BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 3rd October 2024, commencing at 9:00am
Lecture Theatre 2, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Supporting Our People							
1.	**24/25/171**	**9.00 (60 mins)**	**People Plan Discussion.**	M. Swindell/ J. Potier/ S. Owen/ K. Birch	For information and discussion.	**A**	Presentation
PATIENT STORY (10:00am-10:15am)							
2.	**24/25/172**	**10:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
3.	**24/25/173**	**10:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
4.	**24/25/174**	**10:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **5th September 2024.**	**D**	Read enclosure
5.	**24/25/175**	**10.19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
6.	**24/25/176**	**10:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
7.	**24/25/177**	**10.30 (10 mins)**	**Vision 2030 Strategy Deployment Update.**	J. Grinnell/ N. Palin	To receive an update on the current position.	**A**	Verbal

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
8.	24/25/178	10:40 (10 mins)	**CMAST Joint Working Agreement and Committee in Common Terms of Reference.**	E. Saunders	For approval.	D	Read report
9.	24/25/179	10:50 (15 mins)	**Beyond Update.**	L. Crabtree	To receive an update on the current position.	A	Presentation
10.	24/25/180	11:05 (10 mins)	**C&M Financial Position Update.**	R. Lea	To receive an update on the current position.	A	Read report
Operational Issues							
11.	24/25/181	11:15 (10 mins)	**Alder Hey – Autumn and Winter Emergency Response Plan, 2024/25.**	A. Bateman	To receive the Autumn and Winter Emergency Response Plan, 2024/25.	A	Read report
12.	24/25/182	11:25 (45 mins)	**Evidence of Our Performance:** • **Flash Report, M6.** • **Integrated Performance Report for M5, 2023/24:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions**	A. Bateman N. Askew A. Bateman A. Bateman M. Swindell D. Jones R. Lea Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	A	Read report
13.	24/25/183	12:10 (10 mins)	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	A	Read report
Lunch (12:20pm – 12:50pm)							
Unrivalled Experience							
14.	24/25/184	12:50 (10 mins)	**Safeguarding Children and Adults at Risk Annual Report, 2023-2024.**	N. Askew	For approval.	D	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
15.	**24/25/185**	**13:00 (10 mins)**	**Mortality Report, Q1.**	A. Bass	To receive the Mortality Report, Q1.	**A**	Read report
16.	**24/25/186**	**13:10 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 25.9.24.** - **Approved minutes from the meeting held on the 24.7.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 24.7.24.	**A**	Read enclosures
Pioneering Breakthroughs							
17.	**24/25/187**	**13:15 (5 mins)**	**Futures Committee:** - **Chair's highlight report from the meeting held on the 30.9.24.** - **Approved minutes from the meeting held on the 26.6.24.**	S. Arora	To escalate any key risks, receive updates and note the approved minutes from the 26.6.24	**A**	Read enclosures
Collaborating in Communities							
18.	**24/25/188**	**13:20 (10 mins)**	**Collaborate for Children and Young People:** - **Growing Great Partnerships Update.** - **Wider system update.**	D. Jones	To receive an update on the current position.	**N**	Read report
19.	**24/25/189**	**13:30 (10 mins)**	**Liverpool Neonatal Partnership governance.**	A Bass	To receive an update on the current position	**N**	Read report
Supporting our People							

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20.	**24/25/190**	**13:40 (10 mins)**	**People Plan Highlight Report; including:** • **EDI update.** • **Black History Month.**	M. Swindell A Chindiya	To receive an update on key areas and updates from the system on the workforce. To discuss the plans for Black History Month.	**A** **N**	Read report Verbal
21.	**24/25/191**	**13:50 (5 mins)**	**People Committee:** • **Chair's Highlight Report from the 19.9.24.** • **Approved minutes from the meeting held on the 17.7.24.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 17.7.24.	**A**	Read enclosures
22.	**24/25/192**	**13:55 (10 mins)**	**Freedom To Speak Up Update.**	K. Turner	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
23.	**24/25/193**	**14:05 (10 mins)**	**CQC Improvement Notice: Nuclear Medicine.**	U. Das/ E. Saunders	For information and discussion.	**A**	Verbal
24.	**24/25/194**	**14:15 (10 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's verbal update from the meeting held on the 30.9.24.** - **Approved minutes from the meeting held on the 22.8.24.** - **2024/25 Top Key Risks, (M5).**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 22.8.24. To receive an update on the top key risks for 2024/25.	**A** **A**	Read enclosures
25.	**24/25/195**	**14:25 (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

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26.	**24/25/196**	**14:30 (5 mins)**	**Governor Election Results.**	E. Saunders	To receive the outcome of the 2024 summer elections.	**N**	Read enclosure
Items for Information							
27.	**24/25/197**	**14:35 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
28.	**24/25/198**	**14:39 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 7th November 2024, 11:00am – 2:00pm, LT4, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in September 2024: • Sale of Number 2 Garden Cottage.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M5, 2024/25	R. Lea
Beyond: Programme Director's Update (Q1)	L. Crabtree

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 5th September 2024 at 9:00**

Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/140	Ms. N. Palin	Assoc. Director of Transformation	(NP)
Apologies:	Mr. G. Meehan	Non-Executive Director	(GM)

Patient Story

The Chair welcomed Lucas and his parents, who had been invited to September's Board to share Lucas' journey with Alder Hey following a diagnosis of a brain tumour in September 2023.

Lucas' dad provided a timeline of events that culminated in Lucas requiring emergency neurosurgery following a scan at Alder Hey last year. The Board was advised that the team caring for Lucas explained with great clarity exactly what was going to happen in terms of his treatment and after care, which helped the family enormously. The team realised how difficult the situation was and tried to offer Lucas' parents as much support and reassurance as possible.

Lucas' mum informed the Board that from the day of admission staff on 4A made the whole family feel welcome and listened to. Lucas and his family were at Alder Hey for a month to enable him to receive his therapies. It was pointed out that the transition from the ward back into the community was seamless and as a result of this and the amazing care that Lucas received, he is thriving. Lucas' parents offered their thanks and praised all those involved in Lucas' treatment and care.

The Chair thanked Lucas' parents for their kind words and assured them that their appreciation will be conveyed to the respective teams. On behalf of the Board, the Chair wished Lucas and his family well for the future.

24/25/134 Welcome and Apologies

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

24/25/135 Declarations of Interest

There were none to declare.

24/25/136 Minutes of the previous meeting held on Thursday the 4th of July 2024
Resolved:
The minutes from the meeting held on the 4.7.24 were agreed as an accurate record of the meeting.

24/25/137 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 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)* – There hasn't been an opportunity to address this action therefore the action is to remain open. **ACTION TO REMAIN OPEN**

24/25/138 Chair's and CEO's Update

On behalf of the Board, the Chair congratulated Louise Shepherd on her appointment as Regional Director for NHS England (North West Region) and wished her well in her new role when it commences.

The Chair advised that following the major incident in Southport on the 29.7.24 a national learning review took place which Alder Hey was very privileged to be part of. It was reported that the clinical care that Alder Hey provided to each patient following the incident was described as exemplary and this is testament to the teams. During the review colleagues acknowledged how well everybody had done in terms of their response to the major incident but further discussions took place about whether improvements could be made. Thanks were offered to all those involved in the response on the 29.7.24 and it was suggested that time should be set aside to bring staff together to acknowledge what was achieved.

Reference was made to the actions that were taken by the Trust to protect staff and CYP during the civil unrest that followed the incident, which had a huge impact for all concerned. The Chair informed the Board that both herself and the Managing Director, John Grinnell, visited the CAMHS team based in Southport to offer their support and to listen to staff.

The Chair reported that the REACH Staff Network celebrated its first birthday on the 30.8.24. Michelle Cox was invited to the event to share her story which made a real impression. It was pointed out that there is still a lot of work to do, but with the

new leadership in place the network will continue to help the Trust to make strides in this important area.

A visit took place to the Children's Forum by the Chair where members provided an overview of their activities during the summer period. The Chair offered thanks to the Director of Community and Mental Health Services, Lisa Cooper, and her team for supporting the Children's Forum.

Louise Shepherd also referred to the major incident that took place on the 29.7.24 and reiterated the Chair's comments. It was reported that the regional EPRR team visited the Trust and provided positive feedback which it is felt is testament to the excellent work that takes place on a daily basis in terms of how to respond to an emergency scenario.

The Prime Minister, Sir Keir Starmer, visited the Trust in the wake of the tragedy to thank staff in person on behalf of the nation. Alder Hey also received a visit from a senior team from NHSE.

Louise Shepherd provided an overview of the meeting that took place with the Chief Executive of NHSE, Amanda Pritchard, and her team to take stock following the change in Government. The Secretary of State for Health and Social Care, Wes Streeting, was in attendance at the meeting and a presentation was shared by Sally Warren on a piece of work that was led by Lord Darzi which will be published at the end of September 2024.

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

24/25/139 Cheshire and Merseyside Update

The Board was provided with an overview of the Trust's journey from a system perspective. It was pointed out that system interaction has been dominated by the financial position with partners being asked to reforecast to support C&M deliver a deficit plan. This has culminated in the scrutiny of each organisation to determine whether significant intervention is required to support organisations meet their financial plan. It was reported that Alder Hey is part of a group that is at risk of being asked to do more from a financial perspective than other groups. The Board was advised that a set of controls will emerge and attention was drawn to the importance of recognising that the Trust is a part of a system that is under pressure.

A presentation was submitted to the Board to provide a CYP system update. A number of slides were shared that provided information on the following areas:

- Liverpool's emergent strategic picture; including an update on Liverpool Strategic Partnership; the development of the new City Plan which is in draft but likely with a strong CYP theme, and associated partnership working led by the Liverpool City Council Director of Children's services with leadership support from Alder Hey and partners.
- One Liverpool Plan refresh is pending with CYP on the radar/response to LCC Public Health's 'State of Health in Liverpool 2040" report.
- Alder Hey/LUFT partnership working is under development (babies and neonatal+).
- Alder Hey/MFT partnership working also emergent.

Resolved:
The Board noted the Cheshire and Merseyside CYP system update.

24/25/140 Vision 2030 Strategy Deployment Update

The Board received an update on the position for year 2 of the Trust's journey to Vision 2030 for the period from April 2024 to August 2024. The following points were highlighted:

- Since April 2024 the 2030 Programme Board has met on a monthly basis and reports directly into FTPC. The programme board is proactive in terms of taking action to address identified areas of risk.
- *Improved outcomes (revolutionising care)* – it was reported that the implementation of the Neurology Transformation programme has commenced and priority themes have been agreed.
- *Experience (outstanding care and experience)* – The Trust's new starters' induction now includes a section on what it means to receive an Alder Hey warm welcome, as described by CYP. This is an example of a smaller deliverable change.
- *Experience (collaborating for CYP)* – The Wellbeing Hub has entered a soft launch phase, with a more extensive go live event planned that will involve volunteers and ward rounds.
- The Trust is balancing its in-year financial challenges but it has been acknowledged that changes will need to be made.
- It was reported that leadership building is providing a platform for long term change.

Reference was made to the review and update of BAF risk 3.2: Strategy Deployment and it was suggested that it might be beneficial to conduct a stock take of the Trust's strategic goals to look at what is/isn't working in order to adapt the organisation's plans.

It was reported that the scope of work has been expanded. A piece of reflection work is being undertaken with the Divisional leadership teams and the CYP Forum. The outcome of this work will used to shape the programme for 2025/26.

It was queried as to whether there are any areas where projects may have to be closed down. The Board was advised that this will be determined following a stock take.

Attention was drawn to the importance of retaining a sense of direction and having the clarity to do this. It was also felt that there is a need to focus on net zero to ensure the Trust is taking responsibility for this as it's not featuring as it should do.

It was agreed to discuss the outcome of the stock take and comments raised in greater detail during the next Strategy Board session.

24/25140.1 Action: KW/NP/JG

24/25/141 Evidence of Our Performance

Integrated Performance Report for M4, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 4. An update was provided on the following areas of the IPR:

Outstanding Care and Experience – Safe and Caring

- Metrics show an improvement in performance across the board.
- A Never Event occurred in July. This incident is under investigation in line with the PSIRF Framework and a learning review has taken place which received positive feedback from staff involved in the learning process. An update on the outcome of the learning review will be provided via SQAC in due course.

Revolutionising Care – Effective and Responsive

- ED performance achieved 88%, exceeding the national target of 78%.
- It was confirmed that the Paediatric Assessment Unit has been relocated. As a result of this there will be six fewer beds during the winter period therefore the Trust is looking to grow the Virtual Ward to compensate for this reduction.
- The number of patients waiting more than 52 weeks for an appointment is at 657 for July 2024 against a trajectory of 743. This is a decrease from the June 2024 position of 760.
- There has been an improvement in access to Dentistry. The organisation is focused on achieving zero 65 week waits by September 2024, with dental as the main areas of concern.
- *Activity Plan* – The Trust is currently at 123% against plan.
- Challenges;
  - The number of patients waiting two years for a follow-up appointment is a challenge and will require a systemic change to resolve the issue. A patient safety incident approach is to be undertaken and a programme has commenced to reduce overdue follow-ups. Validation is taking place and contact is being made with patients to confirm attendance for appointments.
  - The number of patients waiting for ASD/ADHD diagnosis continues to grow, and huge challenges are being experienced in terms of acquiring ADHD medication due to shortages.

Pioneering Breakthroughs

- A new bid coordinator has been appointed to oversee horizon scanning for external funding opportunities and capture of funding application data.
- An initial meeting has taken place with an organisation to explore a partnership to develop an Artificial Intelligence (AI) clinical coding tool.
- The commercial income forecast for research is ahead of plan.
- The Investment Zone case is underway for £4m funding over a 5-year period. There is a planned submission date of September 2024 and a final decision will be made in November, with a start date of April 2025.

Support our People

- Mandatory training completion remains over 90%.
- There is to be a focus on PDRs as completion has remained below 90%. It was confirmed that compliance is being reported regularly to managers for action purposes.
- The turnover percentage has remained at or below the new target of 10%.
- Total workforce for the end of July 2024 was 5.9 wte below plan.

It was reported that the ICB has asked the Trust to submit its wte plans. The Trust has actioned this request and also submitted its Workforce Plan in addition. The Trust has made a commitment to reduce its workforce by 25 wte via the use of tighter controls. A meeting is to take place to discuss this matter further.

Collaborate for CYP

- Work is being undertaken to measure targets and show how the Trust is achieving them.
- Social Value (SV) is now being captured across two key domains of the National SV Framework. It was felt that this is a good opportunity to share details with others across the Trust to develop an organisational approach to capturing social value.

Fiona Beveridge drew attention to the importance of developing a methodology for capturing SV and suggested a number of areas that the Trust could focus on to increase activity.

Financial Sustainability: Well Led

- In July (M4) the Trust is reporting a position of £0.4m away from plan as a result of industrial action. The Trust is awaiting information about the funding for industrial action but have advised that the organisation is unable to mitigate this risk.
- The Trust has highlighted two risks that may affect the organisation in terms of meeting its financial plan. This issue has been raised with the national team and flagged in the Trust's submission
- Work is ongoing to deliver full savings of £19.9m and significant progress has been made to date resulting in £8m of savings recurrently posted in M4.

Community and Mental Health Division

- *Eating Disorders Service* – There is an improvement plan in place for the service but not all improvements have been embedded to date. Work is ongoing.
- *Speech and Language Therapy (SALT)* – It was reported that the ICB has made a commitment to provide funding for the SALT service.
- *ADHD Medication Shortage;*
    - The Trust has received correspondence advising that the shortage of ADHD medication could continue until October 2024.
    - Parent Carer Forums have been making families aware that this is a national issue rather than a local one.
- *ASD/ADHD Diagnostic Pathway;*
    - A transformation programme has been established and is starting to progress, but it was pointed out that the amount of referrals being received by the service is increasing.
    - The Trust has been approached by Knowsley to provide its ASD service. It was confirmed that a report regarding this matter will be submitted to the Board in due course.

The Chair referred to the shortages of ADHD medication and raised concerns about the effect that this national issue is having on CYP, families and staff. It was queried as to whether this risk could be raised at Government level in addition to national level. It was agreed to give this suggestion some thought.

24/25/141.1 Action: LS/LC

Division of Medicine

- The Division has received two clinical awards.
- National benchmarking has been finalised.
- The third MRI scanner has arrived on site at Alder Hey.
- ED performance was at 92% for August 2024 against a national target of 77%.

- *Neurology* – A transformation programme has been established but it was reported that the Neurology On Call Service remains a challenge. Work is ongoing to address the situation.
- *Urology* – It was reported that the service has been reduced to one consultant due to a member of staff leaving for a job overseas.

Division of Surgery

- The Division achieved 130% for OPNEW and OPROC recovery.
- *Forward Look;*
  - ➢ The Division has signed up to a national programme to improve data and scheduling.
  - ➢ Time is to be set aside to discuss the best use of the Elective Hub £5m reward.
  - ➢ Development to grow the organisation's theatre capacity.

Attention was drawn to the achievement of 130% for OPNEW and OPROC recovery. It was felt that this is an extraordinary achievement and should be celebrated. It was also pointed out that time should be set aside to look at how it has been achieved and whether it is sustainable going forward. A discussion took place about the ways in which this positive story can be presented whilst highlighting the challenges, increase in volume and spike in demand, etc. that the Trust is experiencing.

Digital, Data and Information Technology Update

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

- There is a review underway that is linked to the Spending Review following the recent change in Government. It is unclear at the present time what the digital opportunities will be but it was pointed out that there will be a focus on productivity. The outcome of the review will be announced in the next few months. It was reported that the Chief Digital and Transformation Officer has had a conversation with the national team about the broader opportunities for CYP.
- *Digital Maturity Assessment* – The Trust has submitted its Digital Maturity Assessment and is in the process of reviewing the realignment of its digital work.
- It was reported that the Trust is due a refresh on some of its infrastructure in 2025/26.

The Chair asked as to whether the Trust will be ready to move forward with its plans if the outcome of the Spending Review is favourable. It was reported that the funding is to support transformation but the Trust has got pressures relating to hardware. The Board was advised that an update on capital will be provided during October's meeting.

Resolved:
The Board:
- Noted the content of the IPR for Month 4.
- Noted the Digital, Data and Information Technology update.

24/25/142 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. The following points were highlighted:

- *Springfield Park* – The main areas including the play areas are complete. The final levelling and drainage works around the Alder Centre and swale will be complete mid-September 2024.
- *Gender Development Service* – The building was handed over to the Trust on the 14.8.24. Staff have occupied the new facilities from the 19.8.24 and patients seen on the new premises from the 22.8.24.
- *Beech House (Police Station refurbishment)* – This building was handed over to the Trust and occupation commenced as planned on the 25.7.24. It was confirmed that all moves are complete.
- *Neonatal and Urgent Care Centre* – Progress is being made with the construction of this building and risks are being managed.
- *Catkin and Sunflower House Building* – Letters are being exchanged to try and address the contract claim relating to Sunflower House.
- *Going forward* – It was reported that the Trust has aspirations for a Health and Wellbeing Centre on the Campus site. More thought is to be given to this idea.

Reference was made to the solution for the sprinkler system in the Under-Croft car park and it was queried as to whether a paper could be submitted to the Board to provide background detail on this issue and an update on the current position. It was agreed to submit a report to the Board during October's meeting.

24/25/142.1 Action: DP

Attention was drawn to the risk relating to the Neonatal Unit and Urgent Care Centre in terms of affordability. It was queried as to whether the increase in costs have been included in the organisation's budget for the construction. It was reported that the Trust does have an allocation but is in the process of negotiating its annual revenue, which is ongoing at the present time.

A discussion took place about the Trust's ambitions for a Health and Wellbeing Centre and concerns were raised about the possible impact this could have on the Trust's Capital plan. The Board was advised that the aspiration is to have a strategy to support the self-funding of this project without drawing on the Trust's funds. It was felt that this project will link in with the social value work and the Trust's emerging Vision 2030 Strategy. A suggestion was made about setting time aside for a collective discussion on a partnership strategy for the Campus.

The Chair drew attention to the excessive amounts of litter in the play area in Springfield Park and queried as to whether something could be done collectively to keep the park litter free. It was pointed out that there are charities who arrange for groups of people to go out into the community to litter pick. The Chair agreed to discuss this matter with the CEO of the Trust's Charity, Fiona Ashcroft.

24/25/142.2 Action: DJW

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

24/25/143 Southport Incident Response

The Board was provided with an overview of the initial response to the Southport Major incident, the ongoing care and support of families and the support of staff immediately after the incident and through the subsequent civil unrest.

On the 29th of July 2024 the Trust was called as a category 1 responder to look after eleven children and their families following a major incident in Southport. It was reported that all children affected by the incident who were discharged by the evening of the 5th of August will receive ongoing care as indicated by their clinical case. The families of the three children who died as a result of their injuries are being supported by the Snowdrop team for initial bereavement care. The families are aware of the longer term offer from the Alder Centre and are able to transition to that service at the right time for them.

Alder Hey, working with colleagues from Mersey Care and other parts of the system, will provide wrap around support for all of the families involved including those children who were present at the incident but did not require medical treatment.

Staff involved in providing care to these families have been supported via SALS and clinical health psychology services. Debriefs were also undertaken with all teams involved in the response.

A technical tactical debrief was held on the 9th of August which was facilitated with partners in Cheshire. The event recognised a range of good practice and learning which will help facilitate and improve any future response to a major incident of this nature. This will be collated and reported via EPG and SQAC following the usual governance process. The outcome of the debrief highlighted the need for future funding for resources in the Emergency Preparedness Resilience and Response team (EPRR).

Resolved:
The Board:

- Noted the contents of the report
- Recognised the robust response provided by teams across Alder Hey.
- Noted the intent for future funding request for relevant resources to EPRR.

24/25/144 Brilliant Basics Update

The Board was provided with an update on the progress of the Brilliant Basics (BB) Delivery Plan 2024/25 and the Trust's involvement in Cheshire and Merseyside Improvement Network. The following points were highlighted:

- Progress has been made against three of the four objectives with a clear plan for focus on the fourth objective in Q3/Q4 of 2024/25.
- Alder Hey has demonstrated the progress and impact of the implementation of the BB Improvement System to the Associate Medical Director for Cheshire and Merseyside (C&M) and the Deputy Director for System Improvement for NHS England (NHSE) during a recent visit to Alder Hey. It was agreed that the Trust will support C&M to develop their internal capacity and capability for continuous improvement.

Resolved:
The Board noted the Brilliant Basics update.

24/25/145 Compliments, Complaints and PALS Report, Q1

The Board received the new format of the Compliments, Complaints and PALS report for Q1, 2024/25. The following points were highlighted:

- SQAC received the document in its new format during August's Committee meeting.
- *Complaints;*
  - In Q1 the Trust received 43 new complaints. The main reason continues to be treatment and procedure accounting for more than half of complaints received.
  - 85% of formal complaints were responded to within 25 working days however there is significant room for improvement to ensure families receive a response in a timely manner.
- *PALS;*
  - In Q1 the Trust received 532 PALS concerns. The main themes continue to be access to appointments and communication.
  - Average compliance is at 91% in terms of the improvement in compliance with the 5 working day response.
  - The Divisions of Medicine and Surgery both achieved excellent compliance of 99%; Community and Mental Health achieved an improved compliance of 79% compliance.
  - Corporate services achieved 56% compliance indicating a lack of oversight. It was confirmed that there is to be a focus on turnaround for Corporate services.
- It was reported that the Divisions are capturing actions and sharing learning at the Patient Experience and Engagement Group. It was felt that there is a need to focus on how learning is captured and shared across the organisation.

It was pointed out that Complaints/PALS is an area that's under scrutiny via SQAC and it was queried as to whether the Board should take time to reflect upon the underlying issues and the complaints that are upheld. It was reported that SQAC has started to focus on key themes and there is a consistency in themes with the main one being communication. It was felt that there is an opportunity to refresh the complaints report from a learning perspective and linking in with other areas, for example, the equality agenda, etc.

The Chair commented that a lot of progress has been made and thanked those involved in compiling the new report.

Resolved:
The Board noted the content of the Compliments, Complaints and PALS report, Q1

24/25/146 DIPC Report, Q1

The Board was provided with oversight of Infection Prevention Control (IPC) activity and reporting for Q1, 2024/25. The following points were highlighted:

- Following a visit by NHSE & EPRR leads on the 29.07.24 Alder Hey has now become an accredited airborne High Consequences Infection Disease (HCID) Centre. It was reported that a simulation is planned for the 2.09.24
- During Q1, 6 patients had healthcare-associated Gram-negative blood stream infections. All of these patients had central vascular catheters in place when they developed bacteraemia so the workplan to reduce Central Line Related Line Infections across the Trust has continued during Q1.
- Since January 2024, UKHSA has alerted of a sharp increase in *C. difficile* cases across the UK, for which there is not a clear explanation. The North West is the third area worst affected. As a response to this increase, the Trust has recently updated its *C. difficile* policy and is working closely with the NHSE Efficiency at Scale IPC Collaboration Group.

- Two new IPC practitioners have successfully been recruited into the IPC team, which will allow the Trust to continue transforming the IPC department into a highly effective data driven program.
- Funding of ICNet has been secured with ongoing plans for implementation under the Digital team.

A discussion took place about the challenges experienced in relation to hand hygiene across the Trust. It was reported that work is ongoing to look at innovative and automatic methods of monitoring hand hygiene compliance to effectively promote behavioural change through auditing results.

The Board was advised that the forum and the Trust's CYP would be interested in supporting the organisation on this issue. It was agreed to liaise with the forum regarding this matter.

24/25/146.1 Action: LC

Resolved:
The Board noted the content of the Infection Prevention and Control report for Q1, 2024/25.

24/25/147 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 19.6.24 were submitted to the Board for information and assurance purposes.

Resolved:
The Board noted the approved minutes from the meeting held on the 19.6.24.

24/25/148 People Plan Highlight Report

The Board was provided with a high level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during July and August 20204.

It was reported that a pay offer has been made by the Government to the BMA on junior doctor pay in England. A referendum on whether to accept the offer is open from the 19.8.24 until the 15.9.24. An update on the outcome will be included in October's report.

Reference was made to the update in the report relating to the Agenda for Change pay award which the Government has recently confirmed and it was queried as to whether the Trust will receive funding to cover the cost of this. It was reported that the organisation will calculate the cost of the pay award and highlight any shortfalls if necessary.

The Chief People Officer, Melissa Swindell, drew attention to the collective response that was provided to the organisation's workforce following the major incident in Southport on the 29.7.24. The Board was informed that staff felt that the Trust responded in a very timely manner. Separate discussions were also held with the REACH Network where ideas and lived experiences were shared. Thanks were offered to the new Chair of the REACH Network, Audrey Chindiya, and Associate Chief Operating Officer, Asia Bibi, for their input into the organisational response.

Workforce Equality, Diversity and Inclusion Update

The Board was provided with a high-level overview of the key strategic and operational issues impacting the organisation in relation to Equality, Diversity, and Inclusion (ED&I) during July/August 2024. The following points were highlighted:

- The REACH staff network held a celebration event on the 30.8.24 to mark the 1-year anniversary of the staff network. The celebration event reflected on the progress made over the year and the plans for the future. Non-Executive Director, Garth Dallas, advised the Board that the event was excellent and was well represented by the Trust's Executive Directors.

  Michelle Cox who has 30 years' experience in the NHS, and 26 years as a registered nurse, joined the event. As a black nurse she has shone a light on issues affecting not just black communities and ethnic minorities, in her hometown of Liverpool, but has led on several national programs to elevate understanding around Equality Diversity and Inclusion ensuring that challenges are addressed, and learning embedded throughout NHS organisations. The next step is for Michelle Cox to have discussions with the Trust's Divisional Managers.

- The new EDI training has now been launched on the ESR system along with the Introduction to Equality, Diversity and Inclusion Course for Leaders and Managers.

It was felt that the Trust is making positive steps in terms of EDI and it is imperative that the Board continues to support this work to ensure ongoing progress. It was queried as to whether a collective agreement could be made to agree on two to three tangible markers that the organisation could challenge itself on. It was reported that the EDI action plan is to be submitted to the Board to provide an update on the six markers included in the plan.

The Director of Community and Mental Health services, Lisa Cooper, queried as to whether the EDI training is mandatory and if not offered to pilot the training modules within the Community and Mental Health Division. It was confirmed that the Trust is not at a point where it can make this training mandatory but it is available for staff to book a place on the available sessions.

A discussion took place about equal opportunity and fairness and it was queried as to whether any of the Trust's international nurses have gained a promotion. It was reported that two have but it was felt that this is not enough and further work is required to address this matter. The Chair agreed to have a discussion on the issues around promotion with the Chair of the People Committee, Jo Revill.

24/25/148.1 Action: DJW/JR

The Board was advised that EDI communications across the Trust are improving, and it was reported that the Chair of the LGBTQIA+ staff network, Alex Bowman, has been nominated for a Star Award.

The Chair drew the agenda item to a close and thanked the Head of Equality, Diversity, and Inclusion, Angie Ditchfield, for compiling the report.

Resolved:

The Board:

- Received and noted the People Plan Highlight Report for July/August 2024.
- Received and noted the Workforce Equality, Diversity and Inclusion update.

24/25/149 Wellbeing Guardian Dashboard

The Board was provided with an update by the Wellbeing Guardian on the current progress of the Wellbeing Guardian Nine Principles with the action plan, as detailed in the report.

It was reported that the Board is moving into Phase 3: ‘Health and wellbeing is routinely considered and included in Board activity’. The Board was advised that this area of work has progressed and tribute was paid to those who have supported this progress.

Discussions are to take place with organisational development staff to look at equipping managers to deal with low level problems that can escalate.

Reference was made to Principle 5 in the action plan that is rag rated amber and relates to ‘death by suicide of any member of our NHS people or a learner working in an NHS organisation’. It was reported that the Trust has reviewed the national toolkit and it has been agreed that in the event of a suicide a discussion would take place with the respective team and the national toolkit would be rolled out in order to have a focussed approach.

It was queried as to whether the organisation is able to track trends to gauge outcomes and measure the impact of implemented actions. It was confirmed that the Chair of the People Committee is going to look into this matter to see how it can be done. A suggestion was made about integrating Freedom to Speak Up with this work as having the ability to speak up is fundamental to feeling safe in the workplace. It was agreed to action this for the next iteration of the report.

24/25/149.1 Action: JR

Resolved:
The Board noted the Wellbeing Guardian’s update.

24/25/150 People Committee

The approved minutes from the meeting held on the 15.5.24 were submitted to the Board for information and assurance purposes

During July’s meeting the Committee discussed the People Plan, divisional metrics and received reports from the Communications team and the REACH Network.

Resolved:
The Board noted the approved minutes from the meeting held on the 15.5.24.

24/25/151 Re-appointment of Trust Chair and Well Led Assessment.

The Board was advised that Dame Jo Williams has formally confirmed her intention to seek re-appointment as Chair of the Trust for a final twelve-month period, to February 2026. It was pointed out that the ICB is looking closely at the terms of office of Chairs and Non-Executive Directors beyond the designated term, therefore the Chair of the ICB requested that a piece of assurance work be undertaken on the well led aspect of Alder Hey with particular reference to Non-Executive Directors’ activities. It was noted that whilst the re-appointment of the Chair was a matter for the Council of Governors, the chair of the ICB had requested that the report also be submitted to the Board.

It was noted that from the evidence included in the report and Alder Hey's overall performance both in terms of financial stewardship and quality governance, it is clear that under Dame Jo's leadership the Board demonstrates cohesive, unified and values-driven management and understands that successful leadership is not just about what we an organisation deliver, but how it is delivered.

The report will now be submitted to the Council of Governors at its meeting later in the month.

Resolved:
The Board noted the evidence and position against the Well-Led Framework and the Chair's Appraisal documentation in support of Dame Jo Williams' reappointment.

24/25/152 Audit and Risk Committee

The Board received the Chair's Highlight report for the meeting that took place on the 11.7.24. During July's meeting the Committee focussed mainly on the report relating to the Risk Appetite and Tolerances proposal.

Resolved:
The Board noted the Chair's Highlight report relating to the Audit and Risk Committee meeting that took place on the 11.7.24.

24/25/153 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 24.6.24 and the 29.7.24 were submitted to the Board for information and assurance purposes.

During August's meeting there was a focus on the progress of CYP year on year from a comparison perspective, and a discussion took place on the PWC assessment along with workflow figures. It was felt that there is a break in connection on some of the workflow figures. If this is the case it will be necessary to look at how this issue connects to vacancies/staff bank in order to understand the organisation's workforce figures ahead of having to report into the ICB.

Kerry Byrne reported that MIAA will be undertaking an audit on workforce planning in 2024/25 which should provide assurance on this area of work.

Resolved:
The Board noted the approved minutes from the meeting held on the 24.6.24 and the 29.7.24.

2024/25 Top Key Risks
Resolved:
The Board received and noted the latest position of the 2024/25 top key risks

24/25/154 Risk Appetite and Tolerances Proposal.

The Board was provided with an updated position with regard to the work undertaken in the last 12 months with the Trust's Assurance Committees to further develop the concept of risk appetite and to determine associated risk tolerances within each aspect of the Trust's business. If consensus can be reached, the aim will be to deploy agreed risk tolerances in active risk management decisions, initially on a pilot basis in one or more of the clinical divisions.

During the course of the autumn term conversations on the initial appetite detail will take place and an update on the outcome of discussions will be provided to the Board in due course.

The Board was provided with an overview of the proposed Risk Appetite Statement for Board, as detailed in the report. It was pointed out that the ADHD medication risk is a national issue therefore a discussion will have to take place about the organisation's tolerances in relation to this risk.

Non-Executive Director, Kerry Byrne, advised that it has been difficult in achieving a consensus on risk appetite and tolerance so to reach this stage is testament to the management of this work by Erica Saunders and Jill Preece. Pragmatic feedback was received from the assurance committees following an exercise that was undertaken to re-profile the Trust's current risks against the eleven risk categories linked to appetite, and the Trust is now in a position where it has an updated Board risk appetite statement. A review of risk appetite will take place on an annual basis or if there are any issues.

The Chair pointed out that the work undertaken to reach this position has been fundamental in the way the organisation operates. Alder Hey is clear in terms of risks that are unacceptable to the Trust around quality and safety. Where the Trust has made decisions that have brought some risk, for example, Vision 2030, the Gender service, and the new Neonatal Unit, the organisation has guidance in the form of a framework to enable it to think about the decisions being made. There is a process in place to enable the Board to have discussions in a healthy way and it was felt that the work that has taken place on risk appetite and tolerances will underpin the Trust's decision making process. The Chair offered thanks for the good work demonstrated in the report.

The Managing Director, John Grinnell, pointed out that Vision 2030 is challenging the Trust to be radical and therefore the decision making processes can't take place in insolation. It is imperative to review the Trust's risk appetite continuously and undertake a forward look to determine any foreseeable challenges. It was felt that if the Trust is too cautious in its decision making it may cause conflict with rapid transformation.

Resolved:
The Board approved the risk appetite statement as detailed in the table and noted the next steps in terms of practical application, taking into account John Grinnell's comments.

24/25/155 Board Assurance Framework Report (BAF)

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

- It was reported that the Assurance Committees didn't meet in August but the updating/reporting process of the BAF continued throughout the summer period.

Kerry Byrne felt that a lot of work had been undertaken to update the risks and actions relating to the workforce and system working. Attention was drawn to the EDI risk and it was queried as to whether this could be reviewed as there aren't any gaps or actions for this risk included in the BAF. It was agreed to look into this matter.

24/25/22.1 Action: MS

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

24/25/156 Emergency Preparedness, Resilience and Response (EPRR)

The Board received the Emergency Preparedness, Resilience and Response Annual Report for 2024. The following points were highlighted:

- This year the Trust has reported its self-assessment against the Core Standards as non-compliant, with a compliance standard of 51% submitted to the ICB. This exceeds the projected expectations of 40% compliance following the 2023 submission at 8%. Although the core standards submission remains non-compliant, the Trust has exceeded its projected level of compliance against the Core Standards Workplan.
- The report has been submitted to the Emergency Preparedness Group (EPG) and all relevant committees for endorsement.
- It was reported that ICB colleagues have created an Accountability Emergency Officer (AEO) training package that can be delivered locally by the Trust's EPRR manager to the organisation's AEO and Deputy AEO. It was confirmed that the Trust's AEO has completed this training.
- It was reported that the past year has presented the Trust with continued opportunities for development. The Trust has also undertaken significant change with the approach to EPRR and Business Continuity that have impacted its overall compliance reporting levels. Whilst the report highlights the Trust's progress it is essential to acknowledge there are areas that require further and sustained development.

The Non-Executive lead for EPRR, Kerry Byrne, pointed out that the team who co-ordinate EPRR is a small one and are in need of support from the Divisions and Corporate services. The team continues to plough through the increased requirements and it was felt that to achieve 51% compliance is testament to the work of the team. Thanks were offered to the EPRR manager, Jacob Gray and his team for keeping the Trust safe and driving compliance forward.

Resolved:
The Board:

- Noted the annual EPRR Assurance Report and self-assessment assurance rating of non-compliance in line with the NHS England EPRR Core Standards for 2024.
- Noted and endorsed the Trust's Business Continuity Management Strategy.
- Noted and endorsed with the Trust's EPRR Policy.

24/25/157 Any Other Business

There was none to discuss.

24/25/158 Review of the Meeting

The Chair drew the meeting to a close and thanked everyone for their contributions throughout the meeting. The Chair drew attention to the content of the reports that had been discussed during the meeting and felt that the data demonstrates how much the Trust has achieved in the last two months.

Date and Time of Next Meeting: Thursday 3.10.24 at 9:00am, LT2, Institute in the Park.

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for October 2024							
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	Oct-24	**4.6.24** - This action is in progress. An update will be provided in July. **3.7.24** - The Medical Director is awaiting an update on this matter therefore and update will be provided to the Board in September. **22.8.24** - The Medical Director is awaiting an update on this matter therefore and update will be provided to the Board in October. **ACTION TO REMAIN OPEN**
5.9.24	24/25/142.2	Alder Hey in the Park Campus Development Update	Liaise with Fiona Ashcroft to gain information on charities who arrange for groups of people to go out into the community to litter pick.	Dame Jo Williams	3.10.24	On track Oct-24	
Actions for November 2024							
2.5.24	24/25/51.1	FTSU Update	In order to show the meaning of culture from an FTSU perspective, it was agreed to include more detail in the FTSU report to provide anonymised examples of culture once the Trust has agreed its definition of culture.	K. Turner	5.9.24	Nov-24	**22.8.24** - This action cannot be completed until the Trust has agreed its definition of culture. **ACTION TO REMAIN OPEN**
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	Nov-24	**5.6.24 -** This action is being progressed. An update will be provided during September's meeting. **5.9.24** - There hasn't been an opportunity to address this action therefore the action is to remain open. **ACTION TO REMAIN OPEN**
4.7.24	24/25/111.1	LUFT)/LWH/Alder Hey – Partnership Update	Liaise with LUFT/LWH to organise a Board to Board meeting in September 2024.	E. Saunders/ K. Mckeown	4.7.24	Nov-24	**22.8.24** - Following discussion with LUFT/LWH it has been agreed to arrange for this meeting to take place at a later date. **27.9.24** - An initial meeting is taking place between Erica Saunders and Daniel Scheffer ahead of arranging a Board to Board meeting. **ACTION TO REMAIN OPEN**
5.9.24	24/25/140.1	Vision 2030 Strategy Deployment Update	Agenda item to be included on November's Strategy Board to discuss the outcome of the stock take exercise of the Trust's strategic goals to look at what is/isn't working in order to adapt the organisation's plans.	K. Warriner	7.11.24	On track Nov-24	
5.9.24	24/25/142.1	Alder Hey in the Park Campus Development Update	Provide an update on the resolution for the sprinkler system in the Under-Croft car park.	D. Powell	3.10.24	Nov-24	27.9.24 - This item will be included on November's Board agenda.
5.9.24	24/25/148.1	Workforce Equality, Diversity and Inclusion Update	Discuss the issues relating to promotion across the Trust from an equal opportunity and fairness perspective.	Dame Jo Williams/ J. Revill	7.11.24	On track Nov-24	
Actions for December 2024							
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	Oct-24	**27.8.24** - A request has been made for this item to be included on September's RMF agenda. **27.9.24 -** A request has been made for this item to be included on December's RMF agenda. **ACTION TO REMAIN OPEN**

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 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	
Actions for September 2025							
5.9.24	24/25/149.1	Wellbeing Guardian Dashboard	Integrate Freedom To Speak Up in the next iteration of the Wellbeing Guardian Report.	J. Revill	Sep-25	On track Sep-25	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
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 IFRS 16 impact.	R. Lea	5.9.24	Closed	**25.9.24** - This was covered via a report that was submitted to the Board in P2 during September's meeting. **ACTION CLOSED**
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	Closed	**25.9.24** - This was covered via a report that was submitted to the Board in P2 during September's meeting. **ACTION CLOSED**
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	Closed	**27.8.24** - An update will be provided in October as this matter is not fully solved. **27.9.24** - Progress has been made and the Trust is now submitting an expanded data set. There is still further work to do on improving data quality and meeting some of the complex criteria. **ACTION CLOSED**
4.7.24	24/25/112.2	Integrated Performance Report (M2) - Financial Stability: Well Led	*NHSE Scrutiny of C&M* - Provide an update on the outcome of the exercise that took place at the Finance, Transformation and Performance Committee meeting to determine whether the Trust will stand up to scrutiny or whether mitigations are required to keep the organisation safe.	R. Lea	5.9.24	Closed	**25.9.24** - This was covered via a report that was submitted to the Board in P2 during September's meeting. **ACTION CLOSED**
4.7.24	24/25/124.1	Board Assurance Framework	A further review of the system and financial environment risk be undertaken.	E. Saunders/ R. Lea	3.10.24	Closed	**1.10.24** - This action has been addressed. **ACTION CLOSED**
5.9.24	24/25/141.1	Integrated Performance Report - (Community and Mental Health Division)	Discuss the possibility of raising awareness of the shortage of ADHD medication, at Government level.	L. Cooper/ L. Shepherd	3.10.24	Closed	**1.10.24** - The issue relating to the shortage of ADHD medication has been raised nationally, with the Children’s Commissioner and NHS England. **ACTION CLOSED**
5.9.24	24/25/146.1	DIPC Report, Q1	*Hand Hygiene* - Liaise with the Children's Forum to see if they would like to support the Trust on the issue of hand hygiene.	L. Cooper	3.10.24	Closed	**1.10.24** - DIPC linked to Alder Hey Youth Forum to discuss a hand hygiene campaign. **ACTION CLOSED**
5.9.24	24/25/155.1	Board Assurance Framework	Review the EDI risk to ensure narrative on gaps and actions are included in the BAF for this risk.	M. Swindell	3.10.24	Closed	**1.10.24** - This action has been addressed. **ACTION CLOSED**

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	CMAST Joint Working Agreement and Committee in Common refresh
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	CMAST leadership team

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	To secure Trust endorsement to update the CMAST governance arrangements following a review requested by the CMAST Leadership Board and signed off by the Board (Trust CEOs and Chairs) on 6th September.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
Resource Implications:	N/A - Collaboration is expected to be more efficient and should result in a more pragmatic response to any financial challenges within C&M

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF 3.5	System working to deliver 2030 Strategy					16
Level of assurance (as defined against the risk in InPhase)	☑	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board of Directors

CMAST Joint Working Agreement and Committee in Common refresh

1. Purpose

The purpose of this paper is to secure Trust endorsement to update Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common terms of reference following a review requested by the CMAST Leadership Board and signed off by the Board (Trust CEOs and Chairs) on 6th September.

The Leadership Board recommends for adoption by Trust Boards the updated documentation following a scheduled periodic review (after two years of operation).

2. Executive Summary

Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. This is achieved via our provider collaboration: CMAST.

CMAST has worked together for a period of time and had its ways of working codified and set out including arrangements for shared decision making, when and as required, through a Joint Working Agreement and Committees in Common terms of reference since late summer 2022.

Given the existence of these agreements for a two-year period and a commitment to review following an initial period of operation, a review on or around the two-year anniversary has been progressed and taken forward by the relevant Trust Company Secretaries or equivalent.

3. Proposed changes

Few significant changes have been implemented within the documents but a period of shared review, reflection and questioning has taken place in an appropriately collaborative manner. The areas of both discussion and proposed changes are detailed below, as relevant to each of the two key documents:

Joint Working Agreement (JWA), further detail, and to be read in conjunction with CiC ToR:

- 2.1 – updated vision to align with streamlined vision per CMAST Annual Plan 2024/5
- 2.3 – framed CMAST priorities as *Clinical Improvement and Transformation and Sustainability and Value* per CMAST Annual Plan 2024/5 which in being targeted will enable the achievement of the existing priorities (still referenced)
- Section 3.6.7 made reference to 104 week waiters which was a policy priority in 2022. This text has been updated to reflect the long waiters and is therefore less beholden to developments and/or policy updates.
- Section 4.4 refers to a rotation of Meeting Lead (or CMAST Chair). This has been updated to state that the first review will take place by no later than 2025 and will take place periodically at the will of the membership.
- 8.10 referred to an expectation an information sharing agreement would be developed and/or required. To date the Leadership Board has not identified this requirement, preferring to rely on

established ICB / ICS practices and arrangements. The reference has been updated to state arrangements will be developed when and if the Leadership Board judges that they are required.

Suggestions noted but resulting in no proposed amendment to JWA:

- Reference to city or sub system workstreams – logic for determination is that the Provider Collaborative has been designed, built and operated, to date, sitting above individual and sub groupings of actions and to complement not compete
- Greater reference to the financial challenges the NHS is facing – logic for determination is that the Triple Aim of the NHS is referenced which includes a need for value for money and therefore efficiency. In an ideal world scoping and terms of reference documents should be framed in a way that supports adaptation and interaction without always requiring changes or updates
- Reference the range and scope of professional groups that exist within CMAST – logic for determination is that reference to professional groups is made without need to be beholden to future change or amendments.

Committee in Common - Terms of Reference (CiC ToR), further detail, and to be read in conjunction with JWA:

Suggestions noted but resulting in no proposed amendment to ToR:

- Reference to shared posts and need for clarification of voting – logic for determination is that the detailed CMAST committee in common arrangements (not joint committee) support single vote committees to operate on behalf of each Trust, meeting in common, therefore no changes to voting is required as this is linked to the relevant Trusts.
- Section 6 sets reporting expectations. It has been questioned whether these remain valid. It is suggested that when, and if, CMAST CICs take on delegations that the level or reporting described remains applicable.

Consistent factual updates

- Updating references to Mersey and West Lancashire Teaching Hospitals NHS Trust (from Southport and Ormskirk and St Helens and Knowsley)
- Updated references to be active e.g ICB delivery rather than time bound references to ICB establishment.

4. Conclusion

It is proposed that the documentation captures and appropriately reflects the outputs and culmination of a period of engagement and development with Trust leads nominated by the CMAST Leadership Board and endorses the continued operation, use and application of CMAST mechanisms as may be appropriate.

The documentation delivers stability, reflects feedback and provides an updated position for the operations covered by the scope of the documents which necessarily focus on approach and governance. Business and content will continue to iterate and be defined by Boards as the scope and remit of CMAST develops and the ask of the system, for it, expands, varies or diminishes.

5. Recommendation

To endorse and approve the updated CMAST Joint Working Agreement and Committee in Common terms of reference as set out.

Erica Saunders
October 2024

HILL DICKINSON

Draft No: 1
Date of Draft: September 2024

Dated 2024

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(2) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(3) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(4) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(5) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(6) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(7) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(8) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(9) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(10) **EAST CHESHIRE NHS TRUST**

(11) **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

(12) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

and

(13) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

DRAFT

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1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, , Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey

	Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

Key functions

2.2 The key functions of CMAST are to:

2.2.1 Deliver the CMAST vision;

2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.2.3 Align priorities across the member Trusts,

2.2.4 Support delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.2.5 Direct operational resources across Trust members to improve service provision;

2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.3 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

2.3.3 Reduce health inequalities;

2.3.4 Improve access to services and health outcomes;

2.3.5 Stabilise fragile services;

2.3.6 Improve pathways;

2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

2.3.8 Achieve financial sustainability.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

2.5 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development:

2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.5.2 Cancer Alliance delivery and enablement – subject to requests of the Alliance;

2.5.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.5.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.5.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.5.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

2.5.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

2.5.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards

or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2025.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution**)** in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will seek to ensure that each CMAST programme has the opportunity for a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or

succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMAST Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMAST Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or

technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMAST across the Trusts as envisaged if and when required.. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;

- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and

- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression "counterpart" shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

………………………………………………………
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

………………………………………………………
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

………………………………………………………
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

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For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

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For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

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For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

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For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

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For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

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For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……………………………………………………
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……………………………………………………
For and on behalf of **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……………………………………………………
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

…………………………………………………………
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 3– TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 5 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 12 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 14 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 15 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

V 1-refresh September 2024

CMAST LEADERSHIP BOARD TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative or CMAST	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMAST Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the **[TRUST]** CiC together with the other CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly;
CMAST Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMAST Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMAST;
CMAST Programme Support	Administrative infrastructure supporting CMAST;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of an CMAST CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
[TRUST] CiC	the committee established by **[TRUST]** NHS Foundation Trust, pursuant to these Terms of

	Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
[TRUST] NHS Foundation Trust	[TRUST] NHS Foundation Trust of [Address];
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The [Trust] NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on **[DATE]** and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 Aims and Objectives of the [TRUST] CiC

2.1 The aims and objectives of the [Trust] CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the [Trust] CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The **[TRUST]** NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the **[TRUST]** CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the **[TRUST]** CiC.

3.2 The **[TRUST]** CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The **[TRUST]** CiC is a committee of **[TRUST]** NHS Foundation Trust's board of directors and therefore can only make decisions binding **[TRUST]** NHS Foundation Trust. None of the Trusts other than **[TRUST]** NHS Foundation Trust can be bound by a decision taken by **[TRUST]** CiC.

3.4 The **[TRUST]** CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The **[TRUST]** CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in **[TRUST]** NHS Foundation Trust's Constitution.

4.2 **[TRUST]** CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the **[TRUST]** CiC in paragraph 4 of these Terms of Reference shall be retained by **[TRUST]** NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of **[TRUST]** NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the **[TRUST]** CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to **[TRUST]** NHS Foundation Trust's Board for inclusion on the private agenda of **[TRUST]** NHS Foundation Trust's next Board meeting in order that **[TRUST]** NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The **[TRUST]** CiC shall send the minutes of **[TRUST]** CiC meetings to **[TRUST]** NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

6.3 **[TRUST]** CiC shall provide such reports and communications briefings as requested by **[TRUST]** NHS Foundation Trust's Board for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

7 Membership

7.1 The [TRUST] CiC shall be constituted of directors of [TRUST] NHS Foundation Trust. Namely the [TRUST] NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each **[TRUST]** CiC Member shall nominate a deputy to attend **[TRUST]** CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for **[TRUST]** NHS Foundation Trust's Chief Executive shall be an Executive Director of **[TRUST]** NHS Foundation Trust.

7.4 In the absence of the **[TRUST]** CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend [TRUST] CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of [TRUST] CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a **[TRUST]** CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 The chair of the **[TRUST]** CiC shall be nominated by the **[TRUST]** CiC.

7.6 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of [TRUST] CiC. The **[TRUST]** 's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see CMAST JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of **[TRUST]** CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of **[TRUST]** CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3**Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the

avoidance of doubt, any such persons in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of **[TRUST]** CiC.

9 Meetings

9.1 Subject to paragraph 9.3 below, [TRUST] CiC meetings shall take place monthly.

9.2 The [TRUST] CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the [TRUST] CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the [TRUST] CiC shall be confidential to the [TRUST] CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of [TRUST] Board.

10 Quorum and Voting

10.1 Members of the [TRUST] CiC have a responsibility for the operation of the [TRUST] CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the [TRUST] CiC shall have one vote. The [TRUST] CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the [TRUST] CiC shall comply with the provisions on conflicts of interest contained in [TRUST] NHS Foundation Trust Constitution/Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of

doubt, reference to conflicts of interest in [TRUST] NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the [TRUST] CiC.

11.2 All Members of the [TRUST] CiC shall declare any new interest at the beginning of any [TRUST] CiC meeting and at any point during a [TRUST] CiC meeting if relevant.

12 Attendance at meetings

12.1 [TRUST] shall ensure that, except for urgent or unavoidable reasons, [TRUST] CiC Members (or their Nominated Deputy) shall attend [TRUST] CiC meetings (in person) and fully participate in all [TRUST] CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the [TRUST] CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the [TRUST] CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each [TRUST] CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant [TRUST] CiC meeting.

13.2 The agenda for the [TRUST] CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE [TRUST] CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to [TRUST] NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the [TRUST] CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the [TRUST] CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the [TRUST] CiC meeting with a view to [TRUST] CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by [TRUST] NHS Foundation Trust's Board). Any proposals discussed at the [TRUST] CiC meeting outside of these parameters would come back before [TRUST] NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to [TRUST] CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the [TRUST] CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);

	Decisions delegated to [TRUST] CiC
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.

	Decisions delegated to [TRUST] CiC
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	**Cheshire and Merseyside Financial Update**
Report of:	**Director of Finance and Development**
Paper Prepared by:	Director of Finance and Development

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

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

C&M Financial Update
Trust Board Part 1
3rd October 2024

Executive Summary

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

The key points to note from this paper are:

- C&M system is reporting a deficit of £166.9m at the end of August which is £48.5m adverse to the plan as agreed at the start of the year.
- £9m of the variance relates to the cost of industrial action strikes and it is anticipated funding will be received but allocation not yet known.
- CIP plans are behind plan by £26.6m at Month 5, with only 27% of the full year plan delivered to date.
- Forecast for the year highlights a risk adjusted position of £213m deficit, £63m variance to the £150m deficit plan set.
- Workforce numbers have reduced in the month, however significant reduction still required to hit the plan by the end of the year.

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

1. Year to date System Financial Position

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

As of 31 August 2024 (Month 5), the system is reporting a YTD deficit of £166.9m against a planned YTD deficit of £118.4m resulting in an adverse YTD variance of £48.5m (1.6%) with £27m in the ICB and the remaining £22m within provider positions.

	M1 YTD Actual £m	M2 YTD Actual £m	M3 YTD Actual £m	M4 YTD Actual £m	M5 YTD Actual £m	FY Plan £m	M5 as a % of Plan %
ICB	3.4	1.7	6.9	(0.4)	**(0.7)**	62.3	-1%
Providers	(30.9)	(70.5)	(107.9)	(137.9)	**(166.2)**	(212.3)	78%
TOTAL ICS	(27.5)	(68.8)	(101.0)	(138.3)	(166.9)	(150.0)	111%

The ICB variance largely relates to excess growth and inflation on CHC and Mental Health packages and prescribing costs. The drivers of the provider variance includes the £9m industrial actions costs along with £18m undelivered CIP and £24m of operational pressures which are partly mitigated by non recurrent benefits, underspends, vacancies across a range of providers.

2. Financial Position by Organisation

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

Financial performance surplus/(deficit) for the purposes of system achievement	M5 YTD Plan	M5 YTD Actual	M5 YTD Variance	M5 YTD Variance	M5 Actual Surplus / (Deficit) as a % of YTD Income	Full Year Annual Plan	Month 5 YTD as a % of FY plan
	£m	£m	£m	%	%	£m	%
C&M ICB	26.0	(0.7)	(26.7)	-0.9%	-0.0%	62.3	-1%
Alder Hey Children's NHS Foundation Trust	(3.2)	(3.4)	(0.2)	-0.1%	-2.0%	3.4	-102%
Bridgewater Community Healthcare NHS Foundation Trus	(0.2)	(0.5)	(0.4)	-1.0%	-1.3%	2.1	-26%
Cheshire and Wirral Partnership NHS Foundation Trust	0.1	0.1	(0.0)	-0.0%	0.1%	1.5	6%
Countess of Chester Hospital NHS Foundation Trust	(12.4)	(16.9)	(4.5)	-3.2%	-11.8%	(23.6)	72%
East Cheshire NHS Trust	(8.3)	(8.7)	(0.4)	-0.5%	-10.2%	(14.4)	60%
Liverpool Heart and Chest Hospital NHS Foundation Trust	5.0	4.0	(1.0)	-1.0%	3.8%	14.1	28%
Liverpool University Hospitals NHS Foundation Trust	(59.7)	(65.9)	(6.3)	-1.3%	-13.3%	(80.5)	82%
Liverpool Women's NHS Foundation Trust	(12.8)	(11.8)	1.0	1.5%	-18.9%	(28.5)	41%
Mersey Care NHS Foundation Trust (inc NWB)	2.3	2.3	0.0	0.0%	0.8%	7.1	33%
Mid Cheshire Hospitals NHS Foundation Trust	(13.4)	(16.0)	(2.6)	-1.6%	-9.8%	(35.6)	45%
Mersey & West Lancashire Teaching Hospitals NHS Trust	(18.0)	(19.9)	(1.9)	-0.5%	-5.4%	(26.7)	75%
The Clatterbridge Cancer Centre NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1%	0.9	9%
The Walton Centre NHS Foundation Trust	2.2	2.5	0.3	0.4%	3.1%	5.3	46%
Warrington and Halton Teaching Hospitals NHS Foundatio	(16.4)	(17.4)	(1.0)	-0.7%	-12.2%	(27.8)	63%
Wirral Community Health and Care NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.3%	6.5	2%
Wirral University Teaching Hospital NHS Foundation Trust	(9.7)	(14.5)	(4.8)	-2.4%	-7.2%	(16.3)	89%
Total C&M ICB	(118.4)	(166.9)	(48.5)	-1.6%	-5.4%	(150.0)	111%

There are 3 trusts reporting a year-to date adverse variance to plan relating entirely to the impact of industrial action (Alder Hey, Mersey & West, Warrington & Halton) and 7 Trusts reporting a year-to-date adverse variance to plan which is greater than the impact of Industrial action. It is expected that funding will be received for industrial action, however it is not clear if this will be to meet the cost in full.

3. System Efficiency (CIP)

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

At Month 5 there is currently a shortfall on planned CIP delivery of £26.6m against the YTD plan, with £18.1m attributable against providers and £8.6m against the ICB. The £119.9m efficiencies delivered YTD represent 3.9% of provider and ICS expenditure/allocation against the annual plan of 6.1%, indicating a larger proportion of the savings required in the remaining months. Only 57% of the YTD CIP plan has been delivered recurrently.

	CIP Efficiency - YTD Delivery									CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M5 YTD CIP Performance				Monthly CIP delivery - run rate as a % of Op Ex									
	M5 YTD Plan	M5 YTD Actual	M5 YTD Variance	M5 YTD % Variance	M2 CIP actual as a % of Op Ex	M3 CIP actual as a % of Op Ex	M4 CIP actual as a % of Op Ex	M5 CIP actual as a % of Op Ex	FY CIP Plan % of Op Ex	Actual Recurrent	Actual Non Recurrent	Actual Recurrent as a % of YTD plan	full year CIP (new plan)	YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	%	%	%	£,000	£,000	%	£,000	%
Alder Hey Children's	5,762	5,782	20	0%	2.3%	2.4%	2.8%	3.2%	4.8%	5,692	90	99%	19,950	29%
Bridgewater Community	1,190	799	(391)	-35%	1.2%	1.6%	1.7%	1.9%	6.9%	232	567	19%	6,939	12%
Cheshire & Wirral Partnership	5,210	3,330	(1,880)	-30%	2.7%	2.9%	3.1%	2.8%	5.0%	1,670	1,660	32%	13,913	24%
Countess of Chester Hospitals	5,617	2,612	(3,005)	-53%	0.1%	0.7%	1.4%	1.6%	5.3%	2,612	0	47%	19,822	13%
East Cheshire Trust	2,677	2,683	6	-1%	2.0%	2.0%	2.5%	2.8%	5.0%	1,048	1,636	39%	11,225	24%
Liverpool Heart & Chest	4,050	2,701	(1,349)	-38%	1.9%	2.3%	2.5%	2.6%	4.6%	2,066	635	51%	10,644	25%
Liverpool University Hospitals	35,540	28,878	(6,662)	-21%	4.3%	4.4%	4.6%	5.0%	8.5%	10,615	18,263	30%	114,600	25%
Liverpool Women's	1,746	2,896	1,150	14%	1.2%	1.6%	2.5%	3.8%	3.3%	943	1,953	54%	5,904	49%
Mersey Care	10,819	10,819	0	0%	3.5%	3.4%	3.4%	3.4%	3.5%	10,060	759	93%	25,967	42%
Mid Cheshire Hospitals	8,756	5,552	(3,204)	-43%	2.3%	2.5%	2.7%	3.0%	5.2%	2,852	2,700	33%	22,437	25%
Mersey & West Lancs	13,596	14,763	1,167	9%	2.9%	3.2%	3.6%	3.8%	4.8%	9,846	4,917	72%	45,165	33%
The Clatterbridge Centre	4,167	4,167	(0)	0%	3.3%	3.4%	3.3%	3.3%	3.4%	2,967	1,200	71%	10,000	42%
The Walton Centre	3,498	3,499	0	0%	4.1%	4.3%	4.3%	4.3%	4.5%	2,921	578	83%	8,558	41%
Warrington & Halton Hospitals	4,368	4,535	167	5%	1.7%	2.0%	2.5%	2.8%	5.1%	3,766	768	86%	19,433	23%
Wirral Community	1,979	1,679	(300)	-8%	2.4%	4.0%	4.1%	3.8%	5.4%	357	1,322	18%	6,275	27%
Wirral University Hospitals	9,109	5,328	(3,781)	-29%	3.1%	3.1%	2.7%	2.4%	5.2%	5,328	0	58%	26,878	20%
TOTAL Providers	**118,085**	**100,022**	**(18,063)**	**-15%**	**2.5%**	**2.6%**	**2.7%**	**3.6%**	**5.5%**	**62,974**	**37,048**	**53%**	**367,710**	**27%**
C&M ICB	28,401	19,834	(8,567)	-30%	0.6%	0.6%	0.6%	0.6%	1.0%	19,834	0	70%	72,236	27%
TOTAL ICS	**146,486**	**119,856**	**(26,630)**	**-18%**	**3.7%**	**3.8%**	**3.9%**	**3.9%**	**6.1%**	**82,808**	**37,048**	**57%**	**439,946**	**27%**

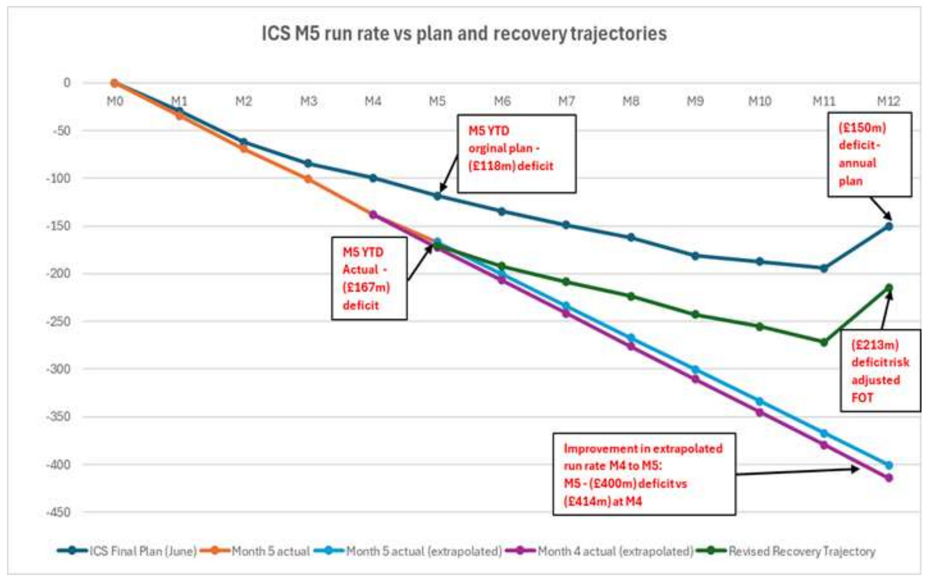
The following table sets out the current risk and development status of efficiency schemes across all organisations with overall 20% of CIP schemes, currently deemed high risk which is similar to the month 4 position.

	Month 5 (end of Aug 25) assessment									% of CIP High Risk	% of CIP Opportunity/ Unidentified
	CIP RISK				CIP DEVELOPMENT						
	Low	Medium	High	Total	Fully	In Progress	Opportunity	Unidentified	Total		
	£m	£m	£m	£m	£m	£m	£m	£m	£m	%	%
Alder Hey Children's NHS Foundation Trust	11.8	4.0	4.2	**20.0**	8.1	9.9	2.0	0.0	**20.0**	21%	10%
Bridgewater Community Healthcare NHS Foundation Tru	1.8	1.3	3.8	**6.94**	3.1	0.0	0.0	3.8	**6.94**	55%	55%
Cheshire and Wirral Partnership NHS Foundation Trust	5.6	4.1	4.2	**13.9**	5.6	4.1	0.5	3.7	**13.9**	30%	30%
Countess of Chester Hospital NHS Foundation Trust	5.8	2.8	11.2	**19.8**	6.6	2.6	10.0	0.7	**19.8**	57%	54%
East Cheshire NHS Trust	5.1	2.1	4.1	**11.2**	4.5	2.7	4.1	0.0	**11.2**	36%	36%
Liverpool Heart and Chest Hospital NHS Foundation Trus	5.0	3.2	2.5	**10.6**	2.5	5.4	2.7	0.0	**10.6**	23%	25%
Liverpool University Hospitals NHS Foundation Trust	62.4	33.7	18.5	**114.6**	104.0	0.9	9.7	0.0	**114.6**	16%	8%
Liverpool Women's NHS Foundation Trust	2.8	3.1	0.0	**5.9**	4.9	1.0	0.0	0.0	**5.9**	0%	0%
Mersey Care NHS Foundation Trust	12.2	13.8	0.0	**26.0**	10.4	15.6	0.0	0.0	**26.0**	0%	0%
Mid Cheshire Hospitals NHS Foundation Trust	8.8	8.8	4.8	**22.4**	14.5	3.4	4.6	0.0	**22.4**	22%	20%
Mersey & West Lancashire Teaching Hospitals NHS Trus	33.7	14.2	0.0	**48.0**	38.2	9.6	0.1	0.0	**48.0**	0%	0%
The Clatterbridge Cancer Centre NHS Foundation Trust	8.0	1.6	0.4	**10.0**	7.9	1.6	0.4	0.0	**10.0**	4%	4%
The Walton Centre NHS Foundation Trust	4.7	3.4	0.4	**8.6**	2.0	6.2	0.3	0.0	**8.6**	5%	4%
Warrington and Halton Teaching Hospitals NHS Foundat	12.5	3.9	3.0	**19.4**	13.0	5.6	0.8	0.0	**19.4**	15%	4%
Wirral Community Health and Care NHS Foundation Trus	3.9	0.7	1.7	**6.3**	3.9	0.0	0.7	1.7	**6.3**	26%	38%
Wirral University Teaching Hospital NHS Foundation Trus	13.2	11.4	2.3	**26.9**	16.4	10.4	0.0	0.0	**26.9**	9%	0%
C&M ICB	12.0	30.0	26.8	**68.7**	40.2	12.2	16.3	0.0	**68.7**	39%	24%
Total	209.2	142.1	87.9	439.2	285.9	91.2	52.3	9.8	439.2	**20%**	**14%**
% of risk / development status - plan (june)	13%	33%	54%	100%	20%	28%	52%	0%	100%		
% of risk / development status - M4	46%	34%	20%	100%	58%	22%	17%	3%	100%		
% of risk / development status - M5	**48%**	**32%**	**20%**	**100%**	**65%**	**21%**	**12%**	**2%**	**100%**		

4. Financial Forecast for Year

The system is still formally forecasting delivery of its plan in line with NHS England requirements. A national protocol process is required before any system is able to deteriorate its forecast. As reported to the ICB board, delivery of this plan remains high risk in some organisations and the chart below shows the profile of the I&E plan submitted to NHSE on 12th June against the actual M5 YTD run rate.

The extrapolated M5 run rate and unmitigated position, (excluding IA) would equate to £400m deficit., a slight improvement when compared to M4 extrapolation of £414m deficit



The system has been developing mitigation plans to deliver the £150m deficit plan and as at the end of August the risk adjusted assessment of the mitigation plan is £213m deficit, with a remaining £63m unidentified gap requiring further action by all organisations to support plan delivery.

An exercise was undertaken to identify the current risks and gaps in organisational plans. This was not a changing of organisations' plans, but an in year estimate of the scale of any additional mitigation required to deliver the overall system plan.

Most organisations provided analysis which set out how the risks to in year delivery of plan would be mitigated and reflected a risk adjusted forecast in line with plan. However, 5 organisations, including the ICB, indicated that there was still work to do to fully mitigate the risks being reported which equates to the £63m unmitigated risk above.

Further work is ongoing to the end of September on actions to be taken to close this unmitigated gap, with an ask for organisations to go further. A national meeting including all CEOs, is due to take place on 9th October to discuss the trajectories. Weekly `gold command` reporting is also being set up both for internal provider organisations but also reporting into ICB.

5. Workforce

During August , the total WTE across C&M reduced by 49 compared to M4, predominately in bank staffing, however a further 1039 reduction is required to achieve the year end workforce numbers for the full system. Greater workforce controls are expected from the ICB to all providers with a focus on recruitment and variable pay which will support delivery of this reduction.

	2023/24	2024/25	2024/25	2024/25	2024/25	2024/25	M5 Variance		M4 to M5	Movement vs M12		2024/25	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M5 Variance from plan trajectory favourable / (adverse)		Change in month M5 vs M4 (increase) / decrease	M12 23/24 to M5 24/25 Actuals decrease / (increase)		M12 Plan (March 25)	Futher change expected M6-12 increase / (decrease)
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%	WTE	WTE	% move	WTE	WTE
Alder Hey Children's	4,368	4,333	4,347	4,326	4,334	4,292	44	1.0%	41	76	0.8%	4,273	(19)
Bridgewater Community	1,434	1,453	1,462	1,447	1,454	1,445	6	0.4%	9	(11)	-1.4%	1,460	14
Cheshire & Wirral Partnershi	4,072	4,061	4,024	4,017	4,000	3,967	(17)	-0.4%	33	104	1.8%	3,936	(31)
Countess of Chester Hospita	4,886	4,849	4,783	4,809	4,829	4,829	(23)	-0.5%	(0)	57	1.2%	4,764	(65)
East Cheshire Trust	2,675	2,691	2,633	2,633	2,656	2,697	(49)	-1.8%	(40)	(21)	0.7%	2,625	(72)
Liverpool Heart & Chest	1,912	1,874	1,880	1,898	1,886	1,889	11	0.6%	(3)	23	1.4%	1,880	(9)
Liverpool University Hospitals	15,448	15,261	15,163	15,041	15,228	15,170	58	0.4%	58	278	1.4%	14,601	(569)
Liverpool Women's	1,687	1,703	1,718	1,717	1,715	1,748	(12)	-0.7%	(33)	(61)	-1.7%	1,764	17
Mersey Care	11,623	11,344	11,224	11,091	11,244	11,286	(67)	-0.6%	(42)	337	3.3%	11,220	(67)
Mid Cheshire Hospitals	5,687	5,445	5,425	5,398	5,429	5,428	71	1.3%	1	259	4.5%	5,469	41
Mersey & West Lancs	10,614	10,458	10,538	10,478	10,556	10,551	76	0.7%	5	64	0.5%	10,564	13
The Clatterbridge Centre	1,893	1,890	1,919	1,920	1,896	1,906	(17)	-0.9%	(11)	(13)	-0.1%	1,907	1
The Walton Centre	1,562	1,554	1,522	1,570	1,552	1,600	(54)	-3.5%	(48)	(38)	0.7%	1,551	(49)
Warrington & Halton Hospital	4,786	4,626	4,646	4,637	4,657	4,615	(17)	-0.4%	42	171	2.7%	4,512	(103)
Wirral Community	1,560	1,587	1,579	1,567	1,566	1,564	1	0.0%	2	(4)	-0.4%	1,512	(53)
Wirral University Hospitals	6,258	6,389	6,499	6,300	6,350	6,315	29	0.5%	34	(58)	-1.5%	6,227	(89)
C&M Providers Total	**80,465**	**79,607**	**79,361**	**78,849**	**79,352**	**79,303**	**40**	0.0%	**49**	**1,162**	**1.4%**	**78,264**	(1,039)

6. Alder Hey Response

At the end of August, Alder Hey is reporting in line with its financial plan, except for the impact of industrial action (£0.4m). Delivery of efficiency savings is in line with plan with only 10% remaining as opportunity, lower than the system average. Our workforce numbers have reduced over the last month, however a further 19 is expected to be taken out by the end of the year and this is net after recruitment has completed for the service developments (GDS, Mental Health etc).

In August, a reforecast was submitted to the ICB showing a mitigated position to the end of March of £3.3m surplus in line with the plan based on a number of assumptions including industrial action funding, resolution of outstanding contract issues and delivery of the remaining efficiency schemes. The forecast will be reviewed each month and reported through finance committee and Trust Board highlighting any changes or any emerging risks.

Alongside the reforecast, the external reviews were concluded, with a report shared by organisation on recommendations and actions to be taken. Following the report shared with Trust Board last month, the associated action plan has now been shared through FTPC and will be monitored over the coming months.

The financial improvement work initiated in July continues internally, however with alignment to the recent actions and guidance from the ICB and with a greater focus on 4 areas of work; Variable Pay, Recruitment, Discretionary Spend and Elective Recovery.

Variable Pay

- Power BI dashboard – weekly reporting
- New Workforce Operating Model (review temp spend, daily staffing controls, rota hub, use of e-roster) – approach and content to be designed and mobilised with BB approach

Recruitment

- Strategic review current vacancies
- Workforce plans at divisional level
- Power BI tracking of workforce plan, actual, starters and leavers

Discretionary Spend

- Automated form through HPL
- Agreed categories to restrict spend for year
- Continuous report on spend

Elective Recovery

- Opportunity assessment – meet with clinical teams
- New business development framework for growth

A workforce efficiency group is now established chaired by the Deputy Chief People Officer, leading on all the workforce actions. Workforce and financial dashboards are in development that will report on key metrics such as bank, agency, WTE, non pay and efficiency, both at trust and divisional level and will be set up from October reporting into the weekly strategic executive meeting. The reporting to FTPC will also be updated to reflect the workforce dashboards ensuring greater oversight of the metrics and trajectory to the end of the year.

The reporting requirements from the ICB are to be shared with organisations imminently and once known, we will be able to adapt the internal reporting to align.

7. Conclusion

The report outlines the latest position across the C&M system, highlighting the risks and challenges in delivering the plan set out and agreed with NHSE earlier in the year. A considerable amount of work is being undertaken across the system to mitigate the risk and a further update is expected early October.

Internally, the financial improvement work continues, however with alignment to the recent actions and guidance from the ICB.

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

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	**Alder Hey - Autumn and Winter Emergency Response Plan, 2024/25**
Report of:	**Chief Operating Officer**
Paper Prepared by:	Associate Chief Operating Officer - Medicine

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

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

Alder Hey Autumn & Winter Emergency Response Plan

September 2024

Version 1

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1. Introduction

As the winter season approaches, the Trust faces an annual increase in demand for services, driven by factors such as seasonal illnesses, increased staffing absences, adverse weather conditions, and heightened pressure on emergency services. To ensure the Trust can continue to provide high-quality care and maintain patient safety during times of increasing demand, a comprehensive Winter Plan has been developed.

1.2 Context and Background

Historically, the winter months have presented significant operational challenges for NHS Trusts. Data indicates a marked increase in patient admissions, emergency department visits, and staff absenteeism. These factors necessitate a robust and proactive approach to ensure the effective management of resources and the continuity of care. This document provides an overview of the anticipated winter pressures and the strategic measures required to address them.

Seasonal influenza and other respiratory conditions, such as bronchiolitis, disproportionately affect children and young people, adding to the complexity of increased ED presentations and seasonal variations in admissions.

1.3 Purpose of the Plan

The primary objective of this Winter Planning Document is to delineate a comprehensive strategy for managing the anticipated demands of the winter season. It aims to provide a clear framework for preparedness, response, and resilience, ensuring that the Trust can effectively navigate the increased demand and maintain the delivery of high-quality care throughout the winter period.

1.4 Scope

This document encompasses all critical aspects of service delivery at Alder Hey which would be impacted by seasonal winter pressures including, urgent and emergency care, critical care and elective care. It outlines the coordination of resources, staffing requirements, patient flow management, and infrastructure considerations. The scope extends to both immediate response mechanisms and longer-term strategic initiatives designed to enhance overall operational resilience.

This plan therefore sets out the modelling, escalation framework and capacity interventions that underpin this year's winter plan. This plan is focused on delivering outstanding safe care to C&YP through, and keeping our staff safe, through this period of higher demand.

2. Approach to Alder Hey's Winter Plan 2024-25

2.1 Overarching Aim

To ensure the Trust is prepared to manage anticipated seasonal pressures, maintaining a focus on providing safe, effective and efficient care for children and young people, while also supporting our staff to remain safe and well at work.

2.2 Key Principles

The overarching aim of the Winter Plan will be delivered through four key principles:

1. Attendance Avoidance
2. Admission Avoidance
3. Capacity & Flow
4. Staff Health & Wellbeing

2.3 Reflections on 2023-24's Winter Plan

Before progressing ahead to develop the Winter Plan for 2024-25 colleagues across the Trust reflected on last years winter plan identifying areas which worked well and areas which may require further focus and prioritisation this year.

The image below is a highlight of the feedback received.

Reflections on previous Winter

What worked well.

- ✓ PAU Pilot Established
- ✓ Expansion of UTC capacity
- ✓ Improved ED streaming out of the department 31% of all attendances
- ✓ Revised rota increasing ED consultant, ACP and senior nurse cover
- ✓ IP Bed flow & occupancy – 50% reduction in cancelled operations for no ward bed
- ✓ Preparedness for any Measles outbreak
- ✓ Visibility of discharge data for acute wards
- ✓ Virtual Ward capacity increase
- ✓ Maintains responsiveness from Crisis Care

Areas for further improvement.

- Oncology demand remained high
- Reduced theatre schedule last winter which will be back to planned levels this winter
- Transparency of system wide data regarding Children and Young people attending Urgent & Emergency Care services
- Re- establishment of trust wide forward look / planning

3. Demand Modelling

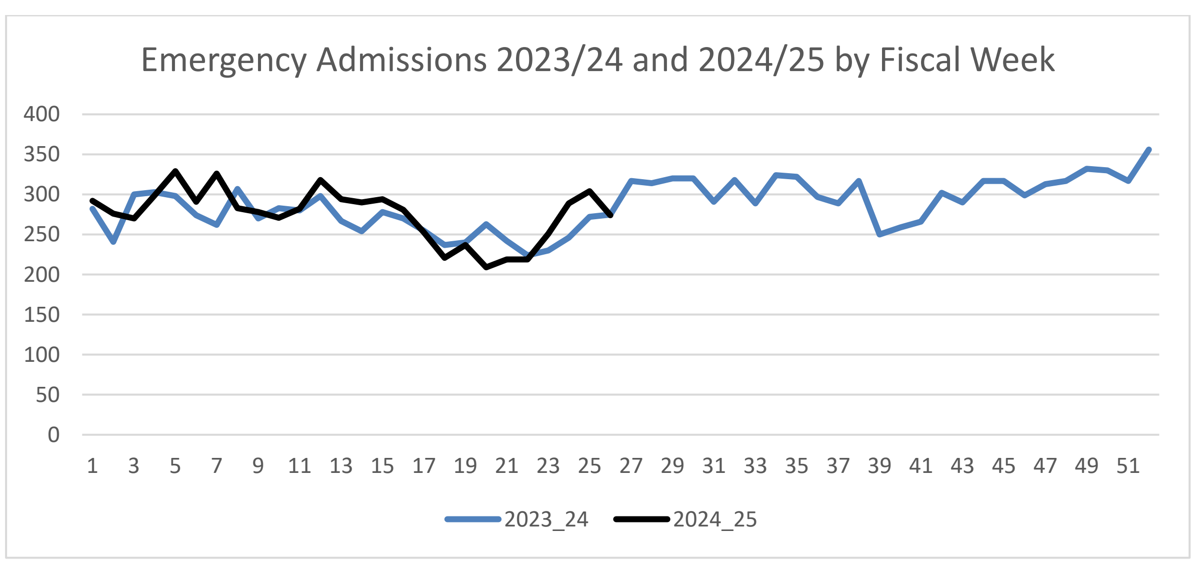
3.1 Emergency Attendances

	2022/23			2023/24			2024/25		
	Attendances	Breaches	%	Attendances	Breaches	%	Attendances	Breaches	%
April	5385	1481	72.5%	5063	800	84.2%	5628	704	87.5%
May	6025	1582	73.7%	5775	873	84.9%	6132	816	86.7%
June	5692	1261	77.8%	5671	815	85.6%	5734	934	83.7%
July	5546	1337	75.9%	5051	461	90.9%	5493	667	87.9%
August	4201	406	90.3%	4479	344	92.3%	4093	301	92.6%
September	4985	815	83.7%	5438	1205	77.8%			
October	6013	1480	75.4%	6512	1956	70.0%			
November	6610	2331	64.7%	6040	1298	78.5%			
December	7419	2843	61.7%	6328	944	85.1%			
January	5167	1212	76.5%	6324	1149	81.8%			
February	4956	1097	77.9%	6189	1334	78.4%			
March	5911	1328	77.5%	6895	1073	84.4%			

Average attendances are in line with 2022-23 at 5500 per month; however, it is not anticipated we will experience a respiratory surge as seen in Q3 2022-23. Based on information from Australia winter months.

3.2 Emergency Admissions

The below chart shows the emergency admissions since 1st April 2023 up to 30th September 2024 including Emergency Decisions Unit and Paediatric Assessment Unit admissions. This shows an increase admission from October 2023-March 2024 compared to the previous six months. Of note, the first two quarters of this year emergency admissions were 3% above the previous year.



3.4 Elective Demand

This winter with the return of all theatre sessions within the theatre schedule an increase elective demand is planned to combat elective waiting lists. The additional demand compared to last winter will be managed and focused on high volume through put through Day Case theatre lists prioritising and forward planning for inpatient theatres.

3.5 Australian Influenza 2024

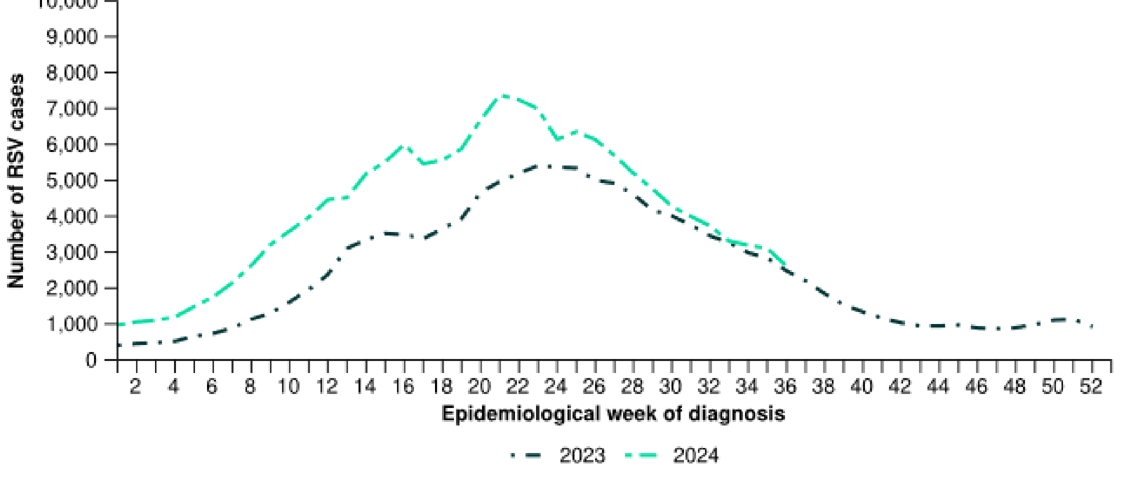
In 2024, Australia experienced a moderately severe flu season, primarily driven by influenza A(H3N2) and A(H1N1) strains. Data shows that the season began around the usual time but saw more pronounced peaks in activity compared to 2023, particularly in terms of hospitalizations and overall notifications.

Compared to previous years, Influenza notifications were higher in 2024 than in the five-year average leading up to the pandemic, with 74,628 cases reported by mid-September, mostly influenza A (Immunisation Coalition).

Vaccination coverage, however, dropped slightly compared to 2023. This decline in vaccination rates (about 12% lower nationally) has been linked to higher illness severity, particularly in populations under-vaccinated like children(Medicine Today).

Overall, the 2024 flu season in Australia highlighted the critical need for continued vaccination efforts and indicated a strong presence of flu strains similar to those in 2023, which could inform the upcoming flu season in the Northern Hemisphere.

Figure 7: RSV cases notified to the NNDSS by year and week of diagnosis*, Australia, 2023 to 8 September 2024



(Australian Respiratory Surveillance Report 12 – 26 August to 8 September 2024)

3.6 World Health Organisation 2024

The World Health Organization (WHO) and other health agencies expect the winter of 2024-2025 to present significant health challenges, especially with respiratory diseases like COVID-19, influenza, and respiratory syncytial virus (RSV). The WHO anticipates a rise in these infections, similar to previous winters, with concerns about co-circulation of these viruses, which may strain healthcare systems. Vulnerable populations, such as the elderly, young children, and individuals with underlying conditions, are expected to be at higher risk.

The winter may also be influenced by environmental factors like the La Niña weather pattern, which the World Meteorological Organization (WMO) has predicted could have a cooling effect, potentially causing more severe winter conditions. These climate changes could exacerbate the spread of respiratory illnesses due to colder temperatures and increased indoor gatherings (World Meteorological Organization).

In summary, WHO is preparing for a challenging winter in terms of respiratory health, stressing vaccination and preventive measures to reduce strain on healthcare systems.

4. National Urgent & Emergency Care Recovery Plan

Nationally the focus continues to be the delivery of the Urgent & Emergency Care recovery plan published in January 2023 rather than issuing new winter planning guidance.

Specifically for the coming months in relation to staff health and wellbeing NHS trusts are asked to:

- ensure their eligible staff groups have easy access to relevant vaccinations from Thursday 3 October, and are actively encouraged to take them up, particularly by local clinical leaders.
- record vaccination events in a timely and accurate way, as in previous campaigns.
- monitor staff uptake rates and take action accordingly to improve access and confidence.
- ensure staff likely to have contact with eligible members of the public are promoting vaccination uptake routinely.

Our vaccination team have the above addressed within their winter planning priorities and are confident on their ability to deliver for 2024-25.

In addition, in relation to Winter preparedness NHS trusts are asked to

- review general and acute core and escalation bed capacity plans: - with board assurance on delivery by the peak winter period
- review and test full capacity plans: - this should be in advance of winter - in line with our letter of 24 June 2024, this should include ensuring care outside of a normal cubical or ward

environment is not normalised; it is only used in periods of elevated pressure; it is always escalated to an appropriate member Copyright © NHS England 2024 6 of the executive and at system level; and it is used for the minimum amount of time possible

- ensure the fundamental standards of care are in place in all settings at all times: - particularly in periods of full capacity when patients might be in the wrong place for their care - if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces
- ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow: - including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way
- ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week: - with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

The initiatives considered in the next section have been devised to meet the above criteria and deliver against the national ask.

PRN01454 Winter and H2 priorities letter -September 2024.pdf

5. Alder Hey's Winter Initiatives for 2024-25

The diagram below provides an overview of the high impact initiatives in place and under development to ensure the delivery of the Winter Plan's aim.

	Description	Initiatives	Goals
Attendance Avoidance	Measures to prevent unnecessary attendance to ED.	- **Promote Self-Care**: Symptom checker expansion & communication plan - **Telemedicine**: Expand virtual consultations e.g GP hot line, 111 scheduling to UTC, ? ED hotline for WICs - **Frequent attenders:** addressing multiple attends with system partners - **Clinical Education & Training –** AH lead training for primary Care	- **Reduce** unnecessary hospital visits - **Decrease** pressure on ED department - **Maintaining** a Safe ED waiting Area
Admission Avoidance	Strategies to prevent or minimise hospital admissions.	- **PAU model:** maintain high turnover assessment beds with discharge plans back to the community. - **Enhances Medical and Senior nursing cover**: allocate resources effectively against demand for senior decision making - **Virtual Ward Expansion**: Improve in-home support	- **Avoid** unnecessary hospital admissions - **Manage** patient care effectively in the community - **Prompt** investigation & assessment
Capacity & Flow	Ensuring efficient management of resources and patient flow.	- **Bed Management**: Optimise utilisation (inc 4 escalation beds) - **Clear escalation** plan & processes - **Effective Board rounds** and clinical plans - **Discharge Processes**: Streamline and expedite (Acute discharge co-ordinator) - **Review of EDDYs** patient pathways - **Appropriate** use of home leave beds - **Prompt in reach to ED**: speciality attendance for their patients and prompt establishment of clinical plan - **Ensuring access** to CC beds - **Delivering Elective Recovery** Plans - **Maximise Low Acuity Streaming** from ED to UTC - Preparing for RSV surges - **Optimising Therapy** input to facilitate flow	- **Improve** patient flow through the system from ED to Critical Care - **Maintain** appropriate capacity levels - **Maintain** the Elective recovery Programme
Staff Health & Wellbeing	Supporting the health & well-being of staff to remain in work	- **High Vaccination Rates**: flu vaccination roll out - **SALS Support** - **Proactive sickness management** - **Proactive planning** to backfill staffing shortages (e.g nursing staff in non-clinical roles) - **Training & Development**: Increase opportunities for skill growth	- **Maintain low** sickness rates - **Reduce** staff burnout - **Enhance** staff morale and productivity

5.1 Attendance Avoidance

Promote Self-Care via Symptom Checker: The already established symptom checker will be promoted and further developed this winter to support self-care and management at home, while also directing C&YP and their families to the most appropriate services available.

Telemedicine: Expanding capacity and availability for virtual consultations e.g GP hot line, 111 scheduling to UTC, ED hotline for WICs. This winter we are collaborating system wide with external partners to ensure our digital Urgent and Emergency Care offer if effective for C&YP across Liverpool. Alongside PC24, 111 and the Paediatric Network operating the Paediatric CAS we are mapping the current service offer available in C&M, before identifying gaps and considering which organisations are best suited to mitigate with collaborative support. The aim of this scheme is to keep C&YP at home once they have made contact with an already established digital offer.

Frequent attenders: addressing multiple attends with system partners to best support Children and Young People.

Clinical Education & Training: The Trust has developed two training programmes to date which will be delivered to over 100 primary care clinicians from November. The areas of focus are the top 6 paediatrics attendance reasons with a focus and dedicated session on respiratory management.

In previous years **Acute Respiratory Infection (ARI) Hubs** have been established to support the increase demand. To date there are not plans for Cheshire and Mersey to establish such facilities for children; however, we will support and work with system partners to consider the most effective direct access hubs for the winter.

5.2 Admission Avoidance

Paediatric Assessment Unit (PAU) – Since the PAU launched in August 2023 the intended benefits of reduce the number of admissions to wards through a thorough assessment pathway led by Consultant Paediatricians and ACP's has been achieved. The unit operates 24/7 and will also accept direct admissions from community services including primary care.

Speciality Response Time to ED – we have initiated conversations across specialities to ensure we have agreed response times of speciality teams to attend ED to review their patients with the aim of reducing the time C&YP wait in ED.

Virtual Ward - Another key element of our plans for this winter period is ensuring that care is delivered as close to home as possible. This ensures that bed spaces at Alder Hey are free for those C&YP who need them most, and that C&YP who need care across the healthcare system this winter have it delivered in the most co-ordinated way possible.

There are several elements to this scheme:

- Condition specific virtual ward that link community care teams with specialist teams on Alder Hey site
- Development of hybrid model of care offer through to extend virtual ward offer to other services
- GP referral scheme to Alder Hey Community nursing teams to avoid admission.
- CCNT staffing resilience for complex discharge caseload
- CCNT led community drop-in clinics to support admission/attendance reduction

New pathways to the virtual ward have been developed for this winter to improve flow out of the Trust from PAU, General Paediatrics and Complex Medical Specialities.

Extension of Rapid Access Clinics – considering the development of a surgical rapid access clinic we have approached other specialities across bother divisions do consider any further requirements anticipated this winter.

5.3 Capacity and Flow

ED Streaming to UTC clinics- This winter we have a full year effect of the Urgent Treatment Centre (UTC) whereby the Emergency Department can stream C&YP to appointment slots if they meet the low acuity criteria. The streaming is conducted by a senior registered nurse or consultant to ensure the most appropriate C&YP are seen in the most appropriate location by the most appropriate staff group.

Primary Care Streaming- We continue to utilise the primary care clinicians on site based from the UTC ensuring a high proportion for low acuity presentations are directed from the Emergency Department to appointment slots in the UTC.

Response Team 24/7- This winter we have a fully established Response Team and Bed Management team who will be working to well established patient flow systems, processes and policies. We therefore have Senior Site Practitioners on site 24/7, working alongside Bed Managers to minimise delays in the elective and non-elective pathways.

Morning Consultant led ward rounds- Ensuring all key specialities have consultant led ward rounds held in the morning rather than the afternoon, learning from the periods of industrial action, recognising that senior clinical decision making earlier in the day has improved in the number of discharges earlier in the day which inevitably improves Trust occupancy and flow.

Promotion of Nurse Led Discharge- Recognising that improved flow and occupancy is associated with clear discharge planning which could be enabled with recognised nurse led discharge planning.

Agreed Escalation Response- Trust escalation response detailed in the next section; however, further operational escalation response has been established within the Emergency Department (ED) escalating to the ED manager of the day who will co-ordinate any escalation required across specialities or to the Hospital Manager of the Week if required.

Weekly LOS Meetings – The Medical Division has a well-established weekly LOS meeting chaired by Head of Nursing and attended by ward leads and the Complex Discharge teams. The Paediatrics Matron/Ward manager undertake daily huddles on 4C to review inpatients with an out of area (OoA) post code with a view to repatriation; bed managers actively manage repatriations to local DGHs once identified.

d. Staff Health and Wellbeing

High Vaccination Rates: flu vaccination roll out aiming for 60-80% of all staff. The trust is offering online bookable appointment and drop-in sessions in addition to targeted vaccination in high volume areas.

SALS Support: ongoing staff support is available via the SALS team with any specific season channels identified feeding into the winter planning meetings.

Proactive sickness management: Review of highest sickness reasons within departments and proactively trying to mitigate.

Proactive planning to backfill staffing shortages (e.g nursing staff in non-clinical roles)

Training & Development: Increase opportunities for skills growth e.g discharge Co-Ordinator roles

6. Capacity and Escalation Plan

This section will focus on the Trust's available capacity this winter and escalation options.

6.1 General & Acute Capacity

Table one – G&A Bed Capacity

G&A Bed Capacity	
2023-24	214
2024-25	207
Variance	-7

This winter owing to a number of estate development works the Trust will be operating with -7 G&A beds compared to previous winter, inclusive of escalation beds.

Table two- detailed distribution of beds and change between 2023-24 and 2024-25

	2023-24		2024-25	
Ward	Baseline Capacity	Escalation Beds	Baseline Capacity	Escalation Beds
1c Cardiac Ward	23	0	23	0
1c Neonatal Ward	9	0	9	0
3a (General Surgery) *reduces to 28 Sat/Sun	32	0	32	0
4a (Neurology/Orthopaedic)	32	0	32	0
3c (Specialist Medicine)	32	0	31	0
4c (General Medicine)	32	0	22	0
EDU & PAU	12	0	10	2 chairs
3b (Cancer Services)	13	0	13	0
4b (Complex Medicine)	21	3	21	3
Burns Ward	5	0	5	0
4 Medical beds on HDU	0	0	0	4
Total Bed Capacity	**211**	**3**	**198**	**9**

The capacity changes have occurred owing to:

3C- permanent loss of a cubical owing to HCID build requirements

4C, EDU PAU- temporary loss of capacity owing to the Neonatal Estate Development. To reduce the impact on General Paediatric beds within the division of Medicine we have split the reduction of beds to 4xspecialits beds and 3xgeneral paediatric beds.

Table Three- summary of core & escalation bed capacity

Core Capacity	**188**
Assessment Capacity	**10**
Escalation capacity	**9**
Total Winter Capacity	**207**

6.2 General & Acute Bed Days

Owing to the bed capacity closers this winter the Trust will have -1274 less bed days this winter. When developing the winter plan the initiatives developed have considered an estimated bed day saving to mitigate the overall lost.

Table four – mitigations for bed days lost

Winter Iniatives	Bed day saving target
PAU reduction in admission	400
4C discharge co-ordinator	200
Oncology care @ home	140
Neurology Rehab patients	100
Therapy access	190
Home Leave Pathways	230
Other capacity & flow improvements	14
Bed Days Mitigated	**1274**

The above is a baseline target developed through the planning phase and will be monitored closely against accuracy of delivery.

6.3 Critical Care

A key priority of the winter plan is to maintain access to critical care services to children requiring emergency or urgent access. Therefore, our plans are centred on resilient staffing and service arrangements to provide care for paediatric patients. If the situation changes to a worst-case scenario either nationally or regionally, we will work with colleagues in the network and support as needed based on the balance of clinical need across all age ranges.

Table five- critical care bed capacity

Critical Care	2023-24 Capacity	2024-25 Capacity	Variance
PICU	21	21	0
HDU	15	15	0
**lost of flexibility as bed spaces now used for medical patients*			

Critical care will be operational with the same volume of beds this winter however will have lost physical space owing to the opening of 4 medical beds on HDU.

Table six- Critical Care surge capacity

	Level 3 beds	Level 2 beds	Total
A. Baseline (commissioned)	21	15	36
B. Severe pressure surge	23	18	41
C. Extreme pressure surge	28	20	48

There is physical space in critical care for 43 beds. Therefore, in level 3 'severe pressures' scenario it is possible to flex capacity up to 41 bed spaces (23 ventilated ICU + 18 HDU). This would be dependent on staffing levels with additional support to ensure safe nurse to patient ratios.

In extreme pressure the additional surge beds in reserve would be opened on the Burns Unit and a business continuity plan for Burns would be enacted re-providing the service in a Surgical Ward.

The staffing for the extreme surge beds would need to be supported from other departments across the trust; therefore, there would need to be a reduction in elective activity to facilitate this.

6.4 ED Capacity

Despite securing increased capacity to See and Treat low acuity patients through the Urgent Treatment Centre, the Emergency department at peak times may experience capacity challenges within the department. This would be within the waiting care, assessment cubicles or within resus capacity. The response in increase demand and necessary steps are included within the ED escalation document.

6.5 Staffing Capacity

Where low staffing availability or high patient acuity affects staffing levels and ratios and capacity requires review, the following process will be followed to request the closure of bed capacity: Opening and Closing of Wards Policy .

3.4 Staffing Escalation

Daily Safer Staffing meetings take place to review nurse staffing levels and arrangements. Where possible the trust will work to maintaining the nationally recognised levels of nursing care. There may be times when the ideal nursing levels will fall short and then the Safer Staffing chair or out of hours is the Clinical Site Practitioner will make decisions to balance the risk across all areas of the organisation.

At times this may lead to working to alternative ratios. The ward mangers and senior nursing team have agreed the minimum staffing requirements which are articulated through a red, amber or green staffing model and describe the skill mix required for each ward. Where an alternative staffing model is in use the nurse in charge of the relevant area will need to make alterations to how staff work to facilitate safe care for all children and young people. This may involve, for example, the use of task allocation nursing. Core key standards relating to staffing will be maintained as referenced in the Respiratory syncytial virus 2021 preparedness Children's safer nurse staffing framework for inpatient care in acute hospitals (2021) which is supported by relevant professional bodies and trade unions.

If the Trust is escalating through capacity levels staff may be required to change their working commitments to support The Emergency Department or Wards. All options will be considered via the Safer Staffing group; however, considerations would include:

- Staff in educational or training roles returning to patient facing roles
- A suspension of non-urgent meetings for clinical managers
- Requesting support from nurse specialities who are not usually base on the wards

All escalation protocols are included in the Trust Escalation Plan Trust Escalation Plan
Escalation Levels

Table Seven – Trust escalation levels as per trust wide Escalation Plan

Measure	Green	Yellow	Amber	Red
Ambulance Handover (mean transfer time in mins)	< 15 mins	15-30 mins	31-60 mins	> 60 mins
Ed attends	160-170	>170	>190	>200
Time to initial assesment within 15 mins (% of patients)	> 95%	80%-95%	50% - 79%	< 50%
Mean time to clinical assessment	< 60 minutes	60-90 minutes	90-120 minutes	>120 minutes
Mean time in department	< 4 hours	4-8 hours	8-12 hours	> 12 hours
Patient in ED over 12 hours	No patients at risk of 12 hour wait	Risk of one or more patients in next 2 hours	One or more patients waiting currently over 12 hours with plans in place	One or more patients waiting over 12 hours with no plans to resolve
ED room space occupied	< 80%	80-100%	100%	>100%
Resus occupancy	>1	1	0 but likely to be available in next 2 hours	0 and none available in next 2 hours
DTAs awaiting beds	<=10%	>10%	>20%	>40%
G&A Bed Capacity	<80%	>85%	>90%	>95%
PICU	>= 2 beds	1 bed open with at least one step down identified	1 bed with no step downs / no beds with 1 step down	No beds / No step downs
Staff absence	5- 7.5%	7.5- 10%	10- 17.5%	> 17.5%
Referrals (external admissions)	All have plans to admit	Referral waiting with no plan to admit	More than 1 with no plan to admit	More than 4 with no plan to admit
Outliers (% of inpatients)	<=2	>2-<4	>4<8	>8
Elective work	Proceeding	Under review with potential cancellations	Cancellation of routine electives	Cancellation of urgent electives

Alder Hey Children's NHS
NHS Foundation Trust

7. Enabling Factors

7.1 Patient Flow

A detailed Patient Flow Policy is in place.

The arrangements and routines for the management of patient flow (including transfers from critical care, emergency and elective admissions are managed as follows) are summarised below:

Daily Bed Meetings and Trust Status Report: Bed meetings run at 08:30 hrs, 12:00 hrs and 15:30 hrs. The aim of the daily bed meetings is to establish the predicted admission rates from an emergency and elective perspective and ensure patient flow is maintained by ensuring timely discharges and inter hospital transfers.

The bed meetings are chaired by the Bed Management Team and supported by the Hospital Manager of the Week.

Safer Staffing Huddle: This meeting runs prior to all the bed meetings to review nurse staffing across and agree the staffing models to be deployed. The meeting is chaired by a member of the trust's senior nursing team and attended by a matron from each clinical division. This staffing model confirms the staffing on each ward and advises it is safe to proceed with the established bed numbers for each ward.

Daily Forward Look/ Bed Meeting: At the 15:30 Bed Meeting, the next day's staffing, elective demand, and capacity is reviewed. This may mean that actions are required to expedite discharges, prioritise TCI's, and in extreme circumstances reduce elective admissions. These actions and decisions are taken by the Hospital Manager of the Week.

Emergency Department Safety Huddle: This daily meeting is held at 17:15 and is attended by the Senior Clinical Site Coordinator, Bed Management Team, Emergency Department Nurse in Charge, the Emergency Department Consultant in Charge, and the Senior Manager On Call when required.

Weekend Planning: Every Friday by midday a detailed weekend plan will be issued by the Bed Management Team.

Tactical Command: In periods of heightened and sustained levels of escalation the establishment of an operational Tactical Command Room will be deployed. This will run by a Tactical Commander appointed by the Chief Operating Officer.

7.2 Escalation Plans

Departmental escalation plans (including for Paediatric Intensive Care Unit and the Emergency Department) are contained in the Trust Escalation Plan.

8. Monitoring

This section of the Trust's winter plan outlines the strategies and systems in place to ensure that the plan is effectively implemented, and that patient care and hospital operations are sustained during the winter months. Monitoring of the plan against demand and performance is crucial to ensure escalation protocols are triggered and maintain focus on ensuring the delivery of safe patient care.

9.1 Performance Metrics and Key Indicators

- **Capacity Utilisation**: Monitoring bed occupancy rates, ICU capacity, and overall hospital space to ensure there is enough capacity to handle increased demand.
- **Emergency Department (ED) Performance**: Regular review of waiting times, particularly the four-hour ED target, and patient flow through urgent care services.
- **Discharge Rates and Delayed Transfers of Care**: Monitoring how quickly patients are being discharged and identifying any blockages in the discharge process to free up hospital beds.
- **Length of Stay**: Tracking the length of patient stays to identify any delays or inefficiencies that could impact capacity.
- **Ambulance Handover Delays**: Monitoring ambulance handover times to ensure patients are transferred to hospital care quickly and that ambulances are available for the next call.

9.2 Data Collection and Reporting

- **Real-Time Data Monitoring**: Acute trusts are required to have systems in place to monitor key performance indicators in real time, using dashboards and reporting mechanisms.
- **Daily and Weekly Reporting**: The trust management must provide daily and weekly reports to NHS England or regional teams. This helps in assessing pressures across the system and identifying where intervention may be required.
- **Bed-State Reporting**: Hospitals report on bed availability to ensure accurate assessments of current capacity and resource allocation.

