaboration and co-production and considering the impact of COVID-19, the EDS has been updated and is now EDS 2022. This is the first year that Alder Hey has implemented the new EDS22. The EDS is an improvement tool for patients, staff, and leaders of the NHS.

It supports organisations in England – in active conversations with patients, the public, staff, staff networks, community groups, and trade unions – to review and develop their approach to addressing health inequalities through three domains:

- Services
- Workforce
- Inclusive leadership

The EDS22 was implemented for the first time at the Trust this year. We engaged with key stakeholders throughout the year to ensure a range of support and guidance to effectively implement EDS22. The EDS22 report was published in March 2024. The process will commence again in early 2024, with further commitment and engagement to ensure that we build on the work we completed in 2023.

## Equality Priorities 2024/2025

As equality monitoring is essential to our EDI work for measuring progress, identifying any gaps, and setting priorities, we will continue to analyse our data in relation to the objectives set to create an inclusive environment.

Over the next 12 months, we will work hard to deliver key objectives which will align to the national Equality, Diversity, and Inclusion (EDI) Improvement Plan. The wide range, and volume, of actions involved in all our EDI work is extensive and there is currently no one set of actions which can easily be shared across the organisation to allow for meaningful, and simple, communication of those things we are focusing on as a Trust which matter, and which will truly make a difference to colleagues.

To simplify matters we will focus on our actions aligning with the national NHS EDI Improvement Plan, employing this as the action plan for the Trust. The national plan, by its very design, ensures Trusts are focused on all aspects of EDI, and provides us with a clear set of objectives which can be regularly monitored at the Trust Board, and shared with colleagues across the organisation as a demonstration of commitment and progress.

## Conclusion

We commence 2024 with a strong leadership commitment to equality, diversity, and inclusion. We have made some steady progress which is reflected in our improved staff survey results. Although we have still work to do, during the next 12 months we will focus on improving and enhancing the experiences of our staff. We want to ensure that we understand the deeper detail, which is presented in the data, whilst listening to the narrative provided by our staff, allowing us to focus our attention on areas which need the greatest support. We will continue to work closely with our staff networks to ensure that we are listening to their voices, and working together to make positive changes that will impact the experiences of our staff.

It is an exciting time at Alder Hey, and we will continue to make valuable changes which will improve the working lives of our colleagues, our children and the young people we care for.

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

| | |
|---|---|
| **Paper Title:** | **Board of Directors - Fit and Proper Persons Checks** |
| **Report of:** | Erica Saunders, Director of Corporate Affairs |
| **Paper Prepared by:** | Governance Manager |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☐<br>Regulation ☐ |
| **Action/Decision Required:** | To note ☑<br>To approve ☐ |
| **Summary / supporting information** | NHS England FPPT Framework |
| **Strategic Context**<br><br>**This paper links to the following:** | **Outstanding** care and experience ☑<br>**Collaborate** for children & young people ☑<br>**Revolutionise** care ☑<br>**Support** our people ☑<br>**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 |
| BAF 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 |
| **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 |

# Fit and Proper Persons Test – Assurance Report

## 1. Executive Summary

The purpose of this report is to provide assurance that an annual check has been undertaken for the Board of Directors to confirm their continuing compliance with the 'Fit and Proper Persons' requirements.

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test' (FPPT).

## 2. Current State

The new NHS England FPPT Framework was published in 2023/24 and this has been adopted fully in the Trust's FPPT Policy, with enhanced DBS checks being completed for all Board of Directors every 3 years, as part of this process. The Trust's Fit and Proper Persons Policy specifies the scope of the staff who are included as:

"All Board Directors – Executive and Non-Executive; (voting and non-voting) attendees of the Board and Governors. It applies to all permanent, acting and interim Board level positions".

The results of these checks are shown in the attached table and the Board of Directors can be assured that no areas of concern have been identified.

In April 2024, the Board of Directors completed the Fit and Proper Persons Test Self Declaration Form and confirmed their compliance with each of the following statements:

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
    - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
    - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
    - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

## 3. Conclusion

The Chair reviewed the signed declarations (SID for the Chair) and determined that all Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test. The required information has been uploaded to NHS England in accordance with the updated guidance.

| Board Member | Date FPP Self-Declaration Signed |
|---|---|
| | |
| Adam Bateman | 07/05/2024 |
| Alfie Bass | 16/04/2024 |
| Benedetta Pettorini | 17/05/2024 |
| Dani Jones | 09/04/2024 |
| Erica Saunders | 02/05/2024 |
| Fiona Beveridge | 07/05/2024 |
| Garth Dallas | 16/04/2024 |
| Gerald Meehan | 02/05/2024 |
| Jo Revill | 12/04/2024 |
| Jo Williams | 11/04/2024 |
| John Chester | 02/05/2024 |
| John Grinnell | 11/04/2024 |
| John Kelly | 07/05/2024 |
| Kate Warriner | 09/04/2024 |
| Kerry Byrne | 17/04/2024 |
| Lisa Cooper | 10/04/2024 |
| Louise Shepherd | 11/04/2024 |
| Melissa Swindell | 03/05/2024 |
| Nathan Askew | 10/04/2024 |
| Rachel Lea | 07/05/2024 |
| Shalni Arora | 15/04/2024 |
| Urmi Das | 16/04/2024 |

In accordance with the new Guidance, organisations are required to undertake the following additional checks on appointment of a Board Member:

- Social Media Check
- Disqualified Director Check
- Charity Commission's Register
- Individual Insolvency Register
- UK Civil Litigation
- Professional Registration

Since these had not been done for current Board Members (on appointment) a 'belt and braces' approach was adopted, and it was agreed to engage the independent services of GatenbySanderson and Neotas who are specialists in this area to undertake these checks and

provide external assurance to the Board. The Trust has received the outcome of these checks which did not present any adverse findings and have been recorded on individual ESR records.

The new Guidance also looks at preventing unsuitable staff from being redeployed or re-employed in NHS, ICBs, and independent healthcare and adult social care sectors. Board Member references therefore need to be completed when a Board Member leaves the organisation irrespective of whether a reference has been requested by a future employer. These have been completed as required and kept locally on file.

## 4. Recommendation

The Board is asked to note the content of this paper and record that the Fit and Proper Persons Test has been conducted for the period 2023/24 and all Board members satisfy the requirements.

Board Members are also asked to acknowledge their ongoing duty to inform the Chair should circumstances change, and you can no longer comply with the Fit and Proper Person Test, as described above.

**Erica Saunders**
**Director of Corporate Affairs**

# BOARD OF DIRECTORS

## Thursday, 4th July 2024

| | |
|---|---|
| **Paper Title:** | **Chair's Report from the Audit & Risk Committee (ARC) meeting on 20 June 2024** |
| **Report Of:** | **ARC Chair** |
| **Paper Prepared By:** | ARC Chair |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☐<br>Information ■<br>Regulation ☐ |
| **Summary / Supporting Information:** | ARC minutes and papers from the meeting that took place on the 20th of June 2024. |
| **Action / Decision Required:** | To note ■<br>To approve ☐ |
| **Strategic Context**<br><br>**This paper links to the following:** | Outstanding care and experience ☐<br>Collaborate for children & young people ☐<br>Revolutionise care ☐<br>Support our people ☐<br>Pioneering breakthroughs ☐ |
| **Resource Implications:** | None |

## 1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board and provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

Whilst the main focus of the June meeting is review of the Trust's Annual Report & Accounts and discussion of EY's report thereon, ARC received the following documents / updates:

- Final update on retrospective sourcing of missing documents from the recruitment process of existing staff
- Verbal update on the discussion and agreement of risk appetite and tolerances through the Assurance Committees
- EY External Audit Report on the Trust's Accounts (tabled and presented on-screen)
- Annual Report and Accounts 23/24
- Paper "Understanding how ARC gains assurance from management"
- Final Director of Internal Audit Opinion and Internal Audit Annual Report for 23/24
- MIAA response to the review of Internal Audit Effectiveness
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Trust-wide Clinical Audit Annual Report for 23/24
- ARC Annual Report
- Committee Annual Reports for:
  - Resources & Business Development
  - Safety & Quality Assurance
  - People & Wellbeing
  - Research & Innovation
- Waiver Activity Report Q3&4 23/24
- Update on progress against the assessments of ARC, External Audit and Internal Audit
- Gifts & Hospitality Register 23/24

Thanks are provided to the Chair of RABD who attends this meeting for the items related to the Annual Report and Accounts.

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

EY's report on the Trust's Annual Report and Accounts was tabled at the meeting and presented on screen. At the time of the meeting there was still

some work to be completed and discussions were ongoing between the Trust and EY to finalise the position in relation to a small number of property related transactions. Whilst the Committee recognised the significant amount of work that was complete, it was not able to endorse the final position of the accounts; this took place at the Extraordinary Board on 26 June 2024.

**4. Positive highlights of note**

Following near completion of a detailed exercise by the HR Team to review the HR and ESR records for all employees to identify any gaps in key recruitment records and then source any outstanding, the Committee recognised the significant improvement in compliance and received assurance on the ongoing processes to source the small number of documents outstanding and the low risk remaining on those thought not now to be available.

The Committee approved the addition of three further audits (ICB Expenditure Controls, E-Roster and Workforce Planning) to the 24/25 Internal Audit Plan following its approval of increased days in the Plan resulting from a recent benchmarking exercise across Cheshire & Merseyside.

Following transfer of procurement services for the Trust to Health Procurement Liverpool, the Committee was pleased to receive a detailed report on tender and quotation waivers for the last two quarters of 23/24. The Committee noted a high number of retrospective waivers which management will investigate.

**5. Issues for other committees**

None

**6. Recommendations**

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

# Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 18th April 2024**
**Lecture Theatre 4, Alder Hey Children's Hospital**

| | | | |
|---|---|---|---|
| **Present:** | Mrs. K. Byrne (Chair) | Non-Executive Director | (KB) |
| | Ms. J. Revill | Non-Executive Director | (JR) |
| **In Attendance:** | Mr A Bateman * | Chief Operating Officer | (AB) |
| | Mr. G. Baines | Regional Assurance Director, MIAA | (GB) |
| | Mr. J. Grinnell | Managing Director/Chief Financial Officer | (JG) |
| | Ms. E. Kirkpatrick | Assoc. Director of Finance - Commercial, Control and Assurance | (EK) |
| | Mrs. R. Lea | Director of Finance and Development | (RL) |
| | Ms. V. Martin | Anti-Fraud Specialist, MIAA | (VM) |
| | Mrs. K. McKeown | Committee Administrator | (KMC) |
| | Miss. J. Preece | Governance Manager | (JP) |
| | Mr. H. Rohimun | Executive Director, Ernst and Young | (HR) |
| | Ms. J. Rooney | Assoc. Director of Nursing and Governance | (JRO) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| | Ms. K. Stott | Senior Audit Manager, MIAA | (KS) |
| **Item 23/24/05** | Mrs. S. Owen | Deputy Chief People Officer | (SO) |
| **Item 23/24/06** | Ms. B. Pettorini | Director of Surgery | (BP) |
| **Item 23/24/23** | Mr. J. Gray | Emergency Preparedness, Resilience and Response Manager | (JG) |
| **Item 23/24/24** | Ms. N. Palin | Director of Transformation and Change | (NP) |
| **Item 23/24/25** | Mr. P. White | Chief Nursing Information Officer | (PW) |
| **Item 23/24/26-30** | Mr. I. Gilbertson | Assistant Chief Digital & Information Officer – Data and Change and Deputy CDIO | (IG) |
| **Apologies:** | Mr. G. Meehan | Non-Executive Director | (GM) |
| | Mr. D. Spiller | Senior Manager, Ernst & Young | (DS) |
| | Ms. K. Warriner | Chief Digital and Transformation Officer | (KW) |

* Up to the Division of Surgery presentation in item 24/25/06

**24/25/01 Introductions and Apologies**

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

**24/25/02 Declarations of Interest**

There were none to declare.