9.3 Escalation Protocols

- **Triggers for Escalation**: Monitoring must identify when predefined capacity thresholds or performance triggers are breached (e.g., high bed occupancy, long waits in A&E, or ambulance delays). These breaches would prompt the activation of contingency measures, such as opening additional wards or redirecting resources.
- **Integrated Care Systems (ICS) Coordination**: Close coordination with the wider Integrated Care System (ICS) and local authorities to ensure that social care and community services are prepared to take patients and support hospital discharges when needed.

9.4 Workforce Monitoring

- **Staffing Levels**: Real-time monitoring of staffing levels, particularly for critical areas such as emergency departments and intensive care. This includes tracking staff sickness rates, which tend to increase during the winter, and ensuring there are sufficient staffing contingencies in place.
- **Agency and Bank Staff Usage**: Monitoring the use of temporary staff to meet demand and ensure they are integrated effectively into teams without compromising the quality of care.

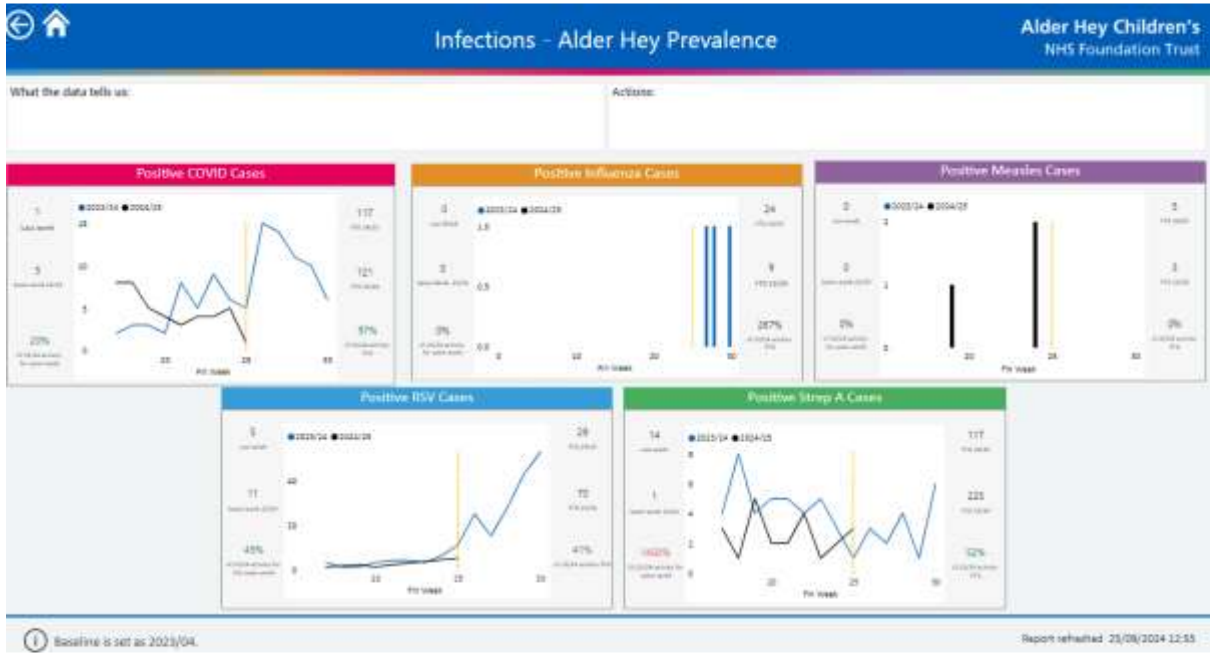
9.5 Patient Safety Monitoring

- **Incident Reporting**: Tracking incidents such as extended waits, infections, and medication errors, which might rise due to pressure on services. This ensures that even in high-demand periods, patient safety is maintained. Relevant incidents reported will feed into the weekly winter preparedness meetings.
- **Infection Control**: Monitoring the incidence of flu, COVID-19, and other infectious diseases, alongside compliance with infection control protocols.
- **Flu and COVID-19 Vaccination Uptake**: Monitoring vaccination uptake among staff and eligible patients to ensure compliance with national targets for flu and COVID-19 vaccination.

9.6 Collaboration with Other Stakeholders

- **Regional and National Reporting**: Acute trusts must collaborate with NHS regional and national teams to provide a comprehensive view of system pressures.
- **Partnership with Primary Care and Community Services**: Close monitoring of referrals from primary care and effective coordination with community services to prevent unnecessary admissions and to manage discharges.

Below are examples of the monitoring reports created via Power BI app including the Trust's Operational daily SITREP and the dedicated Winter Plan report.



The monitoring section of the plan plays a critical role in ensuring that NHS acute trusts are resilient and prepared to handle the increased demands of winter. It focuses on real-time data, rapid escalation of issues, and coordination across the healthcare system to deliver safe and efficient care.

9. Conclusion

In conclusion the Winter Plan outlines a comprehensive strategy to ensure the Trust is fully prepared to manage the increased demand during the winter period. By focusing on optimising capacity, improving patient flow, ensuring robust staffing, and enhancing collaboration with community partners, the Trust aims to provide safe, efficient, and high-quality care to all patients, even during peak pressure times.

Sept 2024

FLASH REPORT

Published 1st October 2024

September 2024 Performance is subject to change.
Targets noted in brackets for metrics.

Outstanding Care and Experience

0

Severe or Fatal Incidents/Never Events (0)

0

Number of PSIIs - Patent Safety Incident Investigations (0)

1

Number of Hospital Acquired Organisms (2)

93.3%

FFT - % Recommending Trust (92%)

Revolutionise Care

84.3%

ED: % treated within 4 Hours (77%)

432

Number of RTT Patients waiting >52weeks (727)

112.2%

Elective Recovery Volume vs 19/20 (112%)

84%

Diagnostic Performance (95%)

Support Our People

10.9%

Staff Turnover (<10%)

Financial Sustainability

YTD - On Plan

Forecast £3.3m surplus.

I&E Year End Forecast

Integrated Performance Report

Published: September 2024

VISION 2030

Our Journey To 2030

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

OUR ASPIRATION
To be world-leading

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

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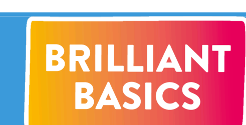


IPR Summary

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.

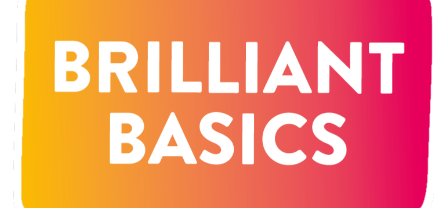
Variation		Assurance: Achieving Target	Assurance: Inconsistently Achieving Target	Assurance: Not Achieving Target
Variation	Special Cause - Improvement	Mandatory Training, Level 1 patient safety training is consistently achieving target with an improving trend	RTT >52 Weeks, ASD/AHD 12 Wk Triage, Severe/Fatal incidents, PSII's, Cat 2 Pressure Ulcers, Liquidity are inconsistently achieving target with an improving trend	MSSA, IHAs are not achieving Target but demonstrating an improving trend
Variation	Common Cause	Category 3 & 4 Pressure Ulcers, Mandatory Training, Cancer (All) and MRSA metrics are achieving targets	F&F (Trust & ED), Complaints/PALs, Sepsis, ED 4hr, ERF, Staff Turnover, Sickness, Medical appraisal and risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	WNB Rate, Theatre Utilisation, Diagnostics, Long Term Sickness and PDRs are not achieving targets and currently not demonstrating statistical improvement
Variation	Special Cause - Concern		Sepsis (ED) & C.Difficile are inconsistently achieving target with a declining trend	

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

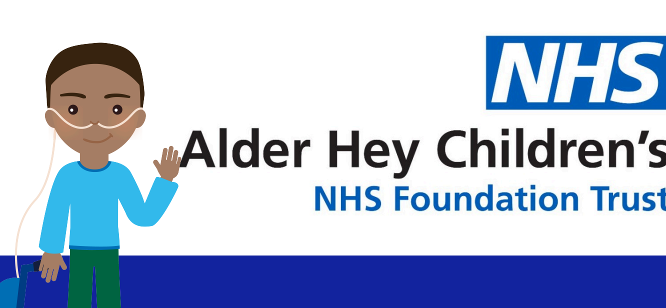
- We are consistently passing 19.6%* of our metrics.
  52.2% of the evaluated SPC metrics achieved the target in the month of August 2024.
- We are achieving 65.2% of our metrics inconsistently.
- We are not achieving the target for 15.2% of our metrics, 0 are showing special cause of concern.

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

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



Integrated Performance Report | September 2024



Outstanding Care and Experience - Safe & Caring

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

Highlights:

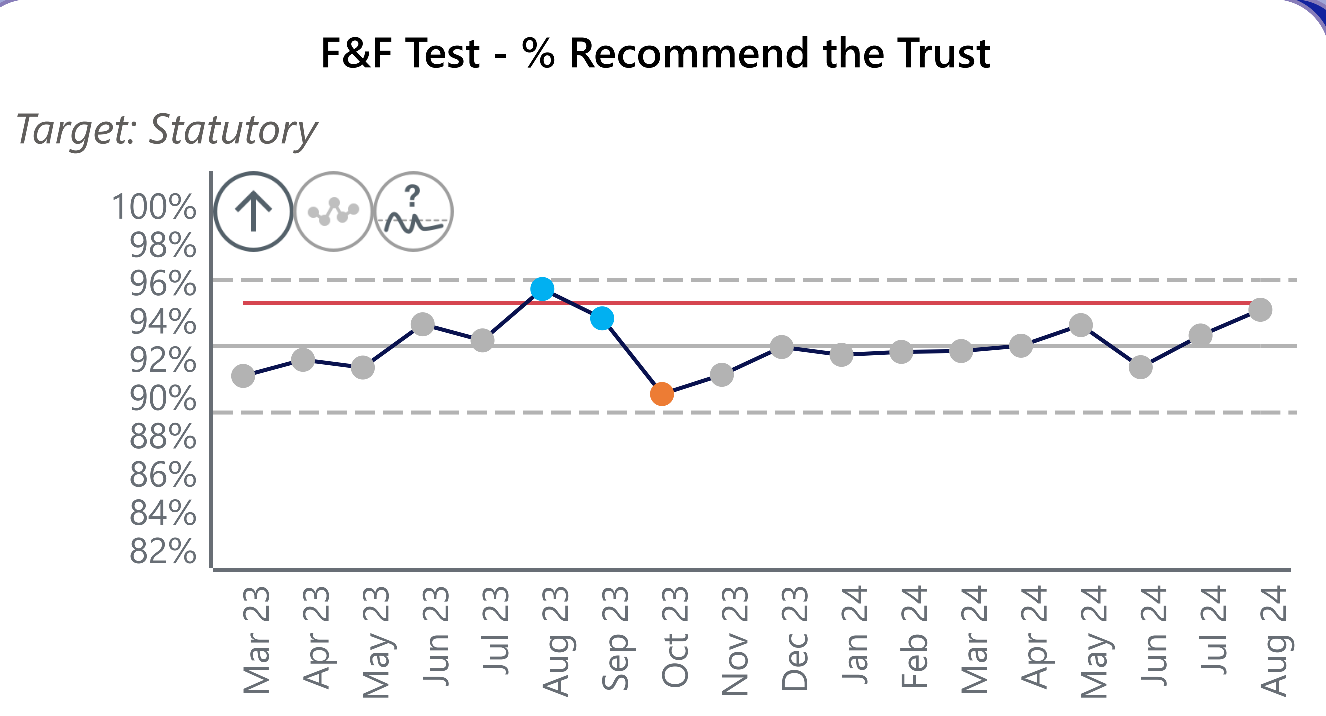
- 95% of families who completed the Friends and Family test would recommend the Trust. 94% of families would recommend ED – this is the highest figure in more than 12 months
- No Category 2, 3 or 4 pressure ulcers – very low rate of Category 2 pressure ulcers following implementation of the tissue viability action plan.
- Decrease in the number of restrictive interventions required
- Sustained decrease over 4 months in medication errors resulting in harm

Areas of Concern:

- Decrease in compliance in responding to formal complaints; 82% in month.
- Decrease in antibiotics administered within 60 minutes for sepsis; 85% of inpatients and 83% of ED patients. Teams and Divisions reviewing

Forward Look (with actions)

- Implementation of a Family Hub where families can meet charitable partners as well as Trust staff to help resolve issues and signpost them to relevant help and support

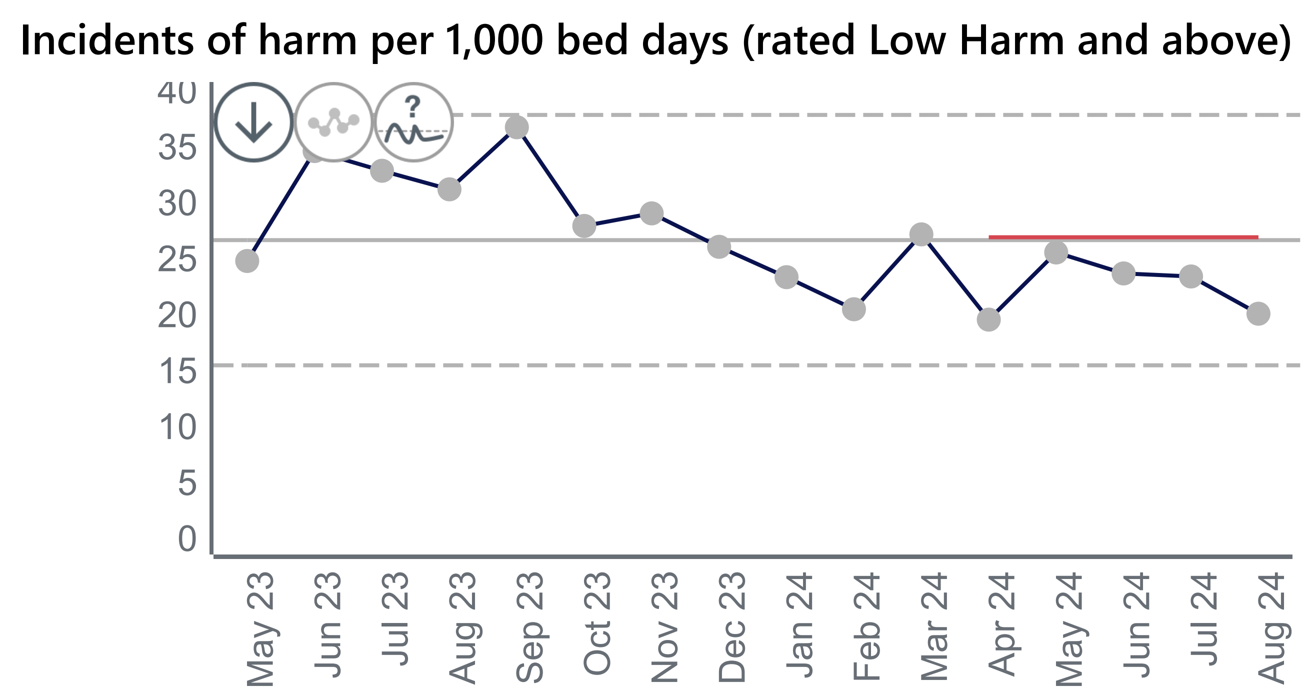


Technical Analysis:

Consistently not achieving the 95% target. August performance of 94.6% represents an increase from July performance of 93.3%. Highest performance since August 2023, with 8 out 9 previous months above 92% performance.

Actions:

Continue with the review of the FFT process

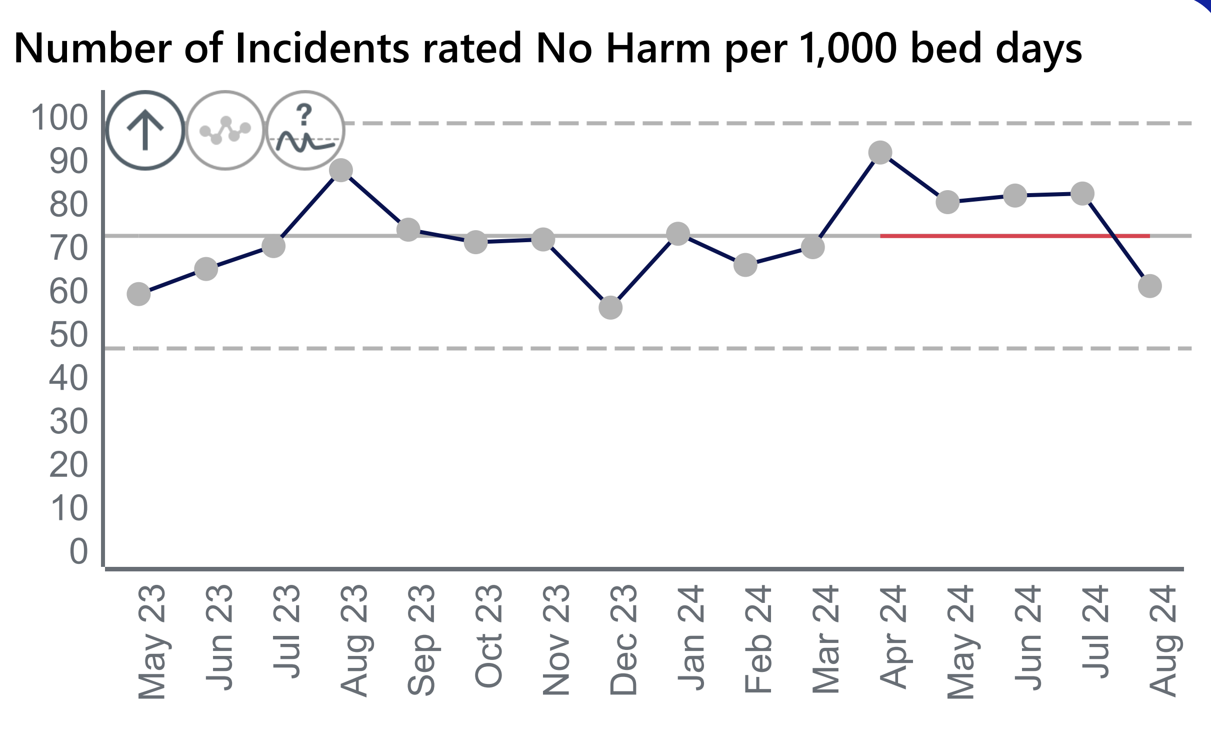


Technical Analysis:

Common cause variation has been observed with performance of 20.2 incidents of harm per 1,000 bed days, with a monthly average of x27 incidents during the period. Incidents are now assessed on Physical and Psychological Harms. The target is set on a 5 % reduction of 23/24, with a monthly target of 27. The period illustrated covers from May-23 only, the month the trusts risk management system

Actions:

Positive downward trend in incidents resulting in harm. Staff encouraged to keep reporting; decrease may in part be attributable to the summer holidays



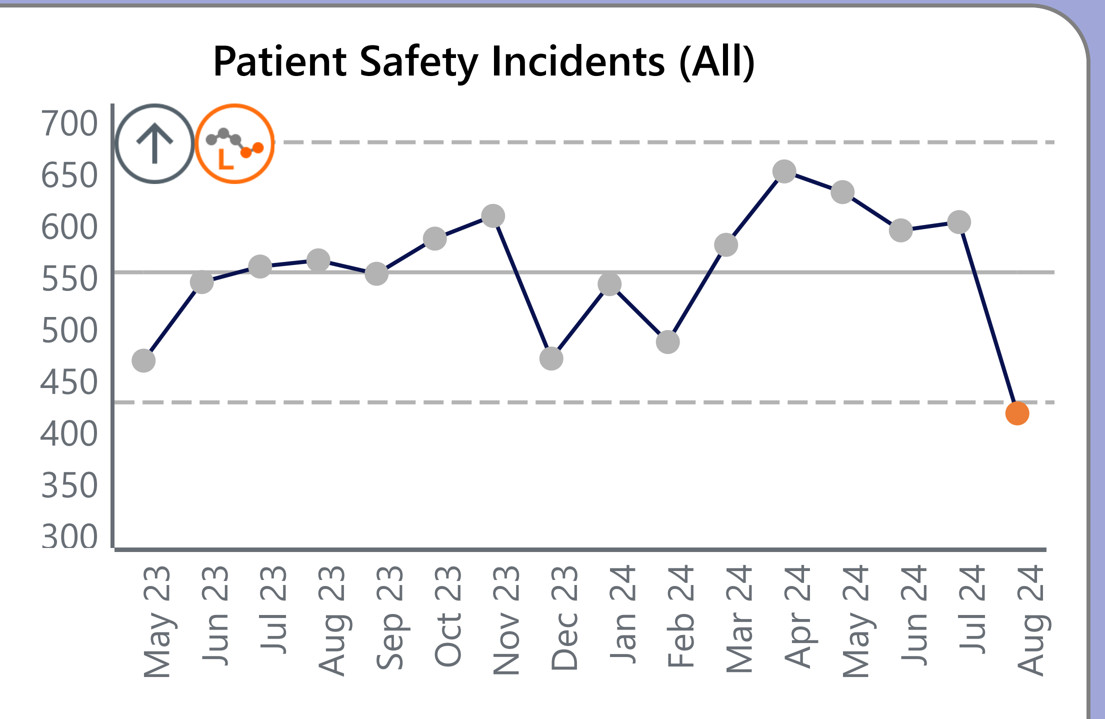
Technical Analysis:

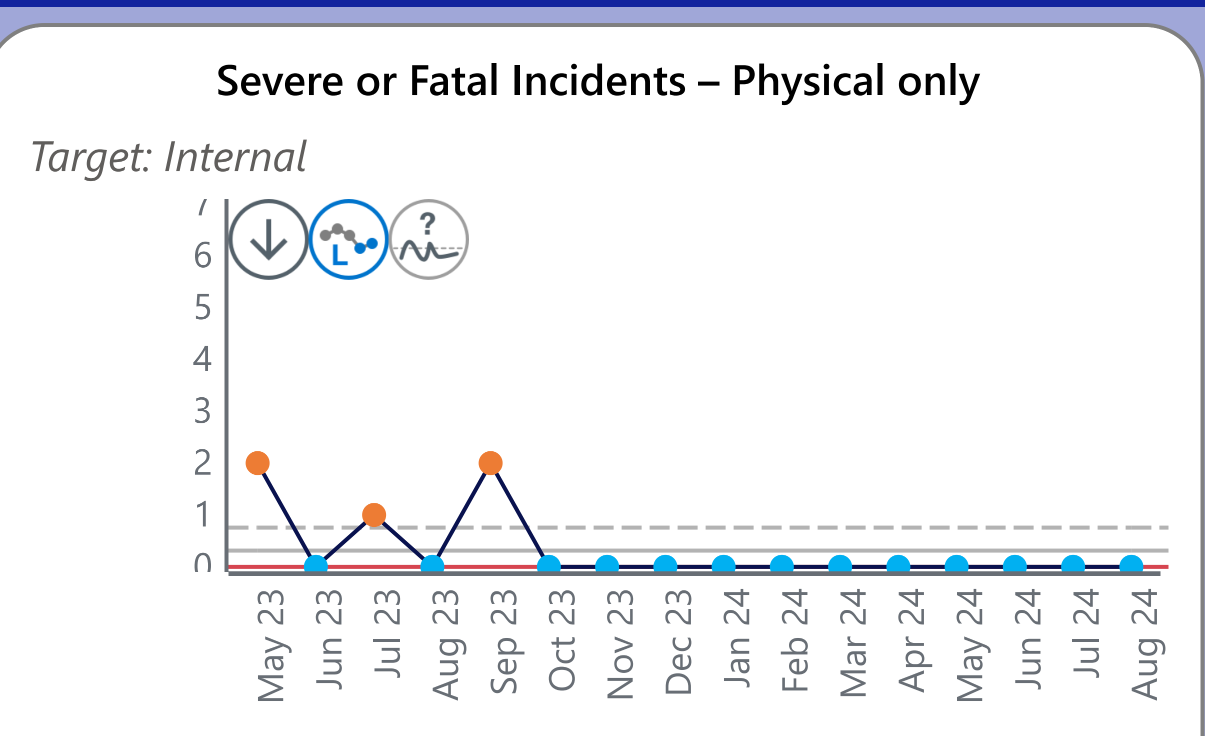
Common cause variation observed with 61 incidents of no harm per 1000 bed days, with a monthly average of 73. This incluces 28 incidents with no harm assigned due to not involving a patient directly. Incidents are now assessed on Physical and Psychological Harms and target is set against a 5% improvement on 23/24 with monthly target 44.1. Period covers from May23 only, when new risk management system InPhase went live.

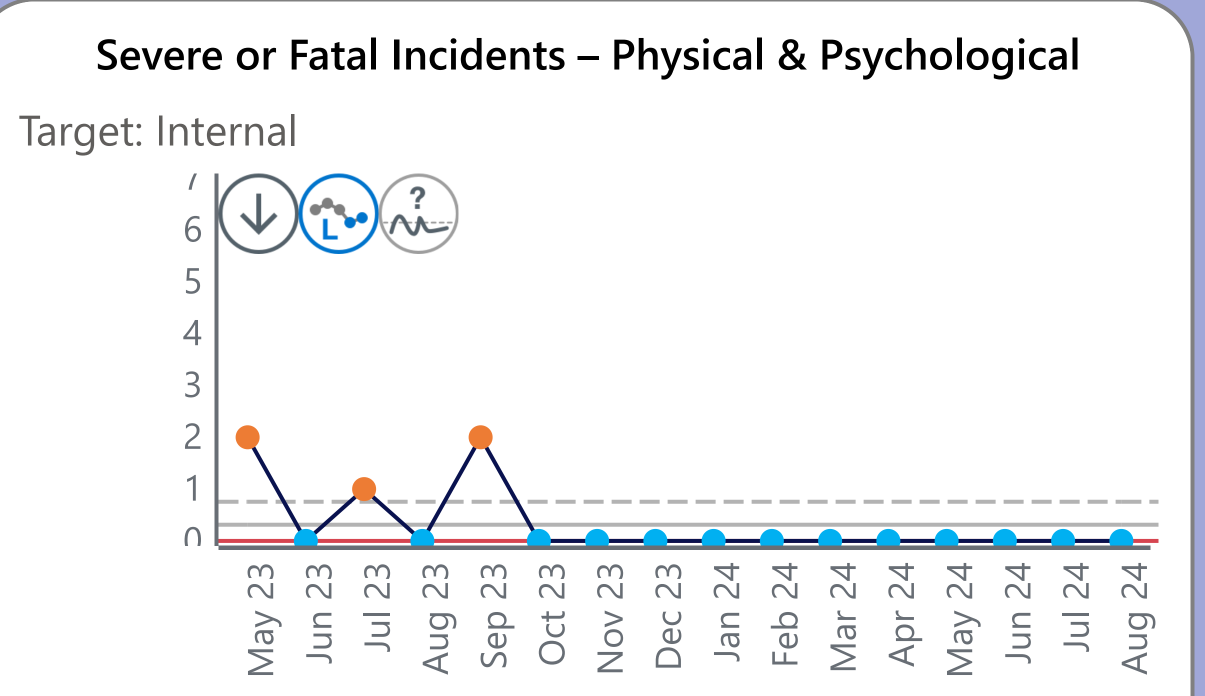
Actions:

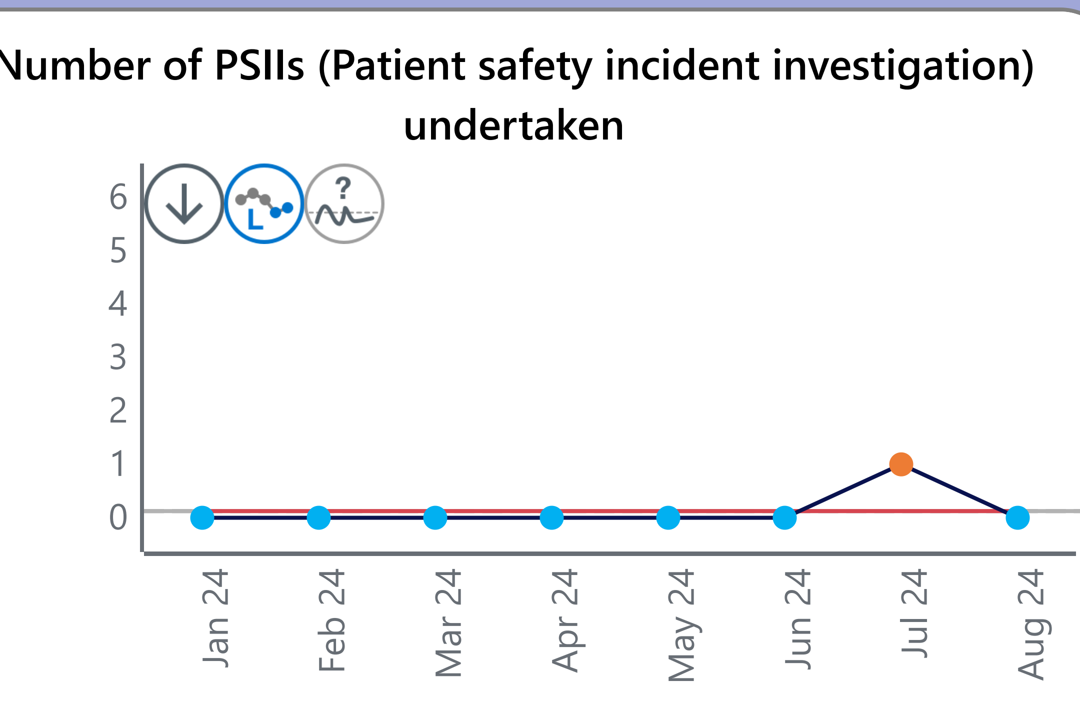
Continue to encourage a culture of reporting incidents and near misses to enable learning

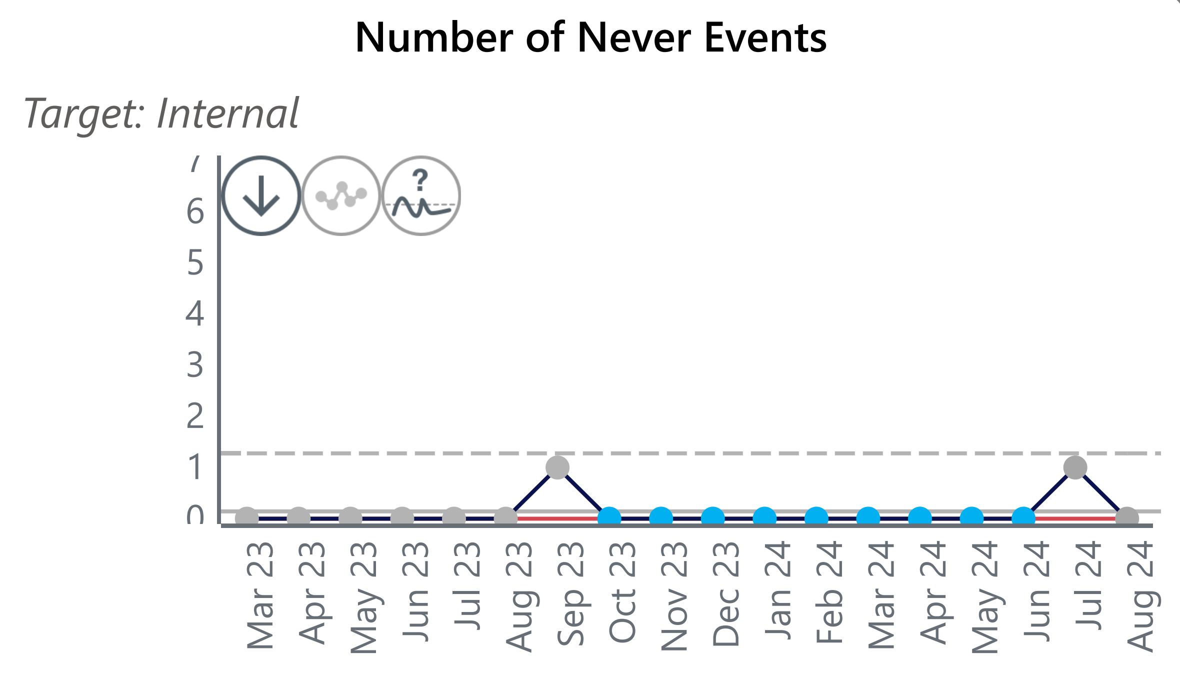
Outstanding Care and Experience- Safe & Caring - Watch Metrics

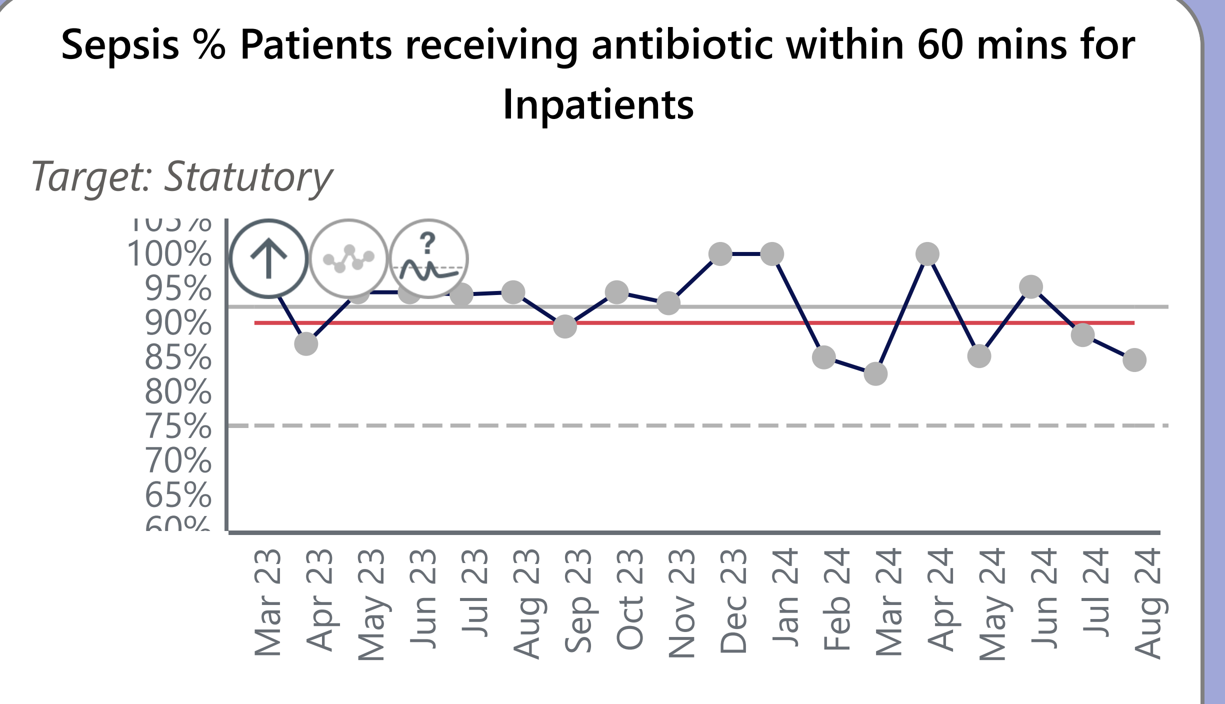


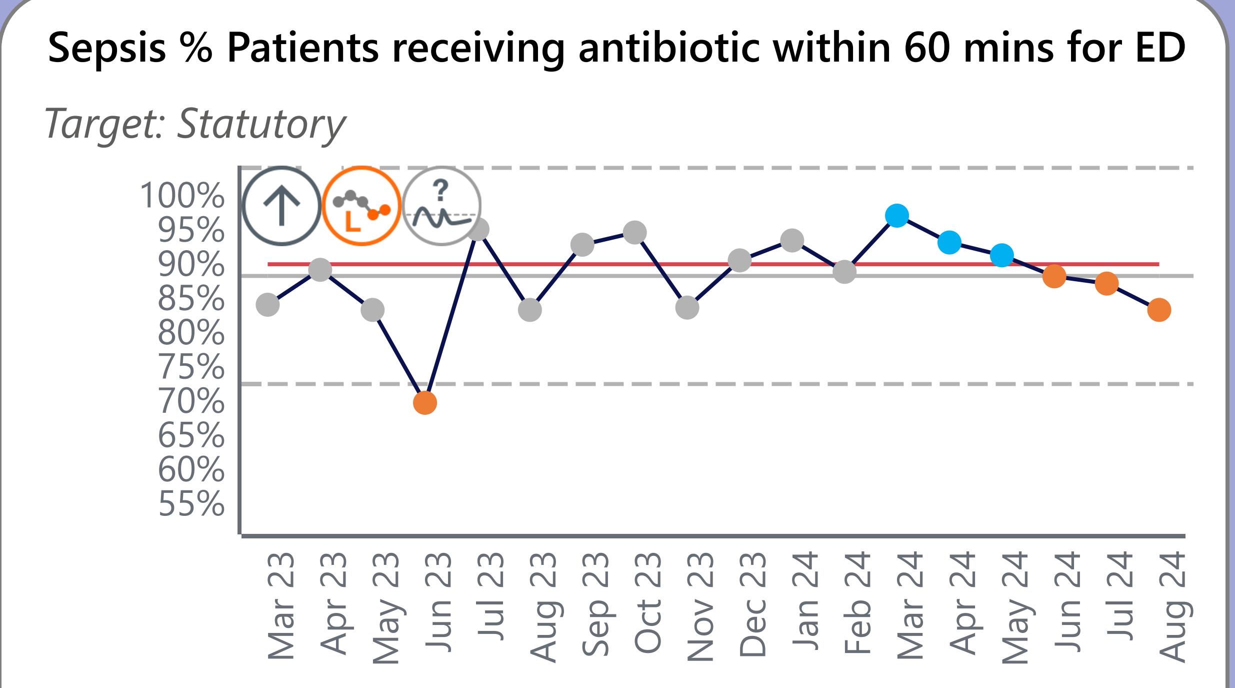


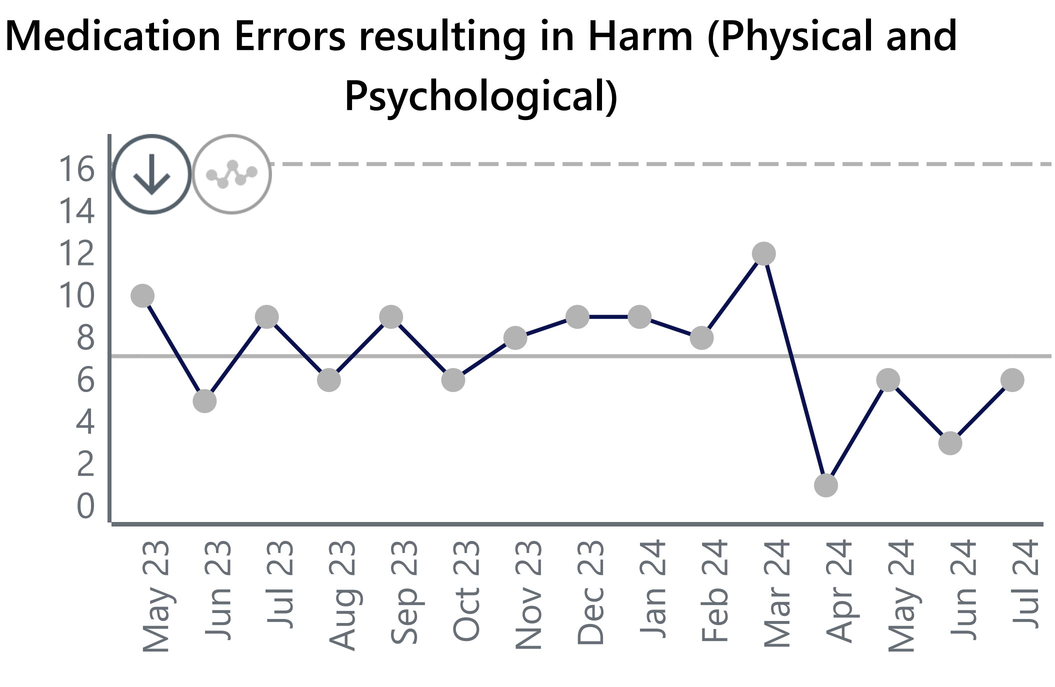


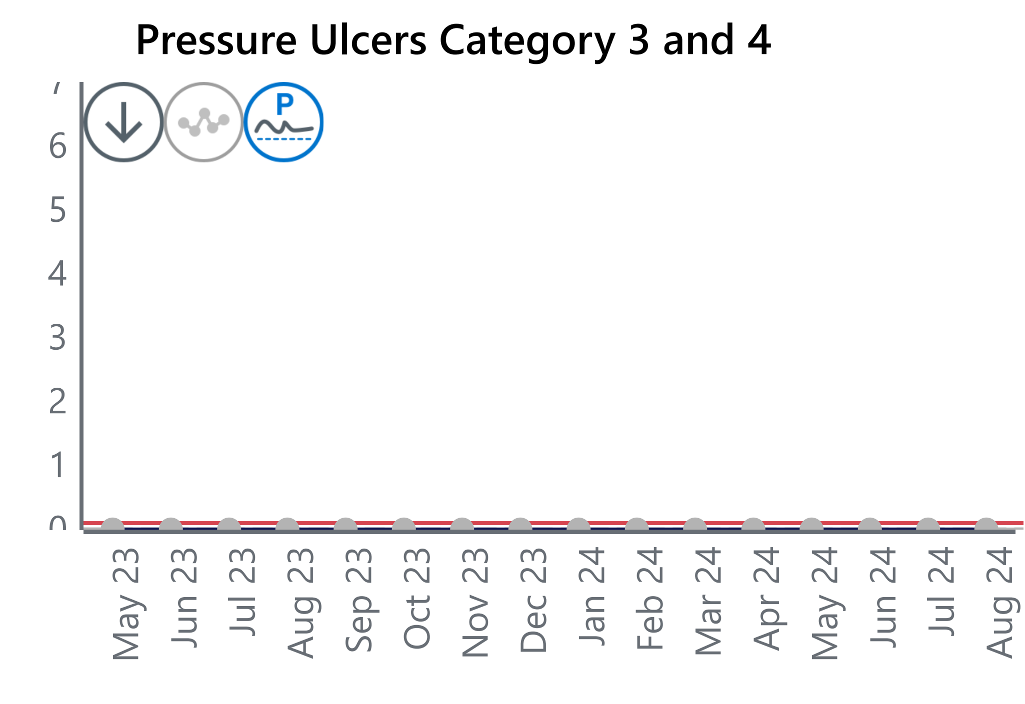


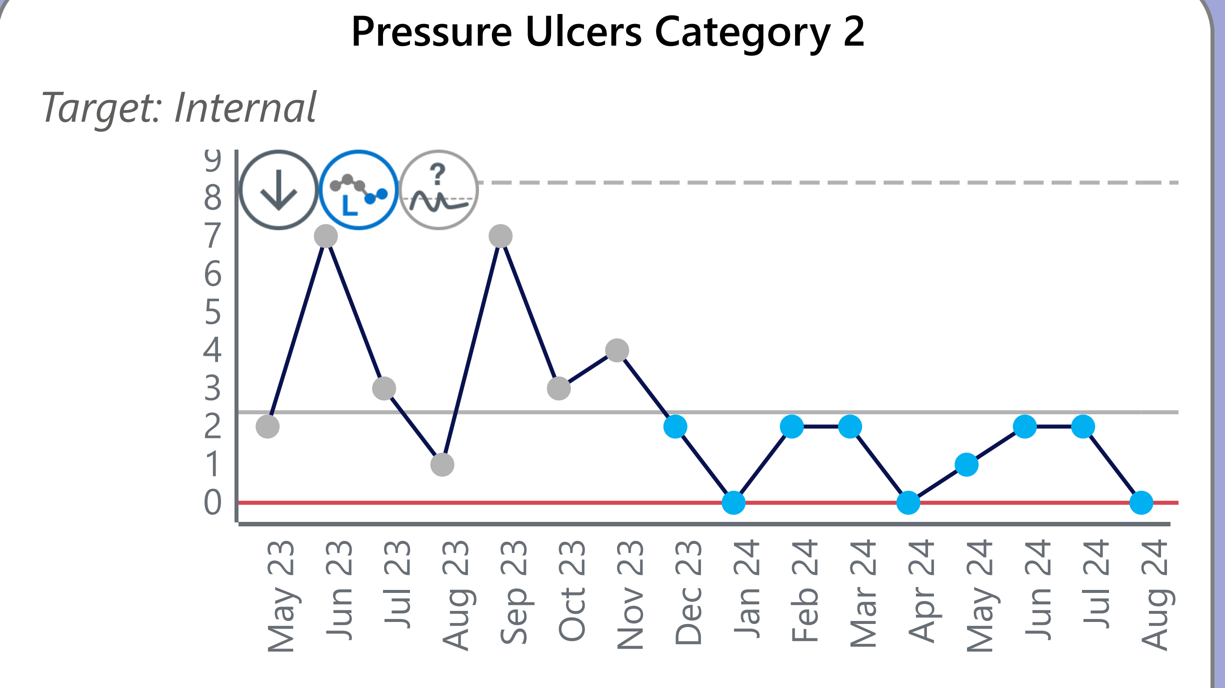


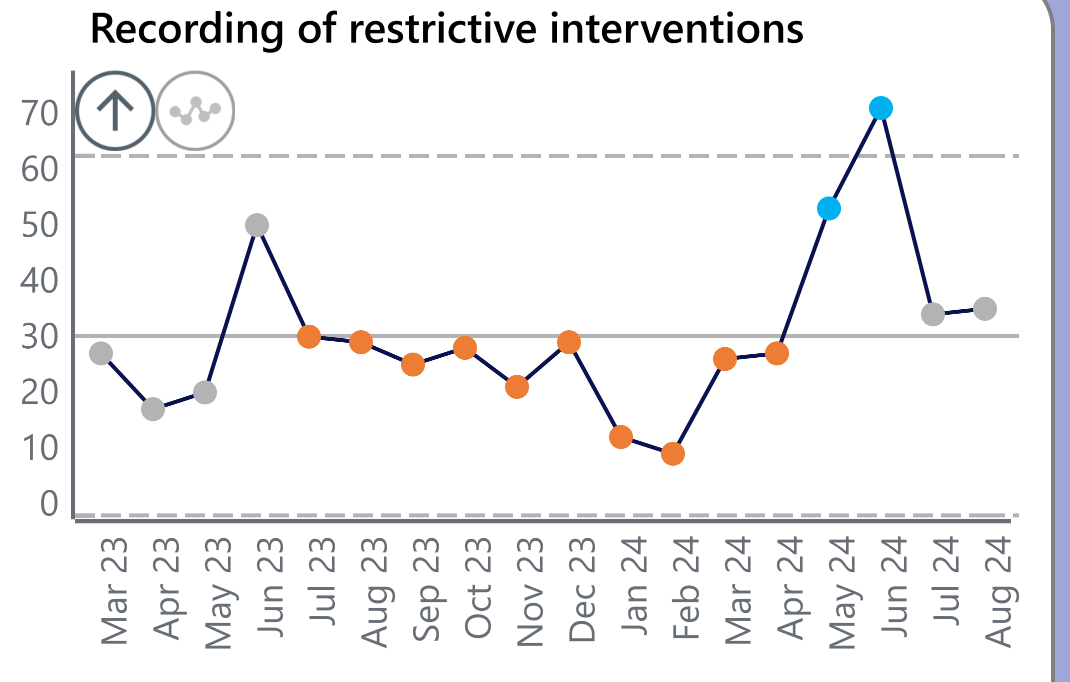


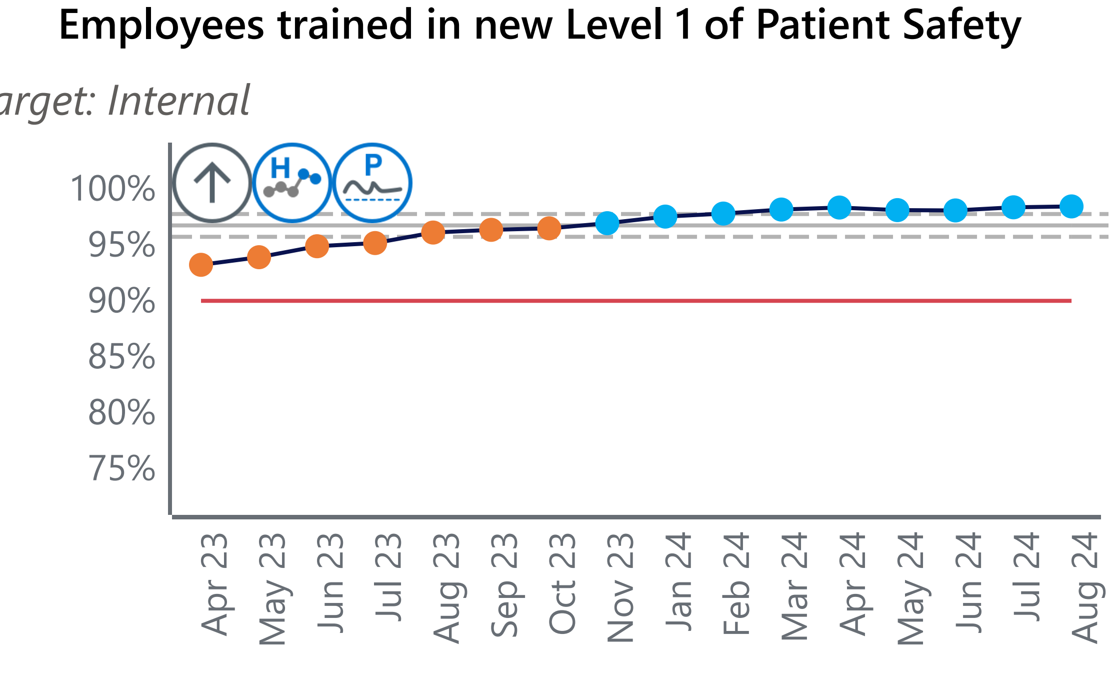












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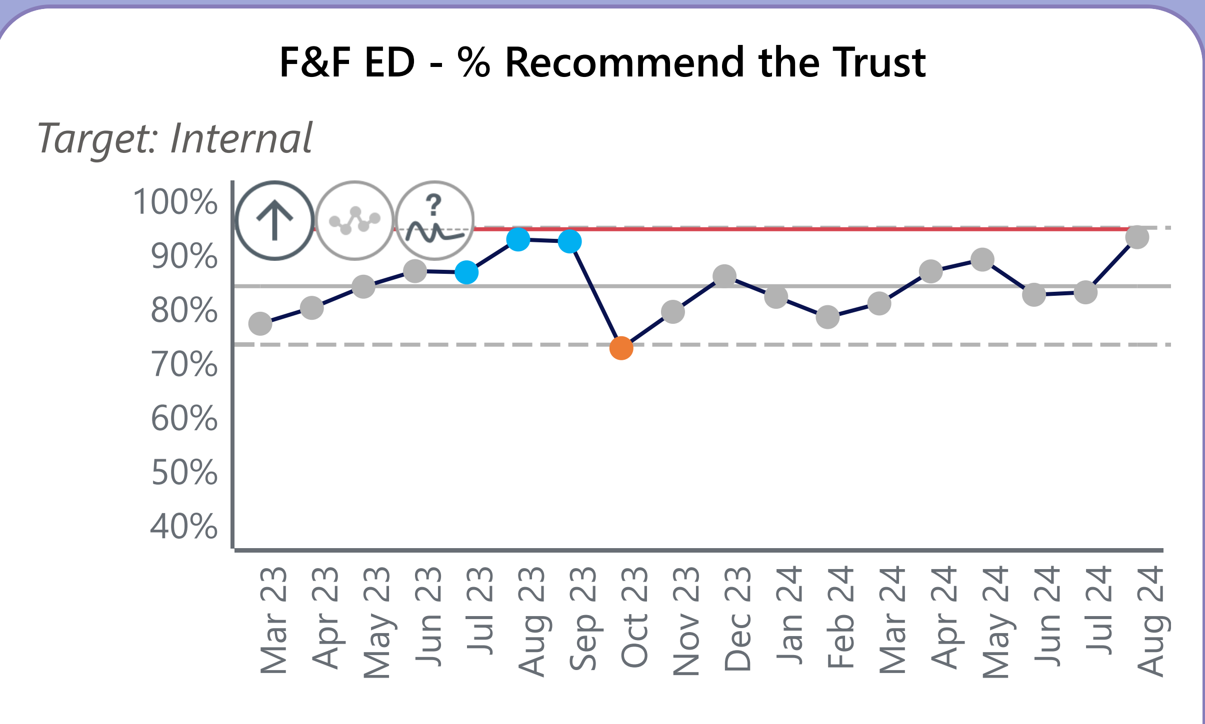
Outstanding Care and Experience - Safe & Caring - Watch Metrics

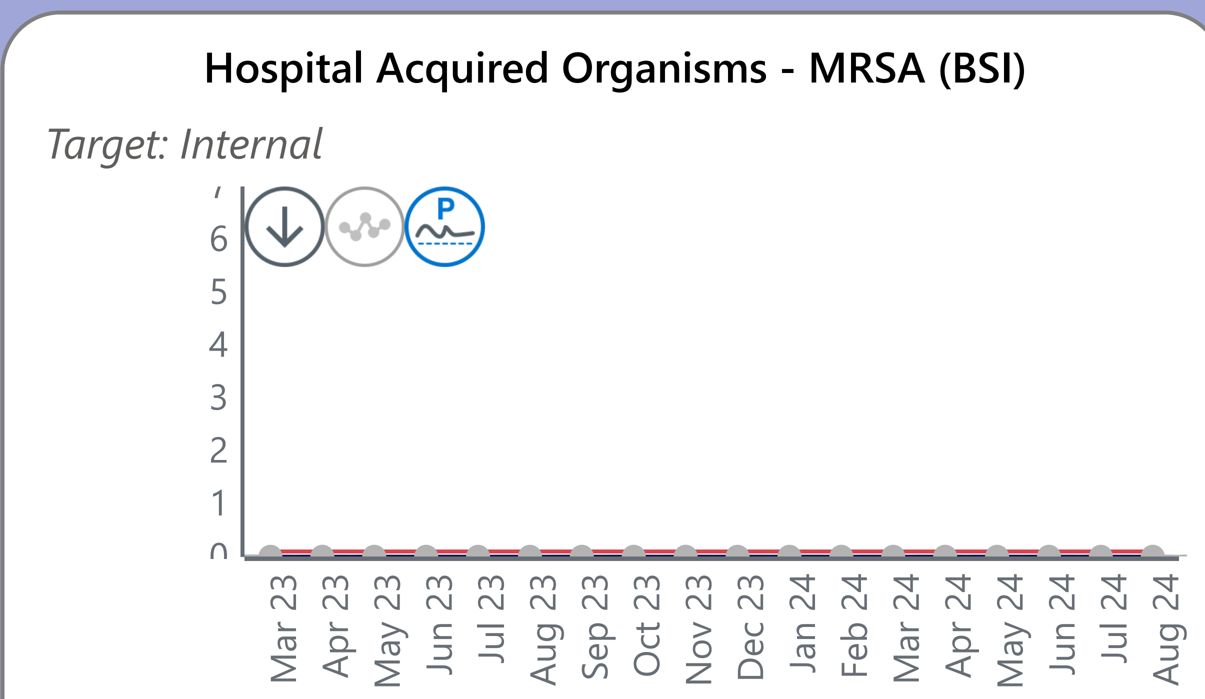
F&F ED - % Recommend the Trust

Target: Internal



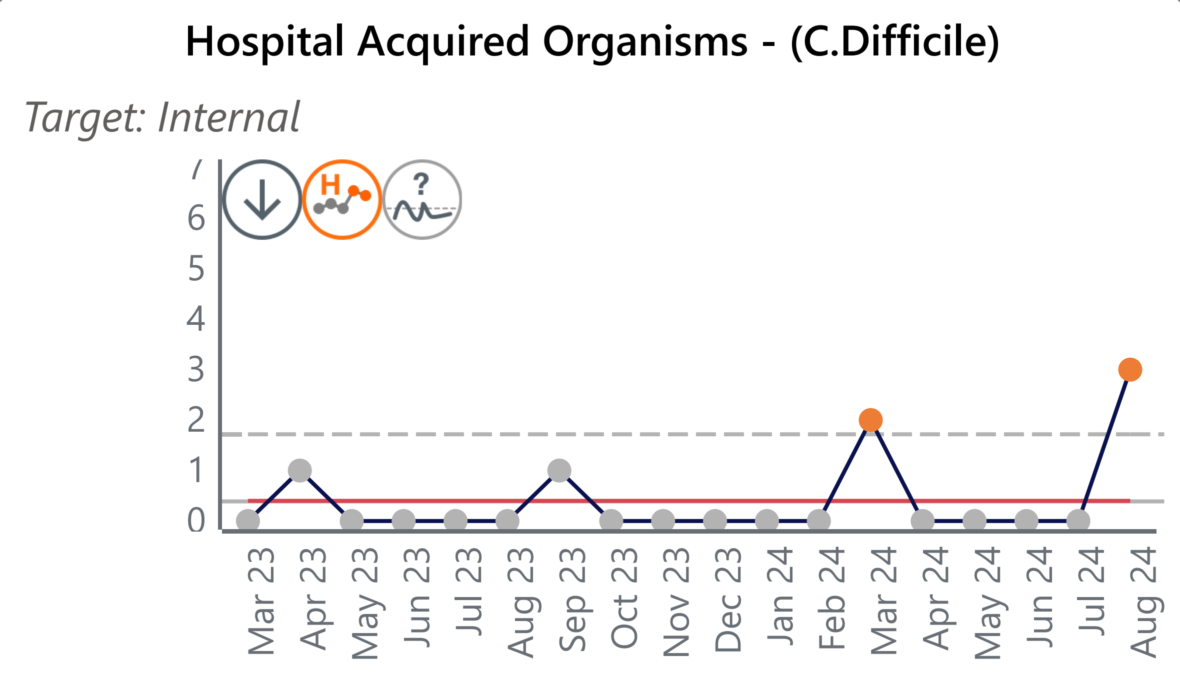
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



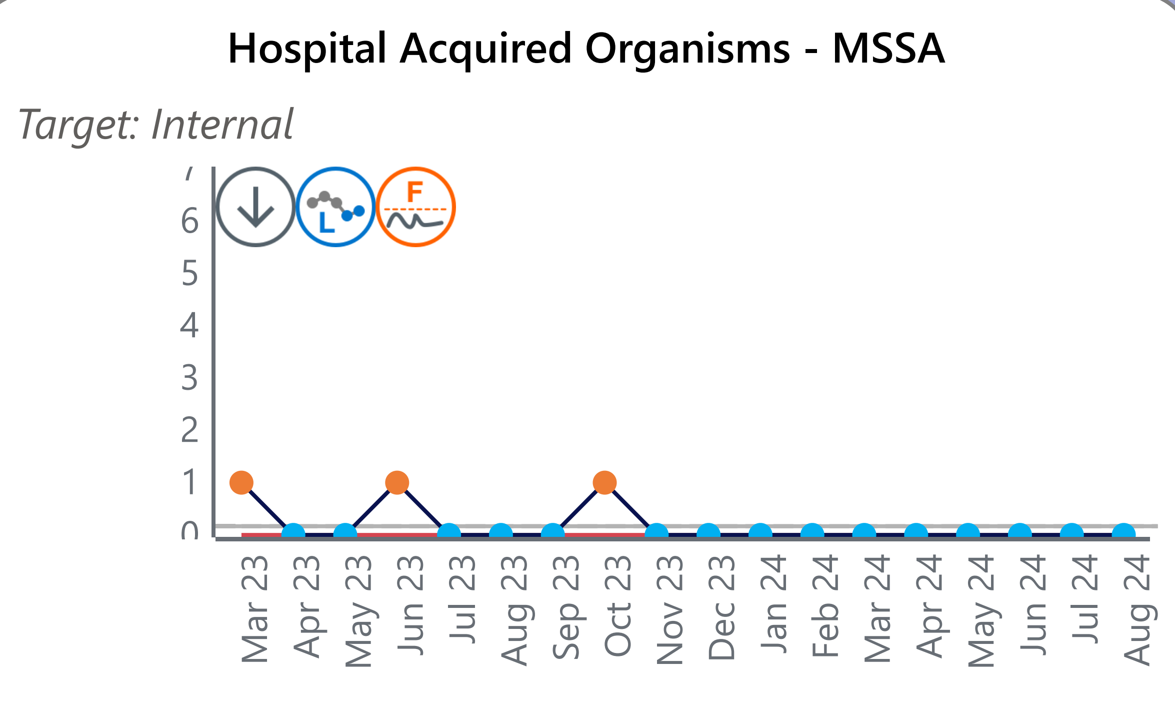
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



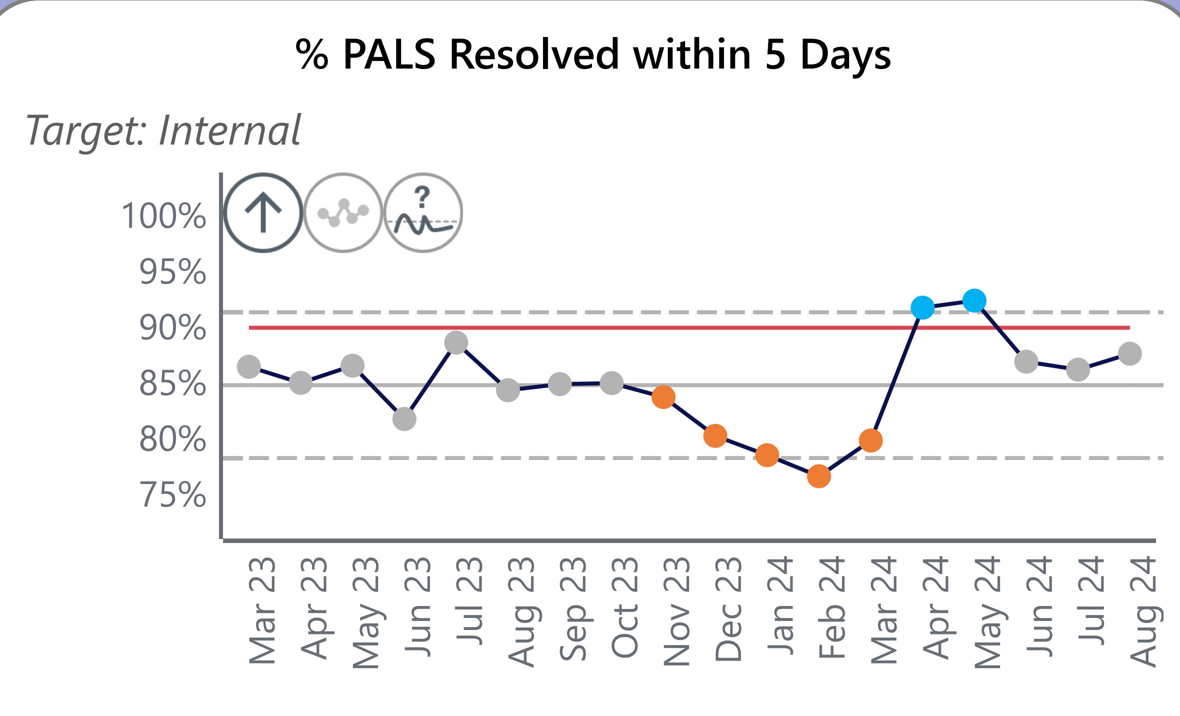
Hospital Acquired Organisms - MSSA

Target: Internal



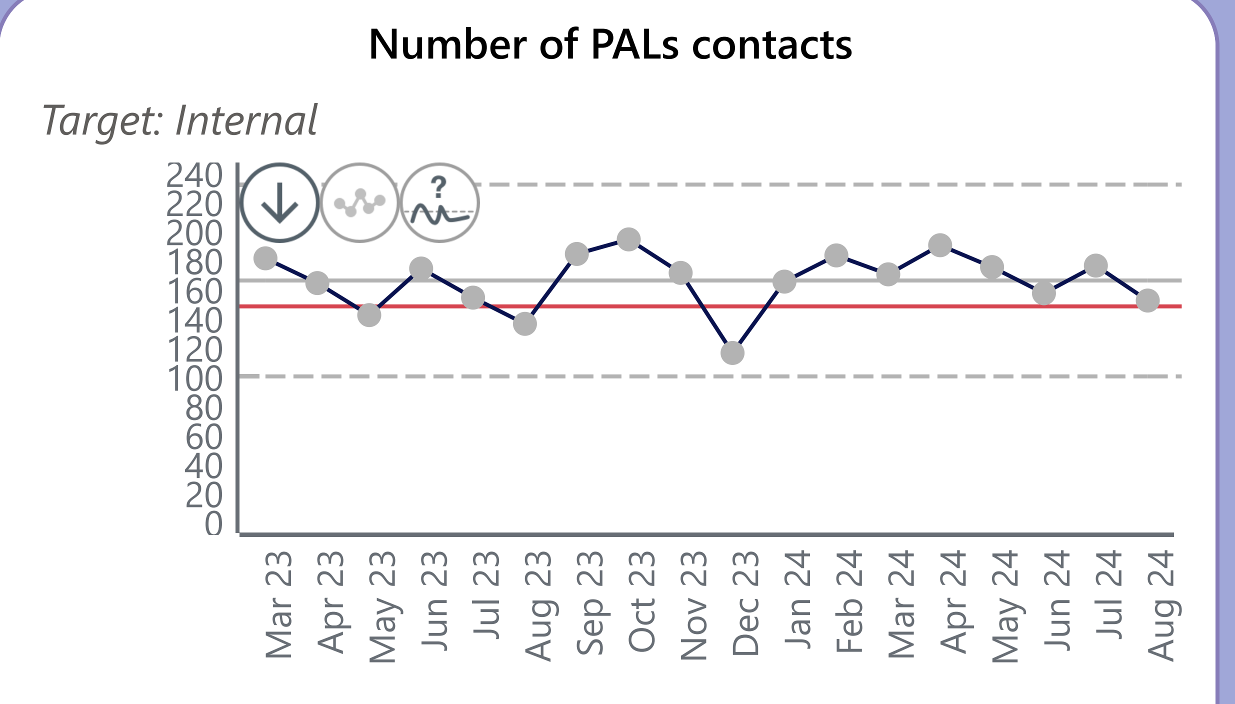
% PALS Resolved within 5 Days

Target: Internal



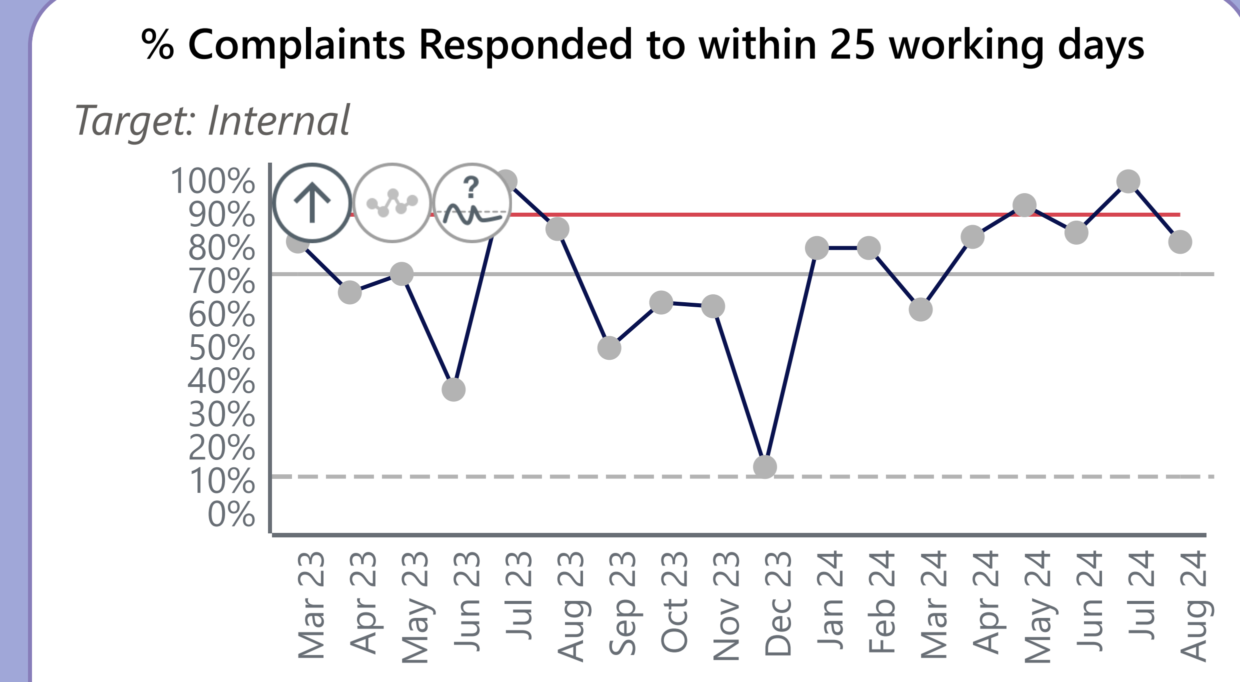
Number of PALs contacts

Target: Internal



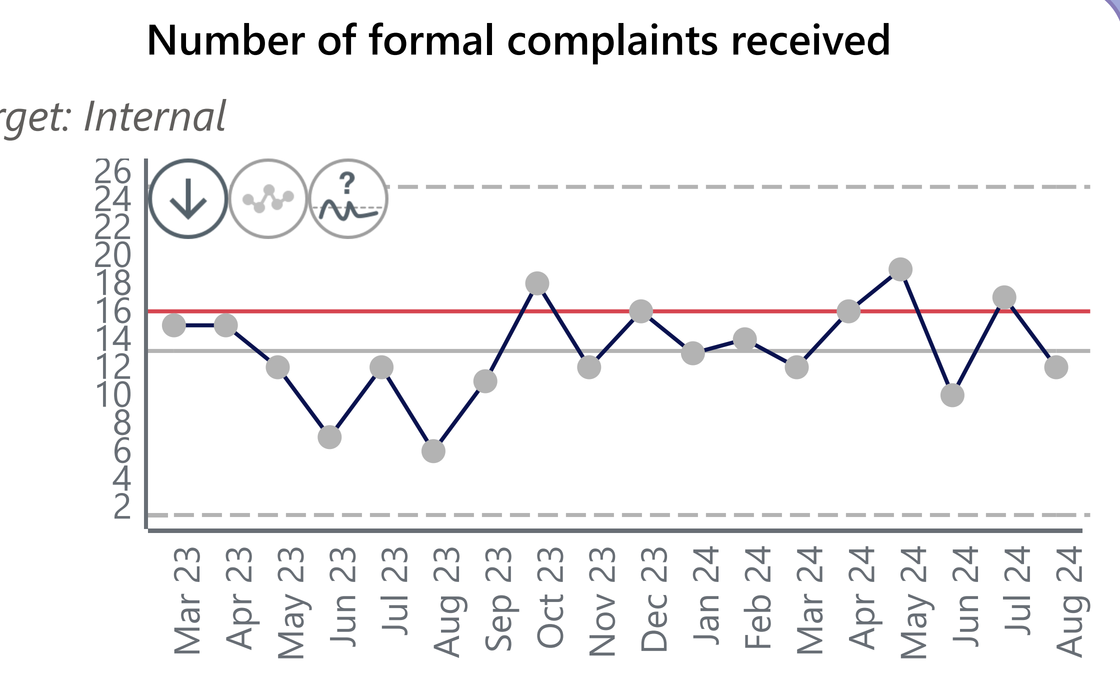
% Complaints Responded to within 25 working days

Target: Internal

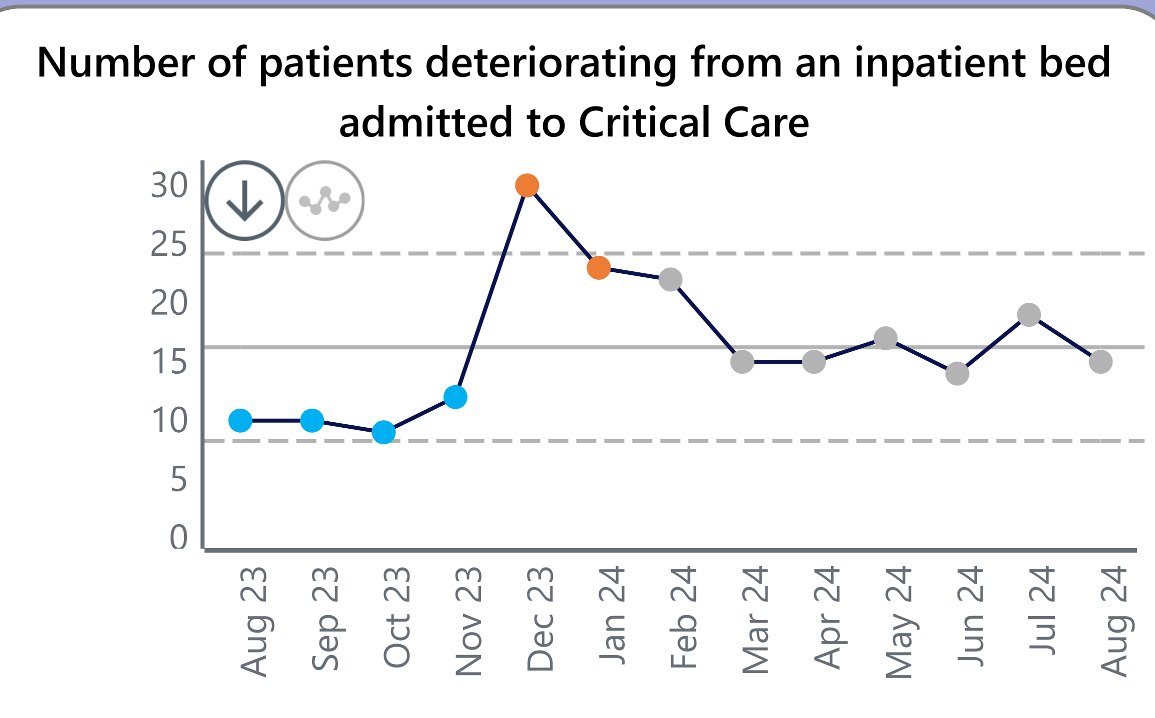


Number of formal complaints received

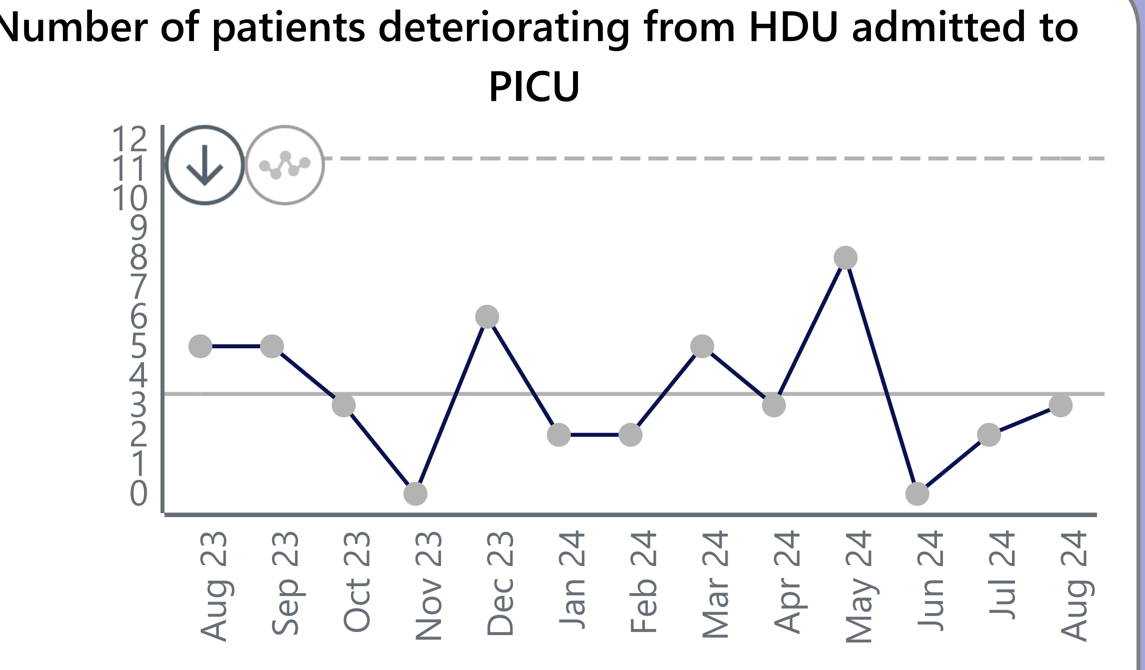
Target: Internal



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



Number of patients deteriorating from HDU admitted to PICU



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:

- A&E performance has improved for the second month, achieving 93% against a national target of 78%.
- Elective admissions and Outpatient attendances per consultant WTE are both above target, indicating an increase in productivity.
- 560 patients waited over 52weeks for treatment against an external trajectory of 727

Areas of Concern:

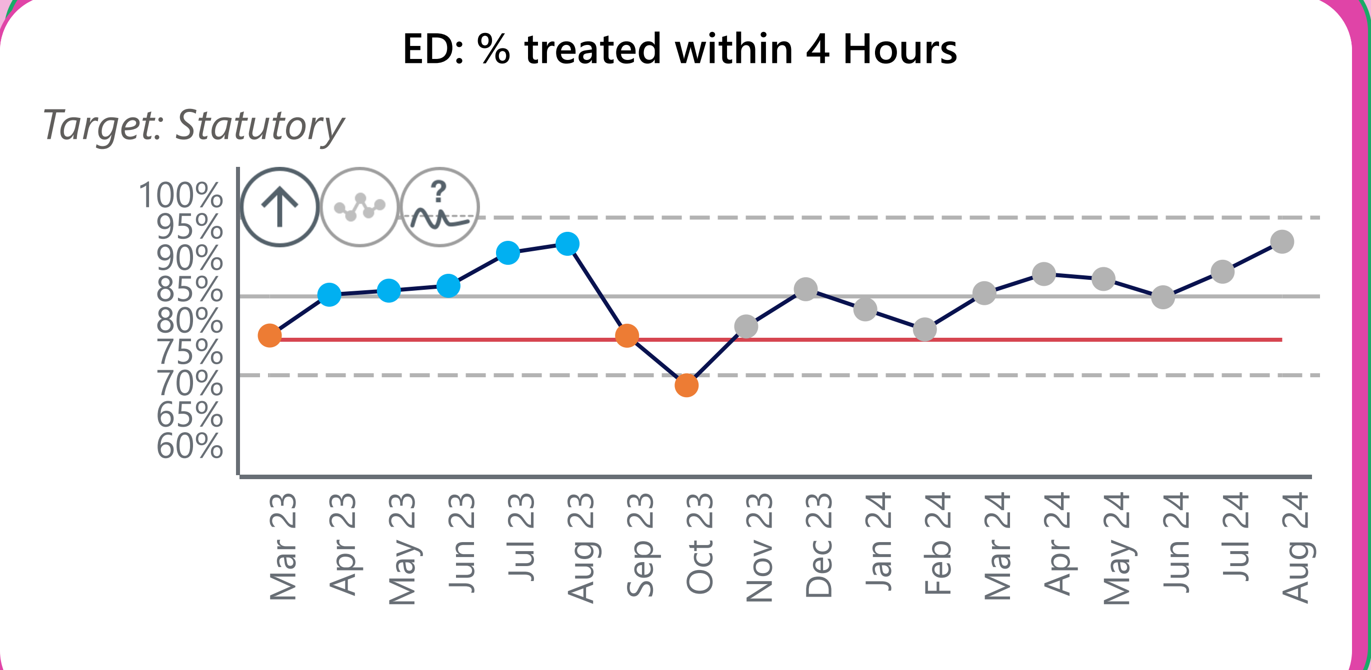
- Theatre touch time showing no statistical improvement however specialities running through the productive theatres programme have shown improvement.
- The WNB rate increased to 12%, however this is reflective of an increase over summer in 2023. This will be monitored closely to ensure this was a seasonal shift.
- The number of patients waiting for ASD or ADHD diagnosis continues to grow, now 3,044 patients are waiting

Forward Look (with actions)

- Consideration given to theatre utilisation reporting whereby volume of patients does not support target due to total turnaround time.
- Continue to run targeted HVLC theatre lists via productive theatres programme. July-Sept +74 additional patients treated.
- Deep dive review and rapid review approach to cancellations on the day in theatre due to opportunity. Focus on pre-op pathway.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

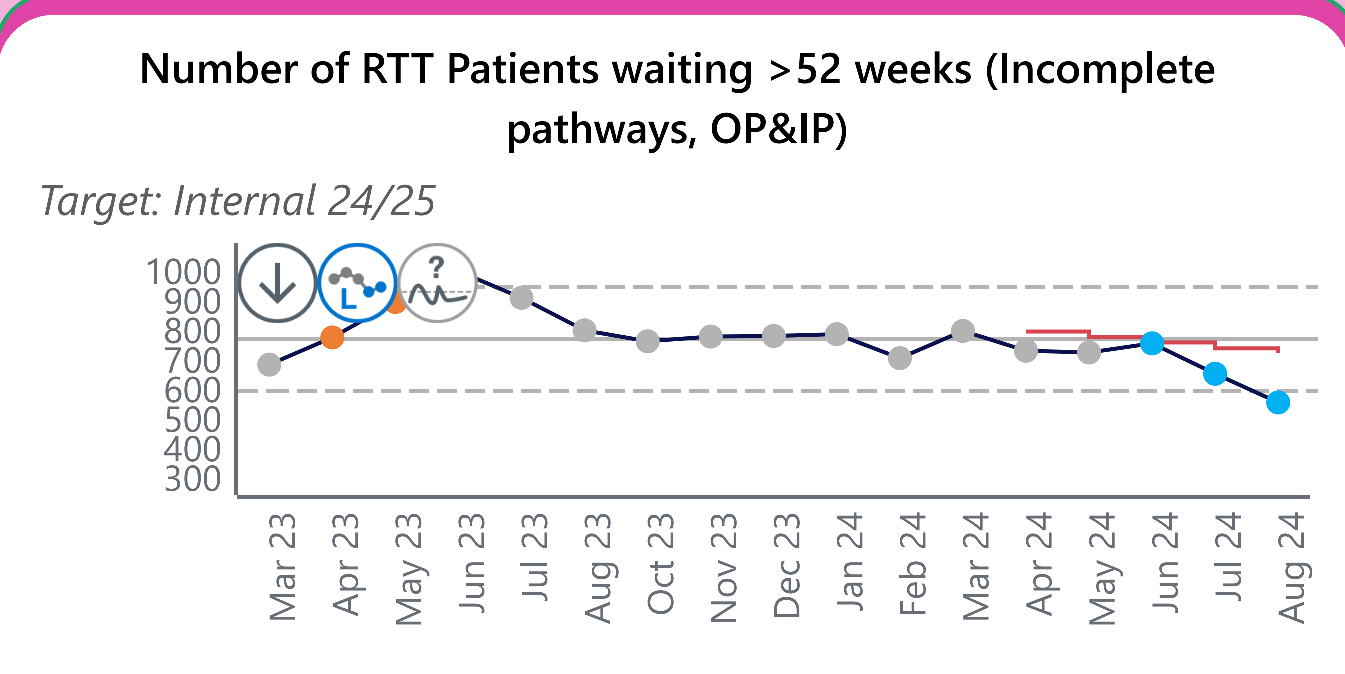
Trust is achieving the national target (>77%) in August-24. Common cause variation has been observed with performance of 92.6%. Improvement from July-24 (87.9%). August-24 performance is +0.3% compared to Aug-23 (92.3%). July-24 seen -381 attendances compared to July-23. 2024/2025 performance to date is 87.4%

Actions:

- High performance has been sustained over the summer months. The Division of Medicine is currently creating the winter plan, which will support mitigating the EDU / PAU moves over the coming months.

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

Target: Internal 24/25



Technical Analysis:

Demonstrating special cause variation of improving nature with number of patients waiting > 52 weeks at 560 for Aug 2024 against a trajectory of 727. Decrease from Jul 2024 position of 657 and the 2nd consecutive month with a reduction. Top 3 services with waiters >52 weeks: Dentistry (n= 253), ENT (n=116) & Neurology (n=56). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

Actions:

- Performance against the 52-week trajectory remains strong. The focus remains on reducing the number of patients waiting over 65 weeks, with all dental patients now offered a TCI date. The focus will move to 52 weeks post September 2024.

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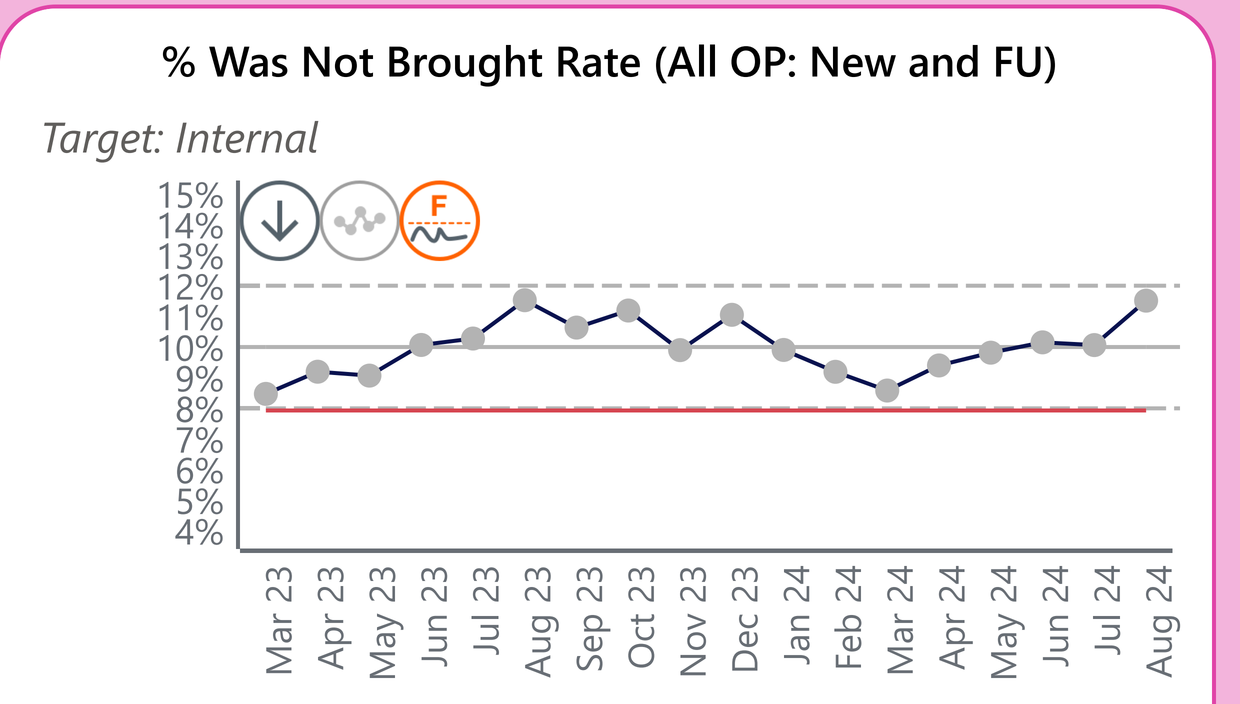
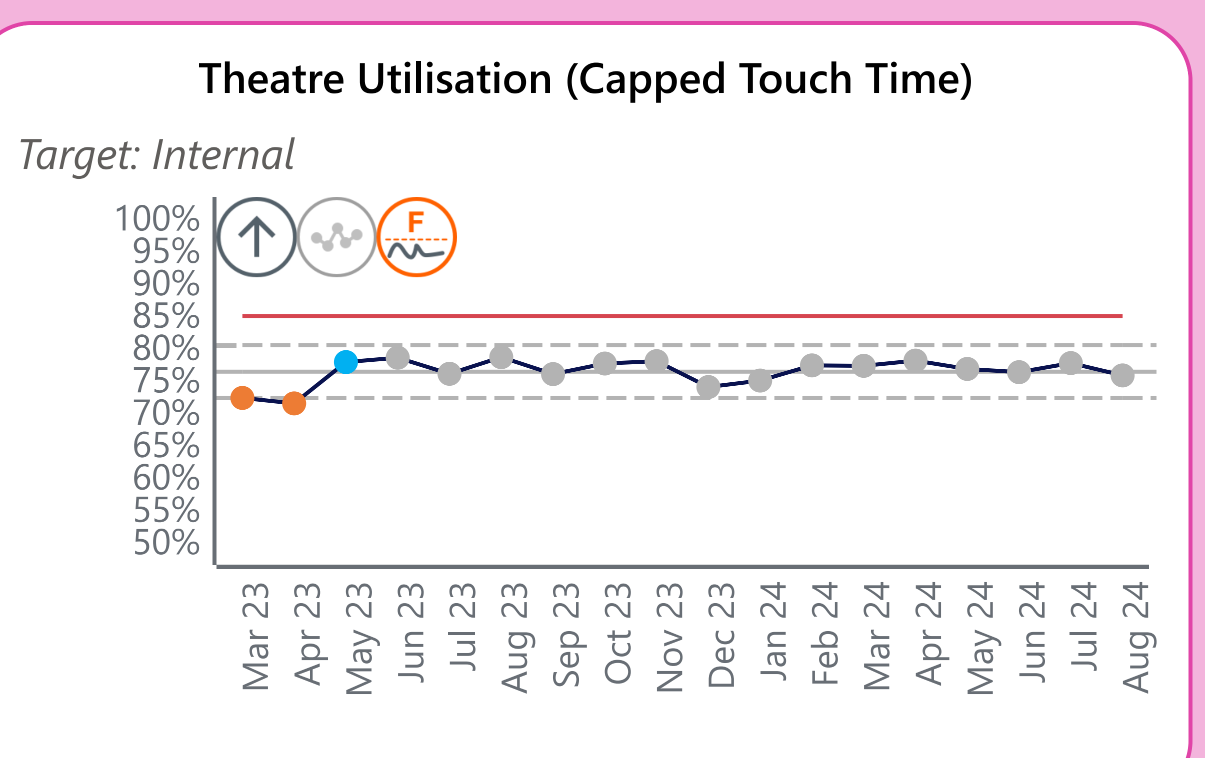
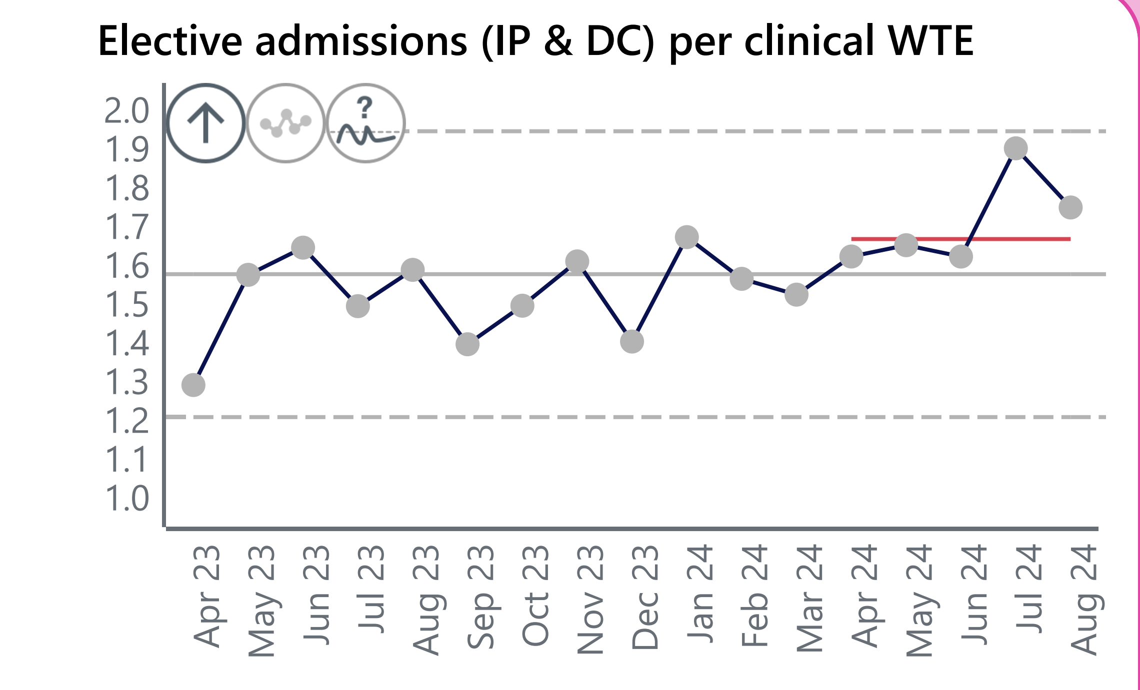
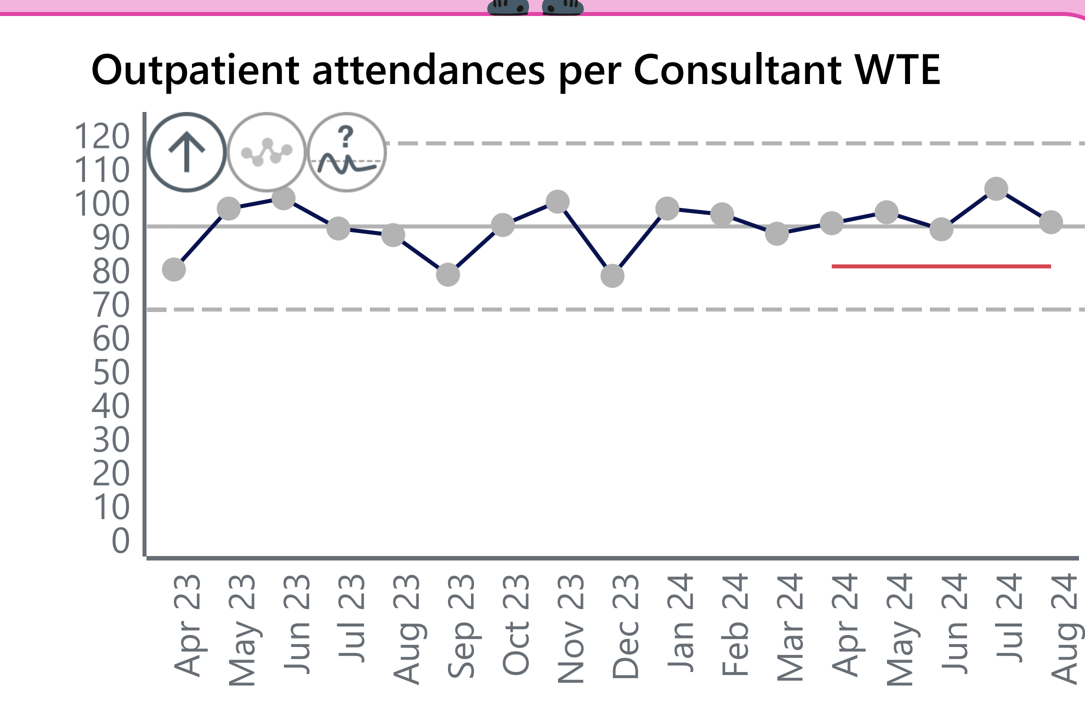
Alder Hey Children's NHS Foundation Trust

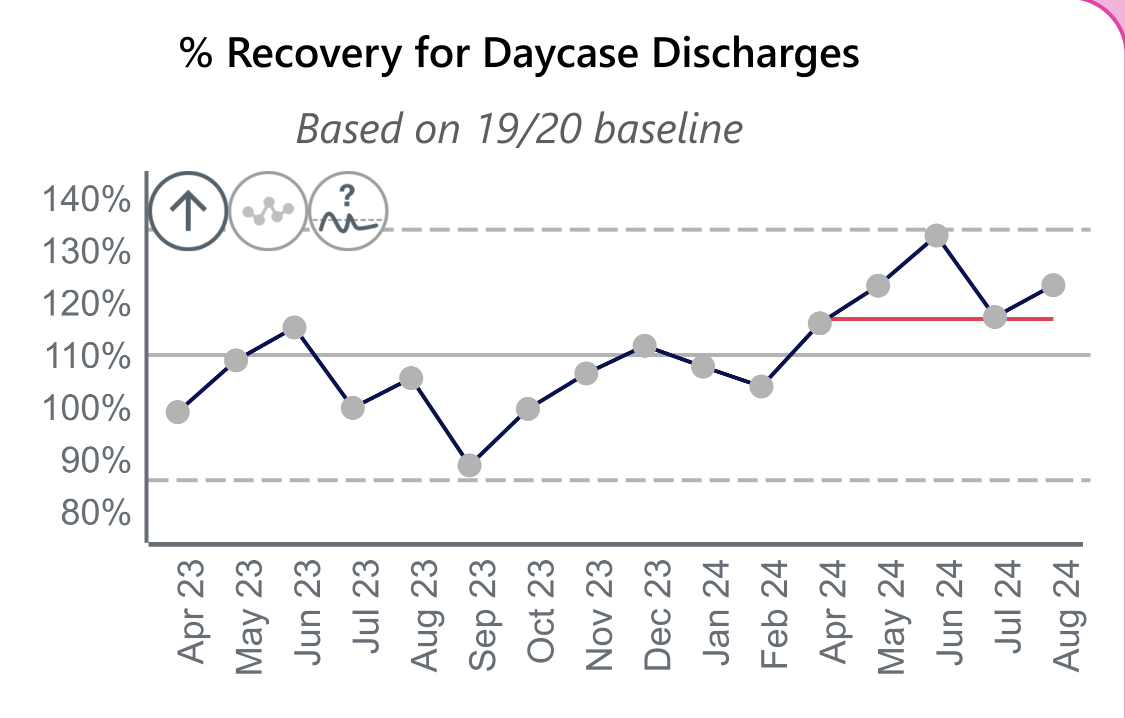
Revolutionise Care - Effective & Responsive - Watch Metrics

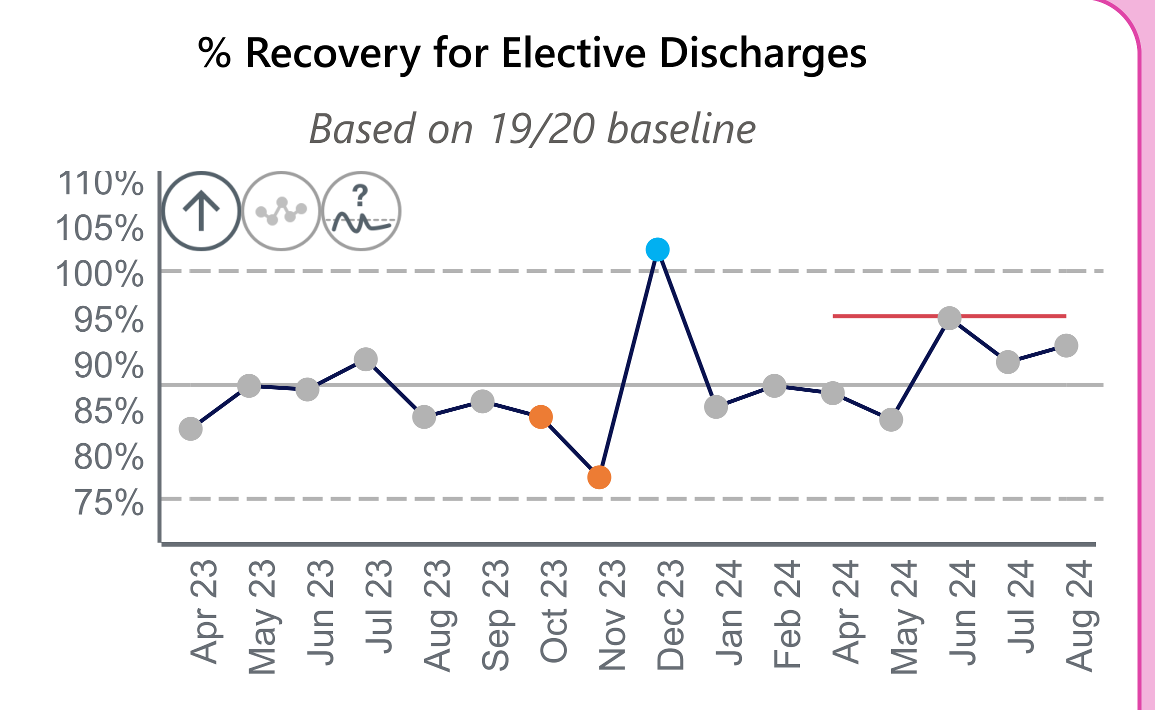


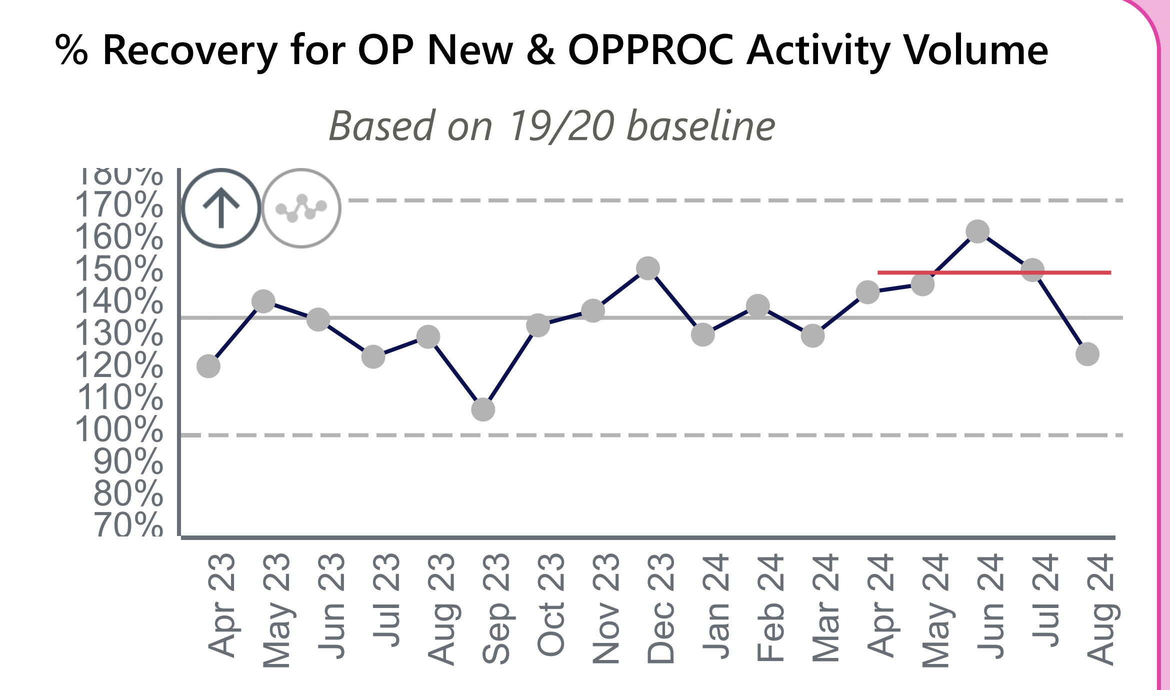


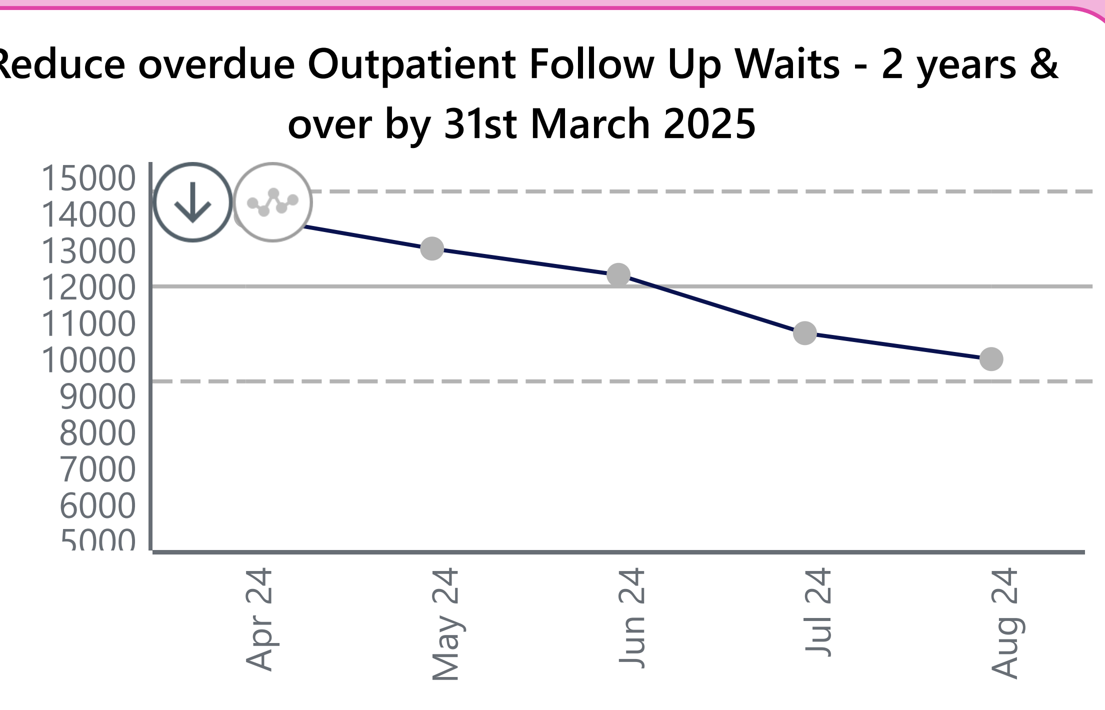


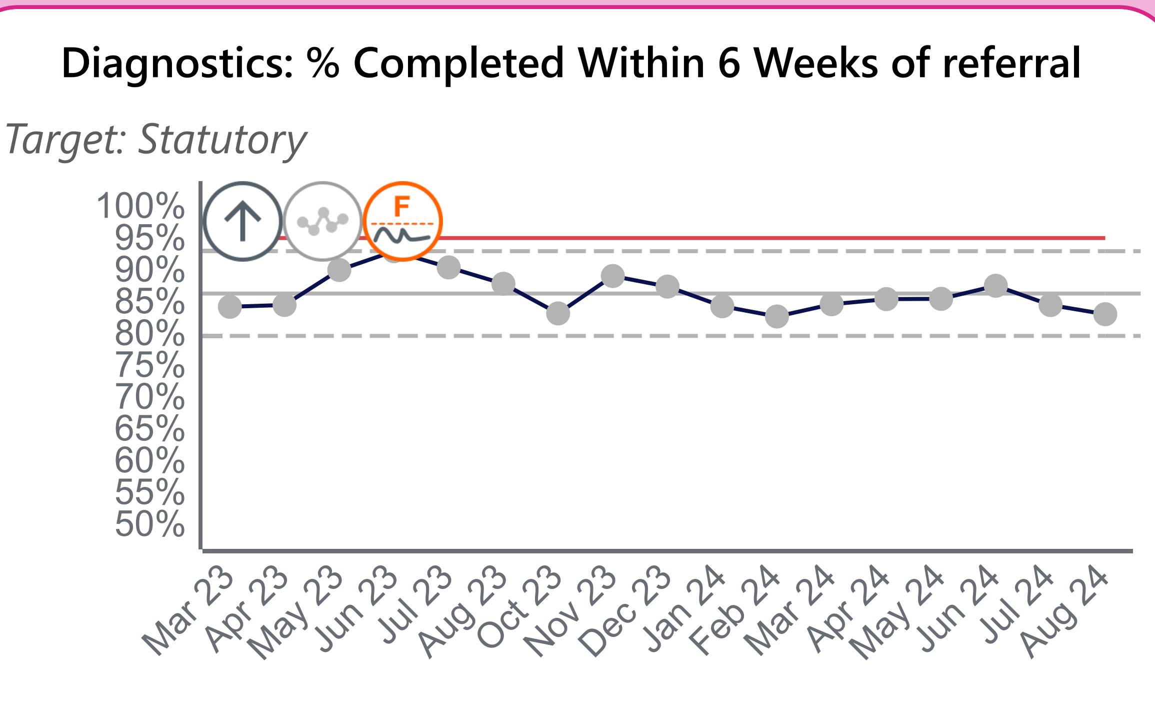


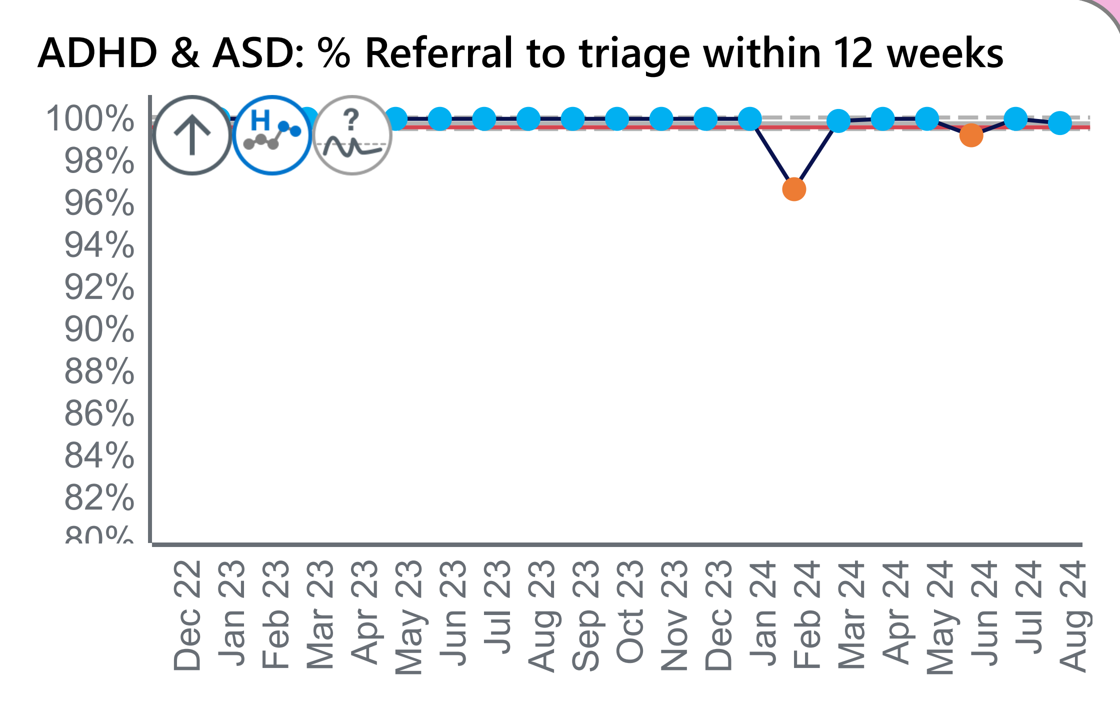


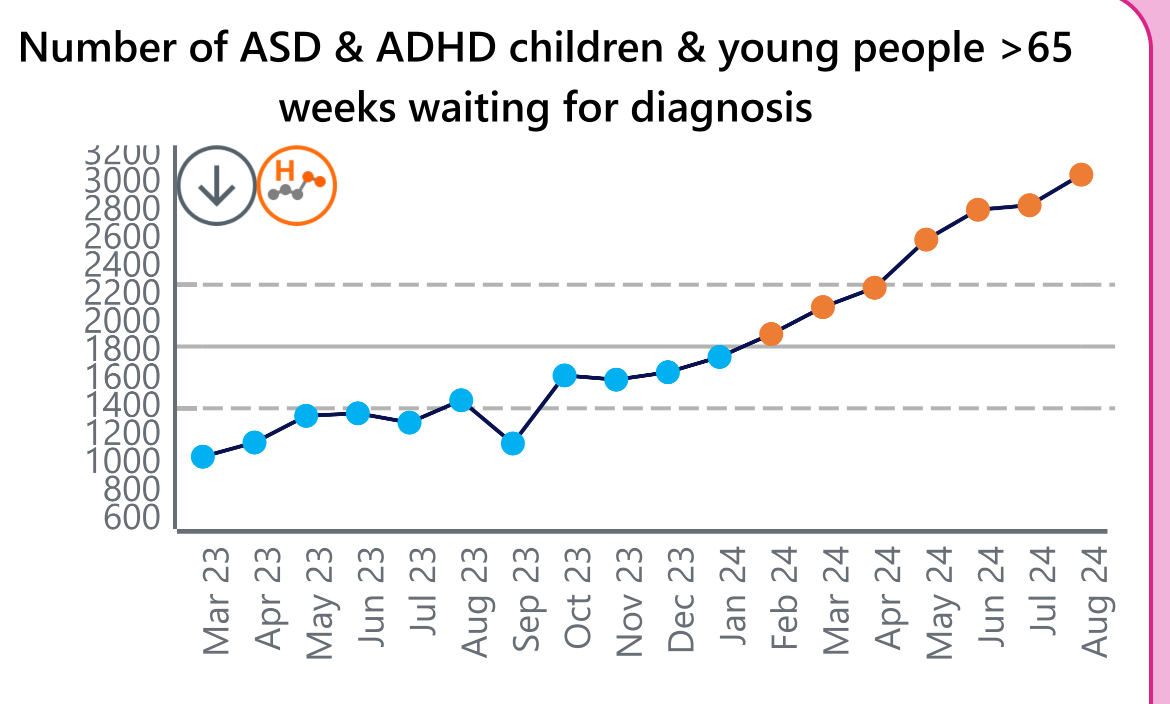




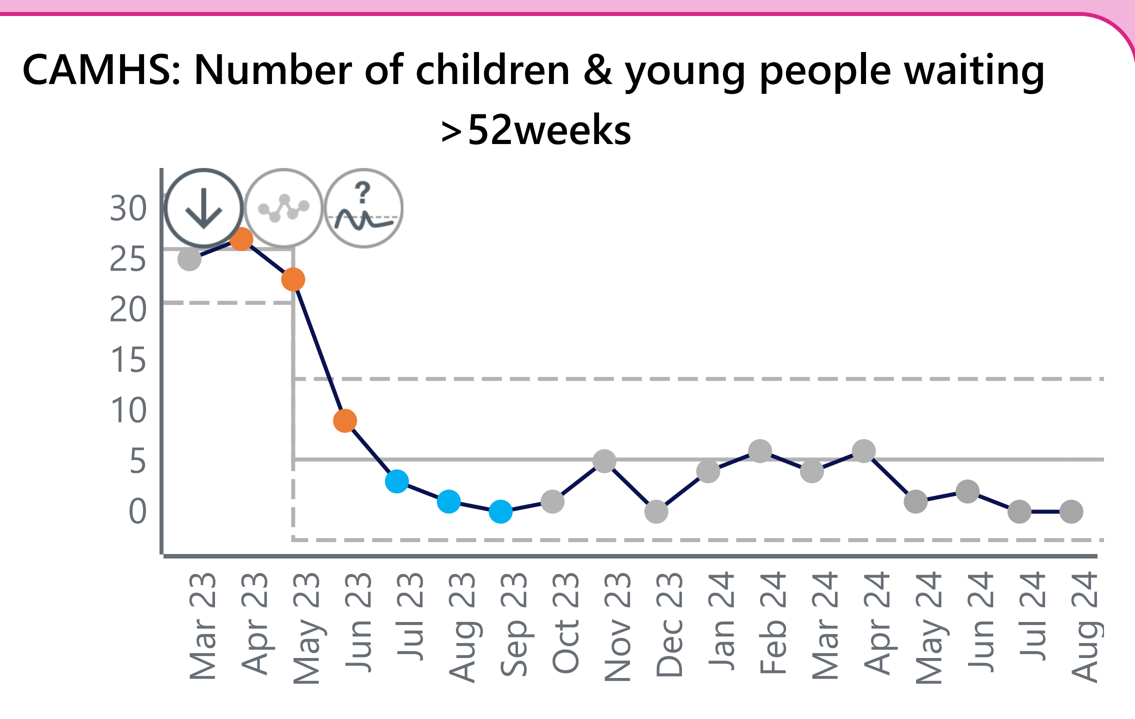


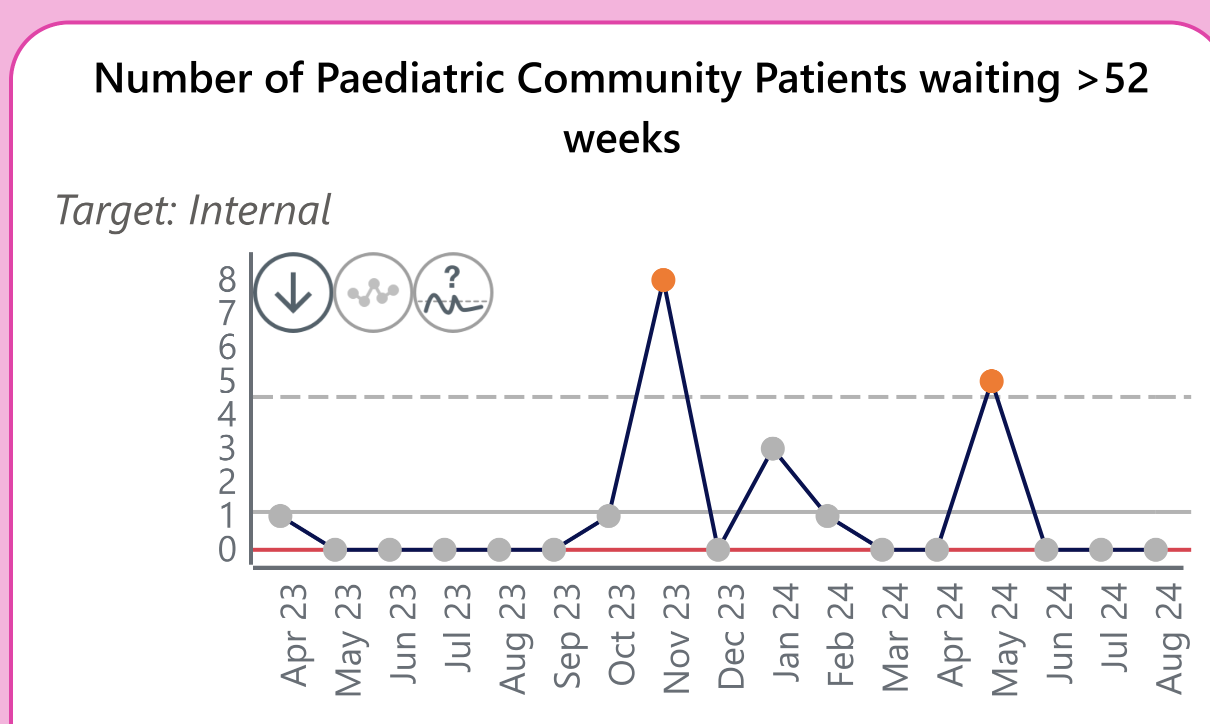


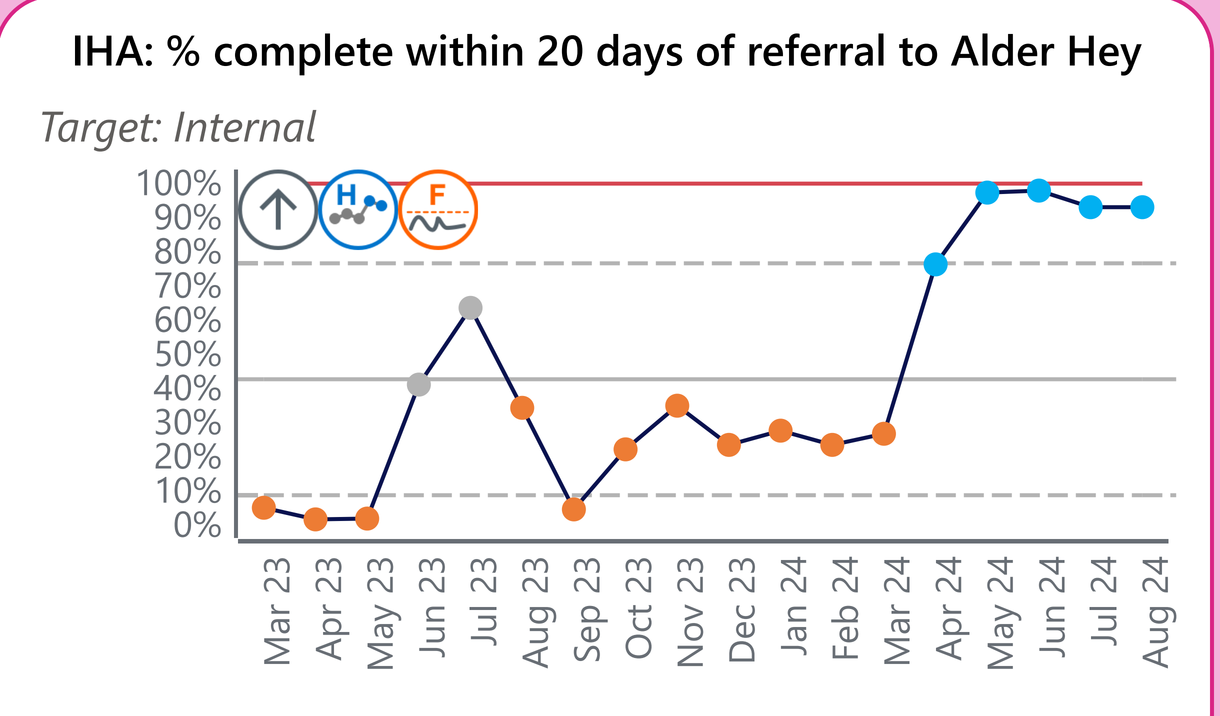


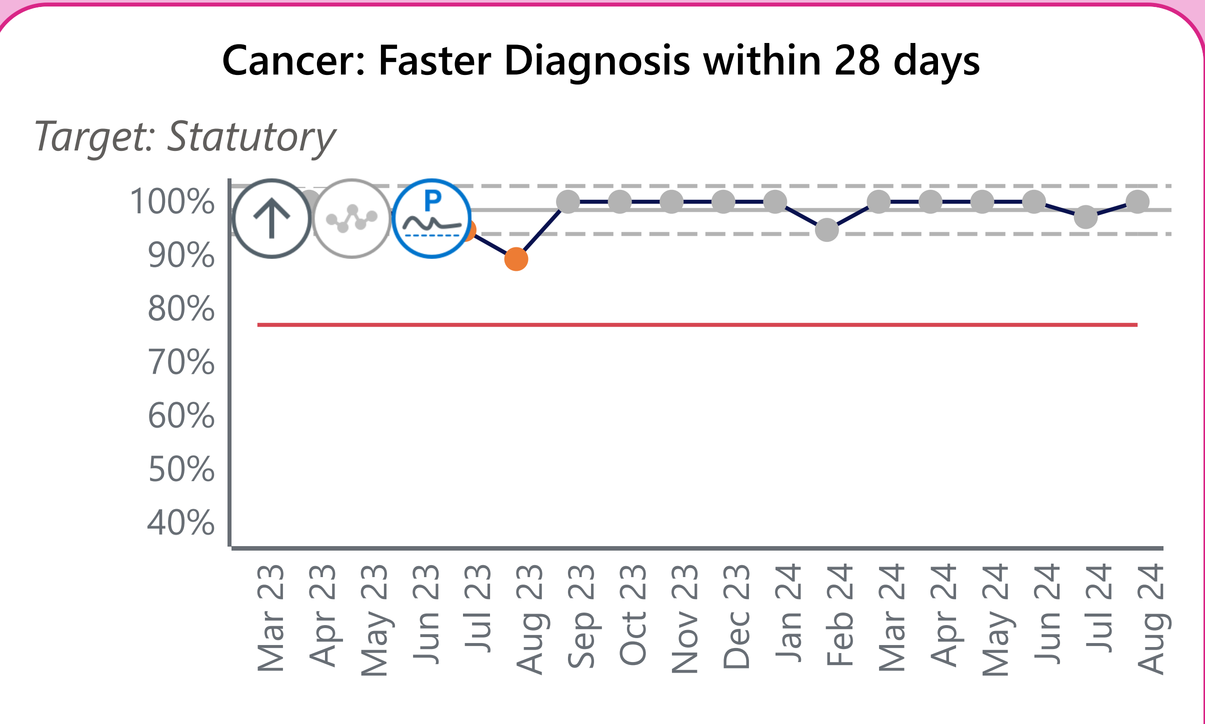


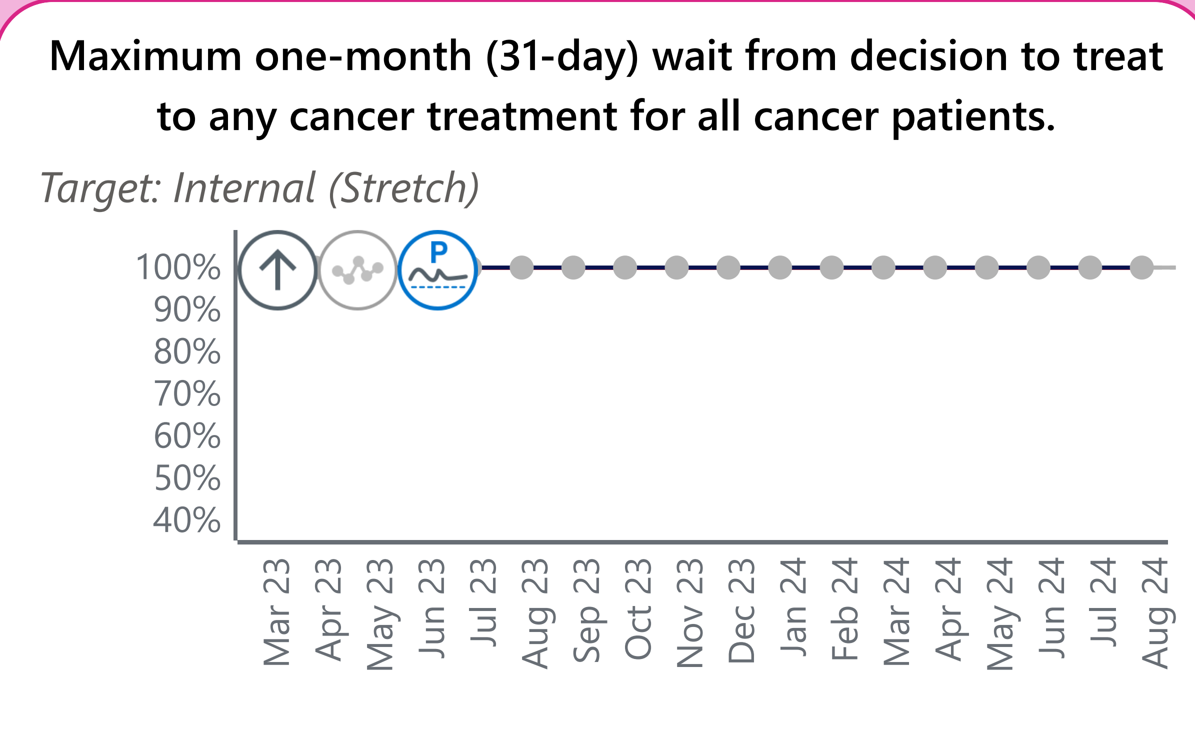
Revolutionise Care - Effective & Responsive - Watch Metrics

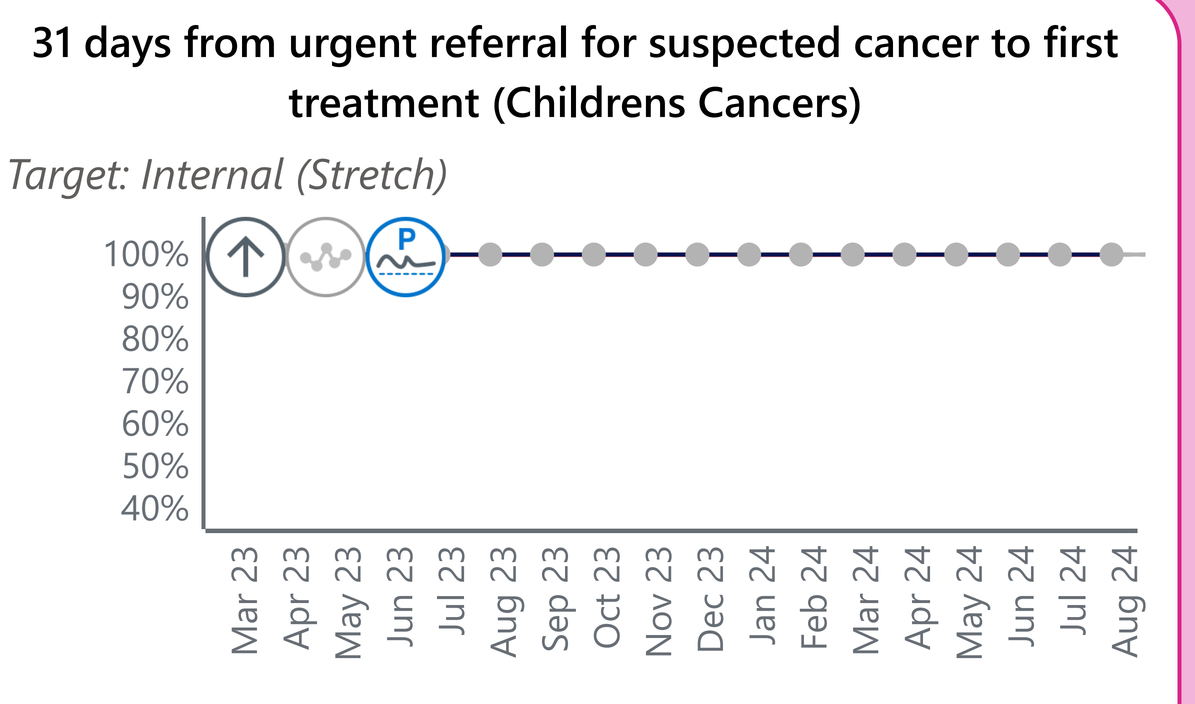












Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

- Mandatory training completion remains over 90%
- Turnover % has remained at or below 10% (the new target)
- Total workforce in August 2024 is below plan

Areas of Concern:

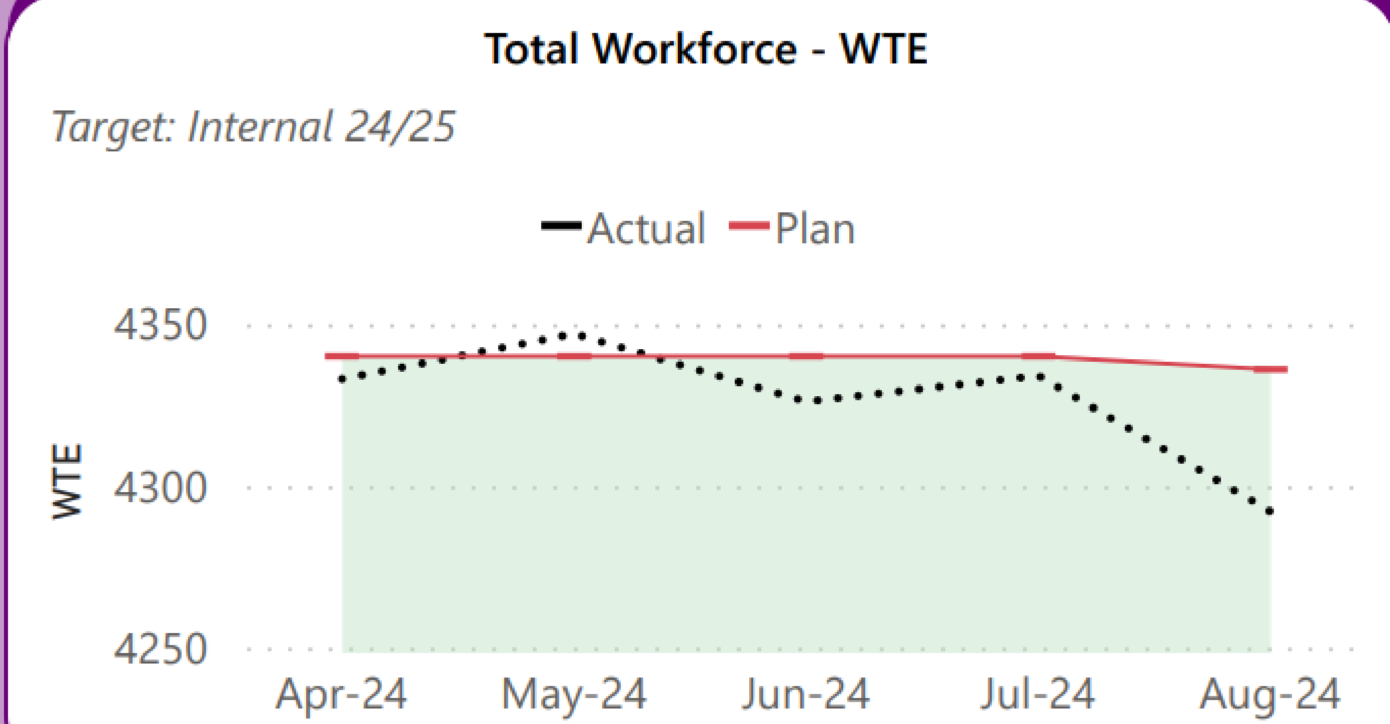
- PDR completion has remained below 90%; there are specific concerns with B7+ PDR compliance which were due to be completed by 31st July. PDR completion is being supported across the L&D and HR teams, with data regularly presented, with reports specifically on B7+ PDR completion going out weekly via email or phone call.

Forward Look (with actions)

- While total workforce WTE is below plan in August 2024, this position is challenging, specifically with WTE in the plan reducing from October 2024. Additional measures to deliver this are being reviewed.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

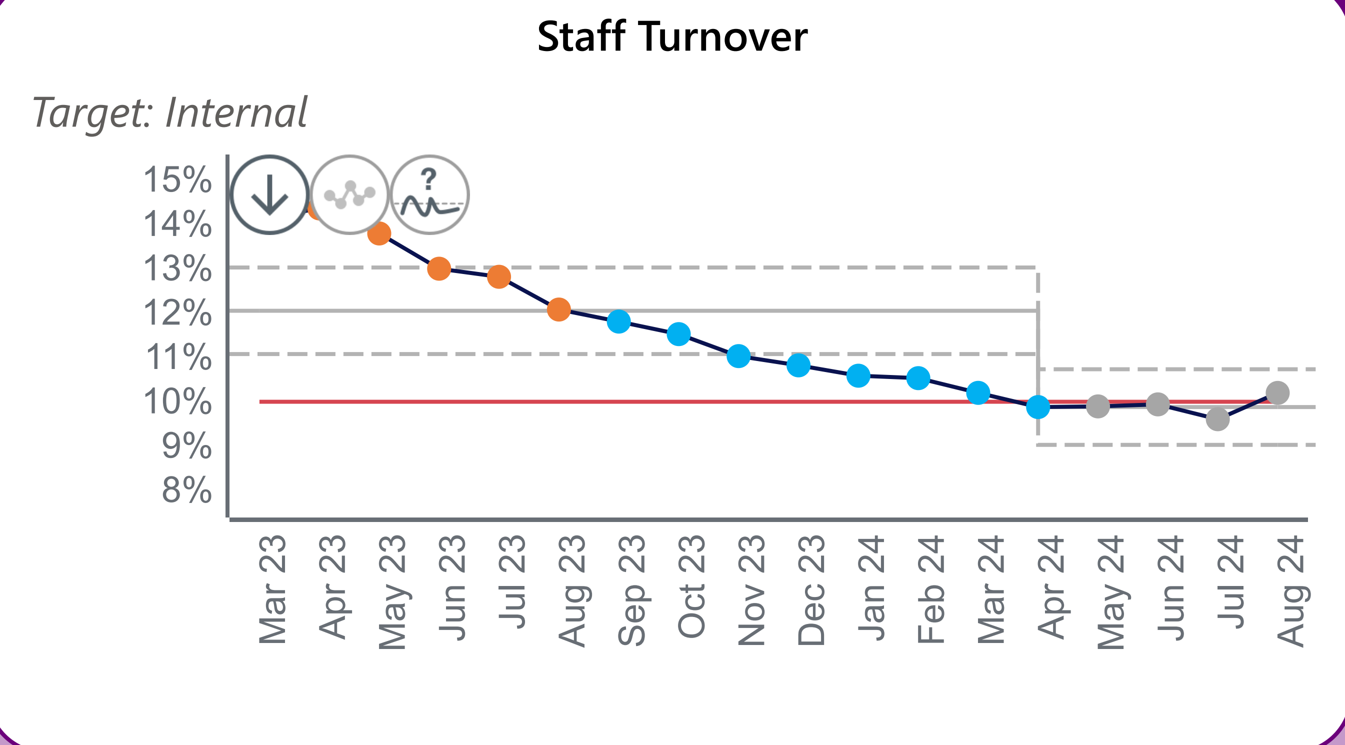
Total workforce for the end of August 2024 was 44 WTE below plan. Actual WTE was 4292.27 against a plan of 4336.3. 24/25 year end plan is set at 4273.4 WTE.

Actions:

Total workforce is the WTE staff in post, plus agency and bank usage (as WTE). While total workforce is below plan in August 2024, this position is challenging with a requirement from the ICB to reduce the plan and actuals further. Additional measures to deliver this are being reviewed. A reduction in WTE for CIP is in the plan from October 2024.

Staff Turnover

Target: Internal



Technical Analysis:

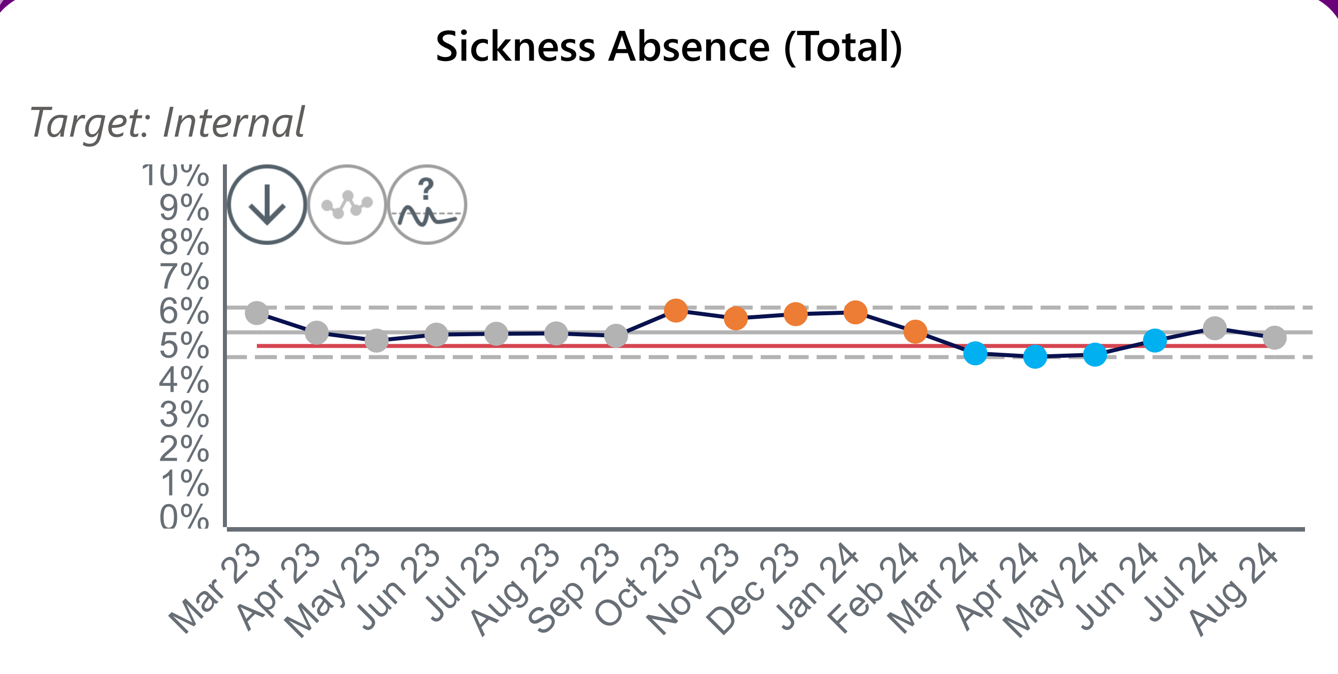
Staff Turnover is demonstrating common cause variation with performance of 10.17% in August 2024. This is the first month month above the 10% target in 2024/2025.

Actions:

Following a significant period of reduction, turnover has remained at or below 10% in month. The position continues to be monitored, with quarterly divisional reports on turnover produced.

Sickness Absence (Total)

Target: Internal



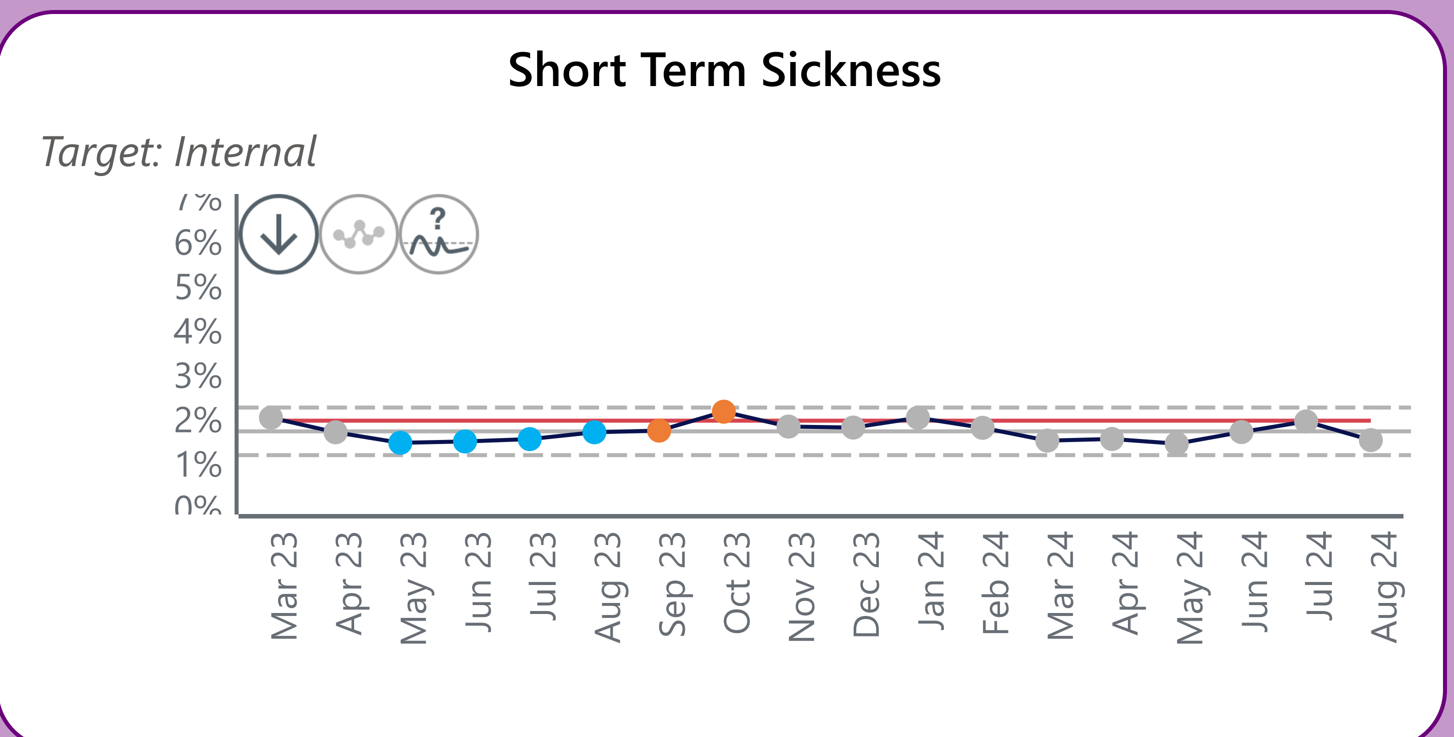
Technical Analysis:

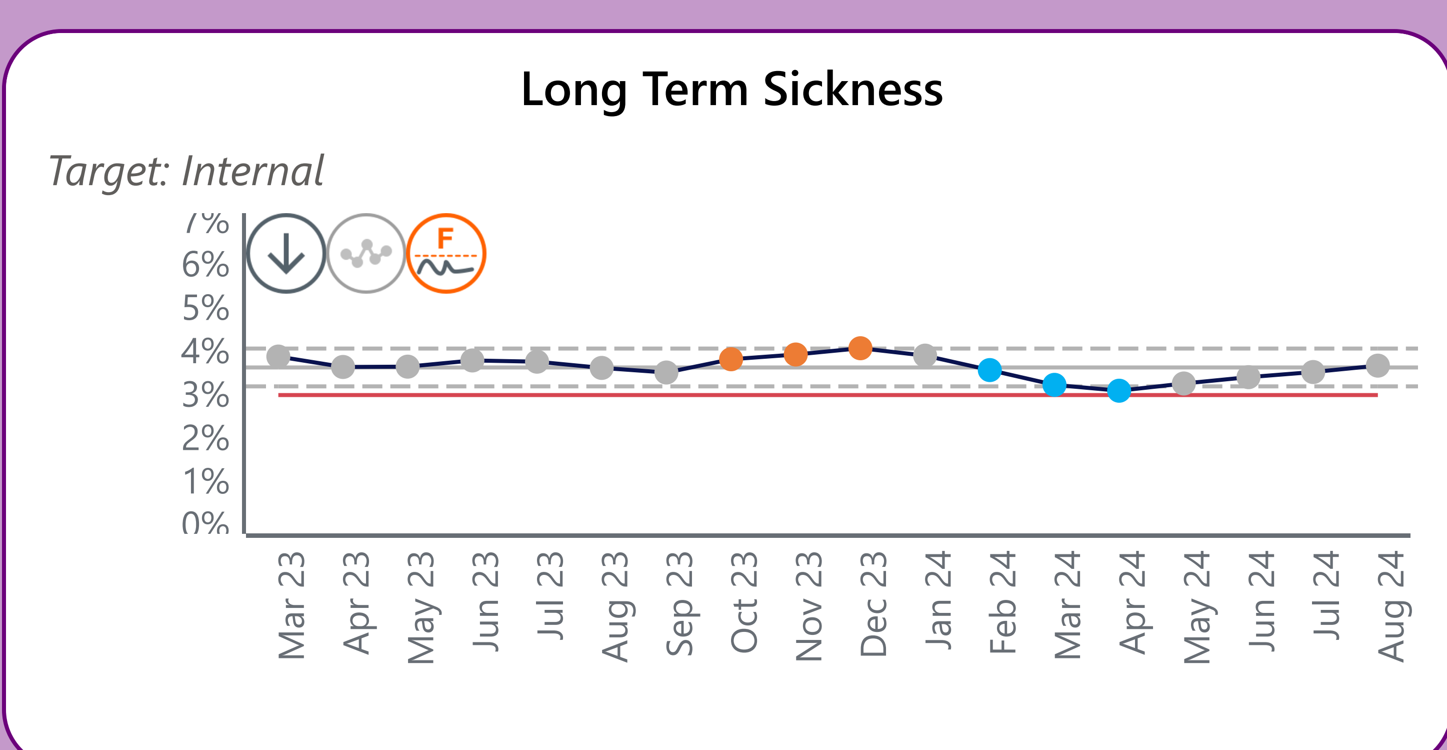
Total sickness absence in August 2024 is 5.23% which is above the 5% target. A decrease from July 2024 at 5.51%. August 2024 performance comprises STS at 1.69% and LTS at 3.54%. Still demonstrating common cause variation, 3rd consecutive month above the target in 24/25.

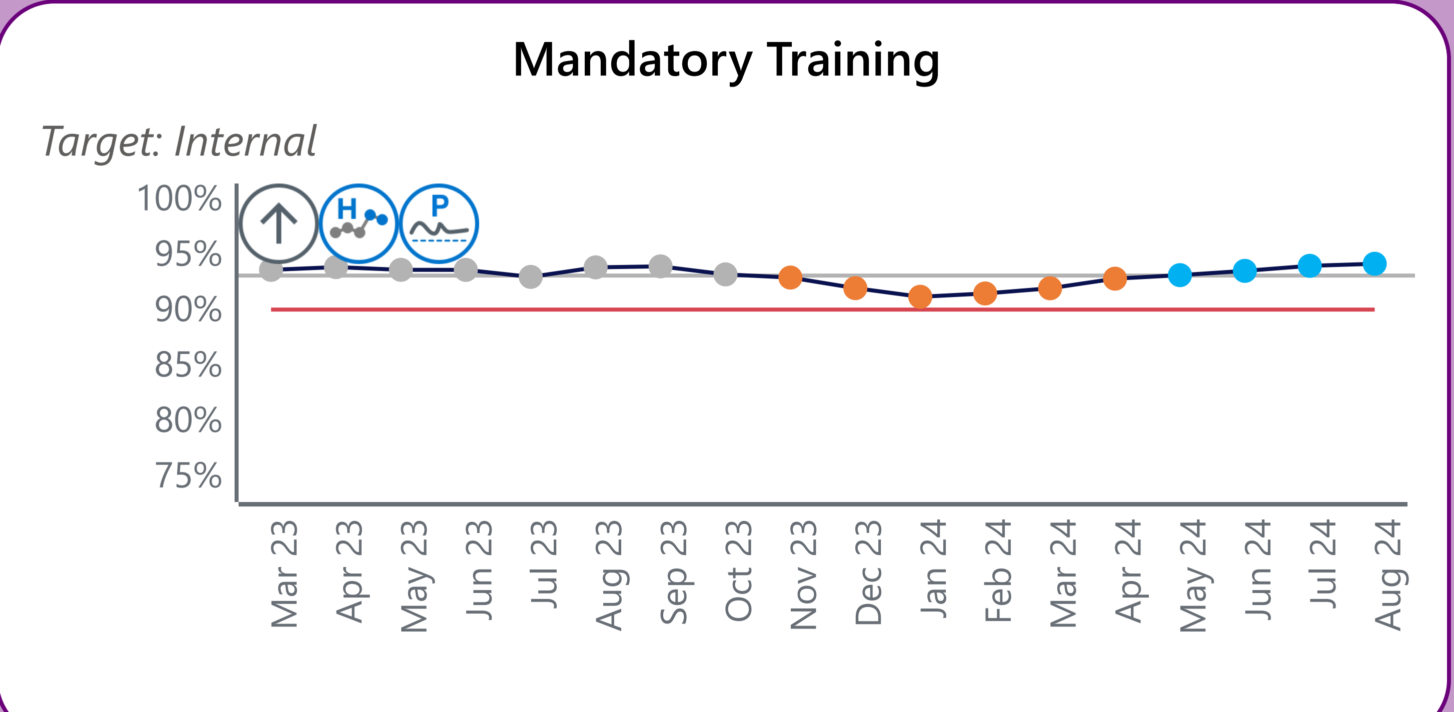
Actions:

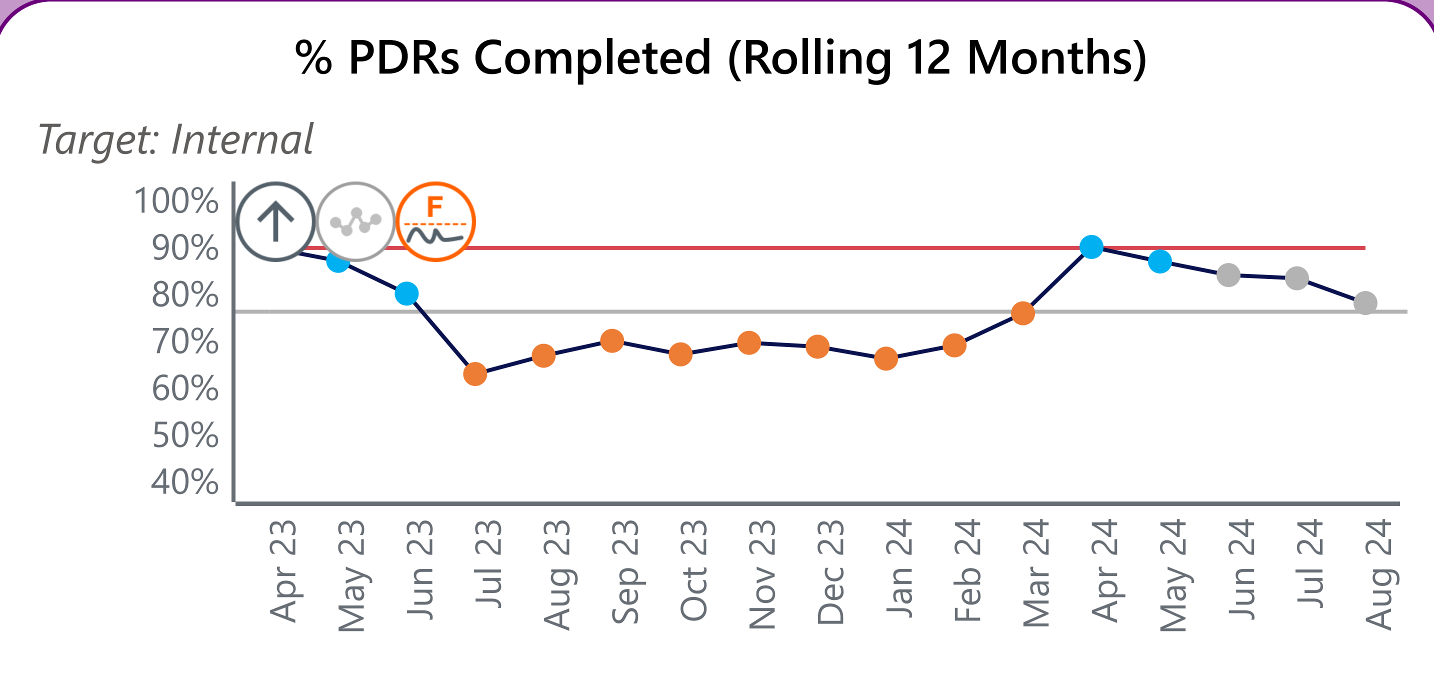
Sickness absence remains slightly over 5% in August 2024 following previous improvement. Review of the Supporting Sickness and Attendance policy has commenced, to include involvement from the staff networks.

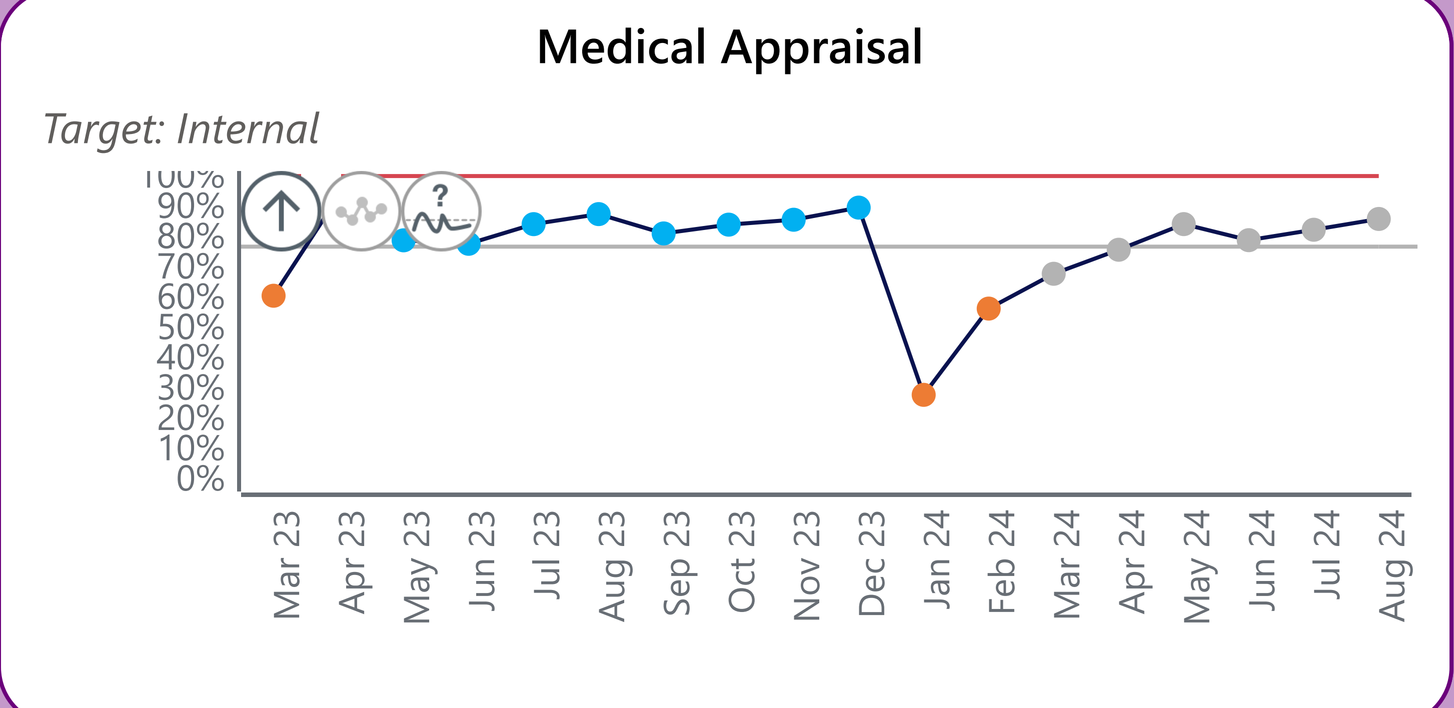
Supporting Our People - Watch Metrics

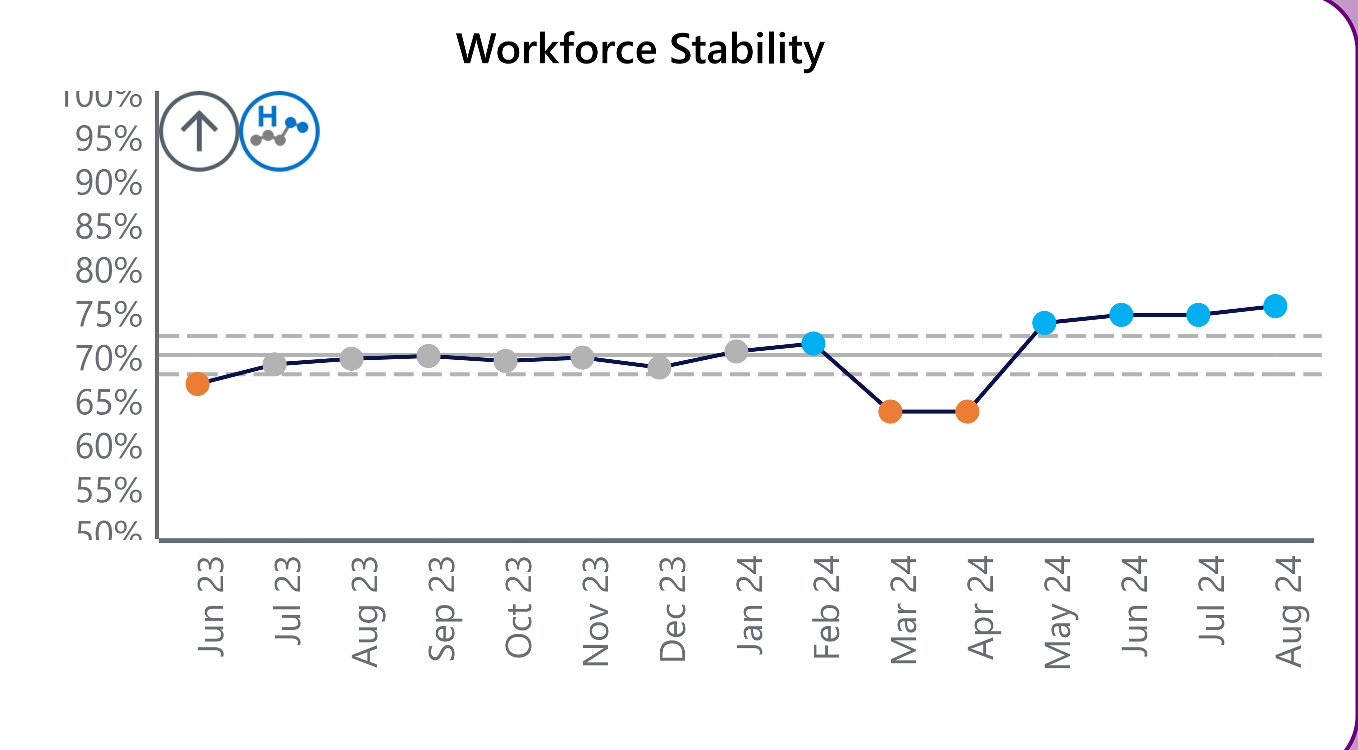












Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

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

Highlights:

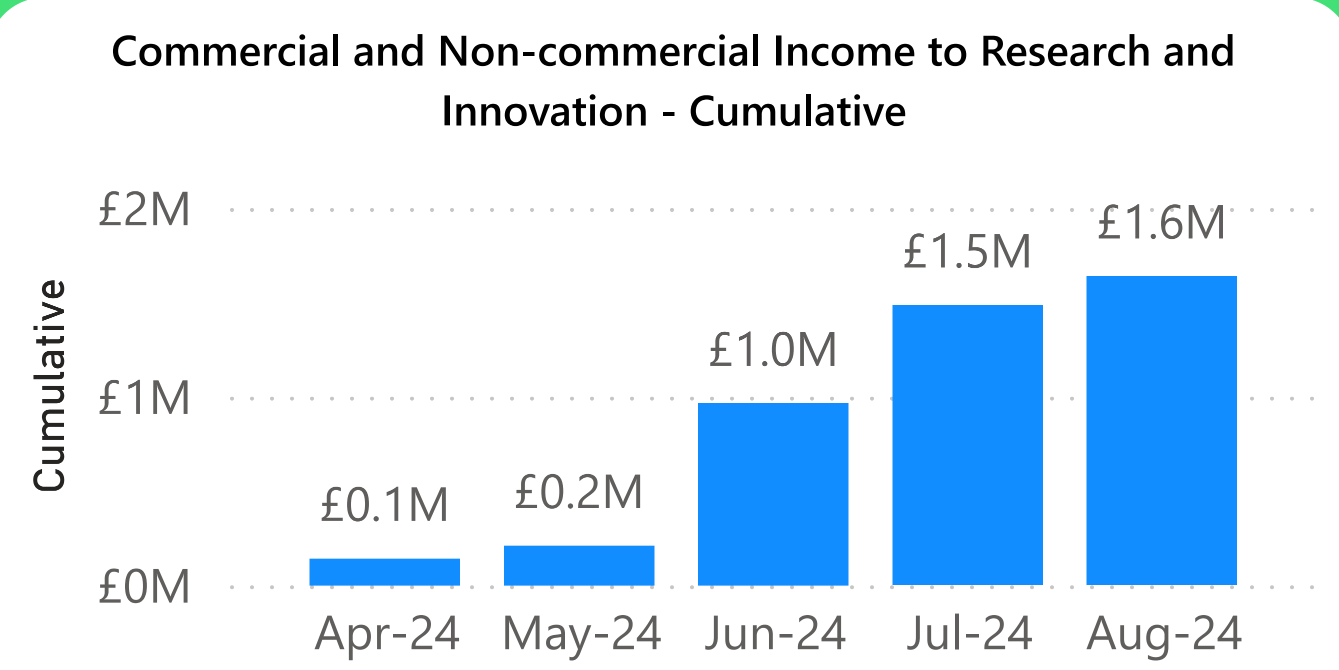
• Cost-neutral Futures business case approved and recruitment processes commenced for new Futures infrastructure posts (including leadership posts and support for comms activities and capacity building) • Investment Zone outline business case near completion for mid-September submission to Combined Authority (£4m over 4 years) • Commercial income forecast for contract research activity remains ahead of target at end of month 5 • Senior Innovation Consultant appointed (start date October) to lead on new ideas (aligned with Futures discovery themes) and integration with clinical divisions and corporate services • Potential AI coding partnership identified with Phare Health • Number of commercial contract research requests continues to increase (16 requests in August)

Areas of Concern:

- Head of Automation post remains vacant (awaiting job matching) leading to pressures in RPA team
- Limited dedicated infrastructure for Futures restricting ability to drive forward implementation plan

Forward Look (with actions)

- Automation team actions to determine progress towards delivering on the business case and remaining capacity for new projects
- Recruitment processes for posts in Futures business case to continue through vacancy panels alongside re-alignment of existing resource

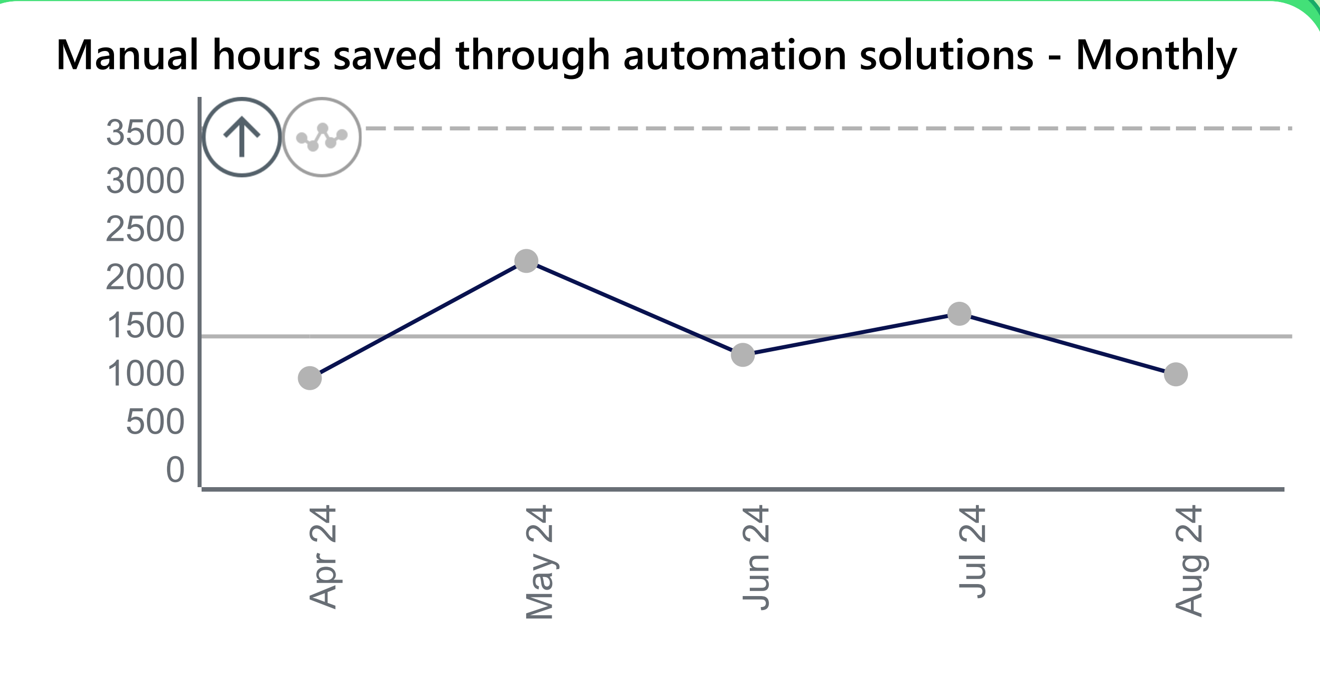


Technical Analysis:

Data currently includes non-commercial income for innovation and research activity cumulatively for the financial year

Actions:

Focus of new Innovation Consultant/Bid Coordinator resource has been primarily on completion of outline business case for Investment Zone funding. Further work on horizon scanning to identify new opportunities will commence in September.

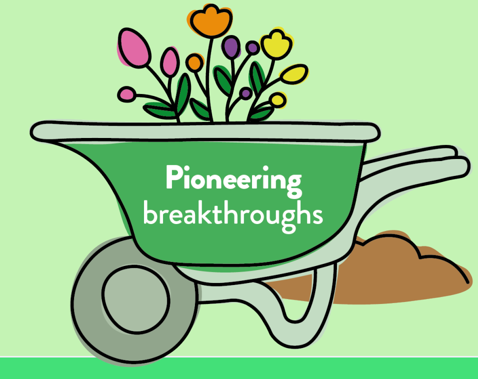


Technical Analysis:

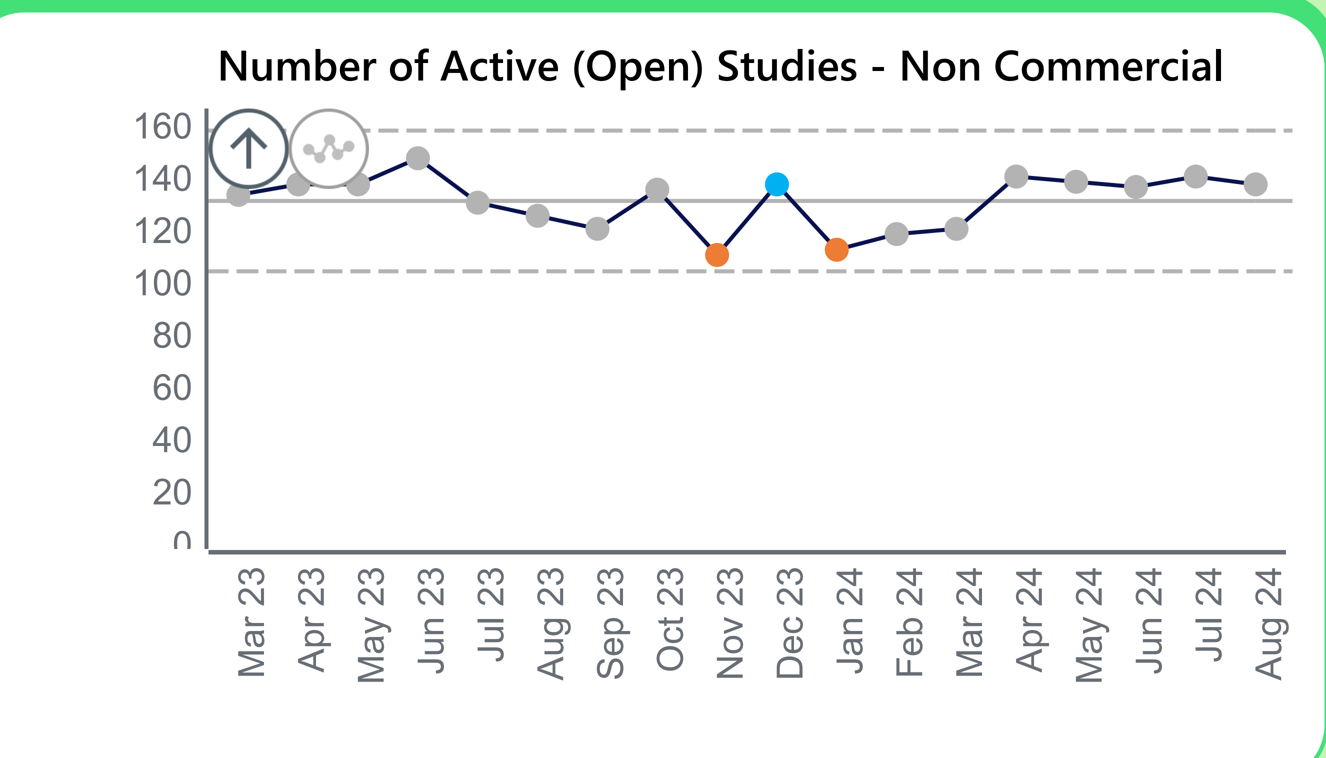
This data is based on our current RPA solutions

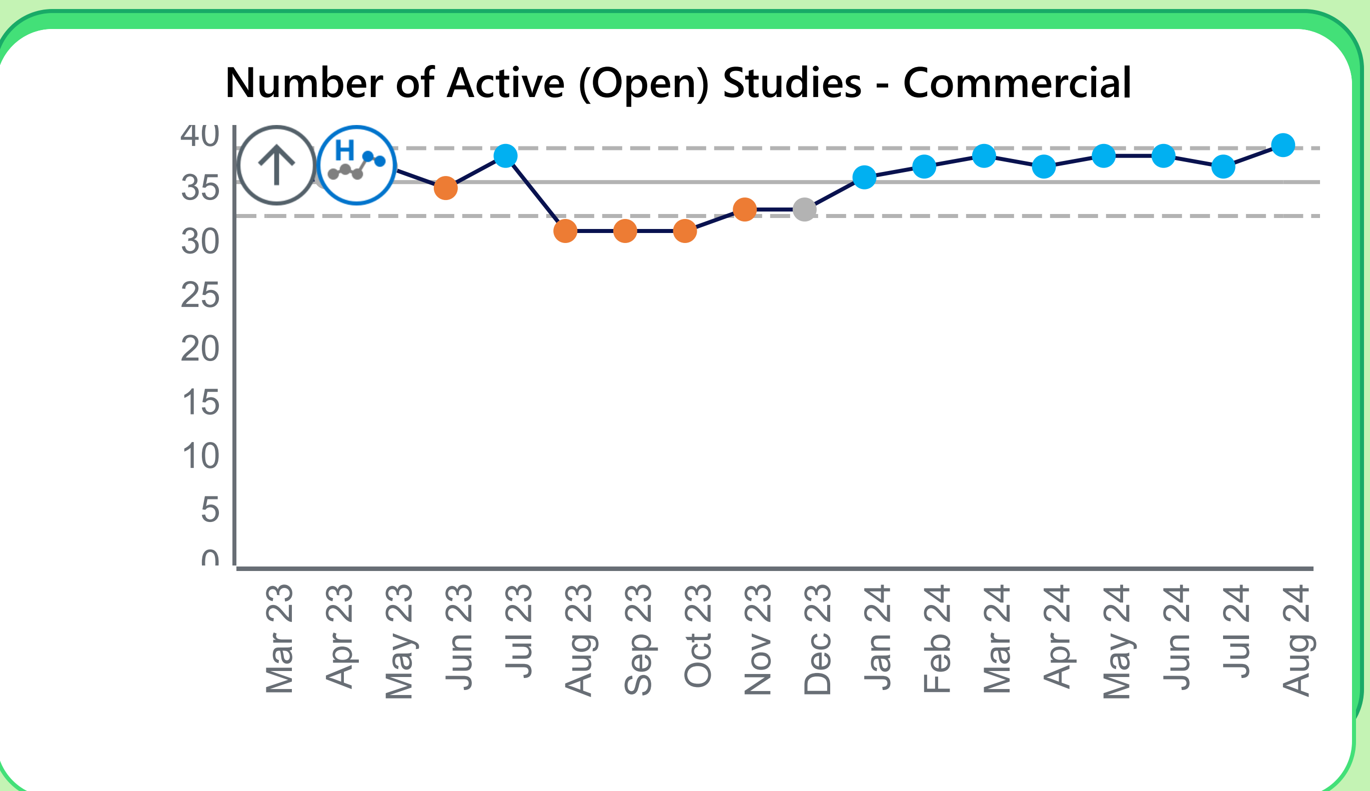
Actions:

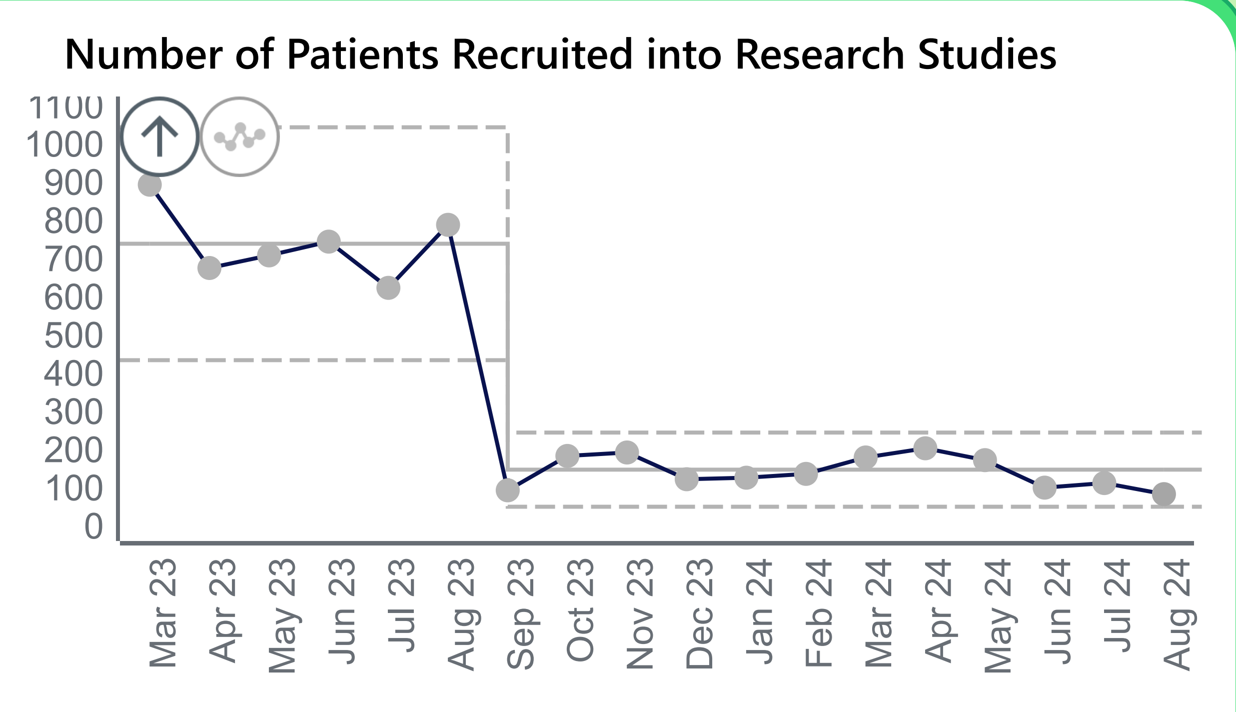
Workshop took place on 28th August to review progress against business case leading to further actions to assess cost benefits and update processes for prioritisation.

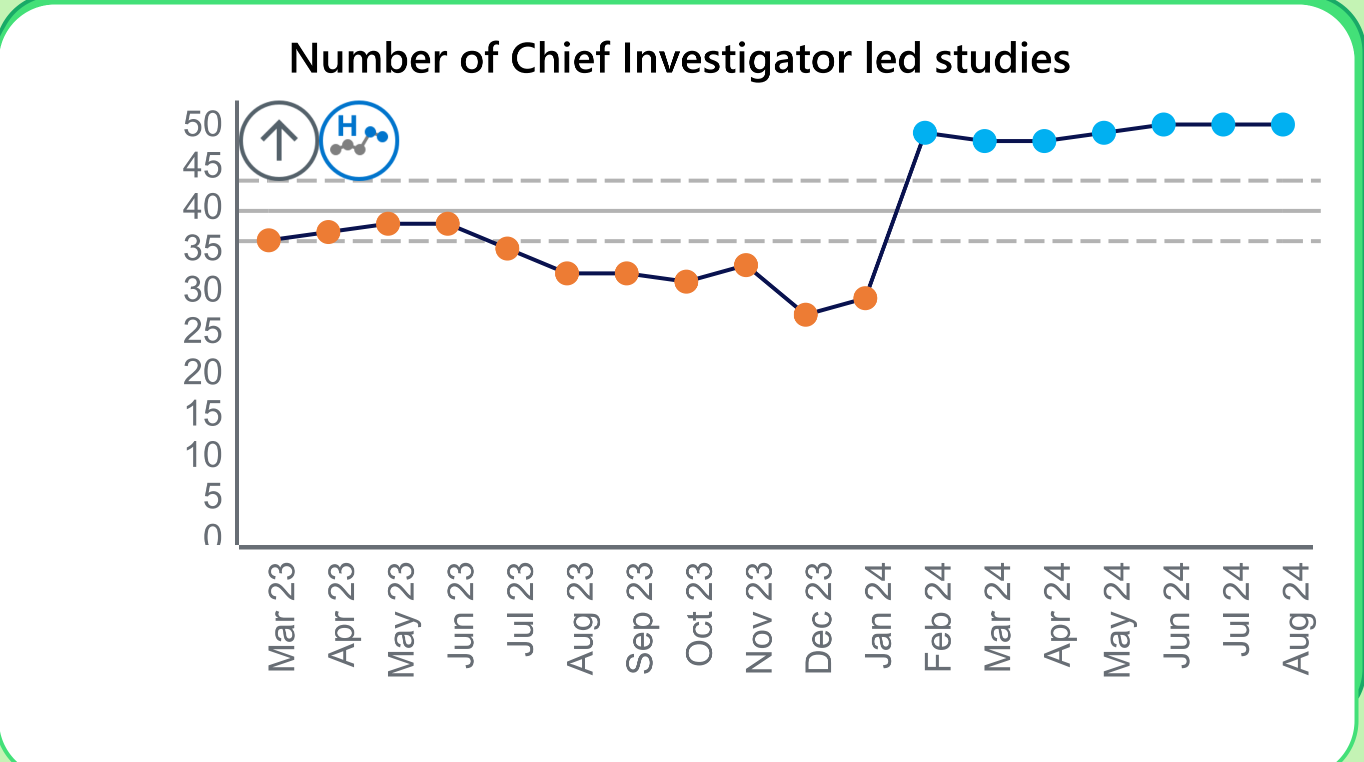


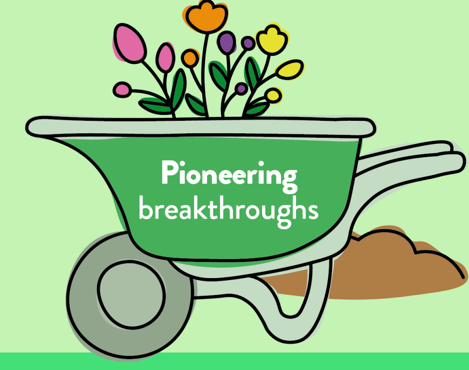
Pioneering Breakthroughs











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:

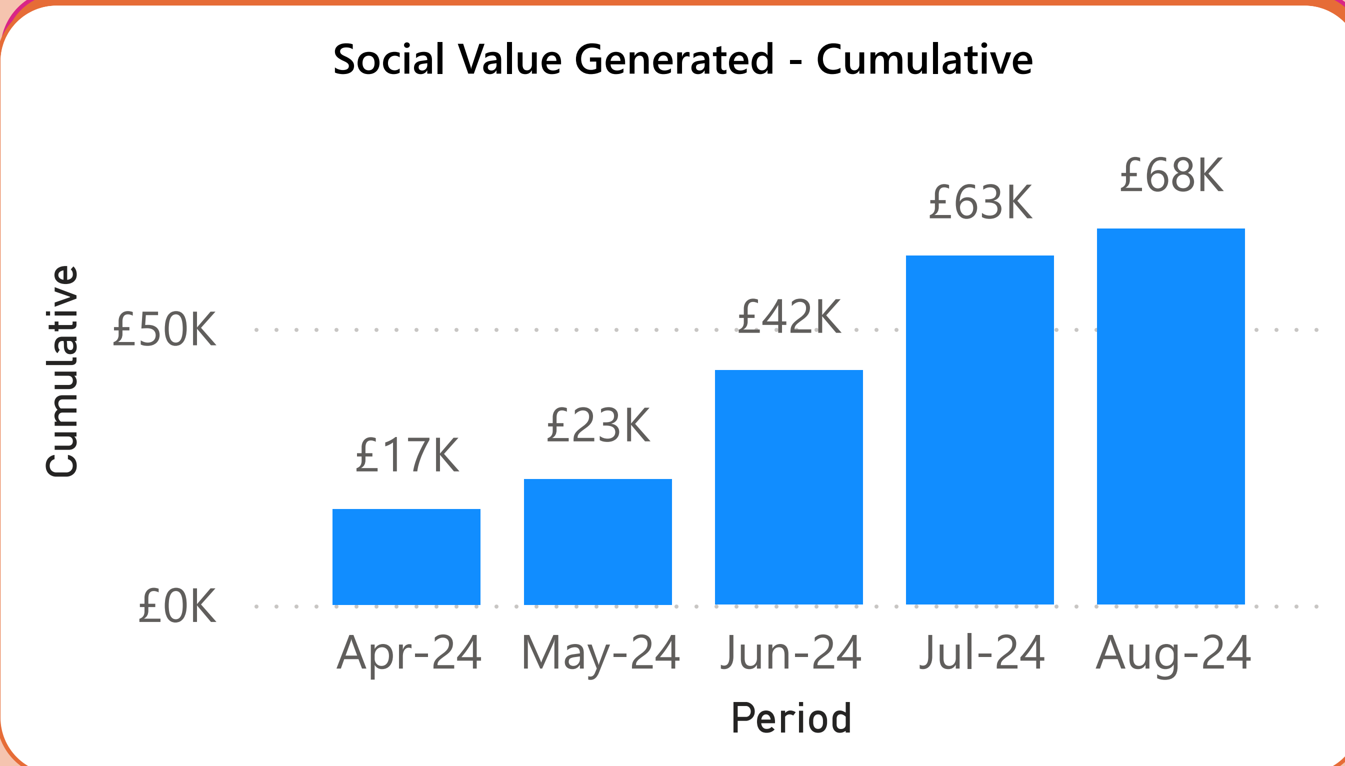
• Vaping clinic - planned to start in November, briefing to be given to Board • MMR vaccination programme - screened 395 CYP, checked the vaccination status of 340, contributed to the management of 42, and given 10 vaccines (to 9 children). This piece of work is being submitted to the Royal College of Paediatrics and Child Health conference. • BB Advocacy Launch Plan shared with Board and Executive team • HIP - Wellbeing Hub - Mobilisation plan continuing to be on target • Secured commitment from C&M Children's Board re prioritising Care Leavers (employability/support); Developing bespoke programme for CEYP

Areas of Concern:

Transition in leadership with green – escalated internally and consideration being given to approach to address, but currently a gap, and therefore impact on timeframes for milestone delivery.

Forward Look (with actions)

• Rescheduling of postponed Improve My Life Chances summit • Establish Working Group to explore capturing social value activity across the organisation as it is a cross-cutting theme across several workstreams.



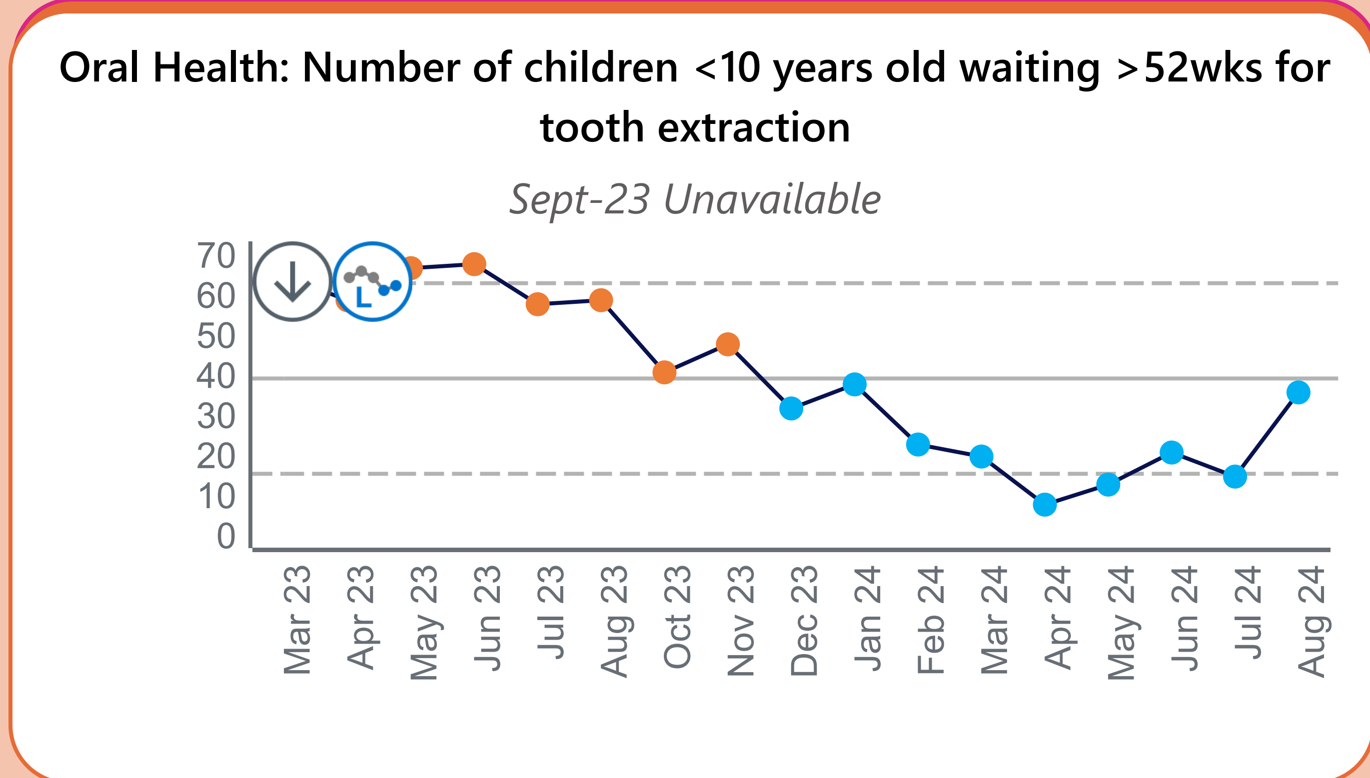
Technical Analysis:

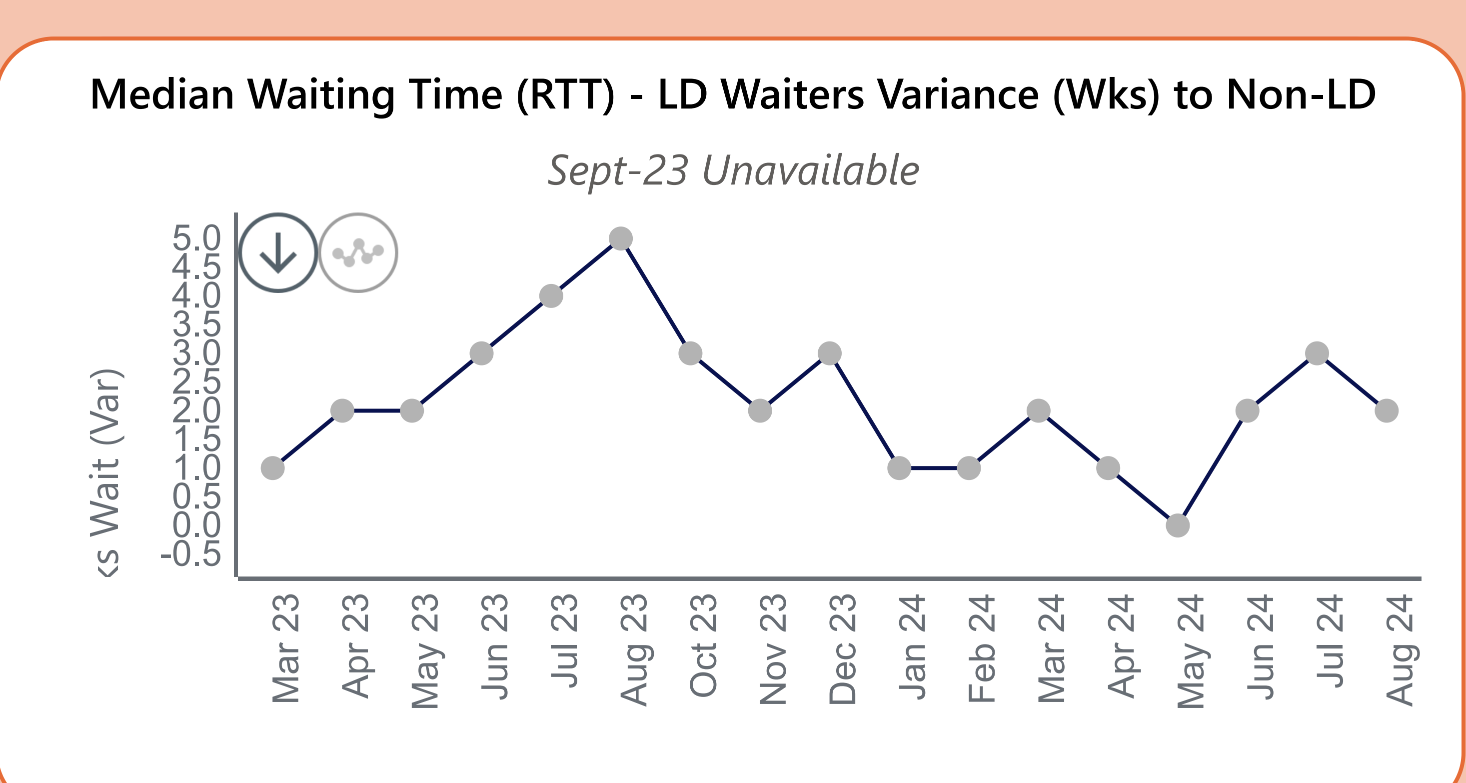
The SV reported links to 2 outcomes within national framework: 1. Supporting the Local Economy: Developing education, skills and training opportunities. 2. Supporting the Local Economy: Employment Opportunities for Local People. Activity typically higher during term time. 2 new starters to the team June 24.

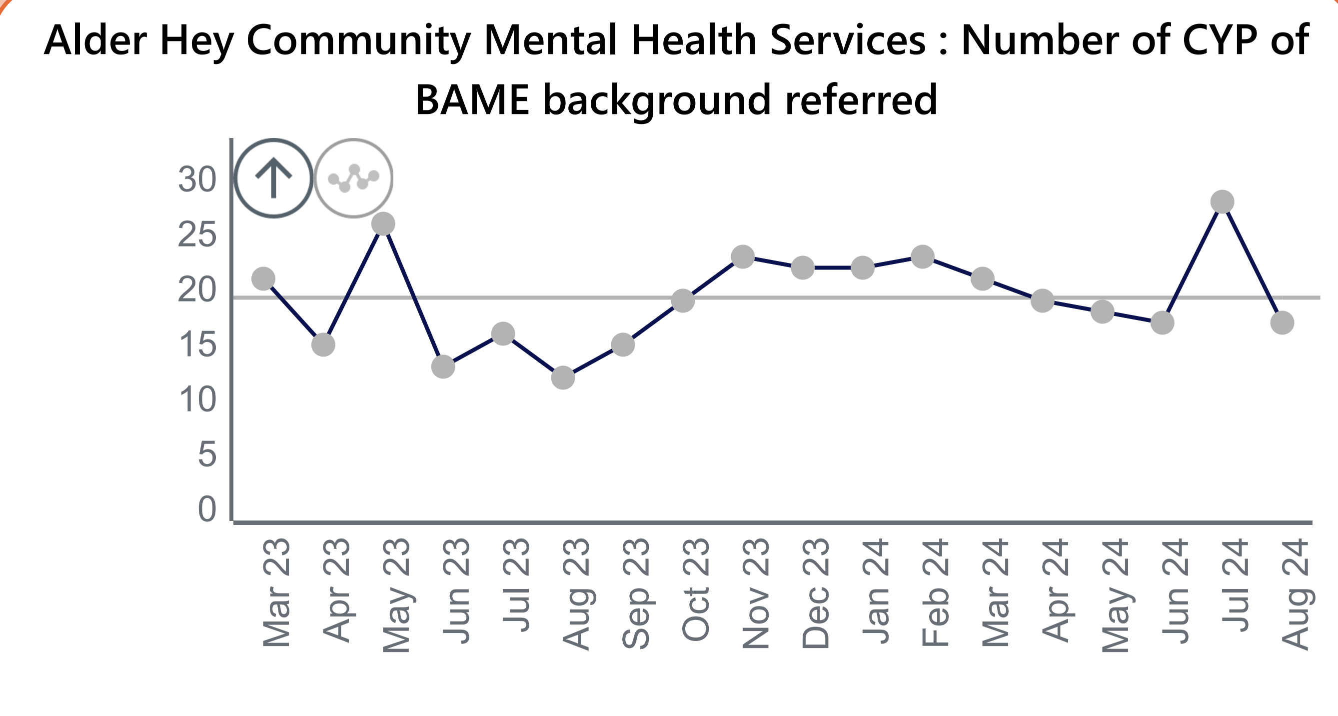
Actions:

Continue to develop partnerships which support delivery of increased SV (NTs1-12).
Development of expanded programme of employment support.
Scope organisation wide approach to capturing SV across all domains of the National SV Framework and enhancing our reporting of this.

Collaborate for CYP







Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

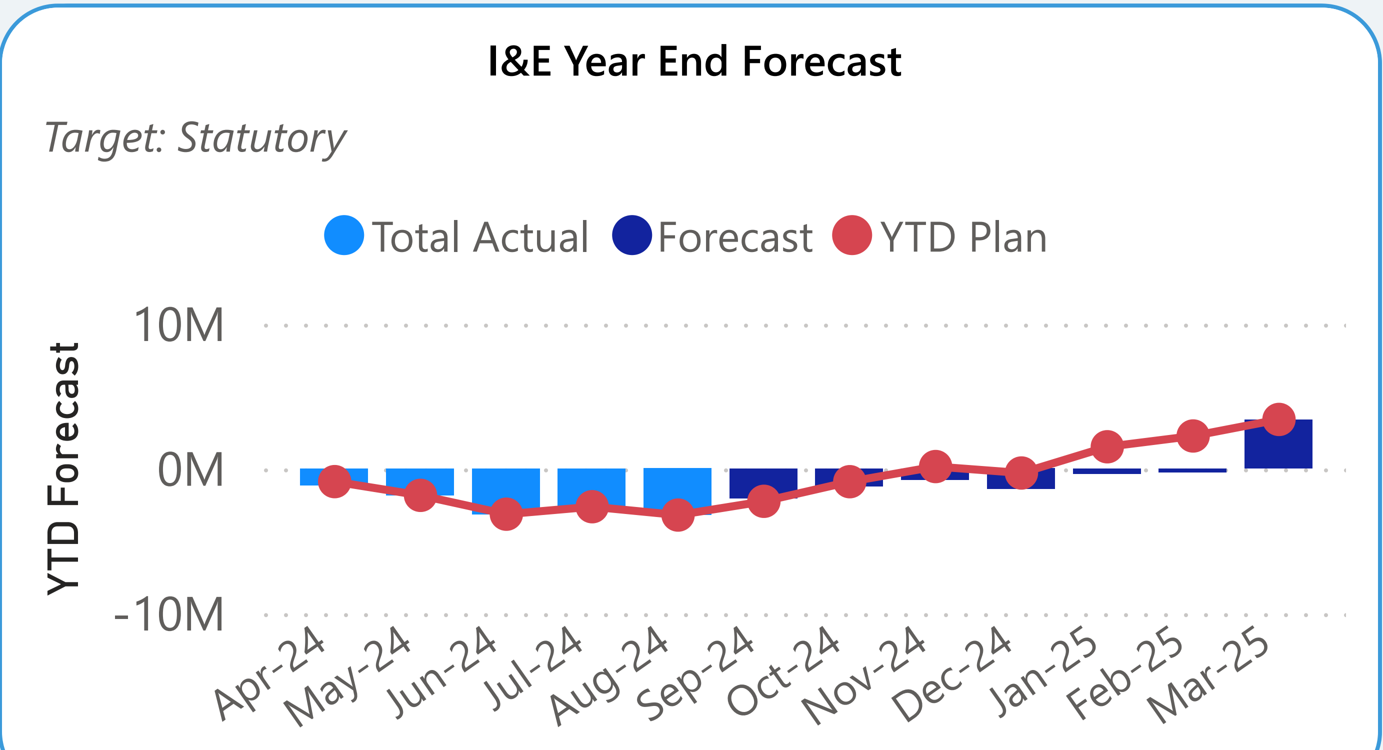
In August (M5), the Trust is reporting a position £0.2m away from plan (£3.4m deficit against a plan of £3.2m). This is due to industrial action. The trust has submitted a revised forecast to ICB as part of a system wide return which has resulted in a profiling change to the forecast, however, overall, the Trust are forecasting to achieve £3.3m surplus. Divisional forecasts have highlighted significant challenges and risk, however, the financial improvement plan and work on sprints has resulted in some significant savings. CIP on plan in M5 and overall, £11m CIP has been transacted in year, with £8.9m in progress and opportunity (amber and red schemes). On track to deliver subject to amber and red schemes. Cash has remained high, although slightly lower than plan due to high levels of accrued income (under review). Capital is £0.2m adverse to plan YTD due to impact of audit adjustments required in 23/24, however forecast the year remains on plan following a re-prioritisation exercise.

Areas of Concern:

Work is ongoing to deliver full savings of £19.9m and significant progress has been made to date resulting in £8.8m of savings recurrently posted in M5. Divisional forecasts have highlighted significant financial and operational challenges, however divisions have been asked to provide mitigation plans. Further industrial action is an emerging risk to the forecast pending clarification from NHSIE on any funding. The capital allocation in year remains tight, however following a re-prioritisation exercise it is believed that this risk has been mitigated in year, but that future year capital allocation remains a challenge.

Forward Look (with actions)

Continued focus on cost control to reach the year end position, with finance improvements in place being monitored through SDG. Continued focus required on achievement of £19.9m efficiency target. Continued prioritisation of capital programme.

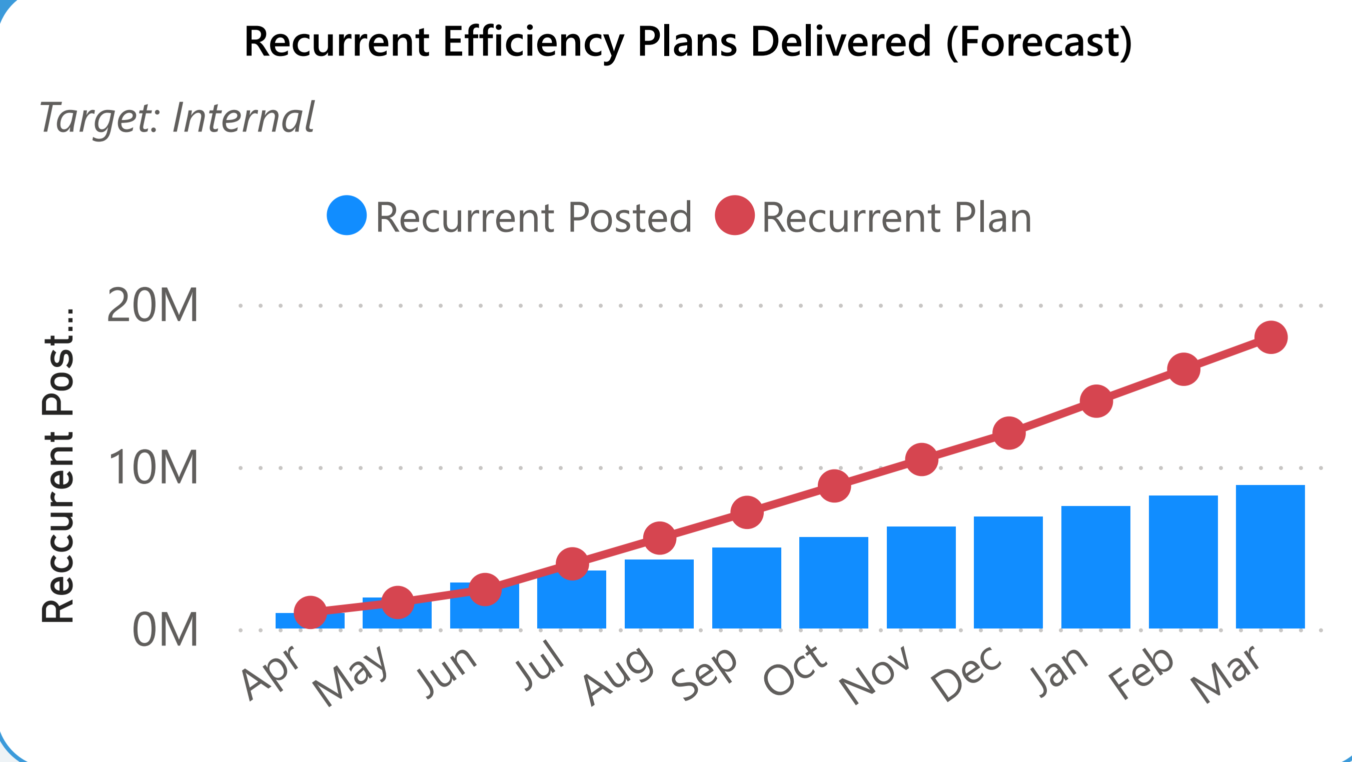


Technical Analysis:

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. A financial improvement plan has been launched with various sprints aimed at supporting achievement of the current plan. Progress is being managed through SDG meetings.

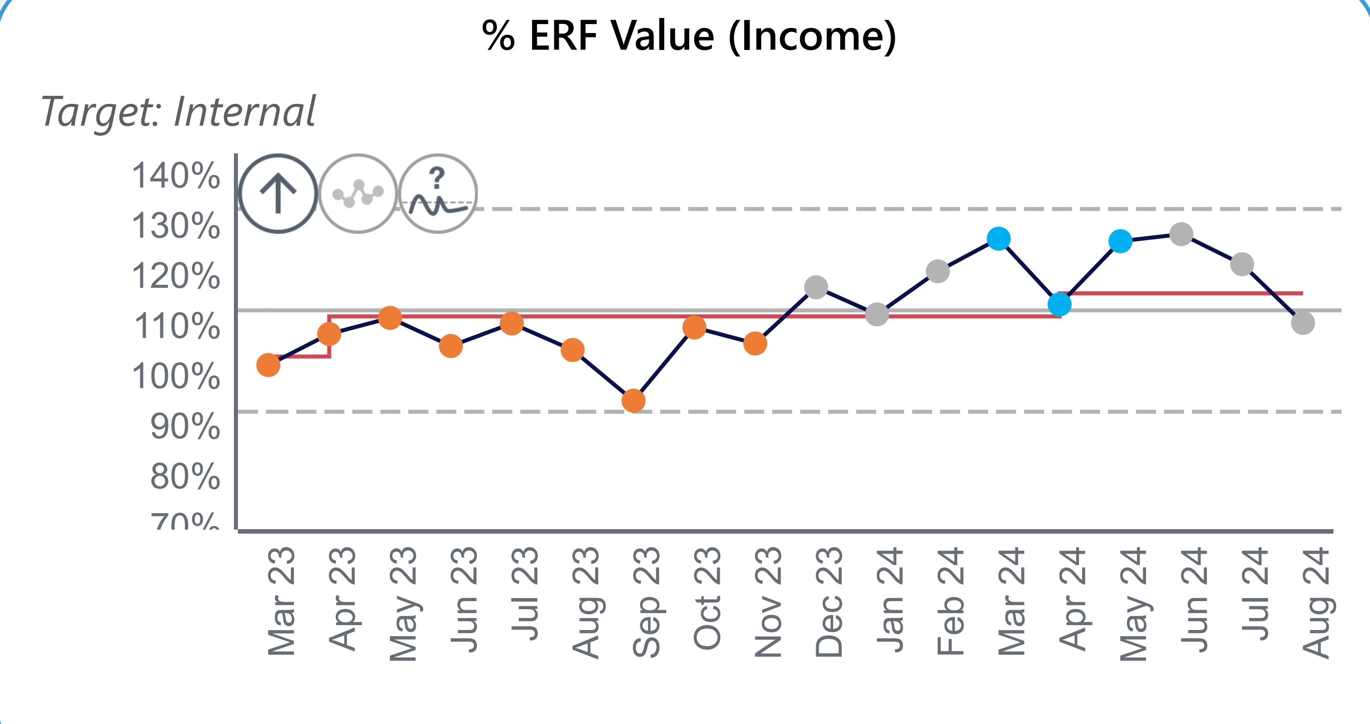


Technical Analysis:

In year CIP identified and in progress is £15.5m whilst recurrent CIP is £13.6m

Actions:

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



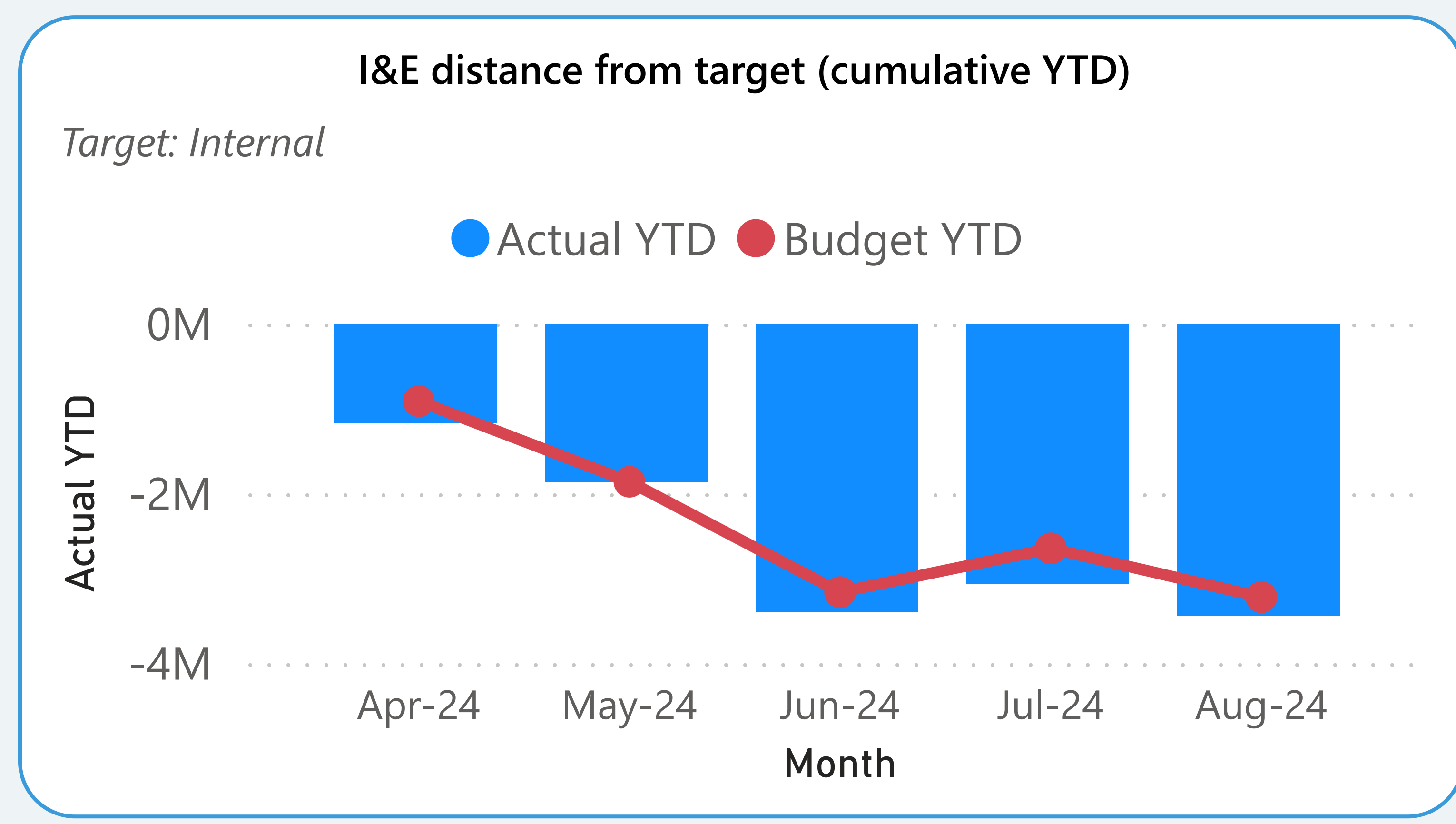
Technical Analysis:

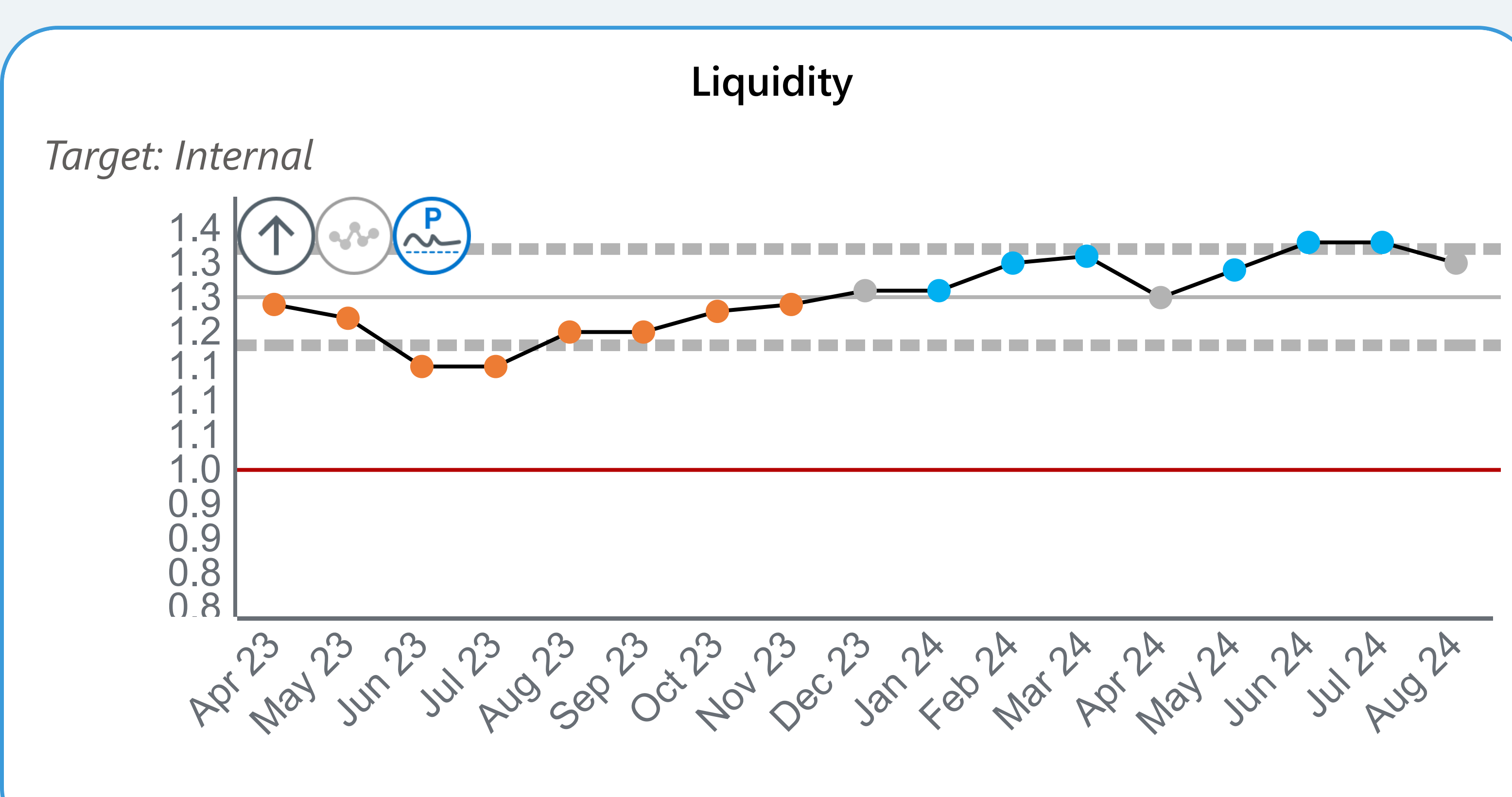
August performance estimated at 110%.