**24/25/03 Minutes from the Meeting held on 25th January 2024**

**Resolved:**

The minutes from the meeting held on the 25th of January 2024 were agreed as an accurate record of the meeting.

**24/25/04 Matters Arising and Action Log**

*Matters Arising*

The Chair advised that agenda items; 24/25/15, 24/25/32, 24/25/34, 24/25/35 are starred items and will be taken as read unless there are any questions that require a response. In terms of annual assurance reports it was asked that only key points be raised. It was reported that the ELFS Payroll Assurance Report and the Waivers Report will be deferred to June's meeting.

*Action Log*

**Action 22/23/81.2:** *Post Project Assessments/Benefits Realisation Exercises on Projects (Conduct a post project assessment/benefits realisation exercise on the new Sunflower and Catkin buildings during Q4 2022/23 or Q1 2023/24 using the developed process. MIAA to review implementation of the assessment and report to the Audit and Risk Committee (ARC) as to whether the recommendation can be closed)* – An update will be provided in June 2024. **ACTION TO REMAIN OPEN**

**Action 23/24/04.2:** *MIAA Follow-up Report (Include the outcome of the IT Assets Hardware follow up review conducted by MIAA in October's Follow-up Report)* – The IT Assets Hardware follow-up is to be circulated outside of the meeting. **ACTION TO REMAIN OPEN**

**Action 23/24/54.2:** *Corporate Report (Create four to five codes for longstanding risks to provide rationale as to why a risk is still outstanding)* – Work is ongoing in readiness for the next reporting period **ACTION TO REMAIN OPEN**

**Action 23/24/58.1:** *Exemptions to Waiver Process (Conduct a six-monthly review of the changes to the SFI in relation to the amendments that were made in July; increase in the quotation limit for requisitions, exemptions to the single tender waiver requirement)* – Trends will be monitored via the Waiver Report, and any issues will be picked up as a result of this. No separate review is required. **ACTION TO BE CLOSED**

**Action 23/24/59.1:** *Non-Clinical Claims Report, 2022/23 (Convert previous data into graphs and include this detail in the 2023/24 Non-Clinical Claims Annual Report)* – This report has been deferred to June 2024. **ACTION TO REMAIN OPEN**

**Action 23/24/72.3:** *Corporate Risk Register (Deep Dive of Adoption related risks) - It is a legal requirement when a child or young person is adopted that their medical record is closed and a new adoption record is created. Erica Saunders agreed to liaise with Lisa Cooper to ensure all mitigations are in place for this risk from a historical perspective and to see whether it would be beneficial to conduct an audit on this area of work)* – A deep dive of adoption related risks took place via RMF, and adoption processes have been included in the Clinical Audit Plan. **ACTION CLOSED**

**Action 23/24/80.1:** *External Audit - Additional Fee Proposal (Submit a report to the Council of Governors to advise of the additional fee, once approved)* – This matter will be addressed virtually. An update will be provided in June to confirm that this action has been completed. **ACTION TO REMAIN OPEN**

**Action 23/24/97:** *Risk Tolerance and Appetite (Meetings to be widened to develop a risk appetite and tolerances for advocacy and JG to be invited)* – Meetings have been held and/or scheduled during April to revisit this piece of work. **ACTION TO REMAIN OPEN**

**Action 23/24/98.1:** *Board Assurance Framework (Liaise with the Chief People Officer the concerns as to number of gaps in assurance and minimal actions recorded to mitigate BAF risks 2.1, 2.2 and 2.3 and ask that this be reviewed)* – A discussion took place during the People and Wellbeing Committee regarding this matter and it was agreed that further work needs to be done. An update on the action that has been taken will be shared with ARC in June 2024. **ACTION TO REMAIN OPEN**

**Action 23/24/98.2:** *Board Assurance Framework* (Request that PAWC undertake a deep dive of BAF risk 2.3) – The ARC Chair has written to the PAWC Chair to request a deep dive of BAF risk 2 (See also, information above relating to 23/24/98.1. **ACTION CLOSED**

**Action 23/24/99.1:** *Corporate Risk Register (Conduct a review of the attendance at RMF to ensure adequate representation from Divisions and Services)* – A review of attendance took place from April 2023 to date. It was noted that there was a reduction in Divisional representation during school holiday periods therefore it has been agreed to try and schedule meetings outside of school holiday periods going forward. **ACTION CLOSED**

**Action 23/24/99.3:** *Corporate Risk Register (JR to liaise with the Surgery Division regarding whether it is premature to downgrade risk 2746 until the new chest drain system has been purchased, rolled out and working effectively)* – It was confirmed that the chest drains have been procured. A Training Needs Analysis is in place and training has commenced therefore the Division of Surgery are in agreement that the risk should be downgraded.
**ACTION CLOSED**

**Action 23/24/101.1:** *Draft Internal Audit Plan, 2024/25 (MIAA to review the need for an audit of Conflicts of Interest in 24/25 and update at the April meeting)* – A Conflicts of Interest review was last undertaken in 2022/23, therefore the next one will be due in 2025/26.
**ACTION TO BE CLOSED**

**Action 23/24/101.3:** *Draft Internal Audit Plan, 2024/25 (Discuss the commercial issues relating to the number of days per audit in the IA Plan to agree a way forward without compromising MIAA from a competitive perspective)* – It has been agreed that the number of days in the Plan will be reported to the Committee, but discussions relating to fees will take place in private. **ACTION CLOSED**

**Action 23/24/102.1:** *IA Progress Report (Review any areas where a high value of on-call payments are made to see if the additional controls implemented in the Digital Team should be implemented)* – A review of non-clinical services has been conducted by Finance and it was confirmed that there is no need for further controls to be implemented. As part of the workforce programme a review of extra contractual payments will take place via the Transformation Programme which reports into RABD. **ACTION CLOSED**

**Action 23/24/102.2:** *IA Progress Report (JR to update ARC following the outcome of discussions with the FTSUG regarding any interim measures required until the FTSU case information can be transferred into InPhase)* – The InPhase FTSU module is currently not in use as the FTSU Guardian doesn't feel that it complies with the National FTSU Guardian's Office guidance in terms of confidentiality. The FTSU Guardian is in agreement to use the module once the system issue has been resolved and is attending a national webinar w/c 22.4.24 with InPhase and the National Guardian's Office to raise this query. It was agreed to close this action as this matter will be part of the InPhase Phase 2 implementation which is to be reported to future ARC meetings. **ACTION CLOSED**

**Action 23/24/103.1:** *Internal Audit Follow Up Report (Payroll Review - Further detail on the actions that have taken place to date to implement the recommendations and the forward plan is required before the Committee can approve the extension to September)* – It was agreed to provide an update outside of the meeting. **ACTION TO REMAIN OPEN**

**Action 23/24/104.1:** *Anti-Fraud Services Progress Update (Submit the local proactive exercise to enable the Committee to agree the focus of the local proactive exercise)* - The proposed Local Proactive Exercise for 2024/25 has been included in the draft Anti-Fraud Work Plan 2024/25 for ARC's consideration/approval. The proposed exercise is the NHS Counter Fraud Authority National Procurement Local Proactive Exercise. **ACTION CLOSED**

**Action 23/24/104.2:** *Anti-Fraud Services Progress Update (Include detail on the nature of the allegations in Appendix C of the report)* – It was agreed to keep this action open until the Committee receives the next Anti-Fraud Progress Report and can verify that Appendix C has been updated. A request was also made for a one page brief to be submitted to the Committee going forward when a fraud investigation has been concluded to provide background detail into the case and to highlight any weaknesses in controls that were identified as a result of the fraud. **ACTION TO REMAIN OPEN**

**Action 23/24/108.1:** *ARC Effectiveness Review (Outcome of the desktop review to be incorporated into the ARC Effectiveness Review Action Plan. A detailed questionnaire to review effectiveness to be issued for results to be reported to October 24 meeting)* – This action has been addressed. **ACTION CLOSED**

**24/25/05 NHS Employment Check Standard Audit.**

The Committee was provided with the final version of the report relating to the Pre-employment Checks Audit undertaken by the Recruitment and Employment Services Team (REST), to provide an update of residual risks following completion of the audit and programme of work. The following key points were highlighted:

- All data held on file, but not recorded on the Electronic Staff Record (ESR) has now been updated in ESR. As a result, over 9,713 data points have been added to ESR records since the audit commenced in October 2023.
- Attention was drawn to the significant increase in compliance against each of the employment checks, as detailed in table 1.1 of the report. It was reported that 'ID Checks' and 'Right to Work' are expected to reach 100% compliance once data has been finalised and updated in ESR. The Committee was advised that 'Professional Registration' is fully compliant (100%).
- In terms of residual risk, 'Qualification' compliance is lower than any other areas at 86%. The Trust has received all qualifications for those who require professional registration however there are a number of staff who have been in post for a long period of time for whom we haven't got a record of their qualifications on file. Work is ongoing with managers to establish the residual risk for this matter which it was reported is very low to date.
- 'Medical Clearance' compliance is 91% and is not expected to increase further. There are internal actions in place to mitigate this such as the Trust's sickness absence management programmes, immunisation programme and surveillance programme for health workers.
- The Committee was advised that, with the exception of six members of staff, the whole of the organisation has had at least one DBS check with further checks

currently underway. The 93% detailed in table 1.1 relates to the Revalidation Programme that was implemented following the Trust's participation in the Lampard Review. This represents those who haven't had a DBS check in the last 3 years and are part of a rolling programme. A report on the renewal of the Mandate and Update Service is to be submitted to the People and Wellbeing Committee (PAWC) to see if further improvements can be made.

- 'References' have increased significantly to 90% compliance after transferring data to ESR. It was reported that the 10% of staff who haven't got a reference on file have been employed for longer than three years which is the requirement under the NHS Employment Checks Standard. DBS, right to work and registration checks are in place therefore the residual risk to the organisation is low.
- It was concluded that the risk to the organisation is minimal and the Trust is confident that all current processes are in place and comply with the NHS Six Check Safer Recruitment Standards. There has been a significant increase in the organisation's compliance position as a result of the audit therefore it is proposed that this process should take place on an annual basis. The Deputy Chief People Officer paid tribute to the REST for the work that has taken place and the significant improvements made.

The Chair referred to DBS checks and suggested monitoring this area of work in the same way that mandatory training is monitored in terms of removing staff who are on long term sick leave from the data to provide a more accurate position.