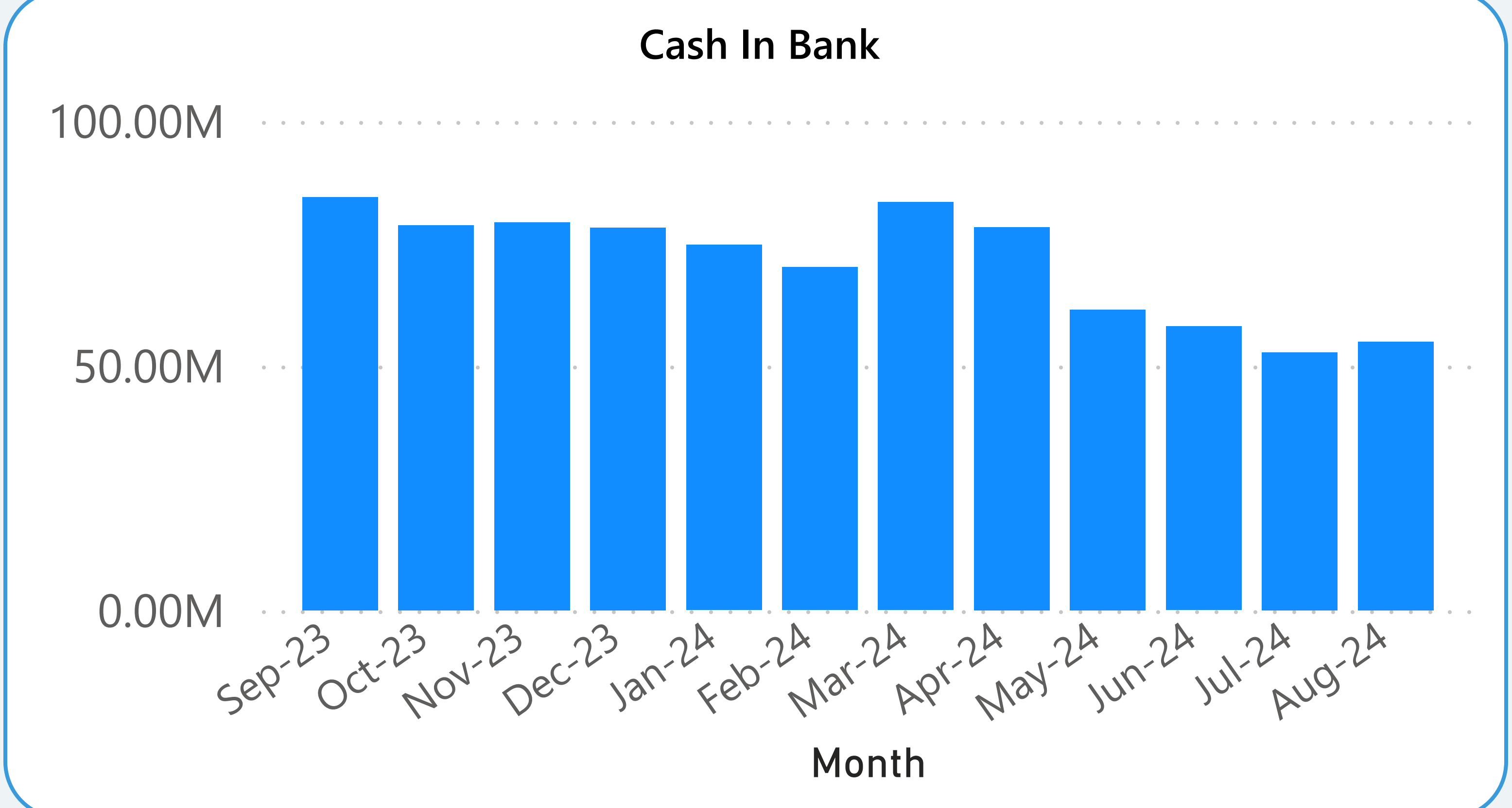
Actions:

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:

- Decease in number of risks reported for August 2024
- Risk management training delivered to members of the booking and scheduling team
- Slight increase from previous month of risk being within review date

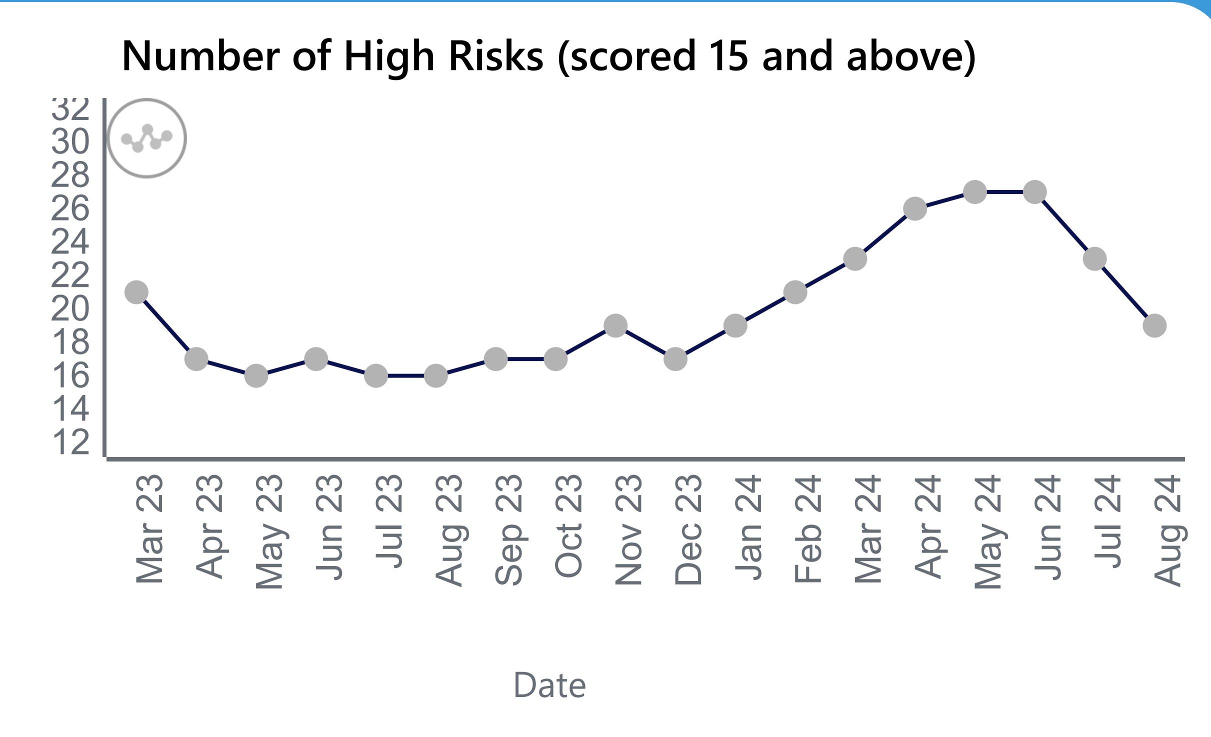
Areas of Concern:

- Despite ongoing requests and emails recurrent theme of limited involvement at risk oversight meetings from all risk owners.
- Staff not always updating risk actions

Forward Look (with actions)

- Pilot of risk appetite to be discussed at Septembers Risk management forum
- Risk action notifications being explored with InPhase

Number of High Risks (scored 15 and above)



Technical Analysis:

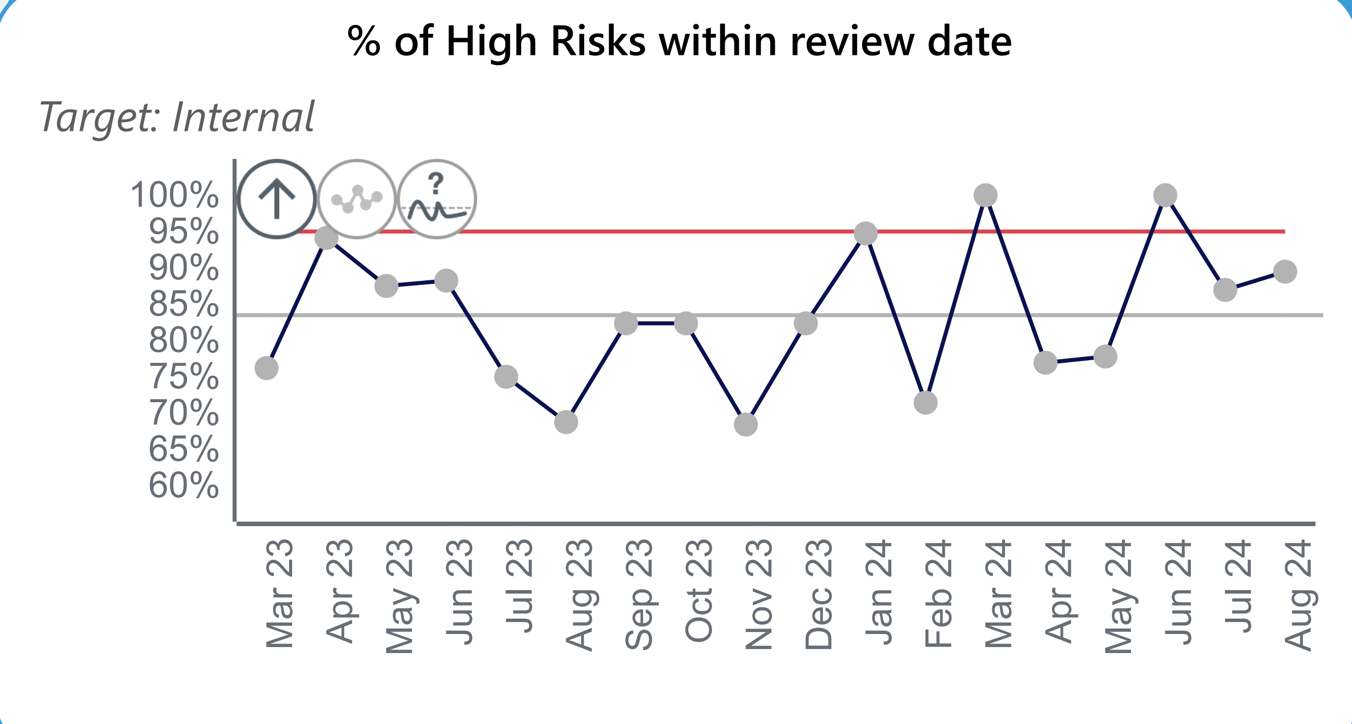
2nd consecutive month with a decrease in reported high risks, with 19 in August 2024. From 23 reported July 24.

Actions:

19 high risks reported in August 2024 a further decrease from the previous reporting period. Risks themed as follows: Quality/safety (9 risks) Workforce (3 risks) Compliance/regulatory (3 risks) Quality/effectiveness (1 risk) and reputation (2 risks)

% of High Risks within review date

Target: Internal



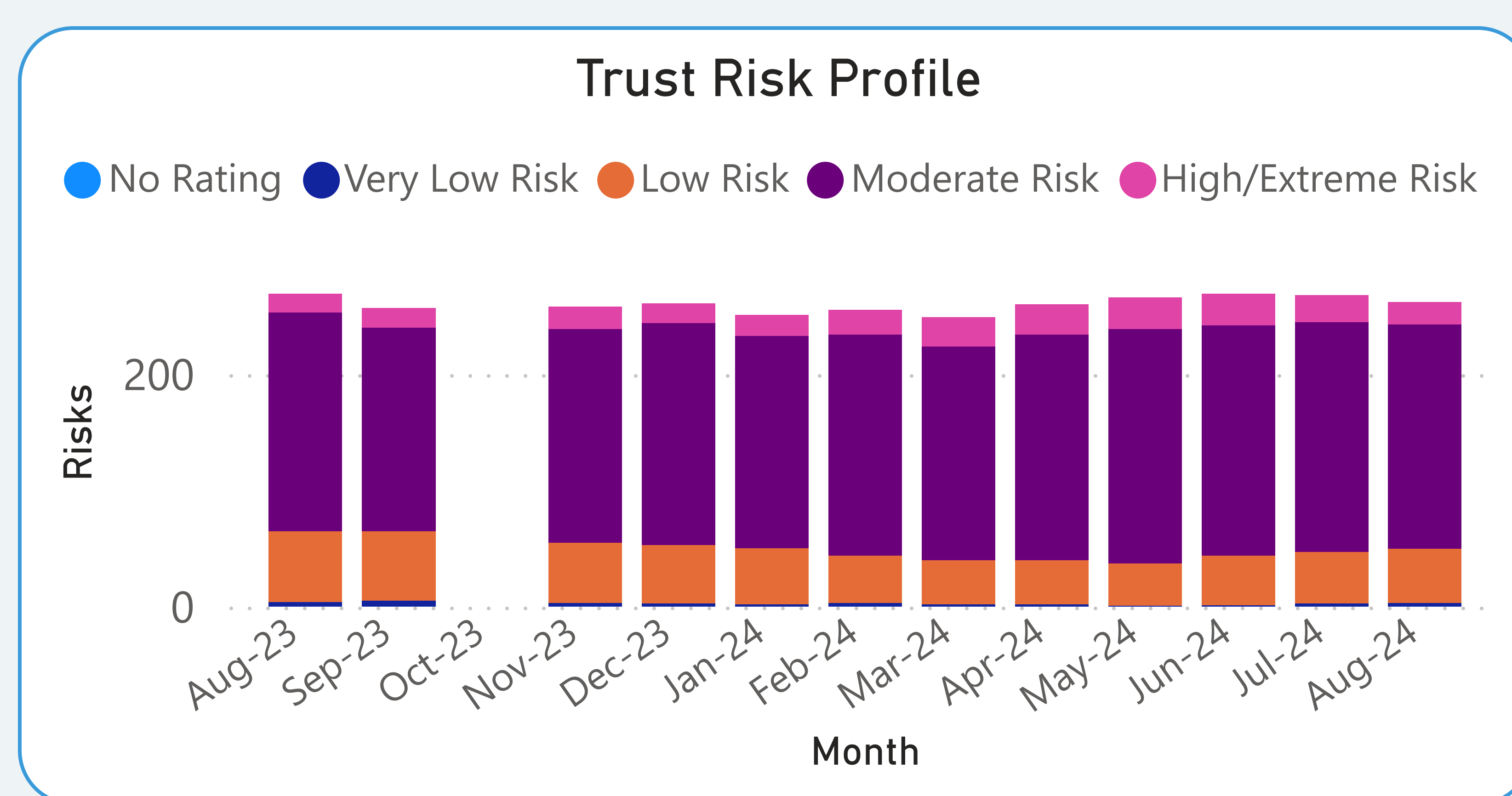
Technical Analysis:

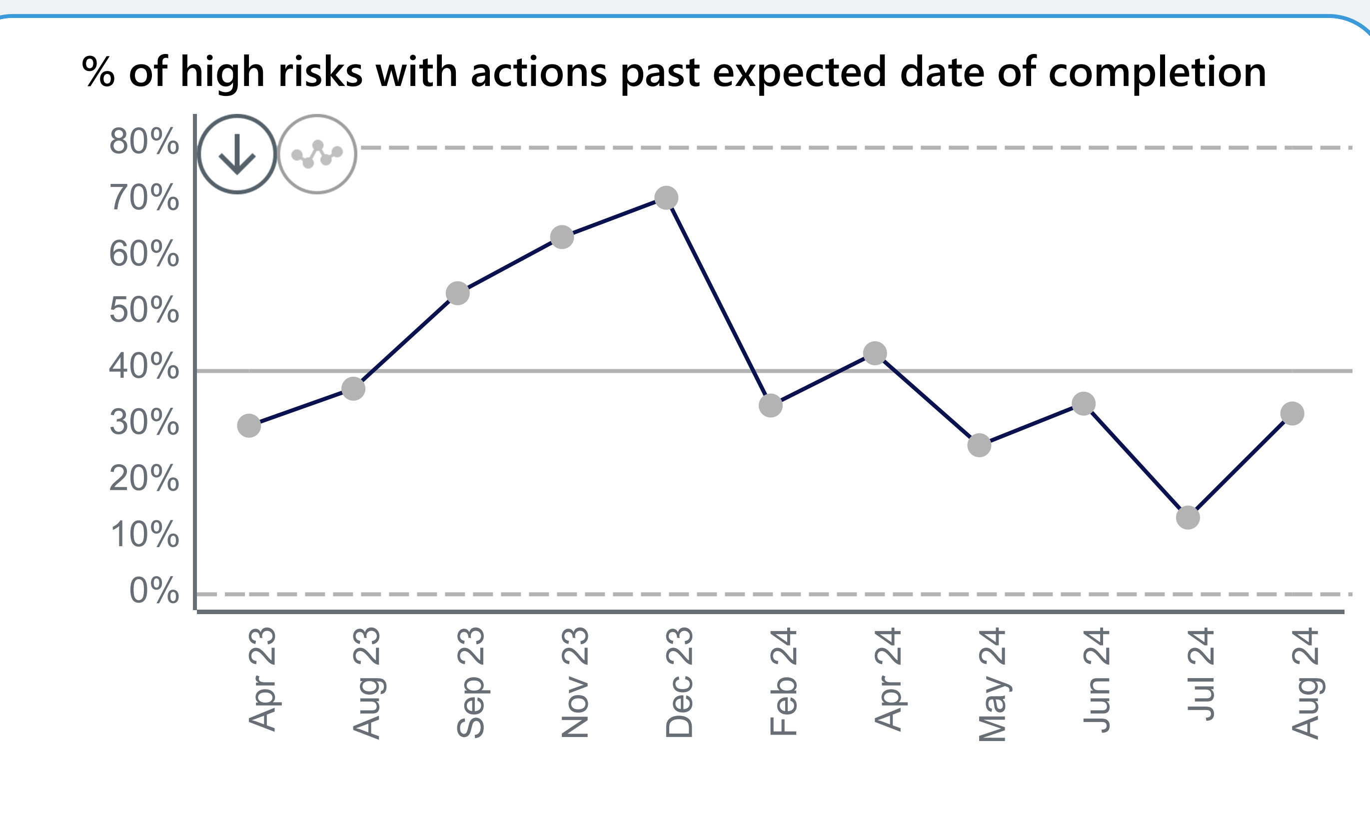
% of High Risks within review date is demonstrating common cause variation with performance of 89% in August 2024. 3rd consecutive month above the monthly average in the period of 83%.

Actions:

89.5% of high risks within review date at the time of reporting. 2 overdue risks have now been actioned following escalation to risk owners.

Well Led - Risk Management





Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Mandatory training compliance remains high (96%).

• Reduction in incidents rated no harm / near miss (77).

• Reduction in the number of complaints received (5) and PALS received (47).

• Increase in the number of PALS responded to within 5 days (68%)

• Virtual Ward reached highest monthly occupancy in August 2024 (142%) with a total of 180 children.

• Zero children and young people waiting over 52 weeks for CAMHS, community paediatrics and therapies.

• Sustained improvement in IHA compliance.

• Waiting times to access community dietetics continue to improve (87%), and reduction in longest wait.

• Longest waits to access SALT have improved. RTT has improved compared to previous month (73%).

• Discharge of a complex long stay young person. The Complex care team have worked creatively with agencies and across areas to support family and young person.

Areas of Concern

• Outpatient Fracture / Dermatology work has commenced. However, delays are now expected due to changes in water safety guidance.

• 21% increase in referrals for Liverpool SALT compared to previous year.

• Was not brought rate has increased in August (14%) - is less than same time last year (16%)

• Work continues regarding 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.

• Continued increase in number of young people waiting for conclusion of ASD/ADHD diagnostic pathway.

• Continued challenges with ADHD medication shortage – unable to initiate medication for ADHD in line with ICB guidance

Forward Look (with actions)

• Height and Weight improvement working group commenced.

• Outpatients "perfect day" workstream commenced.

• ASD: On track to achieve trajectory target of max. wait 104 weeks 31 October 2024.

• ASD / ADHD transformation programme continuing with good engagement from teams and external colleagues.

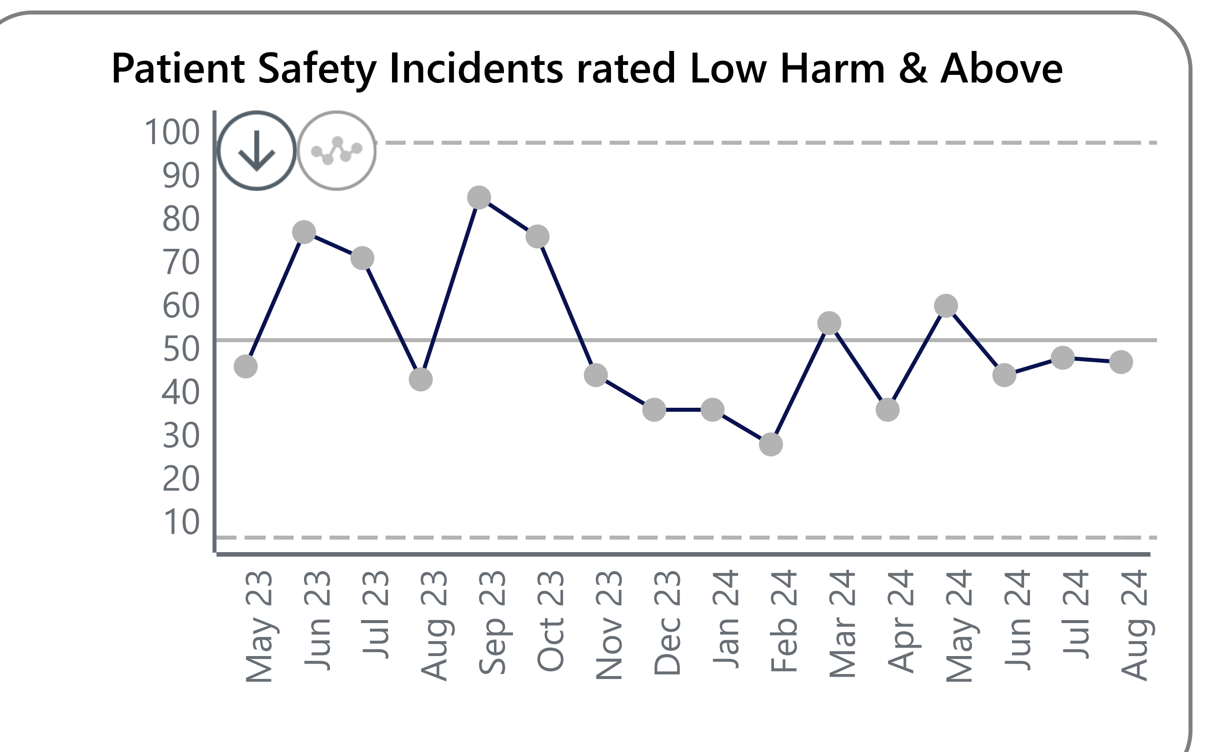
• Work commenced with Victim Support to provide psychological support to children impacted by the Southport critical incident.

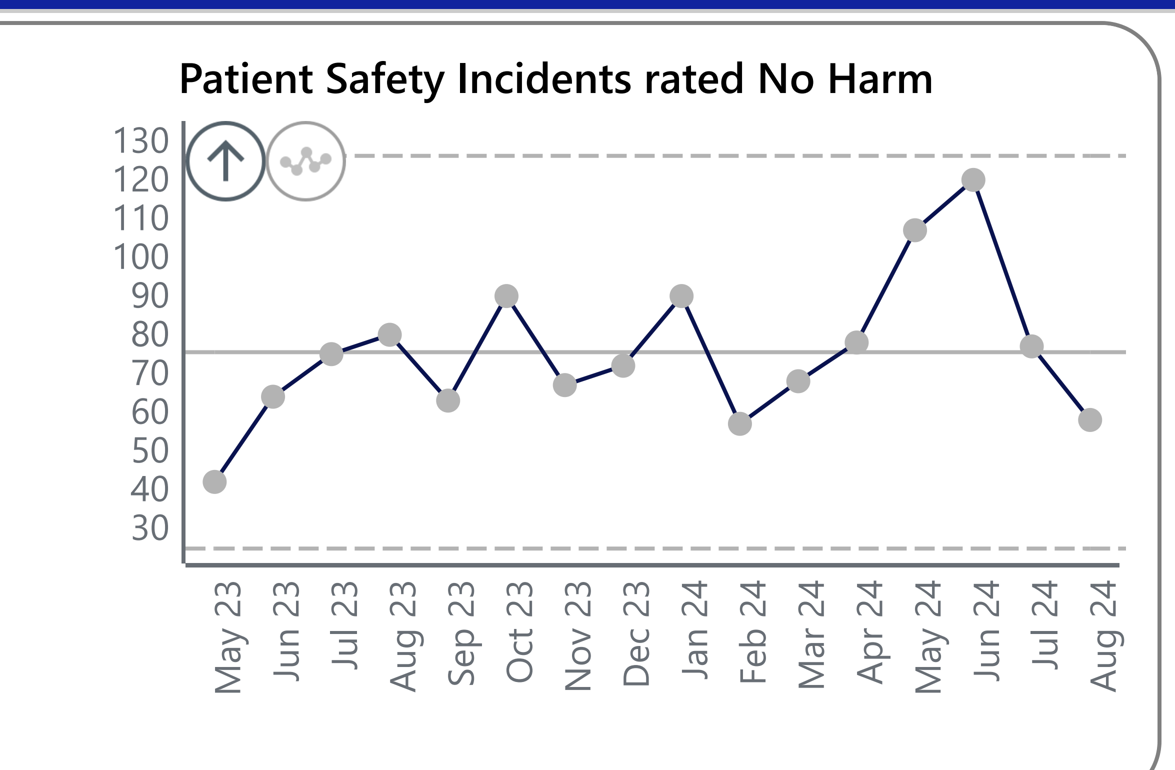
• Demand and capacity work ongoing for Psychiatry with associated workforce plan.

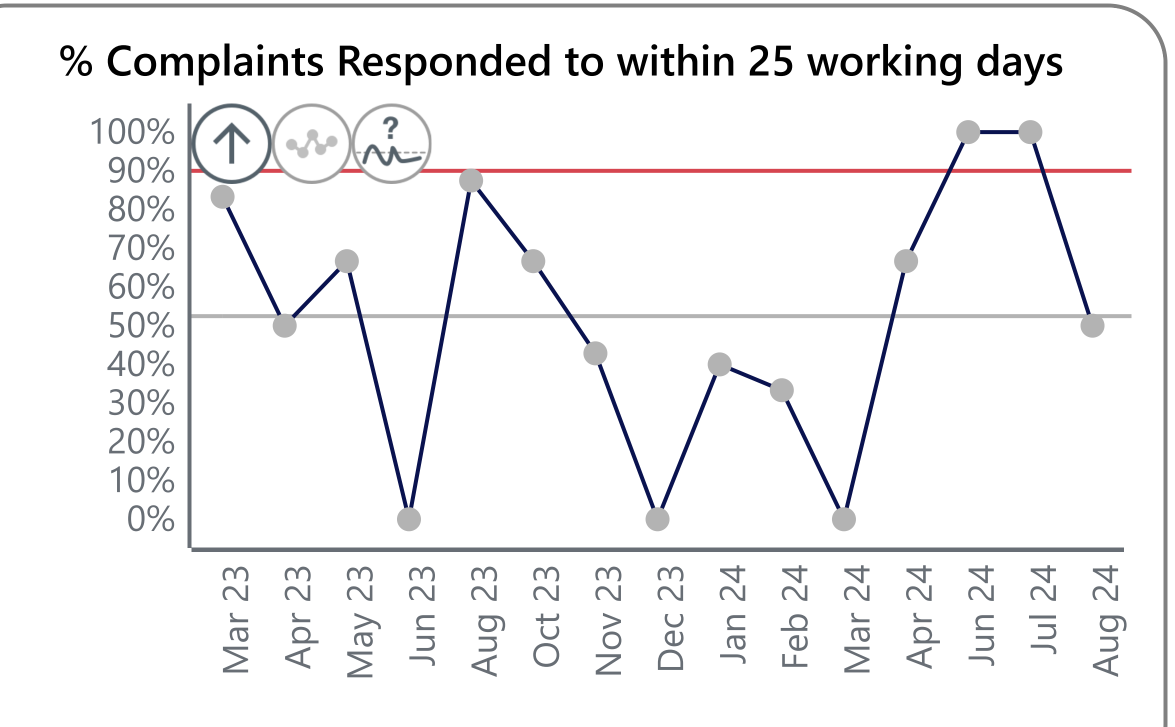
• Demand and capacity work on going for new assessment (choice) capacity – Liverpool CAMHS

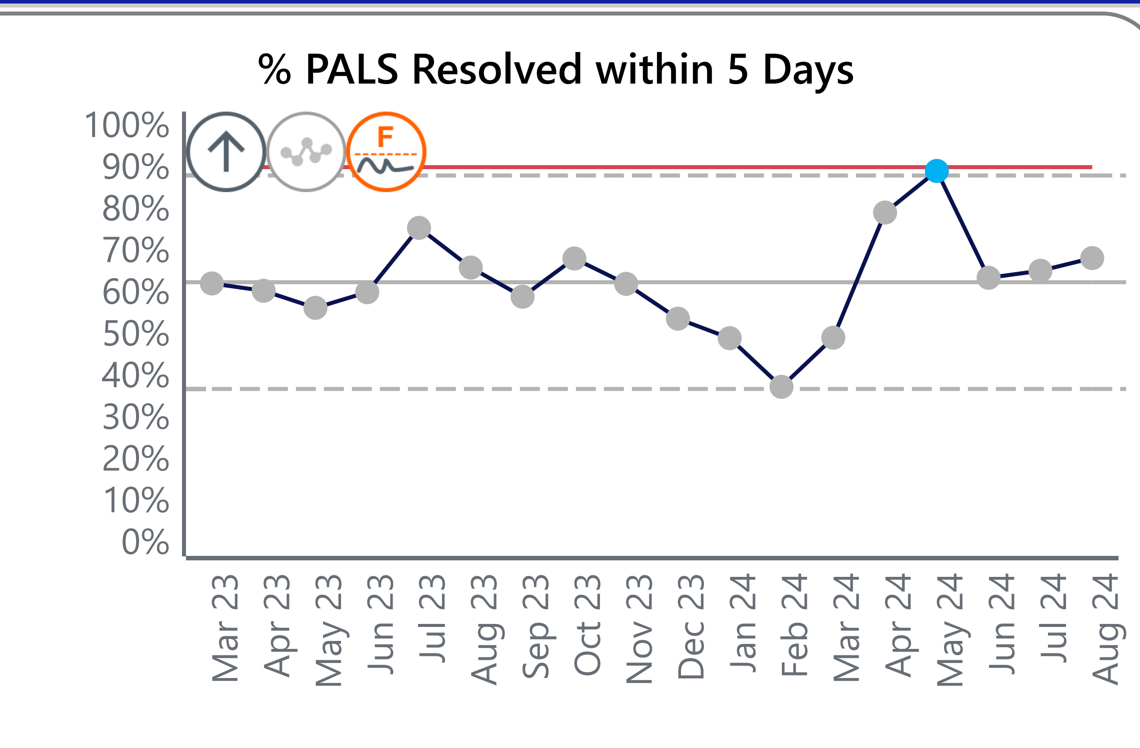
• Continued work ongoing to improve Mental Health data reporting– annual data re-submitted for 2023/24, awaiting feedback. Expected improvement in the number of data errors in MHSDS.

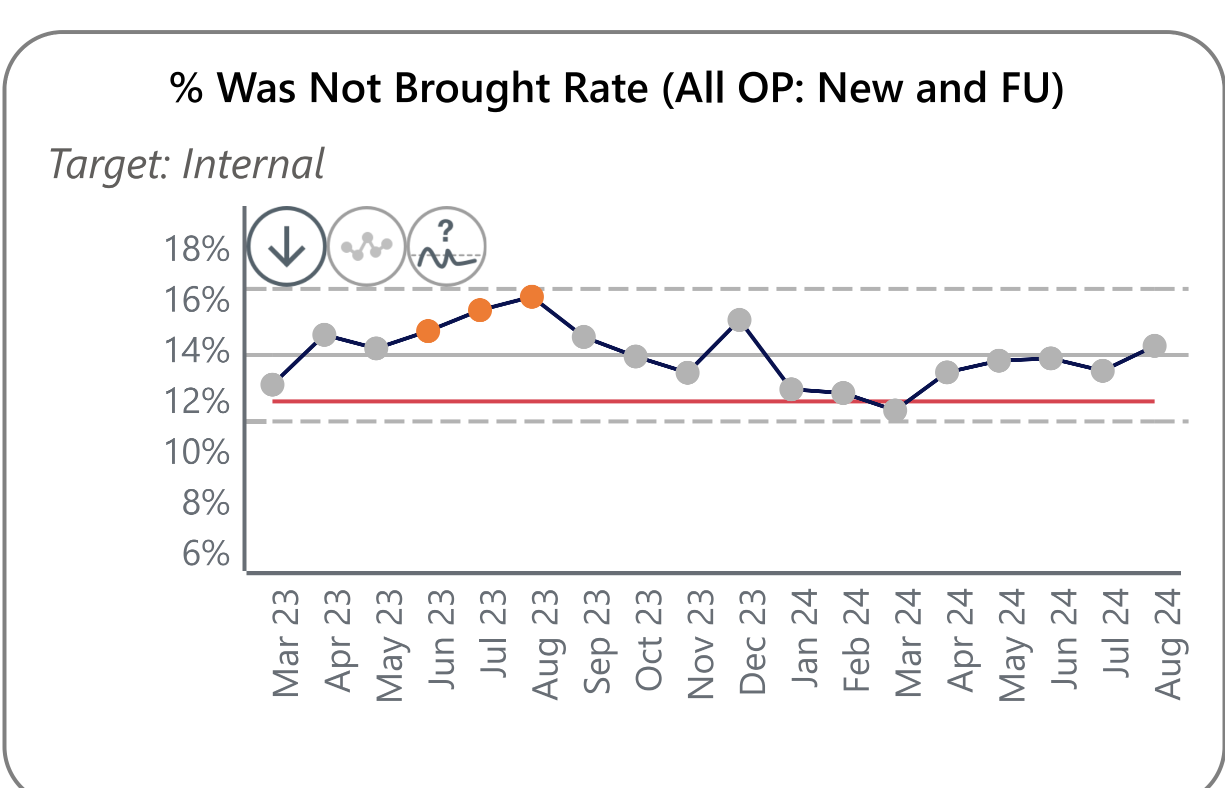
Divisional Performance Summary - Community & Mental Health

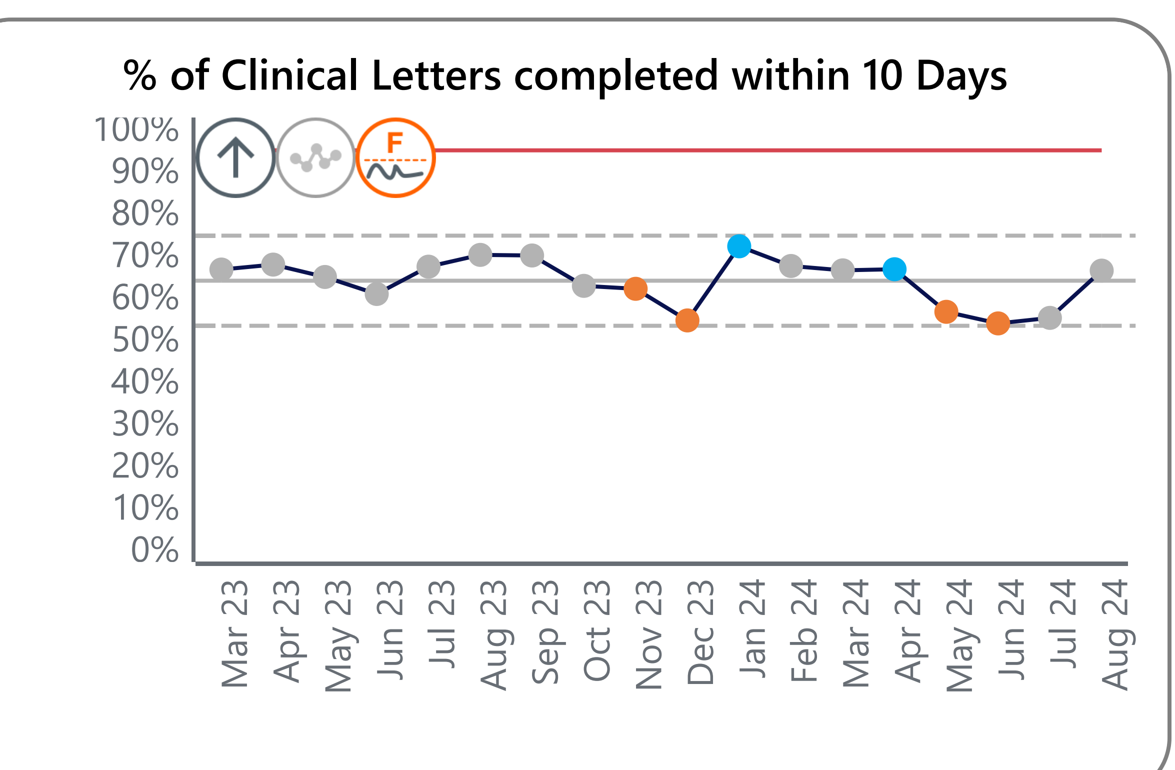


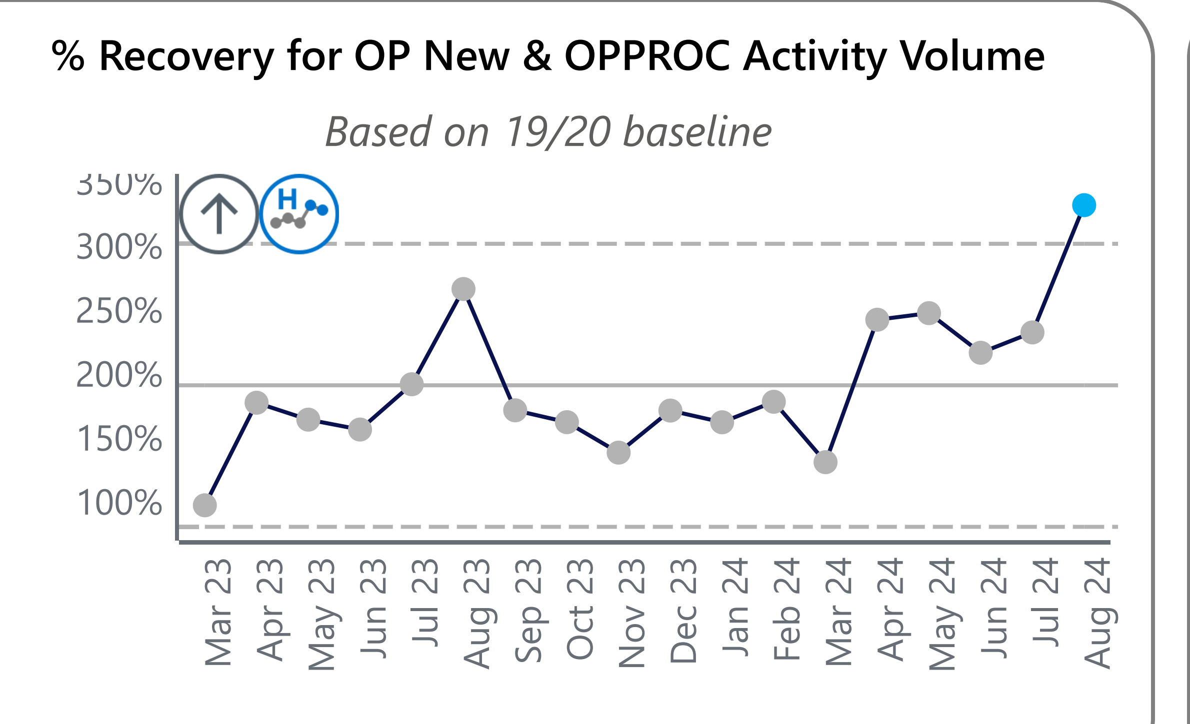


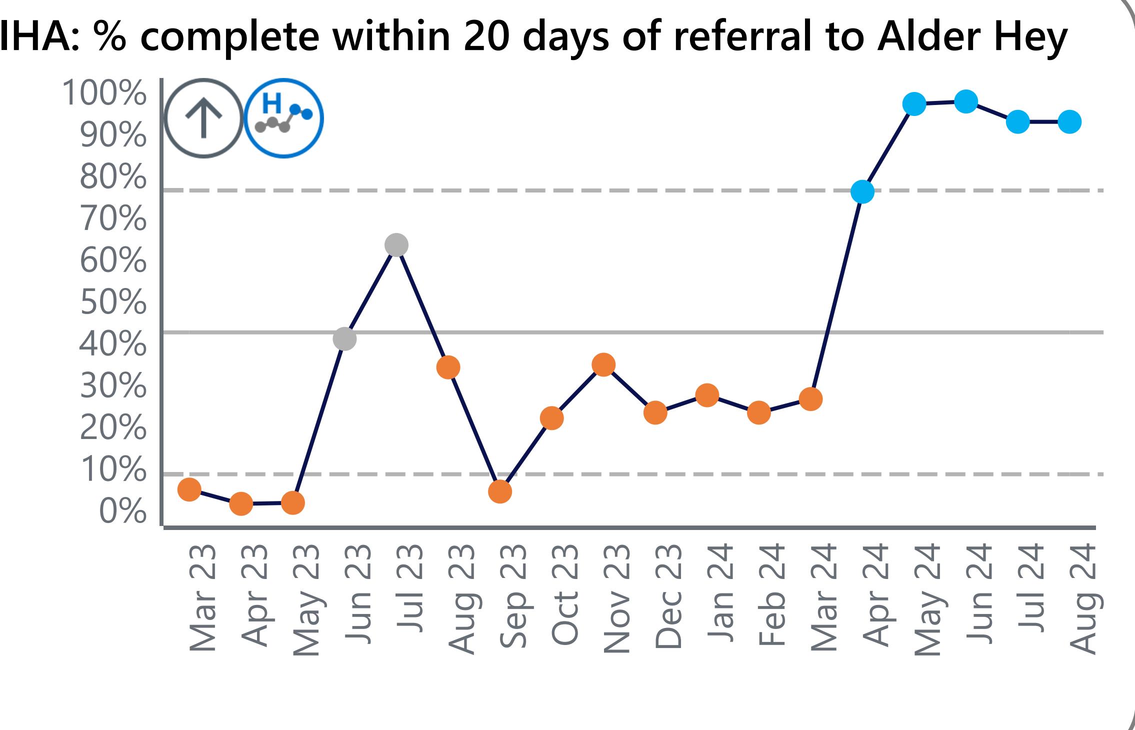


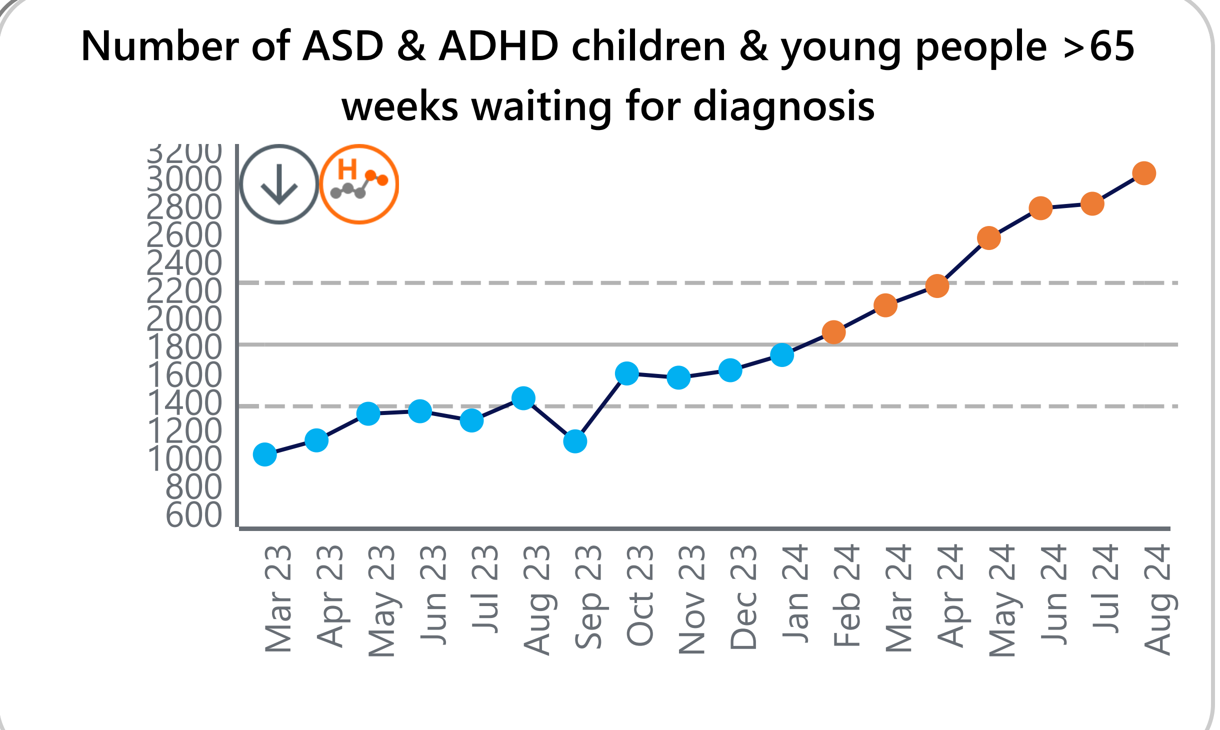


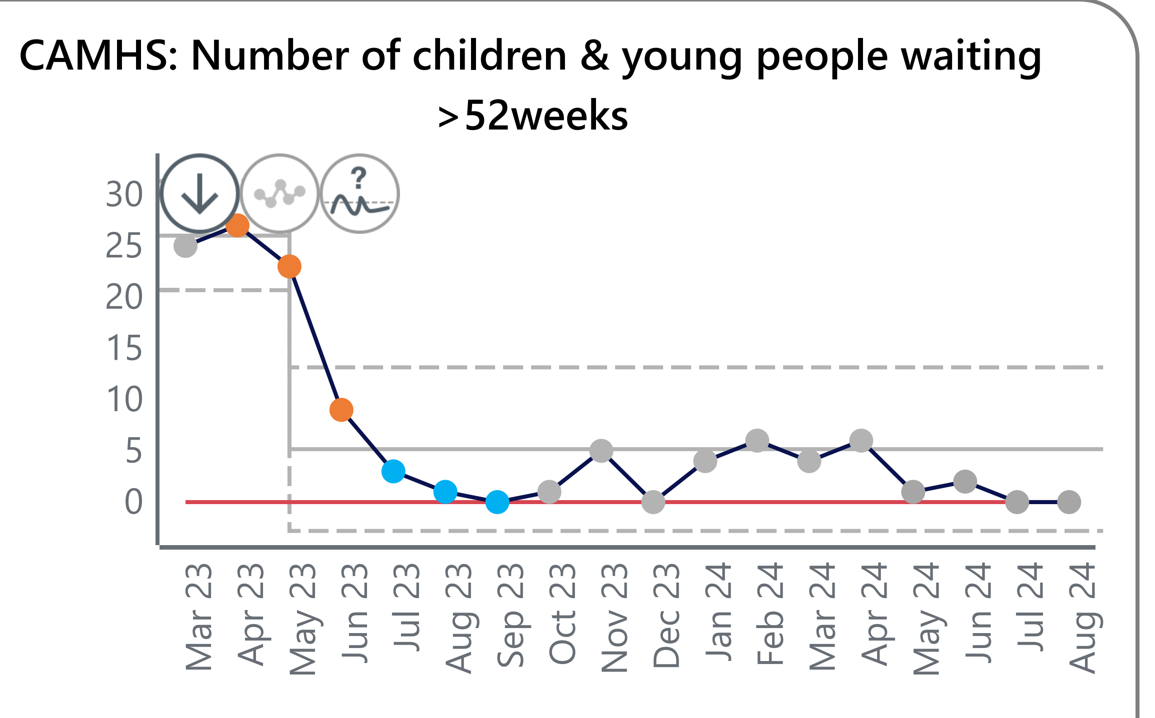


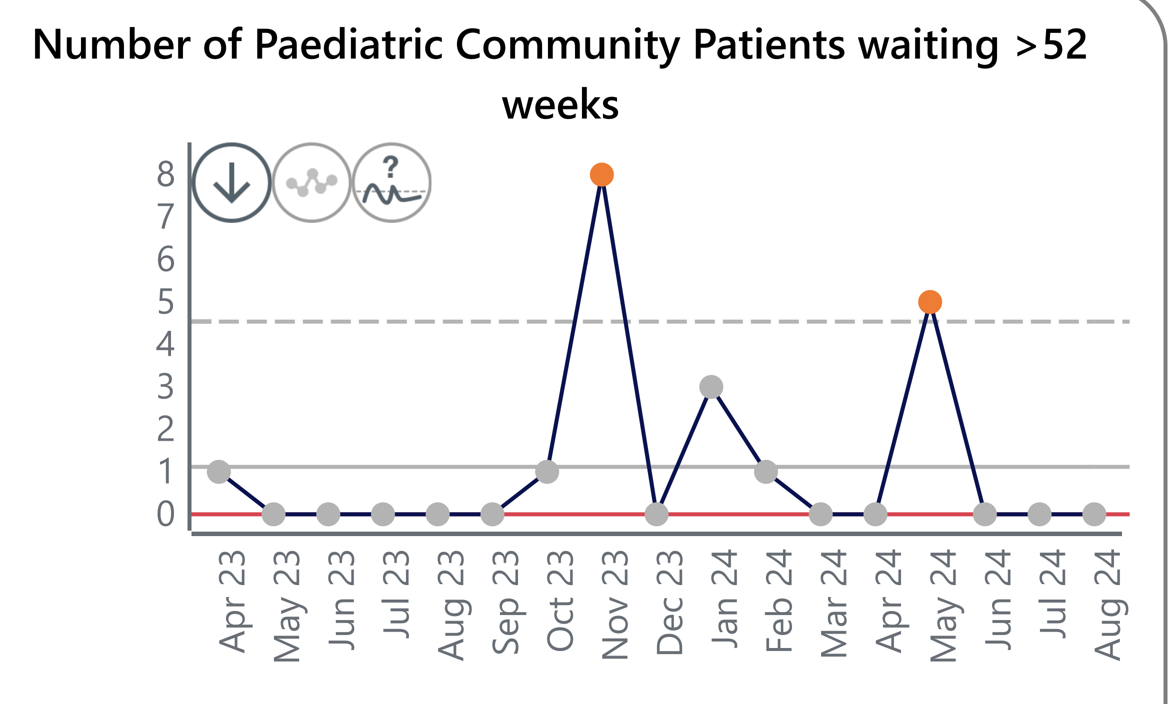


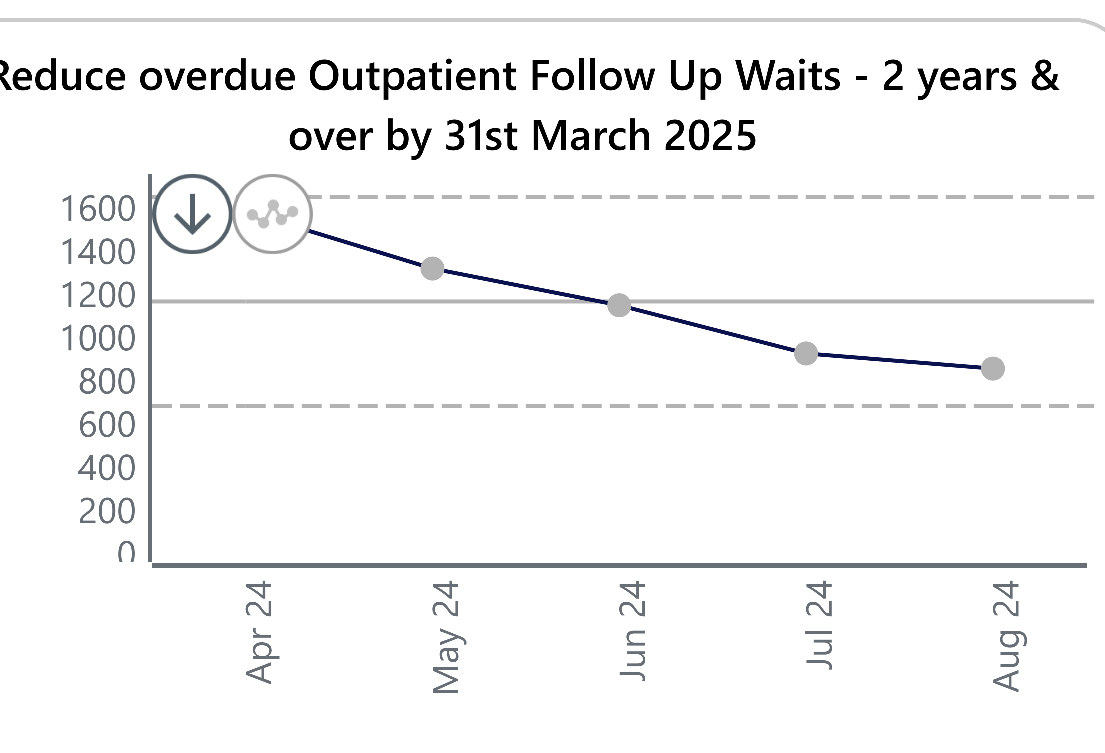












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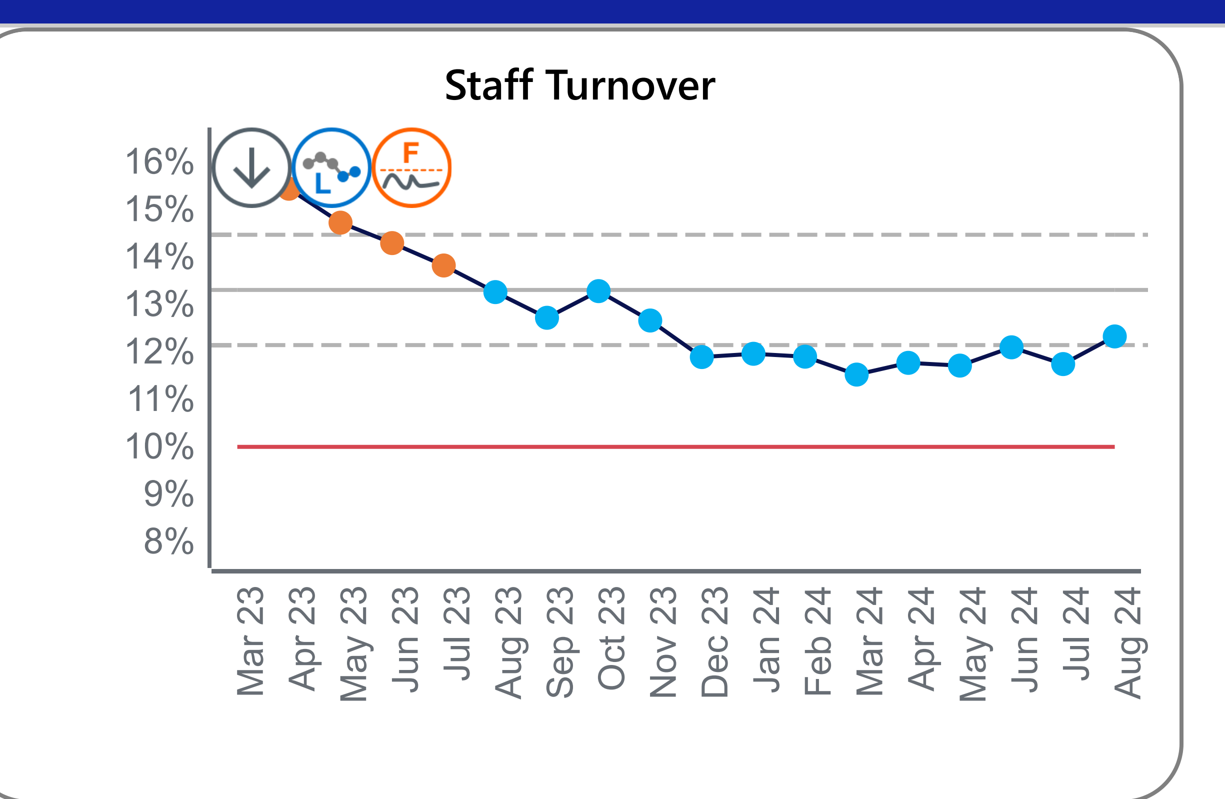
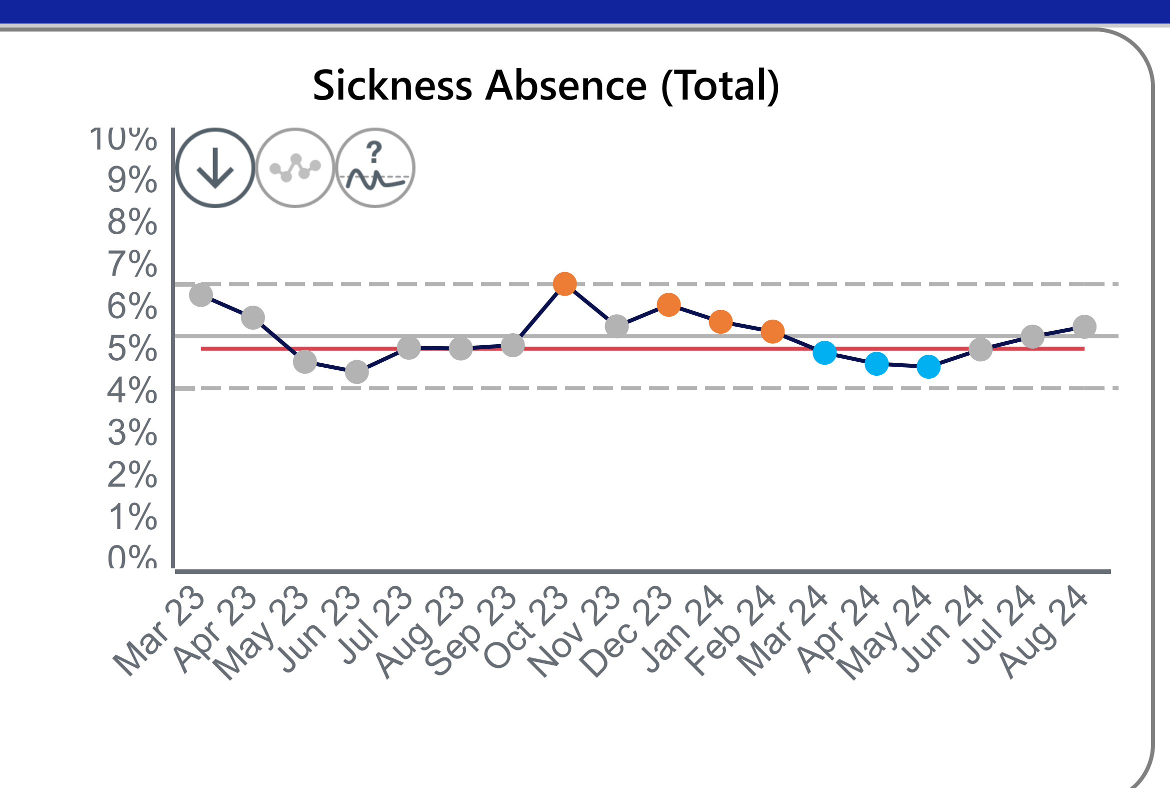
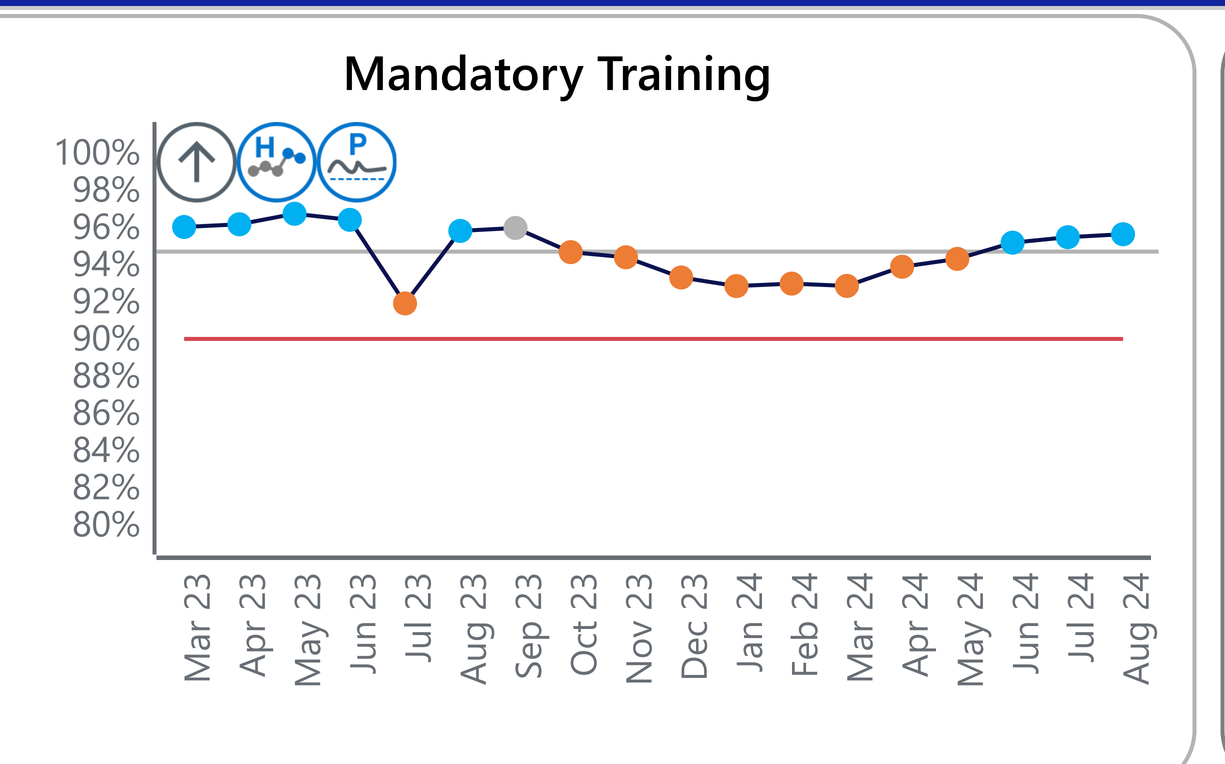
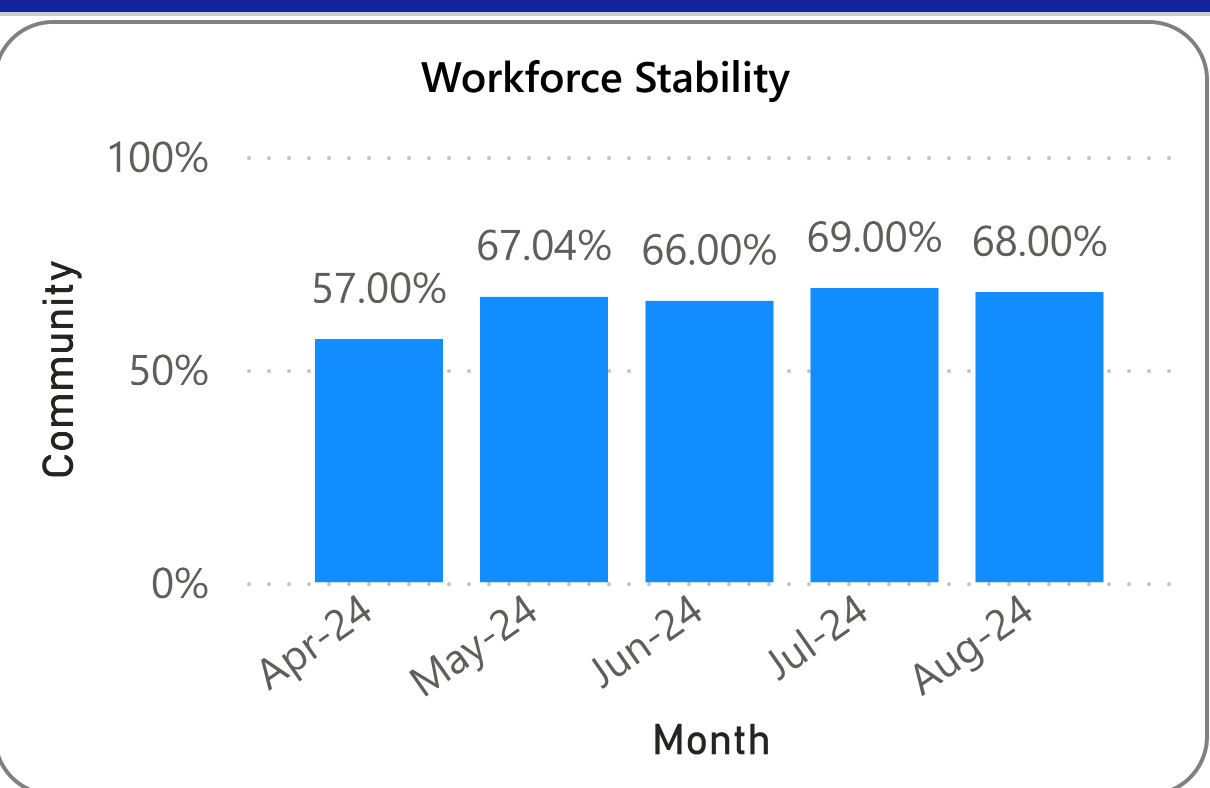
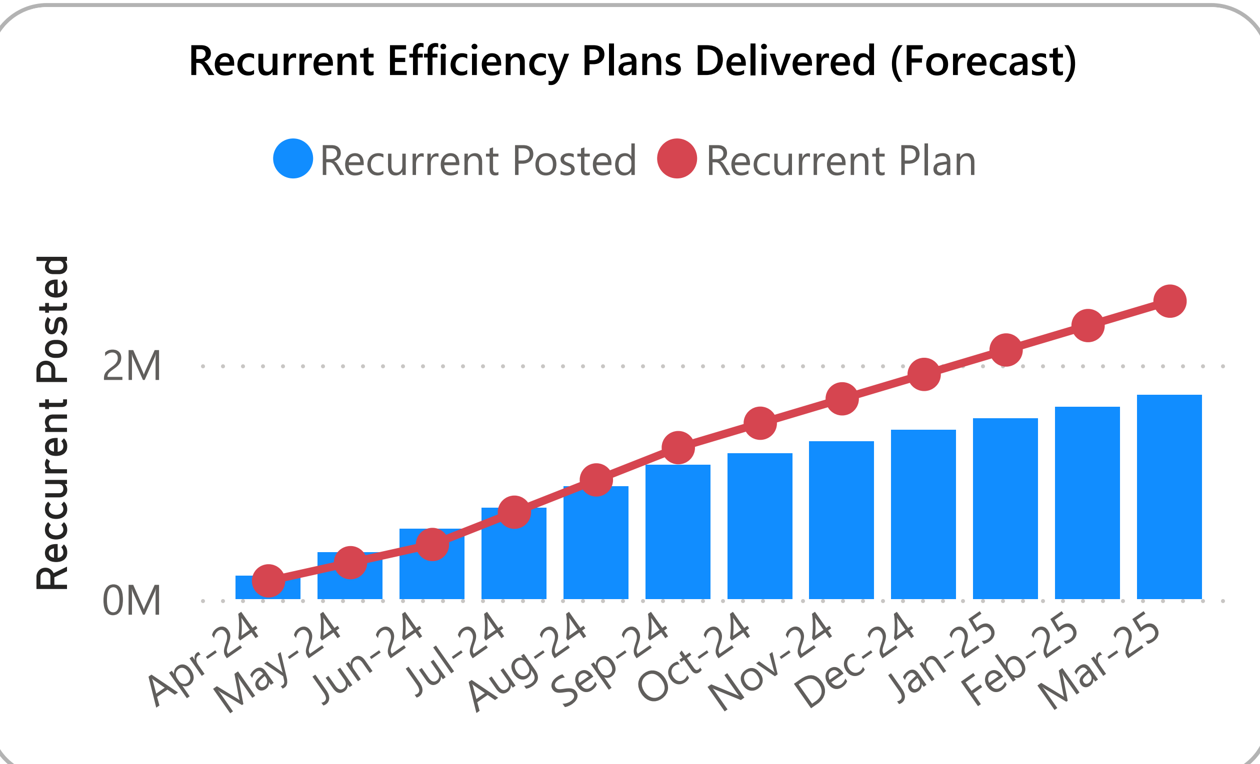
Divisional Performance Summary - Community & Mental Health

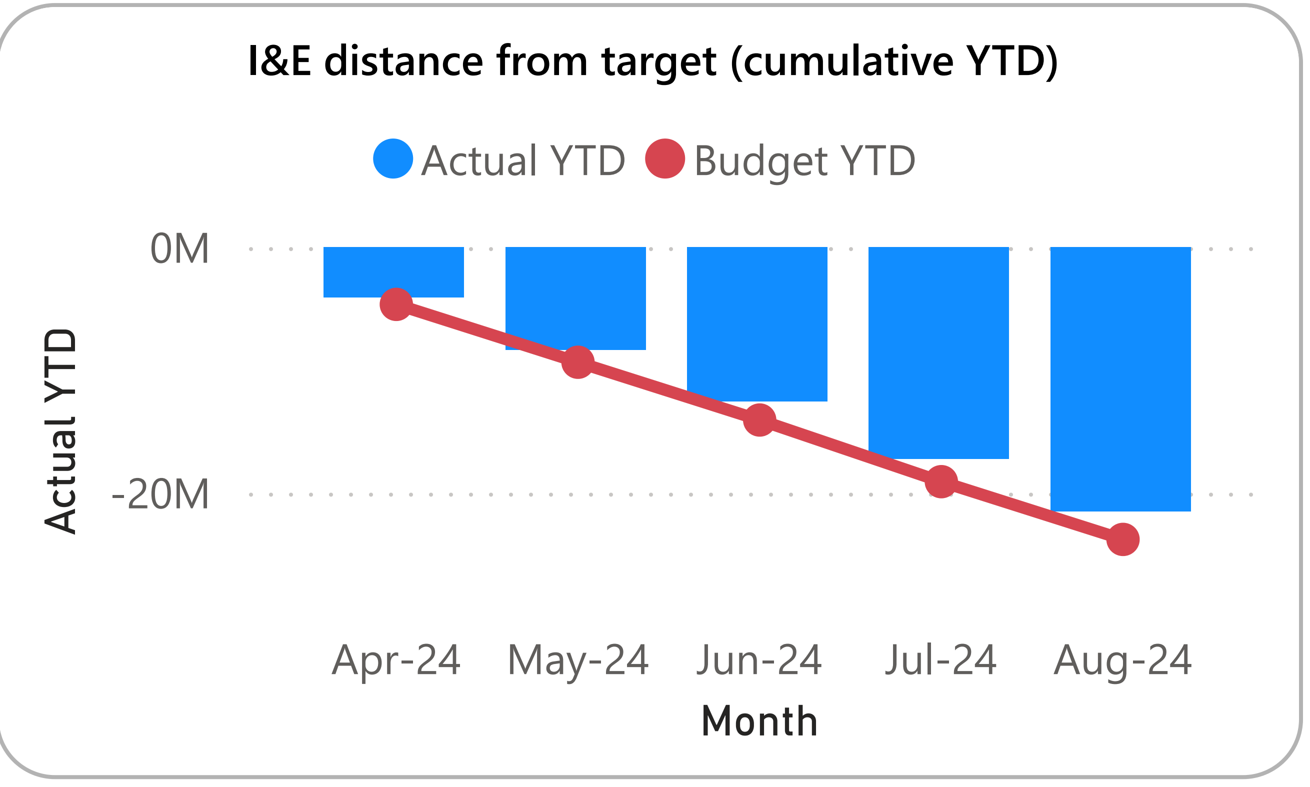


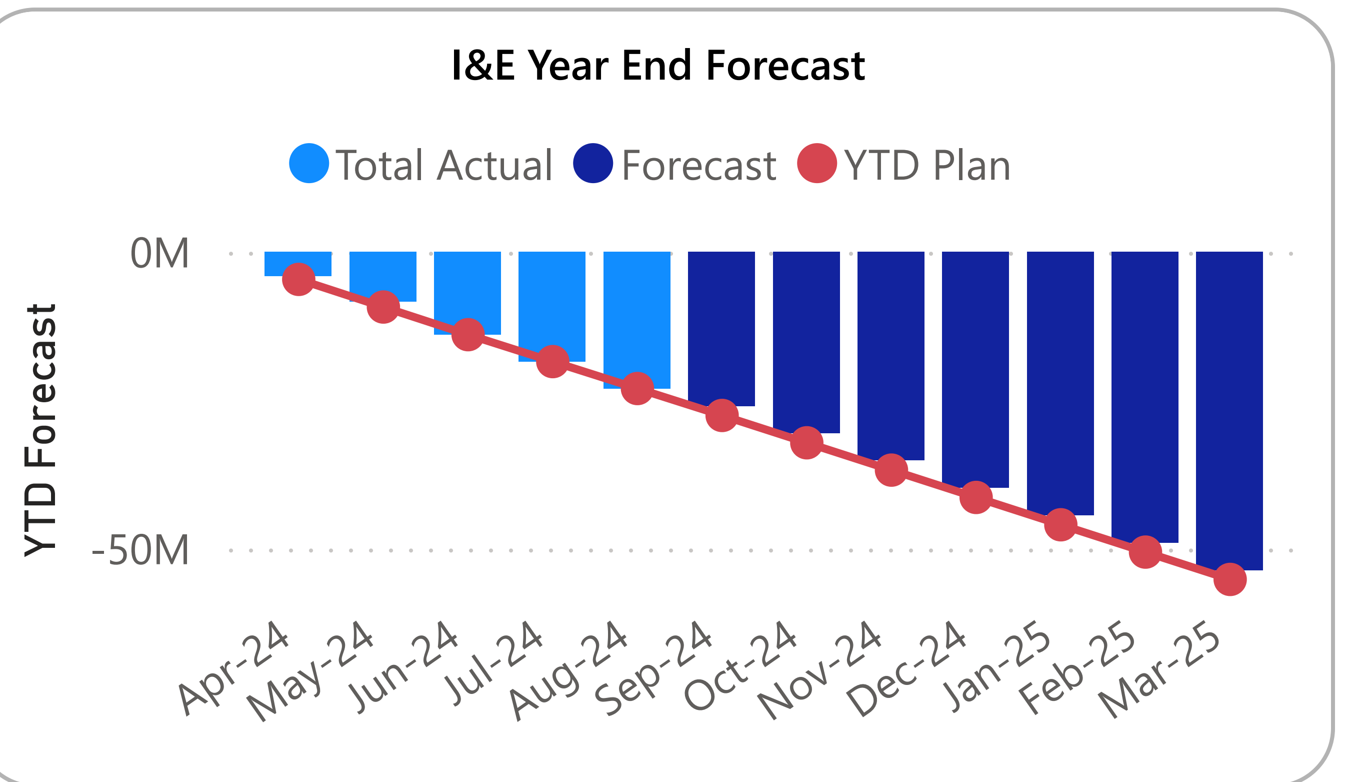


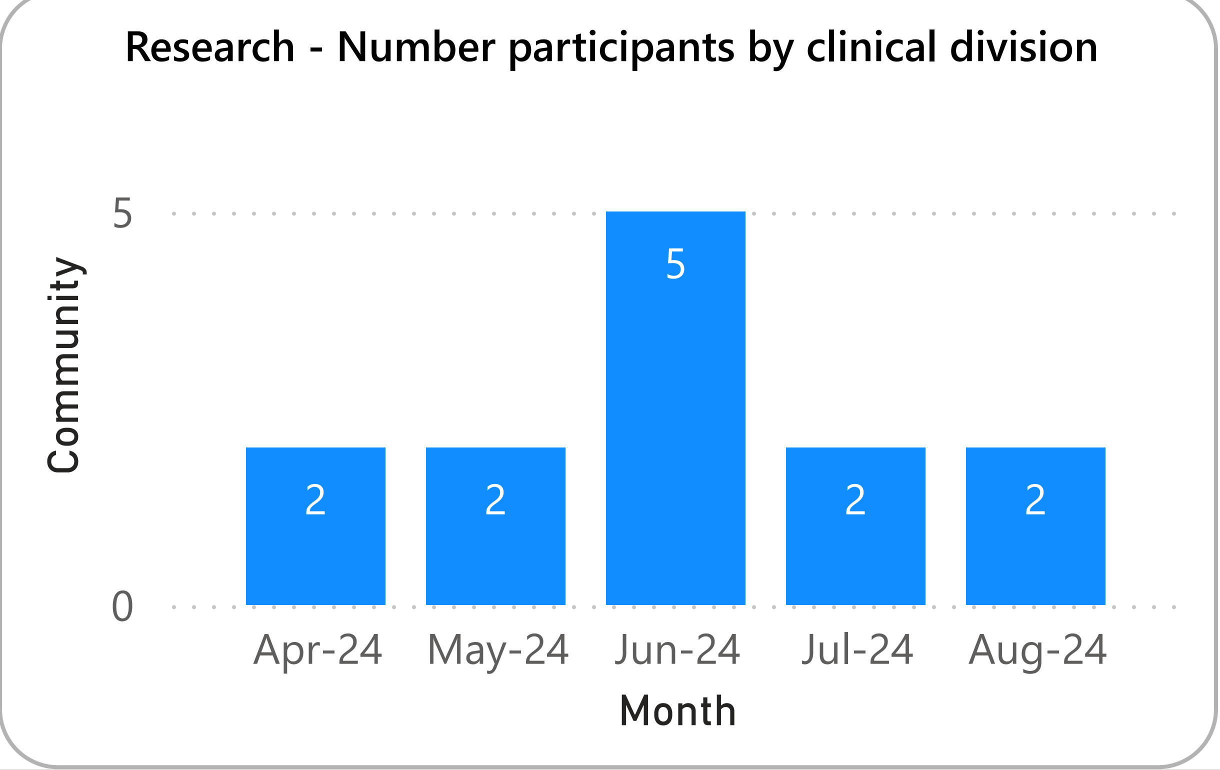


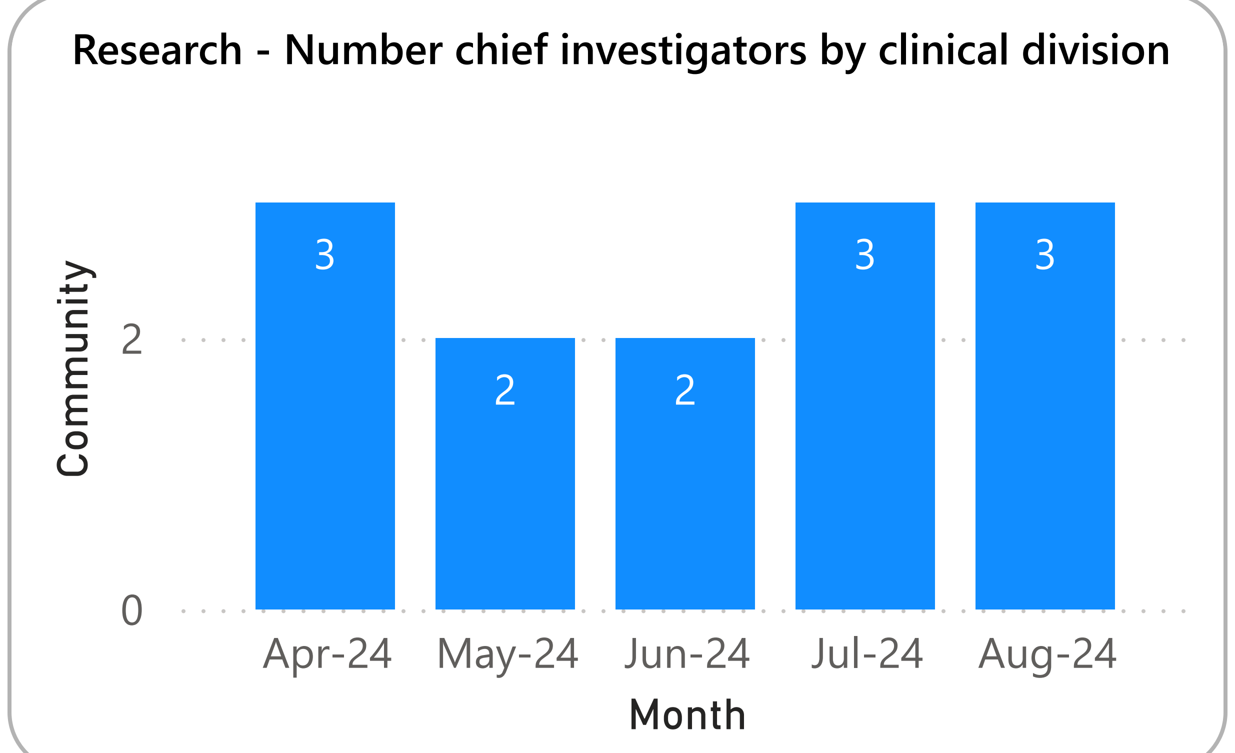












Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• ED achieved 92.6% against the 4 hour standard, 3rd best preforming Trust in England

• Two services shortlisted as HSJ finalist in this year's recognition

• Maintained over performance in OP & Elective delivery

• Increase in day case per working day

• Sickness rates below 5%

• 100% response rate for formal complaints for 9th consecutive month

• 97% compliance in PALS

• Reduction in patients waiting over 52 weeks to receive treatment, continued improvement noting Neurology as the continued area of risk and challenge

• 94% compliance in mandatory training

• Staff turn over remain low, now 8%

• Maintained 100% cancer targets

• Reduction in % recovery for OP and OPROC however remained above 100%

Areas of Concern

• WNB rates increased slightly but remains below previous August

• DMO plan in place to achieve compliance in October however remains area of concern for Gastro & respiratory

• Increase in overdue follow ups despite the focused speciality review; however, forecast plan will reduce in September

• Although all CIP schemes have been identified a challenge remains regarding delivery and transaction of the CIP target

• Suspected dip in reporting owing to significant reduction in incidents recorded of low or minor harm

• Theatre touch time remains a challenge within the division; however, dedicated team reviewing key specialities to consider the data reporting and improvements seen in IR to date

• Reduction in Sepsis compliance in ED, predominantly affected owing to the reduction in attendances rather than increased volume of incidents. Review of each case underway

Forward Look (with actions)

• Preparing for increased Winter demand with winter initiatives coming into place

• WNB rate, short notice booking identified as a key reason. Targeted teams reviewing how they provide more notice for CYP

• DOM1 trajectory in place to monitor performance and impact of improvement plans to ensure material difference seen month-on-month, Gastro compliance planned for October 2024 and LTV by February 2025

• Continued Speciality based approach into follow up care to sustain and progress improvements

• Continued focus on delivering CIP in a financially sustainable manner

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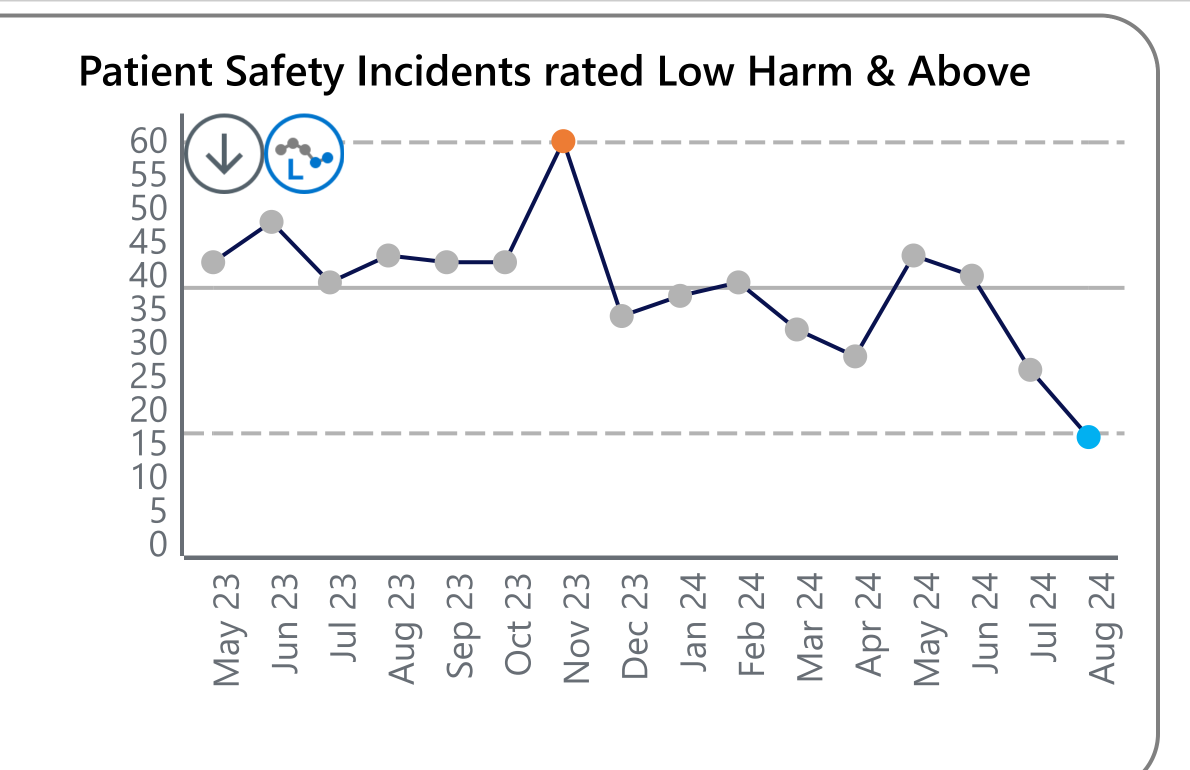
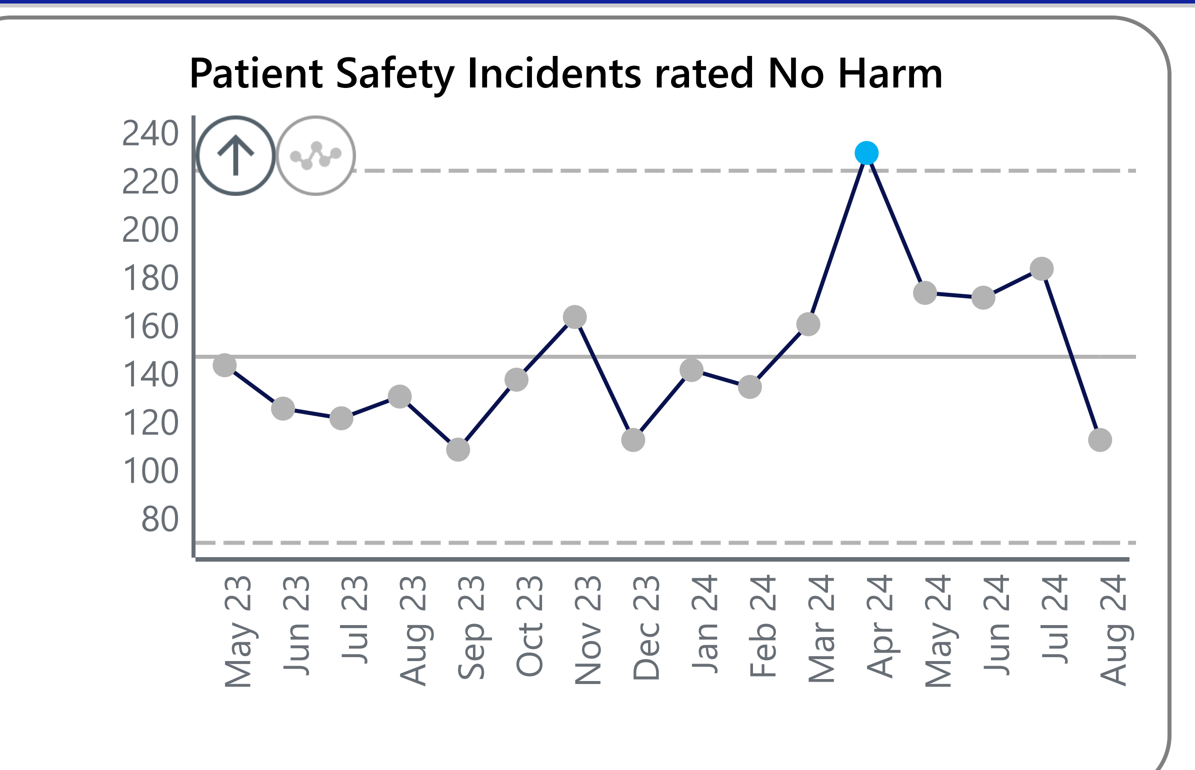
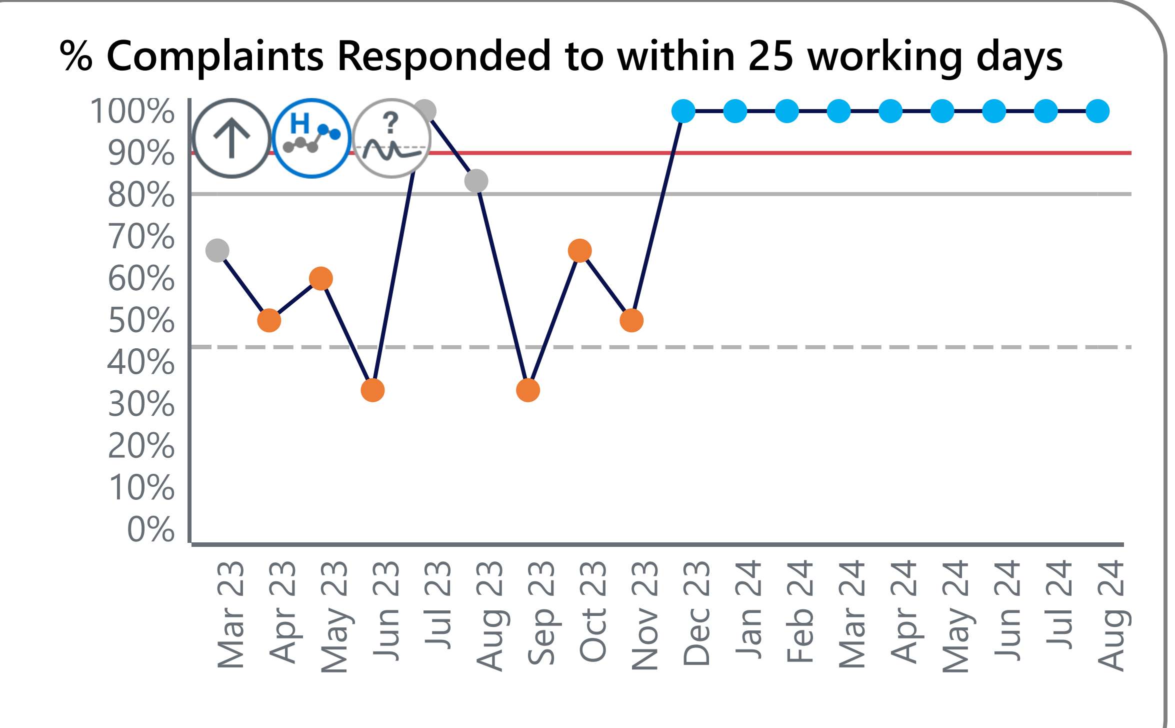
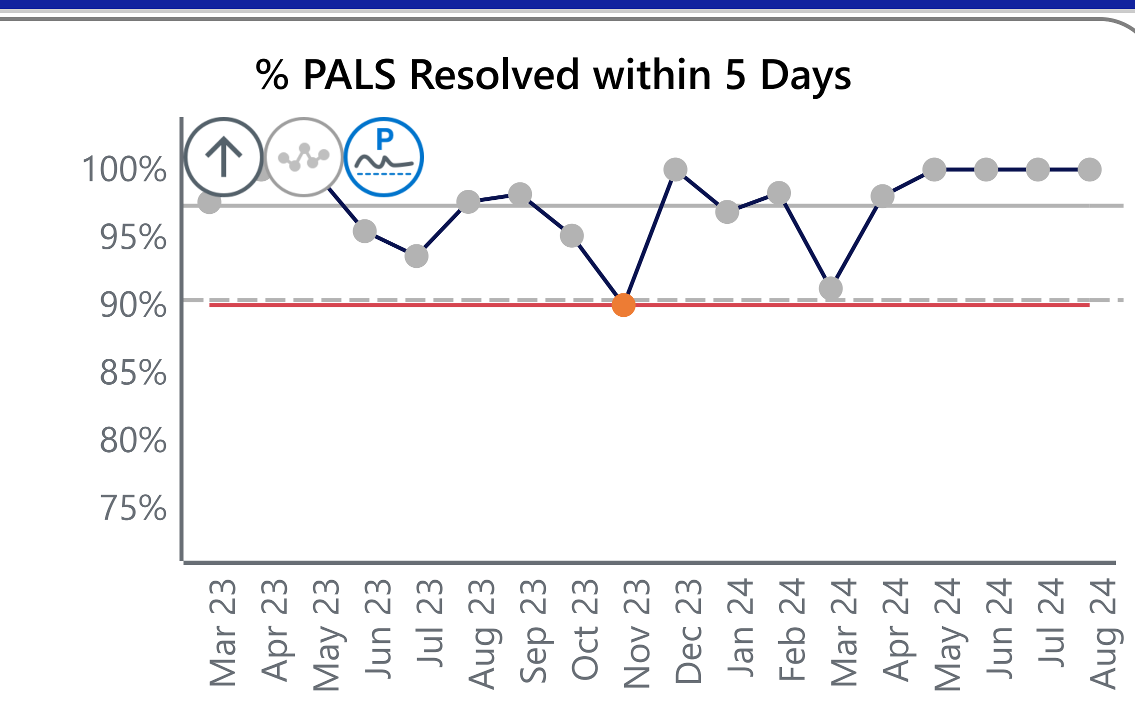
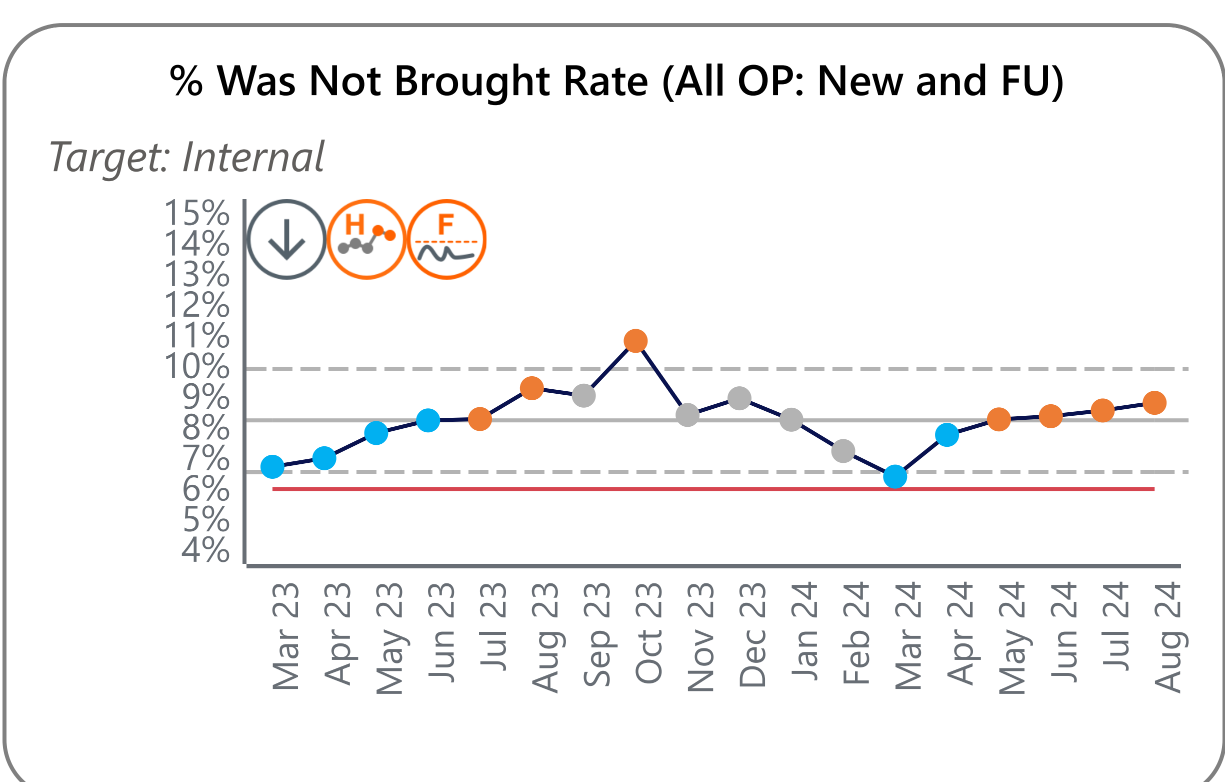
Divisional Performance Summary - Medicine