A question was raised about whether a proactive piece of work can be done by managers to validate and confirm if there has been any performance or other concerns raised during their employment at the Trust for the 10% of staff for who we don't have a reference. It was confirmed that this can be done.

**24/25/05.1** **Action: SO**

A discussion took place about qualification compliance and it was queried as to whether it is acceptable that staff are unable to provide proof of their qualifications. SO confirmed that this element of non-compliance relates to staff who have been in post for twenty years plus and haven't got proof of their GCSEs that they would have needed for an entry level role. These are examples for the majority of staff members who haven't got a copy of their certificates. Following a conversation it was agreed to acquire management assessments for these individual members of staff to confirm that there were no areas of concern .

**24/25/05.2** **Action: SO**

The Chair thanked the Deputy Chief People Officer, Sharon Owen, and the REST for the work that has taken place on the audit.

**Resolved:**
The Committee noted the update relating to the NHS Pre-employment Checks Audit.

**24/25/06** **Update on the Risk Management Process within the Division of Surgery (DoS) and Corporate Services**

The Committee received an overview of the risk management process within the DoS. A number of slides were shared that provided information on the following areas:

- Surgery Division Management Process;
  - Rapid Review Meetings take place twice a week (*risks are logged on InPhase in holding for risk register meeting for approval).*

  - Weekly Risk Review Meeting takes place for risks due that week.
  - Department presents new risks at the Divisional Integrated Governance Committee.
  - Governance Team support weekly drop-in sessions for departments.
- Risks identified for approval process.
- Risk Profile: 39 open risks.
- Details of the Divisional support that is in place to address risk.
- Next steps;
  - Continue with the senior manager's weekly Risk Review Meetings as this has enabled better management of static risks.
  - Challenge where risk reviews/actions have not been performed, following the weekly discussion.
  - *Training* – Risk presentation training developed by Corporate Team shared in Division.
  - Continue to encourage service managers, governance leads to access ESR risk module training.

The Chair pointed out that one of the biggest gaps in any risk management process is risks not being included on the risk register and queried as to how the Division promotes the importance of staff raising risks to enable the organisation to understand the challenges. It was reported that this is done via Rapid Review Meetings plus additional work is taking place around culture which will help staff in terms of reporting risks and being confident to provide challenge.

The Chair asked as to whether there was anything that the Division found challenging about the risk process. BP referred to corporate risks and advised that there is a limit to what the Division can do, for example, gaps in the workforce. It was suggested that BP attend the RMF to participate in the deep dives that take place into corporate risks. The Chair thanked BP for sharing the presentation with the Committee.

**For noting**
AB left the meeting.

*Corporate Services Collaborative*

The Committee received an overview of the risk management process for Corporate Services. A number of slides were shared that provided information on the following areas:

- The purpose of the Corporate Services Collaborative which was established in 2022/23.
- Corporate Services governance structure.
- Risk reporting and assurance process.
- Risk review process.
- Corporate Services risk profile as at the 11.4.24.
- Challenges;
  - Have we captured all corporate services?
  - Are all corporate services risks being captured?
  - Corporate service/team risk decision and oversight process?
- Next steps;
  - Trust wide monthly Corporate Services incident and risk review meeting?

- Risk appetite.

The Chair thanked ES and JRo for sharing the presentation with the Committee and advised of the progress that has been made in terms of the oversight and management of Corporate Services risks following the implementation of the RMF, Corporate Services Collaborative and InPhase.

**Resolved:**
ARC noted the update on the risk management process within the Division of Surgery and Corporate Services.

**24/25/07 Board Assurance Framework**

The Committee received the Board Assurance Framework (BAF) report for March 2024. The following points were highlighted:

- During the next phase the BAF will be updated to reflect the Vision 2030 strategic objectives, language and descriptions which will include risk.
- Work is being undertaken to look at how the organisation will bridge between previous external BAF risks and the Vision 2030 related risks to make it more explicit.
- It was confirmed that the BAF was maintained manually whilst resolving the issues relating to the InPhase system.
- The Committee was advised that the report submitted is a fair reflection of the Trust's strategic risks.

The Chair felt that the Trust is managing its risks but drew attention to the updating of information that is required in the BAF, which is being addressed.

**Resolved:**
ARC noted the content of the BAF for March 2024.

**24/25/08 Risk Management Forum (RMF) Update including the Corporate Risk Register (CRR) and minutes from the last meeting.**

The Committee was provided with an overview of the key points and areas of concern that were discussed during the RMF meeting that took place on the 26.3.24 in particular the deep dive into the risk relating to medical equipment, the Green Plan/Net Zero and overdue risks.

Attention was drawn to the query that was raised during March's RMF about whether the Green Plan and Net Zero should be a standalone risk on the BAF. It was confirmed that the Executive Team will discuss this matter and action it accordingly. Praise was offered to the DoS for the work that has been undertaken to address a large number of complex risks which has led to their risk register being an exemplar.

The Chair advised that she is liaising with the Director of Community and Mental Health Services on the Gender Development Service risks. A deep dive is scheduled for the May RMF and the outcome will be reported to ARC in July. It was pointed out that the Committee wouldn't usually receive this level of operational detail but as the service is brand new it was felt that it would be beneficial for the Committee to have oversight of the service's risks.

*Corporate Risk Register*

The Committee received the CRR for the reporting period from the 1.1.24 to the 29.2.24. At the time of reporting there were 21 high risks, of which, 3 had an increased risk score, 6 high risks were reviewed and the risk score was reduced, 2 risks were closed, 2 risks had no action plans, and there were 7 risks with actions past the expected date of completion. It was reported that risks greater than 12 continue to be reviewed.

Reference was made to the question that was raised by the Chair about whether a discussion has taken place with the Integrated Care Board (ICB) about funding for the risk relating to medical devices. The Committee was advised that capital expenditure has been limited by the ICB therefore a report is to be submitted to the Executive Team on capital spend and prioritisation to determine how the risk can be managed/mitigated. It was reported that there is a lot of work taking place internally to look at the replacement programme and how it can be prioritised, and the Trust has articulated this risk to the ICB who are aware of it.

**Resolved:**
ARC noted the RMF update, CRR and the approved RMF minutes from the meeting held on the 6.2.24.

**24/25/09 Trust Risk Management Report.**

The Trust Risk Management report was submitted to provide the Committee with the opportunity to scrutinise the effectiveness of risk management across the Trust for the reporting period for the 1.1.24 to the 29.2.24. The assurance presented in this report is a direct reflection of the evidence available on the electronic risk management system (InPhase) at the time of reporting. The following points were highlighted:

- There are 255 risks on the Trust Risk Register for the reporting period, a decrease compared to the previous reporting period (262).
- There are 13 new risks identified in this reporting period which is an increase from the last reporting period (4).
- 36 risks were closed in this reporting period. This is an improved position from the last reporting period (17).
- 34 risks were overdue a review. This is an improved position from the last reporting period (55).
- There were 13 risks without an ongoing/agreed action plan compared to 50 in the last reporting period. There is a constant focus on these risks via Risk Oversight Meetings and the RMF. In terms of risks with an overdue action, the Chair has sent an e-mail asking risk owners to address their respective actions.
- Risk number * 22 *(Lack of risk report functionality remains on the risk register with a current risk score of 6)* – This risk is now closed as the issue has been rectified and mitigated.
- High moderate risks are showing an improvement.

It is noted that the number of risks reported with an increased risk score has increased from 0 to 16 since the last reporting period. The Committee was advised this may have occurred due to an error in InPhase therefore a review of previous data will take place to determine if this is the case.

A heat map has been included in the report for the first time and feedback from Committee members was welcomed.

**Resolved:**
ARC noted the content and the level of assurance provided in the report.

**24/25/10 2023/24 Annual Report on Risk Management**

The Committee received the Risk Management Annual Report for 2023/24 which demonstrated the activity of the RMF during 2023/24 and adherence to its Terms of Reference. An overview of the content of the report was shared and the Committee was provided with assurance that appropriate processes are in place for the management of risks and that progress against 2023/24 priorities have been made.

The Chair of the RMF, Erica Saunders, advised that deep dives are a useful tool for ensuring relevant people are addressing actions required to mitigate risk; they also provide an opportunity to disseminate awareness of risks. It was reported that triangulation following Quality Assurance Rounds is going to be undertaken to ensure teams are uploading their risks onto the system.

A conversation took place about the Trust's risk management training programme. It was reported that a training module has been produced in association with the Trust's Academy and was due to be launched w/c 15.4.24. Unfortunately it wasn't viable to run the module as only four members of staff registered for the session therefore it has been decided to test the module with this small cohort to see how it resonates. The training module provides practical examples of risk, risk appetite, assurance, good reporting. There is a basic module on ESR via Health Education England (HEE) but the Committee felt that risk management training should be reinstated as mandatory. Following discussion it was agreed to have a conversation with the Chief People Officer and the Director of the Academy to escalate this matter.

**24/25/10.1 Action: JRO**

It was concluded that the management of risk and the focus on safety continues to be a top priority for the Trust. The RMF has provided evidence and assurance that in its delegated authority from ARC it is fit for purpose and provides the Board with the assurances required.

**Resolved:**
ARC approved the Risk Management Annual Report for 2023/24

**24/25/11 Review of Internal Audit (IA) Effectiveness**

The Committee received the outcome of the (IA) effectiveness review noting the responses to the questionnaire and the action plan based on the responses.

The Chair pointed out that it is clear from the review that IA is valued by ARC and management and that there are no fundamental actions arising. Completion of this process provides independent and objective assurance that IA is effective in delivering their remit. The Chair felt that the exercise has been useful in highlighting some potential enhancements to the service with actions required of both IA and the Trust to enable their implementation.

Following a conversation IA agreed to update the action plan with their responses and submit it to ARC in June for further discussion. GB drew attention to the importance of focussing on recommendation one that relates to benchmarking as soon as possible.

**24/25/11.1 Action: GB**

**Resolved:**
ARC reviewed and approved the recommendations detailed in Appendix 1.

**24/25/12 Review of Resources for the Internal Audit Plan**

Following a review of the resources for the IA Plan it has been agreed that the IA Plan should be increased from the current 190 days to 225 days for 2024/245. This will be reviewed again at the end of 2024/25 with a view to increasing further to 235 days.

It was pointed out that whilst most of the days in the plan are devoted to MIAA there may be some audits that the Trust wants to commission externally which will be part funded from the extra days.

**Resolved:**
ARC approved the increase in days allocated to the IA Plan (to 225 days) and acknowledged that a further review will be undertaken at the end of 2024/25 with a view to further increasing the days to 235.

**24/25/13 Draft Head of Internal Audit Opinion, 2023/24**

The Committee received the draft Head of Internal Audit Opinion for 2023/24. The overall opinion for the period from the 1.4.23 to the 31.3.24 provides Substantial Assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

GC provided an overview of the content of the report and advised that the opinion reflects a really positive outcome. It was reported that the Plan is largely completed with the exception on one piece of work that is outstanding. GB thanked the Trust's management team for their support throughout the year.

The Chair felt that the overall opinion was a really good outcome for Alder Hey pointing out that the Trust has had no limited assurance reports in 2023/24 and there are no overdue critical or high recommendations, which is really positive.