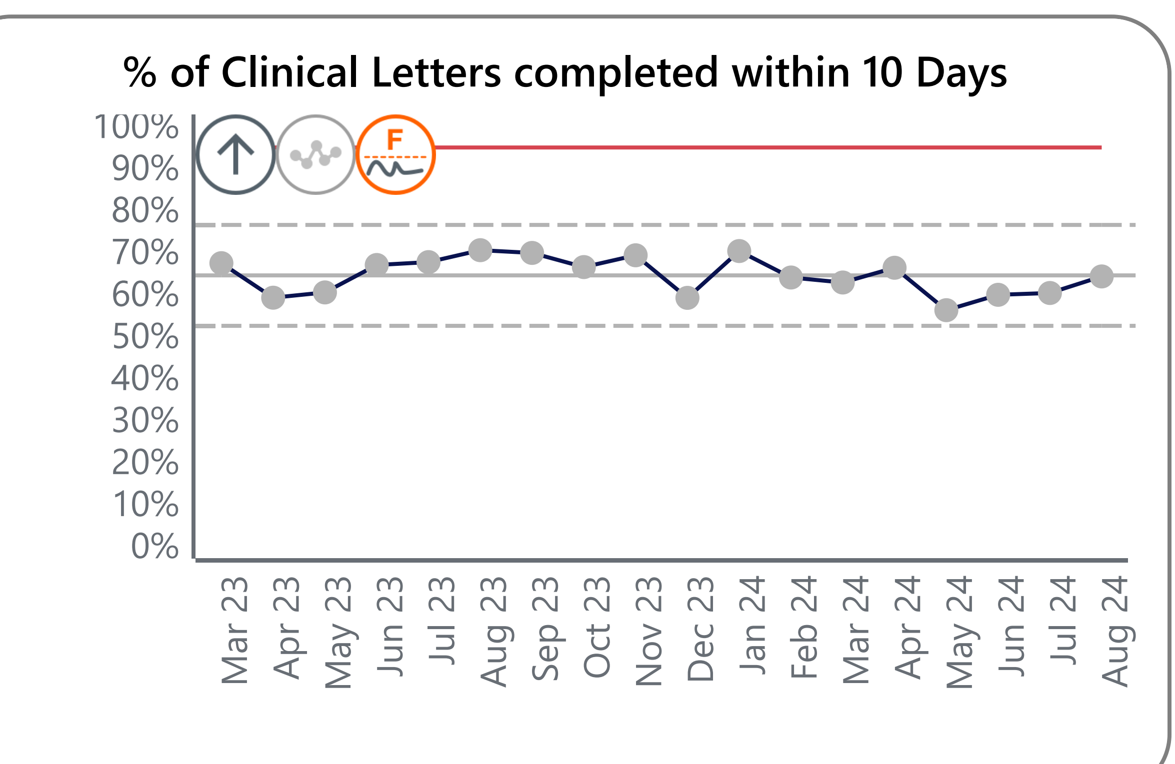


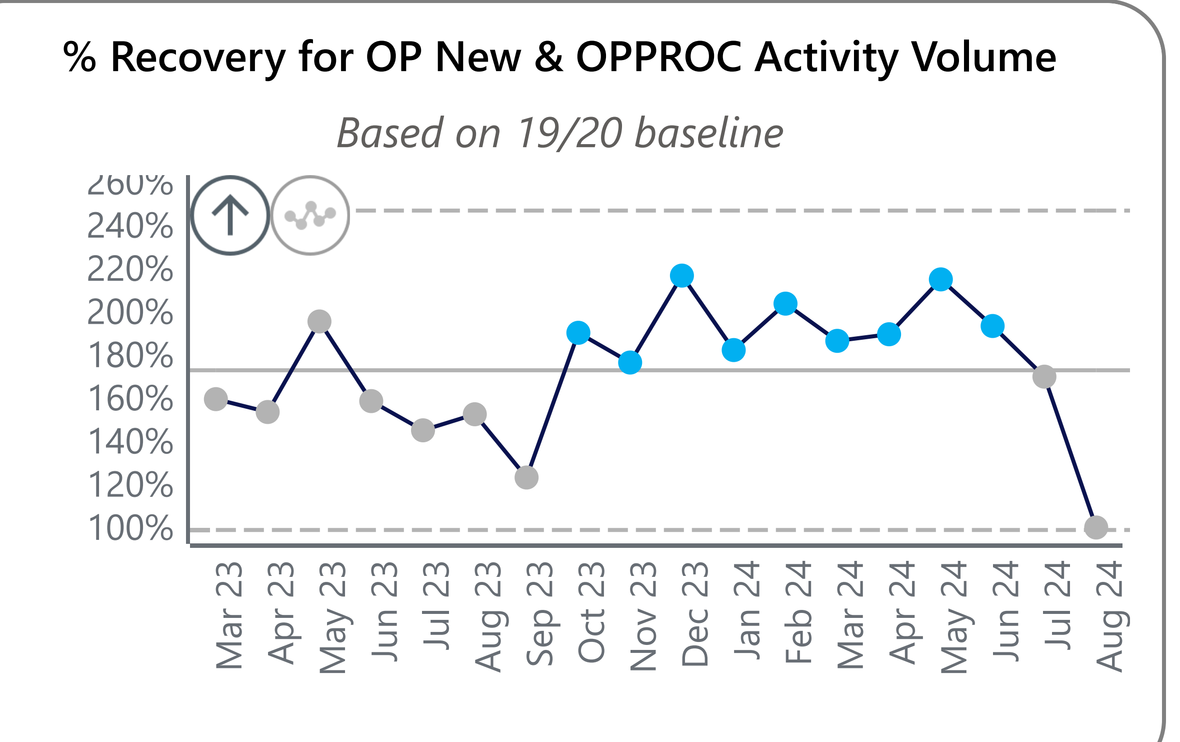


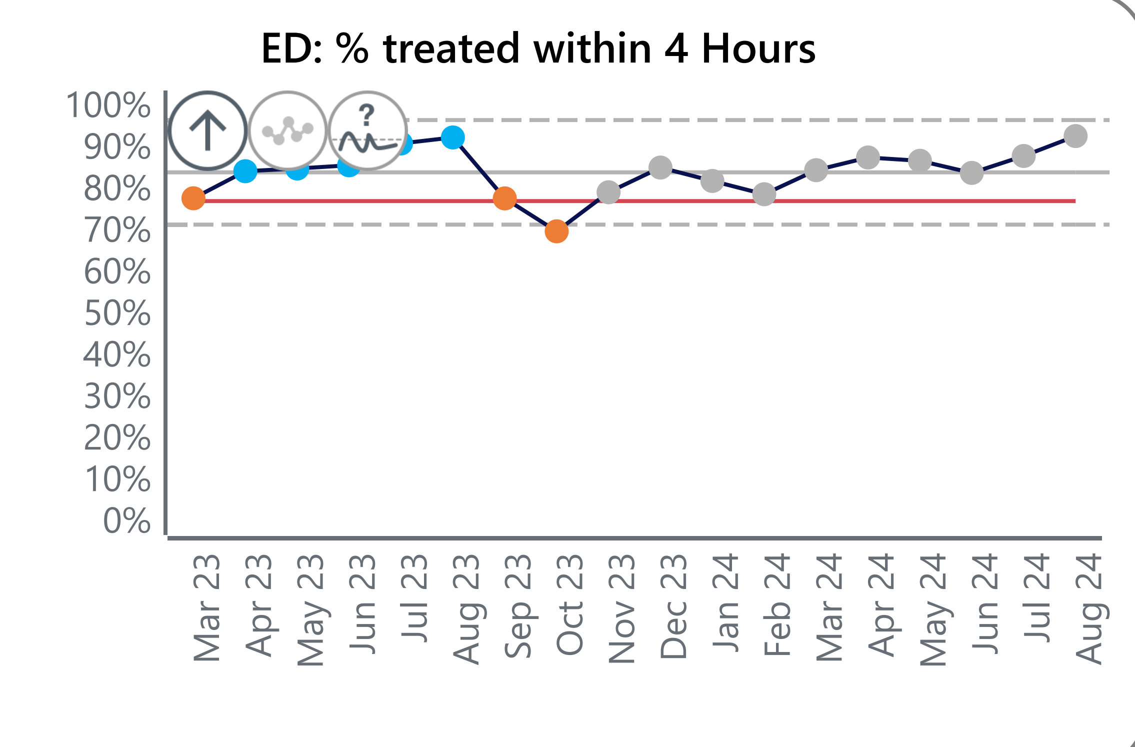


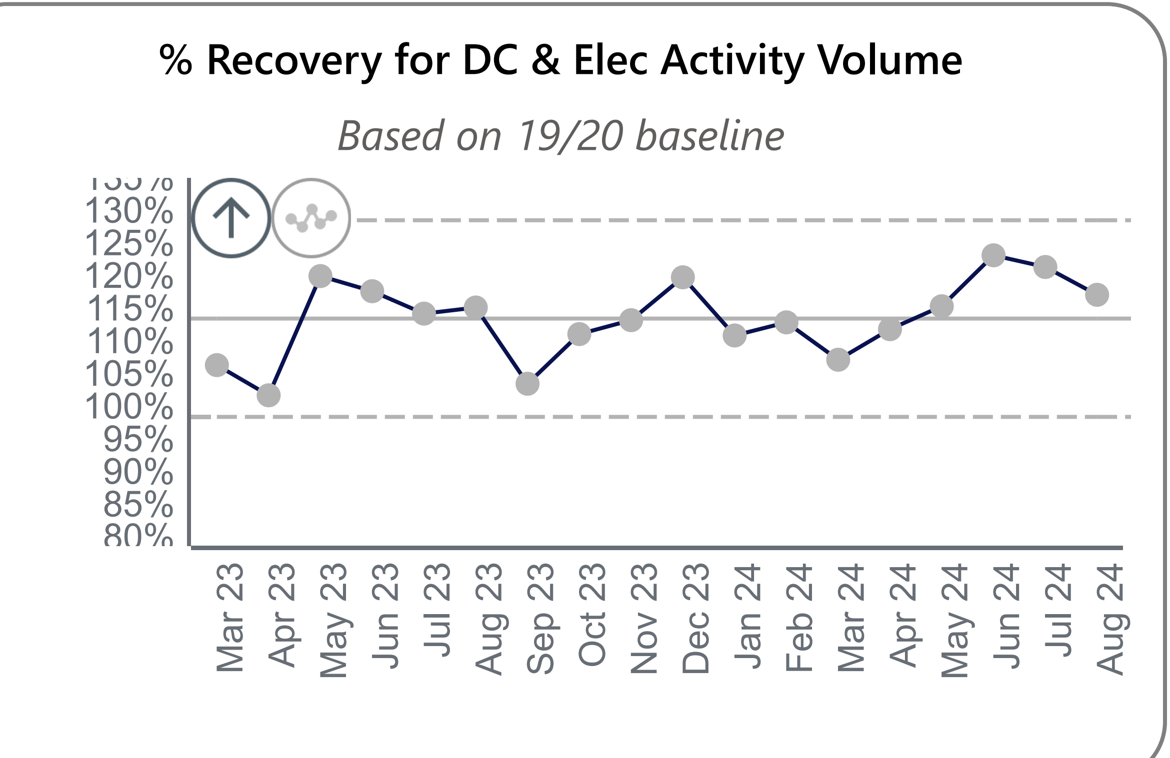


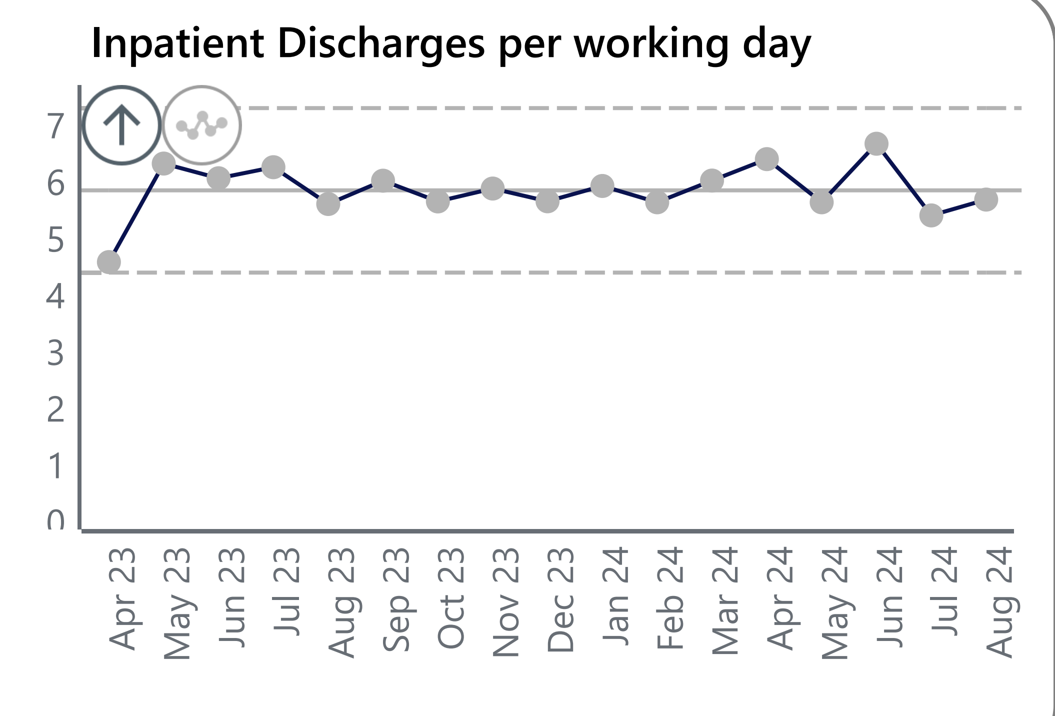


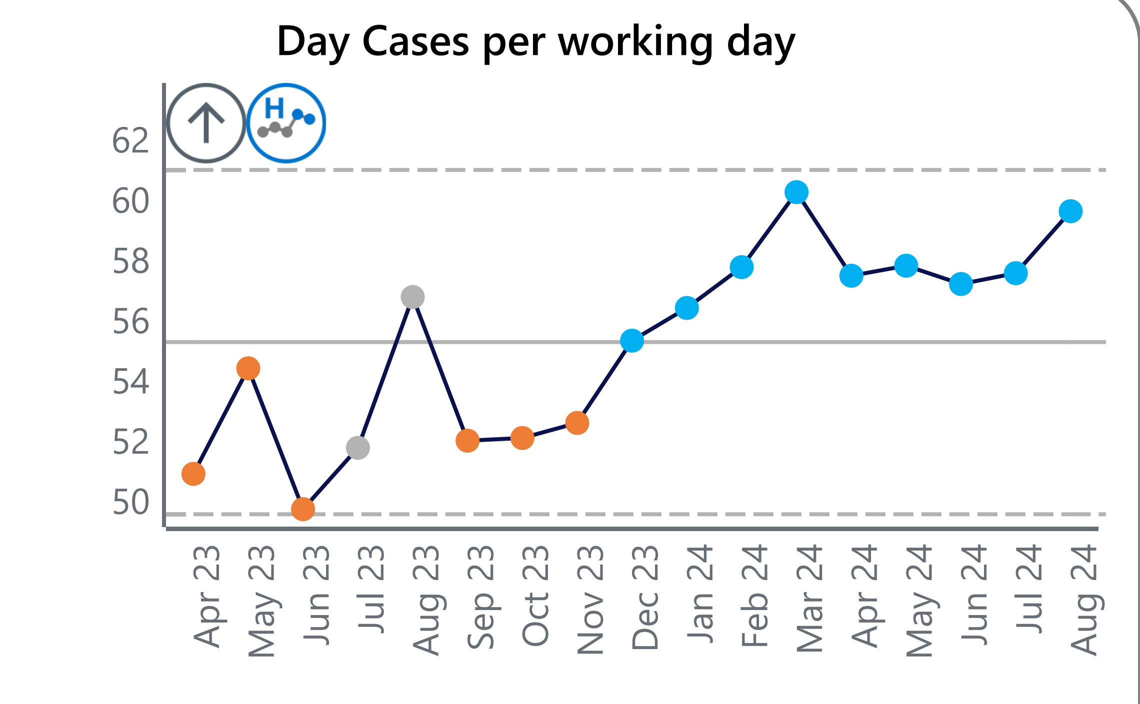


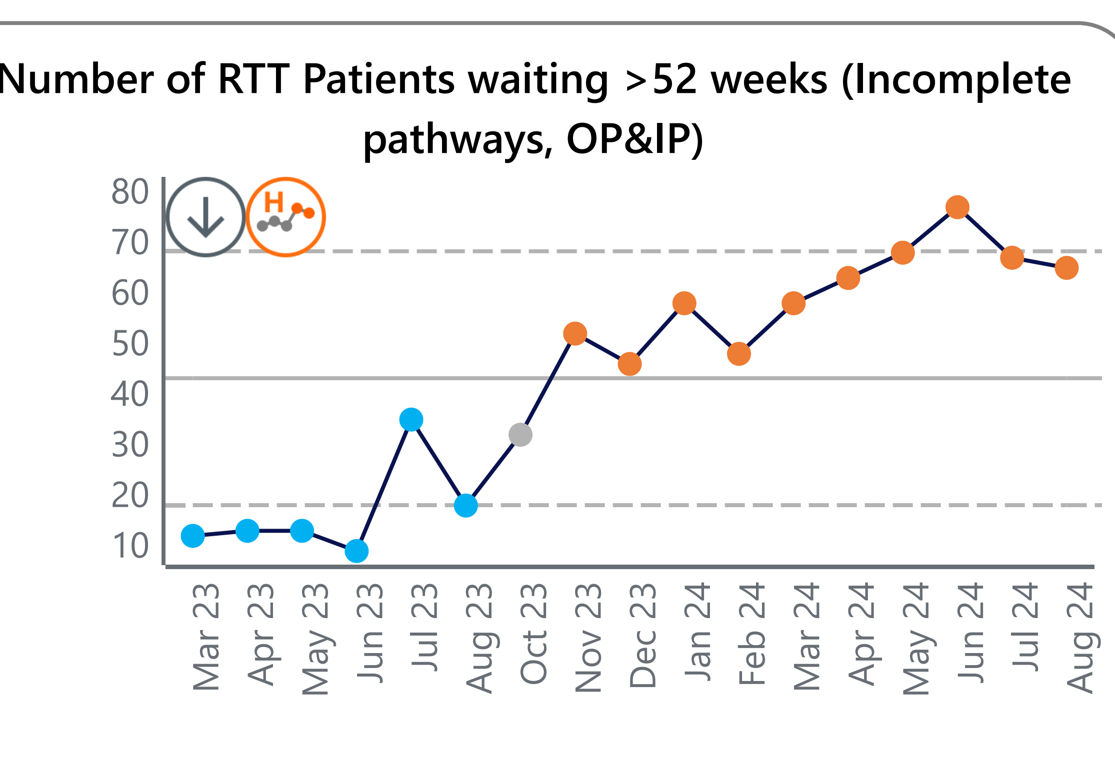












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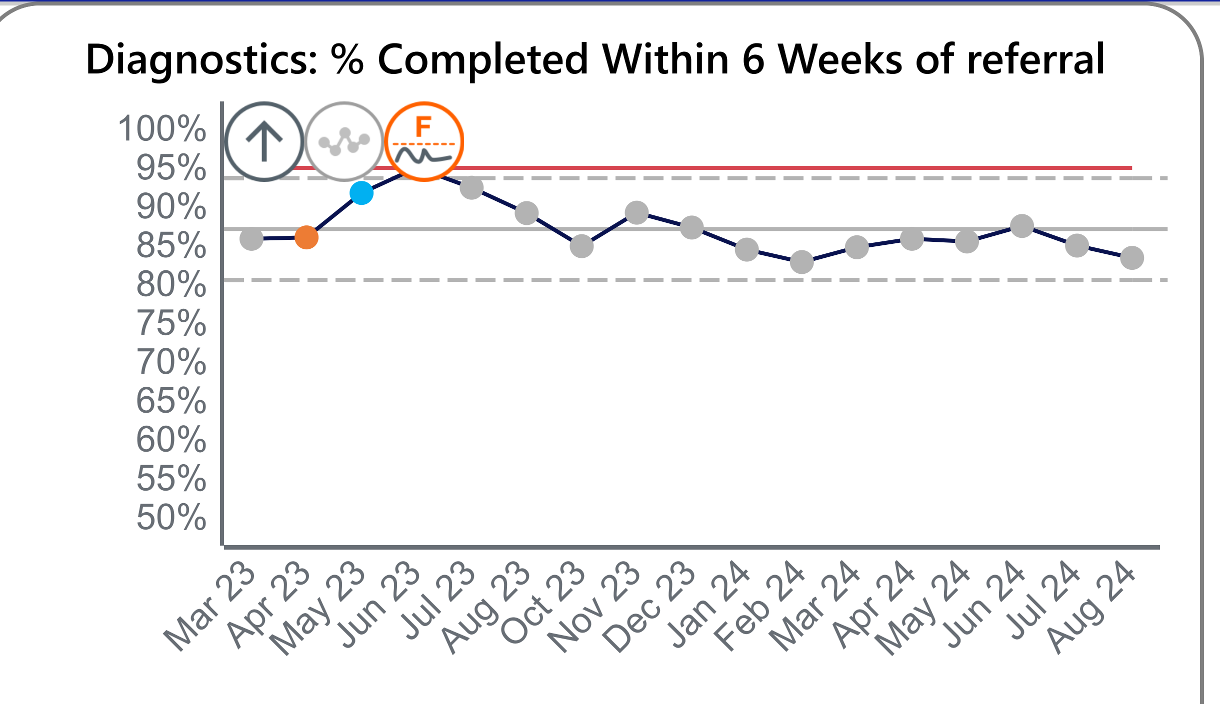
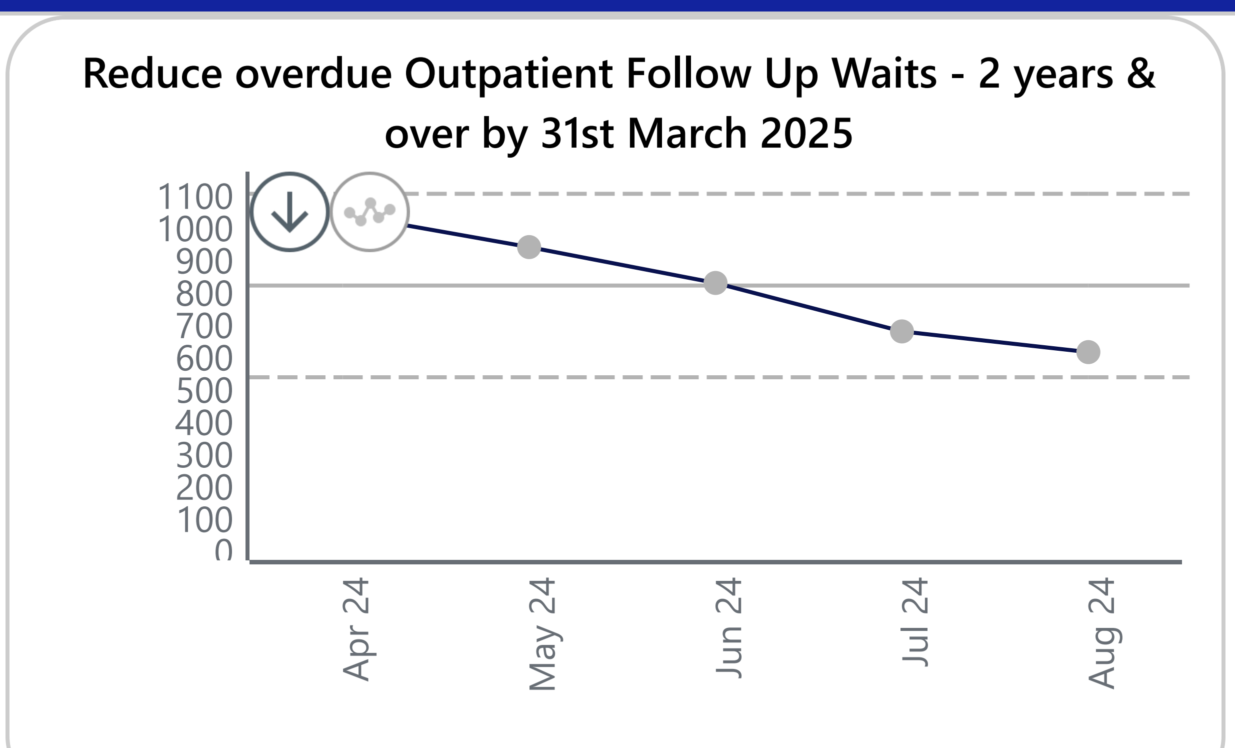
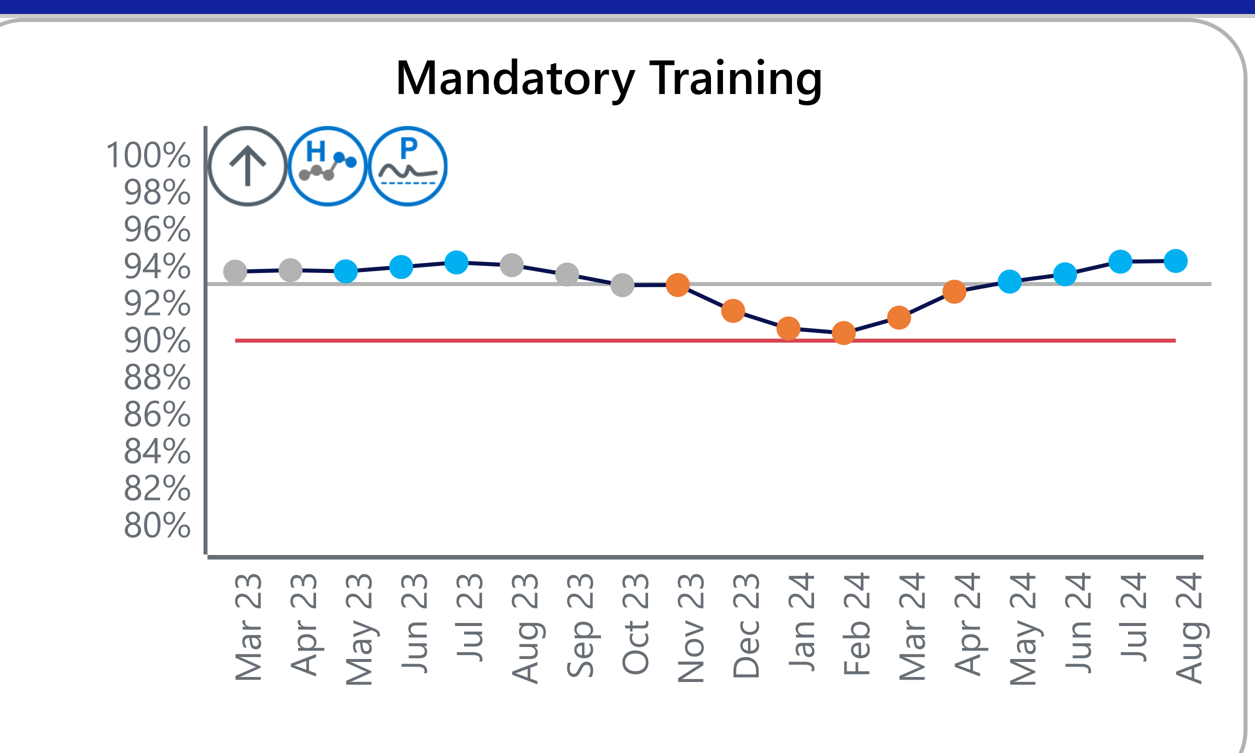
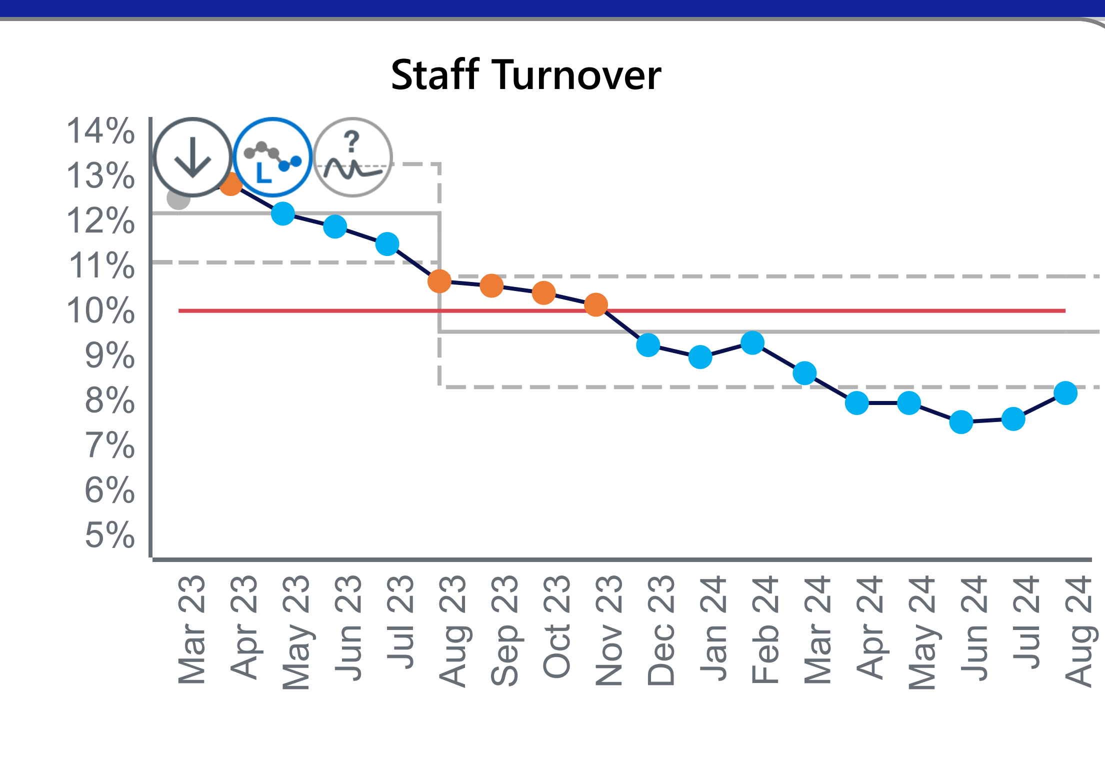
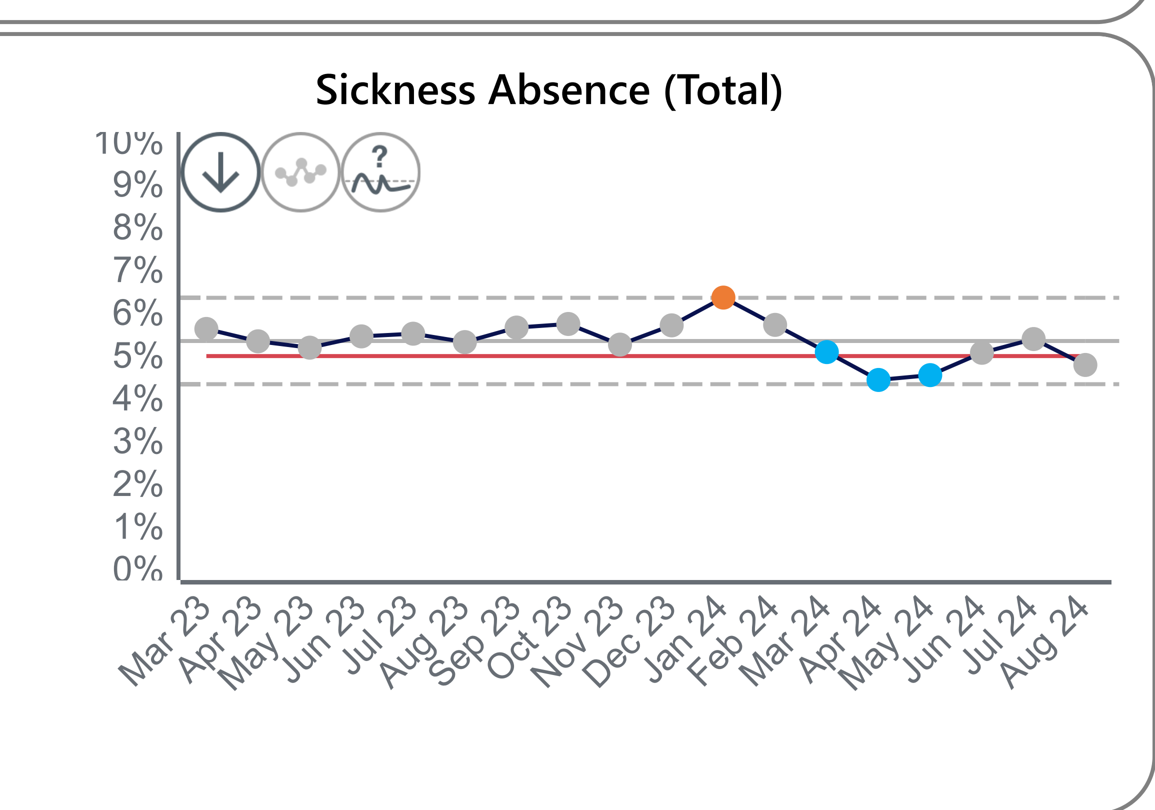
Divisional Performance Summary - Medicine

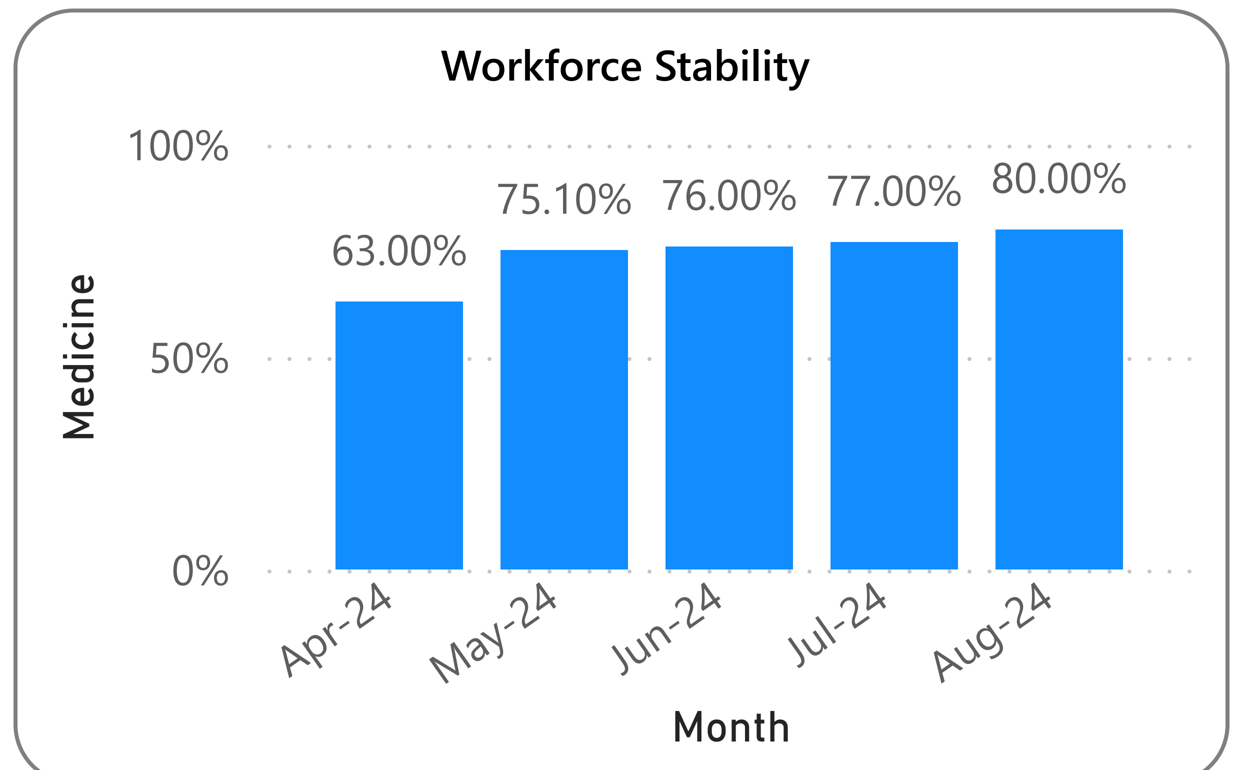


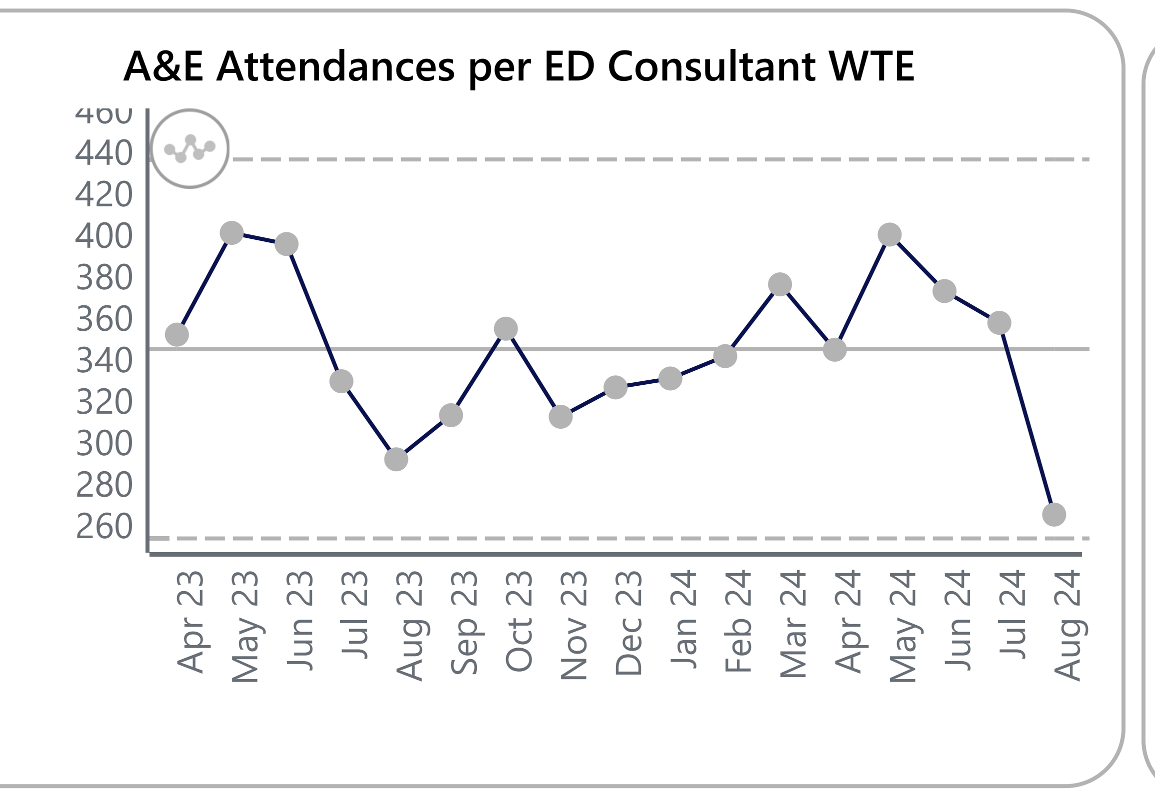


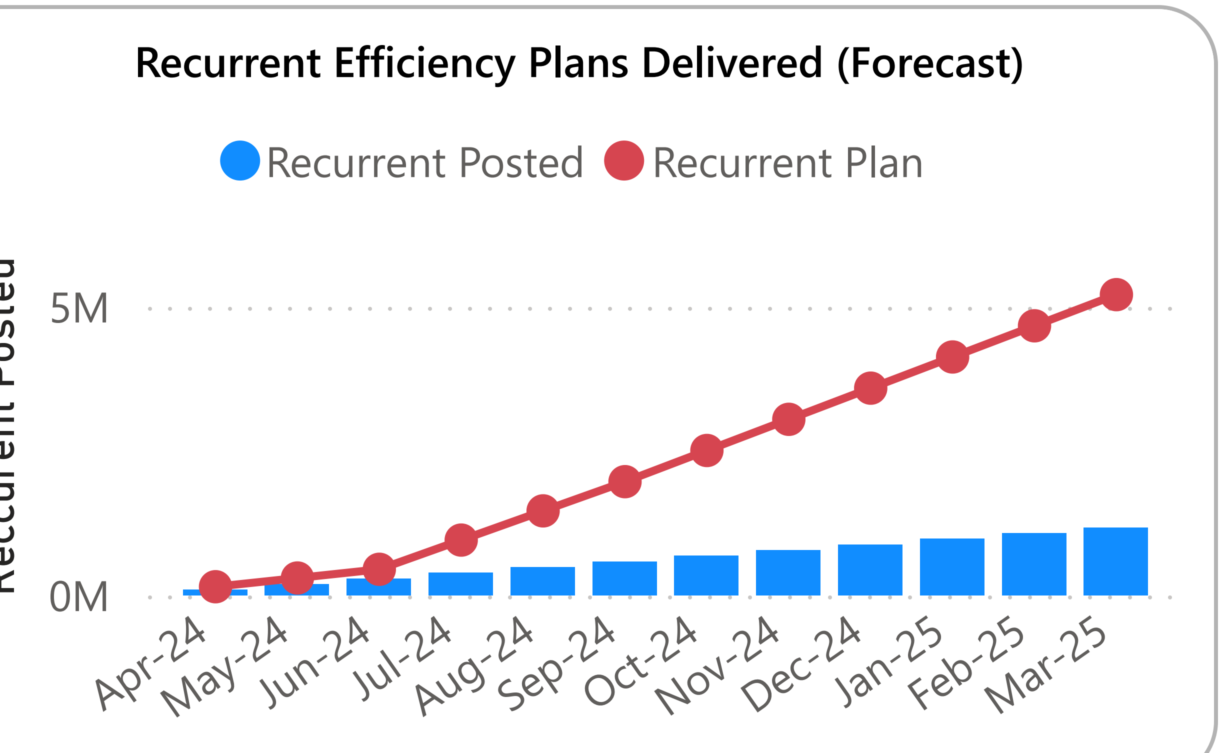


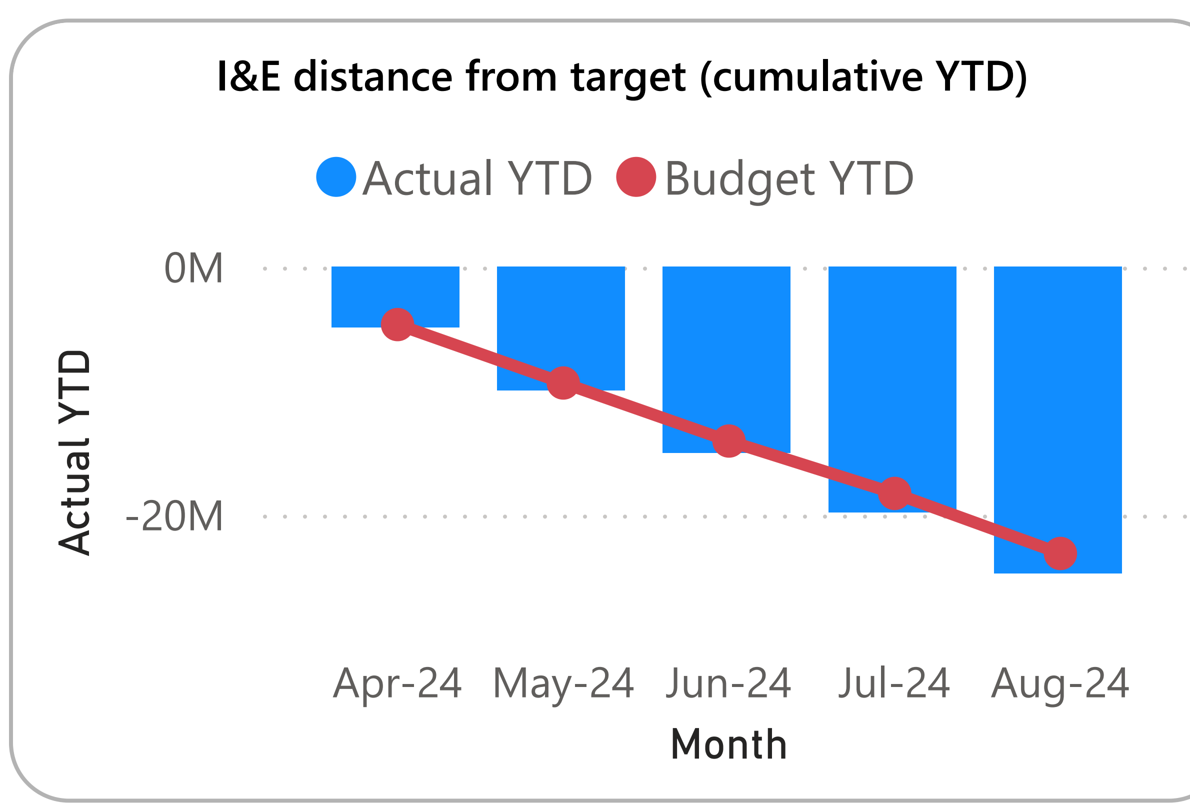


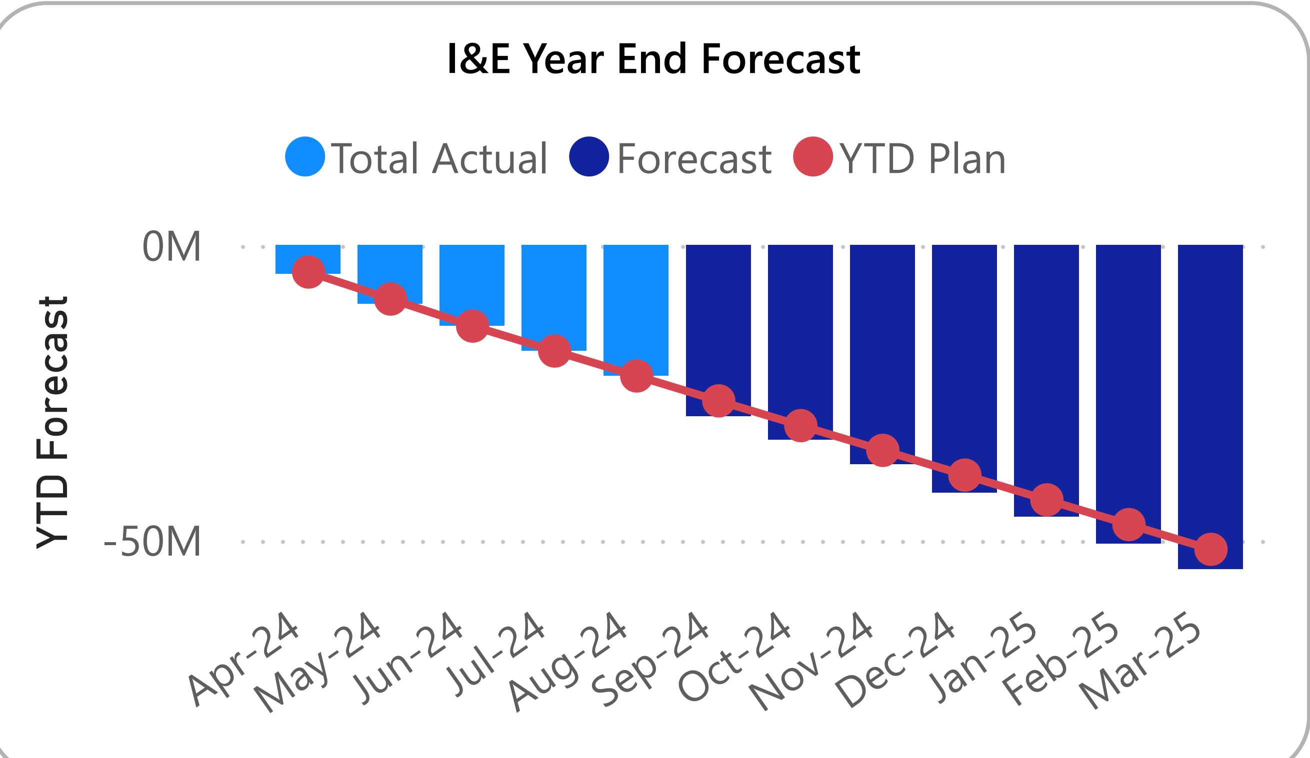


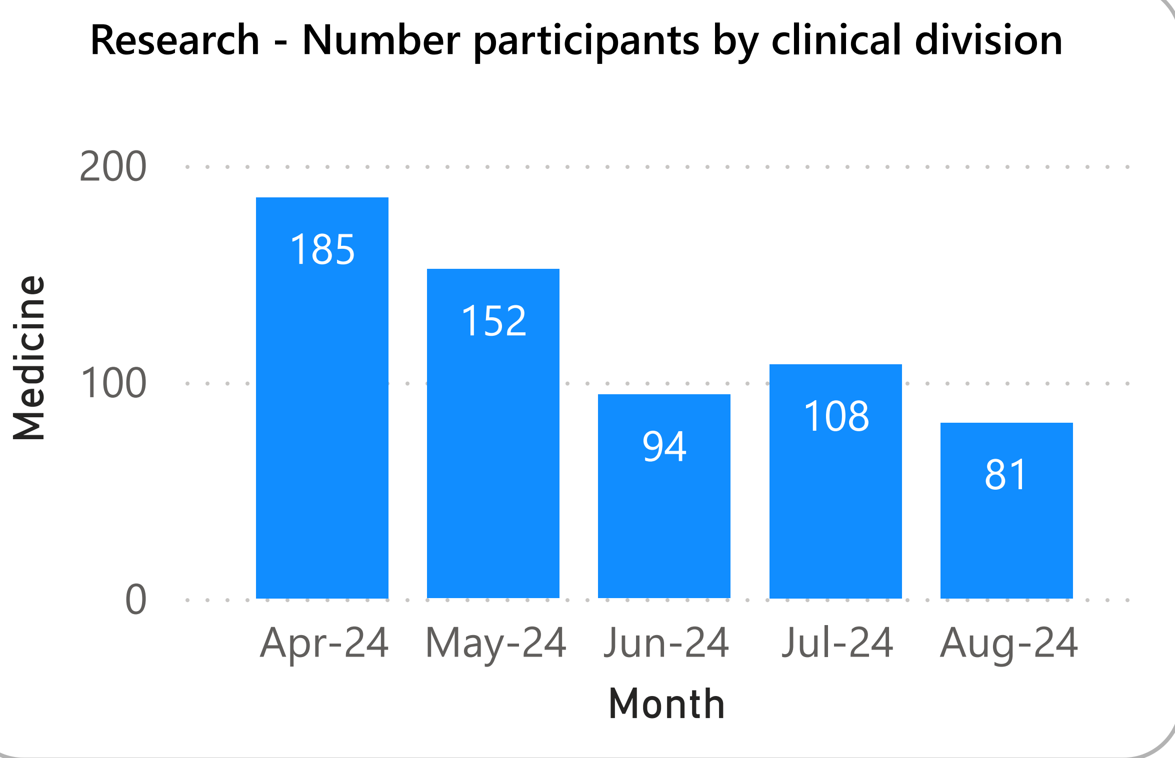


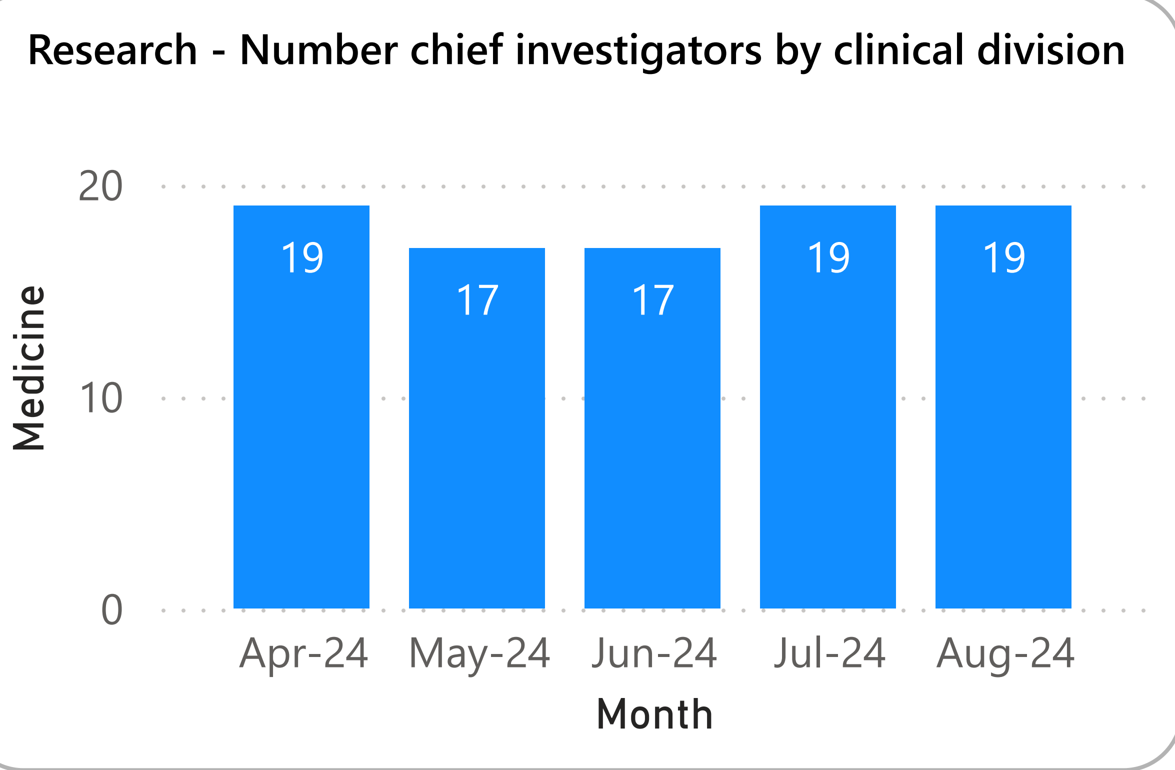












Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• % PALS and complaints responses continue to be resolved within target timeframes

• % recovery for DC & Elect activity volume 114% in M5 with an additional 148 CYP treated against plan

• Continued reduction of total number of CYP waiting > 52 weeks for 3rd consecutive month showing special cause of improving nature with plans to have 0 > 65 weeks by end of September.

• Day cases per working day showing special cause of improving nature, consistently achieving 40+ per day.

• % recovery for OPNEW/PROC continues to be higher than 19/20 with a M5 position of 121%.

• Mandatory training remains above target and improving.

• Division overperformed in M5 on ERF resulting in a YTD overperformance of £500k.

Areas of Concern

• Turnover increased in M5 due to MARS leavers and junior changeover. No areas of concern within the division.

• WNB increased in month with highest rates in Eyes, Audiology and Dentistry.

• Volume of CYP waiting over 2 years for FU increased in M5. There have been a significant improvement in M5 in ENT via source group support, having discharged close to 400 patients via a validation exercise. Local plans are in development for each speciality to be presented.

• Diagnostic compliance consistently below target- volume within the division is low numbers but requires a sustainable action plan. Urodynamic capacity was lost in M5 due to essential Radiology works.

Forward Look (with actions)

• Continued focus on delivery of access targets via controlled approach. Division currently reviewing trajectories & capacity plans to achieve 0 > 52 weeks sustainably by Sept 2025.

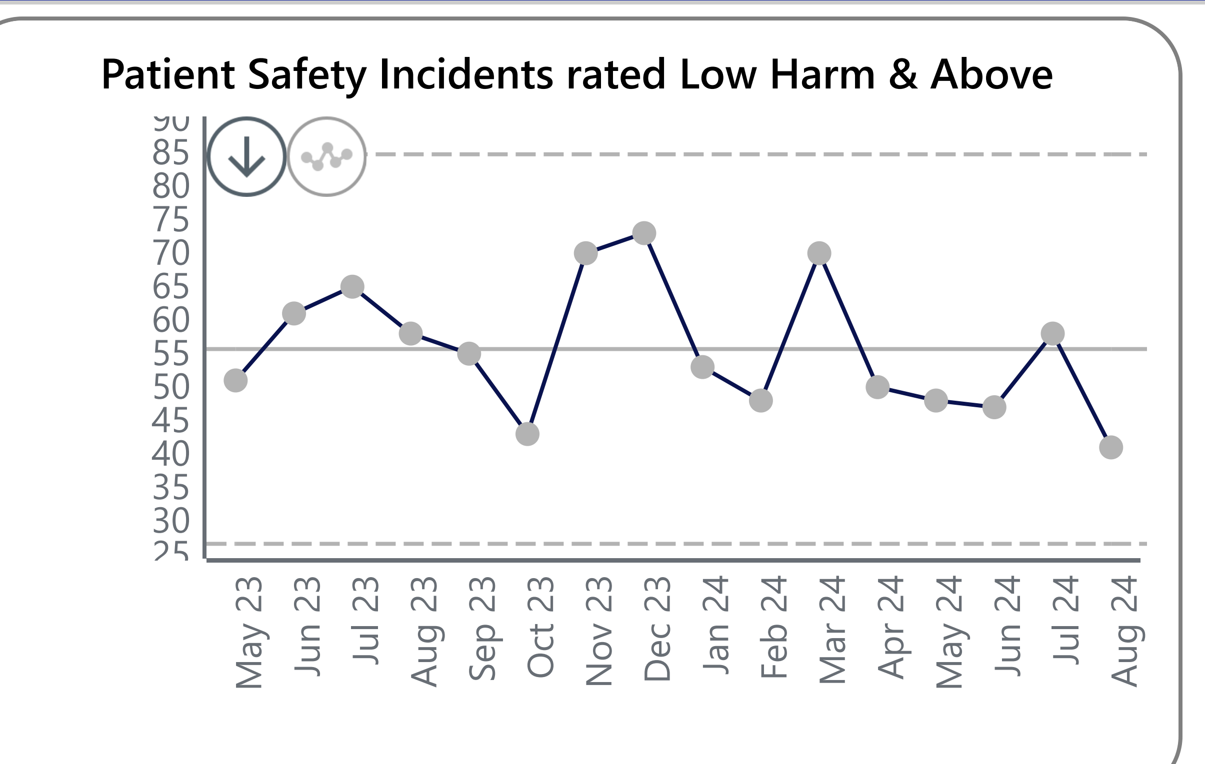
• Divisional session planned mid-month to complete local level FU plans and agree consistent approach to future management of demand.

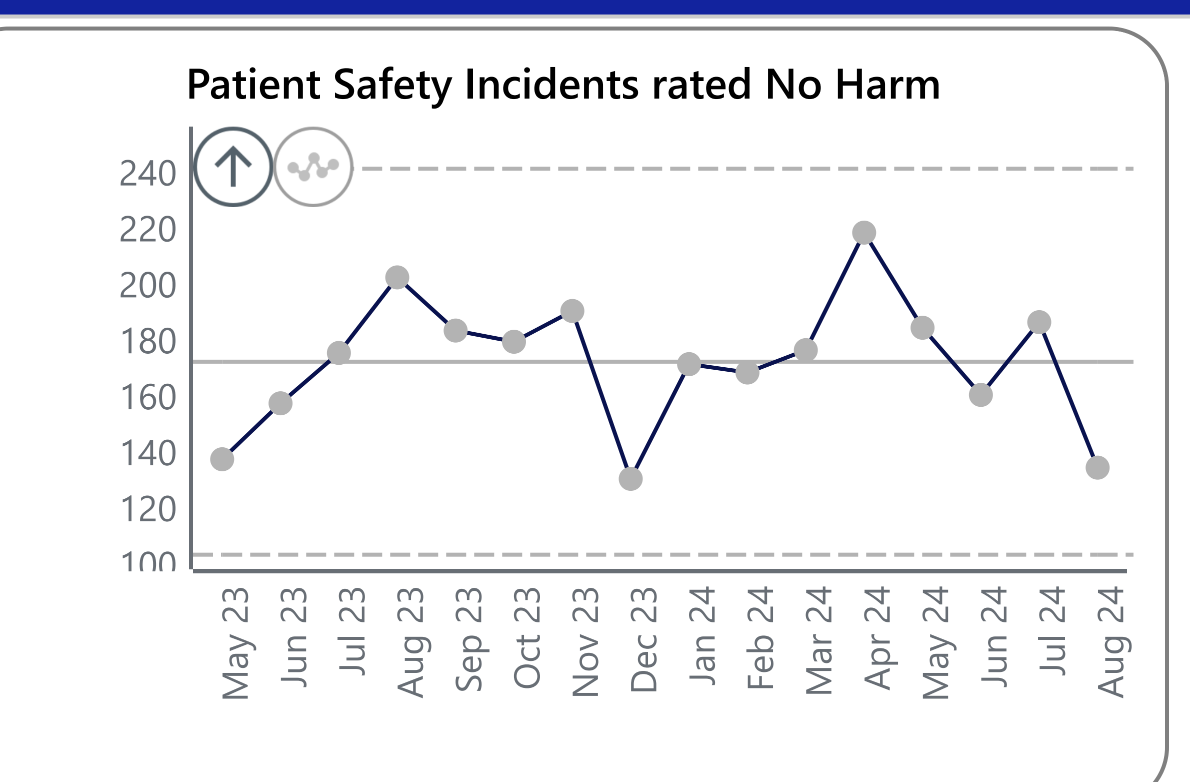
• Productive outpatient group completed deep dive on WNB rates and are agreeing improvement plans for the top 3 specialities: Eyes, Dentistry & Gynaecology.

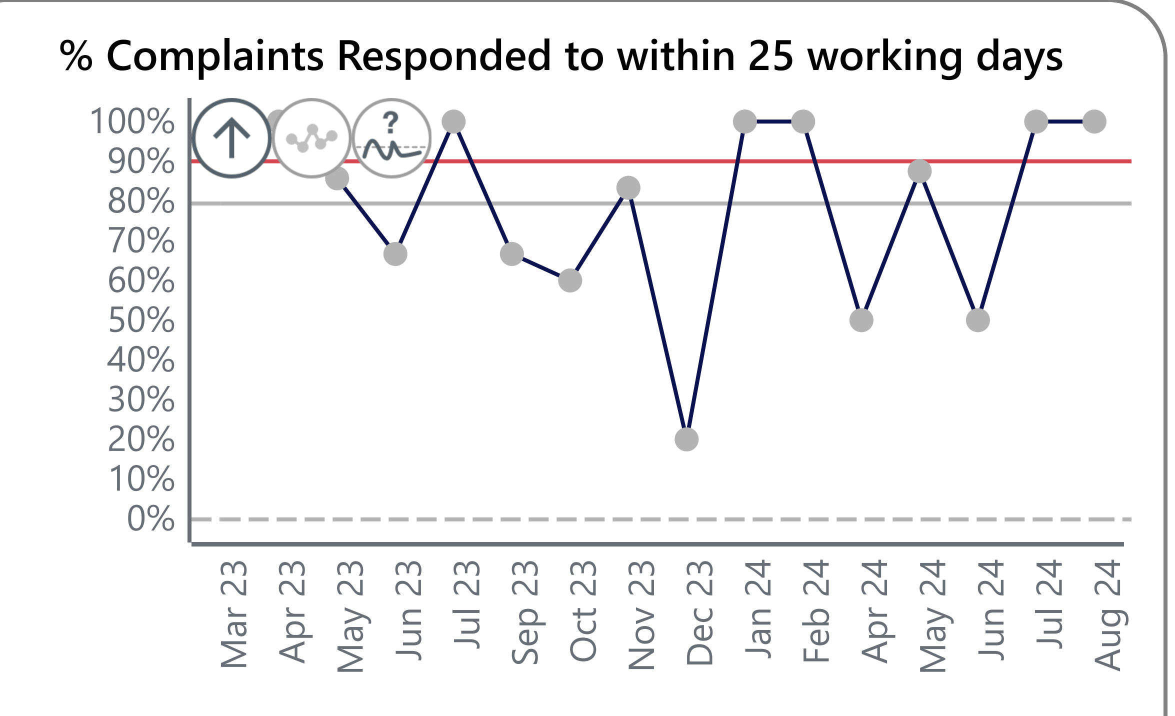
• Clear action plan to be reported to improve diagnostic compliance with a trajectory to get to 95%.

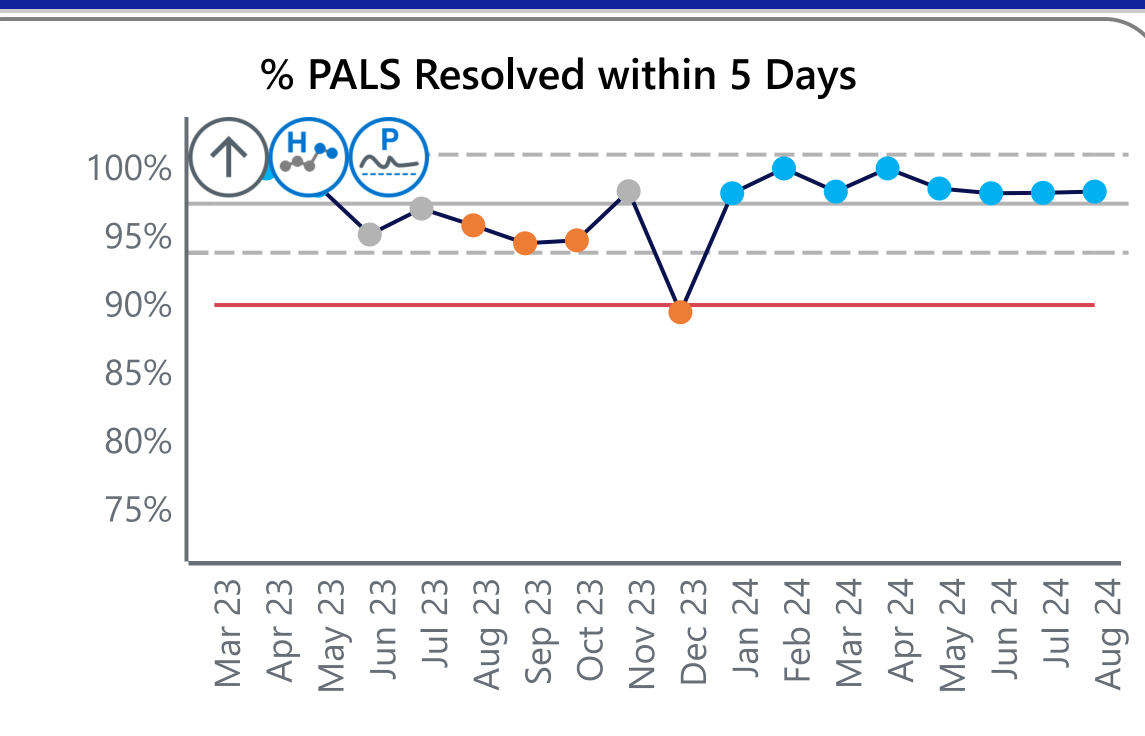
• Focus on delivery of CIP schemes outlined in forecast with mitigating actions to be taken to achieve red schemes.

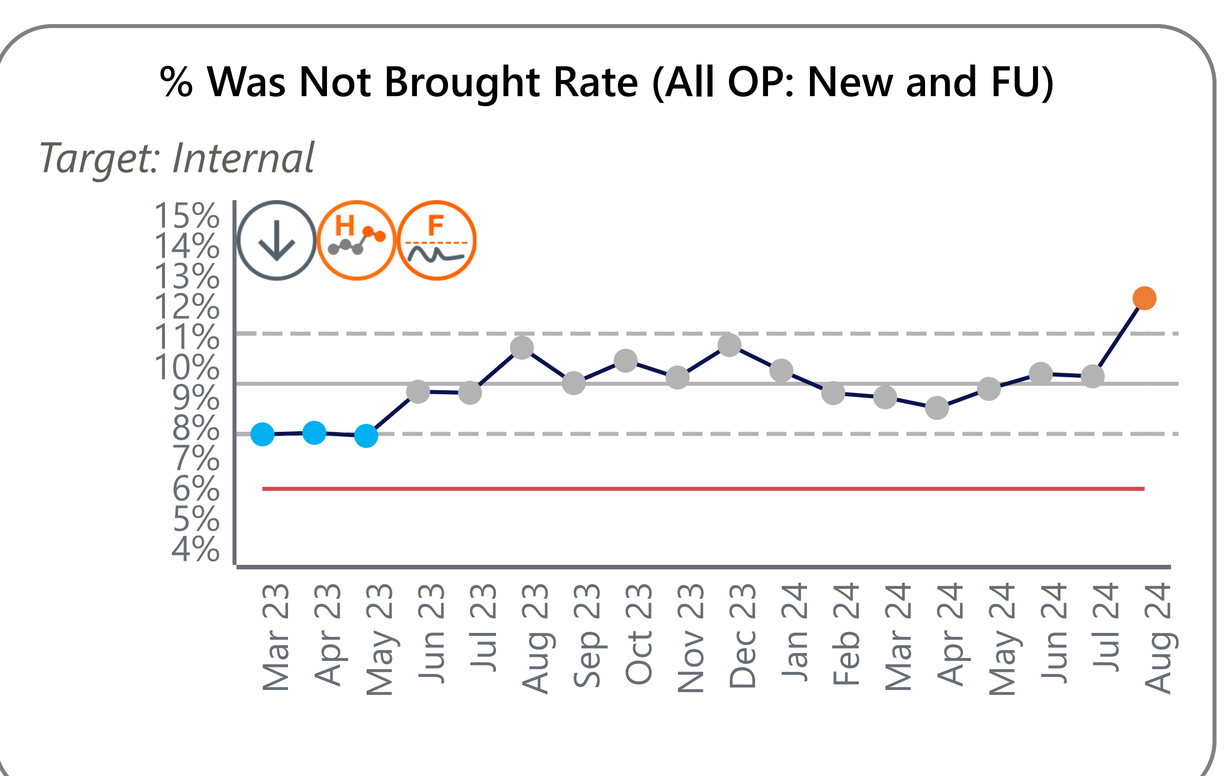
Divisional Performance Summary - Surgery

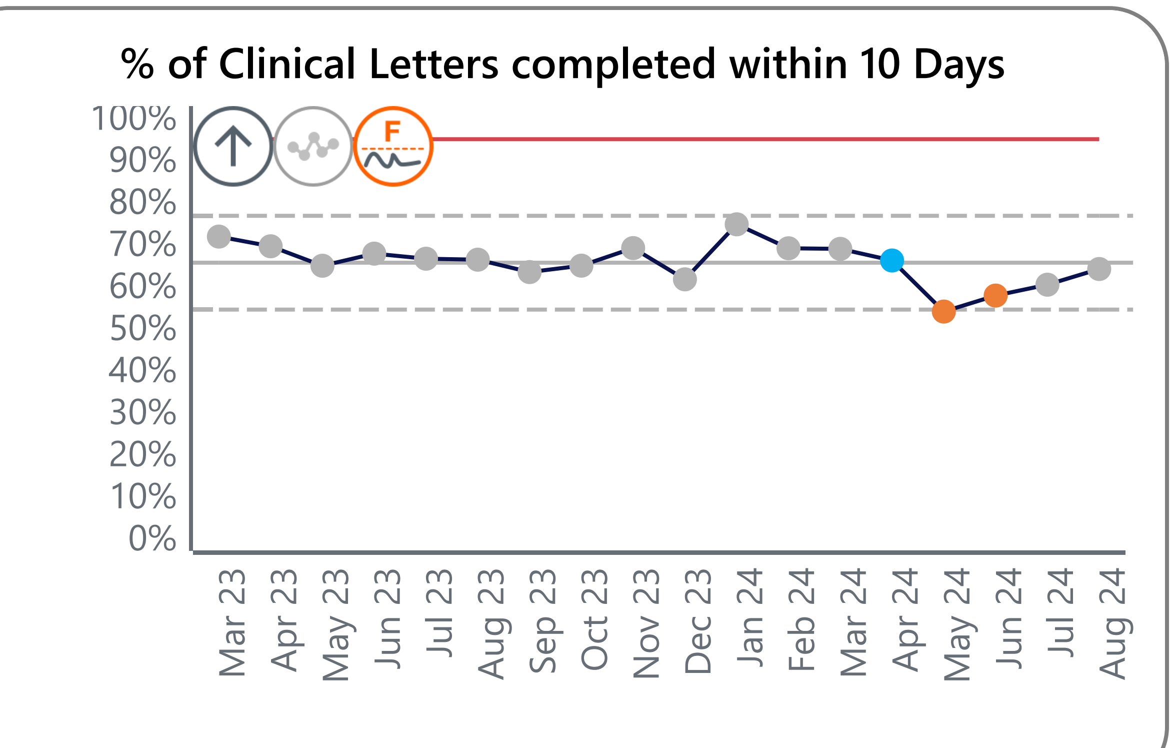


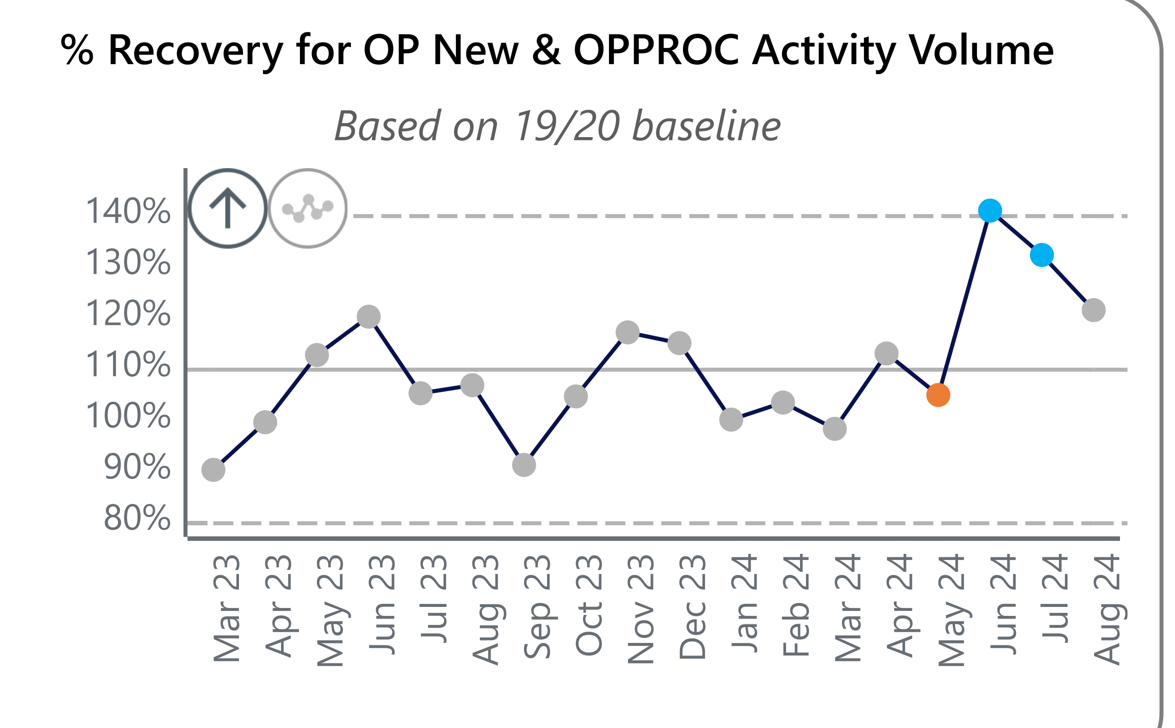


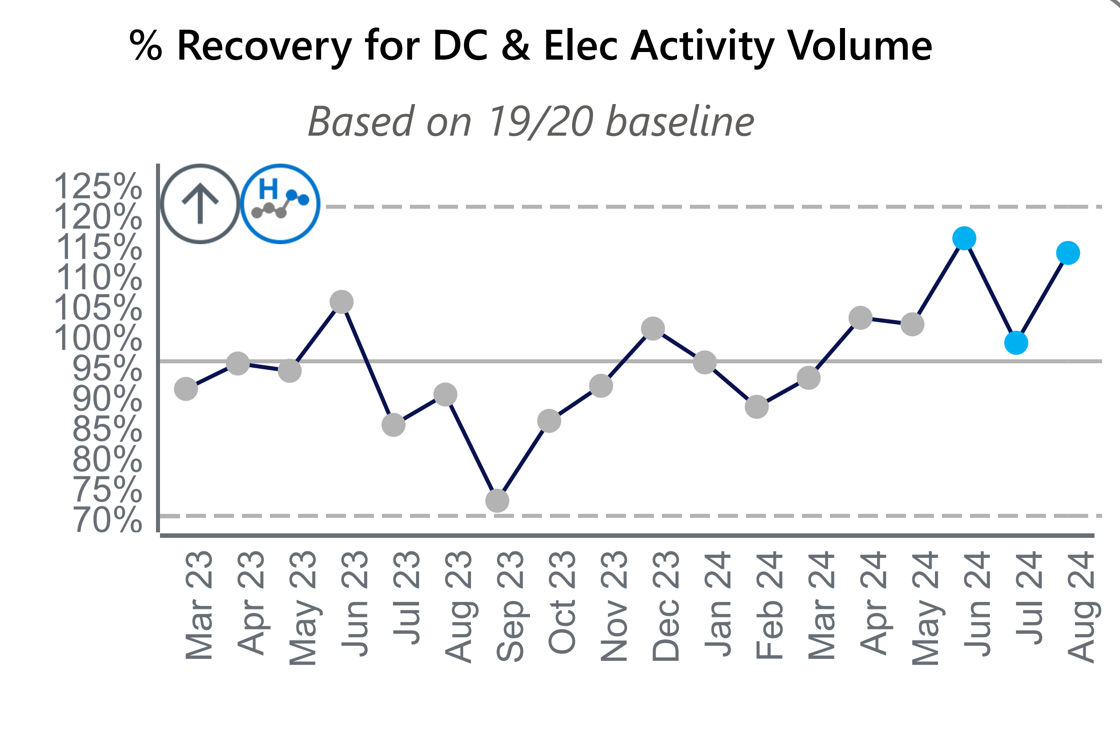


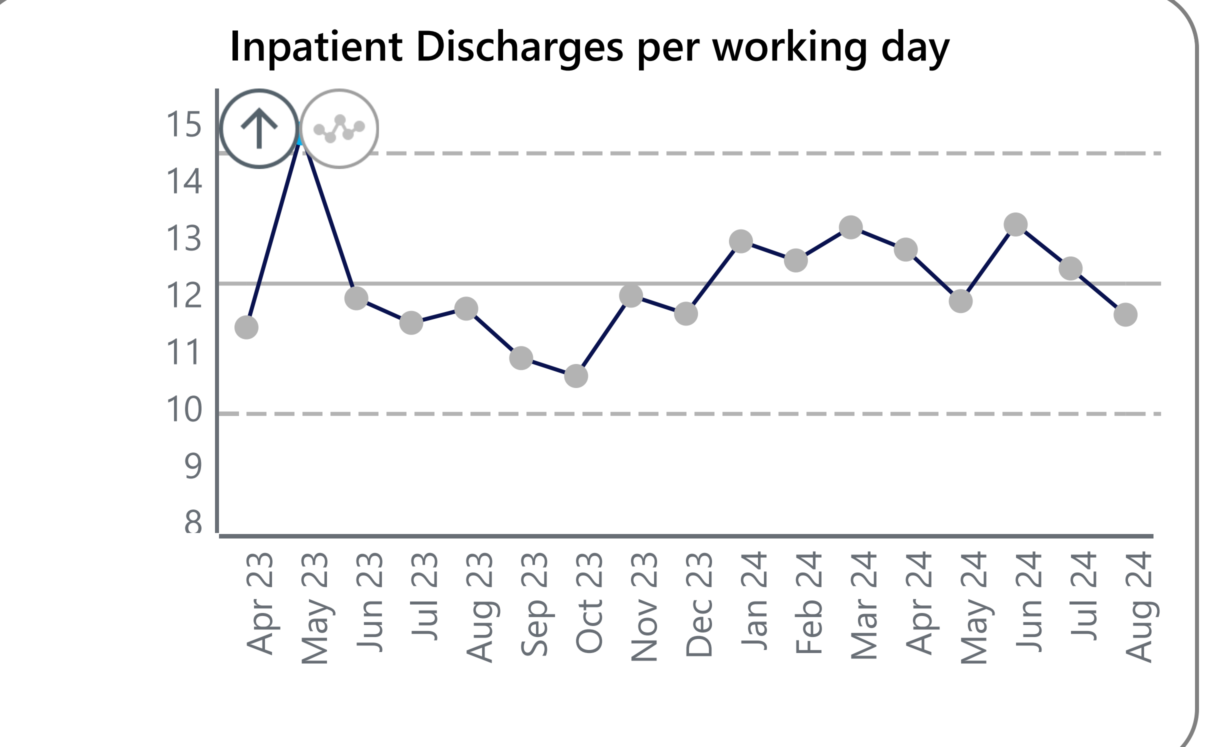


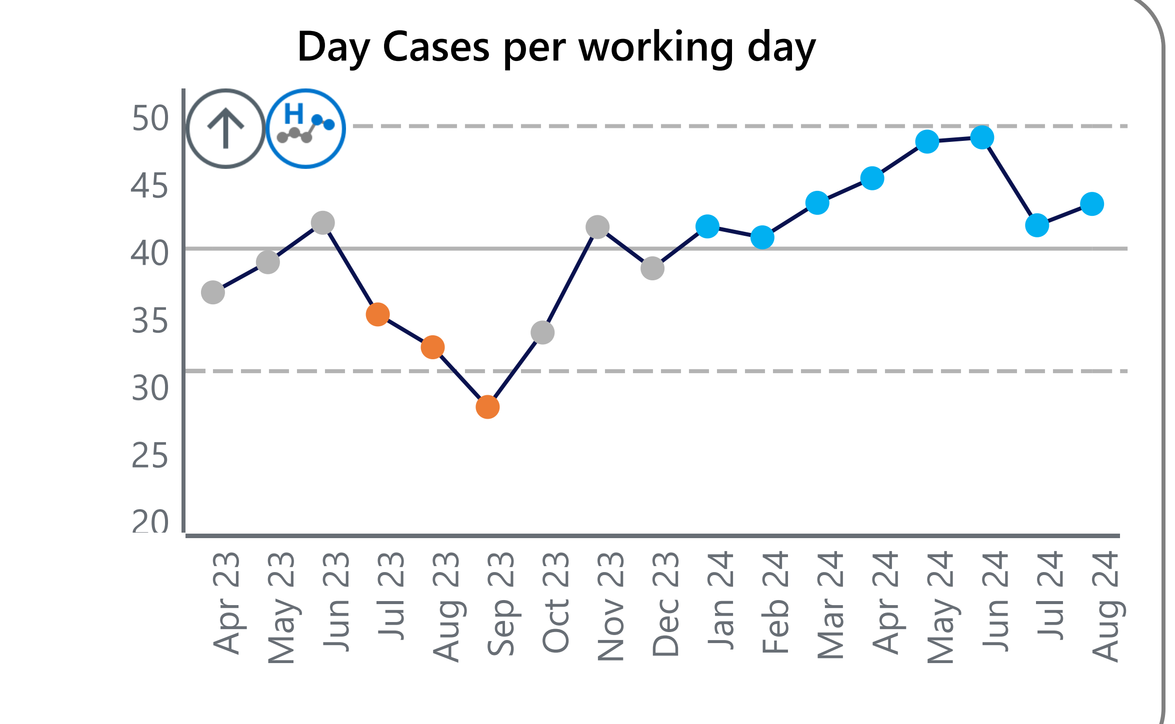


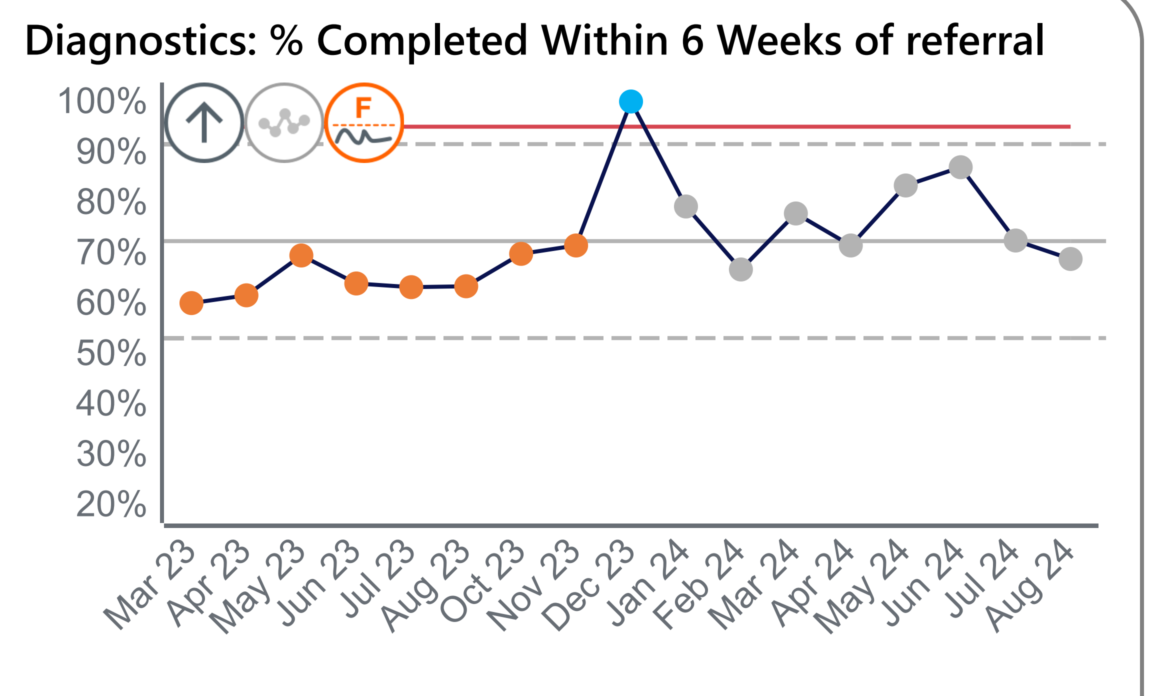


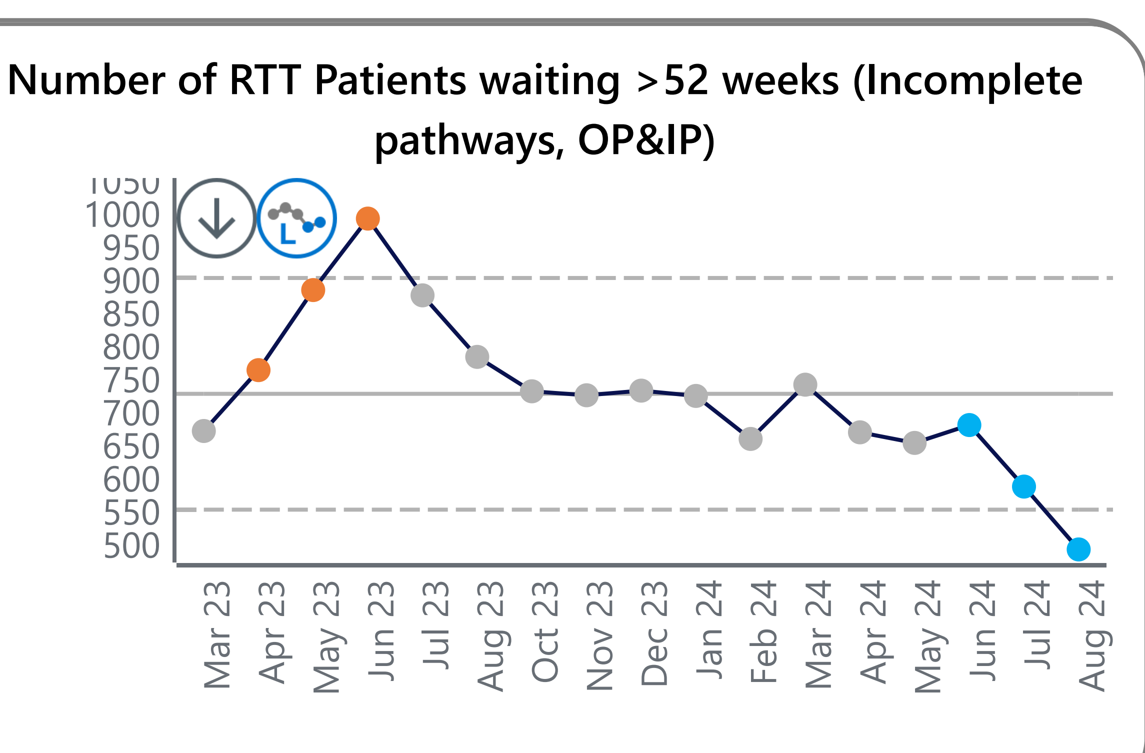












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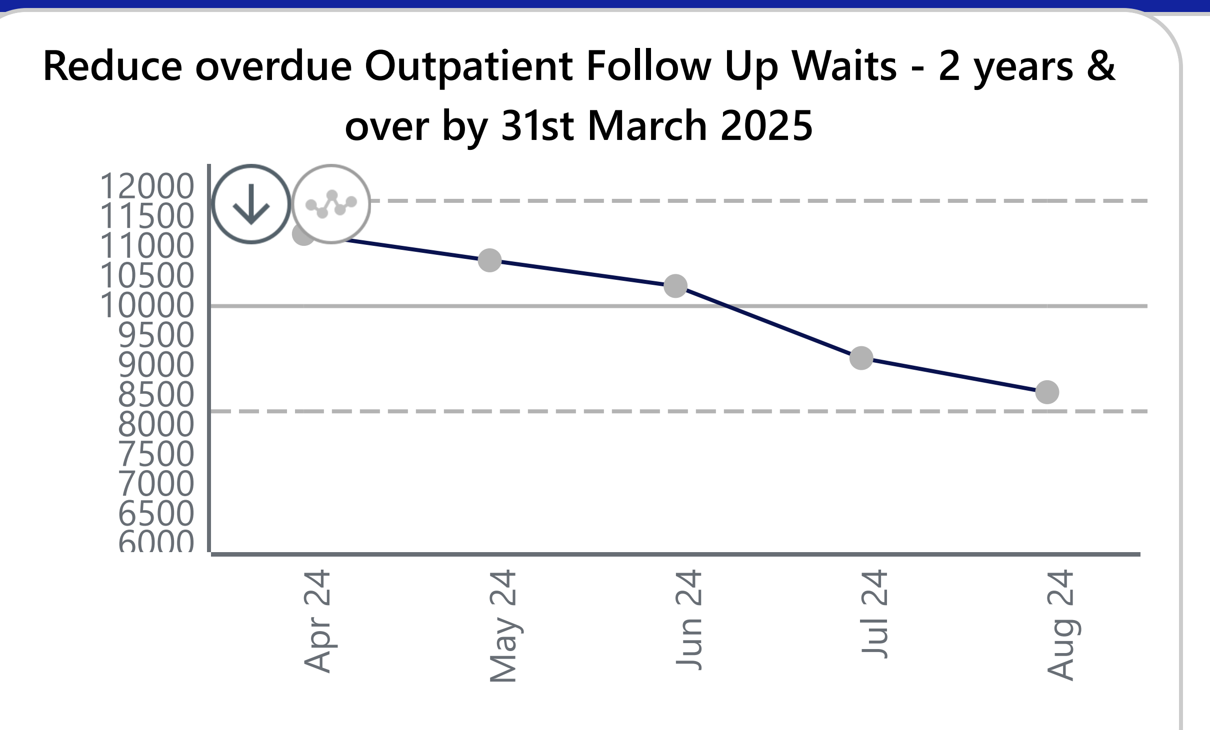
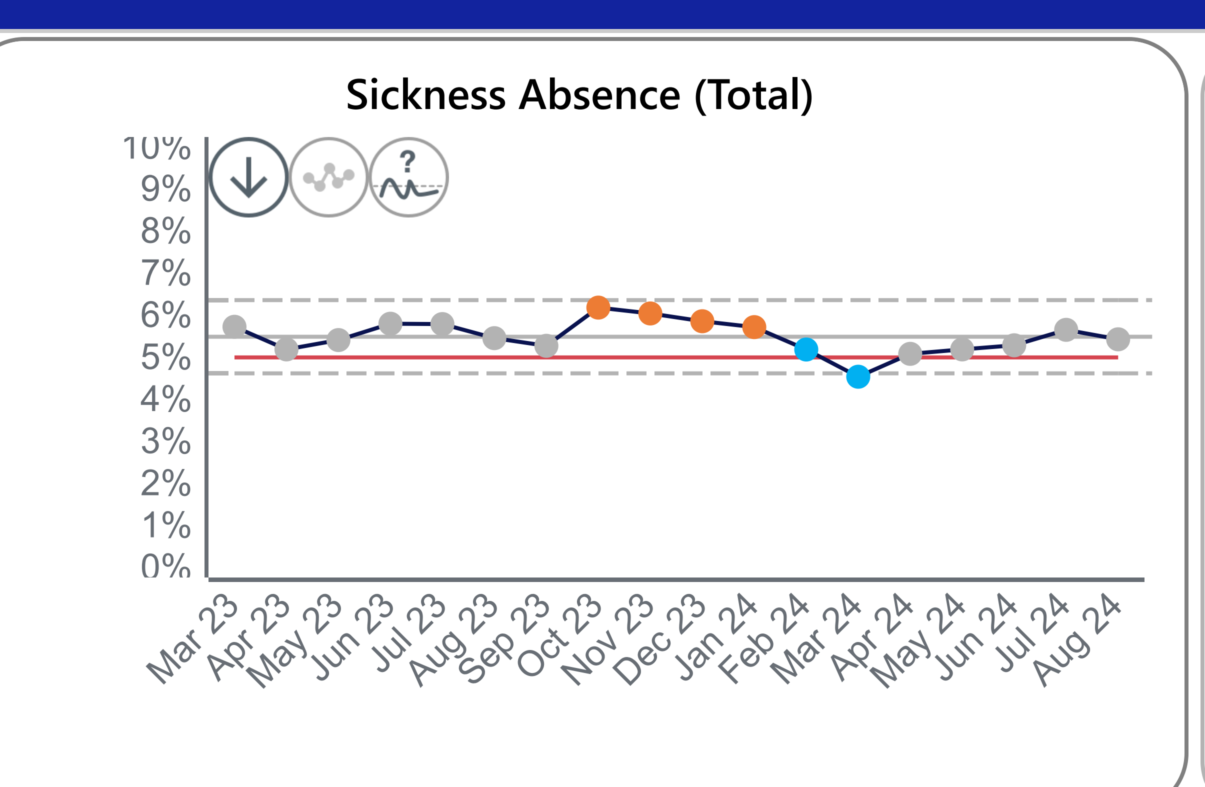
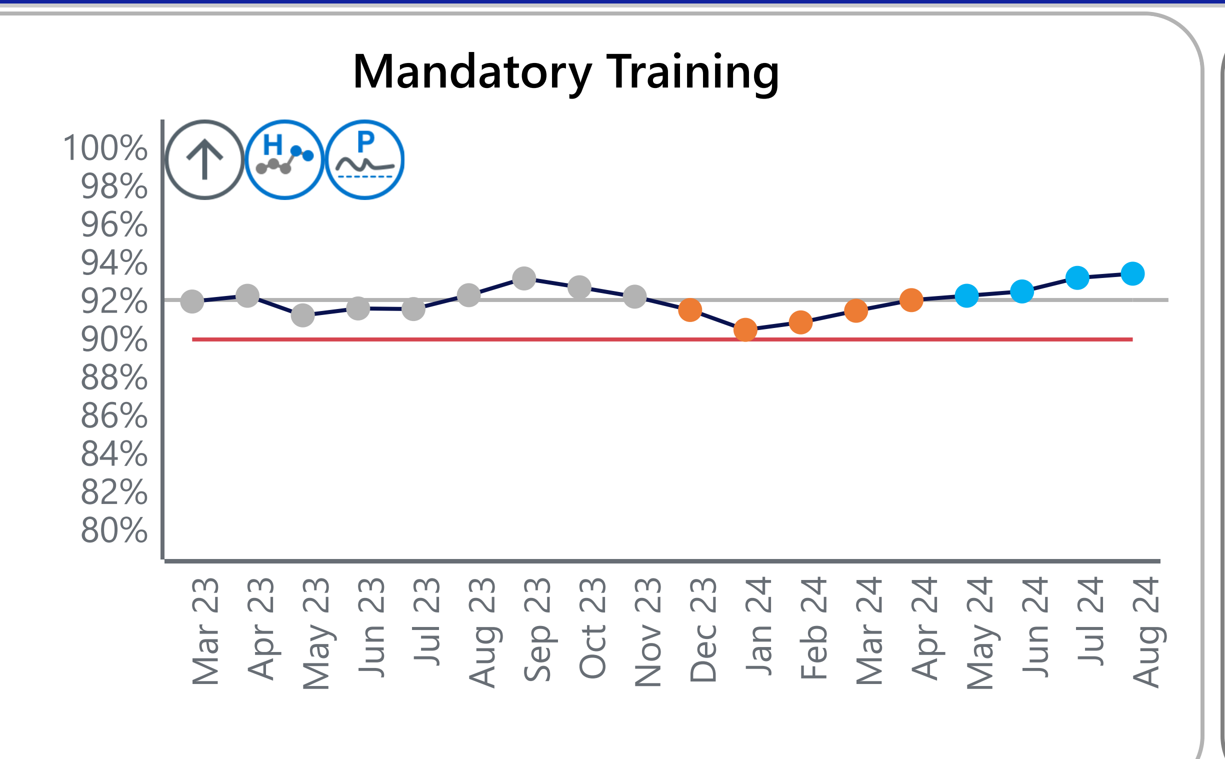
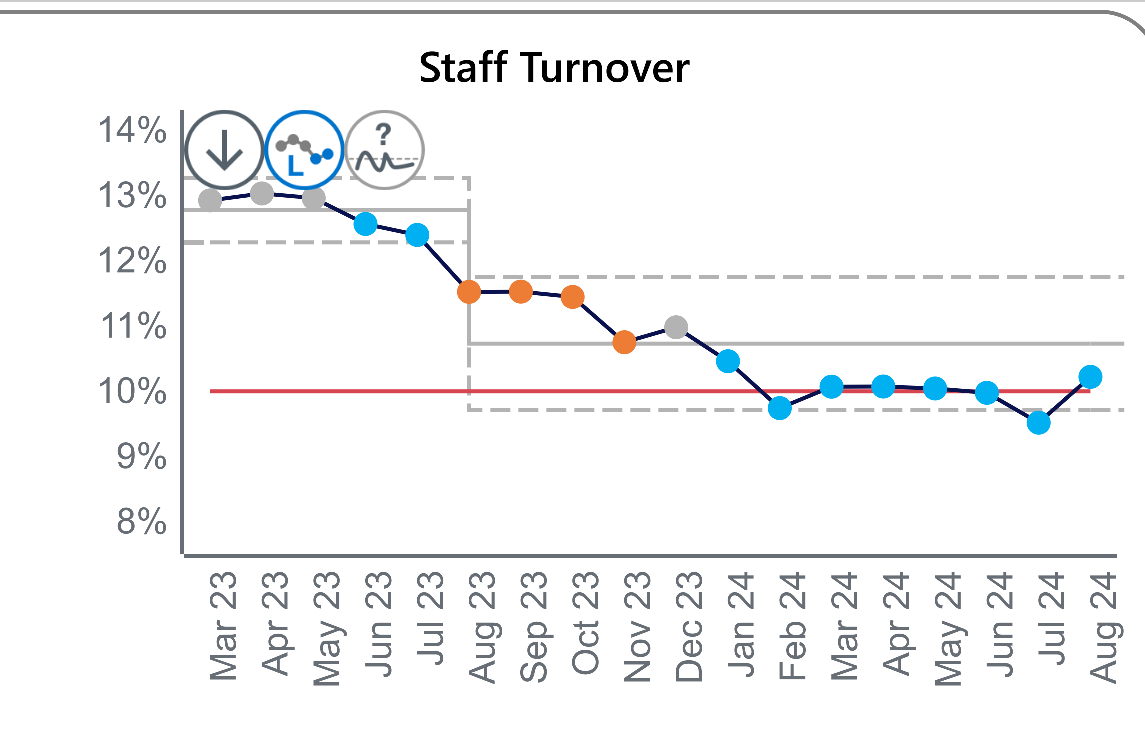
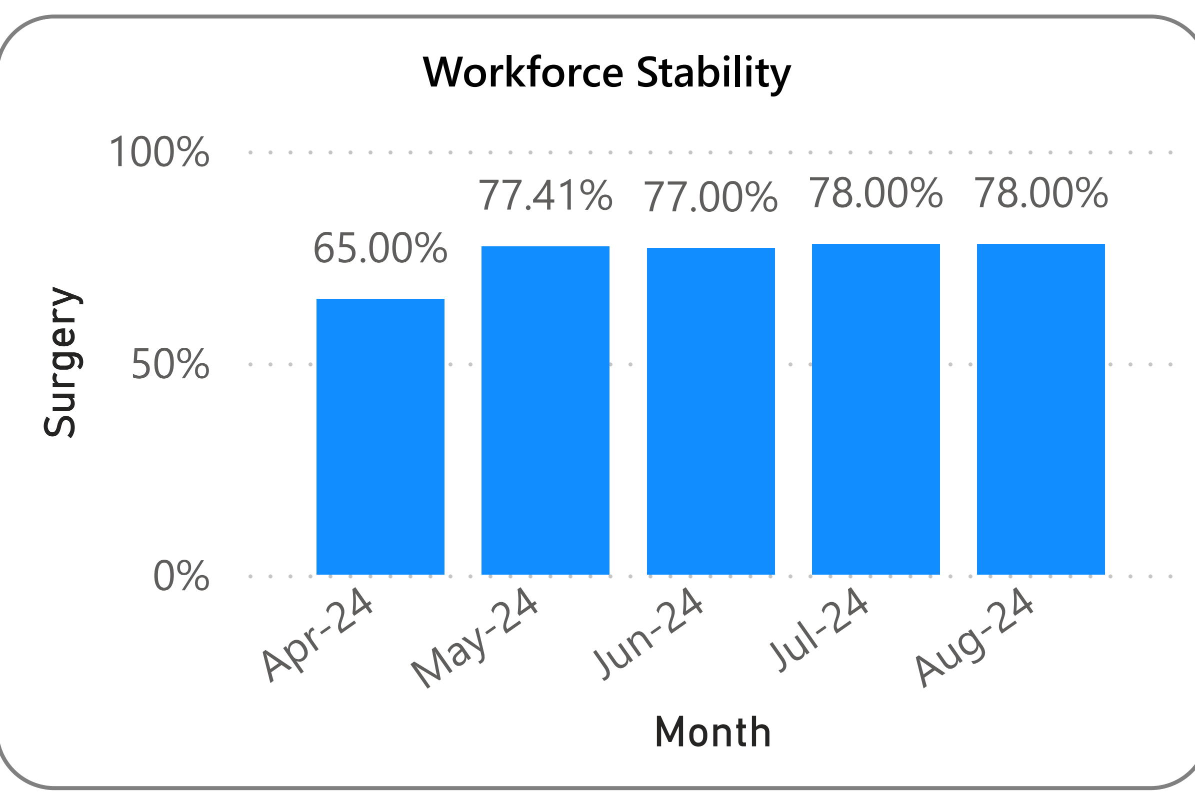
Divisional Performance Summary - Surgery

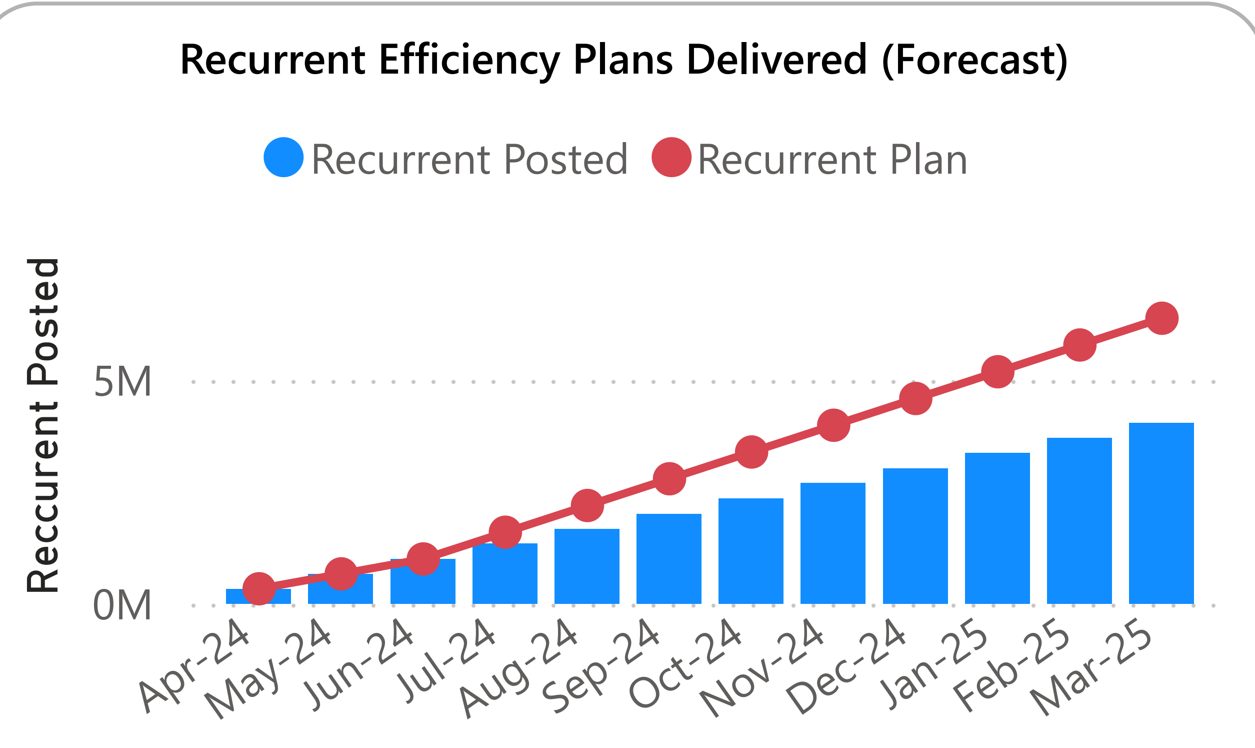


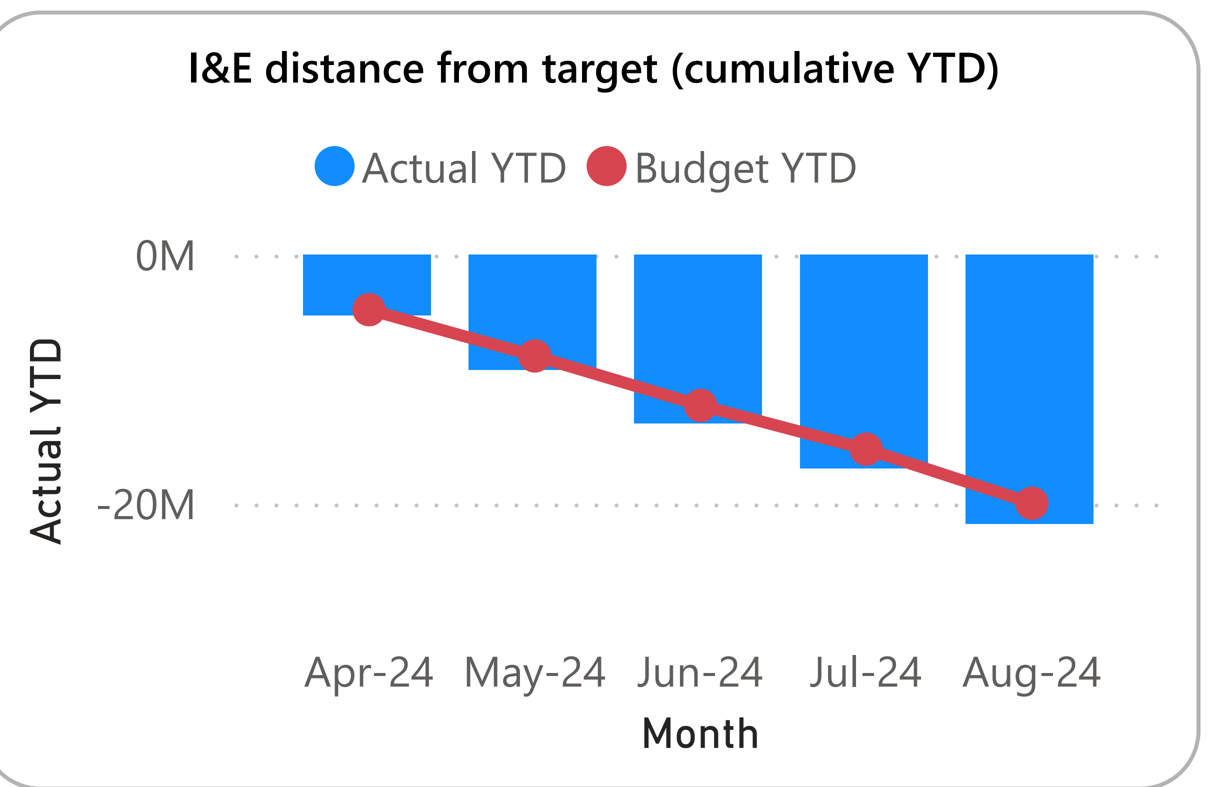


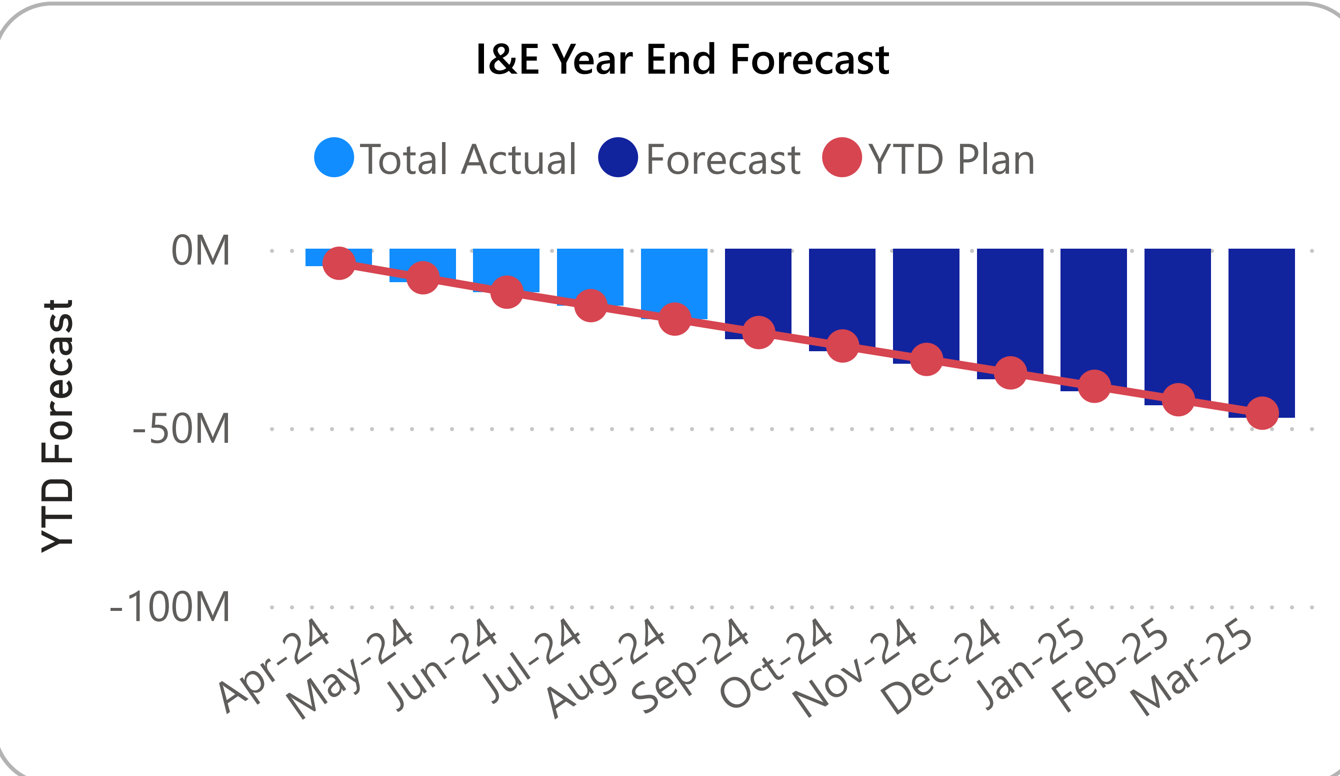


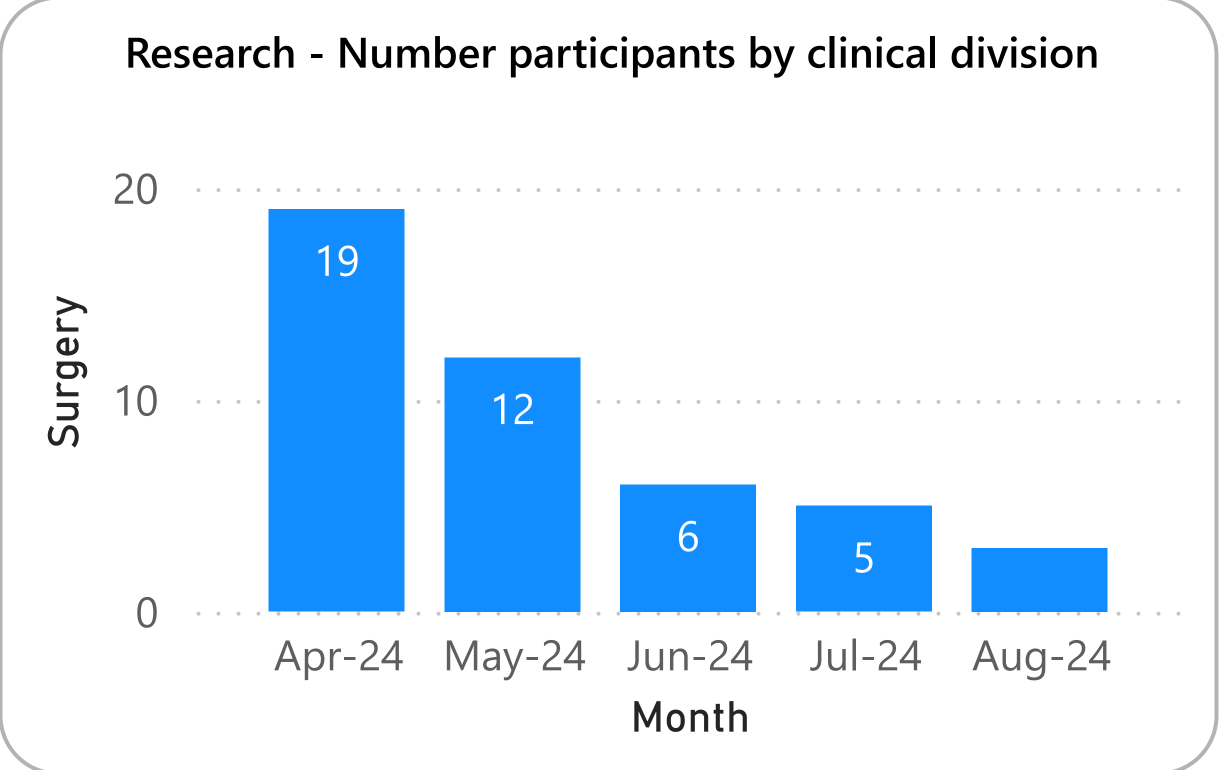


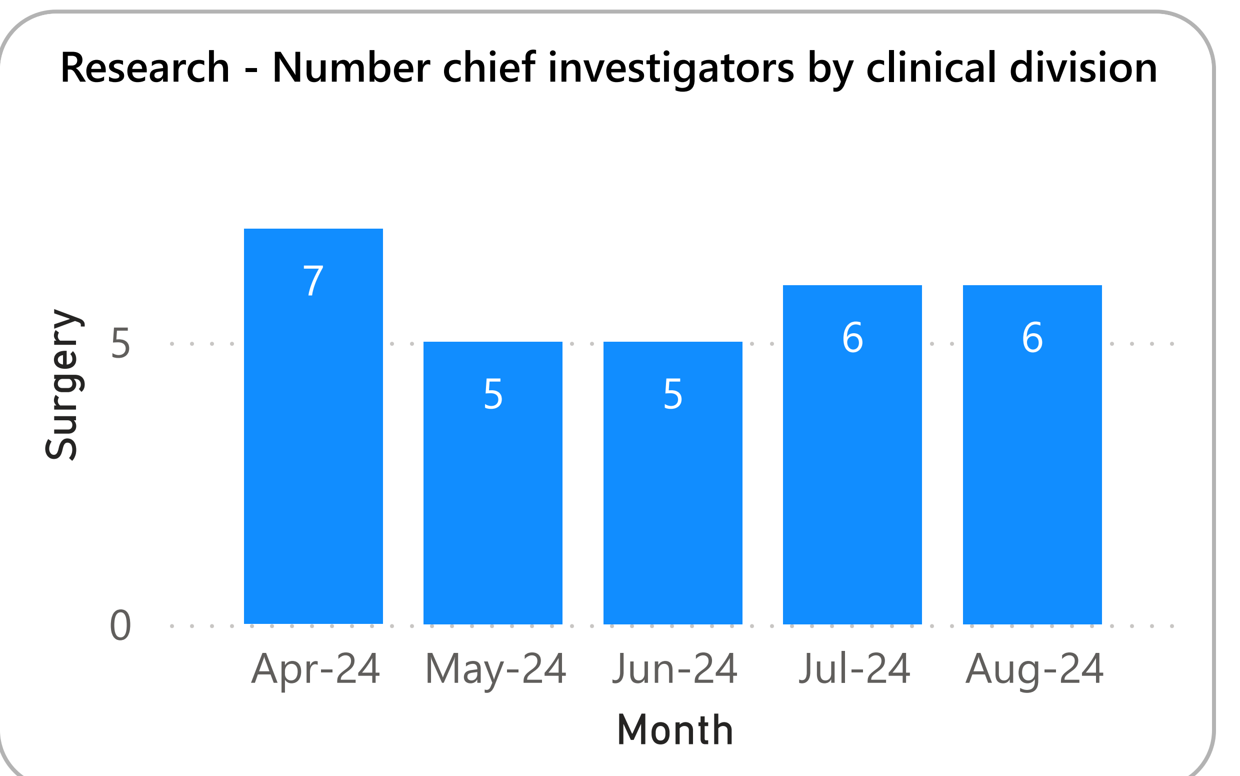












Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- Commercial and non-commercial research income is ahead of target at Month 5 and commercial income forecast is ahead of target for 24/25

- Number of commercial contract research requests continues to increase (16 in August) supporting delivery against NIHR Clinical Research Facility objectives and commercial income targets

- Alder Hey were the first UK site activated for the Knapsack Study (PI – Dr Clare Pain) which comes with a financial incentive

- Dr Claudia Koh has been successful in being offered a personal 1-year RCS fellowship to follow on from her GOSH-BRC funding

Areas of Concern

- Upcoming research staff shortages in labs may limit ability to process research samples – contingency plans under review

- Unavoidable long term sickness issues remain a cause for concern especially in research delivery team

Forward Look (with actions)

- Starting Well capacity building call (with LWH) closes in Sept – multidisciplinary panel to review applications

- Start date confirmed for new Clinical Research Facility Operational Manager (Sept 24)

- Outcome expected for NIHR capital call in Sept

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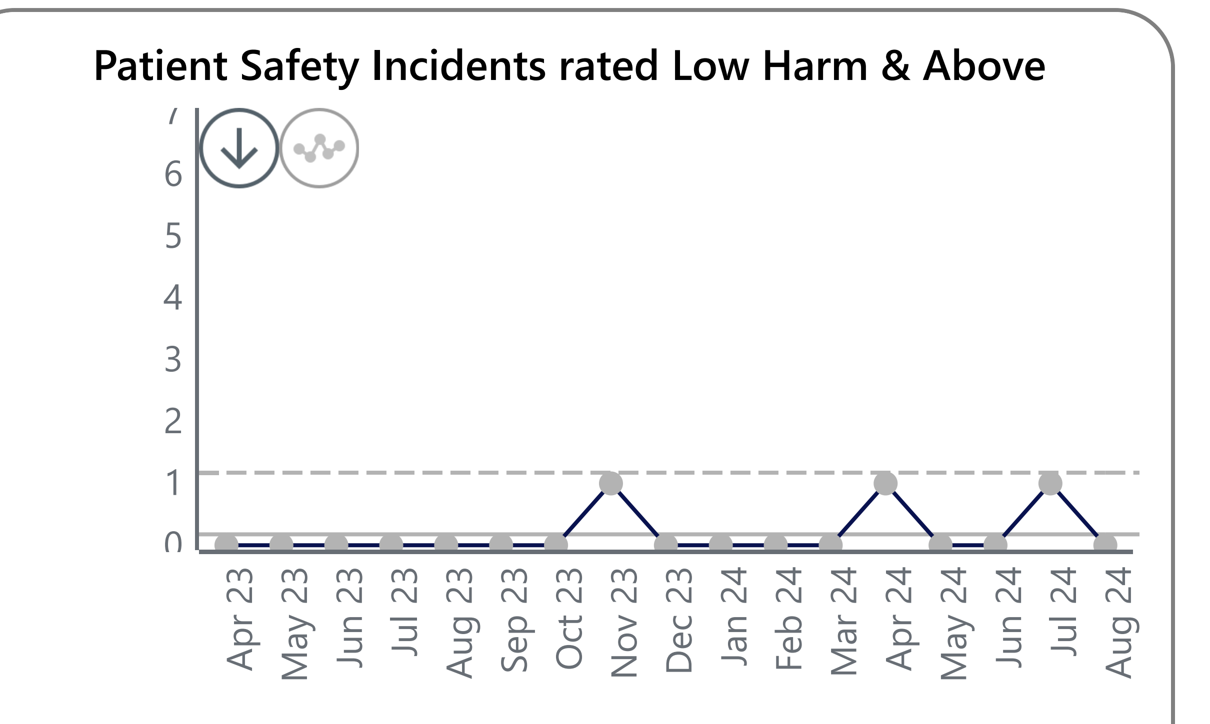
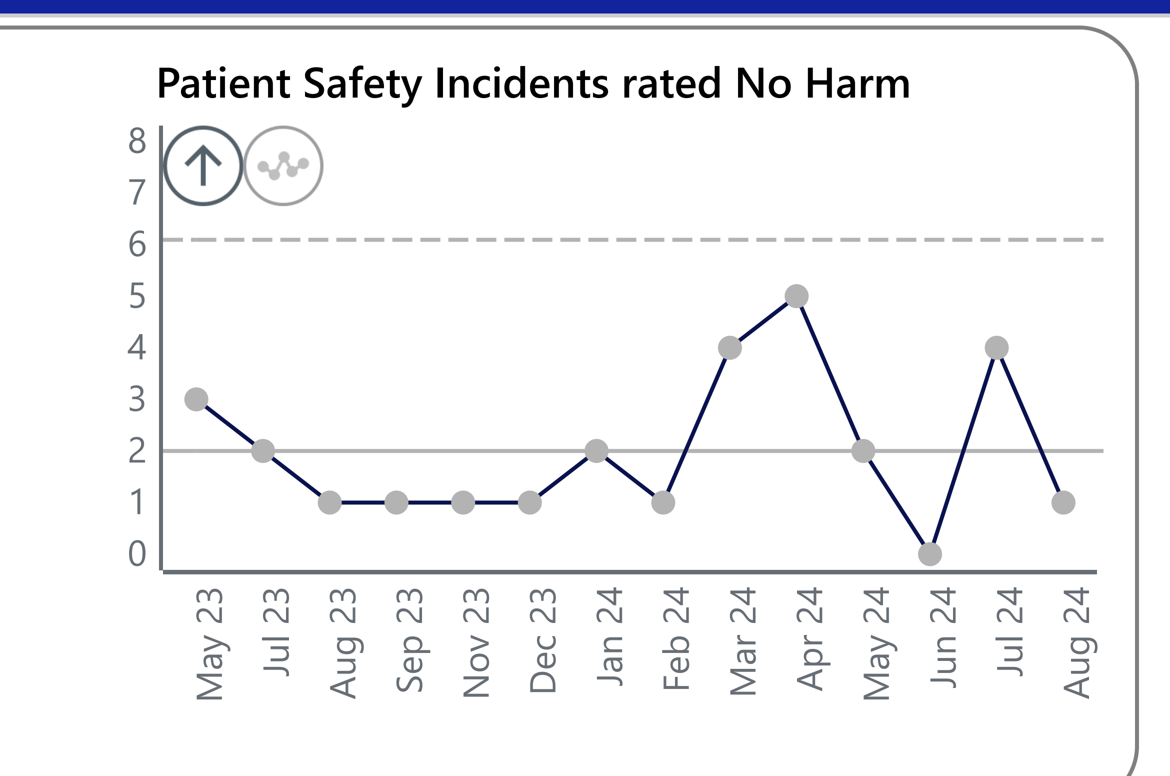
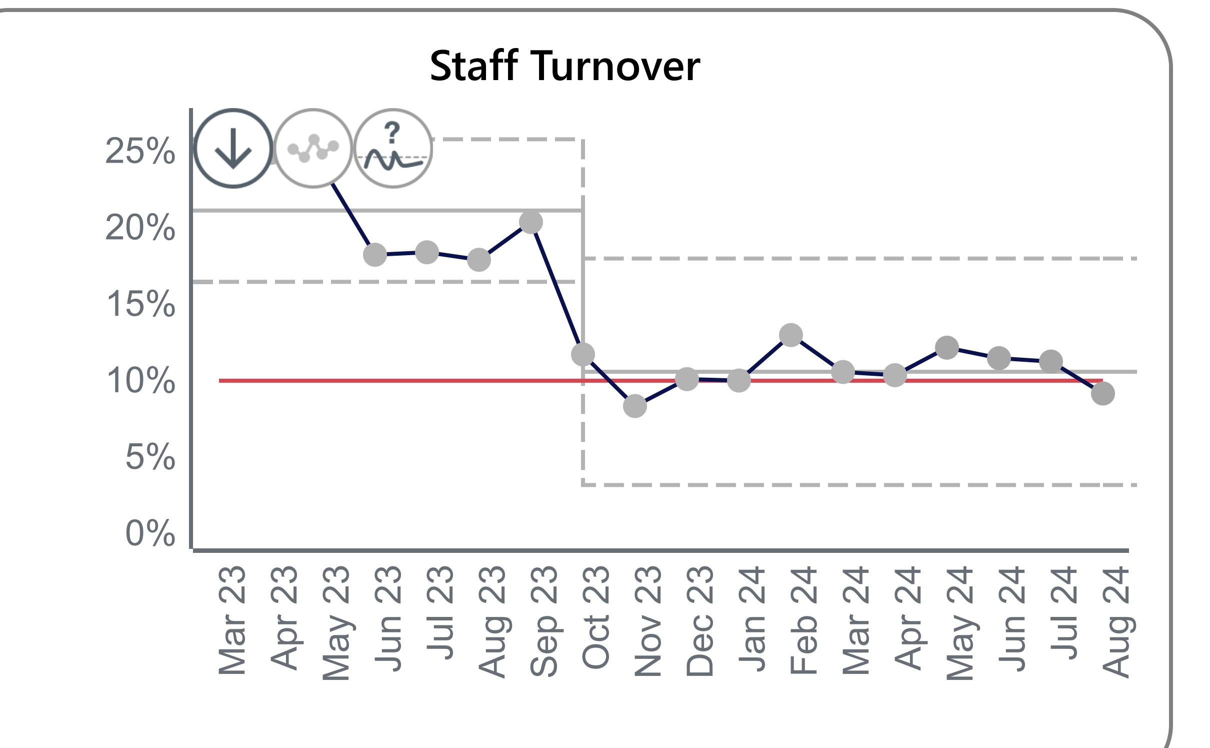
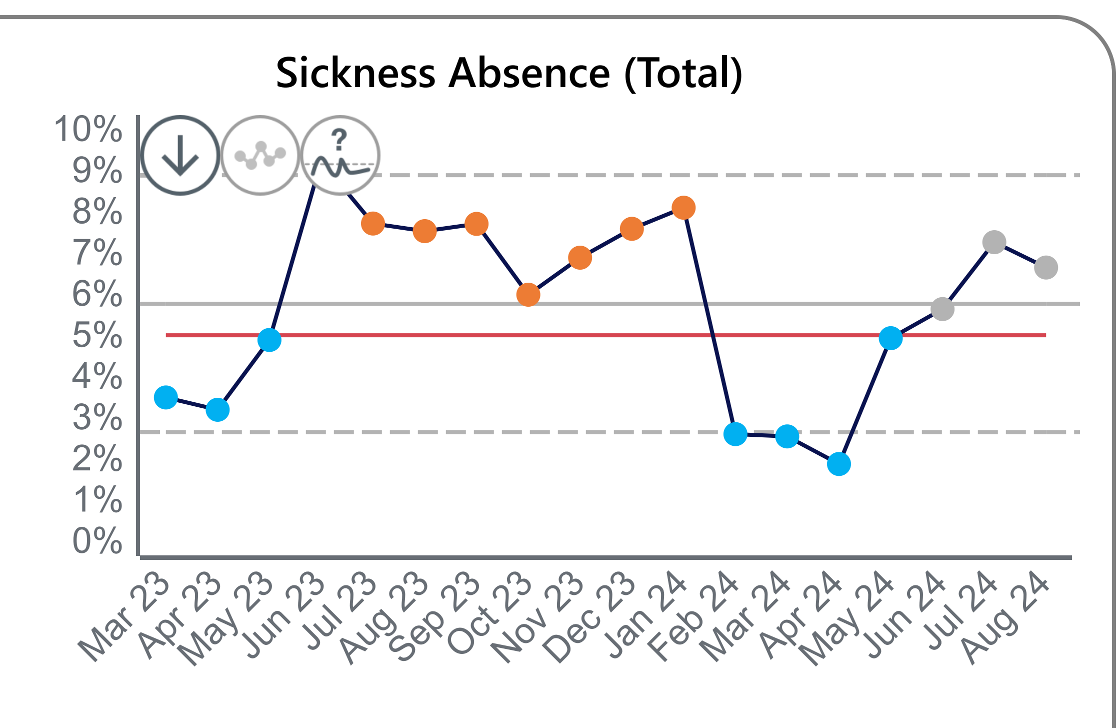
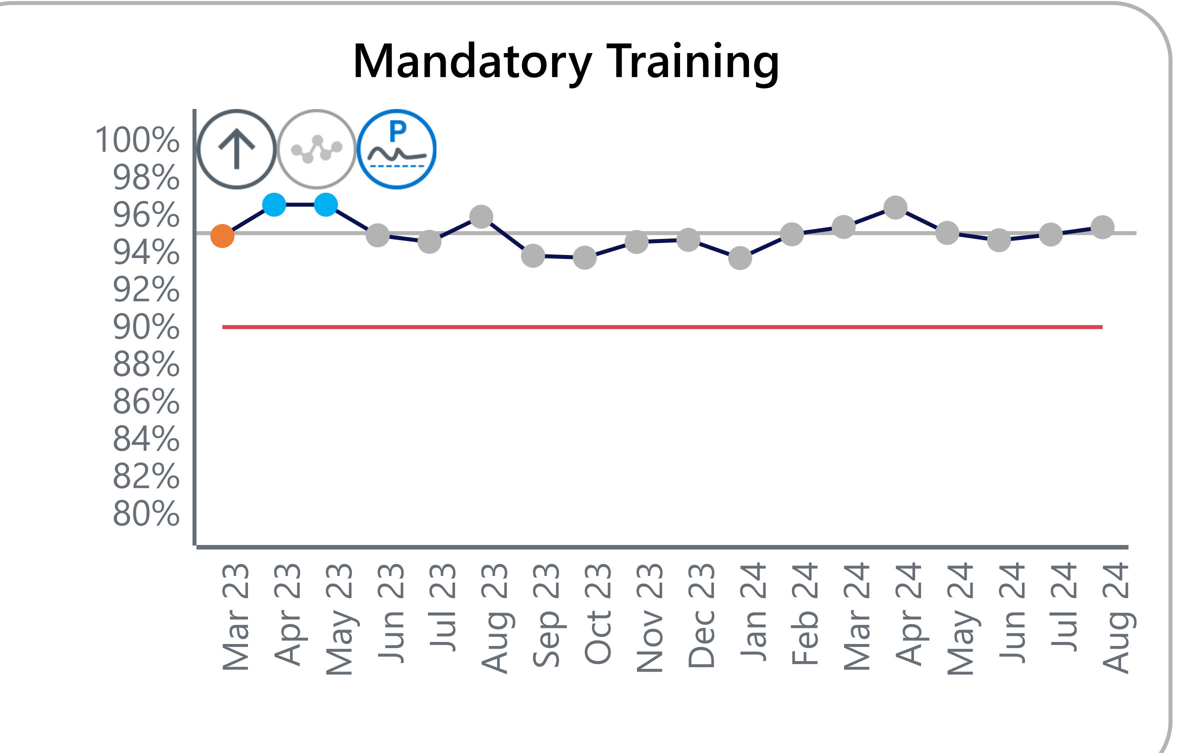
Divisional Performance Summary - Clinical Research

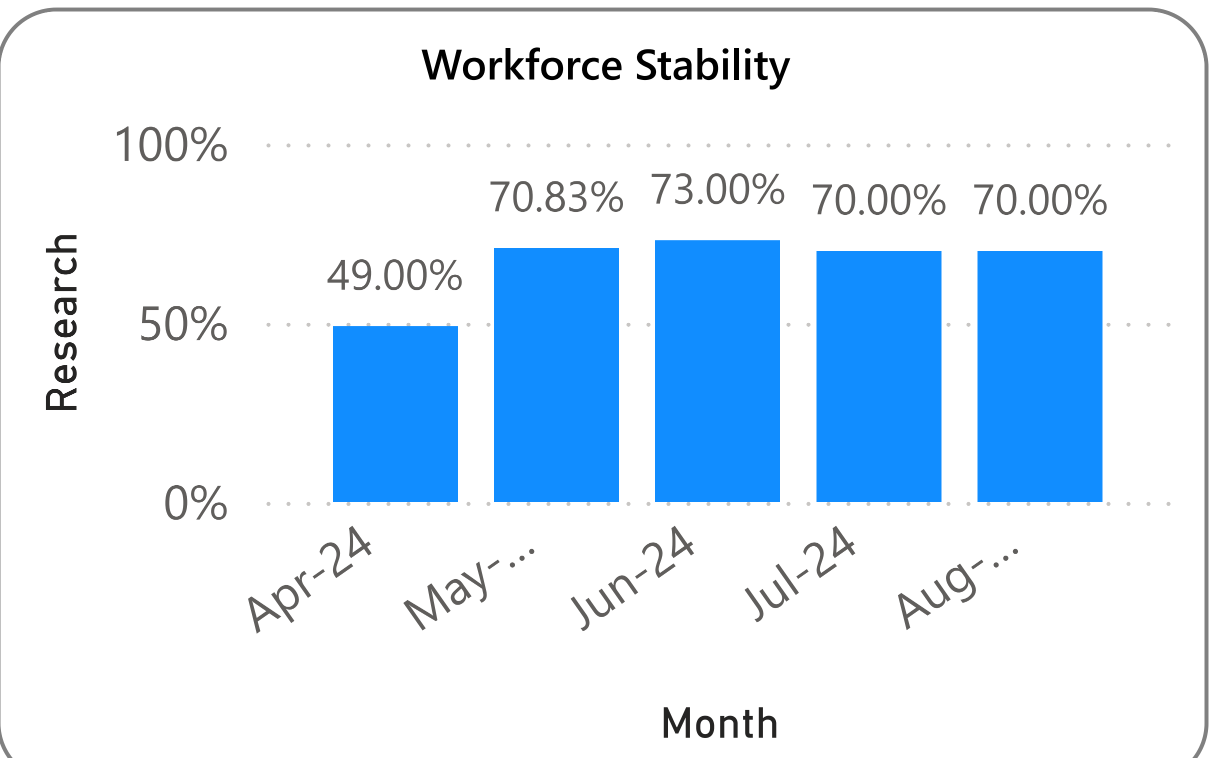


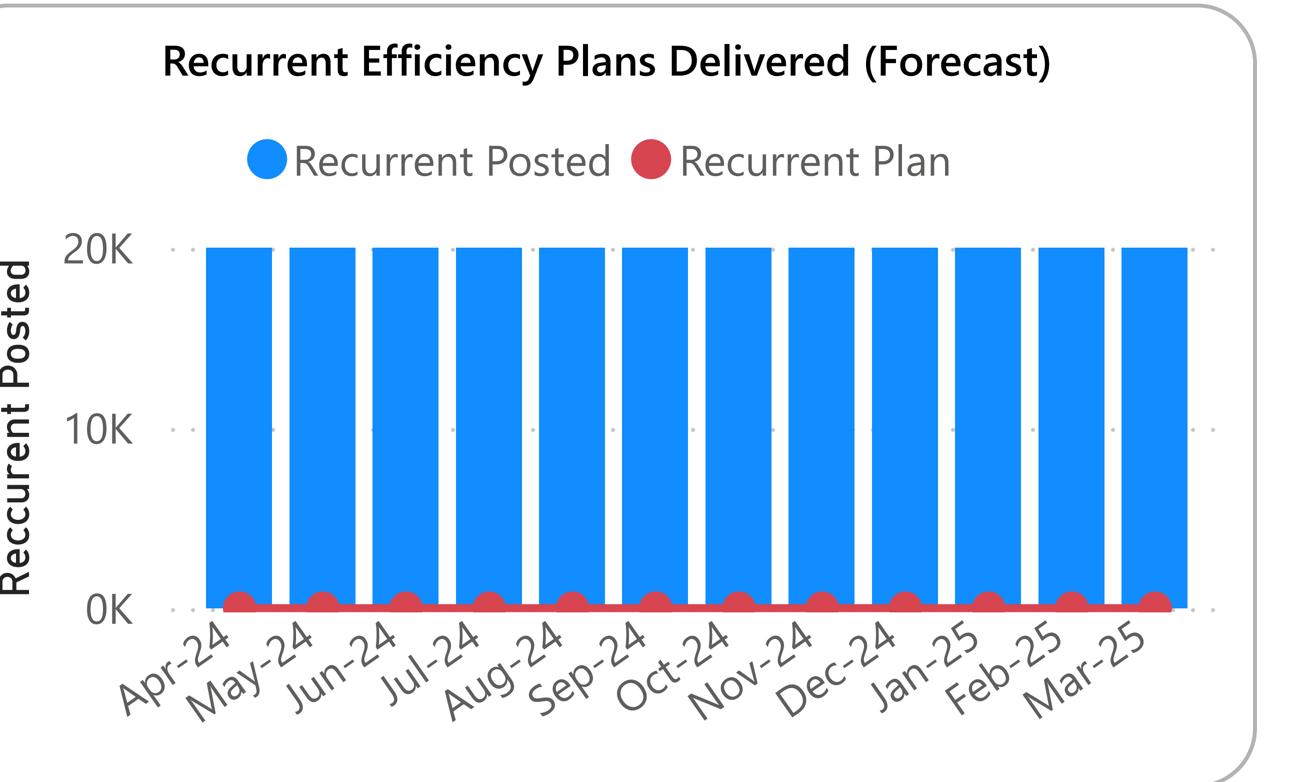


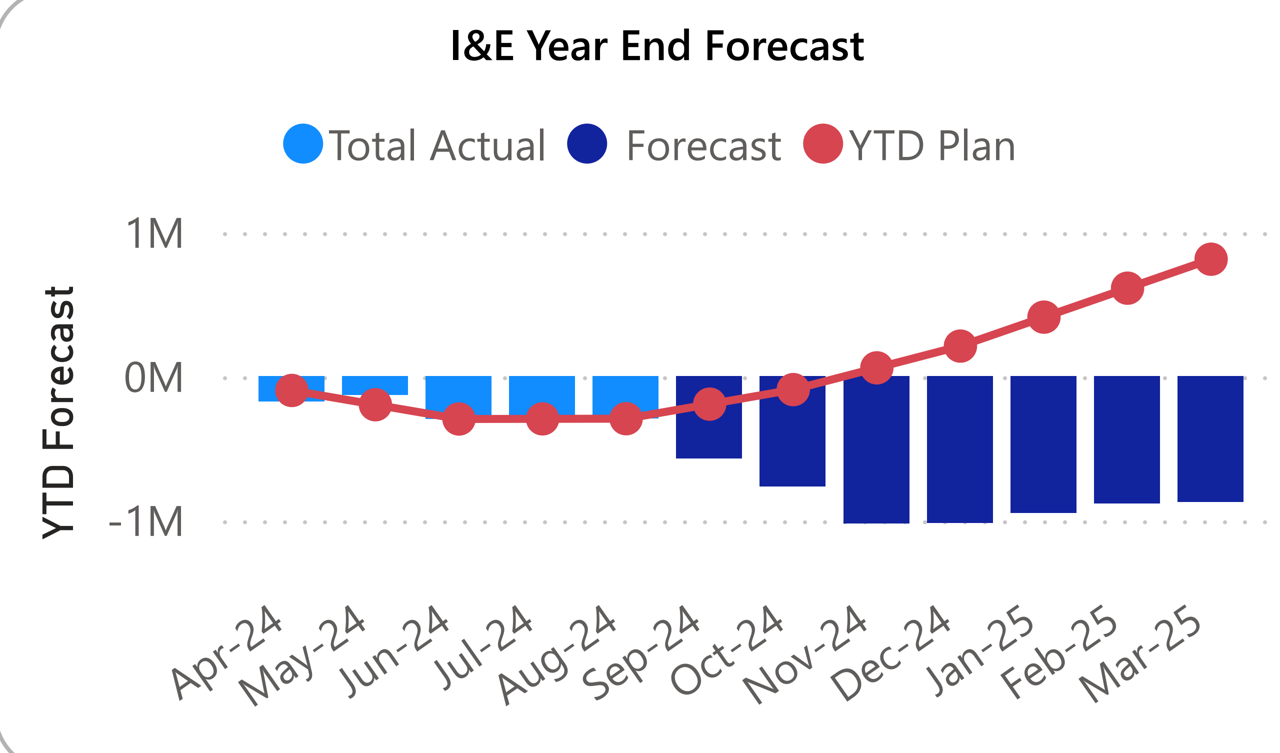


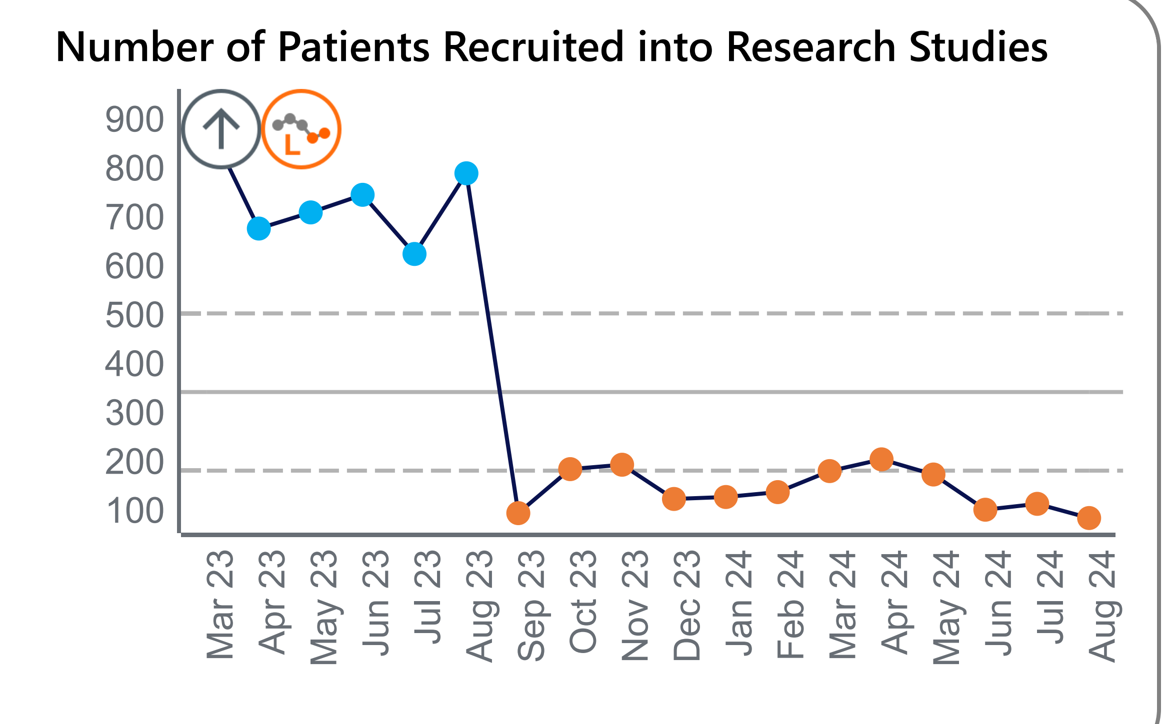


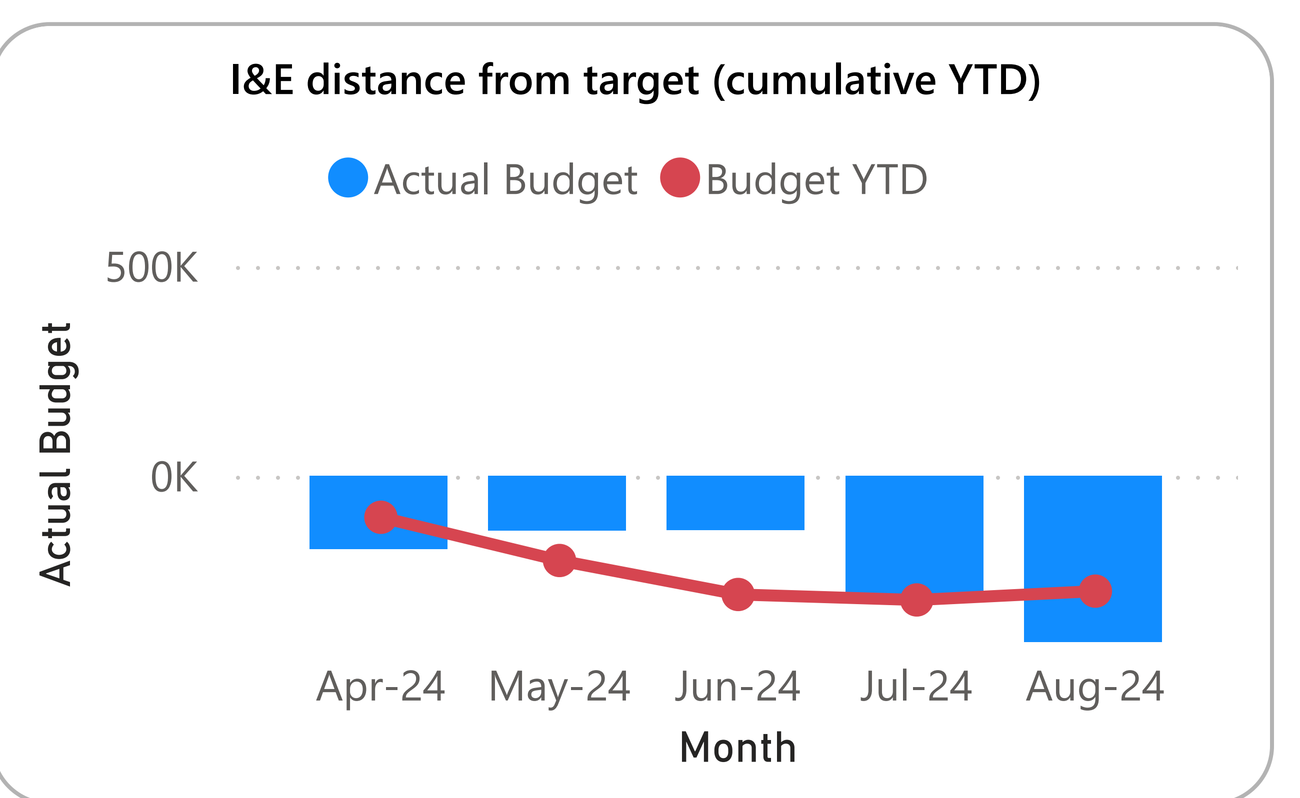












Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative continues to meet monthly with good engagement from all service areas. Highlights from the meeting held on 2nd September are:

• Return to work completion has increased to 84%. Managers are now being issued weekly reports and refresher training is readily available.

• Mandatory training currently at 95%.

• PDRs for all staff is sitting at 91% against a 90% target.

• Short term sickness absence is sitting at 2%.

• 77% of CIP identified and/or delivered at M04.

• 91% of risks were in date at 20th August 2024 (5/55 overdue)

• A number of BIG Conversations have taken place across the Corporate Services Directorate including Digital, Nursing & Quality, Finance and HR.

Areas of Concern

• Sickness absence has increased to 6.7%.

• Time to hire remains above the 30-day target at 40 days.

• PDR compliance for B7 and above is below Trust target at 67%

Forward Look (with actions)

Focus on :

• Financial position, system finance and opportunities.

• Policies and Guidelines due for review.

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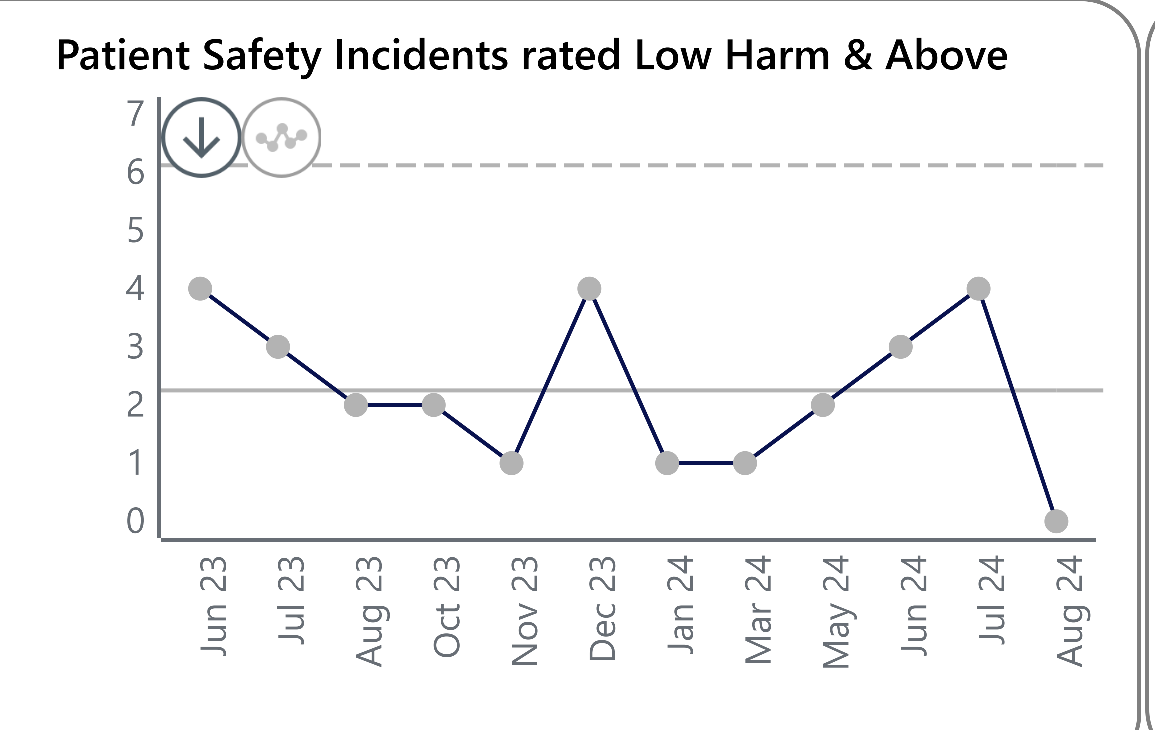
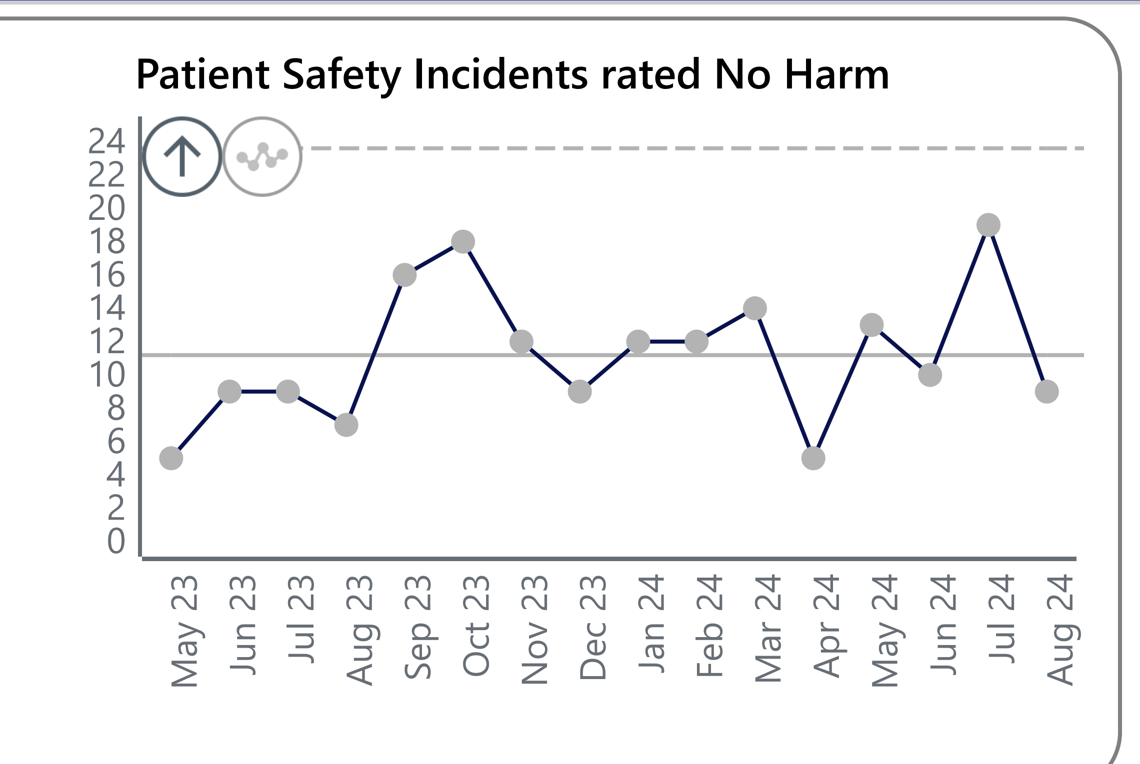
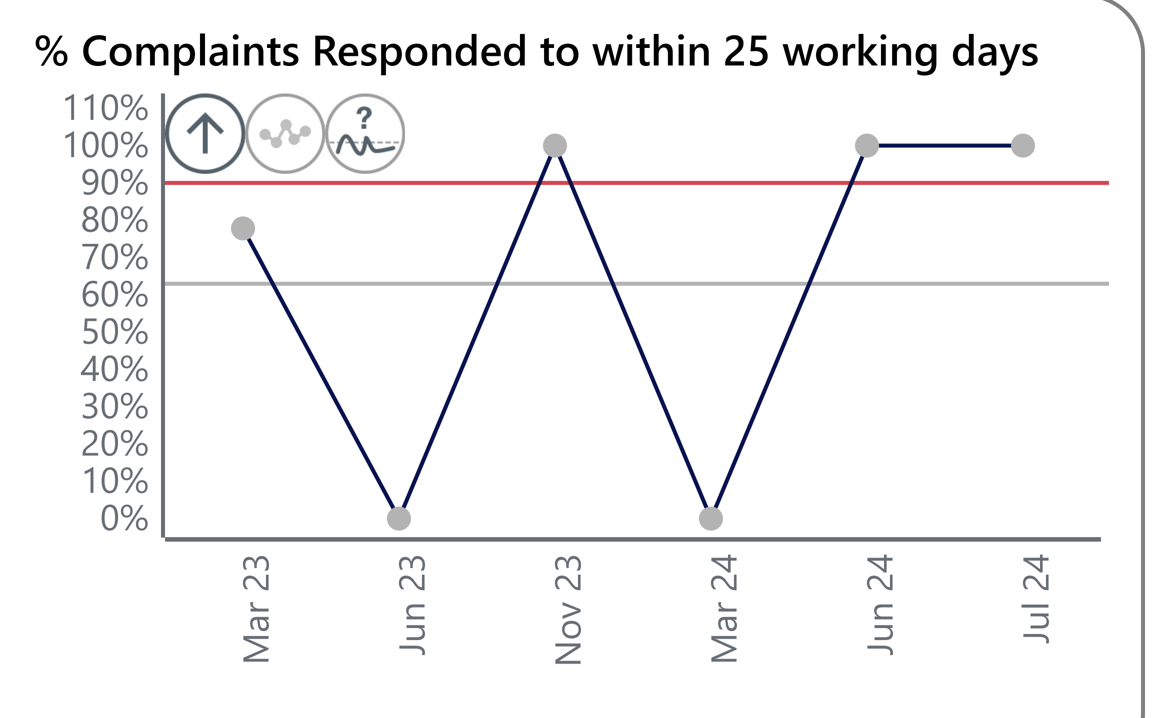
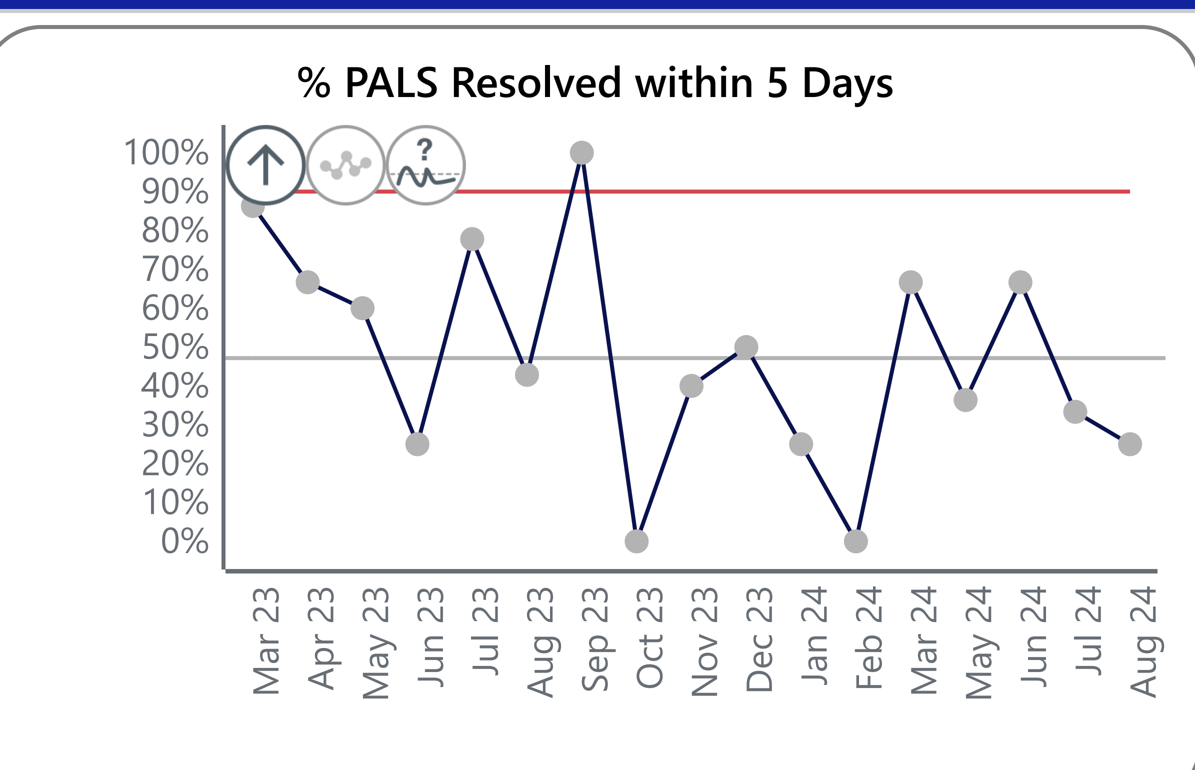
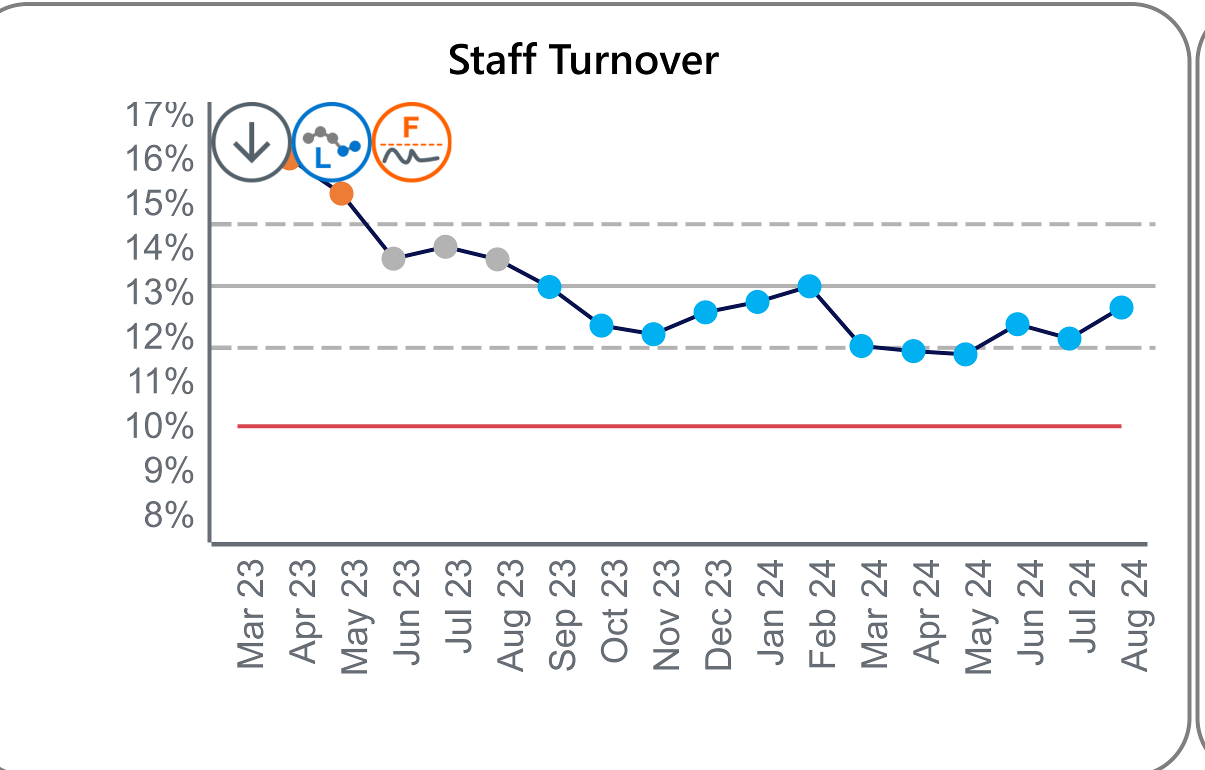
Divisional Performance Summary - Corporate

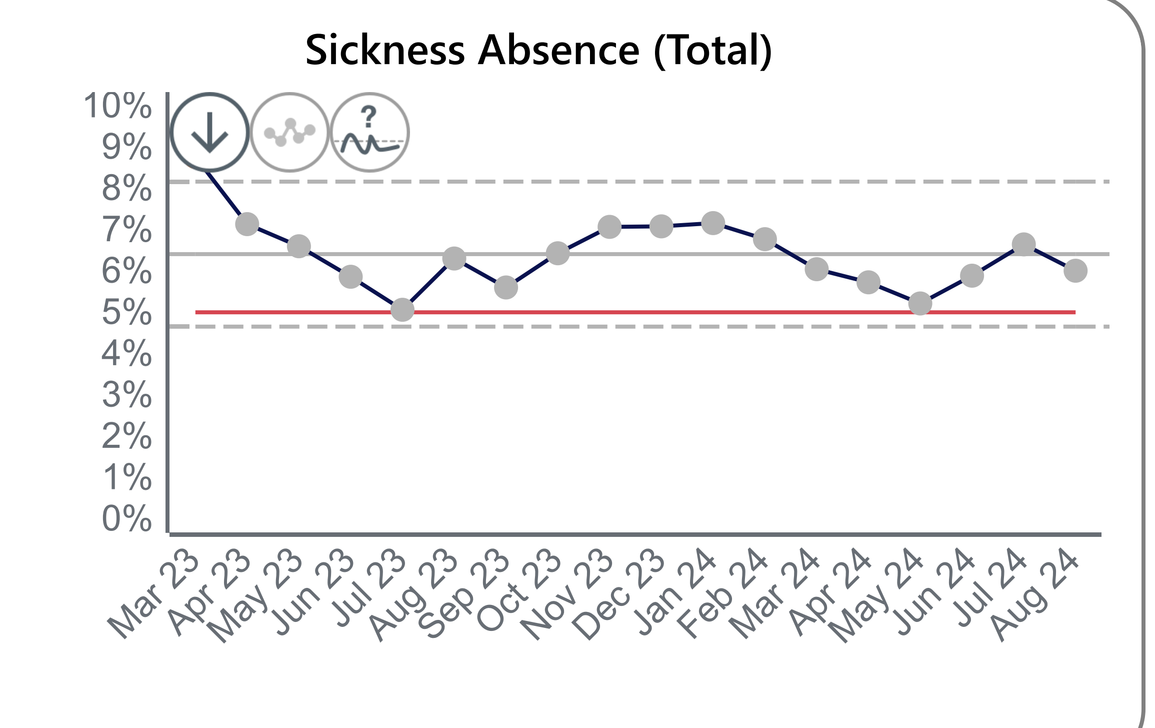


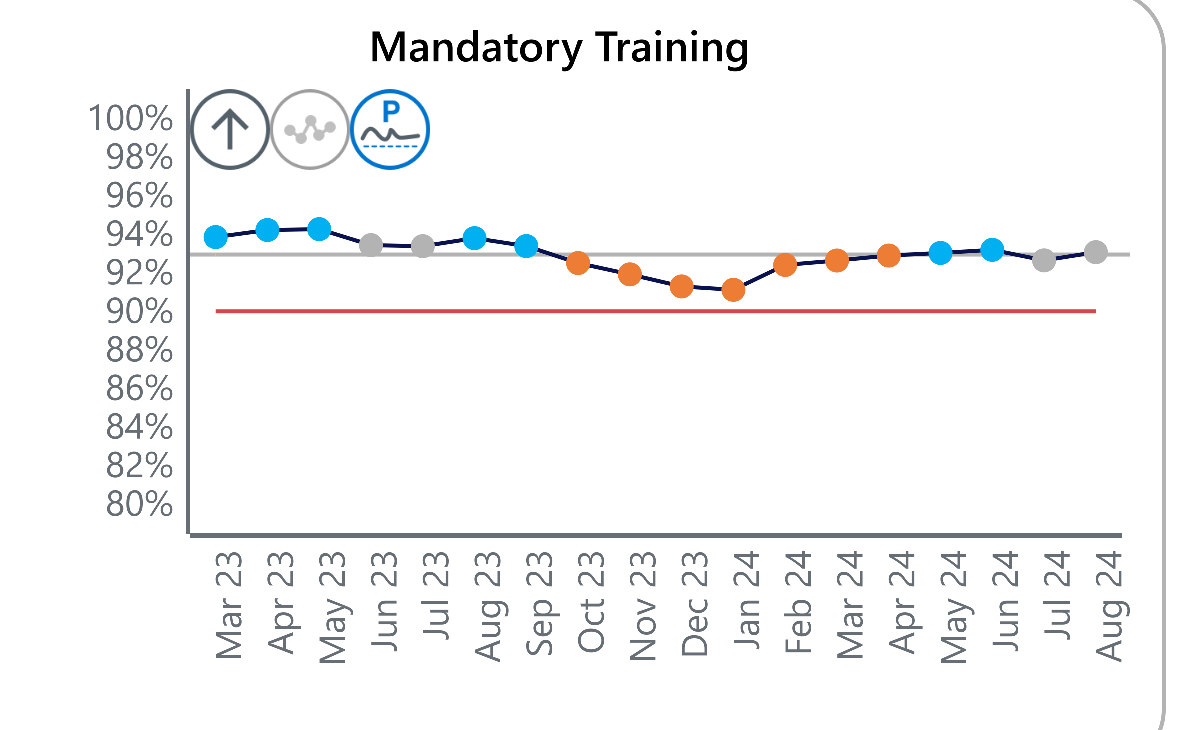


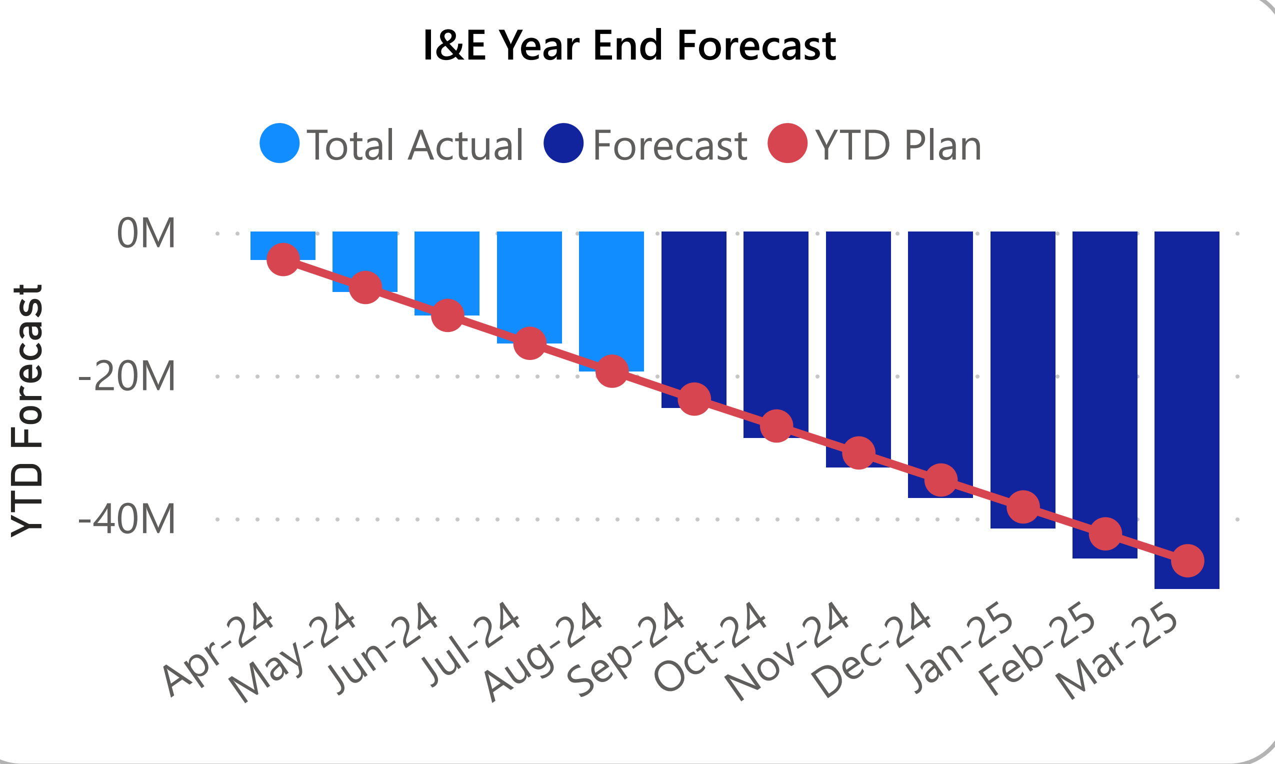


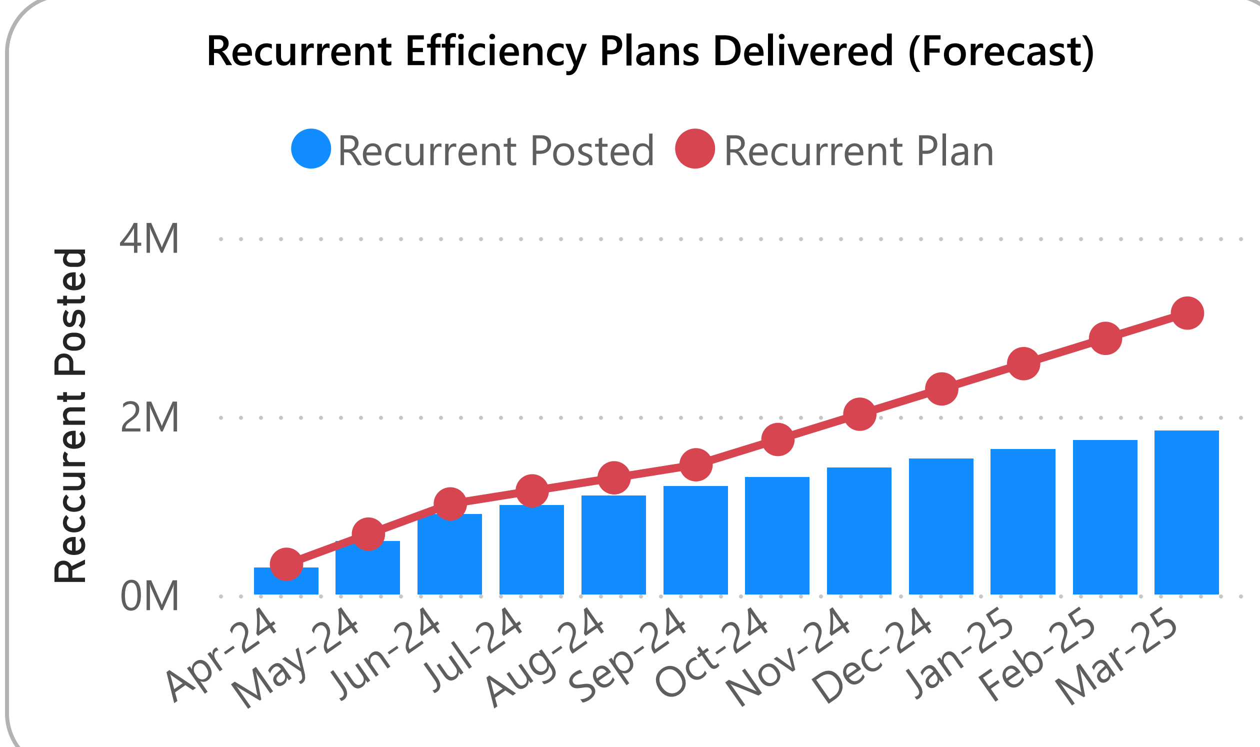


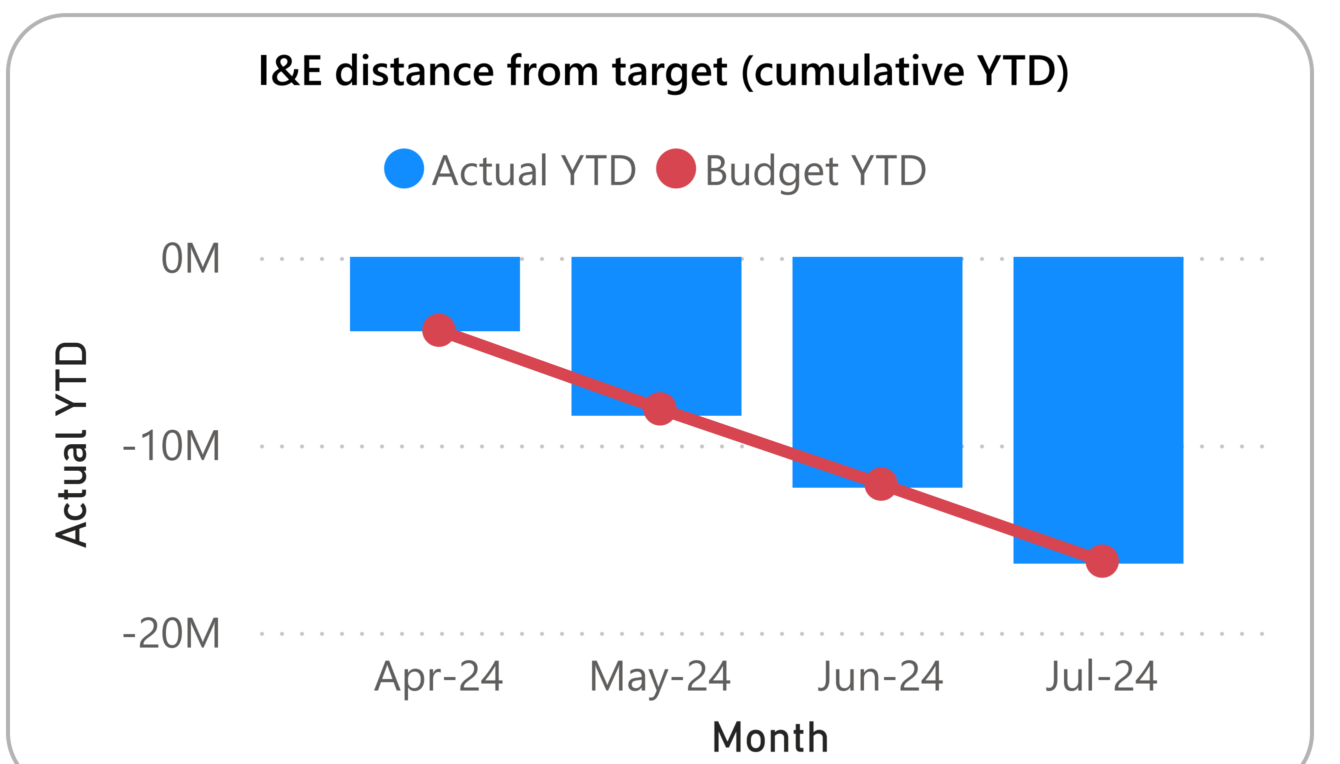












Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

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

	Day		Night		Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate		RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of response	% Very good and good		
Burns Unit	106%	-	100%	-	122	16.7	16.7	-1.30	-7.70%	1.00	50%	0.00	0.00%	0.00	0.00%	7.00	1.29%	1.00	3.33%	0	41	0	1	3	100	0	0
HDU	80%	70%	79%	100%	246	34.1	31.67	-5.19	-6.90%	2.72	51%	0.00	0.00%	0.61	23.47%	225.89	4.53%	18.40	23.47%	12	148	0	3	0	0	1	0
ICU	83%	68%	82%	77%	619	26.8	29.23	6.56	4.00%	2.17	52%	0.00	0.00%	0.00	0.00%	109.89	4.85%	0.00	0.00%	9	205	0	1	3	100	2	0
Ward 1cC	83%	80%	78%	90%	496	13.3	13.3	-2.86	-4.80%	-0.70	-13%	0.00	0.00%	0.00	0.00%	37.70	2.03%	36.80	20.35%	11	102	0	19	10	100	0	0
Ward 1cN	74%	0%	82%	-	193	18.7	18.73	0.92	2.60%	2.20	69%	0.92	2.67%	0.00	0.00%	18.52	1.79%	0.00	0.00%	4	68	0	9	0	0	0	0
Ward 3A	95%	68%	98%	88%	811	9.0	9.3	-3.71	-7.50%	2.23	14%	0.00	0.00%	0.61	4.36%	131.25	8.26%	52.00	12.09%	3	70	0	18	23	86.96	0	0
Ward 3B	95%	127%	98%	-	389	15.2	15.2	-1.02	-2.30%	0.56	11%	0.00	0.00%	0.00	0.00%	60.09	4.45%	32.20	22.74%	4	119	0	9	3	100	0	0
Ward 3C	104%	120%	89%	167%	754	12.8	11.55	-2.74	-4.40%	2.26	23%	0.61	0.94%	0.00	0.00%	104.16	5.31%	3.07	1.33%	6	128	0	6	10	80	0	0
Ward 4A	90%	59%	91%	120%	838	10.1	9.75	-6.10	-9.00%	0.80	14%	0.76	1.03%	0.00	0.00%	99.29	4.49%	26.37	17.92%	4	78	0	5	27	92.59	0	0
Ward 4B	63%	95%	63%	83%	497	15.9	15.9	6.35	14.40%	0.34	1%	0.00	0.00%	0.92	2.54%	71.16	6.29%	55.01	5.11%	8	124	0	6	6	83.33	2	0
Ward 4C	94%	86%	99%	98%	766	10.3	10.26	5.83	10.00%	1.24	11%	0.00	0.00%	0.00	0.00%	61.57	3.96%	34.00	10.84%	12	257	0	7	24	95.83	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 for the above table is based on June 2024 data from the model hospital. Those areas highlighted red fall below this benchmark, this equates to only 1 area for this reporting period which is ICU.

Medicine

1 ward within the Division of Medicine falls below the 80% standard for fill rate. This is 4B, however this is due to the changes in staffing model and therefore not reflective of care hours required. This will be corrected for August as budget has now been adjusted and establishment changed.

3B: Fill rate is similar to the previous month and will continue to improve due to a combination of recruitment of RN’s and decreased sickness.

4C: Continue to have a high fill rate, and for the first time are comparable with the benchmark for CHPPD. The increase in HCA’s is due to 1:1 requirement following risk assessment.

Surgery

Within the Division 2 wards falls below the standard fill rate for RN’s:

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 several 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.

HDU: on night shifts only. The department had high admissions in June which included 37 urgent referrals. 8.28 WTE maternity leave also contributed.

For HCA’s:

3A: HCA line is below 80% for day shifts – this is due to documentation of moves to other areas which are made through safe care, this is not used within other wards currently.

Weekly forward look meetings take place in both divisions and staffing which inform the daily staffing meetings chaired by HON’s.

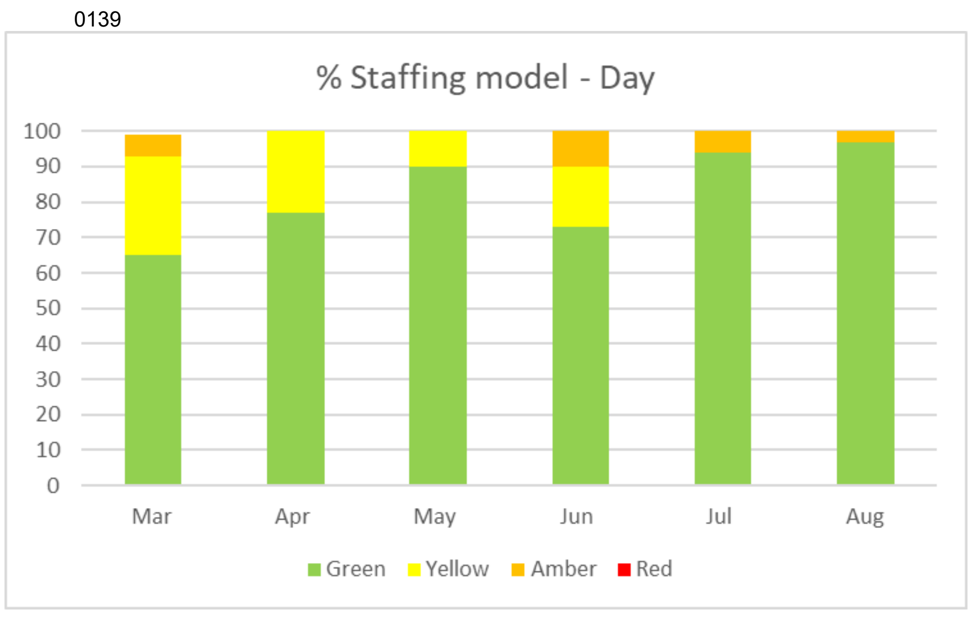
Summary

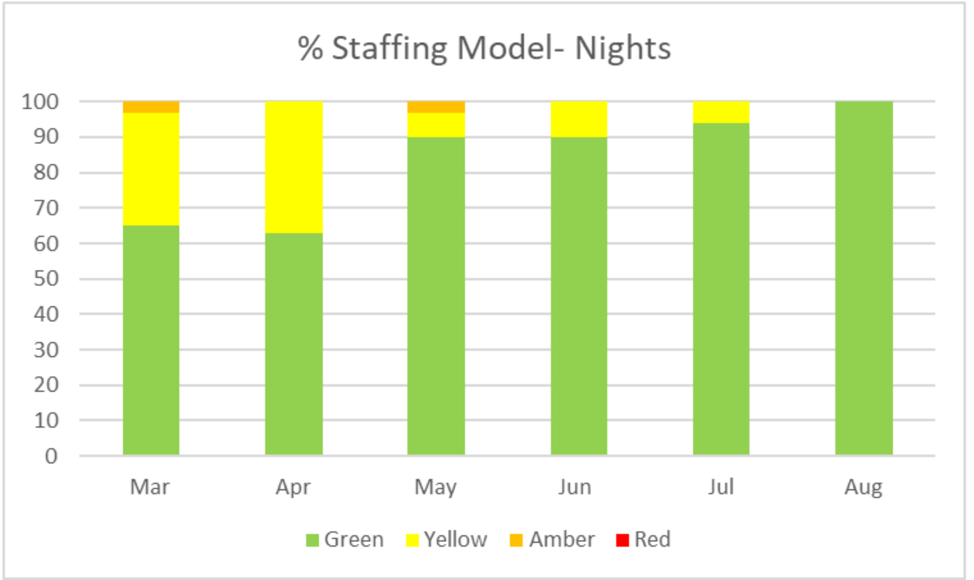
Alder Hey is comparable against the National Benchmark for CHPPD in most wards/departments for April 2024 (highlighted on the data set) The area that is an outlier and below the national CHPPD is ICU which is a less positive position than the previous month. This has not impacted on incidents, PALS or complaints.

4B continues to be an outlier due to the staffing model changes within the ward which are to be reflected in the establishment in month 4.

Summary of Staffing models March – August 2024

Staffing RAG data has continued to show improvement with zero red shifts within the wards and departments for this reporting period. To note a green staffing model was declared for 97% of day shifts (equates to 1 day) and 100% of night shifts in August. This was in part due to decreased occupancy within the wards.





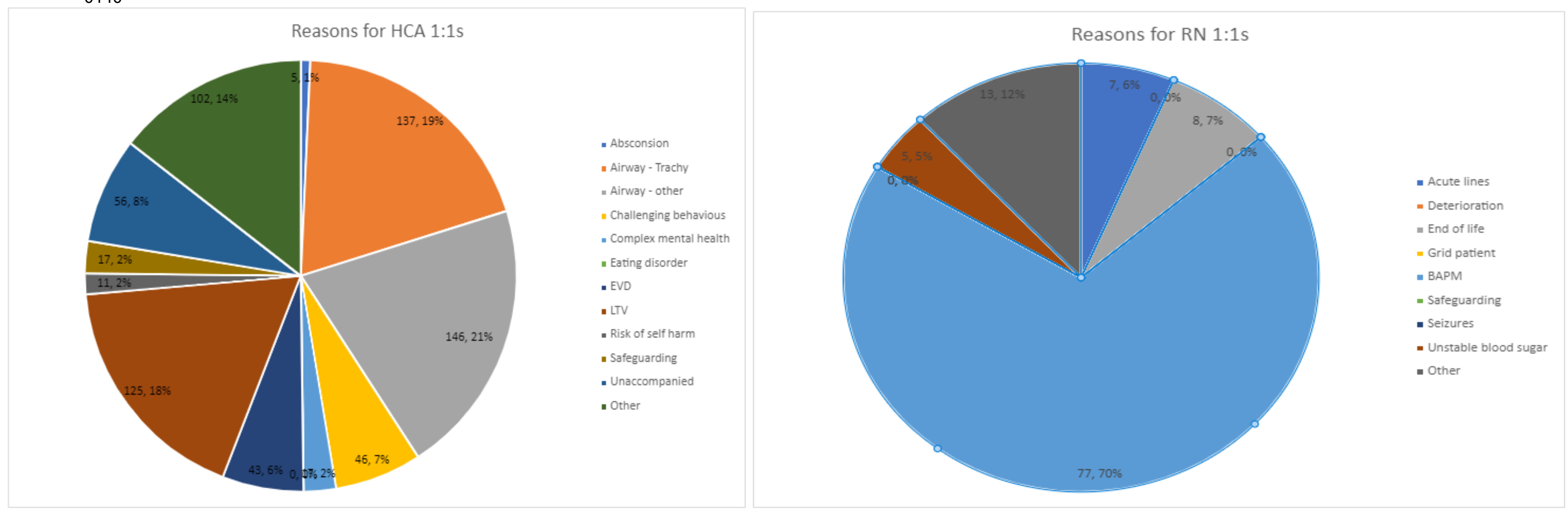
A new template has been introduced from August to capture the daily staffing data including bank usage, patient numbers, and acuity (including 1:1's with reasons for this).

Number of HCA 1:1s

Day Night

Number of RN 1:1s

Day Night



Electronic Roster KPI Report

August Board Paper

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

Summary Narrative

Continued improvement in August. The majority of the KPI's remain within target with some areas continuing to require close attention and focus. The work between the Roster team and the ward managers continues, with increasing areas of green seen in the table. As stated, there continues to be room for improvement in one or two areas. The key elements that have been highlighted from the August KPI data are summarised below:

Org.Units/Metrics	Roster Approval (Full) Lead Time Days (22nd July - 18th August)	% 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)	55	22.55%	80.00	588.92	0.00%	0	0	48.41%	34.41%	4.60%	0.00%	6.01%	0.00%	45.01%
Accident & Emergency - Nursing (912201)	44	37.50%	720.00	367.62	16.50%	1856.5	2	14.87%	17.55%	1.58%	0.13%	6.73%	6.34%	33.28%
Burns Unit (915208)	44	25.22%	140.00	60.25	1.01%	23	2	1.68%	14.20%	1.64%	0.00%	0.82%	0.00%	19.54%
Critical Care Ward (913208)	44	16.02%	1200.00	803.32	1.36%	231.5	1	19.05%	17.28%	1.97%	0.29%	5.06%	3.73%	28.33%
High Dependancy Unit (HDU) (913210)	44	27.17%	640.00	226.68	7.59%	667	4	19.29%	16.02%	3.14%	1.23%	4.48%	7.83%	32.73%
Medical Daycase Unit (911314)	45	34.88%	50.00	-42.97	6.27%	69.67	3	14.68%	20.11%	0.72%	0.00%	0.00%	0.00%	20.83%
Outpatients (916503)	39	50.22%	420.00	737.98	17.17%	1164.17	17	38.54%	11.79%	0.37%	2.91%	14.82%	3.48%	33.37%
Sunflower House (912310)	24	43.07%	190.00	833.7	26.02%	1051	36	20.91%	15.69%	0.00%	0.48%	8.89%	6.05%	34.55%
Surgical Daycase Unit (915418)	44	44.29%	85.00	384.27	7.31%	210.83	1	28.77%	13.80%	0.56%	2.80%	15.86%	0.00%	33.02%
Theatres - Cardiac & Cardiology (915405)	44	35.38%	130.00	4.75	2.28%	55	3	0.61%	7.67%	0.00%	5.90%	6.62%	0.00%	20.88%
Theatres - Emergency (915420)	44	30.26%	230.00	10.25	6.31%	132	2	2.91%	17.06%	1.91%	0.90%	7.87%	0.00%	31.73%
Theatres - IP Anaesthetics (915423)	44	27.29%	82.00	63.58	2.08%	73.25	16	2.04%	13.73%	0.22%	2.06%	4.53%	6.10%	26.64%
Theatres - IP Porters (915435)	26	40.24%	101.00	38.5	5.97%	89	0	12.16%	14.71%	0.00%	2.83%	0.83%	0.00%	25.44%
Theatres - IP Recovery (915422)	44	20.00%	103.00	-18.95	3.44%	52.5	1	9.04%	12.73%	2.66%	6.32%	7.95%	0.00%	29.65%
Theatres - IP Scrub (915424)	44	20.87%	128.00	5	11.97%	210.5	11	8.76%	14.20%	0.36%	0.00%	9.99%	0.00%	31.54%
Theatres - Ortho & Neuro Scrub (915436)	44	36.14%	37.80	0.25	18.81%	396.75	8	9.29%	18.00%	0.38%	0.28%	13.26%	4.59%	36.51%
Theatres - SDC Anaesthetics (915429)	44	35.58%	58.40	-9.08	32.78%	291.5	1	14.50%	10.60%	0.00%	4.58%	1.99%	18.07%	35.24%
Theatres - SDC Recovery (915430)	44	37.97%	177.30	-33.55	12.08%	160	3	6.09%	15.87%	0.56%	3.78%	7.70%	0.00%	29.02%
Theatres - SDC Scrub (915421)	44	31.78%	532.00	234.29	13.50%	362.25	6	10.43%	14.24%	0.13%	2.49%	12.39%	0.00%	29.26%
Ward 1C Cardiac (913307)	44	22.35%	361.00	651.35	4.57%	289.5	0	18.49%	16.25%	1.54%	0.54%	9.76%	7.02%	35.64%
Ward 1C Neonatal (913310)	37	38.56%	556.00	740.15	2.43%	126.5	2	20.29%	12.85%	4.02%	0.16%	4.89%	4.00%	31.17%
Ward 3A (915309)	44	22.71%	371.00	78.93	9.68%	711.5	20	10.77%	15.33%	0.83%	1.11%	10.45%	5.84%	33.67%
Ward 3B - Oncology (911208)	41	20.35%	555.00	601.28	10.74%	579	51	11.07%	15.89%	0.15%	0.29%	9.14%	4.80%	33.62%
Ward 3C (911313)	44	33.33%	607.00	1890.49	18.82%	1640	92	20.17%	17.92%	2.22%	0.91%	6.41%	4.07%	34.09%
Ward 4A (914210)	44	27.46%	634.00	563.3	7.15%	584.5	37	17.87%	17.21%	3.02%	0.87%	6.50%	3.73%	33.28%
Ward 4B (914211)	40	39.52%	533.00	607.67	19.78%	1771	19	23.11%	14.68%	6.92%	0.81%	9.21%	6.61%	38.24%
Ward 4C (912207)	41	26.21%	280.00	-1.42	7.87%	540.92	1	14.20%	17.87%	1.85%	1.77%	5.19%	1.49%	31.04%
Aug-24	**42.2**	**31.37%**	**9001.50**	**9386.56**	**10.13%**	**13339.34**	**339**	**15.48%**	**15.84%**	**1.53%**	**1.61%**	**7.31%**	**3.47%**	**31.38%**
Jul-24	**43.1**	**31.99%**	**9001.50**	**8011.53**	**10.86%**	**13638.25**	**326**	**15.10%**	**13.31%**	**1.98%**	**1.86%**	**8.58%**	**3.66%**	**30.92%**
Jun-24	**43.3**	**32.31%**	**9001.50**	**8197.88**	**11.30%**	**15518.91**	**425**	**14.96%**	**14.16%**	**1.93%**	**1.82%**	**8.17%**	**3.53%**	**30.83%**
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

Performance has been stable in August. This months' sickness has improved from to 7.31% from 8.58%, which is a significant improvement. Some key areas of improvement include study leave which is down to 1,53% from 1.98%, albeit seasonal variance has impacted on this target. Annual leave is also high at 15.84% reflecting the time of year. Bank is down but additional duties are up, and this in line with reduced sickness may be related to higher leave levels or higher levels of 1-1 acuity. Net hours have increased by 1375 hours which is disappointing as this indicator has been on an upward trajectory for some time, hopefully this is just an in-month variantion. Lead times are slightly down but again these figures are impacted by 1 or 2 poorly performing areas.

Across the Divisions, in Medicine lead times remain over the 42-day target at 44 days. Areas of required focus include changes since approval has increased from 29 to 31%, with ward 4B being highest at 39.6%. Net hours increased from 3133 to 4012 an increase of 879 hours in month. Additional duties have only increased by 4 totalling 168, however the roster% unfilled has increased by 4% from 17 to 21%. Annual leave has increased from 13 to 20% above the 15% target.

In Surgery, lead times are above the 42-day target at 43. Bank and agency use has decreased from 10 to 8% along with total hours from 5267 to 4667. Sickness has improved from 7.47% to 6.27% an improvement of 1.2% albeit still above target. Net hours are at 3803 which is an increase of 834 hours. There are however leavers assigned with no duties or unavailability to the roster team are addressing this with the management teams.

In the Community Division, % changed since roster approval has increased from 45 to 47% which is high. On a positive note, Net hours have decreased from 1841 to 1572, a decrease of 269 hours. Net hours meetings have been arranged to focus on this indicator even more closely. Sickness, whilst still above target of 5%, has reduced in August from 17.37% to 11.85%.

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 some areas, with the key challenges continuing in the area of sickness absence. 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 sent to the Divisional nursing leads to share with their managers to continue to improve these key workforce markers.

BOARD OF DIRECTORS

Thursday, 3rd October 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide a Campus and Park progress update. The Board is asked to confirm acceptance of the update and advise if reassurance has been provided.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborative** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
Resource Implications:	None

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

Campus Development Report on the Programme for Delivery

October 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:
- Springfield Park
- Gender Development Service
- Police Station Refurbishment

2024/25 Q3 & Q4:
- Base Camp
- Elective Surgical Hub
- Alder Park Phase 1
- Fracture/Dermatology Outpatients

2025/2026 Q3:
- Neo-Natal & UCC/SDEC

Key Achievements to Report:

Springfield Park
The main Park and footpaths are complete. Final works to finish the Swale are underway and are expected to conclude imminently. Upon completion, residual areas of tarmac will be completed linking up Ronald McDonald House.

Eating Disorder Service – Phase 1 Alder Park: Lyndhurst Building
Site enabling/strip out works are complete.

2. Key Risks

The tables below show the number and rating of key/high project risks managed locally.
The Development Team carried out a review of the full risk register on 20.09.24:

Project	Manager	Open Risks	Low	Med	High (15+)
Springfield Park	KOT	5	1	4	
Site Tidy/ Master Planning	KOT	9	3	6	
Fracture/ Dermatology OPD	KOT	8	3	4	*1
Neonatal & SDEC	JG	17	3	14	

Gender Development Service (GDS)	JG	3	1	2	
Alder Park: Phase 1	JVH/JG	8	3	4	*1
Elective Surgical Hub	JVH/KOT	6	1	4	*1

Overall:

- 25 new risks opened since last reported, relating to increased budget and programme risks, and confirmed risk ratings for Alder Park and GDS.
- 8 risks closed since last reported to reflect completion of the main Springfield Park works, and construction completion of the former police station and GDS projects.
- 3 high scores reported (*subject to detailed review): The high scores Fracture/Dermatology OPD and Elective Surgical Hub relate to on-going PM coordination challenges. The high score Alder Park relates to unexpected budget costs.

Escalation meetings remain in place with Mitie to check, challenge and manage any implications associated with projects in the main hospital building. Progress is noted against projects within this report.

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Springfield Park	Failure to deliver long term vision for park	BAF 3.1	12	Programme continually assessed for mitigations/improvement.
Neonatal & SDEC	Affordability	Not assigned	12	Development team managing mitigation plan for SPV/other costs. Draft services Deed of Variation received and being worked through with Bevan Brittan.
SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Informal discussions have resumed between the contractor and the Trust to establish the contractor's position.

3. Construction Programme Delivery Timetable (Critical Path)

Projects now completed are highlighted in grey

		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	
Springfield Park	Phase 1: Main Park																									
	Phase 2: Swale																									
	Phase 3: Park Handover																									
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																									
Site Completion/ Master Planning	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																									
GDS North Hub Estates Solution Design, Refurb, Commissioning & 'Go Live'	Phase 1 (First Floor)																									
	Phase 2 (Ground Floor)																									

5. Project Updates

Neonatal and SDEC

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Programme: • Draft services Deed of Variation (lifecycle & maintenance) received; this is being worked through with Bevan Brittan. • Heating pipe defect 11.09.24 affecting Ward 1c & Neo-Natal Unit resolved 18.09.24.		Completion of main construction works. Increased construction & SPV costs. Delay to unit opening.	Construction completion reported as 20.10.25. On-going monitoring. Formal monthly Construction Progress meeting.
Costs and Operational Coordination: • PAU/EDU decant to Ward 4c completed. • ED Waiting decant plan being progressed. • Ground Floor shell space design being progressed.		Potential decant costs. Potential budget & programme impact of GF reconfiguration changes.	Agree decant plan ED waiting. Agree shell space design. Draft Move & Commissioning plan. RIBA Stage 5 design sign off.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Informal discussions have resumed between the contractor and the Trust to establish the contractor's position. The details of this are subject to legal privilege.		Possible contract claim.	Continued oversight via Finance Transformation & Performance Committee.
Sprinkler System Under-Croft Car Park: • Cost quotes received from two potential contractors, however excess of initial tender budget. • Potential options discussed at 26.09.24 Executive Director's meeting.		Fire compliance. Budget	Review options to develop an agreed recommendation for approval.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps

Former Police Station Refurbishment (Beech House): • Building handed over to Trust and moves complete. • Three Storey Modular (3SM) dismantled and removed from site.			Management of snags and building defects. After Care meetings in place.
Deliverable (Modular/Office Buildings Cont/d…)	**RAG**	**Risks/Issues**	**Actions/Next Steps**
Space Utilisation: • Alternative Accommodation for Teams/Services Currently Based in the Histopathology Building (to allow demolition of the building): proposals being developed, staff re-location has commenced. • Improved Environment Institute in the Park: carpet replacement to be progressed, general tidy, consideration re: purchase of meeting pods. • Desk & Meeting Room Allocation: space management policy under consideration.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for works/kit.	Full staff engagement exercise to agree final desk allocation, move dates and operational logistics. Budget and scope of works to be finalised.

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Completion Works: • The ground levelling and path works around the Alder Centre are complete. • Works to complete the Swale will conclude imminently. • Preparations to conclude new planning requirements are underway with a target submission date of October 2024.		Resistance to swale from some elements of the community.	In agreement with LCC, handover of Springfield Park will be in 3 phases: 1) Main Park Oct 2024; 2) Swale Dec 2024; and 3) remaining site (Histopathology & surrounding area) Dec 2025.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Work ongoing in line with programme. • Start on Site: 12.08.24. • Construction Completion: 06.12.24. • 'Go Live' 20.12.24.		NHS Estates Bulletin 3 Water Safety Guidance impact on current design. *Note: Trust reviewing potential impact on other schemes.*	Mitie to issue updated programme to Trust following issue of revised TVE. Mitie are reporting a 4.5 week delay.

		Delay to completion, impact on operational running of the services.	Regular meetings. Close monitoring of critical risks.

Site Completion / Master Site Planning

Deliverable	RAG	Risks/Issues	Actions/Next Steps
High level programme to be agreed – 5-year proposed plan developed: • Priority works '24/'25 & '25/'26 TBA. • Master Site Planning presentation to Trust Board 06.06.24. • Informal 9-month key stakeholder engagement.		Budget TBC.	On-going site tidy. Clinical model / estates strategy to be developed.

Elective Surgical Day Case

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Design Team appointments completed. Indicative costs (+/- 20%) and supporting programmes received.		Programme, available budget. Mitie PM resources.	Full design team workshop to develop programme and confirm costs, 03.10.24.

Gender Development Services (GDS) – Estates Solution

Deliverable	RAG	Risks/Issues	Actions/Next Steps
• The building fully handed over and operationally live.		Water results taps – isolated	Regular snag meetings in place.

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

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Enabling Works: • Unexpected issues discovered inc fire stopping and water safety compliance; additional survey & investigation works completed. • Design and cost plan assessed, proposed mitigation plan drafted. • Work is continuing to agree the main contract for the project.		Programme, available budget.	Confirmed scope of works. Sign off final design.

6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 3 October 2024.

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	**Safeguarding Children and Adults at Risk Annual Report 2023-2024**
Report of:	**Nathan Askew** **Chief Nursing, AHP and Experience Officer**
Paper Prepared by:	**Nichola Osborne** **Associate Director for Safeguarding and Statutory Services**

Purpose of Paper:	Decision ☑☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The purpose of this report is to provide an overview of Trust safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team from 01 April 2023 to 31 March 2024, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐
Resource Implications:	N/A

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
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.	20
2393	There is a risk that staff will not understand policies and procedures to follow or may not identify safeguarding risk (Safeguarding Training Compliance)	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

Safeguarding Children and Adults at Risk Annual Report 2023-2024

Safeguarding and Statutory Services

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Executive Summary

The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2023 to 31 March 2024, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

The work activities undertaken by the Alder Hey Safeguarding Team during 2023/24 have been comprehensively documented within the quarterly safeguarding assurance reports received by the Safeguarding and Statutory Services Assurance Group (SASSAG) and the Safety and Quality Assurance (SQAC) Committee This report is intended to provide an overview and 'snapshot' of that work.

Whilst there are good safeguarding systems in place across Alder Hey, there continues to be challenges as safeguarding continues to evolve, in both complexity and scope. With new and emerging risks in respect of contextual safeguarding being identified. As a result, Alder Hey must ensure that its safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee its safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in its care.

The Safeguarding Team remains committed to ensuring that children, young people, and adults at risk using Alder Hey services are safe, and that their health needs are met. The Safeguarding Team will continue to work collaboratively with Trust colleagues and key partners to continuously improve systems to safeguard children, young people, and adults at risk.

Introduction

1. The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2023 to 31 March 2024, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

2. As such a condensed overview of the work activities undertaken by the Alder Hey Safeguarding Team during 2023/2024 are included in this report. These have previously been included in the quarterly safeguarding assurance reports received by the Safeguarding and Statutory Services Assurance Group (SASSAG) and the Safety and Quality Assurance (SQAC) Committee. This report is intended to provide an overview and 'snapshot' of that work.

3. The content of this report will be used to inform and assure Commissioners and may be used to inform and assure Local Safeguarding Children Partnerships (LSCPs) and Local Safeguarding Adult Boards (LSABs).

4. The report outlines the Alder Hey safeguarding governance arrangements and safeguarding activities within and relating to the Trust. It is designed to highlight key issues, working arrangements and recent developments.

5. Safeguarding is 'everybody's business' and the Alder Hey Safeguarding Team works to ensure that it continues to be the 'golden thread' running through all our services.

6. NHS England (2022) state in the Safeguarding Accountability and Assurance Framework (SAAF) that "*Fundamentally, it remains the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the wellbeing of those children and adults is at the heart of what we do*".

Alder Hey and Safeguarding Commissioning Arrangements

7. Alder Hey is one of four stand-alone children's specialist providers in the country. Alder Hey provides a full range of secondary services to its local paediatric population as well as tertiary and quaternary care for a footprint stretching across the Northwest of England and beyond.

8. NHS England principally commission the Trust for tertiary and quaternary care with the commissioning of secondary care services, across a wide population base, via several Place areas within the Cheshire and Merseyside region.

9. Alder Hey provides care for approximately 330,000 children and families each year. The Trust became a Foundation Trust in August 2008 and leads research into children's medicines, infection, inflammatory diseases, and oncology. The Trust has a broad range of hospital and community services, including many accessed directly via primary care referral. The Trust is a recognised Major Trauma Centre and is one of four national Children's Epilepsy Surgery Service centres. The Trust is a designated national centre for head and facial surgery as well as a centre of excellence for heart, cancer, spinal and

brain disease. Alder Hey is the only national centre of excellence for childhood lupus and the only experimental arthritis treatment centre for children.

10. Liverpool Place is the lead commissioner for the Alder Hey Safeguarding and Statutory Services across Liverpool, Sefton, and Knowsley. Liverpool Place undertakes a coordinating role on behalf of Cheshire and Merseyside Integrated Care Board (C&M ICB).

Legislative Frameworks - Safeguarding Children, Young People & Adults at Risk

Safeguarding Children and Young People

11. Safeguarding children and young people and promoting their welfare is defined as:

    - Protecting children from maltreatment.
    - Preventing wherever possible impairment of children's health or development.
    - Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
    - Taking action to enable all children to have the best outcomes.

12. Child protection is defined as being part of safeguarding and promoting welfare. It is the work done to protect specific children who are suffering, or are likely to suffer, significant harm.

13. The Working Together to Safeguard Children (2023) guidance is clear that children are best protected when professionals are clear about what is required of them and how they need to work together with others.

14. In addition, the guidance states that effective safeguarding can only be achieved by putting children at the centre of the system and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.

Safeguarding Adults at Risk

15. Safeguarding Adults at Risk of Abuse is defined in the Care Act (2014) as meaning:

    - Protecting the rights of adults to live in safety, free from abuse and neglect.
    - People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
    - People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, wishes, feelings and beliefs in deciding on any action.
    - Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances and therefore potential risks to their safety or wellbeing.

16. Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be

some challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

17. Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice.

18. Regardless of the developing context, all health organisations are required to adhere to the following arrangements and legislation (NHS England, 2022):

<table>
<tr><th colspan="3">Legislation for All</th></tr>
<tr><td colspan="3">▪ The Crime and Disorder Act 1998
▪ Female Genital Mutilation Act 2003
▪ Sexual Offences Act 2003
▪ Mental Capacity Act 2005
▪ Convention on the Rights of Persons with Disabilities 2006
▪ Mental Health Act 2007
▪ Children and Families Act 2014
▪ Modern Slavery Act 2015
▪ Serious Crime Act 2015
▪ Mental Capacity (Amendment) Act 2019
▪ NHS Constitution and Values (Updated January 2021)
▪ Domestic Abuse Act 2021
▪ Serious Violence Duty: Draft Guidance 2021
▪ Prevent Duty 2015</td></tr>
<tr><th>Safeguarding Legislation Specific to Children</th><th>Safeguarding Legislation Specific to Young People Transitioning into Adults, including Children in Care</th><th>Safeguarding Legislation Specific to Adults</th></tr>
<tr><td colspan="2">▪ United Nations Convention on the Rights of the Child 1989
▪ Children Act 1989 and 2004
▪ Promoting the Health of Looked After Children Statutory Guidance 2015
▪ Children and Social Work Act 2017
▪ Working Together to Safeguard Children Statutory Guidance 2023</td><td>▪ European Convention on Human Rights
▪ The Care Act 2014
▪ Care and Support Statutory Guidance – Section 14 Safeguarding</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019</td><td>Looked After Children: Knowledge, skills, and competencies of health care staff 2020</td><td>Adult Safeguarding: Roles and Competencies for Health Care Staff 2018</td></tr>
<tr><th colspan="3">Framework Specific to both Children and Adults</th></tr>
<tr><td colspan="3">Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2022</td></tr>
</table>

Alder Hey Safeguarding Governance Arrangements

19. The Chief Nursing, Allied Health Professionals (AHP) & Experience Officer is the Board Executive Lead for safeguarding children and safeguarding adults at risk, with the Chief Executive retaining overall statutory responsibility. The Alder Hey Safeguarding Team forms part of Safeguarding and Statutory Services which sits within the Community and Mental Health Division. Day to day Director support for Safeguarding is the responsibility of the Director Community & Mental Health Services.

20. Safeguarding and Statutory Services are led by the Associate Director for Safeguarding and Statutory Services supported by the Named Nurse and Named Doctor for Safeguarding Children, Young People and Adults.

21. The Associate Director for Safeguarding and Statutory Services is the identified statutory lead for Child Sexual Abuse and Exploitation, Forced Marriage, Prevent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Lead as required by the Standard NHS Contract.

22. The Associate Director for Safeguarding and Statutory Services meets with the Chief Nursing, AHP & Experience Officer regularly in relation to safeguarding matters, providing briefings to the Senior Leadership Team as appropriate to discuss issues such as serious safeguarding incidents, Acute Life-Threatening Events (ALTEs), Unexpected Deaths in Childhood (SUDiCs) and allegations against staff members.

23. The Safeguarding and Statutory Services Assurance Group (SASSAG), chaired by the Director Community & Mental Health Services, ensures Alder Hey effectively discharges the Trust's statutory responsibilities relating to safeguarding children, young people and adults and those patients where additional vulnerabilities have been identified.

24. SASSAG provides assurance to the Trust Board via SQAC in the form of quarterly reports that safeguarding mechanisms and processes are integral to the work of the Trust regarding all service provision to ensure safety and better outcomes for children and young people.

25. In 2023, the Safeguarding Operational Group (SOP) was established with the primary purpose is to ensure that safeguarding children and adults is a Trust wide priority with representation from all divisions. The group oversee safeguarding training compliance, discuss incident trends, and explore lessons learned from patient safety incident reviews, safeguarding inspections reports, serious safeguarding reviews such as Local Child Safeguarding Practice Reviews and allegations against staff.

Named Professionals for Safeguarding

26. Alder Hey has both an identified Named Nurse and Named Doctor for Safeguarding in line with the requirements of all NHS Providers as set out in the NHS Safeguarding Accountability and Assurance Framework (SAAF) (2022). The Associate Director for Safeguarding and Statutory Services leads the Named Professionals in their statutory responsibilities to ensure Trust safeguarding arrangements are robust.

27. Alder Hey's Named Professionals have a key role in promoting good professional practice within the Trust, supporting the local safeguarding system and processes, providing advice and expertise for staff, and ensuring safeguarding training is in place.

They work closely with the Associate Director for Safeguarding and Statutory Services, Designated Professionals for Safeguarding in the relevant Place areas, and the LSCPs and LSABs.

Internal and External Assurance Reporting Arrangements

Internal Safeguarding Reporting and Assurance

28. Health Providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working (NHS England, 2022).

29. A Safeguarding Annual Report is provided to Trust Board following approval at SASSAG, and SQAC. The Safeguarding Quarterly Reports are provided to the SASSAG, and the SQAC for scrutiny and oversight as part of our safeguarding governance arrangements.

30. Briefing papers are completed by the Associate Director for Safeguarding and Statutory Services as appropriate to advise SQAC or Trust Board on new and emerging safeguarding issues as appropriate.

Cheshire & Merseyside Integrated Care Board Safeguarding Assurance

31. Data and quality analysis is provided quarterly to Designated Safeguarding Professionals at Liverpool Place who act as 'Lead Commissioner' in line with commissioning arrangement and safeguarding contractual standards. Regular feedback regarding the level of assurance and quality of KPI submissions are provided by Designated Safeguarding Professionals at quarterly Business Meetings with the Associate Director for Safeguarding & Statutory Services and Named Professionals.

32. Designated Professionals for Safeguarding at C&M ICB are invited to attend SASSAG where there is discussion regarding the quality of KPI submissions. Their attendance at SASSAG supports openness, transparency and good working relationships between the Trust and our Commissioners.

Cheshire & Merseyside ICB Commissioning Standards

33. The Alder Hey Safeguarding Team are required to submit evidence bi-annually to Liverpool Designated Safeguarding Professionals to outline compliance against NHS Cheshire & Merseyside ICB 'Safeguarding Children, Young People and Adults at Risk Commissioning Standards 2023-2024'.

34. These safeguarding commissioning standards contain safeguarding audit frameworks which are based on Care Quality Commission (CQC) Fundamental Standards, Section 11 of the Children Act 2004, and the Care Act 2015.

35. The Safeguarding Team populated the audit tool with the support of relevant corporate and divisional colleagues to gather the appropriate evidence.

36. The audit tool includes 63 standards across ten Key Lines of Enquiry (KLOE) as follows:

- Leadership and Organisational Accountability
- Safeguarding Processes
- Safeguarding Policies
- Safeguarding Training and Development
- Safeguarding Children
- Safeguarding Adults at Risk
- Children in Care
- Mental Capacity Act
- Child Death Review
- Lampard

37. Scrutiny Meetings with Designated Safeguarding Professionals took place in Quarter 4 with evidence being reviewed against all standards. Formal feedback from C&M ICB will be provided in Quarter 1 2024/25 and an action plan will be developed by the Safeguarding Team to address any 'red' or 'amber' rated standards.

38. The Commissioning Standards Action Plan will be overseen by SASSAG and submitted to the C&M ICB Designated Professionals for review as part of the quarterly KPI submissions.