**Resolved:**
ARC received and noted the content of the Head of Internal Audit Opinion for 2023/24.

**24/25/14 Internal Audit Plan, 2024/25**

The Committee received the Internal Audit Plan for 2024/25 that was approved on the 25.1.24 subject to a review of PSIRF being included and receiving the outcome of the benchmarking work. The following comments were made:

- The Chair asked if it is possible for senior members of MIAA's team to lead on more technical audits such as risk management, National Cost Collection and, in particular, PSIRF.
- It was requested that the days in the Plan be split out to distinguish between follow-up and contingency.

**24/25/14.1** **Action: KS**

- Reference was made to e-rostering and the importance of conducting an audit to ensure it is working to maximum efficiency particularly in light of staffing pressures.

Attention was also drawn to expenditure controls which has been discussed previously. It was reported that the Chair of Resources and Business Development (RABD) Committee has asked ARC to consider undertaking an audit of expenditure controls. RL advised that e-roster links in with expenditure controls from a data perspective as information can be used to determine why the Trust is spending money on agency/temporary staffing and how it relates to what is happening on the wards. Following discussion it was agreed in principle to undertake an audit on e-rostering and capital expenditure controls. A meeting will take place to discuss the Terms of Reference for both audits and agree the number of days that need to be set aside. An update will be provided via e-mail so that the agreed days can be formally approved.

**24/24/14.2** **Action: KS/RL**

- The Chair advised that an audit of clinical governance should be considered in 2024/25 owing to the increase in virtual wards, remote working, and new models of care. It was agreed that a conversation will take place outside of the meeting to discuss the process for this audit, for example, how it might be approached from an IA and / or Clinical Audit perspective.

**24/25/14.3** **Action: JRO/KB/KS**

**Resolved:**
ARC received and noted the content of the Internal Audit Plan for 2024/25.

**24/25/15** **Internal Audit Charter**

**Resolved:**
ARC noted the contents of the Internal Audit Charter.

The Chair advised that the Charter makes reference to an IA Strategy but pointed out that the Committee hasn't seen this to date. It was agreed to discuss this matter outside of the meeting.

**24/25/15.1** **Action: GB**

**24/25/16** **Internal Audit Progress Report**

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the 2023/24 Internal Audit Plan during the period from January 2024 to March 2024. The following points were highlighted:

- There have been two reports finalised in this reporting period;
  - Assurance Framework - met requirements.
  - Project Management Non-Building Projects – substantial assurance.
- The Cyber Assessment Framework is at the fieldwork stage and is progressing well.

A discussion took place on the results of the overpayment testing work that was completed as part of the payroll audit. It was reported that following the work MIAA made a recommendation around late notified leavers and, as a result, the Trust is currently developing an overpayments process which will be followed up via MIAA's follow up procedure. Two additional recommendations have been made following the overpayment testing around changes in programme hours and late notified maternity leave. It was confirmed that this area of work is being monitored PAWC.

**Resolved:**
ARC noted the content of the Internal Audit Progress Report.

**24/25/17 Internal Audit Follow Up Report**

The Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been made between January 2024 and March 2024. The following points were highlighted:

- Of the 13 recommendations which have fallen due in this reporting period, 10 have been implemented and 3 recommendations relating to the Partnership Governance and Medical Devices reviews remain partially implemented with approval requested from ARC for extensions.

The Chair advised the Committee of the update that was submitted for medical devices explaining the reason for the request for a six-month extension. It was reported that Cheshire and Merseyside (C&M) is in the process of purchasing a specialist cyber tool on behalf of the region which is expected to be in place by September 2024.

**Resolved:**
ARC received and noted the content of the Internal Audit Follow Up Report and approved the requests for extension for the Partnership Governance and Medical Devices recommendations.

**24/25/18 Anti-Fraud Annual Report, 2023/24**

The Committee received the Anti-Fraud Annual Report that sets out the work completed by the Trust's Anti-Fraud Specialist (AFS) during the period from April 2023 to March 2024. An overview of the content of the Report was provided and attention was drawn to the following key points:

- A variety of activities have been conducted throughout the year to raise fraud awareness, including an in person fraud awareness raising event on the site of Alder Hey to promote International Fraud Awareness Week.
- Fraud awareness is included on the corporate mandatory training programme. It was reported that Trust's compliance rate in terms of staff completing the national ESR Fraud Awareness e-Learning module was 98.6% as at the 31.3.24.
- *Prevention and Detection* – A number of national Fraud Prevention Notices, Intelligence Bulletins, local fraud prevention checks and information alerts around specific identified fraud threats were circulated to key staff for relevant checks to be conducted and mitigating actions to be taken where appropriate.
- The AFS has worked with the Trust and Health Procurement Liverpool to review and strengthen procedures to mitigate risk further following a successful bank mandate fraud at the Trust.
- A local proactive exercise on agency/bank staff ID validation and vetting has commenced to strengthen controls and detect fraud in relation to or by bank and/or agency staff. The exercise is currently in progress and the findings will be reported to ARC in due course.
- The Counter Fraud Functional Standard Return (CFFSR) was submitted in Q1 by the AFS. The Trust received a 'Green' rating overall for the 13 Components included in the CFFSR. The return was reviewed and approved in advance of its submission by the Director of Finance and the ARC Chair.

- A fraud risk assessment was undertaken during the year which resulted in the Trust's risk register being updated to split the former one fraud risk into four risks: Scams, Cyber, Timesheet/Overtime/Not working contracted hours, and Bank Mandate.
- *Investigation Activity* – There were 15 referral queries received by the AFS in the reporting period which included a range of fraud types; working elsewhere whilst off sick, timesheets, conflict of interest, cyber enabled fraud. It was confirmed that three of the queries and one investigation have been carried over to the current year. A summary of the investigations has been included in Appendix C.
- The Trust is required to demonstrate at least 80% compliance in relation to declarations of interest in order to attain a Green rating for Component 12. It was confirmed that the Trust's annual compliance rate for 2023/24 is 85% which it was felt is really positive.

**Resolved:**
ARC received and noted the Anti-Fraud Annual Report for 2023/24.

**24/25/19 Anti-Fraud Plan, 2024/25**

The Committee received the Anti-Fraud Plan for 2024/25 for consideration and approval. An overview of the Plan was provided and attention was drawn to the NHSCFA National Procurement Local Proactive Exercise (LPE) that is being undertaken in 2024/25. The Committee was advised that the exercise isn't mandatory but all NHS bodies are being encouraged to participate in the exercise which relates to due diligence and contract management. For those organisations that don't undertake the exercise they will need to submit a response to the Counter Fraud Authority advising of the mitigations in place to address any identified risks. A meeting has been scheduled for w/c 22.4.24 to enable CF specialists in the Procurement Hub to discuss a group approach for managing this exercise. It was confirmed that the proactive exercise has been included in the 2024/25 Plan for ARC consideration.

ARC was advised that the Plan is based upon 2023/24 fees but will be uplifted in line with NHS England (NHSE) planning guidance.

**Resolved:**
ARC approved the Anti-Fraud Plan for 2024/25 which includes the NHSCFA National Procurement Local Proactive Exercise.

**24/25/20 Statement of Going Concern for the 2023/24 Annual Accounts**

It was reported that the Trust's Directors have a reasonable expectation that Alder Hey Children's NHS FT will remain in operation for the foreseeable future. The Trust has a proven track record of consistently meeting the performance and control totals set by the regulator and over the last five years has delivered within these targets often making significant surpluses to support the sustainability of the Trust. The organisation currently has a significant level of its own cash resource available demonstrating strong liquidity *(£78.3m as at the 31st March 2024).*

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.

**Resolved:**
ARC agreed to support and recommend to the Trust Board that the 2023/24 annual accounts and associated financial statements should be prepared on a going concern basis and consider it appropriate for the Trust to prepare its 2023/24 financial statements on this basis.

**24/25/21 External Audit Planning Report for Year-ended 31.3.24**

The Committee received the External Audit Planning Report for year ended 31.3.24. An overview of the various sections in the report was provided and attention was drawn to the following key points:

- *Section 1;*
  - IFRS 16 measurement principles to PFI liabilities is a new requirement and became effective from the 1.4.23. The Trust has a PFI scheme and the model for this will need to be adapted in order to incorporate IFRS16 requirements. The DHSC issued a template model to NHS bodies to update the disclosures required, however, due to the complexity of Trust's model - which contains a fixed element and an element that is indexed with inflation - the Trust is not able to use the Department's template and have engaged specialist support via KPMG to prepare the required disclosures. As a material and complex transaction E&Y has designated this as a significant risk
  - *Property, Plant and Equipment (Valuation)* – A full revaluation exercise was undertaken in 2022/23 therefore there has been a decrease in this risk. It was pointed out that is an area that will still require a significant focus from an audit perspective but E&Y have confirmed that they will undertake the work themselves rather than engaging their valuation specialist.
  - *Property, Plant and Equipment* (*Presentation and Disclosure)* – E&Y will undertake an assessment to see if the correct accounting treatment has been undertaken in 2023/24.
  - *Materiality* – It was confirmed that E&Y will report all uncorrected misstatements relating to the income statement and balance sheet that have an effect on income and misstatements in the SOCI of over £0.3m.
- *Value for Money (Appendix A)* – VFM will be revisited as the audit progresses.
- *Fees (Appendix B)* – The Committee was advised that IFRS16 wasn't in scope and therefore wasn't accounted for in the total fees. An estimate of the additional fee will be provided once the IFRS16 work has been completed.
- *Non-Compliance with Laws and Regulations (Appendix E)* – It was reported that this is a new assessment that has to be undertaken as part of the annual audit.

The Chair queried as to whether work can commence earlier this year on nil netbook value and existence. It was reported that open value existence testing has been undertaken as part of the interim work and all evidence has been provided, therefore anything that was included in the opening value will be tested as part of this work. Attention was also drawn to the importance of the Trust/E&Y raising any issues that could cause a delay in the timing of the audit or cause an increase fees.

The Chair pointed out that there has been a significant increase in external audit fees over the last few years and therefore felt it is important to scrutinise any additional costs that aren't accounted for in the original fees. A discussion took place regarding the out of scope IFRS16 and the reason for the additional fees. It was reported that the variable element of

the Trust's model makes the process more complicated but IFRS16 is a new element to the audit and the fee wasn't part of the scope. It was agreed to have a discussion outside of the meeting once E&Y have reviewed the KPMG model to determine the amount of work that will be involved in the IFRS16 assessment.

**24/25/21.1 Action: RL**

A minor point was raised in relation to the audit materiality value and it was pointed out that the Trust's outturn is slightly higher than the gross expenditure. It was agreed to review this once E&Y are in receipt of the Trust's draft accounts.

**Resolved:**
ARC approved the External Audit Planning Report for Year-ended 31.3.24 pending the minor amendment to the materiality value.