Alder Hey Safeguarding Service Structure

39. The Safeguarding Team are a specialist team who help, advise, and support staff in working together to safeguard children and adults at risk. The team consists of Safeguarding Nurses/Practitioners, on-call doctors, Health Care Assistants and Pathway Co-ordinators.

40. The Safeguarding Team works from the Rainbow Centre and is known widely across the Trust as the 'Rainbow Team'.

41. The role of the team is to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee Trust safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in our care.

42. The Safeguarding Team support the training and development of our workforce of over 4,000 staff in respect of safeguarding to recognise and respond to abuse to safeguarding children, young people, and adults at risk in the Trust's care at the earliest opportunity. They also provide a range of support and supervision to enable the safe decision making.

43. The Safeguarding Team is committed to ensuring that children, young people, and adults at risk using our services are safe, and that their health needs are met. The team work collaboratively with all Trust colleagues and key partners to continuously improve systems to safeguard.

44. The Safeguarding Nursing Duty Team is available Monday -Friday (9am-5pm). The on-call Safeguarding Doctors are available Monday-Sunday (9am -10pm). The Safeguarding Doctors provide advice and support to colleagues across the Trust and complete child protection medicals for those children who are suspected or known to have been abused.

45. The team is based within the Rainbow Centre which is situated on the ground floor near the Emergency Department and provides a 'hub' for the co-ordination of the safeguarding

service across the whole of Alder Hey. The facilities include office space, and an Achieving Best Evidence (ABE) interview suite, as well as two dedicated examination suites, which provide a calm, caring environment where children who are suspected of being abused can be medically examined and interviewed.

46. The Rainbow Centre is a dedicated Examination Centre and child protection service. Our doctors supported by Health Care Assistants and Nurses, examine, and advise on the medical aspects of suspected or actual child abuse. This includes physical and sexual abuse, presenting in the community, Emergency Department (ED), or in our inpatient wards or Outpatients Departments.

47. The Rainbow Centre offers a multi-agency approach to the treatment of abused children with close liaison between Police, Children's Social Care, and Alder Hey staff.

48. The Safeguarding Team works closely with Unscheduled Care, Burns and Plastics, Critical Care, Gastroenterology, Orthopaedics, Paediatric Surgery, Neurosurgery, Oncology, Ophthalmology, Radiology, CAMHS and Medical Photography colleagues in the management of some of the most complex child protection investigations within the region.

49. Alder Hey has a large catchment area and provides secondary health care for the boroughs of Liverpool, Knowsley and Sefton. It is also a tertiary referral centre for specialist services with a specialist Paediatric Intensive Care Unit and Major Trauma Team which receives patients from the local and regional areas, e.g., North Wales, Cheshire and Merseyside, and across the wider Northwest.

50. By arrangement with these Boroughs, Police and Children's Social Care, any children requiring medical examination, are referred as per protocol to the Rainbow Centre at Alder Hey, to be seen by a member of the specialist safeguarding on call team.

51. For those children and young people who are inpatients and concerns of possible abuse are raised, the Consultant with responsibility for the child will follow the relevant Alder Hey safeguarding procedure and make a referral to the Consultant on call for the Safeguarding Team.

52. The Safeguarding Team provides the paediatric input for joint examinations with Forensic Medical Examiners (FME) for examination of children with suspected sexual abuse. The Paediatric Sexual Assault Referral Centre (SARC), located within the Rainbow Centre, is commissioned by NHS England Specialist Commissioners, and led by the SARC Clinical Director. The SARC Clinical Director along with the SARC Nurse Manager ensure the highest standards are maintained, and that existing staff have regular training updates.

53. The Safeguarding Team is required to attend multi-agency meetings to discuss findings of medical assessments, produce confidential medical and or Court reports. They also respond to information requests from both partner agencies and the LSCPs in relation to significant safeguarding incidents or other safeguarding partnership functions, such as multi-agency audit or performance management.

54. The Safeguarding Nursing and Practitioner element of the Team is an integral part of the Trust Safeguarding Service, providing leadership, support, and training across the organisation. They play a central role in supporting the medical team, and children, young people, adults at risk and their families involved in safeguarding investigations.

55. The Safeguarding Nurses and Practitioners within the team provide safeguarding supervision to nursing and allied professional groups on all aspects of safeguarding. They also provide support should staff be required to produce a Court report or attend Court.

56. The team also deliver all face-to-face Level 3 safeguarding mandatory training across the Trust.

57. The Safeguarding Team follows the good practice principles highlighted in the National Service Framework for Children (2004), Working Together to Safeguard Children document (2018), the Children Act (1989, 2004) and the Care Act (2014) and aims to promote child and adult centred care, whilst helping and supporting families through the safeguarding process. The Team supports the safeguarding of vulnerable adults whilst recognising the Mental Capacity Act (2005) and the need to 'Make Safeguarding Personal'.

Safeguarding Child Protection Peer Review

58. Peer Review is the evaluation of work by colleagues in the same field in order to maintain or enhance the quality of the work or performance. It is a process to ensure that a child protection assessment and the medical opinion are as robust, accurate and evidence based as possible.

59. Child Protection Peer Review Meetings are the forum within which the findings and examining clinicians' opinions of child protection medical assessments are reviewed. It applies to both planned child protection medical assessment (those examinations booked by Children's Social Care or the Police expressly for the purpose of child protection assessment) and unplanned child protection assessment (where the child protection concern has arisen following the child's presentation to the hospital or paediatric setting).

60. Relevant members of the Safeguarding Team meet via Microsoft Teams on a weekly basis to discuss, and quality assure child protection cases being managed within Alder Hey.

61. Guidance for 'Peer Review in Child Protection' from the Royal College of Paediatrics and Child Health (RCPCH) (2023) states that for Paediatricians, "*Peer Review in Child Protection has become an established component of the Clinical Governance Framework, providing a safe learning environment. Effective clinical governance 'ensures that risks are mitigated, adverse events are rapidly detected and investigated openly, and lessons are learned'. Child Protection Peer Review is expected by the judiciary, GMC, and professional bodies. Evidence of participation should be presented at appraisal and revalidation.*"

62. In addition, safeguarding clinicians attend six monthly joint Peer Review with the Safeguarding Service from Manchester Children's Hospital which ensures there is a consistent approach to the medical safeguarding investigation process by the specialist tertiary services within the Northwest (Northern Heads).

Child Sexual Abuse Peer Review

63. The Sexual Assault & Referral Centre (SARC) Child Sexual Abuse (CSA) Peer Review aims provides a proactive culture of learning where Forensic Health Professionals (FHP), paediatricians and clinical SARC staff can review cases, discuss procedures, process and evidence bases, underpinning diagnosis and management and in doing so, provide a supportive environment to debrief cases with peers undertaking similar work. In turn this will help prevent professional isolation and aid sharing of best practice.

64. CSA Peer Reviews are face to face and held bi-monthly face with the Safeguarding Clinical Team and the Forensic Medical Examiners (FMEs).

Rainbow Multi-Agency Management Meeting

65. The Safeguarding Team host and chair the Rainbow Multi-Agency Management Meeting on behalf of multi-agency partners.

66. The aim of the meeting is to:

- Ensure high standards of care and multi-agency management of the children and young people using the Rainbow Centre.
- Ensure appropriate oversight and clinical governance of the Rainbow Centre and promote high quality care and improved outcomes for children and young people.
- Ensure good communication and excellent multi-agency working in line with Multi-Agency Statutory Guidance.
- Review compliments and complaints in relation to multi-agency processes regarding children who have attended the Rainbow Centre.
- To support and strengthen multi-agency working and highlight any issue regarding poor communication and areas for improvement.
- To discuss cases for the purposes of identifying learning or strengthening multi-agency processes.
- To discuss any new documents, legislation, and research in relation to safeguarding relevant to the work of the Rainbow Centre.
- To share the outcomes of single and multi-agency audits for the purposes of improving knowledge and service delivery.
- To share information regarding inspections, commissioner visits or Peer Reviews in relation to Rainbow and multi-agency partners.

67. Chaired by the Named Nurse for Safeguarding, this meeting brings together key safeguarding leaders from a range of agencies including Alder Hey Safeguarding and Statutory Services, Children's Social Care (Liverpool, Sefton, Knowsley, Halton, St. Helen's, and Wirral), SAFE Place Merseyside, St Mary's SARC, Merseyside Police, Rape and Sexual Abuse Service (RASA), and Rape and Sexual Abuse Service Cheshire (RASASC).

68. Hosting this forum has helped to build good multi-agency relationships and ensure continuous quality improvement.

Safer Recruitment Practices and Managing Allegations Against Staff

69. A vital element of the Trust's safeguarding arrangements is our safer recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults.

70. Alder Hey has a robust Recruitment and Selection Policy, this includes the requirement for Disclosure and Barring Service (DBS) checks as part of our safer recruitment arrangements in line with the NHS Standard Contract General Conditions.

71. Offers of employment at Alder Hey are made on a conditional basis as they are subject to satisfactory NHS safer recruitment pre-employment checks, including verification of identity, right to work, references, qualifications, professional registration (where appropriate), a DBS check and occupational health check.

72. Once employed, all staff are subject to DBS checks every three years during their employment with the Trust.

73. Alder Hey Standard Operating Procedures for Safeguarding Children and Vulnerable Adults have been written in line with the Children Act (1989, 2004), Working Together to Safeguard Children, a guide to inter-agency working to safeguard and promote the welfare of children (2023), LSCPs and LSABs policies and procedures.

74. Section 18 of the Procedures for Safeguarding Children and Vulnerable Adults is used when allegations are made against a person who works with children and their own family has been subject to child protection investigations or criminal prosecution.

75. It is essential that any allegation of abuse made against a professional who works at Alder Hey is dealt with fairly, quickly, and consistently, in a way that provides effective protection for the child or adult at risk and at the same time supports the person who is the subject of the allegation.

76. Allegations may relate to a person who has:

- Behaved in a way that has harmed, or may have harmed, a child or children/ or an adult with care and support needs.
- Possibly committed a criminal offense against children or related to a child, or an adult with care and support needs.
- Behaved towards a child or children or an adult in need of safeguarding in a way that indicates they may pose a risk of harm to children or adults with care and support needs.
- Behaved or may have behaved in a way that indicates they may be unsuitable to work with children or adults with care and support needs.

- Behaved in a way which raises questions about their ability to provide a service to an adult with care and support needs which must be reviewed, for example a conviction for grievous bodily harm against a person who does not have care and support needs.

77. The above-named procedures are overseen and managed by the Associate Director for Safeguarding and Statutory Services in collaboration with the Deputy Chief People Officer who inform relevant senior leaders in the event of a concern.

78. Senior leaders then make a determination regarding whether a referral should be made to the Local Authority Designated Officer (LADO) under the 'Allegations against people who work with children LADO procedures' or to the LSAB under the 'People in a Position of Trust (PiPoT) with adults with care and support needs protocol'.

Safeguarding Policies

79. The Trust has a suite of safeguarding policies which include all relevant thematic areas of safeguarding which are in line with legislation and local, regional, and national guidance.

80. All safeguarding policies and procedures are ratified by the SQAC. An overview of all safeguarding policies and procedures is detailed below including the date issued and the date of review:

Policy Name	Date Issued	Review Status
M2 – Safeguarding Adults Policy	November 2021	Review date November 2024
M3 – Safeguarding Children Policy	November 2021	Review Date November 2024
M70 - Domestic Abuse and Violence Policy	September 2020	Currently being reviewed
M69 – Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) Policy	January 2021	In draft awaiting approval
RM19 – Prevent Policy	June 2021	Review date June 2024
Merseyside Joint Agency Protocol – Sudden Unexpected Death in Childhood (SUDIC)	June 2020	In draft awaiting approval
Standard Operating Procedure Name	**Date Issued**	**Review Date**
Procedures for Safeguarding Children and Vulnerable Adults (Version 14)	January 2020	Currently being reviewed

81. Standard Operating Procedures for Safeguarding Children and Vulnerable Adults outline processes in relation to Child Protection of Children in Specific Circumstances:

- Abuse by children and young people.
- Bullying.
- Children and Young People presenting with Deliberate Self Harm Behaviour.
- Children At Risk of Sexual Exploitation (CSE).
- Out of Area Looked After Children.

- Emotional Support for Victims of CSE And Sexual Abuse.
- Organised or Multiple Abuse.
- Harmful Practices.
- Forced or early marriage.
- So-called ‘honour’-based violence.
- Female Genital Mutilation (FGM).
- Child Abuse linked to a belief in spirit possession or witchcraft or other spiritual or religious belief.
- Dog Bites.

82. All policies and procedures are reviewed and updated in line with any changes in legislation or guidance.

Safeguarding Training

83. Safeguarding is a key part of our Trust mandatory training requirements to develop and embed a culture that ensures safeguarding is acknowledged to be everybody’s business and the ‘Golden Thread’ throughout all services.

84. The Trust is required to maintain safeguarding training for all staff at 90% and this forms part of safeguarding KPIs overseen by Designated Safeguarding Professionals at Liverpool Place on behalf of Cheshire and Merseyside Integrated Care Board (ICB).

85. The NHS England SAAF (2022) outlines that all health providers must have effective arrangements in place to train all staff commensurate with their role and in accordance with the following intercollegiate documents:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).

- Looked After Children: Roles and Competencies of Healthcare Staff (2020)

- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).

86. In addition, the SAAF states that safeguarding must be included in induction programmes for all staff and volunteers. Named Professionals for both Safeguarding and Children in Care present at the face-to-face induction day for all new staff.

87. The Safeguarding Team provides mandatory safeguarding training for both clinical and non-clinical staff in accordance with the Royal College of Paediatrics and Child Health (RCPCH) standards, Royal College of Nursing (RCN), General Medical Council (GMC), Nursing & Midwifery Council (NMC) and Working Together (2023).

88. The Intercollegiate Documents, provide a framework to indicate the level of safeguarding training required for individual staff groups. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth Edition Intercollegiate Document (January 2019) suggests specialist trusts such as Alder Hey should be accessing additional mandatory training, which would include more in-depth safeguarding children knowledge, safeguarding adults and Looked After Children.

89. Level 1 and 2 safeguarding children training is completed via e-learning (with additional face to face sessions for staff unable to access online learning). Staff requiring level 3

safeguarding children and level 2 safeguarding adults were being offered training face to face in person or via Microsoft Teams to maintain their compliance.

90. Compliance for safeguarding and prevent training has been as follows throughout 2023/2024:

Alder Hey Children's NHS Foundation Trust **Percentage % Compliance Rates 2023/24**				
Training Level (Target Compliance 90%)	**Q1**	**Q2**	**Q3**	**Q4**
Level 1 Safeguarding Adults (Every Year)	**92.3%**	**92.3%**	**90.3%**	**91.5%**
Level 2 Safeguarding Adults (Every 3 Years)	**90.5%**	**90.9%**	**89.8%**	**90.3%**
Level 1 Safeguarding Children (Every Year)	**94.7%**	**96.2%**	**95.2%**	**94.7%**
Level 2 Safeguarding Children (Every 3 Years)	**92.3%**	**92.1%**	**91.7%**	**94.2%**
Level 3 Safeguarding Children & Adults (Every 3 Years)	**86.2%**	**86.9%**	**82.1%**	**84.1%**

91. The Safeguarding Team have continued to provide additional safeguarding training sessions in a bid to improve compliance. Training figures for safeguarding mandatory training have reduced to below the 90% compliance target set by Liverpool Place during the year for some training sessions.

92. In 2023/24, 662 staff were trained in Level 3 Safeguarding over 26 sessions (see table below):

Safeguarding Training 2023-24	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**		
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
Level 3 Training Sessions Delivered	1	2	2	2	2	2	4	1	2	3	2	3
Total Number of Staff Face to Face	15	19	27	22	29	20	85	33	29	55	32	88
Total Number of Staff MS Teams	0	7	13	29	26	30	37	0	23	22	17	0
Total Per Month	**15**	**26**	**40**	**51**	**55**	**50**	**122**	**33**	**56**	**77**	**49**	**88**
Total Per Quarter	**81**			**156**			**211**			**214**		
Total 2023-24	**662**											

93. The Safeguarding Team have continued to highlight the reduction in staff compliance to senior leads, service leads, team leaders and individual staff. Safeguarding training compliance is a standardised agenda item at the bi-monthly Safeguarding Operational Group (SOG) which is attended by senior leaders and Divisional Associate Chief Nurses and is held every two months.

94. The establishment of the SOG has helped the Safeguarding Team to have a more focused discussion regarding safeguarding training compliance and work more effectively with Divisional colleagues to address areas with poor compliance.

95. Training compliance continues to be shared with Designated Professionals at Liverpool as part of the KPI quarterly reporting submission.

96. Training compliance is included in the safeguarding quarterly report submitted to SQAC to ensure senior oversight and action regarding supporting non-compliant staff to access mandatory training. The Safeguarding Team work closely with the Learning and Development Team and receive regular reports identifying all staff that are within 90 days of becoming non-compliant.

97. In addition to delivering Level 3 Safeguarding Training, the Safeguarding Team has delivered additional internal targeted training which have included:

- Bespoke Safeguarding Training to Rocking Horse Nursery staff
- Adolescent health and Safeguarding to Emergency Department staff
- Special alerts on records to Outpatients staff and receptionists
- Trust wide 'Spotlight On' session on Safer Sleep
- Voice of the Child
- The Impact of Childhood Trauma in the Early Foundation Years
- Parental and Infant Mental Health
- Safer Sleep
- Acute Life-Threatening Events (ALTEs) and Sudden Unexpected Deaths in Childhood (SUDiC)
- Child Protection Information Sharing (CP-IS) project alerts
- Professional Curiosity
- Child Criminal Exploitation (CCE) and Child Sexual Exploitation (CSE)
- Difficult Conversations
- The Brook Traffic Light Tool Training (Sexually Harmful Behaviour)
- Spotlight on Safer Sleep

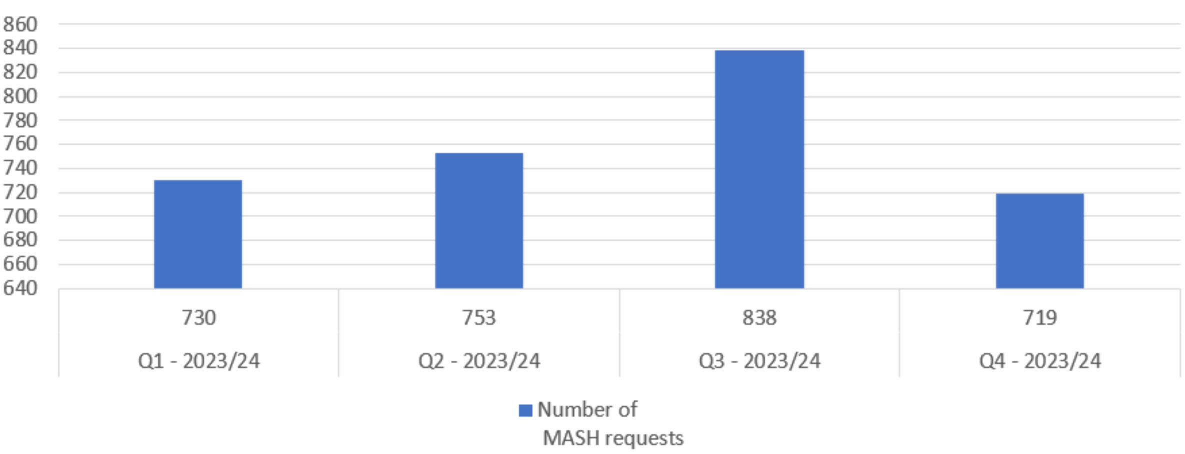
Multi-Agency Safeguarding Processes

Multi-Agency Safeguarding Hub (MASH) Requests

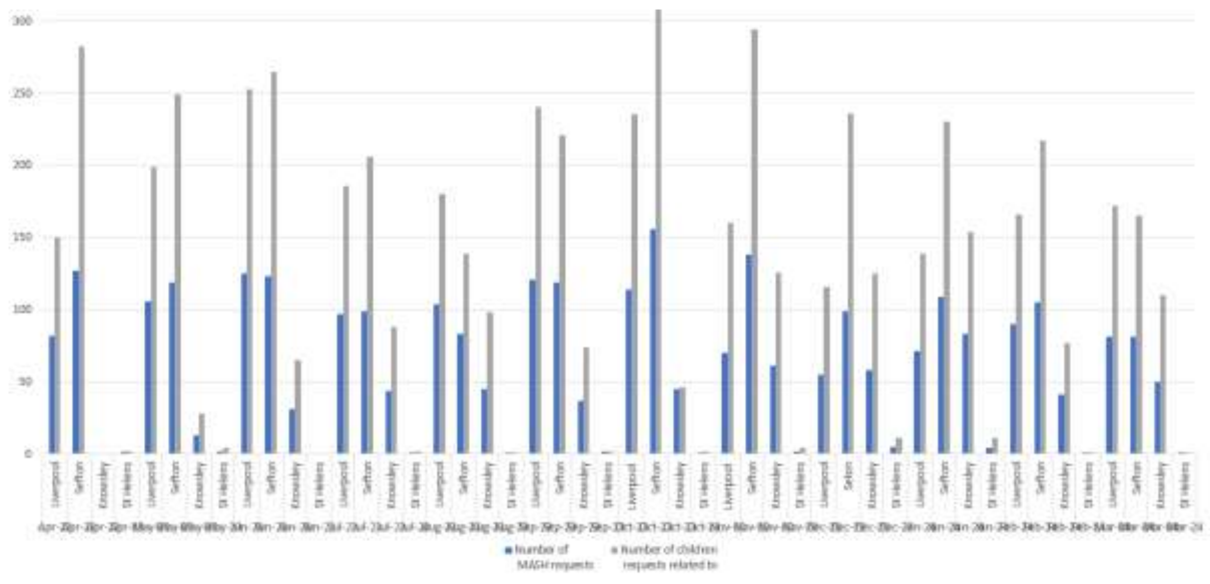
98. Alder Hey Safeguarding Team receives requests from five local authorities to share information with the Multi Agency Safeguarding Hubs (MASH) health representatives in respect of previous attendances and ongoing involvement for children where safeguarding concerns have been raised.

99. The MASH is the front door to Children's Social Care for all child protection and immediate safeguarding concerns which brings together agencies (and their information), to identify risks to children at the earliest possible point and respond with the most effective interventions.

100. In total the Safeguarding Team have responded to **3040 MASH requests** in 2023/24, relating to **6174 children**.



101. The graph below displays the MASH request by area:



102. The volume of MASH requests into the Safeguarding Team continues to be monitored. The Safeguarding Team started to collect data in relation to MASH request commenced from Quarter 3 of 2022/23.

103. When the data from Quarter 3 2022/23 is compared to Quarter 3 2023/24 there has been an **increase of 66.6%** in the number of MASH requests. The number of children MASH requests related to has **increased by 67.9%** between Quarter 3 2022/23 to Quarter 3 2023/24.

104. The overall increase in MASH requests continues to be raised with Designated Professionals for Safeguarding at Cheshire and Merseyside ICB for wider discussion with multi-agency partners.

Alder Hey Referrals into Children's Social Care and Adult Social Care

105. All practitioners have a responsibility to refer a child to Children's Social Care under Section 11 of the Children Act 2004 if they believe or suspect that the child:

- Has suffered significant harm.
- Is likely to suffer significant harm.
- Has a disability, developmental and welfare needs which are likely only to be met through provision of family support services (with agreement of the child's parent) under the Children Act 1989.
- Is a Child in Need whose development would be likely to be impaired without provision of services.

106. The Care Act 2014 defined safeguarding duties as applying to an adult who:

- Has needs for care and support (whether or not the Local Authority is meeting any of those needs) and
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

107. In 2023/24 there were a total of 229 referrals made to Local Authority Children's Social Care and Adult Social Care:

Referrals 2023/24	Q1	Q2	Q3	Q4	Overall Total
Children's Social Care	63	68	55	42	228
Adult Social Care	1	0	0	0	1
Total	**64**	**68**	**55**	**42**	**229**

108. The Safeguarding Team currently quality assure all referrals made to Social Care and our numbers for referrals are scrutinised by Cheshire and Merseyside ICB Designated Professionals for Safeguarding as part of quarterly KPI submission.

Statutory Safeguarding Inquiries and Reviews

109. The Safeguarding Team are required to contribute to the following statutory safeguarding reviews which are commissioned by LSCPs and LSABs:

Domestic Homicide Reviews (DHRs)

110. A DHR is convened by the Local Community Safety Partnership Board, is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

111. In 2023/24 the Safeguarding Team have not been asked to contribute to any DHRs.

Safeguarding Adult Reviews (SARs)

112. A SAR is a multi-agency process that considers whether serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

113. In 2023/24 the Safeguarding Team have not been asked to contribute to any SARs.

Safeguarding Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs)

114. Safeguarding Rapid Reviews are initiated by Local Safeguarding Children Partnerships (LSCPs) following a serious child safeguarding incident where:

- Abuse or neglect of a child is known or suspected; and
- A child has died or been seriously harmed. This may include cases where a child has caused serious harm to someone else.

115. Following a serious safeguarding incident LSCPs conduct a Rapid Reviews which should identify, collate, and reflect on the facts of the case as quickly as possible to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

116. A Rapid Review will determine whether a Local Child Safeguarding Practice Review (LCSPR) should be commissioned using the criteria set out in Working Together 2023. A LCSPR is a multi-agency safeguarding review to identify improvements needed to local practice and wider systems.

117. In 2023/24 the Safeguarding Team have **completed 15 Rapid Review request submissions** from Local Safeguarding Children Partnerships.

118. This area of work is time consuming, complex and involves reviewing and critically analysing distressing information which has a significant impact on the capacity of the Safeguarding Team.

119. The Safeguarding Team also contribute to thematic and reflective reviews of cases of concern or ‘near miss’ scenarios which do not meet the threshold for a LCSPR.

120. A LCSPR is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death and there is cause for concern as to the way in which the relevant authority or persons have worked together to safeguard the child. LCSPRs replaced Serious Case Reviews.

121. The Safeguarding Team have a statutory responsibility to ensure that recommendations and any learning for the Trust from these reviews are appropriately actioned. This involves embedding learning and providing evidence to give assurance to Designated Professionals for Safeguarding at Place and LSCPs that learning has been embedded.

122. In 2023/24 the Safeguarding Team have contributed to **5 Local Child Safeguarding Practice Reviews.**

123. Themes in respect of safeguarding children reviews included domestic abuse, parental and child mental health, neglect, substance misuse, adverse childhood experiences (ACEs), suicide, child sexual abuse (CSA), child sexual exploitation (CSE) and child criminal exploitation (CCE).

124. Key learning themes from all safeguarding reviews across the life course include communication and information sharing between agencies, service user engagement, lack of professional curiosity and professional challenge and the need for improved record keeping.

125. LCSPRs should be completed and concluded within six months. However, the Covid 19 Pandemic resulted in the majority of LCSPRs taking significantly longer. This backlog in completion of LCSPRs has continued throughout 2023/24.

126. The Associate Director for Safeguarding and Statutory Services along with the Named Nurse for Safeguarding work in partnership with Designated Nurses for Safeguarding Children in Liverpool, Sefton, and Knowsley in relation to active LCSPRs.

127. The Alder Hey Safeguarding Team continue to work with relevant services to embed the learning from these reviews and provide assurance both internally within the Trust and externally to Designated Professionals for Safeguarding and the relevant LSCPs.

Channel Panel

128. The Channel Panel is an early intervention safeguarding programme and the element of the national Prevent strategy that provides bespoke support to children and adults identified as being vulnerable to radicalisation, before their vulnerabilities are exploited by terrorist recruiters who would encourage them to support terrorism, and before they become involved in criminal terrorist related activity.

129. Like other safeguarding interventions, Channel Panel works by identifying individuals at risk of radicalisation via referral, assessing the nature and extent of the risk and then

developing a support plan for the individual concerned. It is a confidential and voluntary programme. Referrals come from a wide range of partners including the police, health professionals, schools, youth offending teams, children and adult services as well as members of the public.

130. The Channel Panel takes a multi-agency approach tailoring support to individual need. The type of support available is both bespoke and wide ranging and includes help with accessing mainstream services such as education, career advice, dealing with mental or emotional health issues, drug/alcohol abuse and theological or ideological mentoring from a specialist Channel Intervention Provider who works with the individual on a one-to-one basis.

131. As with other safeguarding work streams, Channel Panel is fluid in terms of the number and complexity of cases at any given time. The Safeguarding Team has attended monthly and contributed to the discussion and sharing of information pertaining to **43 children and young people** at Channel Panel. The team support Channel Panel not just by attending and contributing to the meetings, but also by information sharing and acting as a conduit between Channel Panel and Alder Hey Services.

Safeguarding Team Meditech Orders

132. The Team also receives a significant number of safeguarding orders via our Electronic Patient Record System (EPRS) Meditech from across the Trust in relation to safeguarding issues which require specialist support and guidance. These may include concerns regarding parental substance misuse or parental mental health concerns, domestic abuse, chronic neglect, self-harm, Perplexing Presentations/Fabricated and Induced Illness, non-attendance known as ‘Was Not Brought’, non-compliance, or complex discharge issues.

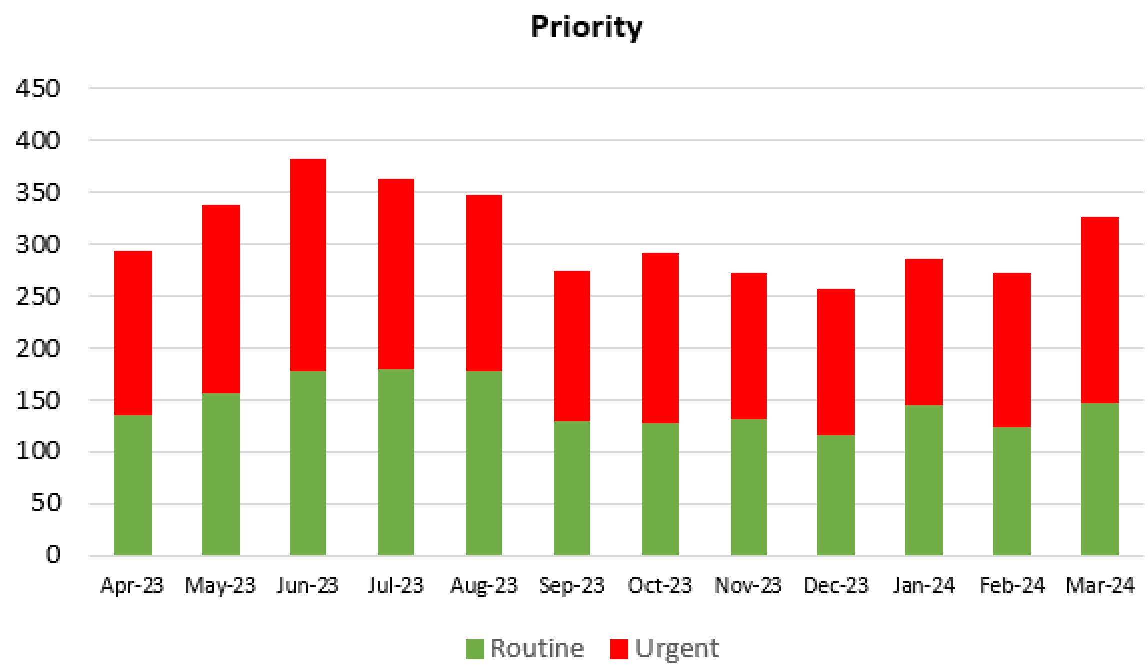
133. The Safeguarding Team have been working with digital colleagues to develop a data dashboard which outlines the current demand upon the service in respect of safeguarding orders.

134. At the end of 2023/24 the first iteration of the dashboard highlighted that the Safeguarding Team have received 3691 safeguarding orders in 2023/24 as follows:

Orders by Priority

Priority	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Routine	137	157	179	180	178	130	129	132	118	146	125	148	1759
Urgent	156	180	203	181	169	143	161	140	137	138	146	178	1932
Total	**293**	**337**	**382**	**361**	**347**	**273**	**290**	**272**	**255**	**284**	**271**	**326**	**3691**

135. The data reflects that **1759 were classified as 'routine'** and **1932 being classified as 'urgent'**.



136. Access to this data helps the service to better understand demand and manage capacity going forward. The Safeguarding Team will continue to work with digital colleagues to gather relevant data to inform planning.

Contributions to Local Safeguarding Adult Boards (LSABs) and Local Safeguarding Children's Partnership (LSCPs)

137. The Alder Hey Safeguarding Team continue to work with Designated Professionals to support the work of the LSCPs and LSABs (Liverpool, Sefton, and Knowsley) where appropriate. This has included developing action plans in response to recommendations and findings from Rapid Reviews/Critical Incident Meetings and Local Child Safeguarding Practice Reviews (LCSPRs) and Safeguarding Adult Reviews (SARs), ensuring they are robust and actively address any areas for practice improvement.

138. The Safeguarding Team has a vital role in embedding findings, recommendations and learning in front line practice; and ensuring Alder Hey can evidence impact of intervention. The team also takes a lead role in identifying wider thematic learning and ensuring that these themes inform our planning for workforce development, training, and quality assurance processes.

139. The introduction of the Children and Social Work Act (2017) brought about significant changes for safeguarding children. Local Safeguarding Children Board were abolished, and Local Safeguarding Children Partnerships were created. These changes resulted in NHS Provider Trusts being asked to step back from attendance at various LSCP forums Executives and Sub-Groups.

140. During 2023/24 the Alder Hey Safeguarding Team participation in LSCPs Sub-Groups has dramatically increased along with the requirement to work with Local Authority

Children's Social Care partners in their improvement journeys. This has been a welcome development and has allowed the Trust to better contribute to multi-agency safeguarding work, however it has significantly impacted on the capacity of the Safeguarding Team.

Successes During 2023/2024

Review of Safeguarding Level 3 Training

141. During 2023/2024, the Safeguarding Team reviewed and updated the Level 3 safeguarding training to ensure the Trust safeguarding training offer fully complies with the intercollegiate documents. This resulted in the face-to-face component of level 3 training being extended to a full day of training.

142. The Safeguarding Team worked with Learning and Development colleagues to develop and present a proposal to the Education Governance Meeting regarding the number of hours needed. The Team reviewed and developed the content of the training to ensure it reflects learning from local and national safeguarding reviews and engages staff.

Establishing a Safeguarding Operational Group

143. In 2023/24 a Safeguarding Operation Group (SOG) was established to build on the improved governance arrangements for safeguarding following the creation of SASSAG in 2022/23.

144. The SOG has improved operational discussion and divisional engagement in relation to safeguarding issues. The bringing together from staff across the Trust allows the exploration of safeguarding themes and trends and ensure that lessons learned from incident reviews and safeguarding reviews are embedded.

145. The Safeguarding Operational Group is accountable to the SASSAG and minutes from each meeting are submitted to SASSAG.

Safeguarding and Statutory Services Resource Review

146. In 2023/24 the Associate Director for Safeguarding and Statutory Services will work with Named Professionals for Safeguarding to review existing resource within the team with a view to developing business cases if additional resource is required.

147. A business cases was submitted to Cheshire and Merseyside ICB (C&M ICB) for additional funding in Statutory Services which was successful as follows:

    - 1 WTE Band 7 Specialist Nurse for Children in Care
    - 1 WTE Band 3 Administration Support for Statutory Services
    - 11 Programmed Activities (PAs) of a Medical Advisor for Fostering and Adoption. This is a statutory role completed by a Consultant Community Paediatrician.

148. In addition to the above business cases were completed and approved within the Trust for the following roles within Safeguarding and Statutory Services:

- 6 PAs of Named Doctor for Children in Care to be completed by a Consultant Paediatrician.
- 2 WTE Band 6 Sexual Assault Referral Centre (SARC) Nurses
- 2 WTE Band 7 Safeguarding Specialist Nurses
- 1 WTE Band 4 Pathway Co-ordinator for Child Death
- 1 WTE Band 3 Safeguarding Health Care Assistants
- 1 WTE Fixed Term Band 3 Administration Support Role

Child Death Policy and Processes

149. During 2023/24, the Safeguarding Team have been working with Brilliant Basics to fully scope out child death processes across the Trust. The Safeguarding Team have formally agreed and approved the new child death flowcharts with support from colleagues in the Emergency Department, Snow Drop Team (Bereavement), Mortuary Team, and Hospital Response Team in the implementation of the new arrangements.

150. The Trust has contributed to the review of the Cheshire and Merseyside Sudden Unexpected Death in Childhood (SUDiC) Protocol and our child death flowcharts will be included in this multi-agency document.

151. Once the SUDiC Protocol has been agreed across Merseyside it will be presented to SQAC for inclusion on the Trust Document Management System (DMS). An Alder Hey Child Death Policy will be developed in 2024/25 once the SUDiC Protocol has been agreed and finalised to ensure they align.

Safeguarding and Statutory Services Away Day

152. The first away day for Safeguarding and Statutory Services was held on 06 October 2023. All staff from across the three strands of the service which includes safeguarding (operational and corporate functions), Sexual Assault Referral Centre (SARC) and Statutory Services - Children in Care, Adoption and Fostering.

153. The agenda for the day included:

- Safeguarding and Statutory Services Overview
- Psychological Safety and Team Values
- Capturing Team Views & Looking to the Future
  - Achievements - What's working well?
  - Challenges - What are we worried about?
  - Priorities - What do we think needs to happen?
- Thematic Discussions in relation to:
  - Roles, Responsibilities and Expectations
  - Service Operation
  - Record Keeping
  - Morale and Psychological Safety
  - Communication
  - Children and Young People Voice and Patient Experience
- Alder Hey Vision 2030
- Safeguarding and Statutory Services Vision and Strategy
- Service Priorities 2024/25

154. The team were grateful to the Managing Director and Community & Mental Health Division for opening the day and sharing their reflections on the service achievements and challenges.

Challenges During 2023/2024

Named Professionals and Safeguarding Capacity

155. Whilst Alder Hey has identified clinicians in the Named Professional Safeguarding roles there have been challenges through 2023/24 in relation to the roles being fully completed due to key personnel being absent.

156. This has significantly challenged the capacity of the senior nursing leaders regarding the management of safeguarding issues such as Perplexing Presentations and Fabricated and Induced Illness (FII) cases.

157. The interview process for the Named Nurse for Safeguarding took place in the week commencing 26 February 2024. The process included a panel face to face interview, a cross divisional staff focus group and a focus group with children and young people from The Forum. The Named Nurse for Safeguarding will commence in post on 01 May 2024.

158. Recruitment is in progress for the Named Doctor for Safeguarding with interviews planned in Quarter 1 of 2024/25. The interview process will include a panel face to face interview, cross divisional staff focus group and a focus group with children and young people from The Forum.

159. During 2023/24 there were gaps in both the 1st On Call and 2nd on Call (Consultant) medical rotas for Safeguarding. The usual 1 in 7 Safeguarding Consultant Rota was reduced to 1 in 4 at point within the year due to long term sickness and changed work patterns. The Safeguarding Consultants have kindly worked additional hours to cover gaps and the Service has continued to operate safely.

160. These challenges were added to the Service Risk Register, and mitigations put in place to safely staff the Service.

161. It is anticipated that the additional investment in Safeguarding and Statutory Services (outlined below) will help to improve the capacity of the Service in the context of increasing demand.

Contributions to Local Safeguarding Adult Boards (LSABs) and Local Safeguarding Children's Partnership (LSCPs) and Local Authorities.

162. The Alder Hey Safeguarding Team continue to work with Designated Professionals to support the work of the LSCPs and LSABs (Liverpool, Sefton, and Knowsley) where appropriate. This has included developing action plans in response to recommendations and findings from LCSPRs and SARs, ensuring they are robust and actively address any areas for practice improvement.

163. As outlined above Liverpool and Sefton SCPs have reviewed their safeguarding partnership arrangements following recent Ofsted Inspections and have now requested that health providers attend several forums and sub-groups.

164. Whilst this is a positive development this has significantly increased the number of meetings the Alder Hey Safeguarding Team are required to attend.

165. As part of the service work with LSCPs and LSABs the Safeguarding Team participates in multi-agency audits and works to embed findings, recommendations and learning into front line practice, ensuring Alder Hey can evidence impact of intervention.

Safeguarding Priorities for 2024/2025

Safeguarding Policies & Standard Operating Procedures

166. During 2024/2025, the Safeguarding Team will comprehensively review all Trust Policies and SOPs owned by the team to ensure they are compliant with NICE guidelines, statutory guidance and LSCPs policies.

Safeguarding Patient Pathway Review and Digitalisation of the Service

167. The Safeguarding Team will work with a divisional Project manager to map the current patient pathway thorough Safeguarding and Statutory Services. This work will help us to identify outstanding policies and SOPs, documents for review and opportunities to digitalise the Service which remains largely paper based.

Improving Patient Experience

168. The Safeguarding Team will work with children and young people to improve the patient experience across Safeguarding and Statutory Services.

Improving Visibility of the Safeguarding Team

169. The Safeguarding Team will work with divisional colleagues to improve the visibility of the team across the Trust and outline the role and function of the team. This will provide a good opportunity for the new Named Professionals to build strong networks and inform future service planning.

Conclusion

170. The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee Trust safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in our care.

171. Work continues to train and develop the Alder Hey workforce to recognise and respond to abuse to safeguarding children, young people, and adults at risk in the Trust’s care at the earliest opportunity.

172. There are good safeguarding systems in place across the Trust. However, there continues to be challenges as safeguarding continues to evolve, in both complexity and scope, and with new and emerging risks in respect of contextual safeguarding. As a

result, the Trust must ensure that all safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

173. The Safeguarding Team remains committed to ensuring that children, young people, and adults at risk using our services are safe, and that their health needs are met. The Safeguarding Team will continue to work collaboratively with all Trust colleagues and key partners to continuously improve systems to safeguard.

174. This Safeguarding Annual Report for 2023/2024 has focused on the governance arrangements in place to deliver the safeguarding agenda; and the role that the Safeguarding Team plays in providing assurance, both internally and externally, so that the Trust fulfils its statutory safeguarding responsibilities.

175. Trust Board and the SQAC are asked to note the content of this report and accept assurances that systems and processes are in place to ensure Alder Hey Children's NHS Foundation Trust fulfils its statutory safeguarding responsibilities.

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	**Trust Mortality Report Quarter 1 2024-25**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass/Julie Grice

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

Does this relate to a risk? Yes ☐ No ☑

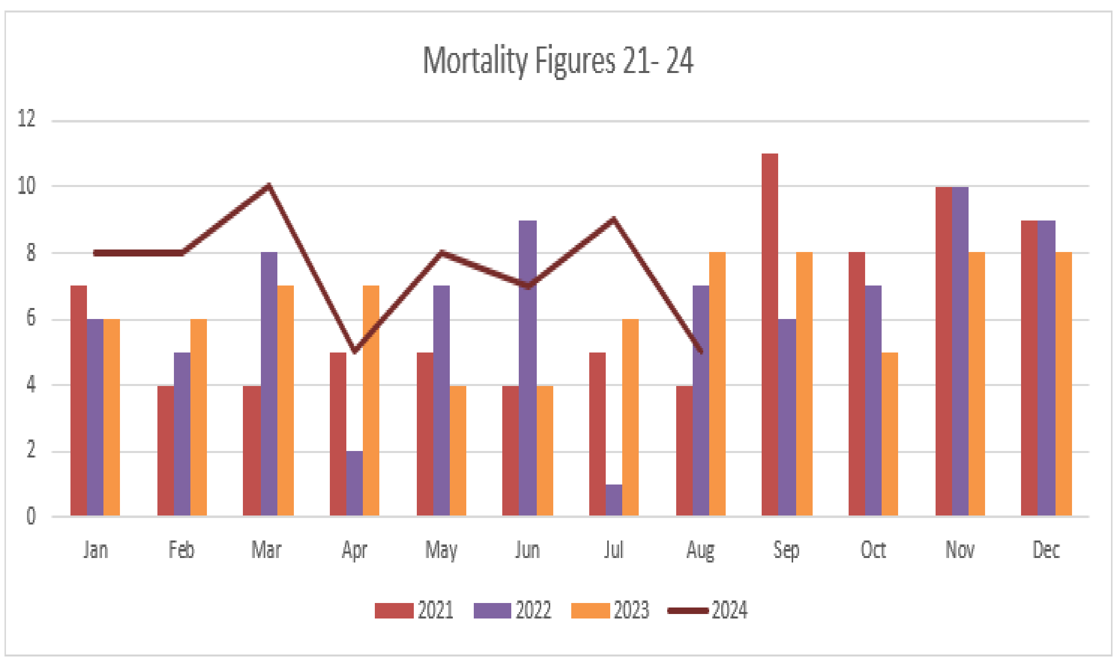
If "No", is a new risk required? Yes ☐ No ☐

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

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

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

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



This graph above denotes the number of deaths at Alder Hey. The trend shows a higher death rate than previous years to date. However, there are often fluctuations and the average over the year is usually similar. The group have noted that there does still appear to be an increase in the number of out of hospital cardiac arrests over the last 6 months and this has been highlighted to the Liverpool CDOP (Child Death Overview Panel) for further scrutiny. Out of hospital cardiac arrest is an uncommon paediatric presentation, and the prognosis is poor.

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

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

   The AHCH pilot for the ME process began in March 2024 and became a legal requirement from September 2024. The ME process at AHCH is being undertaken by the Liverpool University Hospitals NHS Foundation Trust Medical Examiner Service, and they are supported by two pediatricians (1 actively working & 1 recently retired from AHCH). There have been 51 paediatric deaths scrutinised by the ME team to date.

   In this period, 6 incidents have been reported via InPhase with no common theme. The clinical and bereavement teams are being encouraged to complete incident forms to ensure ongoing learning and improvement whilst the new system becomes embedded in practise.
   a) 1x MCCD rejected by the local Registrar.
   b) 1x death not scrutinised due to issues contacting ME. This was a faith death and therefore there was an urgency for the body to be released for burial.

   It is worth noting that this new system may adversely impact on members of our population in whom an early burial is required for reasons of faith. There is a longer delay from when the death certificate is written, until it can be sent to the registrar to authorise the release of the body to allow for medical examiner scrutiny. Currently, there are not medical examiner services at the weekend or on bank holidays. However, it is important to consider that the registrars would also need extended opening hours (currently now all open weekends/BH) and some mosques are unable to carry out burials at the weekend. The Medical Examiner Office are aware and working in collaboration with other services to find a solution.

2) As highlighted in the previous mortality reports, there are ongoing issues with administration support for the HMRG process. There was limited admin support for some months and then a period of time with no admin support. A new administrator has started but there is a significant backlog with both the HMRG database and completing forms so that

they can be sent to the Child Death Overview Panels. It will take time for the administrator to become established and hence the performance of the group may continue to decrease as these issues are addressed.

3) The need for translating services to support the bereavement process. It is recognized that the invitation for families to provide feedback to the child death review process and to be invited to a bereavement follow up should be in their first language if their understanding of English is limited. A process is being formalized so that the Snowdrop (bereavement) team will ensure that letters are translated when necessary.

4) Postmortem (PM) reports in the event of a Coroner's PM are sent by the Coroner's officer to the family. The treating clinicians are not always made aware. Following family feedback, we have discussed this with the Coroner's Chief Clerk and they will now contact the Snowdrop (bereavement) team by email to inform them so that the Snowdrop team can offer the family support and inform the lead clinician that the PM has been received.

5) The HMRG Review form updated in accordance with the National Child Database guidance to ensure compliance and all relevant data collected to ensure maximum learning.

Current Performance of HMRG

Summary of 2024 Deaths

Number of deaths (Jan. 2024 – Sep. 2024)	60
Number of deaths reviewed	21
HMRG Primary Reviews within 4 months (standard)	21/26 (81%)

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

Most cases are 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 2024

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

Potentially Avoidable Deaths

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

Learning disabilities

The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 21 cases, so far reviewed in 2024, 10% 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.

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

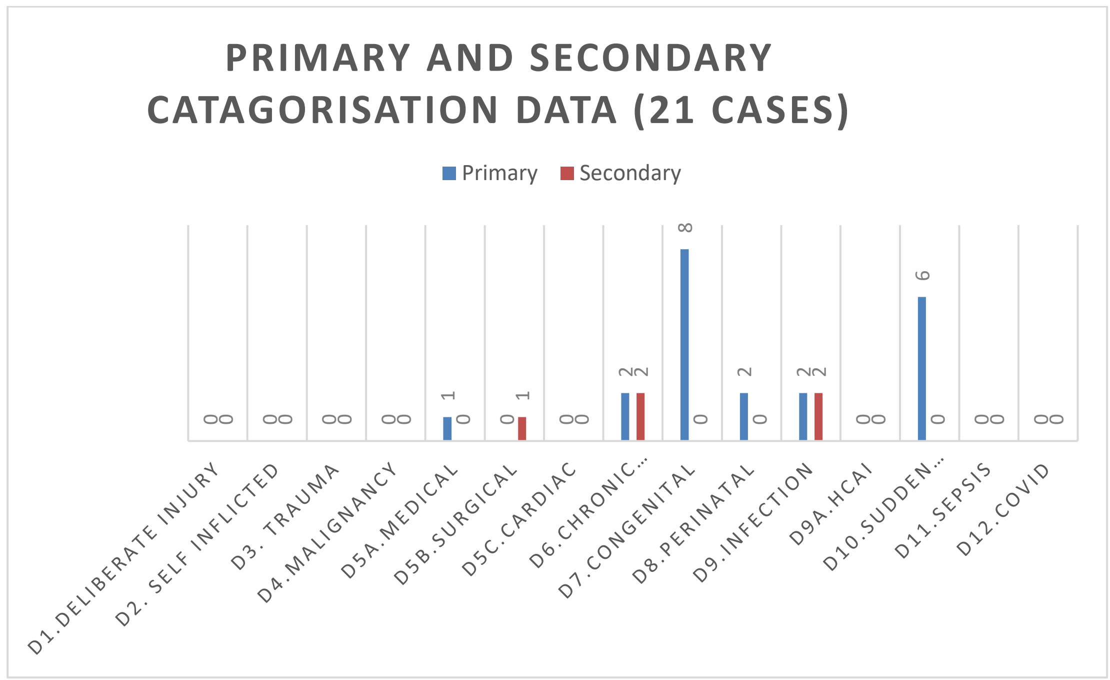
Family

The Snowdrop (bereavement) team at Alder Hey provide an excellent service, supporting the family after a patient has died. There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to 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. We do not send family's the HMRG forms as, in keeping with the child death review guidance, a plain English summary is written 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

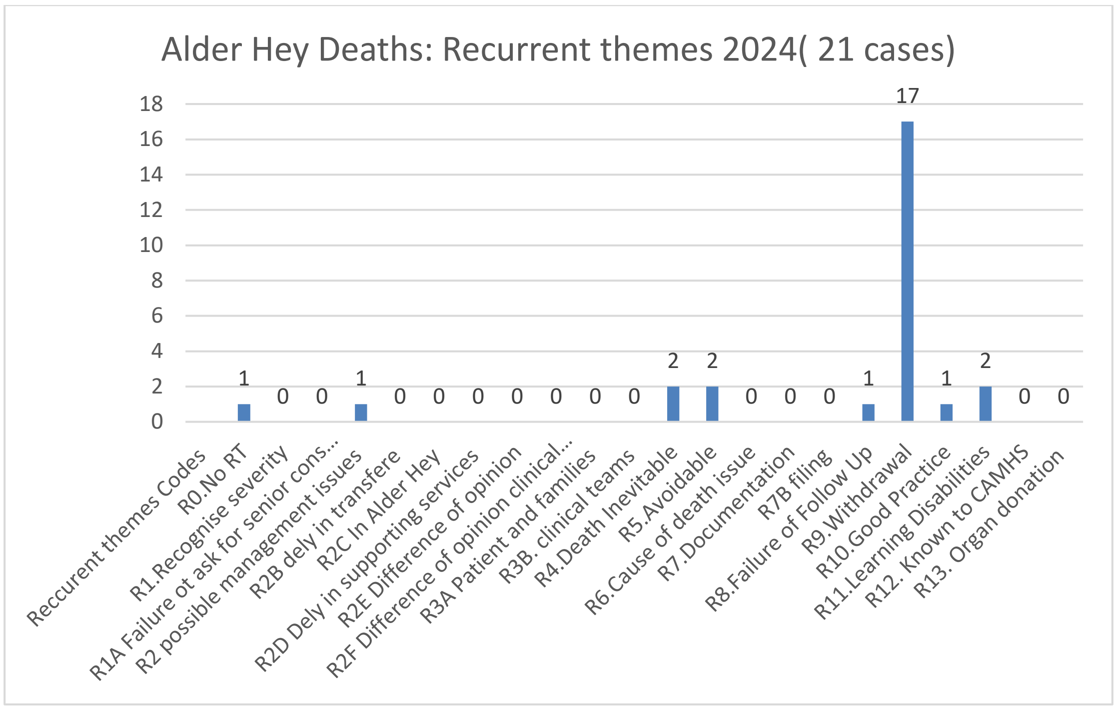


The cases reviewed in 2024 show that the highest diagnostic code is 'children with underlying chromosomal, genetic and congenital conditions' (38%). These are often complex and vulnerable patients. These conditions, depending on the case, can be life limiting and often the care they have received by AHCH and their families have enabled them to live longer than anticipated.

Next, with 29% is the diagnostic code: 'SUDI – Sudden unexpected death Infant /child. These are the cases which follow the coronial pathway so the coding will be changed if appropriate following PM or more information. This would include the out of hospital cardiac arrest which were mentioned above as increasing in frequency.

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

Recurrent Themes



The main recurrent theme in 2024 to date is withdrawal of life-sustaining care (81% of cases). This demonstrates that the intensive care team are working with families to ensure that no child/young person suffers unnecessarily when available treatment options are no longer felt to be in the best interests of the C/YP.

Death was concluded to be inevitable in 10%, regardless of the care and expertise that was provided at AHCH. This category also includes the cases where death was inevitable with hindsight. These cases are included to highlight that it is not a reflection on the care AHCH provides as children are transferred for investigations which then indicate conditions which are life-limiting.

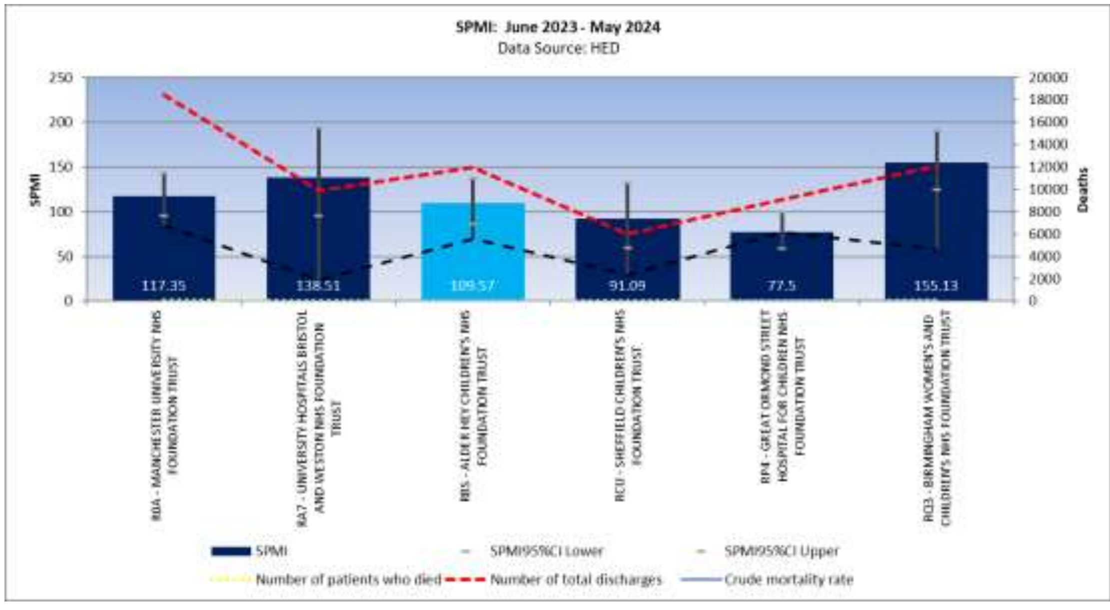
The LD and avoidable deaths have been discussed earlier in the report.

Section 2: Quarter 1 Mortality Report: April 2024 – June 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.



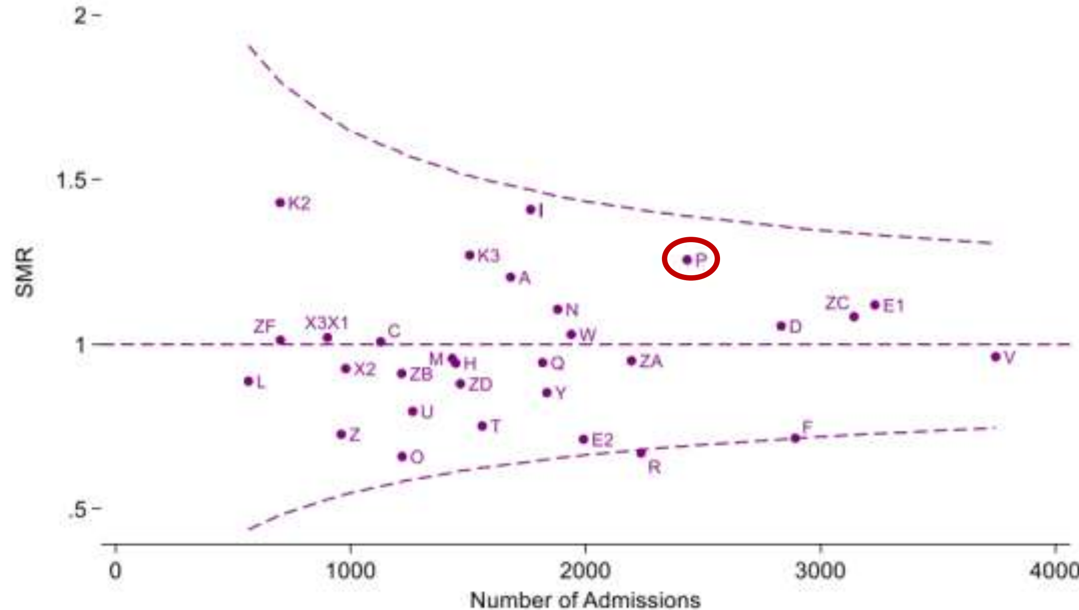
The chart shows that Alder Hey has performance of 76 deaths against 70 expected deaths. This is slightly higher than expected but there have been an increased number of out of hospital cardiac arrests with an associated poor outcome. Over this period there were also a significant number of cases which were coded as death inevitable so there was nothing that could be done resulting in increased mortality 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 (PICANet State of the Nation Report 2023, including data from 2020-2022), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
There was no evidence that any PICU had an excess mortality rate compared to what would be expected based on the level of sickness at the time of

admission across the three-year reporting period. This is illustrated in Figure 5 based on inclusion of all SMR estimates being contained within the control chart limits.

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



Key
——— SMR = 1 (expected deaths are equal to observed deaths)
- - - - 99.9% control limits[2]

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

Statistical analysis of mortality:

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

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.

The mortality rate in PICU for 2024 to date is currently 7.27. This is comparable to 2023 where it was 7.23. During the months of April, May and June, we had 4, 7 and 5 deaths respectively. Prior to this, a peak in March of 12 deaths caused a rise in the RSPRT, but this did not reach the upper threshold to trigger a reset. Rather, there was a downward trend towards baseline in May. Currently for the RSPRT we remain with the 'safe zone'.

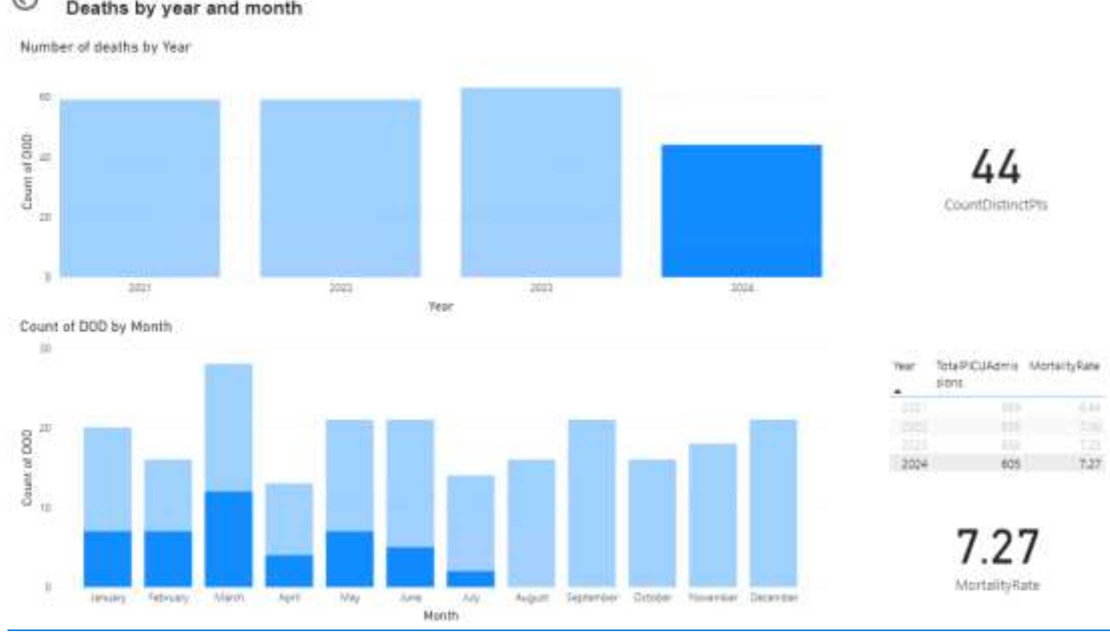
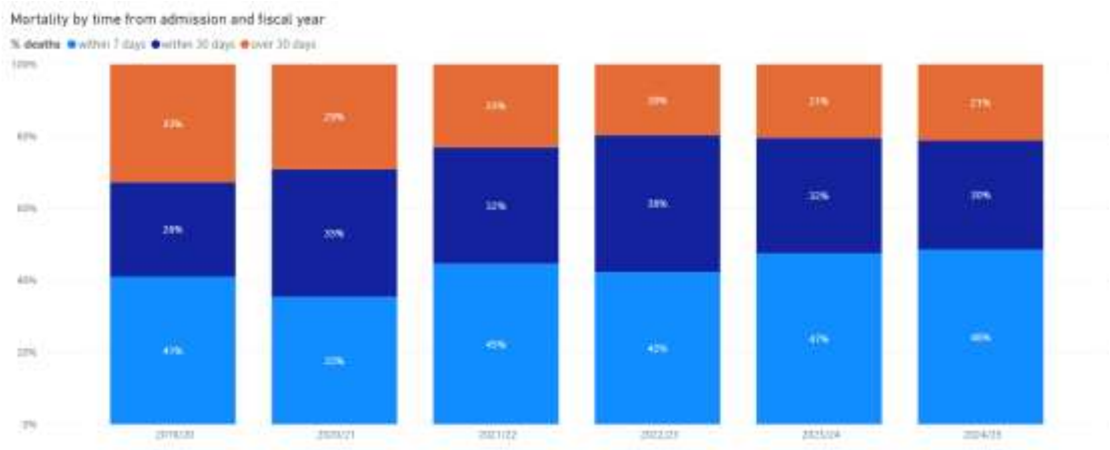


Figure 1: PICU mortality dashboard updated 12.07.24

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 41-48% of deaths occur within this time frame. In the financial year April 2024 – June 2025, 48% occurred within 7 days of admission, 30% occurred within 8-30 days from admission, and 21% of deaths occurred over 30 days from admission.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner. The 4-month review target is running at an acceptable level in view of the workload and the complexity of the cases. The drop in the cases completed within the 4/12 target is due to administration issues resulting in a work backlog. The aim is for this to be addressed over the next quarter. The ME process continues to evolve and we will monitor to ensure no undue impact on the families.

There are no concerning trends that have been identified for patient deaths and all issues that have been raised by staff or families, have work underway to try and resolve them. The two potentially avoidable deaths as a result of external factors will be reviewed and acted upon by the relevant CDOP (Child Death Overview Panel). AHCH has representation on the panel so there should be

clear communication between the two organisations enabling all possible learning.

References

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

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

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 10**

BOARD OF DIRECTORS

Thursday, 3rd October 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 25th September 2024, along with the approved minutes from the 24th July 2024 meeting.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
1.1. 1.2. 1.4.	Inability to delivery safe and high-quality services Children and young people waiting beyond the national standard to access planned care and urgent care Access to children & Young People's Mental Health					9 20 15
Level of assurance (as defined against the risk in Inphase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

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

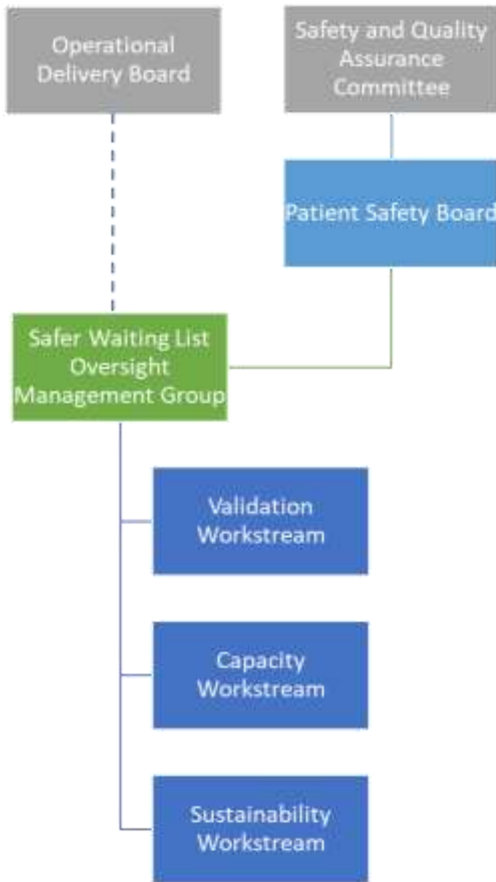
- SQAC noted the Patient Safety Strategy update. SQAC agreed to receive a detailed update at the October SQAC meeting regarding antimicrobial resistance. SQAC also raised questions regarding natSIPPs on which SQAC received clarification.
- SQAC received the ED monthly report, ED@ its best update. The positive update was welcomed: SQAC noted the positive statistics regarding time to triage and the overall waiting times. SQAC noted the challenges regarding Sepsis and delivery of antibiotics within 1 hour and sepsis training.
  SQAC noted the month-on-month variations in the paediatric assessment unit statistics with regards to the pathways for those patients, which would be interrogated further.
- SQAC received the Quarterly Infection Prevention Control Report. SQAC noted prior warning of national challenges regarding C difficile and a good discussion was held regarding healthcare acquired infections, with some suggestions regarding how to raise awareness.
- SQAC received the Safe Waiting List: Outcome of Validation work update, SQAC noted the good progress regarding understanding the data and capacity to address this issue. SQAC approved the governance and reporting arrangements which were proposed, with update to be shared with the Board of Directors – see Appendix 1. SQAC also noted the need to identify and share good practice between specialities.
- SQAC received the Board Assurance Framework with good discussion held. SQAC noted the shift with regards to the risk profile of risk 1.2 Access and identified a couple of developments with regards to risk 1.1.
- SQAC received the Mortality Report, with no significant concerns raised. SQAC would receive a future update regarding out of hospital cardiac arrests which are not unique to Alder Hey, and is a potentially worrying national trend.
- SQAC received the first Gender Development Service quarterly report, with positive developments noted.
- SQAC received the Clinical Effectiveness & Outcomes Group Chair's Highlight Report which highlighted a couple of issues that required attention, particularly regarding one of the data sets which we are required to report on nationally and where the Trust requires a solution to be created to enable this.
- SQAC received the Liverpool Neonatal Partnership Integrated Governance Report. SQAC noted that the LNP Board meets regularly and that K Byrne has joined the LNP Board. SQAC noted that there are challenges regarding recruitment to the Speech & Language Therapy position. Good discussion was held regarding how the PSIRF methodologies are making a difference to how incidents are being follow up.

- SQAC received the Divisional updates and noted the successes and challenges across the divisions.
- SQAC received the Health Inequalities Report, with good discussion held regarding the early success regarding being able to launch a vaccine catch-up programme for some of our very vulnerable patients and also the proposed launch of the anti-vaping/do not vape service.
- SQAC received the Ward Accreditation Report – N Askew to address issues offline regarding the frequency and vigor of Ward Accreditation across the organisation.
- SQAC received the Quality Assurance Rounds Report. SQAC agreed it would be helpful to supplement this overview of Quality Assurance Round themes and outcomes with examples of good practice, and indications of agreed actions. F Beveridge to share the Quality Assurance Round Report with Non-Executive Directors.
- SQAC received the Research quarterly update which summarised the monthly divisional update and the longer-term overview of the Research Division. SQAC welcomed future Research Quarterly reports containing updates regarding developments and building up on capacity within research and a stronger focus on new studies within the Research Division and progressing with the Research Strategy.
- SQAC received and Ratified the Incident Reporting and Management Policy subject to any minor amendments.
- SQAC received and Ratified RM47 – Duty of Candour Policy subject to any minor amendments.
- SQAC received and Ratified C56 – Parental Nutrition (PN) Policy
- SQAC received and Ratified C53 – Vaccine Cold Storage Policy
- SQAC received and Ratified C69 – Chaperone Policy subject to any minor amendments
- SQAC received and Ratified Patient Safety Partner Policy

4. Recommendations & proposed next steps

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

SQAC agreed the Safe Waiting list governance arrangements, and agreed to receive a Safe Waiting List update at SQAC on a quarterly basis.



Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 24th July 2024
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing, AHP & Experience Officer, Chair (ACCN)	(NA)
	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	John Grinnell	Managing Director	(JG)
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	(JP)
	Laura Rad	Head of Nursing – Research	(LR)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Cathy Wardell	Associate Chief Nurse, Medicine Division	(CW)
	Kate Warriner	Chief Transformation and Digital Officer	(KW)
In Attendance:			
24/25/76	David Porter	Consultant Infection & Immunology, Sepsis Lead	(DP)
24/25/81	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	(NO)
24/25/85	Sophie Stubbs	Analytics Lead, iDigital	(SS)
24/25/88	Susan O'Neil	Deputy Head Neonatal Nursing Liverpool Neonatal Partnership	(SN)
24/25/89	Kelly Black	Head of Nursing and Allied Health Professionals, Division of Surgery	(KB)
24/25/91	Andrea Gill	Interim Principal Pharmacist & Senior Research Pharmacist	(AG)
24/25/93	Grace Khong	Consultant ENT Surgeon	(GK)
	Leila Brown	Associate Director – Digital Transformation	(LB)
	Hilary Peel	Governor	(HP)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)
Apologies:			
	Pauline Brown	Director of Nursing	(PB)
	Bea Larru	Director of Infection Prevention & Control	(BL)
	Gerald Meehan	Non-Executive Director	(GM)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RP)
	Laura Rad	Head of Nursing - Research	(LR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS)

24/25/71 Welcome and Apologies

The Chair welcomed everyone to the meeting and particularly welcomed Hilary Peel, Governor who was observing SQAC meeting.

24/25/72 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.

24/25/73 Minutes of the Previous Meeting

The Committee members were content to APPROVE the notes of the meeting held on 19th June 2024.

24/25/74 Matters Arising/Review of Action log

The action log was reviewed and updated.

FB advised that as in previous years that SQAC would not formally meet in August 2024. FB advised that the SQAC data pack would be issued in August 2024, and should colleagues have any comments or questions relating to any of the reports contained within the data pack that issues should be raised

with report authors. FB stated that should there be an urgent requirement for discussion in August that a smaller meeting would be convened to focus on any issues raised.

24/25/75

Assurance on Key Risks
Delivery of Outstanding Care
Safe

Patient Safety Strategy update

JR presented the Patient Safety Strategy update

- Patient Safety Strategy Board had applied careful scrutiny to workstreams 1, 16, 17, 21 and 22.
- As PSIRI panel is now embedded there is a general downward trend in the number of incidents resulting in harm reported in the last 7 months, with an upward trend in incidents reported resulting in no harm. JR stated that colleagues are hoping that this is due to the correct use of the risk harm classification and challenge regarding why staff are reporting the level of harm, and colleagues can amend accordingly.
- Metrics are reporting an increase in restrictive interventions, this currently relates to a young person who is sectioned under the Mental Health Act.
- PALS - 5 day response rate had remained over 90%.
- Despite the number of formal complaints received increasing for the 2nd month there had been a continuing trend in maintaining the timely response to those complaints and their families within the 25 days.
- All objectives had been achieved for Workstream 16 – Learning Disabilities and Autism, Patient Safety Strategy Board are pending delivery of a closure report, this would then transition to business as usual.
- Patient Safety Strategy Board had noted the continued improvement in ED 60 minute antibiotic compliance of greater than 90%.
- Workstream 17 – Antimicrobial Resistance - Patient Safety Strategy Board had noted that there had been little uptake in relation to IV to oral switch antibiotic training by nursing staff despite interest from the Practice Educators, this is being addressed by the pharmacy team and a programme manager had been offered for support.
- Workstream 21 – Total Parental Nutrition – whilst the number of instances reported had been low, there had been an increase in April 2024, specifically relating to the management of lipids.
- Workstreams 22 –Unacknowledged notices, the Unacknowledged notices are continuing to accumulate, currently circa 7,000 Unacknowledged notices had not been reviewed over 28 days. Dashboard highlighted challenges of tracking notifications mainly for junior colleagues and leavers.
- JR advised that the DMO had assessed the overall programme as positive, with no escalations required.
- Sepsis trend towards reducing the inpatient 60 minute antibiotic dose compliance had decreased to below 90%, this is due to a number of reasons, one of which relate to the national training package, which is not functioning correctly, the Learning & Development team are supporting the Sepsis team to find alternative solutions.

KB referred to the antimicrobial workstream and alluded to a lack of protected time, surgery input into MDT, and lack of admin support and alluded to any interventions required as the key themes report only relate to ICNET. JR stated she had not been involved in the discussions.
Resolved: NA advised that JR would relay KB comments to the Antimicrobial Steering Group, and that an update would be provided to KB offline.

NA expressed his concern regarding the Unacknowledged notices and the increasing trend across all Divisions. NA stated that he is uncertain that there is sufficient traction to manage the increasing Unacknowledged notices and queried whether Dr M Neame should provide an update to SQAC at September 2024 meeting.

ABA advised that he had met with Dr. Neame on 23.7.24, and that the data presented is slightly out of date as the data is from May 2024. ABA advised that 15 clinicians had been identified who had accumulated significant numbers of Unacknowledged notices. ABA had written to these clinicians individually with support to manage the Unacknowledged notices, this had resulted in significant

improvements. ABA advised that the Trust had reached a point relating to culture change for the consultants and that he had received assurance from Dr. Neame that all consultants are now using the system. Other issues relating to leavers and high generation areas were briefly discussed and will be addressed in the next report.

FB alluded to the Junior Doctor issue, and also staff who are off sick, and the difficulties in this regard. ABA stated that a programme would be required to support each team.
ABA alluded to the systemic issues within fracture clinic, pre op and PICU which have solutions for, and the turnover of Junior Doctors remains a challenge.

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

24/25/76 Sepsis Quarterly update

SQAC received the Sepsis Quarterly update, which provided an overview of the current sepsis position

- ED sepsis nurse had commenced maternity leave, there is an effective nurse in post to cover maternity leave.
- Inpatient Antibiotic Administration <60 minutes – the Trust had been above 90% for last 3 year period
- Month by month figures are variable as the numbers are small, month to month trends are monitored
- Inpatient Antibiotic Administration <90 minute target, the Trust had maintained >90% since the data reporting resumed in June 2022, with the exception of September 2023 when this was 89%.
- ED Antibiotics Administration within 60 minutes is extremely encouraging
- Sepsis Training had been challenging during the last quarter, with a significant problem with the training package that the training figures are generated from though the training package is now online.
- Training package software license is due to expire in September 2024 as NHSE have not renewed the license, therefore the Trust need to obtain an urgent alternative.
- Inpatient sepsis nurse continues to undertake ongoing work to improve training compliance, which is an ongoing issue.

Next six months – continued focus on the Sepsis Dashboard, there is a prototype dashboard built.
Work on ED/inpatient working – harmonisation of data is going to be progressed; with continued focus on improving training compliance; urgent search required for solution to maintain online sepsis training, continued liaison with teams to improve training compliance review of staff roles and sepsis training assignments – Learning and Department working to implement.

FB acknowledged the challenge regarding sepsis training and thought required regarding an additional piece of work regarding this, with the need for a focussed 6 month plan given the transition to a different training package, with good comms.
KW alluded to the Sepsis training regarding the shift made regarding 2030 and whether Futures could be requested to support and whether a multi-disciplinary approach through the Futures team would be supportive.

Resolved: FB requested that DP, KW and appropriate colleagues discuss this offline to explore potential options and to consider whether a bespoke programme is required given sepsis training is a persistent issue.

ABA stated that he had personally written to all the doctors who were less than 70% compliant with their Mandatory training to improve mandatory training compliance.

ABA alluded to trying to build mandatory training into appraisals to show 100% compliant with mandatory training, and that the Trust need to think about the increments that staff receive

AB alluded to the wider arrangements for the extra days leave, this is not guaranteed for 2024, and potentially linking this with mandatory training and connecting this for this year.
NA stated that this should be discussed at Executive Team regarding how compliance could be improved.
Resolved: Executive Team to discuss offline

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

24/25/77 ED monthly report: MH attendances and ED@its best

CW presented the ED Monthly Report:

- Quarter 1 performance was extremely positive at 85.97%.
- During June 2024 ED achieved 83.7% against the national four hour standard of 78%.
- Median time to triage remained constant at 15 minutes and is in line with the national standards, however, whilst the median position remains constant the heatmap shows that the majority of the week being Green which is different to the previous hotspots on Monday and Tuesdays during the evenings.
- There is continued focus on the distribution of workforce with a real emphasis on the right staffing in the right place at the right time.
- Median time to clinical assessment is 11 minutes higher than the national average, ED had seen a 3 month improvement from May 2024. CW expressed concern that this may increase in July 2024 due to the consultant long term sickness within the department, circumstances are unprecedented, this had been included on the Risk Register with a risk score of 12, mitigation included reviewing the skill mix and reviewing junior doctors, ACPs and considering what the service needs are across the week to ensure that the service is appropriately staffed.
- PAU average length of stay was just over 6 hours during June 2024, with focussed work ongoing to ascertain whether this could be reduced further.
- CW advised on the ongoing focus presently to operationalise EDU, PAU move to allow the estates work and the new build to continue, with the confirmed date of move of 14th August 2024.

ABA sought clarity whether it would be possible to include conversion to the virtual ward as this data would be extremely helpful. CW confirmed that she would review this.
ABA stated that on review of the sit rep for the hospital that ED that nursing numbers are constantly displayed as Red and sought clarity whether this is a data collection issue, CW stated that she would review this offline and would provide feedback offline to ABA.

KW advised that both she and J Kelly had recently attended a Quality Assurance Ward Round with the ED team which was excellent, and the improvement journey was extremely reflective within the Quality Assurance Ward Round.

KW stated that as the ED report is further refined in the future that it would be helpful to include information regarding future plans/forward look with regards to the improvement journey.
CW queried whether this could be presented separately in the future.
Resolved: FB stated that this could be shared with SQAC at the September or October 2024 meeting, and that SQAC could take the ED report as read and focus on the forward look update.
KB alluded to the time to clinical assessment and the time to triage which shows significant worsening in performance between August-September 2023, KB sought clarity regarding any contributing factors for the worsening performance. CW advised that she would need to look into the drivers for this and report back in her next report.

AB advised that the team are also reviewing the Friends and Family test and that the Trust does not have a sample size that provides an indication of families experience of care and asking families at time of attendance, and that in some circumstances it is not helpful or appropriate, AB advised that colleagues are rethininkg in a more sophisticated way regarding obtaining a larger proportion of families sharing what had went well or what could be improved.

Resolved: SQAC received and **NOTED** the ED monthly report: MH attendances and ED@its best

24/25/78 Patient Safety learning review report

JR presented the Patient Safety Learning review report, and provided SQAC with a comprehensive overview of the case. SQAC welcomed the report and the first under the new PSIRF that had been approached in this way.

A number of recommendations were included in the report which were noted by SQAC. JR advised that the learning review process had provided staff with the opportunity to reflect and make sense of their personal involvement/experience and had provided the opportunity to identify several areas for improvement, the process had been well received by all attendees, and had provided a safe space to speak up and share experiences and had enabled feedback on health and wellbeing of young person and young person's daughter from the safeguarding leads.

Next Steps are to consider the areas for improvement that had not been yet actioned and to collectively and collaborative develop a SMART action plan, the implementation of the action plan would be overseen by PSIRI panel.

JG alluded to safety for girls around the park and campus and suggested that it would be helpful for JR to contact Kieran O'Toole in this regard with regards to Alder Hey campus being a safe space.

NO, advised that this had been accepted as a local child safeguarding practice review by Liverpool Safeguarding Children Partnership and that the information would be submitted into this process and that other multi agency partners would also be focussing on their learning with regards to lessons learned from this incident.
FB expressed her thanks to all colleagues who had been involved in this incident which had been addressed extremely well.

Resolved: SQAC received and **NOTED** the Patient Safety learning review report

24/25/79 **Drugs & Therapeutics Quarterly Report/Annual Report**

- PS advised that the department now have an excellent drugs budget report based on medicine spend.
- Risks continue to be monitored by MMOC and MSC.
- PS alluded to the A3 slide with regards to a risk of harm to patients due to the lack of Pharmacy Oncology Team, Medicine colleagues had been working with the brilliant basics team and oncology colleagues, with significant progress made. PS advised that the report presented to SQAC is slightly out of date, with significant ongoing progress made to date.
- 3 risks had moved to closure.
- Significant work had been undertaken and is ongoing regarding TPN, with regards to adopting PSIRF methodology, with ongoing progress which is on trajectory.
- Pharmacy audit calendar had been included within the report, this would remain in future reports.
- Drugs & Therapeutics work continues, PS alluded to a number of policies, guidelines and procedures that had been reviewed during this quarter and advised that this information would not be included in the report on a regular basis. PS highlighted the volume of work going undertaken through MMOC and alluded to challenges regarding guidelines due to the volume of work. PS stated that colleagues are asking for consultants and other staff to support with regards to reviewing/amending and approving guidelines, PS stated that this is difficult to obtain support, despite best efforts.
- PS continues to attend ICB meetings and national committee meetings.
- Progress is being made on the report content and format and would evolve further over time.

PS requested to improve the alignment of the Drugs & Therapeutics Quarterly Report to future SQAC meetings, which would ensure that the information presented includes up to date data.
PS proposed to present Quarter 1 report for 24/25 in August 2024, which would improve alignment and identify progress currently being made.

FB confirmed that SQAC are happy to better align the reports to the actual cycle of work. FB stated that it would also be helpful to receive reports in advance in a timely manner to ensure that SQAC have sufficient time to review in advance of the meeting.
KB stated that it would be helpful to receive an Executive summary within future reports.
KB alluded to the highest Risk regarding TPN, and sought clarity whether colleagues are hopeful that the current workstream is going to have an impact, as this had been a longstanding risk.

PS stated that this had been one of the PSIRF themes for the Patient Safety Strategy Board, with ongoing work taking place, PS advised that he does not have a timeframe regarding when this risk could be stepped down. PS stated that this is being well managed, with high level actions which are

on trajectory, PS envisaged this risk would be stepped down, however colleagues are still seeing risks regarding TPN and therefore this risk cannot be stepped down at present, with the aim that this would improve with the ongoing work.

KB alluded to the risk regarding the Temperature monitoring of the fridges. PS stated that he envisaged that this risk would be closed shortly. SOP had been signed off by MMOC, system is currently being trialled, with the aim to close this very soon.
JG alluded to improved insight and analytics regarding drugs usage and advised that he would welcome a broader view/outlook, regarding any potential over prescribing, issues with polypharmacy, children with multiple prescriptions/medications.
PS stated that this would need to be considered offline to understand where this aligns.

FB stated that within the Medical Division there would be colleagues who are interested in this issue, and that it covers different assurance paths, with fundamental issues, and it is important to correctly address and ensure there is a right informal group to agree the way forward, PS advised that he happy to be part of the discussions.
Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Quarterly Report/Annual Report

24/25/80 Fuller Inquiry Action Plan Quarterly Report

NO advised that she had presented a Trust Board paper in April 2024 regarding the Phase 1 recommendations from the Fuller Inquiry. The Phase 1 recommendations were made to Maidstone and Tunbridge Wells Trust, there was a decision made to self-assess and benchmark the Trust mortuary arrangements against the recommendations to look for any opportunities to improve and strengthen assurance.

- Self-assessment had been completed and a working group had been convened.
- Security walkabout had taken place on 6th June 2024 to review security arrangement in the mortuary in relation to swipe card access and CCTV coverage.
- Action plan had been developed with recommendations.
- Phase 2 of the Fuller Enquiry would explore wider recommendations for the wider NHS.
- Internal recommendations include an Annual security walkabout to review arrangements which would include the Executive Safeguarding Lead or the Human Tissue License Holder which is the CMO; an Annual Assurance Report to be presented to Trust Board to provide an overview of the Mortuary arrangements and includes reference to the compliance with Human Tissue Authority standards and most recent inspections, this would be a brief assurance framework; with Divisional oversight regarding assurance for the mortuary, Safeguarding arrangements would align to the Division.

NO advised that the plan is to continue to progress the Action plan through the working group which is led by NO and the Associate Chief Nurse for Medicine, update reports would be presented to SQAC, and the future plan is that the action plan would be handed over to be managed by the Division.

Resolved: SQAC received and **NOTED** the Fuller Inquiry

24/25/81 Safeguarding Children Annual Report

NO presented the Safeguarding Children Annual Report 2023/2024 and expressed her apologies for the late submission of the report. NO advised that there is a large amount of repetition within the Annual Report from the Quarter 4 report presented at the last SQAC meeting. NO had noted NA comments at the June 2024 SQAC meeting to present the Annual Report in place of a Quarter 4 report.

- There had been improvements regarding the ability to share data regarding activity.
- There had been 6,174 multi agency safeguarding hub (MASH) requests with information shared with police and social care.
- Safeguarding Team Meditech order - A dashboard had been developed regarding the number of safeguarding orders received, with 3,691 orders, 1,900 of these orders being marked as urgent.
- During 2023/23, the Safeguarding Team reviewed and updated the level 3 safeguarding training and is fully compliant with new statutory requirements.
- In 2023/24 a Safeguarding Operational Group (SOG) was established to build on improved governance arrangements.
- A Business Case was submitted to Cheshire & Merseyside ICB for additional funding in Statutory services which had provided successful in securing investment.

- Whilst Alder Hey had identified clinicians in the Name Professional Safeguarding roles there had been challenges through 2023/24 in relation to the roles being fully completed due to key personnel being absent.
- During 2024/25 the Safeguarding Team would comprehensively review all Trust Policies and SOPs owned by the team to ensure that they are compliant with NICE guidelines, statutory guidance and LSCPs policies.
- Safeguarding priorities for 2024/25 include digitalising the Safeguarding Service; working with children and young people to improve the patient experiences across Safeguarding and Statutory Services; improving visibility of the safeguarding team.

KB stated that it is good that the Trust had now recruited to the Named Doctor and the Named Nurse role and highlighted the importance of future succession planning for these roles.
NO advised that once the Named Doctor is in post they would be working regarding the training programmes for Dr's and ensuring that people feel this is an issue worth pursuing in the future.

KB referred to the data within the report and alluded to the nature of the cases and the mixture of caseload which would be extremely useful for future.
NO stated that at a previous SQAC meeting discussion took place regarding how activity could be better reflected and that from Quarter 1 report Safeguarding colleagues would try to include some of this data, ensuring that the Trust is protecting confidentiality and the detail of the cases, whilst sharing the volume, trends and patterns regarding the number of child protection medicals and the number of forensic examinations from SARC. With the aim to include in Quarter 1 report.
FB sought clarity whether there is a sector wide or statutory set of categories that colleagues would log safeguarding issues under. NO advised with regards to children subject to child protection plans – that they are categorised into the different types of abuse, and that the Trust interface with Sefton, Knowsley and Liverpool local authorities and the Trust is receiving richer data regarding how many children are on child protection plans, child in need, early help. Internally the Trust could now see some information regarding safeguarding orders, which had not previously been possible. The Safeguarding Team can now see the gender of the children, the geographical areas they are presenting from, and from which areas within the Trust. As the Safeguarding move to digitalise the Safeguarding Service there would be a need to refine and categorise the data.

Resolved SQAC received and **NOTED** the Safeguarding Annual Report

Caring
Effective

24/25/82 **Board Assurance Framework**

SQAC received the Board Assurance Framework.

- ES alluded to ongoing work regarding follow ups and whether this should be included temporarily in the gaps in assurance. ES stated that there are some legitimate concerns regarding this within 1.2.
- ES referred to the specific risk regarding the Gender service, which had been assigned to Trust Board. This would be an emerging issue. ES suggested that SQAC take an interest in this risk in the short term regarding any potential safety issues as they emerge.
- ES advised that the risk appetite work is progressing and had been discussed at Audit and Risk Committee and would be shared at Trust Board.

KB advised that she had been working closely with LC and the team regarding the next level of Gender Service risks. KB stated that she is happy to follow up offline with LC to develop this risk.

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

24/25/83 **NICE Compliance update**

JR presented the NICE Compliance update for the reporting period of 1st - 30th June 2024.

- A total of 7 NICE guidance publications were received by the Trust since the last reporting period.
- 2 publications were confirmed as relevant, and 5 publications confirmed as not relevant.
- A total of 13 NICE Guidance are currently open across the Trust. Open guidance includes 4 at Stage 1 (Baseline Assessment) and 9 at Stage 2 (Action Plan).

- 1 NICE guidance is just over the 3 month assessment timescale, this is within the Medicine Division and relates to Sepsis this is currently being reviewed by the Clinical Lead.
- 2 Actions plan had not progressed, one of which is within the Corporate Division (NG209 – Tobacco: preventing uptake, promoting quitting, and treating dependence), this is currently on the risk register with a risk score of 6 due to non-completion. An update is expected at the next Corporate Services Collaborative meeting. Remaining action plan which had not progressed related to NG206 -Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management and aligns to the Medicine division, this is currently being assessed for level of risk due to non completion. Both of these guidelines had been noted and escalated as appropriate.
- Colleagues are currently working with the Brilliant Basics team regarding the reporting format for future meetings.

FB acknowledged the remarkable improvements and thanked JR for ongoing work, FB welcomed the new format report in the future.

Resolved: SQAC received and **NOTED** the NICE Compliance update and the continued trend in compliance with baseline assessment and revisions of action plans since the last reporting period.

24/25/84 **Clinical Audit Assurance Report**

SQAC received the Clinical Audit Assurance Report for the reporting period of 1st -30th June 2024.

- At the time of reporting a total of 16 nationally mandated audits are included on the Trusts Annual Audit Plan for 2024-2025.
- The Trust is currently non-compliant with full date submission for 3 mandated audits, all of which had been escalated to the CMO, relevant Division and to the new Division of Medicine Clinical Audit Lead. JR alluded to the National audit for seizures and epilepsy also known as Epilepsy 12. The Trust had received outliner notification from the Royal College of Paediatricians, the Trust had now responded to this, and they have confirmed the outliner status, the Trust had submitted an action plan which would be overseen by the Division, the General Manager within the Division has ensured sufficient systems in place to ensure timely submission of data.
- JR advised that submission of data for the National Paediatric Diabetes audit had been limited, PCO support was provided, however the person was not knowledgeable with excel or data handling and submission currently being undertaken by the consultant. Since submitting the clinical Audit Assurance report the data had been submitted for 2023/24 and colleagues are now reviewing the position of obtaining solutions for submission of data for 2024/25, however the new Clinical governance lead within the Division of Medicine would be supporting this process.
- National Acute Kidney Injury Audit – whilst compliant with submitting audit data the UK Renal Registry Annual Report 2021 published June 2023 noted a number of gaps in the data fields from the Trust due to IT issue. This issue had been escalated to the Digital team for support in the interim colleagues are submitting what information that they can.
- Major Trauma Audit (TARN) - JR advised that there was a national cyber-attack and that colleagues across the country were unable to submit data, and that from April 2024 the national database had been developed by NHSE and that the Trust had started to accept data submissions from Quarter 3 onwards.
- At the time of reporting there are 3 internally chosen audits registered.
- At the time of reporting there are 23 local trust priorities.
- Clinical Audit team are working with Brilliant Basics regarding the reporting format for future meetings.

JP sought clarity whether there are any future plans regarding training and education regarding audits. JR stated that the teams are finding that the requests for the national mandated data sets require medical knowledge to decipher and that teams have done their best to submit information. JR highlighted the importance of being aware when teams are struggling.

NA stated that the Trust is given sufficient advance notice of audits and requested each of the Divisions to review upcoming prospect audits to ensure appropriate solutions are found for those teams.

NA stated that it would be helpful to receive confirmation that this had been completed within the next Clinical Audit update.

JR stated that the baseline had already been discussed and that with the exception of the 3 clinical audits there are no issues or concerns. JRo would address offline with NA.

Resolved: SQAC received and **NOTED** the content and findings of the Clinical Audit Report and **NOTED** the current status of the 3 nationally mandated audits and escalation to divisions for oversight and actions to address.

24/25/85 **Data Triangulation/Canary Charts**

SS provided a verbal overview of Data Triangulation/Canary Charts. SS advised that information within the chart detailed RTT, complaints and mandatory training. SS advised that there is scoring system based on performance for each particular metric, and that the higher the score the higher cause of concern. SS stated that the request for the charts had been scoped, and that colleagues had met with divisions and individual specialties, the initial scope was 8 metrics and currently there are a total of 19 metrics including finance, Human Resources and safety metrics across the Trust. SS advised that once the data is populated this enabled production of canary charts. SS advised that the next steps are to work with the Trust to identify a new operational lead, there had only been one report to date, with the expectation of a quarterly report, this is still in infancy, analytical team are also undertaking a mapping exercise, with specialities and divisions.

FB alluded to number of different metrics and stated that it is important that the Trust does not create an alternative version of the truth within the organisation and that the metrics chosen to align with key metrics that are feeding into the assurance processes. FB stated that she can see the benefit of assisting local areas that are problematic for them.
FB requested whether SS could provide clarity regarding what the charts are seeking assurance on.
SS stated that WW had created the 8 initial metrics and that she is not certain where these initial metrics originated from. SS stated it would be helpful to cap the number of metrics. SS would ascertain where the initial metrics originated from.
KW advised that this had been discussed at Executive Team and that there is some alignment with the information reviewed within the IPR, and that this just provides a different way of reviewing team specific areas.

FB stated the importance of the Executive Team having oversight and that resource is focussed appropriately. KB would feedback to Executive Team.

FB thanked SS for her verbal update and welcomed the visuals in due course.

Resolved: SQAC received verbal update and **NOTED** the progress made to date

24/25/86 **Confidential enquiries/national guidance report**

- During Quarter 1 the Trust participated in 6 National Confidential Enquiries:
- There is a new study that had been brought in during June 2024 - Emergency procedures in children and young people; the aim of this study is to identify good practice and remediable factors in the care and delivery provided to children and young people undergoing emergency non elective procedures under anaesthetic or sedation. As part of this study there would be 20 patients per hospital sampled for inclusion, spreadsheets had been disseminated to the relevant teams to identify relevant patients and submit data.
- The NCEPOD Transition from child to adult services - report recommendations continue to be overseen by the Transition group, discussions regarding transition training are ongoing with the transition manager and the Academy lead with the aim of developing a competency based learning module, no date had been agreed to date.
- Suicide children in young people report – policy is scheduled to be shared at Parity of Esteem group for multidisciplinary cross divisional oversight at the end of July 2024.
- Urology team are required to present their findings of the baseline assessment regarding the Twist and Shout Testicular Torsion study to CEOG in September 2024.

Resolved: SQAC received and **NOTED** the Confidential enquiries/national guidance report and **NOTED** the progress and oversight of the Trust participation and compliance with the National Confidential Enquiry submissions.

24/25/87 Clinical Effectiveness and Outcomes Group Chairs Highlight report

JR presented the Clinical Effectiveness and Outcomes Group Chairs Highlight report

- CEOG noted that the Trust continue to comply with CAS alerts and NICE guidance.
- Acknowledgement of national leadership with the GIRFT Testicular Torsion being developed at Alder Hey.
- Approval of a proposal to embed a link to an evidence table in all Trust clinical guidelines in line with other world leading children's hospitals.
- Inaugural Clinical Audit Masterclass (face to face) took place June 2024 generating a positive, enthusiastic, collaborative discussion with a view to hold 3 Masterclasses per year.

Issues for escalation - Following a baseline of nationally mandated audit data, the Trust is currently non-compliant with data submissions for 3 nationally mandated audits.

FB sought clarity whether the actions are already in place with regards to the 3 nationally mandated audits.

JR advised that there is a full action plan in place with regards to Epilepsy 12 which is overseen by the Division. The data for 23/24 was late in submission but had been submitted for the National Diabetes audit and colleagues are working with the Division on a plan for submission of data for 24/25.

The National Renal Registry, data is already submitted however there is an issue regarding meditech not being able to be input into the national Renal Registry which had been escalated to Digital who are submitting data, however there are gaps in the submission.

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

24/25/88 Liverpool Neonatal Partnership Assurance Report

SN presented the Liverpool Neonatal Partnership Report.

- LWH had been identified as a positive outlier for Retinopathy of Prematurity Screening at 93.6%.
- Areas of improvement and key challenges remains regarding the neonatal presence of parents on ward rounds, from reviewing this metric it highlighted some discrepancy regarding colleagues not documenting if a parent had not been present, there is a quality improvement initiative in progress and the QI lead and Badger lead are supporting compliance.
- Key challenge regarding recruitment of Speech & Language Therapist for neonates which is key requirement for neonatal patients, recruitment is in progress.

Successes

- March cohort of the Qualification in speciality (QIS) had been completed with excellent feedback from students.
- Implementation of learning from deaths and incidents meetings which had been ongoing for 3 months, this a cross site meeting which had been well attended from staff across both sites with ongoing staff engagement, with positive feedback received.
- Recruitment is ongoing, cohort 3 recruitment had been completed, with 9 new band 5 who are due to commence in September 2024.
- One single survey is being developed to enable Patient Experience feedback for the LNP Partnership
- Key challenges, regarding equipment, this had been escalated and there is working group in place to reach a resolution, in the meantime the interface had been switched off and values are being entered manually from the infusion pumps – this is on LWH site only.
- Good practice regarding rapid reviews, implementation of skin newsletter which had been well received from staff, there had been a significant reduction in medication incidents and there is now a medication newsletter's which highlights themes and trends, all incidents are discussed at the neonatal medication meeting.

KB stated that she had recently joined the LNP Board and sought clarity regarding some technical questions regarding the data. NA stated that it would be helpful for SN and KB to meet to discuss this further.

JRo stated that she is happy to support going forward. SN stated that KB could be invited to Liverpool Integrated Governance meeting if helpful. KB would speak with NA/AB offline to ascertain if appropriate.

FB alluded to the SALT recruitment and sought clarity whether this post is going out to advert again or whether colleagues are reviewing any other approaches given this had been a longstanding issues.

SN advised that there is currently a suggestion if not successful to recruiting to a Band 7 to have training and support for training for a band 7 which may be the route that the LNP have to follow.
JP stated she is happy to liaise with SN offline to consider any creative solutions to help making the posts appear more attractive for future posts.
JG queried whether there is sufficient information detailed regarding mortality.

Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership Assurance Report

24/25/89 **Divisional Update**
Division of Surgery – KB presented the Division of Surgery update
KB expressed apologies due to missing data relating to IPC data and the risk data.

- Tissue viability nursing service had expanded temporarily, with effect from 1st July 2024 whole hospital ward round could take place on a daily basis, with targeted work to reduce grade 2 pressure ulcers and moisture associated skin damage. With the additional resource could also expand tissue viability to undertake evening clinics, which would be trialled.
- Challenges regarding environmental and hospital cleanliness, areas of concerns relating to oversight, assurance, audit, and roles and responsibilities, some improvement had been noted. Surgical Matron chairs the cleanliness forum, recent Quality Round was wall attended, with over 100 responses, good appetite for improvement with good engagement from staff. Next steps are to hold a cleanliness collaboration inviting key stakeholders focussing on key priorities and issues.
- Incident themes from digital relating to incorrect discharge codes, this had been escalated and is being monitored for improvements.

FB alluded to cleanliness collaborative and sought clarity whether this is Trust wide, KB confirmed that this is Trust wide.

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

- Successes – Mental Health practice Educator has had two abstracts accepted into the European Association of Paediatric Sciences; conference is scheduled to take place in October 2024.
- Community & Mental Health Division had hosted the Annual Transition conference on 5th June 2024, 266 people had attended, with positive feedback received.
- SharePoint page had been established to provide 1 page clinic profile detailing relevant information regarding risk assessments, health and safety, first aid, to ensure staff have appropriate information across the sites in which they work.
- Challenges – estates working in multiple sites challenges regarding suitability, IPC, Wi-Fi, and part of this division have set up a regular meeting to review challenges and agree solutions.
- Challenge regarding increasing AlderC@are downtime and connectivity issues at bases away from the hospital site – incidents had been reported and the Division are currently with the Divisional CCIO and CNIO.
- Referral logging and triage process -this is a Trust wide issue relating to visibility for clinicians, partially related to the dictionary for selecting people but also the link between Web acute and Referral Management Desktop. Colleagues are working with developers to address.

KB requested whether it is possible to have a focus on reducing the incidents overdue review as the numbers seem high.

Resolved: NA stated that he would like to see an improvement next month across all of the Divisions regarding the incidents and risk overdue review and required focus in this area across divisions.

KB stated that there is targeted work within the Division of Surgery to close off the historic risks.

Medicine – CW provided the Divisional update

- Success related to health and wellbeing week, this is the 2nd Health and Wellbeing week, staff visited wards and departments and staff received a range of support, which had resulted in a positive impact on staff.
- Challenge remains within Haematology and transfusion, due to the ongoing staffing crisis, mitigation is in place, staff have been trained, risk had reduced from 25 to 20.

- Division of Medicine continue to have 100% compliance regarding PALS and complaints, reduction is noted in both PALS & Complaints this month, with focus on staff addressing concerns and issues raised at the time on the ward.
- Focus within the Division on audit and NICE with significant progress made over the last week in relation to overdue audits, with continued focus over the next month.
- Focus within the Division regarding sepsis mandatory training following the external ESR fault, which had resulted in a decline in training compliance, with continued focus within the Division.

FB alluded to the risk score reduction and sought clarity whether the Division envisage this being reduced again. CW stated that there is a four month period of staff being trained and stated that there are staff who are on long term sickness and stated that this would be reduced in the near future.

Research Division - LR presented the Research Divisional update

- Division had a productive big conversation event which had recently been held, with a wellbeing session and support from Brilliant Basics team, 3 objectives were agreed for the year.
- Division held a Research celebration event in June 2024.
- Challenges regarding long term sickness within neuromuscular research portfolio with 2 significant absences. Division had agreed to pause any new studies to ensure current patients in trials remain safe, this is due to resolve over the coming months.
- Play distraction support had also been affected, this is resolving in month.
- Division are now able to extract Friends and Family Tests score

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

24/25/90 *Well Led*
Responsive

Healthcare Transition update

- JP advised on plans to the change to Healthcare transition offer at the end of the fixed term contract of the Transition lead role in October 2024, with the aim of a more integrated approach to Healthcare Transition. Division are working with representatives from Medicine and Surgery Division reviewing specialisms involvement into Healthcare transition, Integrating into complex care team to ensure more integrated offer, with a detailed plan including within the next report.
- Ongoing challenge regarding reporting quantifiable data regarding young people who need a healthcare transition offer and those who are in process. Colleagues are working with Business Intelligence and cleansing data, there is no data currently available for June or July. Colleagues are also looking to simplify the questions.
- Ongoing challenge regarding clinical capacity to provide additional time for healthcare transition preparation – NCEPOD standard regarding people having dedicated time regarding healthcare transition as part of the clinical work. JP stated colleagues are looking at how the Trust can streamline the process as much as possible and how to embed healthcare transition.
- Baseline compliance - good progress had been made, the Trust is taking a more pragmatic approach to once the action plans are compliant, to close this piece of work and monitor the actions going forward.
- Next Steps - colleagues continue to work with BI team to develop the data reports and working with the development team regarding what is detailed on Expanse to ensure it is more user friendly at point of contact.

KB stated that she does not underestimate the ongoing work and stated that previous reports were extremely high level. KB requested whether the format could remain the same for each quarter, which details progress or lack of progress.

FB stated that the SQAC changed its focus also, as originally SQAC were keen to hear who was responding in each division and that this had moved to a trust wide view.
JP confirmed that she would address this for future reports.

Resolved: SQAC, received, **NOTED** the Healthcare Transition update

24/25/91 **Parental Nutrition Policy**
Resolved: SQAC received, **NOTED** and Ratified the Parental Nutrition Policy

24/25/92 **Absconsion Policy**
SQAC received the Absconsion Policy
NO stated that on reviewing the Absconsion Policy that there are still a number of paragraphs that do not appear completed on page 7 or 8, however this does not effect this being approved.
NA suggested that this could be sent back for minor amends, and chair could sign off.
Resolved Policy to be reviewed to ensure it is in a finished format.