**24/25/22 Clinical Audit Trust-wide Plan 2024/25**

The Committee received the Trust's Clinical Audit Plan for nationally mandated audits and Trust wide priority clinical audits for 2024/25. It was reported that regional mandated audits will be added to the Plan once they have been published and approved. The following points were highlighted:

- A total of 16 national mandated and 23 local Trust priority audits are currently included on the Trust's Clinical Audit Plan for 2024-2025. The Committee was advised that there may be a number of local Trust priority audits that are pending confirmation from commissioners that will need to be included in the Plan.
- The Committee was asked to approve the Plan in its current state with the caveat that there may be additional audits included at a later date. It was noted that SQAC has approved the Plan and it has also been shared with CEOG.

The Chair felt that it was beneficial for the Committee to receive the Clinical Audit Trust-wide Plan as it provides ARC with an opportunity to put forward audits that it would like included i.e. clinical governance and PSIRF. The Committee confirmed their approval of the Plan.

The Committee was advised of the potential challenges that have been identified relating to the compliance of national mandated audits. Epilepsy 12 is one of the Trust's national mandated audits and it has come to light that there is a lack of capacity in the team to submit this data. It was reported that the team was unable to submit data for cohort 5 in 2023, and Cohort 6 is now open until November 2024. Discussions have taken place with the Director of Medicine and the lead paediatrician who are looking at a solution to rectify this issue ahead of this year's submission. The team has been notified that they are an outlier and this has been escalated to the Trust's Medical Director, Alfie Bass.

**Resolved:**
ARC received and approved the Clinical Audit Trust-wide Plan 2024/25

**24/25/23 Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – EPRR**

The Committee was provided with an overview of the 2023/24 Annual EPRR Assurance Report/Forward Plan for 2024/25. The following key points were highlighted:

- NHSE has implemented stringent standards following a check and challenge process with NHSE North-West. Each standard is made up of a number of

assurances and if any of them don't fully meet the compliance requirements the whole standard is deemed as non-compliant. It was reported that this process has been implemented across the entire North of England to date.
- The Trust's latest submission (September 2023) was 8% compliance. It was confirmed that the Trust isn't an outlier in this regard.
- Work is taking place on all projects and workstreams and currently the Trust is at 23% compliance. The Committee was advised that the Trust is not expected to meet full or partial compliance by September's submission therefore an update will be provided to the Trust Board on this matter in May 2024. The ICB is also aware of the Trust's position.
- The Committee was advised that the Trust is in a safe position when it comes to the operational running of the hospital and incident responses. The organisation is able to maintain critical functions and has safe methods of working to ensure staff/patient safety. There is a focus on Incident Response Plans at the present time and work is taking place on each of the domains.
- *Lessons Learned following Incidents and Events (Appendix 2)* – As a result of a Major Incident in October 2023 thirteen lessons were identified which have been turned into lessons learnt and embedded into plans, process and policies which will be rolled out across the organisation via incident responses.

The Chair advised that meetings take place every two months between the EPRR lead, Chief Nurse (as the Executive member responsible for EPPR) and herself (as the NED responsible for oversight of EPRR) to progress the current situation and felt confident that the work that is being undertaken will enable the Trust achieve compliance over a period of time.

JG pointed out that there has been a downward trend in a number of areas that seems to be offsetting the ones that are making progress. In terms of the overarching message the Committee is being assured that the organisation is safe therefore it was queried as to whether information can be included in the report which is going to May 2024 Board to provide evidence of this. Following a discussion it was agreed to look at whether the data can be framed in a different way to make if more meaningful.

**24/24/23.1 Action: JGRAY**

The Committee was informed that the downward trend is as a result of the twelve month rolling programme and an internal hard reset that has been implemented to ensure that the Trust is confident that it has the evidence/assurance that is says it has, especially as data has been recreated and can now be generated via resources that the organisation didn't have ahead of last year's submission.

**Resolved:**
ARC received and noted the 2023/24 Annual EPRR Assurance Report/Forward Plan for 2024/25.

**24/25/24 Annual Assurance Report 2023/24 and Forward Plan for 2024/25 - Project Assurance**

The Committee was provided with an overview of the 2023/24 Annual Project Assurance Report/Forward Plan for 2024/25. The following key points were highlighted:

- The Committee was advised of the substantial assurance that was secured following a project management audit by MIAA. This outcome offers a high level of confidence

around the organisation's systems of controls and the approach that has been taken to manage its programmes.
- It was reported that 2023/24 has been a transitional year with a whole new programme established and aligned to Vision 2030. This saw the Delivery Management Office (DMO) focus its resources on oversight of strategically important programmes. The assurance framework also evolved to enable ideas to be developed into full programmes of work.
- Assurance ratings were maintained for programmes that remained strategically important, and a number of programmes were realigned with guidance from the Business Analysis Unit (BAU) and the Operational Framework. Safe systems have been implemented to manage the organisation's programme, as illustrated in the Report. The feedback received on an improved approach to audit has also been acknowledged.
- For 2024/25 the Trust is proposing a more robust assurance framework for programmes and asked for the Committee's approval of the framework as detailed in Appendix 1 of the report.

It was pointed out that Appendix 1 was circulated slightly later than the original Committee report pack and therefore there was limited time to review it. JRe was asked to advise NP of her approval of Appendix 1, via e-mail. The Chair confirmed her approval of Appendix 1.

**24/25/24.1** **Action: JRe**

NP provided a response to the Chair's query regarding the process for measuring/capturing social value.

**Resolved:**
ARC received and noted the 2023/24 Annual Project Assurance Report/Forward Plan for 2024/25.

**24/25/25** **InPhase – Lessons Learnt.**

The Committee received a summary of the feedback and lessons learned from the implementation of the InPhase Risk and Incident Management project (Phase 1).

The Chair asked that a discussion take place on implementation of the remaining modules of In-Phase "Phase 2" to understand how the lessons learned from Phase 1 and the elements that went well with the Alder Care implementation (see next agenda item) can be transferred to non-strategic projects (including In-Phase) and to look at the resources required to support Phase 2. The following key points were highlighted:

- It was reported that the incident, risk management, BAF, PALS, complaints and volunteering modules are live and in use. The modules for Legal and Claims, NICE, CAS, Mortality and FTSU require implementation. The Nursing Audits module hasn't progressed due to the lack of developer resource to migrate from the previous system to InPhase. It was confirmed that this issue is a priority for Phase 2 of InPhase. The other areas that are being explored in terms of potentially using InPhase solutions to align and triangulate are document management systems and the organisation's policies and guidelines.
- Attention was drawn to the importance of having dedicated super users as the Trust progresses to Phase 2. The organisation had planned to train its governance leads but due to the complexity of the system it wasn't feasible. Reference was made to the

success of other organisations who have a dedicated team, and it was felt that it would be a great opportunity for the Trust to fulfil its ambitions and increase the scope of InPhase if it was able to invest in a developer. The Committee was asked to support ongoing developments and acknowledge the need for resources.

- It was pointed out that the status of the modules and the forward plan for 2024/25 was not included in the report. A copy of this information will be circulated after the meeting.

**24/25/25.1** **Action: PW**

The Chair felt that it was imperative to have a system owner at Exec level who will drive this area of work forward. A request was made for the compilation of a forward plan for Phase 2 which lists all modules to be implemented, provides an overview of what needs to be delivered, the resources required and the costs. The forward plan should initially be submitted to relevant management groups and ARC should have formal oversight by June/July of what has been agreed.

**24/25/25.2** **Action: PW/NP/IG**

A discussion took place around internal project management support, the assumptions that were made with Phase 1 of InPhase, having the right level of programme management to complete a PID, and teams having a broader understanding of key questions when commencing a programme.

It was agreed that a forward plan is required due to the lack of investment in the original business case and the complexity of the modules in Phase 2. It was felt that having an Exec system owner, a new business case and a PID is important to the success of Phase 2, as is ensuring the assumptions are as accurate as possible.

JG felt that the lessons learnt need to be applied to Phase 2 to ensure that the system is used to its full potential/capacity. It was pointed out that having the right leadership is imperative as is the repurposing of existing resources. JG felt that the organisation should be able to use existing resources to appoint a system lead and if this isn't the case it then it is a concern.

**For noting**
A discussion took place and it was agreed that Phase 2 of InPhase would report to ARC until the Committee was assured on the control environment and the benefits delivery of the programme. Following this it will report to SQAC from a business as usual perspective.

**Resolved:**
ARC received and noted the InPhase lessons learnt report

**24/25/26** **Alder Care Lessons Learnt Report.**
**Resolved:**
ARC noted the findings from NHS England independent assurance review on the Trust's transition to a new version of its Electronic Patient Record (EPR) – AlderCare.

**24/25/27** **Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Data Quality.**

The Committee was provided with an overview of the 2023/24 Data Quality Annual Assurance Report/Forward Plan for 2024/25. The following key points were highlighted:

- The Trust has a Data Quality Maturity Index (DQMI) score of 89.8, in comparison to a national average of 75.1. It was reported that the Trust's overall performance is good against national standards.
- There has been a focus on Alder Care and the impact it has had on the teams. Restoring the organisation's reporting capabilities was challenging but throughout the programme the Trust has maintained a strong position.
- MIAA published a report on the data quality audit which focussed on two metrics within the Integrated Performance Report in September 2023. The findings were given substantial assurance and all recommendations have been implemented following the audit.

The Chair queried as to whether data quality reports into other Assurance Committees on a regular basis other than ARC. It was reported that a decision needs to be made to agree a reporting process for data quality in terms of where it fits. IG agreed to look into this matter.

**24/25/27.1 Action: IG**

**Resolved:**
ARC noted the content of the report and received assurance of data quality activities and improvements made during 2023/24

**24/25/28 Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Cyber Security.**

The Committee was provided with an overview of the 2023/24 Cyber Security Annual Assurance Report/Forward Plan for 2024/25. The following key points were highlighted:

- It was reported that the Trust's performance has been good during 2023/24 across a range of areas and is meeting targets.
- Phishing attacks are an ongoing risk for the organisation and can result in account compromises at the Trust. Alder Hey has a secure process in place for managing this but it has been recognised nationally that there is a need to apply Multi Factor Authentication for all remote access. This will be introduced and rolled out in June 2024 to mitigate risk. There is a risk rated as 12 on the risk register relating to Phishing.

The Chair pointed out that information relating to penetration testing hadn't been included in the report. It was confirmed that penetration testing has taken place and the Committee was advised that the organisation has other internal targets that could be included in future reports. The Chair asked for this data to be included in next year's annual report.

**24/25/28.1 Action: IG**

JRe referred to the new legislation that has been published in relation to online safety and asked as to whether this will impact the Trust. It was reported that the only information that the Trust has received from a national perspective is the implementation of the Multi Factor Authentication which will provide an extra layer of protection. It was agreed to look into this matter.

**24/25/28.2 Action: IG**

**Resolved:**
ARC noted the content of the report and received assurance of Cyber Security activities and improvements made during 2023/24

**24/25/29 Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Data Protection.**

The Committee was provided with an overview of the 2023/24 Data Protection Annual Assurance Report/Forward Plan for 2024/25. The following key points were highlighted:

- The organisation demonstrates strong controls and processes which support data protection compliance;
  - The Access to Health Team have coordinated and disclosed 2,004 subject access requests achieving 99.51% compliance against statutory disclosure timeframes. Processes were audited by MIAA in May 2023 receiving substantial audit opinion.
  - There has been 98.29% in year organisational coverage of mandatory Information Governance (IG) data security and protection training by all staff.
  - There has been a 33% reduction in IG/data protection incidents reported.
- The IG Team were shortlisted as finalists for the National Health and Social Care Information Governance Annual Awards 2024

The Chair made reference to exemptions and queried as to whether there are two people involved in this process to ensure they aren't incorrectly classifying an exception. It was agreed to look into this matter and confirm the formal process.

**24/25/29.1 Action: IG**

**Resolved:**
ARC noted the content of the report and received assurance of data protection activities and improvements made during 2023/24.

**24/25/30 Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Freedom of Information.**

The Committee was provided with an overview of the 2023/24 Freedom of Information (FOI)Annual Assurance Report/Forward Plan for 2024/25. The following key points were highlighted:

- The Trust responded to 650 FOI requests during the reporting period and achieved 93.38% compliance against statutory timeframes. This is a significant and notable organisational improvement in comparison to 71.45% compliance reported during 2022/23.
- The trend of increased volume of requests received has again been evident with a 6% increase in comparison to 2022/23. Despite this huge progress has been made.
- There have been no formal complaints, information notices or enforcement action received via the ICO in relation to Alder Hey FOIA practices or compliance.

**For noting**
It was reported that there were a number of sensitive FOI requests that the Executive Team weren't sighted on therefore a list of topics has been provided to the IG and Data Protection Officer, Wyn Taylor, of the things that need to be raised at the point of triage. This discipline needs to be brought back.

**Resolved:**
ARC noted the content of the report and the significant improvements that have been made since 2022/23.

**24/25/31 Annual Governance Statement.**

The Managing Director, John Grinnell presented the draft Annual Governance Statement (AGS) for 2023/24 to the Committee and drew attention to some of the work that has taken place during the year. The AGS provides a positive look back over the year and lays out the organisation's system of internal control mechanisms and accountability structures.

The following points were raised:

- The Trust continues to have a high reporting culture and has a rigorous Patient Safety Strategy that is overseen via SQAC.
- The CRR gives a true representation of the risks Alder Hey faces as an organisation and the hierarchy works well via its management functions. There are a number of areas that the Trust is challenging itself on, for example, the current risk appetite work that is being conducted. It was pointed out that the organisation considers the risk appetite regularly which is used to inform the management of the Assurance Framework. The data included in the AGS is evidence based supported by intelligence from the organisation's assurance processes, i.e. Quality Assurance Rounds which are going from strength to strength. There is also a well embedded Brilliant Basics methodology which is one of the management controls.
- Reference was made to EPRR non-compliance which it was felt should be included in the AGS.
- The Committee was advised that it has been a challenging year with huge pressures as a result of demand, the financial environment, industrial action, etc. Regardless of this the organisation's performance has been outstanding in terms of its safety and experience measures, the access to services that has been provided to CYP, meeting national targets, looking after the health and wellbeing of staff whilst maintaining the workforce, delivering a new EPR system, and finding the headspace to refresh Alder Hey's Vision 2030 Strategy which is critical in terms of being a strategic organisation as well as a safe one.

It was concluded that there have been no significant internal control issues identified in 2023/24. The Committee was advised that there are a couple of amendments to be made to the AGS along with some further points of clarity relating to the EPRR and InPhase.

**Resolved:**
ARC reviewed and approved the 2023/24 Annual Governance Statement, pending the amendments.

**24/25/32 Fraud, Bribery and Corruption Policy**

The Committee received the Anti-Fraud, Bribery and Corruption Policy and Response Plan. It was reported that MIAA has reviewed and updated the Policy and Plan on the Trust's behalf to reflect the latest NHS Counter Fraud Authority strategy document (2023-2026). ARC were asked to ratify the updated Policy.

The Chair asked that a small number of amendments be made to section 2 and 3. It was agreed to address this outside of the meeting.

**24/25/32.1 Action: KB/EK**

**Resolved:**
ARC approved the Anti-Fraud, Bribery and Corruption Policy and Response Plan, pending the Chair's amendments.

**24/25/33 Waiver Activity Report; Q3/Q4.**

**Resolved:**
This item has been deferred to June.

**24/25/34 Approach to Review of the Effectiveness of ARC, Internal Audit, External Audit and the Counter Fraud Service**

**Resolved:**
ARC approved the approach to review the effectiveness of ARC, Internal Audit, External Audit and the Counter Fraud Service.

**24/25/35 Audit and Risk Committee Terms of Reference and Annual Workplan.**

**Resolved:**
The Committee approved the ARC Terms of Reference and annual Workplan.

**24/25/36 Any Other Business**

There was none to discuss.

**24/25/37 Meeting Review**

It was felt that the meeting was long due to the extensive agenda. The Chair thanked everybody for their patience and input during the meeting.

**Date and Time of the Next Meeting:** Thursday 20th June 2024, 2:00pm-5:00pm, Room TBC

# BOARD OF DIRECTORS

**Thursday, 4th July 2024**

| | |
|---|---|
| **Paper Title:** | Finance, Transformation and Performance Committee |
| **Report of:** | John Kelly, Non-Executive Director |
| **Paper Prepared by:** | John Kelly, Non-Executive Director |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☐<br>Regulation ☐ |
| **Action/Decision Required:** | To note ☑<br>To approve ☐ |
| **Summary / supporting information** | This paper provides a summary from the recent Resources and Business Development Committee meeting held on 29th April 2024, along with the approved minutes from the 26th March 2024 meeting. |
| **Strategic Context**<br><br>**This paper links to the following:** | Delivery of **outstanding care** ☑<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☐ |
| **Resource Implications:** | |

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

## 1. Executive Summary

To provide an update to the Trust Board on the previous Resource and Business Development Committee held on 23rd May 2024.

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

- Top 4 Risks
- M1 Finance report
- M1 Integrated Performance report
- Benefit Transformation Programme
- Campus update
- Liverpool Neonatal Partnership
- Board Assurance Framework
- Risk Appetite
- PFI
- Terms of Reference

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

None reported.

### 4. Positive highlights of note

The Chair noted new input that raised a number of questions that will hopefully be worked through the divisional FPC.

### 5. Issues for other committees

None reported.

**Resources and Business Development Committee**
**Minutes of the meeting held on Thursday 23rd May 2024 at 13:00, Via Teams**

| | | | |
|---|---|---|---|
| **Present:** | John Kelly | Non-Executive Director (Chair) | (JK) |
| | Shalni Arora | Non-Executive Director | (SA) |
| | Dame Jo Williams | Non-Executive Director | (JW) |
| | Adam Bateman | Chief Operating Officer | |
| | Rachel Lea | Deputy Director of Finance | (RL) |
| | Kate Warriner | Chief Digital and Information Officer | (KW) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| **In attendance:** | Beth Duncall | (Shadowing Kate Warriner) | |
| | Hari Parekh | (Shadowing Rachel Greer) Item: 26 | |
| | Rachel Greer | CAMHS COO Item: 26 | |
| | Esme Evans | Business Accountant CMHS Item: 26 | |
| | Audrey Chindiya | Associate Finance Director – Operational Finance | (AC) |
| | Dani Jones | Director of Strategy and Partnerships | (DJ) |
| | Emily Kirkpatrick | Deputy Director of Finance | (EK) |
| | Jane Halloran | Acting Deputy Development Director | (JH) |
| | Chloe Lee | Associate Chief Operating Officer – Surgery Agenda item 31 | (CL) |
| | Andy McColl | Deputy Director of Finance | (AMC) |
| | Graeme Montgomery | Business Accountant – Surgery | (GM) |
| | Julie Tsao | Executive Assistant (*minutes*) | (JT) |

**24/25/21 Apologies**

Apologies were noted from:

| | | |
|---|---|---|
| Nathan Askew | Chief Nurse | (NA) |
| John Grinnell | Managing Director / CFO | (JG) |
| Natalie Palin | Associate Director Transformation | (NP) |
| Erica Saunders | Director of Corporate Affairs | (ES) |

**24/25/22 Minutes from the meeting held 29th April 2024**

The minutes were approved as a true and accurate record.

**24/25/23 Matters Arising and Action log**

Updates to outstanding actions were given during the meeting.

**24/25/24 Declarations of Interest**

There were no declarations of interest.

**24/25/25 Top 5 Risks**

1. **Immediate financial performance including system position (RAG HIGH)**
   24/25 plan challenging and increased risk of system plan in a deficit position.

   M1 off plan due to efficiency savings. Cheshire & Merseyside (C&M) is also off plan, 24/25 C&M target is £150m deficit. Following on from NHS meeting it is likely the target will change, further update to be received at Trust Board. It is likely that AH's target will increase from the current £4.9M surplus.

2. **Capital Programme (RAG MEDIUM – under review)**
   Limited CDEL allocation in 24/25.

Capital Management Group (CMG) for 24/25 has been reinstated. £5m UEC incentive Capital has been approved and will ensure ground floor of NICU is completed.

RL noted that the RAG rating for this risk was likely to increase due to medical equipment replacements. AB and RL noted the good clinical leadership that are managing the current challenges through CMG.

SA asked if the medical equipment review would cause implications with the Neonatal programme and the Futures strategy. RL advised the equipment for Neonatal has been included in the capital plan however there will be risks around the cost of the equipment increasing. In relation to Futures Strategy a DeTect Fund has been released and further grants will be looked into as a source for supporting the medical equipment programme. KW noted her support with a request that had been made to CIOs with developing DeTect funding nationally.

SA and AB discussed support from the Charity with Innovation and Research projects as well as top us to medical equipment to enable Alder Hey to receive higher specifications.

3. **Efficiency Programme (RAG HIGH)**
   Plan for delivery is £19.3m forecast is currently £12m recurrently. Work continues to look at reducing gaps that are not recurrent.

4. **Benefits realisation, governance and prioritisation of change programme to 2030 (RAG MEDIUM)**
   KW noted the overlap between the Efficiency Programme and the Benefits Realisation querying if the Transformation programme should be included within the Benefit Realisation risk.

   RABD noted the challenge of the efficiency programme. It was agreed to widen benefit realisation risk to include Transformation programme.
   **Action: KW/NP**

5. **The campus & Park developments (RAG MEDIUM)**
   An update on the programme would be received under the agenda item.

**24/25/26** **Community and Mental Health Divisional Update**

Due to time constraints at the April RABD RG presented the above quarter 4 report noting activity is ahead of plan. The Chair asked for details on a breakdown for patients who have been seen and are going through various patient pathways. RG advised a paper on this had been presented to the Operational Delivery Group this morning on metrics to highlight when timescales are due to end as well as time to triage.

23/24 YTD the division ended on a favourable £5.730m. This was due to funding for Mental Health Investment posts and a number of the posts taking some time to recruit to. The Chair queried if it was likely outstanding posts would be recruited to in 24/25. RG responded noting departments will continue to recruit to vacancies and over recruit to areas needed if possible. A discussion was held regarding opportunities with Health Education to recruit to lower bands including training programmes.

The Chair queried if the workforce risks should be included within the Top 5 Risks. RL agreed to discuss this further with MS outside of the meeting to ensure this wasn't a duplication of what goes to People and Wellbeing Committee.
**Action: RL/MS**

CIP for 23/24 was achieved. 24/25 plan is for £2.5m, over £1m has been achieved and the division continue to look at options for closing the gap.

RG went through the priorities and Efficiency targets for 24/25. Priorities included SLR model and changes to service line reports.

**Resolved:**
RABD noted the achievements and challenges for Community and Mental Health Division quarter 4.

**24/25/27** **Finance Report**
**Month 1 Financial Position**
£1.2MD was reported for M1, this is £200k away from the plan due to undelivered CIP.

Income is ahead by £0.5m, this is offset by overspend in non-pay mainly in relation to drugs and research.

CIP target for 24/25 is £19.3m, £6.2 recurring has been secured.

The Chair queried if there has been an update in terms of the ERF funding. GW advised that an update is due at the end of June 2024.

The Chair asked if any further strikes are likely to take place. MS advised that whilst the BMA were in discussions on agreeing a deal it was currently unclear whether this would include junior doctors, if not it was likely there could be further strikes.

The end of year audit reports have been submitted to external auditors, no queries on the submissions have yet been requested.
**Resolved:**
RABD received and noted the M1 Finance report.

**24/25/28** **Month 1 Integrated Performance Report**
AB highlighted the following challenges:
- Some patients are waiting 2 years for a follow up appointment. Investment was approved at the end of last year to invest in new models of care to reduce these wait times. A pilot is due to start in June 20204 on four specialties.
- Reducing Elective wait times to under 52 weeks. Approval was given at Operational Group this morning to invest £400k in ENT and Dentistry for additional capacity to treat an additional 1200 patients.
- To support with letters being sent to patients a new technology is to be trailed soon.

Positive areas include:
- Approval has been give for £5m ED incentive.
- Virtual Ward continues to positively support capacity and flow.

The Chair asked if it would be possible to share the productivity dashboard. It was agreed this would be an item on the June RABD agenda.
**Action: AB**

**Resolved:**
RABD received and noted the M1 Integrated Performance report.

**24/25/29 Benefit Transformation Programme**

KW provided an update noting the second Programme Board was held last week. Highlights from the programme include:

- Agreed for the change and scope to include the non-clinical review.
- Review People Programme will be presented at the June Programme Board for approval.
- Deep Dive completed in Personalised Night Programme.

The Chair asked if it would be possible to review dates of completion within the programme to ensure they were achievable.
**Action: KW/NP**

A discussion was held on the high savings under the People Programme. RL provided an update on the MARS retirement scheme that is due to close at the end of July noting some applications may be reviewed prior to the close of the scheme.

**Resolved:**
RABD received and noted Benefit Transformation Programme.

**24/25/30 Campus update**

JH went through the draft two five year plans for the Project Management Group:

- Completion of the Park this Summer.
- Demolition of a number of buildings including Histopathology and nursery.

Future planning with capital schemes will include Elected Surgical Hub and Alder Park in two phases.

An update will be presented at Executive Committee on 30th May in relation to the Offices project to propose accommodation for any outstanding teams.

**Resolved:**
RABD received and noted the Campus update.

**24/25/31 Liverpool Neonatal Partnership**

CL gave an update on the implementation of the operational phase:
Areas of concern include:

- The decant of PAU/EDU and waiting areas. Surgery and Medicine Division are looking into this.
- Workforce budget for the project is being reviewed.
- Cot demand & capacity to be refreshed from original business case (22 cots) against current demand & agreed clinical criteria.
- Leadership team realigned to roles & responsibilities redefined with additional programme resource.

AB noted an Exec to Exec meeting with Liverpool Women's NHS FT taking place next week to ensure both Trust's are aligned.
SA asked if there had been any progress in regards to working with Phillips. AB and KW advised that it was likely the costs were to high. AB/KW agreed to confirm at the next RABD
**Action: AB/KW**

**Resolved:**
RABD received and noted Liverpool Neonatal Partnership

**24/25/32 Board Assurance Framework**
**Resolved:**
As ES was unable to attend the meeting this item was deferred until the next RABD on 24th June 2024. The Board Assurance Framework had been shared in the papers.

**24/25/33 Risk Appetite**
**Resolved:**
As ES was unable to attend the meeting this item was deferred until the next RABD on 24th June 2024.

**24/25/34 PFI**
**Resolved:**
It was noted that nobody was available to present the PFI report which was taken as read.

**24/25/35 Terms of Reference**
Tracked changes had been included in the papers.

RABD discussed name change options to the committee of either:
Finance, Resources and Performance or
Finance and Performance

After discussion RABD agreed Transformation should be included in the title and agreed future RABD meetings would be called:
Finance, Transformation and Performance Committee.
**Resolved:**
- RABD received and APPROVED the Terms of Reference.
- Future meetings to be renamed: Finance, Transformation and Performance Committee.

**24/25/36 Any Other Business**
No other business was recorded.

**24/25/37 Review of Meeting**
The Chair noted the discussion around including workforce under Top 5 risks.

Going forward it was Corporate finances would be reported the month after the quarterly Divisional updates.

**Date and Time of Next Meeting: Monday 24th June 2024 at 1:00pm, via Teams.**

**BOARD OF DIRECTORS**

**Thursday, 4th July 2024**

| **Paper Title:** | **Board Assurance Framework Report (May 2024)** |
|---|---|
| **Report of:** | Erica Saunders, Director of Corporate Affairs |
| **Paper Prepared by:** | Executive Team and Governance Manager |

| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☐<br>Regulation ☐ |
|---|---|
| **Action/Decision Required:** | To note ☑<br>To approve ☐ |
| **Summary / supporting information** | Monthly BAF Reports |
| **Strategic Context**<br><br>**This paper links to the following:** | **Outstanding** care and experience ☑<br>**Collaborate** for children & young people ☑<br>**Revolutionise** care ☑<br>**Support** our people ☑<br>**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 May 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 11th 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 May 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk 1.1 has been reviewed in light of the 2030 vision and will be reflected in next months update.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in May significantly increased above the national standard of 78%, achieving 86.7%

  Continued improvement plans are in place for Sleep Studies (sickness) and Gastro (availability of theatres) to improve the Overall DM01 compliance, achieving 86.7%, a slight decrease from April, and against a national target of 95% by March 2025.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. The trust achieved zero 78 weeks at end of May 2024. The number of patients waiting over 65 weeks at end of May was 42, an increase from April. 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. Trajectory is in place and this is being monitored weekly.

  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)***
  Updated corroded pipework position report received from Project Co in May, 43 Amber status pipes still to be replaced. GD has raised on several occasions that these need to be actioned as soon as possible.

  Meeting with key project co stakeholders on the 5th June with Executive colleagues in attendance. Further workshop to be setup in regard to next steps.

  Leak incidents have reduced over the last three years.

  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 are informed that progress is being made on water temperature works.

  Works on the skylights will commenced on the 15th April 2024 with all lights completed and compound struck down with landscapes re-instated by December 2024.

Chiller commissioning works continue positively with further works planned during June which will then bring all chillers into active use.

- ***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 undertaken and actions updated. Full review of BAF to take place in June 2024 to ascertain levels of risk and potential revised scores

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (MS).***
  Thorough review of actions to mitigate gaps in assurance undertaken in month. No change to risk score.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS)***
  Risk reviewed and actions reviewed and updated. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Actions are on track. The people plan actions for 2024/25 will further address this.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed - no change to score . All actions being progressed in line with timescales.

- ***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 2030 Programme Board recently reviewed the risk assessment, and there has been no change to the scoring. Delivery plans are in place, and strong governance is evident across the programme, which is beginning to deliver benefits for CYPF and our staff. 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.

- ***Financial Environment (JG).***
  Risk reviewed and score remains as 16 due to the ongoing financial challenge and risks to deliver the 24/25 financial plan.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed. No change to score in month.

- ***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).***
  Review of actions completed.  no change to risk score in month.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  Risk reviewed, adequate controls in place and score static. AlderCare Optimisation continues to progress well. Work is well underway aligning the Digital programmes to Trust 2030 strategy with paper to be presented to relevant committees in June. Options appraisal supported via AH Execs for reconfiguring Data and Analytics leadership which will be mobilised in June also. Cyber security plans progressing and collaboration with Clatterbridge in place.

## 5. Corporate risks (15+) linked to BAF Risks (as at 30 May 2024)

There are currently 28 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)** | | | | | | |
| 151 | Expanse Referral Process ***(NEW)*** | 5x4 | Business Support | 4.2 | May 2024 | May 2024 |
| 70 | National ADHD medication shortage ***(NEW)*** | 4x4 | Community | | Sept 2023 | May 2024 |
| 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 | 4x4 | Surgery | 3.4 | Aug 2022 | Feb 2024 |

| Risk | Risk Title | Score (IxL) | Division | Linked | Date opened | Increased to Corporate |
|---|---|---|---|---|---|---|
| | 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 | | | | | |
| 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.<br>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 |
| 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 |

| Risk | Risk Title | Score (IxL) | Division | Linked | Date opened | Increased to Corporate |
|---|---|---|---|---|---|---|
| 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 |
| 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 |

| Risk | Risk Title | Score (IxL) | Division | Linked | Date opened | Increased to Corporate |
|---|---|---|---|---|---|---|
| 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 |
| 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)** | | | | | | |

| Risk | Risk Title | Score (IxL) | Division | Linked | Date opened | Increased to Corporate |
|---|---|---|---|---|---|---|
| | None | | | | | |
| **3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (3x4=12)** | | | | | | |
| | None | | | | | |
| **3.4 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)** | | | | | | |
| 151 | Expanse Referral Process ***(NEW)*** | 5x4 | Business Support | 1.2 | 16 May 2024 | May 2024 |

* risk movement data not available pre-move to InPhase

## 6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

**Erica Saunders**
**Director of Corporate Affairs**

| Inability to deliver safe and high quality services | |
|---|---|
| Risk Number | Strategic Objectives |
| 1.1 | Delivery of Outstanding Care |

| CQC Domains | Linked Risks | Owner | RM03 Risk Rating | | |
|---|---|---|---|---|---|
| | | | Actual | Target | Assurance Committee |
| Safe | | Nathan Askew | 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. |

| Jun 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<br>2. Robust reduction programme in the number of medication incidents and near misses<br>3. Impact of Industrial action in the safe delivery of care and progress against recovery<br>4. The CQC will move to a new oversight framework which may reduce our CQC ratings<br>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<br>6. The new models of care workstream will need to redefine the delivery of services whilst maintaining the principles of the strategy<br>7. Alder Care (Expanse) has been implemented across the organisation which poses risks until stabilisation. |

| Action | Description | June 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<br>▪ 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.

### Jun 2024

| Control Description | Control Assurance Internal |
|---|---|
| Controls for waiting time in the Emergency Department (ED):<br>- Winter Plan with additional staffing and bed capacity<br>- ED Escalation & Surge Procedure<br>- Additional shifts to increase staffing levels to deal with higher demand<br>- Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS) | Daily reports to NHS England<br>-@ Daily Performance summary<br>-@ monthly Performance report to Operational delivery group<br>-@ Performance reports to RABD Board Sub-@Committee<br>-@ bed occupancy is good |
| Controls for referral-to-treatment times for planned care:<br>- Weekly oversight and management of waiting times by specialty<br>- Weekly oversight and management of long wait patients<br>- Use of electronic system, Pathway Manager, to track patient pathways<br>- Additional capacity in challenged specialties<br>- Access to follow-up is prioritised using clinical urgent signified by tolerance for delay | Corporate report and divisional Dashboards<br>-@ Performance reports to RABD Board Sub-@Committee<br>-@ Use of electronic patient pathway forms to signify follow-@up clinical urgency and time-@frame |
| Controls for access to care in Community Paediatrics:<br>- Use of external partner to increase capacity and reduce waiting times for ASD assessments<br>- Investment in additional workforce for Speech & Language service in Sefton<br>- Weekly oversight and management of long wait patients | Significant decrease in waiting times for Sefton SALT<br>-@ Corporate report and divisional Dashboards<br>-@ Performance reports to RABD Board Sub-@Committee |
| Controls for access to care in Specialist Mental Health Services:<br>- Investment in additional workforce in Specialist Mental Health Services<br>- Extension of crisis service to 7 days<br>- Weekly oversight and management of long wait patients | monthly Performance report to Operational delivery group<br>-@ 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:<br>- SAFER<br>- Best in Acute Care<br>- Best in Outpatient Care<br>- Best in Mental Health care | monthly oversight of project delivery at Programme Board<br>-@ 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<br>- Weekly 'Executive Comm Cell' meeting held<br>- 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 | June 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 |

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

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

| Risk Number | Strategic Objectives |
|---|---|
| 1.4 | Delivery of Outstanding Care |

| CQC Domains | Linked Risks | Owner |
|---|---|---|
| ▪ Caring<br>▪ Effective<br>▪ Responsive<br>▪ Safe<br>▪ 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.

### Jun 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:<br>• Weekly Tuesday/Wednesday meeting with PCOs<br>• Divisional Waiting Times Meeting each Thursday<br>• Trust Access to Care Delivery Group each Friday<br><br>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:<br>• Monthly contract statements<br>• 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 | June 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 | 31/07/2024 | |
| 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 | 31/07/2024 | |
| Review of KPIs and Reporting Measures | Review of KPIs and reporting measures for Sefton & Liverpool place | 31/07/2024 | |

| 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<br>▪ 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.<br>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.<br>3. Not developing inclusive recruitment and talent management practices to improve workforce diversity |

| Jun 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<br>- 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<br>- Apprenticeship workstream implementation<br>- Leadership workstream implementation<br>- Professional Development Hub<br>- Thriving Workstream<br>- 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<br>2. Sickness absence levels higher than target<br>3. Lack of workforce planning across the organisation<br>4. Lack of robust talent and succession planning<br>5. Lack of a robust Trust wide Recruitment Strategy<br>6. Lack of inclusive practices to increase diversity across the organisation |

| Action | Description | June 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 Overall Mandatory training is above 90% and achieving trust target however it is recognised that some key and important topics are less than 90%. A newly appointed Head of L&D has a full action plan in place to increase compliance across the organisation and this is supported by the Academy Director. Gill Foden Head of L&D is the owner of this action. | 31/03/2024 | Mandatory training activity is monitored by Education Governance Committee as a standard agenda item.<br>As at May 24 overall trust compliance was 93.00%.<br>Areas of concern are highlighted, discussed and supported with subject experts. The current area under review is SEPSIS. |
| 2. Sickness absence levels higher than Trust Target | The sickness Target has been reduced for 2024 to 5% and the start of the year has commenced with sickness absence being below target. Ongoing interventions remain in place to support the management of sickness, however until the absence has had a sustained reduction it will continue to monitored as a risk impacting on this overall BAF risk. | 31/03/2025 | |
| 3. Future Workforce | 3. Review of skill mix, talent and succession planning across the organisation against full demographic analysis. Annual operational plans are in place, Establishment control in place. | 31/03/2025 | Establishment control project close to completion before commencing the wider workforce planning project |
| 4. Lack of Robust talent and succession planning | The next stages of the People Plan and key deliverables for 24/25 were presented to Trust board on 6th June 2024 and the plan approved. The plan requires key strategic areas of focus, one of those three areas is the development plans for Future workforce. Succession and Talent management is a workstream that sits beneath this strategic initiative. HR, OD and Academy will work together to review skill mix, talent and succession planning, prioritising those areas were there is the most need over the next 12 months. | 11/06/2024 | |
| 5. Lack of a robust Trust wide Recruitment Strategy | The next stage of the people Plan 24/25 there is a key work stream related to the Future Workforce, which addresses accessible and diversified recruitment and the Trust recruitment strategy. This action is addressed through the 24/25 People Plan. | 31/03/2025 | |
| 6. Lack of inclusive practises to increase diversity across the organisation | Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030. EDI is central to all elements of the people plan with particular focus on learning, recruitment, development, and retention in 2024/25 - with operational leads assigned to each area. A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes. | 31/03/2025 | |

| Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families | |
|---|---|
| Risk Number | Strategic Objectives |
| 2.2 | The Best People Doing Their Best Work |

| CQC Domains | Linked Risks | Owner |
|---|---|---|
| ▪ Caring<br>▪ Safe<br>▪ 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. |

| Jun 2024 | |
|---|---|
| Control Description | Control Assurance Internal |
| The People Plan Implementation | Monthly Board reports<br>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<br>- lack of understanding about a just and restorative culture approach<br>- lack of consistent compassionate leadership<br>- Inconsistent application of Trust values and behavioural framework<br>- insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas<br>- insufficient OD resource available to fully address all culture tensions and challenges when they arise |

| Action | Description | June 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 Thriving Index pilot complete and implementation plan being developed. Thriving Teams MDT up and running with work planned to develop metrics for identifying vulnerable teams as part of this process. Discussed with CPO. Methodology to be agreed and to incorporate work already done by Director of Medical Services in discussion with MD |
| 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 and Operational Leaders programme. | 30/10/2024 | Strong Foundations review complete. Clinical Leaders programme scoping underway with listening sessions with all clinical leads to take place between July and Sept 2024. Scoping also underway to develop Operational Leaders programme. Thriving Leaders Framework to include these components and to be supported as part of Vision 2030 programme support with relevant people invited to attend and become part of development team. |
| 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. | 31/07/2024 | 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. | 31/12/2024 | |

| 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<br>▪ 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.<br>- Failure to take steps to become an inclusive work place where all staff feel their contribution as an individual is recognised and valued.<br>- Failure to provide equal opportunities for career development and growth.<br>- Non-compliance with the public sector equality duties |

| Jun 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<br>-@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<br>- EDS Publication |
| Equality, Diversity & Human Rights Policy | - Equality Impact Assessments undertaken for every policy & project<br>- Equality Objectives |
| Actions taken in response to the WRES | monthly recruitment reports provided by HR to divisions.<br>-@Workforce Race Equality Standards.<br>-@ 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.<br>-@ Workforce Disability Equality Standards.<br>-@ 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 |

| Jun 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<br>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:<br>1. Adoption of the SWALE by United Utilities<br>2. Park Handover<br>3. Weather conditions causing potential delays<br>CAMPUS:<br>1. Stakeholder Engagement<br>2. Successful realisation of the moves plan.<br>3. Funding availability and potential market inflation. |

| Action | Description | June 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:<br>- translate the 2030 Vision into operational plans and systematically execute.<br>- 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. |

| Jun 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)<br>Strategy 2030 - Approved at Trust Board (March 2023)<br>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<br>2. 2030 delivery programme and plan in development<br>3. Failure to develop capacity for delivery<br>4. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy<br>5. Failure to deprioritise to enable requisite focus on areas of need and transformational change<br>6. Risk of 'mission creep' associated to the Strategy |

| Action | Description | June 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 | |
| Understand the impact of organizing ourselves around the needs of and the impact on income. | As part of vision 2030 we are seeking to meet the needs of CYP, this includes working and thinking different. Our current working approaches have often been designed to support the organisation and the opportunity to secure income for activity; that allows us to delivery world class specialised care. There are however examples emerging that indicate that whilst a change will be positive to CYP it could potential impact on received income. A balance between doing the right thing / or the better financial return. Work to be undertaken with costing team, transformation and divisional colleagues. | 28/05/2024 | |

**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 |
|---|---|---|
| ▪ Effective<br>▪ Responsive<br>▪ Safe<br>▪ Well-Led | | John Grinnell |

| RM03 Risk Rating | | |
|---|---|---|
| Actual | Target | Assurance Committee |
| 16 | 12 | Resource And Business Development Committee |

| Description |
|---|
| Failure to meet NHSI/E targets.<br>Inability to invest in the capital programme. |

| Jun 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<br>-@ Full electronic access to budgets &@ specialty Performance results<br>-@ Finance reports shared with each division/@department monthly<br>-@ Financial in-month and forecast position reported through SDG, Exec team, RABD, and trust Board<br>-@ Financial recovery plans reported through SDG and RABD<br>-@ 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.<br>2. Long Term tariff arrangements for complex children shows underfunding of c£3m for Alder Hey<br>3. Devolved specialised commissioning and uncertainty impact to specialist trusts<br>4. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme<br>5. Long Term Plan shows £3-5m shortfall against breakeven<br>6. Deliverability of high risk recurrent CIP programme<br>7. Increasing inflationary pressures outside of AH control<br>8. Divisional budget positions are not acheived due to emerging cost pressures and impact of Industrial Action. |

| Action | Description | June 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 Efficiency programme | 6. Ongoing monitoring of efficiency schemes through Sustainability Delivery Group. Assigned finance lead to all transformation efficiency schemes. Benefits realisaiton approach for all transformational schemes to ensure financial saving captured. Weekly updates to strategic execs on the status of the efficiency programme. Assurance report into RABD and one of the top areas of focus for the committee. | 31/03/2025 | |
| Inflationary pressures | 7. Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations. | 31/03/2025 | |
| Shortfall against Long Term Financial Plan | 5. Long Term Financial Plan to be updated for latest position and to take us to 2030 as part of financial strategy. | 30/09/2024 | 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. Use of SLR and PLICS to understand tariff shortfall and reasons and then build case for discussion with commissioners. | 31/03/2025 | |

| 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.

**Jun 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<br>CMAST - CYP alliance established.<br>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.<br>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<br>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 | June 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 |
|---|---|---|
| Well-Led | | John Chester |

| RM03 Risk Rating | | |
|---|---|---|
| Actual | Target | Assurance Committee |
| 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.<br>Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities.<br>Risk of exposure to ethical challenges and national and international reputational risks. |

| Jun 2024 | |
|---|---|
| Control Description | Control Assurance Internal |
| Resource and Business Development Committee (RABD)<br>Additional oversight of financial and commercial aspects of R&I activity | Reports to Trust Board |
| Research Management Board and Innovation Management Board<br>(and subsidiary committees - Sponsorship Oversight Committee, Data Access Panel etc)<br>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.<br>2. Levels of activity targeted at maintaining and enhancing reputation not yet sustainable.<br>3. Financial model and levels of income not yet consistent with growth and sustainability.<br>4. Capacity and capability of clinical staff and services to participate in R&I activities.<br>5. Comms Strategy for Futures not yet fully described. |

| Action | Description | June 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.

**Jun 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 | June 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 | |