24/25/93 **C35 – Tracheostomy Policy**
Resolved: SQAC received, **NOTED** and Ratified the Tracheostomy Policy

24/25/94 **Any other business -** None.

24/25/95 **Review the key assurances and highlights to report to the Board.**

- Good discussion held regarding unacknowledged notices regarding Patient Safety Strategy
- Good discussions held regarding sepsis. SQAC Noted the progress regarding dashboard and challenges regarding training and a shift to a different approach.
- Positive report from ED, ED are continuing to make good use of data.
- Report on MDT learning review – really helpful discussion and review – with thoughtful review of a difficult incident and learning.
- Numerous good reports received providing assurance
- Parental Nutrition Policy – Ratified
- Absconsion Policy – Policy to be reviewed offline to ensure that it is in a finished format
- C35 – Tracheostomy Policy - Ratified

23/24/96 **Date and Time of Next Meeting:** 25th September at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 3rd October 2024

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

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	This paper provides a summary from the recent Futures Committee meeting held on 30th September 2024, along with the approved minutes from the 26th June 2024.
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Implications:	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 presentation was received from Dr Lyvonne Tume on the Clinical Research Development Programme for non-medical staff.
- The Committee received an update on the Futures Business Case which has now received approval at Executive Directors.
- The Committee received an update on the Investment Zone bid including timescales for submission, external and internal peer reviews.
- The Committee received an update on the Strasys Partnership including a review of 2023/24 and a look ahead to 2024/25 of the partnership.
- An update was received on the Futures implementation programme, including the four pillars of Discover, Develop, Grow and Transform.

3. Positive highlights of note

Key areas of progress:

- Discover: Plans are now in place for the Northern Institute for Child Health & Wellbeing launch on 3rd October 2024.
- Develop: Scoping of a Futures Fellowship Programme; embedding Futures into Induction and Strong Foundations.
- Grow: NIHR capital award and CRF funding.
  Investment Zone business case due to be submitted October 2024
- Transform: Data Warehouse capital bid ready to be taken to next Capital Management group for first stage approval.
  Pre-contract technical discussions are ongoing for the Ambient AI LyreBird project with contracts expected to be signed shortly.
  Alder Hey Anywhere governance group now in place with strategy around Alder Hey Anywhere to be brought to next Committee meeting.
  AI coding solution commercial partnership being explored.

4. Recommendations

The Board is asked to note the Chair's Highlight report for the meeting that took place on 30th September 2024.

MEETING OF THE FUTURES COMMITTEE
Confirmed Minutes of the meeting held on **Wednesday 26th June 2024 at 1:00pm**
VEC Meeting Room

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mr. J. Grinnell	Managing Director/Chief Finance Officer	(JG)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Director of Finance	(RL)
In Attendance:	Ms. F. Ashcroft	CEO of the Charity	(FA)
	Mr. D. Cole	Senior Project Adviser	(DC)
Part Meeting	Mr. I. Hennessey	Clinical Director for Innovation	(IH)
	Ms. E. Kirkpatrick	Associate Director of Finance	(EK)
	Ms. S. Leo	Head of Research	(SL)
	Ms. L. Brown	Associate Director – Digital Transformation	(LB)
Part Meeting	Mr. D. Hawcutt	Clinical Director of Research	(DH)
	Mrs. E Rees	Executive Assistant (minutes)	(ER)
Item 24/25/28	Prof. P McNamara	Consultant Respiratory Paediatrician	(PM)
Apologies:	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mr. A. Bass	Chief Medical Director	(Aba)
	Mr C. Beaver	Deputy Director of Communications	(CB)
	Ms. K. Birch	Academy Director	(KB)

24/25/22	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
24/25/23	**Declarations of Interest** There were none to declare.
24/25/24	**Minutes of the Previous Meeting** The minutes from the meetings held on the 16 April 2024 were agreed as an accurate record of the meeting.
24/25/25	**Matters Arising and Action Log** There were no matters arising and the action log was reviewed and updated.
24/25/26	**Futures Strategy** **Resolved:** The Committee received and approved the Futures Strategy.

24/25/27	**Futures Business Case and Implementation Plan**
	AB advised that the business case and implementation plan complimented the strategy and detailed the approach. This was a plan for how to initiate futures and there are 4 options: **Option 1** required no new investment. **Option 2** proposes the recruitment of 9.6 WTE at a cost of £0.7m, however 84% of this will be met from repurposed budgets (£0.6m and 6.2 WTE). Initiate 3 of the pillars (discovery, developing people and growth) **Option 3** contains the resources within option 2 plus additional *indicative* costs for the Transform pillar. **Option 4** was based on delaying the initiation of the Futures implementation plan, so is not investment request and no costings are proffered at this stage. AB stated that option 2 was the preferred option which would be a lot of repurposing and some modest investment enabling 3 of the pillars to start. Key leadership roles would be appointed to, allowing work to commence. The committee discussed the need for leadership as well as staff to implement the strategy. There is also a need for a comms and marketing strategy. JG gave a couple of reflections on the commercial and partnership aspects. GD asked if there was a risk profile on option 2. AB referred to the People pillar and KB had asked for a modest expansion in the Learning and Development team otherwise the risk was that incremental progress would be made. KB requested an organogram on who would do what in the team. AB responded that there were 'doers' in terms of the bid writing and comms as a repurposing of a non-pay budget that is not being utilised properly He had spoken to CB about support from Comms but the team are lacking someone with the skills for Futures. DC advised that IH had had concerns regarding the allocation of resources from Innovation and whether there were going to be any changes to deliverables and targets. AB confirmed that he had spent time with IH on the proposal and would follow up with him after the meeting to discuss in more detail and provide assurances. AB to follow up resource allocation proposal with IH.
24/25/27.1	**Action: AB**
	SL stated that we need to factor in time to consult with staff to give the team the context of the changes before the posts were advertised and the staff are supported. GD supported option 2 and commented that staff must be looked after while the strategy is not compromised. JC confirmed that to achieve the ambitions of Futures option 2 should be considered and approved. FA and RL discussed resource sharing for bid and grant writing LS shared that she was supportive of the proposal but questioned whether there was enough in the discovery leadership. JC stated it was difficult to balance what we would like to do against what we could do with the constraints. AB advised that they would like to progress with some of the proposals before the transformation funds were released and welcome a steer to get things moving but to not compromise the financial position.

	JC stated that staff consultations were part of the process and were making progress with the team with the support of SO and JP. **Resolved:** The Committee approved the direction of travel with option 2 with a bit more work on some of the issues but agreed that an organogram should be included with dotted lines to others within the organisation and agreed to take it to Execs and Strategy Board.
24/25/28	**Staff Story and Case Study: LifeArc CF Trailfinder** PMc gave a presentation to the committee on the CF Trailfinder which gave an update on the treatment and diagnostics for cystic fibrosis. JC noted that LifeArc were launching the children's cancers centres network work with Manchester and they are going to visit and give an update to the Trust. JC noted that it illustrated the importance of the work in Futures and the scientific discovery to lifechanging stories. SA noted that this was part of our Discovery pillar and asked if there was a way of capturing these updates at the Committees to remember what is happening so we can report against it. JC agreed to give some thought as to how this could be captured.
24/25/28.1	JC to consider how to capture updates within the Discovery Pillar for reporting. **Action: JC** JG asked how there can be more joining-up of things created and have them in one place as there are lots of partnerships. SA stated we could come back to it when we look at the Growth pillar as there will be a role in there for somebody to join it all up. The presentation from the last meeting needed to be captured in the same way. **Resolved:** The Committee noted the update on the LifeArc CF Trailfinder and thanked PMc for his presentation.
24/25/29	**Pillar 1: Discovery - Overview and Update** SL gave an update in the Discovery pillar and noted that 4 workstreams had been identified. Patient involvement work and planning would take place over the summer with groups already engaged with to talk them through the Futures strategy. She added that the second workstream related to the funding pool, noting that there were 2 research funding pools that have been launched this year and now closed and that applications are now under review. Partnerships was another theme, looking at our internal triage system and the last was evaluation and the protocols for the rapid evaluation of projects. SL advised that there was a realignment of resource of LHP with project managers to support the Discovery pillar. **Resolved:** The Committee noted the update on the Discovery Pillar.

24/25/30	**Research Funding Calls (Charity Seedcorn and NIHR Capacity)** SL advised that there have been two research-focused funding calls to enable new projects and initiatives that would enhance our ability to deliver against the priorities of Vision 2030, Futures Strategy and 2024-2030 Research Strategy. 12 applications were received for the charity's Seedcorn funding, a review has been done to ensure that awards are of the right amount of money. SL added that there has been a new call for the NIHR Research Capability Fund clinical research capability funding with £150k available and 10 applications had been received. It was noted that the iFactor was launched last week looking for new ideas about solutions to the challenges faced in the hospital and how Innovation could support these. **Resolved:** The Committee noted the update on the Research Funding Calls.
24/25/31 **24/25/31.1**	**Innovation Pipeline** DC gave a presentation on the Innovation Pipeline and noted that the comments from last time had been taken on board and the number of projects reduced from 65 to 31; the main thing was to align the themes with the Futures / Vision 2030 work and show where they fit and what impact and opportunities we have. DC agreed to share the slides with the Committee. DC to share Innovation Pipeline slides. **Action: DC** SA asked whether the review of the triage process had taken place so that they were aligned with the Futures themes. DC advised that themes coming through were now aligned. **Resolved:** The Committee noted the Innovation Pipeline update.
24/25/32	**Northern Institute** JC advised that there had been progress but not as much as he had hoped and the launch had now been postponed until the Autumn. Meetings had taken place with the University and there had been fantastic support from the Charity. He added that funding was being sourced to hire a Foundation Director to take the project forward. **Resolved:** The Committee noted the Northern Institute update.
24/25/33	**Pillar 2: People** AB advised that KB had set out that this pillar was about attracting and retaining talent and also seen as a priority was to foster the cultures and link it to the work on International. There had been progress on embedding the Futures work into Strong Foundations and the new induction programme, which would start in

	September. He noted that initial discussions had begun with external people on the Futures Fellowship programme but the key risk was the lack of funding and resource. **Resolved:** The Committee noted the Pillar 2 People update.
24/25/34	**Pillar 3: Grow** SL advised that there was three-pronged approach: fuelling investment, growing workstreams and creating capacity. The Grant co-ordinator post has been appointed to and currently awaiting a start date. She added that other areas were securing new investment and business cases were being developed. The other activity was working with partners on the NHIR incubator bid and there was also a C&M wide research centre application for the NHIR. SL referred to leveraging funds from other grants and following the presentation from PMc and LO. LO had won awards, but these were paid to the University who then subcontract dependant on the nature of the award. SL referred to the Strasys partnership which was on the agenda and the risk in terms of securing new investment with the diminished resource in the Innovation team. **Resolved:** The Committee noted the Pillar 3 Grow update.
24/25/35	**Futures Financial Framework** RL explained that this framework sets out some of the financial principles to guide how Futures activities could evolve, looking at how to grow Futures and ensure sight of how to secure investment but also how to think a little bit more creatively and build a financial framework that meets what Futures is trying to achieve. JC advised that a financial framework is crucial that allows the team to operate within the constraints that the NHS provides but look to be imaginative in terms of funding and resources. EK advised that the framework sets out the commercial and growth objectives and the principles to sign up to these included: • Covering costs and overheads • Pricing • Grants, external funding and pricing due diligence • ROI • Benefits sharing and reinvestment: • Surplus sharing • Ongoing revenue costs **Commercial Vehicles Option Appraisal** EK advised that the paper summarised an assessment of different organisational structures for an independent entity to support some futures activities and commercial developments. The objectives were: • Freedom to operate with increased flexibility and agility

	• Ability to lead on funding bids and access alternative funding streams not open to the NHS • Freedom to employ talent outside of NHS terms and conditions • Ability to reinvest funds into Alder Hey Futures related activities outside of NHS financial/governance framework EK advised that various options had been reviewed and two had stood out; Company Limited by Guarantee (CLG) and Company Limited by shares although there were a number of pros and cons. The preferred option was to progress with CLG. She added that the next steps would be to assess which activities would flow through such a company. The Committee had a discussion regarding the options and whilst they supported the direction of travel, it was agreed that further professional advice was required before any approval was given. **Resolved:** The Committee noted the Futures Financial Framework and supported the direction of travel in relation to the Commercial Vehicles options but agreed that further discussion was required before a decision could be made.
24/25/36 **24/25/36.1**	**Investment Zone (IZ)** DC advised that Alder Hey have now been through a number of rounds of the IZ process with £4.5 million provisionally allocated to Alder Hey, and we are now at the final stage of the Investment Zone bid process for which a final detailed business case was required. He added that workshops had been held and would be looking to bring in some bid writers. The next phase was to get the right resource from the Trust to help with the key strategic initiatives to put into the business case. JC noted that it was crucial we got this right and suggested a 'sprint' to get to the next step. There was no formal deadline but noted he would like to get this completed by September. JC to pull together a small working group together to review the business case in August. **Action: JC** **Resolved:** The Committee noted the Investment Zone update.
24/25/37	**Strasys Partnership** MJ advised that the partnership for year 1 was coming to an end and there were some recommendations for the Committee to discuss: • To continue the partnership through to the end of Year 1 • To endorse the twin-track approach of near-term opportunities to drive cash flow and strategic opportunities that position Alder Hey for the future To request Strays and Alder Hey develop a proposal for Year 2, learning some of the lessons from Year 1. MJ stated that they were recruiting some additional people to support the partnership.

24/25/37.1	GD referred to China and the relationship with Liverpool. MJ confirmed there was a link with Vietnam and would pick up the Shanghai link. MJ to pick up Shanghai link. **Action: MJ** **Resolved:** The Committee agreed to continue with the partnership and the proposal would be taken to the Board for approval.
24/25/38	**<u>Charity Investment Strategy</u>** JC advised that the Charity had been asked to support the Northern Institute along with a request to extend the funding across Futures setting aside an amount each year and would bring an update to the next meeting. FA agreed that the funding request still needed to go through the charities governance procedures but this would be fed into the report. JC to bring paper outlining Charity funding requests to next meeting.
24/25/38.1	**Action: JC** **Resolved:** The committee noted the Charity Investment Strategy update.
24/25/39	**<u>Pillar 4: Transform</u>** LB advised that the transform looked at technology to enhance our data and digital capabilities and the pillar was split into 3 workstreams; trusted data environment insight portal, generative AI architecture and Alder Hey anywhere. The trusted data environment supported research studies and allows collaboration national, regionally and internationally. There was huge potential for generative AI. Alder Hey anywhere is a patient and clinician portal for improving experience. She gave a synopsis on the progress to date. LS referred to the Federated Data Platform and asked whether we are aligned nationally with this. AB confirmed that they were meeting the team to discuss and to carry out the due diligence with ES and KW. It was agreed to take the discussion to Execs. AB & KW to take discussion on FD Platform to a future Execs meeting.
24/25/39.1	**Action: AB** **Resolved:** The Committee noted the update on the Transform Pillar.
24/25/40	**<u>Lyrebird Health: AI Transcription Tool</u>** The Committee received a short demonstration on the transcription tool but there were a few technical difficulties, so LB agreed to circulate the link. LB to circulate link for LyreBird demonstration.
24/25/40.1	**Action: LB**

	It was noted that this is commercially sensitive information at the moment. **Resolved:** The Committee noted the update on Lyrebird Health.
24/25/41	**<u>Research and Innovation Finance Report</u>** EK advised that the budget for Innovation this year was £783k and broadly on plan and based on that the income target will be met after additional costs, however £0.1m rated red, and £0.4m rated amber, and so there is some risk around this forecast. The research budget was currently £386k and the YTD was favourable by £100k. **Resolved:** The Committee noted the Research and Innovation Finance Report.
24/25/42 **24/25/42.1**	**<u>Overview of Operational Performance in Research and Innovation</u>** SL advised that the quarterly reports were not ready yet but would be ready for the next meeting. SL to bring quarterly reports for Research & Innovation to next meeting. **Action: SL**
24/25/43	**<u>Risk Register Overview</u>** SA advised that the risks had been drawn out through the discussions today.
24/25/44	**<u>Board Assurance Framework and Risk Appetite</u>** The Committee received the Board Assurance Framework Report (BAF) for May 2024. **Resolved:** The Futures Committee noted the contents of the BAF report for May 2024 and the outline for refining risk level and appetite.
24/25/45	**<u>Any Other Business</u>** DH advised that there had been some good news from the University of Cambridge for the CGUL programme which would have to achieve our business case. The Committee formally thanked Emma Hughes for all her work and contributions to the Futures agenda.
	Date and Time of Next Meeting: Monday 30 September at 9am – 12pm in the VEC Meeting Room (Innovation Hub).

BOARD OF DIRECTORS
Thursday, 3rd October 2024

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

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

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

Introduction

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

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

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

Alder Hey play a leadership role for CYP within C&M. The Trust is actively working to ensure CYP are effectively represented and served at each of these levels. The partnerships and partner programmes described are important vehicles to enable setting and achievement of joint objectives across one system, with the needs of CYP at the heart. They aim to address the key issues facing CYP's health and care today, influence strategic decision making and allocation of resources, share knowledge and expertise, bring together the networked CYP workforce and share innovations to revolutionise care delivery. This is essential to improve CYP outcomes, experience, and to make system efficiencies.

Q2 24/25 has seen continued development of key aspects of the collaborative CYP system in C&M; a macro view of the core CYP functions of the C&M system is included as Appendix 1. This paper highlights progress within these functions.

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

1.1 The C&M Health and Care Partnership

CYP remain a key priority area for the HCP. The HCP strategy (2024 – 2029) *All Together Fairer: Our Health and Care Partnership Plan*[1], is underpinned by the commitment to tackle the wider determinants of health with a vision to ensure that "everyone in C&M has a great start in life and gets the support they need to stay healthy and live healthier for longer." This is tabled for final sign off at the HCP board on 1st October 2024. CYP are explicitly reflected in several of the 'Headline Ambitions' and further detail will be shared with Board following

[1] PowerPoint Presentation (cheshireandmerseyside.nhs.uk)

publication. Alder Hey are linked clearly with the system strategy and plans (described further below) and Alder Hey's Chair is a member of the HCP Board.

1.2 C&M ICB Children and Young People's Committee

C&M ICB / HCP have CYP as strategic priorities. The CYP Committee is becoming embedded, placing the needs and voices of CYP, parents and carers at the heart of system decisions, whilst ensuring a system wide approach to better outcomes for CYP. Strategic priorities for the CYP Committee remain major cross-cutting issues: Neurodiversity, Mental Health / Appropriate Places of Care, Oral Health and CYP Edging Towards Care.

The June 24 and August 24 CYP Committee meetings included updates on:

- **Youth Voices** – ensuring inclusive approaches to co-production and delivery. Beyond are leading the development of a campaign with young people to ensure their voices are heard at appointments within health and social care.
- **Neurodiversity** – the C&M approach, with the emphasis on how the system can better meet the needs of CYP – regardless of diagnosis.
- **The C&M Mental Health Plan** (led across 3 C&M transformation programmes – Mental Health, Beyond and Learning Disabilities) – 8 priority areas including:

Inclusive: Co-production with CYP and families to support transformation and continuous improvement

Timely Access: For CYP needing emotional wellbeing and mental health support;

18–25 years offer: Design and develop an equitable offer of mental health support for young adults

Eating Disorders: CYP have timely and equitable access to high quality and evidenced based eating disorder support;

Crisis Response: To anticipate and support CYP who may experience mental health crisis or escalating needs;

Appropriate Places of Care: Address gaps in our current support offer for CYP with the most complex needs

Specialist Mental Health Care: Provide high quality and evidence-based specialist mental health care based on the needs of our Cheshire and Merseyside population;

Innovative: System change and transformation to be actively driven through research and innovation.

- **Oral Health** – sharing of the draft C&M response to consultation on Water Fluoridation Expansion Programme.
- **Appropriate Places of Care** – next steps to meeting the needs of CYP with complex needs and the development of a system-wide business plan.
- **Care Leavers Covenant –** Update on a programme of work, led by Alder Hey's Academy Director on behalf of the system, with a commitment from the ICB to progress identifying "care-experienced young people" as a protected characteristic for job interviews / mentoring etc.
- **Children and family poverty in C&M** – sharing the independent report, commissioned by the subregion's Directors of Public Health and Population Health, published in August 2024, "A rapid situational analysis on child and family poverty in Cheshire and

Merseyside"[2] with an ambition that "**No child in Cheshire and Merseyside lives in poverty".** Sefton Public Health team presented their work to address child poverty and their Child Poverty Strategy.[3]

1.3 C&M Beyond CYP Transformation Programme – Leading whole-system CYP Transformation

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

- **Children's voice and influence campaign:** a stakeholder event has been planned and an expression of interest for CYP to be part of project group to develop communications plan for the campaign was issued**.** The programme continues to support the Children's Committee with ensuring CYP are embedded within the meeting.
- **System governance has continued to evolve**, with Beyond providing input into the Children's Committee including coordination of the Single Line of Sight report.
- **Input has been provided to the Joint Forward Plan**, working with system partners to ensure that CYP's needs are reflected within planning and delivery.
- **Input has been provided into the CHAMPs CYP Poverty Strategy** to ensure links are made with both the use of data and programme delivery within Beyond.
- **All Together Smiling:** three-year Oral Health programme to deliver Supervised Toothbrushing has been mobilized.
- **Appropriate Places of Care initial phase completed:** local area business case template developed along with supporting place-based data packs - ongoing work to support implementation continues.
- **Child Health Equity Collaborative (C/HEC):** Pilot intervention stage is being mobilised. Liverpool Public Health Team are leading on delivery of the CHEC intervention: 'Working with parents, families, and infants to cultivate the skills of storytelling to support improved family literacy and school readiness in Liverpool.' This programme will directly contribute towards the good level of development at 2 to 2 ½yrs and school readiness at the end of Reception in our 20% most deprived communities and across the wider City.
- **Learning Disability, Difficulties and Autism workstream** has been pivoted to support the ICB Recovery and the CYP Neuro Disability pathway programme. All existing projects have either closed or are due to close in the next quarter with plans in place to ensure learning is captured and shared.
- Seven programmes of work have concluded; a further 20 are being delivered within expected timeframes. Seven projects are experiencing some delays, but recovery plans are in place and will be monitored in Q1 2024/25 with oversight from the Beyond senior team.

Further details of delivery and outcomes are available in the Programme Director's report within the October 24 Board information pack.

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[2] https://champspublichealth.com/wp-content/uploads/2024/08/A-rapid-situational-analysis-on-child-and-family-poverty-in-Cheshire-and-Merseyside-Final.pdf
[3] Sefton's Child Poverty Strategy

1.4 C&M CYP Alliance – leading NHS-specific collaborative improvements for CYP across the 2 Provider Collaboratives (C&M Acute & Specialist Trusts, and Mental Health, Learning Disability & Community)

The Alliance is committed to making significant improvements in the delivery of urgent care and elective procedures for CYP in our region, including driving implementation of elective/dental hubs, widening the roll out of paediatric virtual wards, paediatric 111 and making improvements across mental health initially with inpatients, and improving community waits/access.

Work is ongoing with health trust partners, the C&M Paediatric Network and CYP system leads to simplify architecture, delivery, reporting, accountability, and governance, whilst raising the collective ambition for a healthier future for CYP. This requires effective resourcing and oversight and avenues for resource include the ICB, the C&M Paediatric Network and Beyond, all of which are in development.

Alder Hey provide leadership via the CMO as the Alliance Co-Chair (alongside Deputy CMO Mid Cheshire/Chair C&M Paediatric Network) and have identified an Associate COO lead for the elective work stream, along with clinical / operational contributors working alongside district general hospital, community, and mental health partners C&M-wide.

2. Place – Collaborating with our Local Communities

2.1 Liverpool

Liverpool has a growing CYP agenda. To deliver Alder Hey's Vision 2030 and meet CYP needs (in particular, to "improve my life chances" and "get me well") we must work collaboratively with partners at Place level. The city requires partners to join up interdependent services around Family Hubs/Neighbourhoods, and we are committed to broadening our clinical reach from Alder Hey into community settings, to putting prevention and early intervention at the heart of our pathways, and to fulfilling our commitments as an anchor organisation. To this end, Alder Hey have appointed a Consultant in Public Health Medicine, and the Trust plays a leadership role for CYP in several key City initiatives;

- The **Liverpool Strategic Partnership** – and its oversight of public sector reform and the new City Plan in which CYP are likely a strong theme;
- A new approach to **CYP partnership** across the City is being spearheaded by the Director of Childrens Services in partnership with Alder Hey and CYP system partners. This will develop our shared understanding of CYP issues and opportunities and shape our city's vision and strategy for CYP, defining shared priorities and activities to meet CYPF needs, and positioning Liverpool as a CYP leader in the system / nationally;
- The **Healthy Children and Families Segment** – has evolved significantly over Q2 24/25 in response to the ICB Recovery plan, and brings partners together to design a system and take action on population priorities such as urgent and emergency care / respiratory health (admissions avoidance); the neighbourhood community model including physical & mental health; Health inequalities & prevention; delivery of the Healthy Child Programme for the City; impact of Family Hubs; and the whole-system partnership response to the LCC Public Health 'State of health 2040' report. Target areas include;

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

- **A new partnership between Alder Hey and Mersey Care** for the potential provision of Liverpool's 0-19 public health services. The service is currently under procurement and could offer significant benefit to CYP and families by bringing together our joint strengths, providing transformed, seamless pathways and interventions in the Healthy Child Programme aligned with local neighbourhood needs, and set within a new community model for CYP and families in the city.

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

Alder Hey continues to work in partnership across the North West, via the NW Paediatric Partnership Board (NWPPB) which we lead jointly with Manchester Foundation Trust / Royal Manchester Children's Hospital (RMCH). The MOU governing this partnership, previously approved by Trust Board in 2019, is being updated to reflect the progress in joint service development and partnership working. This will be put before Board for approval in Q3 23/24. Priorities for the partnership in 25/26 include;

- **Fragile Specialised Services** – Working in partnership to progress our vision for new service models across the North West, and nationally with the CHA (more below) in partnership, for example our vision for a NW paediatric cardiology single service and new service model for paediatric burns, and taking a proactive and planned approach to our specialised services which are already or may become fragile without appropriate intervention;
- **Joint Services (mature)** – Supporting and maintaining positive working relationships across long standing joint services, such as e.g. Northern Children's Epilepsy Surgery Services, NW Long Covid CYP Hubs, NW Cleft Lip and Palate Service and the Paediatric Intensive Care Transport Service – NWTS;
- **Joint Services (Recently Established)** - Continuing to develop recently established joint services, which need an increased strategic and operational focus. These include NW Complications of Excess Weight (CEW) Service (Tier 3) and the NW CYP Gender Service.
- **Clinical Networks (formerly Operational Delivery Networks/ODNs)** - Providing joint oversight of hosting responsibilities for networks including NW Paediatric Critical Care,

Long Term Ventilation and Surgery in Children ODN, NW Paediatric Major Trauma ODN, NW Children's Cancer ODN, NW Neonatal ODN, and NW Cardiology ODN (All age);

- **Women's and Children's Transformation Programme** – Working jointly to contribute to the specialist commissioner-led Transformation Programme agenda;
- **NW Childrens Strategy** - Developing a shared annual plan for 25/26 promoting a transparent approach to expected opportunities and challenges, with an aim to reduce variation across services in the North West (e.g. workforce, performance, patient access) and identifying shared priorities for system action.

4. Collaborating Nationally for Children and Young People

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

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

- **Specialty specific insights on fragile services –** Workshops to consider solutions and best practice around fragile services, connecting in with NHS England's Women & Children Programme of care team (linked with NW work outlined above).
- **Transforming services** – Engagement with NHS England CYP team, CYP Stakeholder Council and NHS Confederation to consider the role of the specialist centre in supporting out of hospital models and community capacity.
- **NHS productivity review and driving forward research and innovation** - Using members perspectives to respond to the specialist sector challenges and sharing these with the Darzi Review.
- **Policy & advocacy** - Meetings with the new Labour government on challenges and specific proposals around specialist CYP services including funding to deliver the child health action plan, a workforce plan to increase expertise and address service fragility, and better commissioning and delivery models to improve quality.
- **Comms & member engagement** - Sharing regular intelligence across the CHA.

4.2 Policy Update and Horizon Scanning

Lord Darzi's Independent Investigation of the National Health Service in England: Assessing patient access, quality of care and the overall performance of the health system, the report presents stark findings, including a strong view that a greater proportion of NHS budget needs to be spent in prevention, primary care, and community settings. The report will provide an evidence base for how government will set out its new 10-year plan for health (due Spring 2025) that will be guided by three fundamental shifts: analogue to digital, sickness to prevention, hospital to community.

Transforming child health services in England: a blueprint: the Royal College of Paediatrics and Child Health are calling for UK Government to commit to restoring and prioritising health services for CYP, in response to the underinvestment in CYP health and social care over the past decade, and the widening gap between adult and CYP service recovery post-pandemic. The blueprint proposes four national foundations to transform CYP health services: 1) fair funding for services 2) prioritisation within Integrated Care Systems 3) a sustainable child health workforce 4) improved data and digital innovation.

Recommendations from the report are designed to be low-cost or cost-saving, and implementable within one parliamentary term.

Political party conference season: the Liberal Democrats met in in Brighton, followed by Labour in Liverpool, and Conservatives will meet in Birmingham. The Lib Dem's urged current Government to invest in the NHS, to make this year's winter pressure crisis our last. Meanwhile, Labour received criticism of their 'the NHS is broken' messaging, though the Health Secretary stood by that message in his speech to conference, stating that recovery of the NHS was not possible without reform.

Industrial Action in the NHS: a pay settlement was agreed between the BMA and UK Government for resident doctors, bringing an end to the 18-month dispute which saw 11 separate strikes. In the same week, Royal College of Nursing members voted against a 5.5% pay offer made by Government and are awaiting a response by the Health Secretary on next steps. By law, the RCN would need to issue a new statutory ballot by post to authorise industrial action.

Alder Hey Charity Campaign: was officially launched on the final day of Labour party conference. Chaired by Liverpool's Metro Mayor Steve Rotheram, a panel of young people presented their key issues in child health and wellbeing and called on Government to prioritise them in all policy making. Liam Robinson, Leader of the City Council provided closing remarks and Alder Hey's local MP Ian Byrne made several commitments including to ask a question in Parliament and request that the Charity CEO Fiona Ashcroft is added to Government's Child Poverty Taskforce.

5. Partnership Governance

Appendix 2 provides an assurance summary of the key joint services and strategic partnerships, demonstrating named executive leads, purpose, partners, governance/reporting arrangements, summary progress and any risks for escalation to Trust Board.

6. Risks and Issues to Highlight

The Board is asked to note the following issues;

1. The increasing requirement for strategy/system resource across multiple work programmes, alliances, and strategies;
2. The impact of the ICB Recovery plan on all elements of Trust system working and planning.

The Executive team continue to monitor priorities and capacity to respond to system requirements prioritising as appropriate.

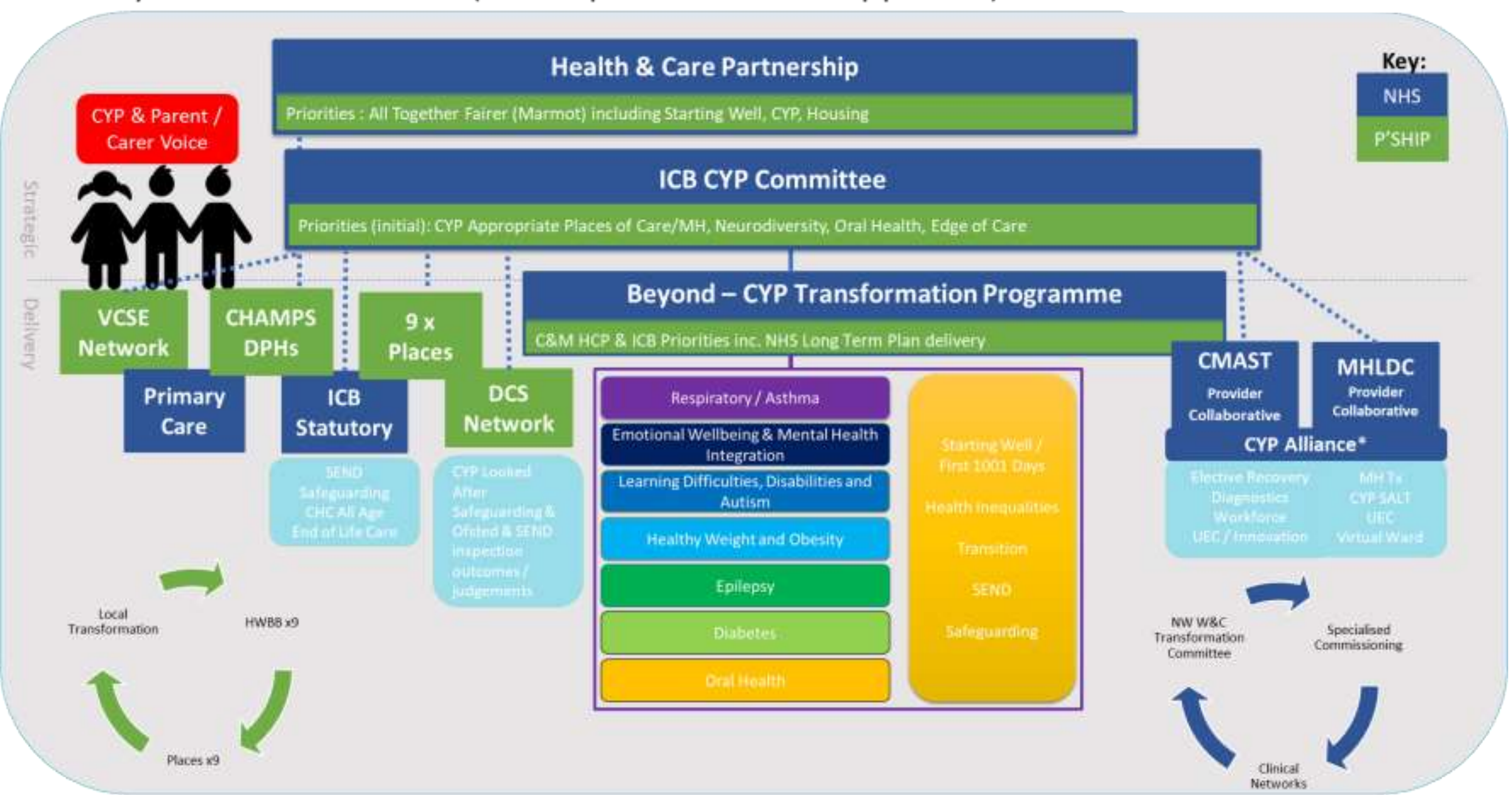
7. Recommendations

Trust Board are recommended to:

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

Appendix 1:

C&M System - A macro view (CYP Population Cohort Approach)



Appendix 2: Joint Services / Partnership Assurance Summary

Purpose	Partners	Established	Governance/ Reporting Arrangements	Summary Progress 23/34	Risks / Issues for Escalation to Trust Board
Liverpool Neonatal Partnership Executive Lead: Alf Bass					
Joint delivery of Level 3 neonatal service	Liverpool Women's FT (LWH)	2020	Liverpool Neonatal Partnership (LNP) Governance structure LNP Board (monthly) provides assurance to Trust Boards at LWH & Alder Hey LNP Integrated Governance (monthly) – assurance to Surgical Critical Care Board (Alder Hey) and Family Health Board (LWH) Internal – Division of Surgery	LNP governance structure is in the process of being reviewed and will be presented at Board in Jan 2024. LNP Board has moved to bi-monthly with leadership team meeting MD's between boards. Monthly risk and integrated governance meetings continue with feedback into Family Health Divisional Board and Surgical risk meeting. New programme board has been established with programme plan and this will be supported by both divisional teams, and report in to both divisional boards. Positive recruitment of nursing staff with good retention. ANNP recruitment has been difficult, however, fellow recruitment has supported this. Consultant recruitment continues.	Managing the capacity and flow during the build period and the supporting of neonatal care outside the 1C environment. Recruitment of tier 1&2 medial team (inclusive of ANNP's). Procurement of equipment and increasing costs. Ensuring safe and effective governance across both sites.

				Build progressing in line with expected timeframes.	
Liverpool Adult Congenital Heart Disease (CHD) Partnership **Executive Lead: Alf Bass**					
Joint delivery of Level 1 adult CHD service	Liverpool Heart & Chest FT; Liverpool University Hospitals FT; LWH	2018 – revised Memorandum of Understanding (MOU) Sept 2020	External – Liverpool ACHD Partnership Board (quarterly) – now merged in joint governance with CHD ODN Board Internal – Division of Surgery	-North West wide delivery of seamless all-age CHD service in partnership -Joint governance with CHD ODN to remove duplication in the system fully embedded -Previous plans for a single patient treatment list have been superseded by the development of a CHD database which will have this functionality built in – database go live anticipated in Summer 2024	None for escalation.
NorCESS - North West Epilepsy Surgery **Executive Lead: Benedetta Pettorini**					
Joint delivery of Northern Epilepsy surgical service - aim to improve the uptake and access to epilepsy surgery in those children for whom surgical control or amelioration for their epilepsy is a possibility	Royal Manchester Children's Hospital (RMCH)	2012	External – North West Paediatric Partnership Board (NWPPB - Alder Hey & RMCH) Internal – Division of Surgery	-NorCESS is a long-standing specialist commissioned service by NHS England, receiving regular funding and serving CYP across the North West - the multidisciplinary team (MDT) review children with epilepsy who meet the criteria for evaluation for surgical intervention, provide a comprehensive pre-surgical evaluation and co-ordinate epilepsy surgical procedures for children for whom it is identified as appropriate.	Ongoing risks re: persistent problems with specialist recruitment (e.g., neurology and neurophysiology). These are logged within the joint service and escalated via an agreed escalation plan to NWPPB and widespread across NHSE as a recognised national issue.

North West Obesity Tier 3 service Executive Lead: Urmi Das					
Joint delivery of level 3 obesity hub & spoke model	RMCH	Nov 21	External - NHSE monitoring & C&M CYP Programme Board (quarterly) Internal - Division of Medicine Monitored through divisional routes and NWPPB as a joint service	-Service running across 2 hubs (AH & RMCH) and spoke in Preston. -Inequalities uplift in funding for 23/24 -Led for Alder Hey by Dr Senthil Senniappan. - Currently no transition at Aintree so all discharge back to GP	Service remains in pilot phase with capped funding. Challenges with demand and issues are region wide and escalated to NHSE regarding adult transition and tier 2 obesity services.
Alder Hey & Public Health Liverpool Executive Lead: Dani Jones					
Delivery of a shared work plan via collaborative resource	Liverpool City Council Public Health	May 21	Internal – Health Inequalities & Prevention Steering group à Safety & Quality Committee	-Collaborative funding with LCC for public health consultant - Consultant in Public Health Medicine appointed at Alder Hey -Health Inequalities and Prevention Steering Group continues - coalescing the - Trust's Health Inequalities activity – chaired by Public Health professional -Prevention Pledge commitments – in partnership with the ICS. Priority project work includes: -Prevention in pathways: supporting long waiters with access to preventative support e.g., Mental health, food insecurity etc -Dental / Oral Health	None for escalation.

				-Smoking Cessation (CYP, families and staff) -Healthy Weight & Obesity – community/VCSE local delivery	
North West Paediatric Partnership (NWPPB) Executive Leads: Dani Jones / Alf Bass					
Joint oversight of NW ODNs & commitment to collaborative delivery of specific specialist / tertiary paediatric services as mutually agreed.	RMCH	2019 Under refresh: to Board for Q3 24/25	External – North West Paediatric Partnership Board NWPPB – biannually) Internal – Resource and Business Development – ODN assurance paper (biannually)	-Meeting held with Alder Hey, RMCH and Spec Comm. Plan to look at a NW strategy for CYP. -Partnership board to include colleagues from Spec Comm to commence thinking on what is required to develop a strategy. - ODNs to remain under Specialist Commissioning for the time being.	None for escalation.

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	Quality Assurance Report
Report of:	Liverpool Neonatal Partnership Integrated Governance Report
Paper Prepared by:	Susan O'Neill, Interim Head of Neonatal Nursing Justine Collins Governance Lead Neonates

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☑
Summary / supporting information	Neonatal Clinical Dashboard
Strategic Context **This paper links to the following:**	☑ Delivery of **outstanding care** ☑ **The best people** doing their best work. ☑ Sustainability through **partnerships** ☑ Game-changing **research and innovation** ☑ **Strong Foundations**
Resource Implications:	None identified in this reporting period

Does this relate to a risk? Yes ☐ No ☐					
Risk Number	Risk Description				Score
Level of assurance (as defined against the risk in the risk register)	☐	**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 report is to provide assurance and oversight of neonatal activity to the Liverpool Neonatal Partnership (LNP), Divisional Governance meetings for Liverpool Women's Hospital and Alder Hey Children's Hospital.

2. Summary of key Successes/ Top Achievements

Success	Comments
Positive outlier NNAP Standards for ROP Screening	Rated as "Outstanding" with a screening percentage of 93.6% with the national average at 78.4%.
100% Environmental Audit	Quarterly audit performed by Trust IPC team
LNP Power BI Dashboard	Version 1 LNP Power BI produced.

3. Summary of Key Challenges

Challenge	Actions
EBME (provision of service, maintenance and repair with specialist neonatal experience	Escalation trust wide as risk details local controls and mitigations. Organisational review of SLA requested
Different systems to capture patient feedback	Challenges in accessing systems for reporting patient experience across both sites.
PSIRF Established processes	To role out across partnership (consultants, ANNP's, AHP's, nursing teams) following team leaders session. Challenges is capacity and commitment to attend sessions
BBAS (CQC) Action Plan required to align with revised standards	An action plan is under development to support cqc preparedness

4. Operational Performance and Activity

The operational dashboard is below highlighting the occupancy of the NICU on both sites by financial year. The expected activity commissioned for the service is 80%. It is expected that there will be variance in activity levels, but the rolling average should equate to 80% over the reporting period (financial year).

Activity is monitored by the Northwest Neonatal Operational Delivery Network on a monthly basis and any exceptions to occupancy or acuity are discussed at the Neonatal Steering Group (quarterly). There is an annual review of activity, capacity and demand which informs any changes to capacity levels throughout the network with a three-year average used in the decision making to ensure for consistent reporting and monitoring.

Nurse staffing levels are managed in accordance with the Safer Staffing Tool and reflect increases and decreases in occupancy and acuity as appropriate. Medical staffing levels are in line with BAPM recommendations.

Currently, reporting of occupancy for NICU is calculated as a percentage and the occupancy for 1C is calculated in days. There is ongoing work within the LNP to align reporting metrics to demonstrate parity in reporting across the partnership.

The table below details the total occupancy for both NICU and 1C and is highlighted red for the months where occupancy has been greater than 80%.

Table 1

NICU Total Occupancy		Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	August
Intensive care	(%)	71.1	78.0	103.9	88.2	72.0	80.7	91.1	97.2	81.2	61.7	69.1	85.2
High dependency	(%)	84.7	59.1	64.4	86.3	79.60	**94.8**	78.5	65.8	84.1	68.6	84.4	75.8
Special care	(%)	59.2	75.5	61.8	76.6	58.5	69.7	80.3	55.2	63.4	82.2	56.9	43.2
NICU Total Occupancy	(%)	**69.4**	**71.7**	**74.0**	**82.4**	**68.0**	79.5	82.8	69.5	73.9	72.9	67.7	63.5
1C Total Occupancy	Days	216	186	258	225	249	247	222	217	248	211	274	258
Intensive care	Days	15	17	45	25	58	32	27 (9.7)	48 (17.8)	71 (25.4)	64 (23.7)	51 (18.3%)	61 (21.9%)
High dependency	Days	188	169	160	177	147	186	166 (59.5)	142 (56.6)	70 (60.9)	118 (43.7)	209 (75)	184 (65.9%)
NNSU Occupancy	(%)	**80.0**	**80.6**	**87.4**	**80.6**	**89.2**	98	79.6	80.4%	88.9	78.1	98.2	92.5
LNP Total Occupancy	**(%)**	**71.2**	**73.2**	**77.7**	**82.1**	**71.6**	**85**	82.2	71.4	76.4	73.8	72.9	68.5
Intensive care	(%)	73.2	**82.5**	**113.2**	**94.9**	**87.4**	89.9	94.4	107.6	100.3	77.3	83	101.6
High dependency	(%)	78.3	**61.6**	**62.2**	**76.5**	**67.9**	79.1	70.4	60.2	74.2	57.9	82.9	71.6
Special care	(%)	61.3	**81.8**	**70.7**	**80.3**	**65.5**	69.6	84.9	57.7	64.5	87.0	61.1	45.3

5. Safe

5.1 Quality and governance

The performance metrics displayed below includes the 10 national performance metrics required by the national Neonatal audit programme (RCPCH / NNAP), to review if babies on neonatal units in England, Scotland and Wales receive consistent high-quality care, and identify areas for quality improvement. The neonatal quality dashboard demonstrates current activity and performance against these standards namely.

- Perinatal optimisation (AN steroids, Mg Sulphate, temperature at admission, delayed cord clamping)
- ROP screening
- Complications (cooling, necrotising enterocolitis, bronchopulmonary dysplasia, pre-term brain injury and encephalopathy)
- Breastmilk
- Sepsis
- Mortality
- Parental consultation
- Parental ward rounds
- Respiratory Support
- 2 year follow up
- Nurse staffing

Table 2 outlines the standards applicable to the Liverpool Neonatal Partnership for both NICU and 1C.

Table 2	Target%	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	August
Temp recorded within 1hour & within range- 36.5-37.5 (<34wks) LWH	90	70	79	75	91	92	57	70	64	95	67	71	100
ROP Screening LWH	NNAP 80%, ODN 69%	100	88	83	75	100	100	100	100	80	88	100	100
Breastmilk at discharge <34 weeks LWH	>80	67	70	38	36	60	33	75	85	78	58	67	100
Breastmilk at discharge (all) LWH	No flag	64	66	44	47	60	54	66	57	61	62	69	51
Parental consultation within 24hrs LWH	100%	95	94	79	85	83	86	99	93	100	84	99	100
Parental presence on ward round	Benchmarking	63	78	71	95	91	63	77	78	74	28	28	46
% Nurse Qis LWH	>70	100	100	98	97	100	98	98	100	95	100	100	95
NNSU Parental consultation within 24hrs	100%	71	69	38	87	69	86	100	100	93	54	50	71
NNSU Parental presence at ward round	Benchmarking	67	94	100	76	92	91	93	100	87	57	52	67
NNSU Breast milk at discharge	No flag	38	67	42	50	64	67	67	70	75	76	55	56
NNSU % Nurse Qis	>70	43	56	37	66	48	41	52	52	27	57	45	52
Number of Blood Stream infection (infection per 1000 CVL days)	Benchmarking						20	15	8.3	6.0	10	5	8.3
Number of Blood stream infection clearly pathogenic growths							1	1	0	1	2	2	0
Number of blood stream infection unclear growth							7	6	5	7	4	3	2

The neonatal performance metrics are shared with the teams for action for those standard targets that were not met in month. The metrics were escalated at the LNP Integrated Governance Meeting. The following actions were taken following review of the quality dashboard in table 2:

- A letter detailing provisional notification of positive outlier for the National Neonatal Audit Programme ROP screening has been received.

  LWH has been rated as "Outstanding" with a screening percentage of 93.6% with the national average at 78.4%. Positive feedback has been shared with the team to acknowledge their success.

- A review of the NNAP metrics remains under review to align to benchmarking standards. Power BI Dashboard is being enhanced for automated collection of data from BadgerNet.

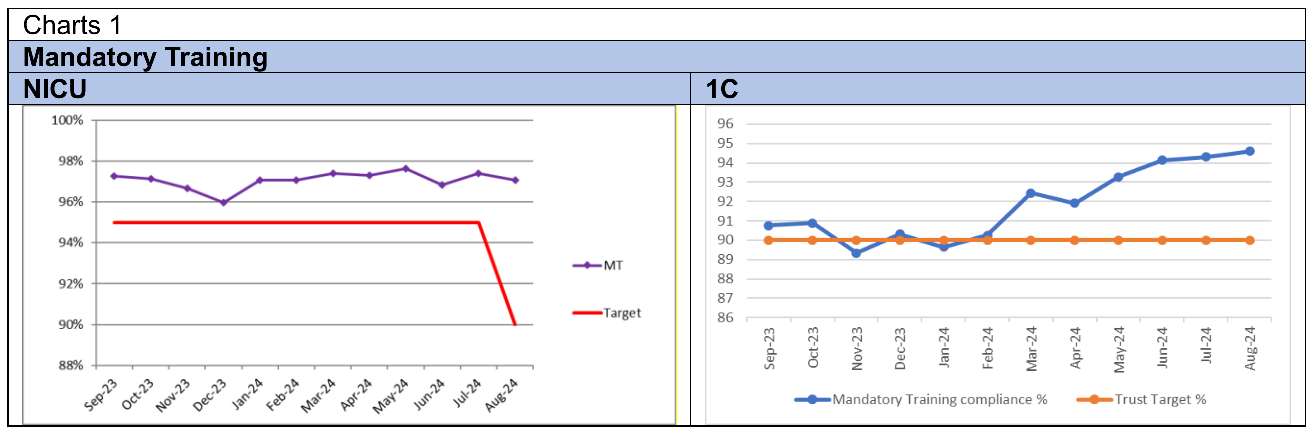
- The NICU Databook will be aligned with NNAP benchmarking and other metrics which are routinely collected.

- QIS nurses at NNSU has increased to 52% as a result of training taking place following the recent recruitment of staff.   Safe staffing maintained on shifts for higher acuity babies who require nurse with QIS

- Work continues Power BI to enhance NNAP standards and benchmarking reporting.

5.2 Mandatory training (NICU / 1C)

Mandatory training metrics for both NICU and 1C are detailed below. Please note there are differing levels of compliance for each Trust. The metric covers all essential clinical and local mandatory training.



Narrative for NICU

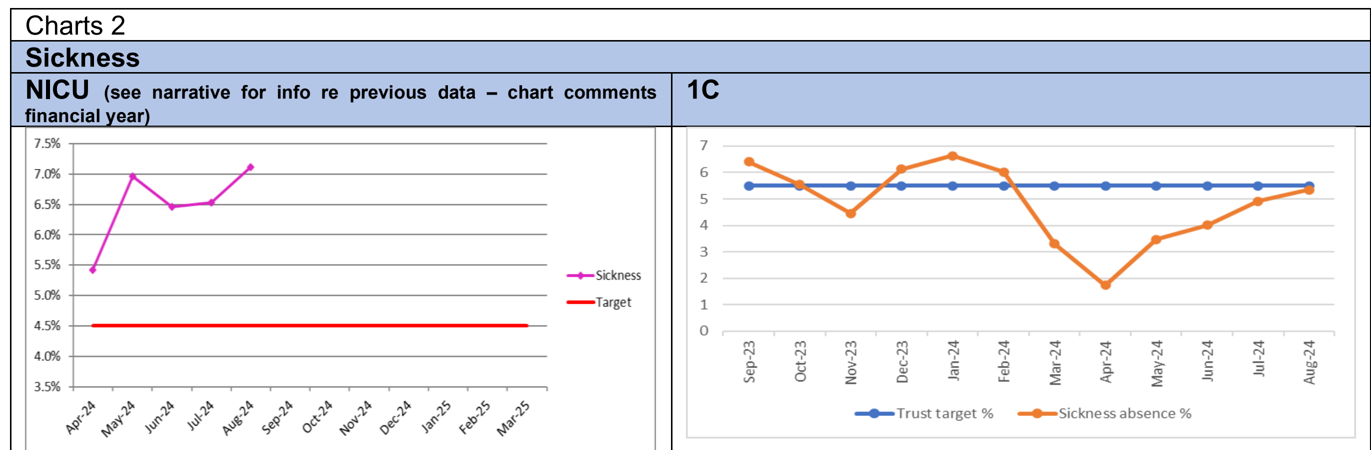
- Mandatory training compliance maintains well above the 95% target for LWH with compliance at 97.40% The Trust target has reduced to 90 % target compliance in line with Alder Hey target.

Narrative for 1c

- Mandatory training compliance has again slightly increased within month, to 94.61%, which remains above the Trust target of 90%. The Learning & Development team continue to share a report within the division and management team to identify the outstanding modules for employees to focus on to support maintain compliance at the Trust target.

Sickness

Sickness metrics for March both NICU and 1C are detailed below. Please note there are differing levels of compliance for each Trust.



Narrative for NICU

- Overall sickness absence for this reporting period has slightly increased to 7.12% from the previous reporting period (of 6.53%). Short term sickness has reduced to 32.20% from the previous reporting period (of 36.89%). Long-term sickness has decreased to 61.80% from the previous reporting period (of 63.11%.

- All sickness absence has been well managed by the team leaders, in line with the sickness policy with support from the divisional HR representative and Occupational Health referrals have been completed.

- The top three diagnosis for short term sickness remain anxiety, stress, depression, GI problems and other musculoskeletal problems.

Narrative for 1C

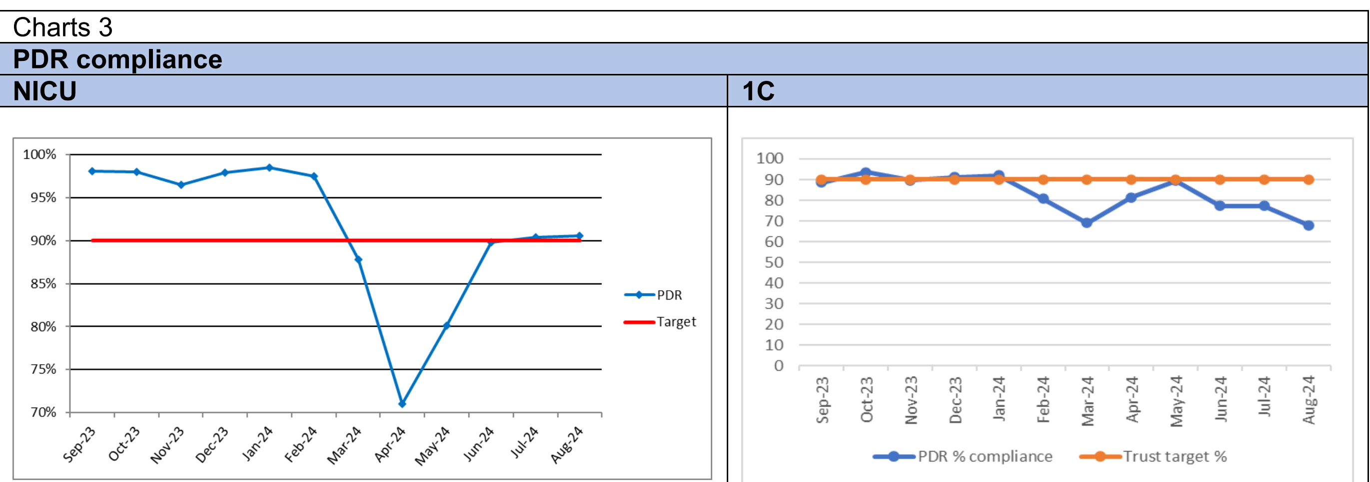
- Sickness absence has continued to increase for the fourth consecutive month to 5.34%, although remaining just below the Trust sickness target of 5.5%. Short term sickness has decreased again within month to 2.05% and long-term sickness has continued to increase (3.29% compared to 1.86% in July 2024).

- There were 10 open episodes of sickness absence in August 2024 and 9 of these episodes ended within the month. The top reason for sickness absence has changed in August 2024 and to “heart, cardiac and circulatory problems” compared to “skin disorders” which was the top reason for July 2024. Management continue to be supported by the HR team to ensure that employees are being appropriately managed in accordance with the Trust’s sickness policy

- Within month, the % of RTW interviews recorded on the systems has decreased within month to 80% (compared to 100% in July 2024). The weekly Return to Work Assurance Meeting, overseen by a Head of Nursing & AHPs, are continuing and providing support to nursing managers as well as understanding any blockers they face in from either completing RTW interviews or recording the RTW details on the roster. HR and Roster colleagues also attend these meetings.

PDR

PDR compliance for both NICU and 1C is detailed below.



Narrative for NICU

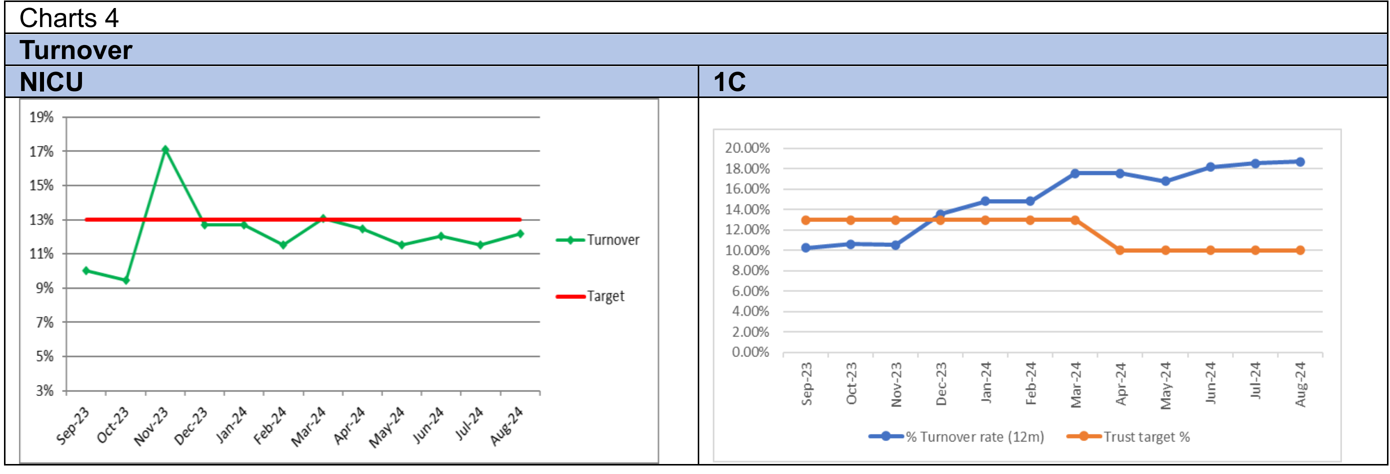
- PDR compliance has slightly increased to 90.52% from the previous reporting period (of 90.43% and remains above the target of 90%.

Narrative for 1C

- PDR compliance has decreased within month to 67.92% (77.36% in July 2024), remaining below the Trust target of 90%. Of the 17 outstanding PDRs, 7 are for employees whose most recent PDR took place 12 months ago (in August 2023).

Turnover

Turnover metrics are detailed below for both NICU and 1C.



NICU

- Turnover has slightly increased to 12.21% from the previous reporting period (of 11.51%) which is below the trust target of 13%.

1C

- The rolling 12 month turnover rate has slightly increased again within month to 18.74% (compared to 18.54% for July 2024), which is above the Trust target. Within month, there were no new starters but 2 leavers from the unit.

- As of 31 August 2024, there have not been any questionnaires completed by leavers from 1C Neo.

6. Joint Risk Register

The combined Liverpool Neonatal Partnership Risk Register is reviewed monthly, to all ensure risks are reviewed regularly and effective controls are in place. All risks are reported to demonstrate they are being managed/mitigated and associated actions remain on track.

To ensure there is parity when assessing risk for the joint risk register (NICU5+5+5) and 1C (5x5) risks are displayed by colour.

For update:

Alignment of LNP risks to relevant workstreams for monthly update and mitigation has taken place.
Multiple digital systems

Risk 2898 Equipment (EBME)

Local controls and mitigations are regularly reviewed. The provision of EBME cover for NICU has been escalated to • Request assurance re the plan to provide the EBME team specialist training required for all neonatal equipment. • To consider review of the current SLA to with regards to the provision of expert neonatal EBME provision for NICU.

Risk 2866 – Fresenius pumps (interface not reading through to BadgerNet)
For escalation • Enquiries with Procurement re contractual arraignments/ SLA ongoing • SWARM huddle (system learning on NICU identified pump interface switched off increased pressure in the room as manual input required) • The fault remains as it has not been identified where the issue originates between the two suppliers. • Risk & SBAR updated. • Both organisations are required to provide oversight at meetings (next meeting end Sept) • Of note, a timeframe for resolution has not been specified to date

Table 3: Liverpool Neonatal Partnership ongoing risks

Liverpool Neonatal Partnership

12 Liverpool Neonatal Partnership - Open Risks (8 NICU / 3 1C)						
Risk	**Description**	**Mitigations/Controls**	**Dates**	**Initial Score 5 x 5**	**Current Risk Score 5+5+5 NICU 5x5 1C**	**Target Risk Score**
2088 NICU	Risk: Non-colocation between neonatal and paediatric services Consequence: Delays in required care provision, MRI, CT, delayed access to paediatric transfusion expertise, avoidable transfers, impaired patient and parental experience, potential patient harm and death. Complaints, serious incidents and claims • Blood transfusions, Delays in radiography, Delays in getting blood results **Proposed alignment with Workstream 1 Clinical Processes & Education/Research for monthly reporting and risk update**	Overarching action plan on track on Ulysses *Action to control risk adequately has started and appears to be effective*	Date identified: 16/11/17 Target Date: 30/4/25 **Next review: 05/10/24**	25 (S5 X L5)	12 (L5+S4+C3) ←→	9 (S5+L2+C2)
0220 1C	Risk: Lack of Neonatal Out of Hours medical cover on 1C 8.30. pm & 8.30 am– Escalation of deteriorating patient pathways **Proposed alignment with Workstream 3 Governance & Workforce for monthly reporting and risk update**	Overarching action plan on track on Ulysses Risk is adequately controlled	Date identified: 03/06/24 Target Date: tbc **Next review: 30/09/24**	16 (S4 X L4)	12 (S4 X L3)	4 4 X 1
2430 NICU	Risk: Network outlier for pre-term mortality - rate is higher than the national average Cause: review being undertaken by the neonatal network Consequence: negative public perception of the trust	Action plan in place QI project ongoing Preterm optimisation *Action to control risk adequately has started and appears to be effective*	Date identified: 15/04/21 Target Date: 30/4/25 **Next review: 31/10/2024**	16 (S4 X L4)	11 (L4+S4+C3) ←→	6 (L3+S2+C1)
RISK 2898	Risk: There is variance in EBME provision re skills, competencies and experience to consistently undertake maintenance, servicing and repair for the neonatal specialist equipment. Cause: The EBME lead for neonatal equipment has reduced available hours (following promotion) to support NICU to 7.5 hour per week. This has created a significant skills gap in EBME provision for NICU as the current structure does not have equitable specialist experience to service, maintain and repair neonatal specialist equipment. Consequence: Delays in maintenance, servicing and repair. Current gaps in skills & competencies of EBME for neonatal equipment	Identification of lead consultant, identification of lead nurse, system to be implemented to receive information from Medusa re status of equipment, PSSI identified learning, establish process within NICU to capture all EBME Escalation of risk trust wide as controls limited to NICU	Date identified: 05/09/2024 Target Date: 30/4/25 **Next review: 12/10/24**	11	11	6
0221 1c	Risk: Recruitment of neonatal Speech and Language Therapy (SALT) staff and dietetics **Proposed alignment with Workstream 1 Clinical Processes & Education/Research for monthly reporting and risk update**	Overarching action plan on track on Ulysses *Risk is adequately controlled*	Date identified: 03/06/24 Target Date: tbc **Next review: 31/10/24**	12 (S3 X L4)	9 (S3 X L3)	6 (S3 X L2)
0219 1C	Risk: Variance in policy and procedures across two sites **Clinical policies - Proposed alignment with Workstream 1 Clinical Processes & Education/Research for monthly reporting and risk update** Staffing policies - **Proposed alignment with Workstream 3 Governance & Workforce for monthly reporting and risk update**	Overarching action plan on track on Ulysses *Risk is adequately controlled*	Date identified: 03/06/24 Target Date: tbc **Next review: 31/10/24**	12 (S4 x L3)	8 (S4x L2)	4 (S4 x L1)
2667 NICU	Risk: Delay in access to timely radiography out of hours Cause: There is no onsite radiographer out of hours Consequence: There will be a delay in diagnosis and treatment of the baby	Overarching action plan on track on Ulysses *Risk is adequately controlled*	Date identified: 15/03/24 Target Date: 30/4/25 **Next review: 08/12/24**	20 (S5 X L4)	9 (L2+S5+C2) ←→	8 (L2+S5+C1)

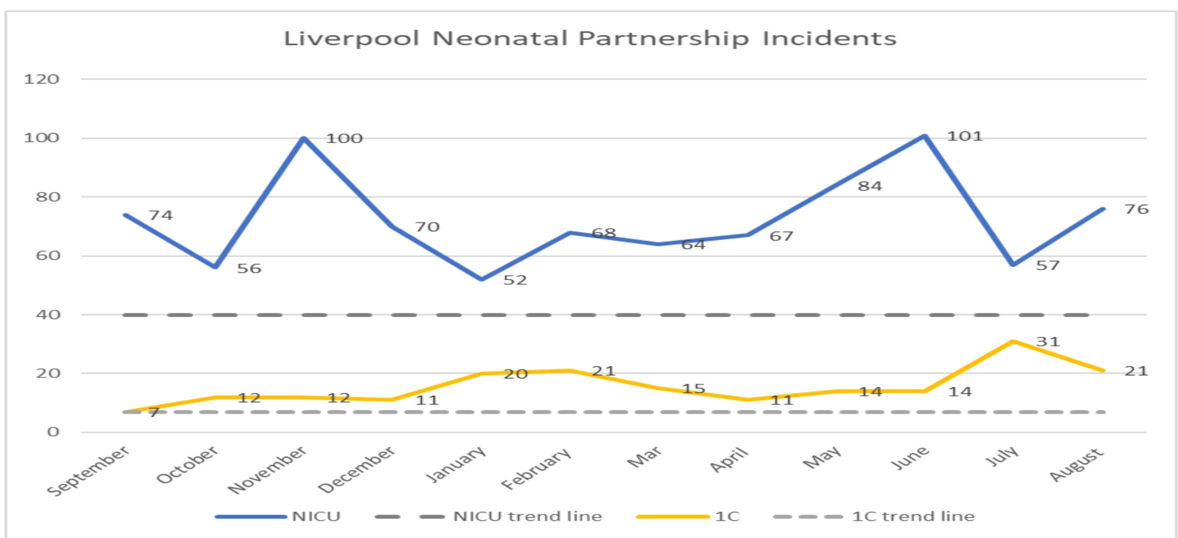
12 Liverpool Neonatal Partnership - Open Risks (8 NICU / 3 1C)						
Risk	**Description**	**Mitigations/Controls**	**Dates**	**Initial Score 5 x 5**	**Current Risk Score 5+5+5 NICU 5x5 1C**	**Target Risk Score**
	Update: Snapshot audit in progress to monitor potential delays for radiography out of hours. Proposed closure of risk if snapshot audit demonstrates issue resolved					
2866 NICU	Condition: The Fresenius pumps are inconsistently miscalculating occasional infusions on the volumetric pumps therefore displaying on BadgerNet inaccurate larger volume than what has actually infused.	Overarching action plan in progress on Ulysses *Action to control risk adequately has started and appears to be effective*	Date identified: 05/06/24 Target Date: 30/11/24 **Next review: 12/10/224**	10 (L3+S3+C4)	09 (L3+S3+C3) ←→	06 (L2+S3+C1)
2223 NICU	Risk: LWH has been involved in a police investigation of public and media interest as a Neonatal Nurse on the Local Neonatal Unit at Chester who has alleged involvement in the murder and harm of babies. Cause: The Neonatal Nurse has worked on the NICU at LWH for 16 weeks over 2 periods. Consequence: There will be extensive press coverage over coming months which may have a negative impact on the reputation of the Trust.	Overarching action plan on track *Risk is adequately controlled*	Date identified: 03/08/18 Target Date: 30/4/25 **Next review: 04/12/24**	12 (S3 X L4)	8 (L3+S3 +C2) ←→	6 (L2+S3 +C1)
2419 NICU	Risk: The maternity EPR does not have the capacity to record all the relevant postnatal pathway information for babies in specialist neonatal care groups resulting in the use of paper records for some elements of neonatal care. Cause: Lack of lack of integration of neonatal pathways into K2 with ongoing reliance on paper notes Consequence: Ongoing reliance on paper records and the risks associated with this. Gaps in immediately available clinical information and the impact on patient care. **Risk update: Risk reduced but not eliminated as jaundice charts and NEWS scoring remains paper based (there is overlap with maternity risk 2457)**	Overarching action plan – risk aligned with risk 2457 Maternity. *Risk is adequately controlled*	Date identified: 16/03/21 Target Date: 30/4/25 **Next review: 11/12/24**	15 (S3 X L5)	8 (L3+S3 +C2) ←→	6 (L2+S3 +C1)
2812 NICU	Condition: Delayed timeliness of MRI scans in newborn babies Cause: Lack of pathway to use onsite MRI facilities and potential delays accessing MRI facilities at AHCH Onsite MRI Facility **Risk update: Guideline on Eolas. SOP work in progress / development of pathway Training for MRI in progress.**	Overarching action plan on track on Ulysses *Action to control risk adequately has started and appears to be effective*	Date identified: 26/03/24 Target Date: 31/03/25 **Next review: 11/12/24**	12 (S3 x L4)	8 (L2+S3+C3) ←→	5 (L1+S3+C1)
2811 NICU	Condition: Lack of onsite specialist cooling equipment Cause: Due to the age of current machines and the purchase of new machine being delayed due to awaiting CE marking. Consequence: Potential avoidable harm for inborn babies requiring paediatric cooling and possible delays in babies being transferred to the unit for cooling. **Machine purchased – training in progress.**	Overarching action plan on track on Ulysses *Risk is fully controlled*	Date identified: 26/03/24 Target Date: 31/10/24 **Next review: 11/12/24**	9 (S3 x L3)	6 (L2+S3+C1) ←→	5 (L1+S3+C1)

7. Liverpool Neonatal Partnership Incidents (NICU / 1C)

The number of incidents reported across the Liverpool Neonatal Partnership is detailed below for both NICU and 1C for a twelve-month reporting period. To demonstrate the reporting culture across the partnership, the tolerance for the minimum number of incidents to be reported is calculated at 5% of admissions for both NICU and 1C. Currently this equates to 40 incidents for NICU and 7 incidents for 1c.

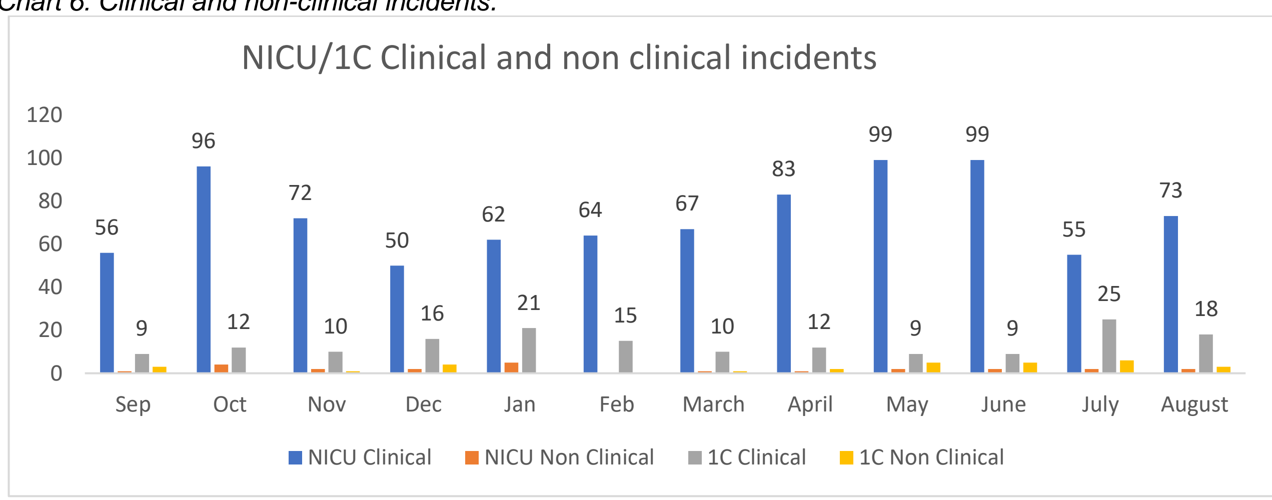
Incident reporting across the Liverpool Neonatal Partnership has remained above the minimum tolerance levels and the number of incidents reported in March are within normal reporting parameters.

Chart 5: Trend of neonatal incident reported across both organisations - 2023/24.



The total number of incidents reported across the Liverpool Neonatal Partnership between 1 September 2023 and 31 August 2024 is **1057** which is a slight decrease from the previous reporting period of (1068). There are 878 NICU and 189 1C incidents respectively. The Chart below details the breakdown of incidents by clinical and non-clinical incidents.

Chart 6: Clinical and non-clinical incidents.

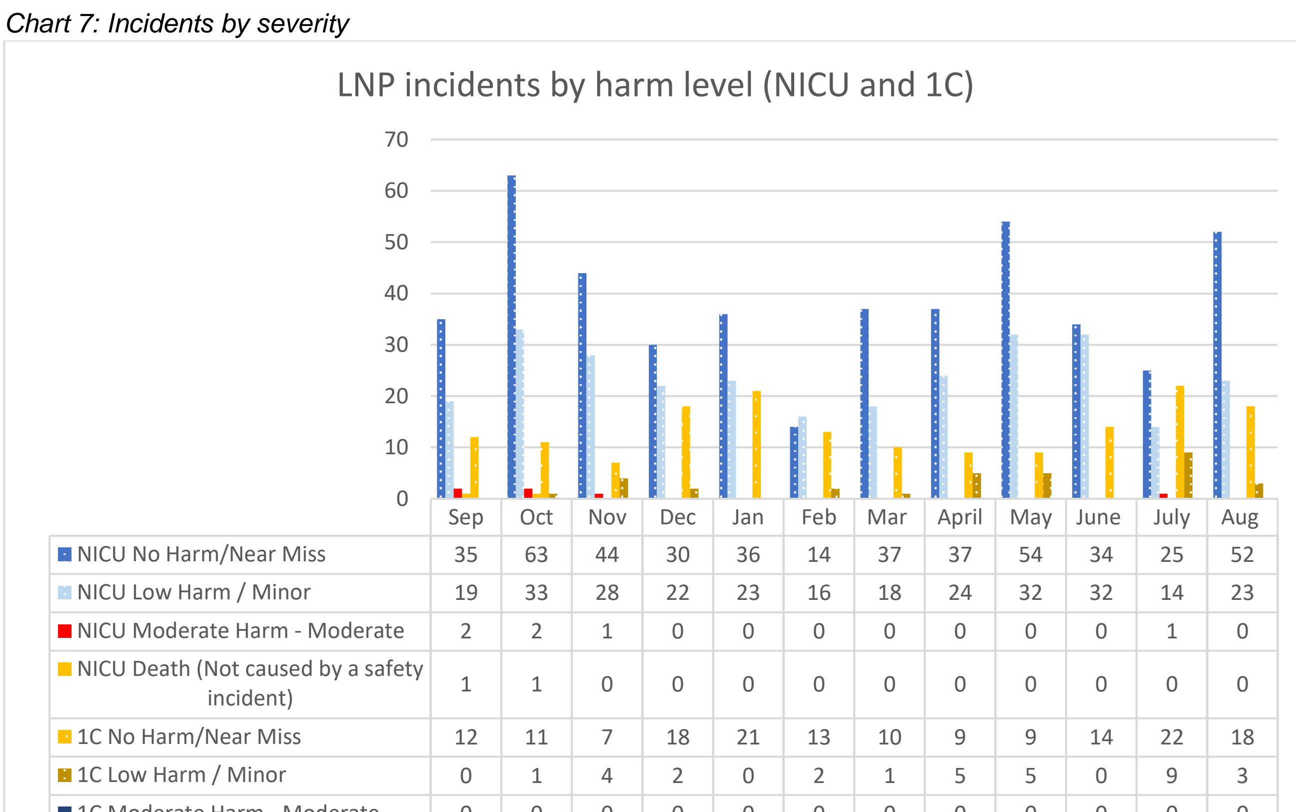


The majority of incidents are reported as no harm, low harm and near miss incidents on Ulysses and InPhase in comparison to a relatively low number of moderate harm and above incidents. This indicates a positive reporting culture across the partnership.

A thematic review of 1C medication incidents identified that there were 57 medication incidents on 1C Neo (rolling 12 months). Medication incidents come under general category but fall under a wide variation of sub titles i.e. medication, administration, dispensing etc. - no particular themes were highlighted.

Incidents continue to be monitored and reported monthly to the monthly risk meeting to identify themes and trends for learning across the partnership.

Chart 7: Incidents by severity



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug
NICU No Harm/Near Miss	35	63	44	30	36	14	37	37	54	34	25	52
NICU Low Harm / Minor	19	33	28	22	23	16	18	24	32	32	14	23
NICU Moderate Harm - Moderate	2	2	1	0	0	0	0	0	0	0	1	0
NICU Death (Not caused by a safety incident)	1	1	0	0	0	0	0	0	0	0	0	0
1C No Harm/Near Miss	12	11	7	18	21	13	10	9	9	14	22	18
1C Low Harm / Minor	0	1	4	2	0	2	1	5	5	0	9	3
1C Moderate Harm - Moderate	0	0	0	0	0	0	0	0	0	0	0	0

<u>Of note at the time of writing this report there are 0 incidents awaiting allocation of harm</u>

All incidents reported across the LNP partnership in August are low harm or no harm/near miss incidents as detailed below

LNP incidents	No
Medication	25
Equipment	19
Clinical Management	10
Injury	8
Blood Transfusion	8
Invasive Procedure Problem	5
Expected Death	4
Admission / Discharge / Transfer	3
Communication	3
Feeding Issue	2

Resuscitation	2
Access, admission, transfer, discharge (including missing patient)	2
Pressure Ulcer	1
Violence, Aggression, Racial Abuse, Sexual Harassment / Safety	1
Complaint	1
Documentation (including records, identification)	1
Investigations	1
Nutritional issue (for TPN see Medication)	1
Grand Total	**97**

Incident rates to activity for August 2024 are detailed below:

Table 4	
Incident Rate to Activity	
NICU	1C
76 incidents reported. Total days 1087 Incident rate to activity =6.99%	21 incidents reported. Total patients 258 The incident rate to activity is 8.13%
There was low occupancy/acuity in August	

7.1 Incident themes reported across both organisations.

To identify incident themes across the partnership, the top 5 incidents for both NICU and 1C are reported monthly to the risk meeting. The table below details the top 5 incidents across the partnership in March along with a comparison for the previous reporting period.

Table 5: Top 5 incident themes (NICU and 1C)

Incident type	NICU	1c	Total	←→ ⇧ ⇩	Narrative	Previous reporting period

Medication	18	7	**25**	⇧	NICU
					16 Administration
					• 6 CD documentation
					• 6 Missed Medications
					  ○ 3 Antibiotic missed
					  ○ 1 Vitamin missed
					  ○ 1 Miss loading dose Vanconmycin
					  ○ 1 TPN late
					• 1 Missing documentation
					• 1 Pump error – increased
					• 1 Documentation
					• 1 Infusion
					
					1 x Prescribing (Documentation)
					
					1 x Medication Dispensing Pharmacy
					
					1C
					6 x Administration
					• 4 Infusion
					• 1 wrong route
					• 1 documentation
					
					1 Prescribing Documentation
						15
						9 NICU / 6 1C

Learning

- Red tabards have been introduced and medicine drug trolley following AAR.
- Signage has been displayed in NICU to provide information about the red tabards and to request all staff and visitors to not interrupt clinical staff when wearing red tabards.
- Prescribing has seen a reduction in incidents for this reporting period.
- SWARM huddle re an incident involving pump volumes bein inadvertantly increased which has identified learning to request BadgetNet to reinstate the colour change when drug rate changes.
- Medication incidets are the highest reported incidnet type –for NICU. The SPC chart details the number of medication incidents for a twelve month period.

1C

- Lipids – focus of the week re second nurse checking lines/staff safety huddles

Medication Incidents C-Chart

High acuity

Reporting returned to usual parameters

45 40 35 30 25 20 15 10 5 0

18.3

01/09/23 01/10/23 01/11/23 01/12/23 01/01/24 01/02/24 01/03/24 01/04/24 01/05/24 01/06/24 01/07/24 01/08/24

Month

Values — Mean — Upper control limit — Lower control limit

Equipment / Medical devices	13	6	**19**	↑	NICU 13 equipment related incidents 6 Equipment Device Failure • 2 Transwarmer • 1 Cold Lights • 1 Guidewire • 1 Cooling mattress markings • 1 ET tube 5 Equipment faulty/Damaged (three chairs broken, High flow prongs, blunt needle, cold lights, nasal canula) 1 Equipment / Device Error (Oxygen limits not readjusted) 1 Equipment device (Cooling Machine 1C 6 Failure of device/equipment • 3 TPN Leaking line • 1 TPN Leaking bag • 1 TPN issue with lipid pump • 1 snapped butterfly	15 7 NICU / 8 1C

Learning

- Equipment risk reported on risk register re provision of EBME.
- CQC action plan in progress which includes equipment issues
- Provisional Lead Consultant and nurse dentified to lead on equipment in NICU
- Cooling machine being trialled on unit with training in progress currently at 69%

<table>
<tr><td>Clinical Management</td><td>9</td><td>1</td><td>10</td><td>↓</td><td>NICU 9 clinical management

3 communication issue (clinical management)
• 1 Oxygen limits
• 1 Communication re delivery / hydrops
• 1 Renal pathway

2 Failure to monitor appropriately
• 2 oxyen limits

2 Failure to follow guidelines
• 1 gentamicin
• 1 renal pathway

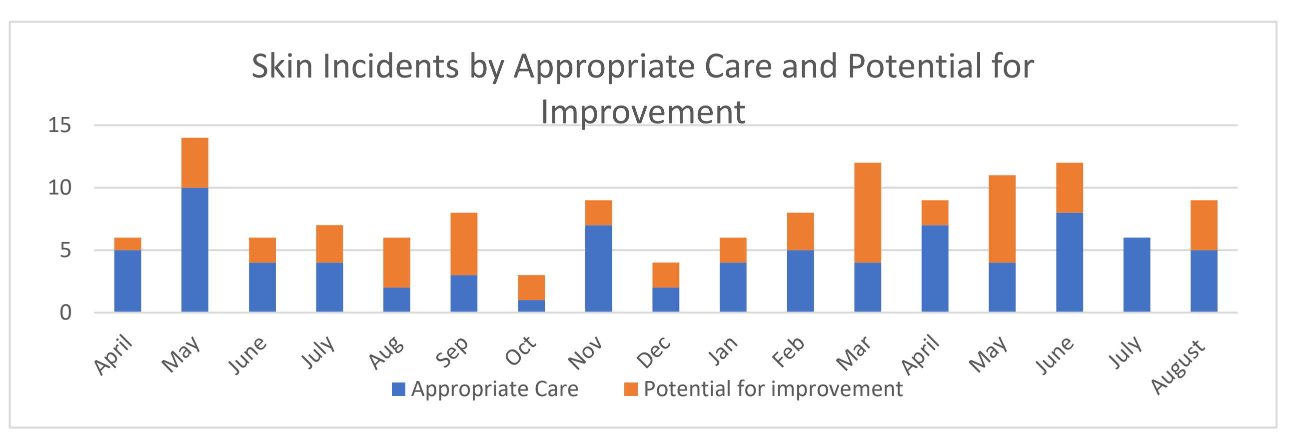
1 Bradycardia (clinical management)
1 Equipment faulty – ventilator alarming

1C
• Delay in treatment (incorrect prescribing)</td><td>11
9 NICU / 2 1C</td></tr>
<tr><td colspan="7">Learning
• Oxygen limits re recent guideline update (no harm incidents – ranges within safety parameters of previous guideline)
• Renal pathway under review
• Improved reporting to support the idenification of incident themes is required – to be managed though Workstream 3 Governance & Workforce</td></tr>
<tr><td>Injury (skin damage)</td><td>9</td><td>0</td><td>9</td><td>↓</td><td>There is an slight increase in reporting of low harm skin injuries from the previous reporting period

• 6 Bruising (2 blood transfusion, 2 sats probe, 1 canulation, 1 haematoma,
• 2 (medical device injury - skin probe)</td><td>7
6 NICU /1 1C</td></tr>
<tr><td colspan="7">• Newsletter production re use of adhesive removal wipes for when removing wriggle pads
• Reeducation re use of full body maps on admission
• All skin injuries are reviewed by Tissue Viability Nurse/Link Nurse
• Good practice identified – positive reporting re written documentation in nursing care notes shows mask and prongs have being changed 4 hrly and documented. Imprância of vigilent skin checking for babies on long term CPAP
• An overarching improvement plan in progress

Next Steps:
Next edition of skin newsletter in progress
Formalise regular clinical review on skin (audit process)

The chart below details the number of skin injuries on the unit over time by potential for improvement and appropirate care</td></tr>
</table>



Blood transfusion	6	2	**8**	↑	6 Blood transfusion incidents • 1 Blood tracking traceability • 1 O Neg • 1 Traceability • 1 Blood sample incorrectly labelled • 1 Blood product expired • 1 Delay 1C • 1 Traceability • 1 Clinical Delay	2 5 NICU / 0 1C
Learning **Ordering blood products -** Nurses and medical staff should check line availability prior to ordering blood products to avoid wastage. This reminder has been circulated through the newsletter and WYNTK.						

7.2 PSIRF

PSIRF is operational across the Liverpool Neonatal Partnership. Details of incidents which have been reviewed using PSIRF tools within this reporting period are below.

Table 6 PSIRF Tools

PSIRF Tools		
PSIRF Tool	**NICU Details**	**Learning**
Rapid Reviews	4X Expected deaths 1 delivery suite IV Extravasation	3 x No safety actions identified as part of rapid review process 1 x Documentation re failure to complete risk assessment re ventilated baby and following bereavement checklist. **A swarm huddle undertaken.** Good practice was identified in the use of transwarmer. *Learning identified to review pathway (maternity / neonatal re comfort care for a death reported by Maternity* Rapid review completed – AAR scheduled 16/9/24
PSIRF tools	SWARM Huddle	3 Swarm Huddles • Medication (pump volume increased) • Medication (Vancomycin omitted) • Communication – IV
PSSI';	113113 – Never Event – Retained foreign object (guidewire)	PSII commissioned – in progress

Next Steps

- **Improved reporting on Ulysses**
  - To improve reporting to demonstrate learning identified following PSIRF tools as standard practice. This is to include standardisation of categories (e.g. medication/equipment)
  - Improved reports (updating current reports within Ulysses to capture pertinent information and standardise fields) – to ensure parity with reporting metrics

- **Embedding PSIRF culture**
  To mitigate single point of failures - SEIPS training with team leaders completed
    - Require Seips training - consultants & ANNPs

- **Duty of Candour**
  Duty of Candour training produced
    - Attend Senior Ops, Consultants Meeting and ANNPs

- **Embedding Learning**
  Commitment to attend / review Learning from deaths and safety incidents
  Production of learning booklet
  Recruitment of LNP Educator
  Quarterly education meetings to review learning arising out of incidents.

7.3 Interface incidents (including joint reviews/investigations)

The following interface incidents for this reporting period:

Safeguarding – PSIRF MDT Review identified learning relating to improved communication re safeguarding information. Action plan in progress in conjunction with both safeguarding leads at LWH and AHCH.

Safeguarding incident – identified a breakdown in communication in discharge processes to handover safeguarding information

- **Learning:** Learning identified – to review safeguarding pathways and feed safeguarding themes identified into LNP work instreams

Diagnosis – delayed post-natal (oesophageal atresia/trachea-oesophageal fistula).

- **Learning** - Review in process

7.4 Learning from deaths and safety incidents

The following learning was shared at the learning from deaths and safety incidents meeting:

- Incident data and themes
- Rapid reviews learning from deaths
- Cooling reviews
- Safety focus ‘nothing is routine’

7.5 CAS Alerts

There was 1 cas alert received within NICU and 1C

8. Caring

8.1 Complaint and PALS

There were no formal complaints received across the Liverpool Neonatal Partnership for this reporting period.

There were no Patient Advisor Liaison Service queries received across the Liverpool Neonatal Partnership in June 2024..

Table 7		
Patient Advisory Liaison Service (Pals)		
August 2024		
1	Pals	Family flat in poor condition and required cleaning. Deep cleaning and apology provided.

8.2 Friends and Family

There no friends and family questionnaires to report on 1C. The team have focused communication with families to improve completion of patient feedback. The QR code for FFT will now be included in the discharge paperwork for families.

Patient feedback is produced quarterly for NICU.

9. NICE Guidance

NICE guidance and has been identified as an area for improvement within the unit. This has been included in the workstream for governance & workforce to review current processes and identify areas for improvement.

Power BI Dashboard detailing the status of NICE Guidance is now available.

Details of open NICE guidance in progress is below:

Service	Type of guidance	Guidance ID	Guidance Title	Month Issued	Guidance status
Neonates & Infection Control	NICE Guidance	NG195 (Apr 21)	**Neonatal infection: antibiotics for prevention and treatment**	Apr-21	Completed remaining action
Neonates & Infection Control	NICE Guidance	NG195 (Update March 24)	**Neonatal infection: antibiotics for prevention and treatment**	Mar-24	In Progress
Neonatal	Quality Standards	QS205	**Neonatal parenteral nutrition**	Mar-22	In Progress
Neonatal	Clinical Guidance	CG98 (update Oct-23)	**Jaundice in newborn babies under 28 days**	Oct-23	In Progress
Neonatal	Quality Standards	QS75 (Update Jan-24)	**Neonatal infection**	Jan-24	In Progress

10. Issues to note:

Incidents:

- **LNP Incident Reporting**
    - to standardise incident themes to support Power BI and theme /trend analysis
    - To improve reporting to demonstrate learning identified following PSIRF tools as standard practice.
    - Improved reports across the LNP (Ulysses/InPhase) to ensure parity with reporting metrics

- **Embedding PSIRF culture**
    - Require Seips training - consultants & ANNPs (Swarm/AAR) –

- **Duty of Candour**
  - Attend Senior Ops, Consultants Meeting and ANNPs

- **Embedding Learning**
  Commitment to attend / review Learning from deaths and safety incidents
  Production of learning booklet

Risk

- **Multiple IT systems**
  Identification of merged records on ICE – SBAR completed, and strategy meeting took place to assess risk
  Escalation: Trust risk for multiple IT systems has been raised at TSM.

- **Equipment**
  Local controls and mitigations are regularly reviewed. The provision of EBME cover for NICU has been escalated to
  - Request assurance re the plan to provide the EBME team specialist training required for all neonatal equipment.
  - To consider review of the current SLA to with regards to the provision of expert neonatal EBME provision for NICU

- **Fresenius pumps (interface not reading through to BadgerNet)**
  Enquiries with Procurement re contractual arraignments/ SLA ongoing.
  There is no agreed timeframe for resolution

CQC MOCK INSPECTION

- CQC action plan in progress.
- Monthly meetings scheduled to monitor progress.
  Action: IG workplan - CQC/BBAS action plan

NICE Dashboard Power BI

- Reporting from NICE Dashboard to be added into IG Workplan

11. Recommendations

The LNP to note the performance and actions taken to mitigate areas of escalation across the LNP Partnership

- To note the content of this report.
- To note escalations

Name – Susan O'Neill / Acting Head of Neonatal Nursing, Liverpool Neonatal Partnership
Justine Collins / Governance Manager Neonates

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	People Plan highlight Report.
Report of:	Chief People Officer
Paper Prepared by:	Sharon Owen, Deputy Chief People Officer & Kathryn Allsopp, Associate Director of People

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

Does this relate to a risk? Yes ☑ No ☐ **If "No", is a new risk required?** Yes ☐ No ☐					
Risk Number	Risk Description				Score
#2664 #16 (2.1 BAF)	Industrial strike action impacting staff availability. Workforce sustainability and Development				12 15
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

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

2. Workforce Metrics

The monthly workforce metrics are provided in the Integrated Performance Report (IPR). As September workforce information was not available at the date of this writing this report, it is based on August 2024 workforce data.

Key highlights from the workforce metric data:

- **Sickness** - The sickness absence target for 2024 is 5%, which comprises of a target for both short term and long-term sickness absence. The short-term sickness absence target is set at 2% and long-term sickness absence is 3%.

  Sickness absence in August was **5.23%** and above Trust Target of 5%, though a slight decrease from the previous month. Sickness absence continues to be driven largely by long term sickness absence at just over 4%, with under 2% being Short Term sickness absence. Divisional HR Business Partners continue to support divisions to ensure that there are action plans in place to support all staff absent from work due to sickness.

- **Turnover** - Turnover in August was **10.17%**, against a target of 10%. The position continues to be monitored, with regular reporting continuing. Turnover has seen significant improvement across the past 12 months.

- **Personal Development Reviews (PDR's)** - PDR completion has remained below 90%; there are specific concerns with B7+ PDR compliance which were due to be completed by 31st July 2024. PDR completion is being supported across the L&D and HR teams, with data regularly shared with managers for action.

- **Total Workforce WTE** - Total Workforce WTE (whole time equivalent) has become an increasingly prominent metric, both internally and externally. Total workforce includes bank and agency as an WTE, doctors in training working at the Trust, and all staff in post (including maternity leave). The plan reflects the 2024/25 budgeted WTE, with reductions from October 2024 to account for a level of workforce CIP.

  The workforce efficiencies programme is in place, chaired by the Deputy Chief People Officer, and reporting through SDG. The programme is focused on

workforce spend and potential efficiencies for 2024/25, alongside a review of controls and schemes to enable potential future savings (into 2025/26). The WTE report is now available at a divisional level.

3. Staff Survey

The 2024 staff survey is now open and closes on 29th November 2024. Information has also been shared highlighting actions taken following previous survey feedback, and the importance of the feedback received. Response rates will be shared to promote continued completion throughout October and November. At the time of writing (27th September) the return rate is 14%.

4. Agenda for Change Pay Award

The 5.5% pay award will be paid in October, backdated to 1 April 2024. While Unison and Unite members have voted to accept the NHS pay award, Royal College of Nursing (RCN) members have collectively not voted in favour for the 2024/25 pay award, with 64% of those who voted saying they don't believe that the award is sufficient. Though a strong indication of feeling, this was not a ballot on industrial action, nor has such a ballot been signalled.

In response, the RCN have confirmed that they are looking for the government to demonstrate its commitment to nursing staff "by showing that its NHS reform plans will transform the profession as a central part of improving patient care".

5. Industrial Action

BMA junior doctors have voted in favour of the government's pay offer, which brings an end to the industrial action. The uplifts in pay for 2023/24 and 2024/25 will be paid in November 2024 salaries. Locally employed doctors on equivalent salary points (which ours are) will also receive the uplift in November 2024.

The pay offer included some non-pay measures, mainly looking to reform the current system of training and rotational placements (looking at the number and frequency of rotations for example), and amendments to the exception reporting process will be led centrally by Department of Health and Social Care, and NHS Employers respectively.

The BMA have also confirmed that they will no longer use the term 'junior doctor' instead using 'resident doctor'. This has been supported by NHS employers and adopted at Alder Hey. The term 'doctors and dentists in training' remains unchanged.

Of note, there remains an active dispute between the government and General Practice colleagues.

6. Conclusion and Next Steps

- Continuation of Divisional HR support to identify appropriate interventions needed, to support thriving teams and improve workforce metrics.
- Focus on workforce spend and potential efficiencies for 2024/25 through the workforce efficiencies workstream.
- Communication to be imminently issued in respect of the pay award for junior/resident doctors.
- Amend Trust documents to adopt the term ‘resident doctor’ where we would have previously used ‘junior doctor’.

BOARD OF DIRECTORS

Thursday, 3rd October 2024

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

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	None
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	
Associated risk (s)	BAF risk 2.3

1. Introduction

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 concerning Equality, Diversity, and Inclusion (ED&I) during August and September 2024.

2. Alder Hey Anti-Racist Statement

Alder Hey has committed to becoming an anti-racist organisation and is working towards implementing the North West BAME Assembly Anti-Racist Framework. This has been a dedicated area of development for us, brought into sharper focus following the Southport tragedy and subsequent violent events that followed. These events have challenged us to reflect on how racism affects our organisation, our children and young people, and our staff, and we will do all we can to ensure that our culture is safe, inclusive and free from discrimination. We have started to have open, honest and challenging conversations with our staff, supported by the REACH network and other colleagues, in the hope that we can develop a statement of intent which encompasses staff voices.

The first meeting was held in August, where we started to create a meaningful statement that sets out our commitment to being an actively anti-racist organisation. Our final meeting is scheduled for Monday 30th September in which we will agree on the final draft statement which will then be shared with the executive team. Our anti-racist statement will align with our organisational values and support the work we are embedding.

3. Staff Networks

Our staff networks continue to make positive changes to support the workforce, working to enhance the experiences of our staff working at Alder Hey.

- ACE - Disabilities and Long-Term Conditions staff network continue to actively work with HR to promote ESR, raising awareness of the importance of declaring disabilities on ESR. The staff network has also been working closely with our HR business partners to provide feedback on policies and the revised sickness absence policy has been shared with the group for feedback. Relationships between the staff networks and HR colleagues are growing and the members have appreciated being included in these developments. The network is planning an 'ACE Week' for early 2025. 'ACE Week' will include events and support for staff to raise awareness of the network and also disabilities and long-term conditions.

  An innovation currently in development is the 'empathy lab'. This will provide a learning space for staff to share someone else's feelings and perspectives, providing them with tasks and equipment which will allow them to experience what it feels like to live with a disability/impairment. They are also engaging with colleagues to support walkabouts and site visits for new projects to ensure correct accessibility and inclusive facilities.

- The Armed Forces staff network attended the Veterans Aware Conference in St George's Hall in September. It was an opportunity to meet with other Trusts and social providers of care to exchange ideas and gather further information on what is available to veterans and serving personnel with regards to physical and mental health care. Plans continue for the Remembrance Day service which will take place on Monday 11th November in the Atrium 10:30am – 11:30am, where we will be joined by the local armed forces cadets who will support the event. The staff network is also collaborating with The Clatterbridge Cancer Centre and we will be joining their networks.

- The REACH staff network had a fantastic celebration event at the end of August to mark 1 year anniversary of the network, and were joined by several members of staff to reflect on the progress made over the year. The network is now holding monthly meetings which will take place face to face to ensure that staff are supported. October is Black History Month and we have plans to celebrate throughout the month to ensure that the month recognises and celebrates the impact of black heritage and culture. Some of the network members will be sharing their reflections throughout the month, we will hold a lunch and learn session and we will be sharing a video on black history in Liverpool. We aim to launch our organisational anti-racism statement towards the end of October and will mark the event with a range of activities, including a cultural performance in the atrium.

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

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	People Committee: Chair's Highlight Report from the meeting held on the 19.9.24.
Report of:	Jo Revill, Non-Executive Director
Paper Prepared by:	Jo Revill

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent People Committee meeting held on 19th September 2024, along with the approved minutes from 17th July 2024 meeting.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
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

0261

1. Executive Summary

The People Committee (PC) is responsible for providing strategic direction and board assurance in relation to all workforce matters, and making recommendations, as appropriate, on workforce matters to the Board of Directors, in support of the delivery of high-quality patient and family centred care. In particular ensuring that the strategic objectives relating to people as set out in the Trust's People Plan are met.

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

- The Committee received the Internal Communications report and noted the progress.
- The Committee received a People Plan update and held a good discussion on current progress which continues to move forward aligned to 2030 Vision plans.
- The Committee received the Trust people metrics report which shows an overall stable position.
- The Committee received the Divisional Metrics Reports showing a good trend of data across the divisions with assured actions plans in place.
- The Committee received the Staff Temperature Check update and held discussion on proposals in preparation for launching in Q3 2025.
- The Committee received a position paper on overpayments to date, noting all management actions and mitigations in place to support a reduction.
- The Committee received the WRES/WDES reports
- The Committee received a Gender Pay Gap report update
- The Committee received the Improving Working Lives of Junior Doctors report.
- The Committee received the Annual ER report.
- The Committee received the Whole Time Equivalents (WTE) Workforce Efficiencies Programme update.
- The Committee received the Board Assurance Framework report for August 2024.
- The Committee received and ratified the following policies: Uniform & Dress Code Policy, Capability & Performance Policy, Supporting Colleagues Policy.
- The Committee received the LNC Minutes for information.
- The Committee received the EGC Minutes for information.
- The Committee received the JCNC Steering Group Minutes for information.
- The Committee received the H&SC Minutes for information.
- The Committee received the EDI Minutes for information.

3. Recommendations & proposed next steps

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

People and Wellbeing Committee
Minutes of the last meeting held on 17th July 2024
Teams

Present:

	Name	Role	
	Jo Revill	Non-Executive Director **(Chair)**	(JR)
	Nathan Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Fiona Beverage	Non-Executive Director	(FB)
	Katherine Birch	Director of Alder Hey Academy	(KB)
	Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
	Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
	Chloe Lee	Associate COO – Surgery	(CL)
	Sarah Leo	Associate Chief Operating Officer – Research	(SL)
	Jo Potier	Associate Director of Organisational Development	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS
In attendance:	Neil Davies	Human Resources Business Partner	(ND)
	Anne Doyle	Volunteer Manager	(AD)
	Joe Fitzpatrick	Internal Communications Manager	(JF)
	Greg Murphy	Local Security Management Specialist	(GM)
	Phil O'Connor	Deputy Director of Nursing	(PO)
	Sharon Owen	Deputy Chief People Officer	(SO)
	Jill Preece	Governance Manager	(JP)
	Darren Shaw	Head of Organisational Development	(DS)
	Kerry Turner	FTSU Guardian	(KT)
	Jennie Williams	Head of Quality Hub, Brilliant Basics	(JW)
	Tim Czarnecki-Wilson	HRBP Medicine Division	(TCW)
	Julie Worthington	Staff Side Representative	(JW)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Apologies:	Alfie Bass	Chief Medical Officer	(AB)
	Rachael Pennington	Associate Chief Nurse – Surgery	(RP)
	Angela Ditchfield	EDI Lead	(AD)
	Adam Bateman	Chief Operating Officer	(AB)
	Garth Dallas	Non-Executive Director	(GD)
	John Chester	Director of Research & Innovation	(JC)
	Urmi Das	Director, Division of Medicine	(UD)
	Rachel Hanger	Associate Chief Nurse – Surgery	(RH)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
	Pauline Brown	Director of Nursing	(PB)
	Carolyn Cowperthwaite (CC)	Acting Associate Chief Nurse – Surgery	
	Jacqui Pointon	Associate Chief Nurse - Community	(JP)
	Lisa Cooper	Director of Community & Mental Health Services	(LC)

24/25/021 **Declarations of Interest**

No declarations were declared.

24/25/022 **Minutes of the previous meeting held on 20th March 2024.**

The minutes of the last meeting were approved as an accurate record.

24/25/023 **Matters Arising and Action Log**

Action log was updated accordingly.

24/25/024 **Internal Communications Update:**

The Committee received the Internal Communications Update report. JF drew the committee's attention to the following highlights:

The Internal Communication Team maintain oversight in relation to activity across the organisation in connection with the People Plan agenda.

The Staff Awards will re-launch and a date will be scheduled in due course – all nominations are now live which is receiving good number of responses.

The Communications team are working alongside the FTSU Champions who are currently working on projects regarding awareness raising.

JR queried the effectiveness of internal emails and asked about plans in terms of benchmarking. JF commented that our Microsoft package does not have built in-house analytics capability. He went on to inform colleagues that the Team are trialling an analytical process with the Medication Safety and Pharmacy Teams given the importance of these emails. This work is in its early stages but should give us an initial benchmark in terms of staff interactions. If successful, this could be rolled out to other service areas.

Action: JF will come back to the committee in January 2025 to provide the committee with an update on progress on all ongoing projects.

JW talked about one of the main principles of Brilliant Basics being co-design with Children and Young People and queried if this approach had been considered with colleagues in terms of how they want to receive the information that a) we need to tell staff and b) the information we would like to share with staff. JF welcomed a conversation with the Brilliant Basics Team to consider this approach and went on to talk about a piece of work undertaken some time ago with Listening into Action relating to email etiquette and stated that some of the lessons learned could be revisited as part of better understanding the most optimal communication channels.

Resolved: The Committee noted the contents of the Internal Communications Report.

24/25/025 **Monitor Progress against the People Plan:**

The Committee received a verbal update on the progress against the People Plan. MS highlighted the following for the Committee attention:

MS reported that a presentation was made to Trust Board following the July 2024 People Committee outlining the next steps of our cultural journey which received positive feedback. A dedicated session is planned to work through the feedback and direction of travel, deployment of resources and Trust commitments aligned to the Board's vision. An update will be brought back to this committee in September 2024 and then follow to Trust Board in October 2024.

JR asked if there are any critical areas we should be aware of. MS advised that resource remained a focus for delivery of the People Plan and was pleased to advise that Kathryn Allsopp will be stepping into the Associate Director of People role with an existing Business Partner stepping into Kathryn's role. These appointments will ensure the right people are in post to ensure progress is being made.

Resolved: The Committee noted the contents of the People Plan update.

Trust Wide Metrics

The Committee received the Trust Wide Metrics report.

- Turnover remains on a positive trajectory as we are progressing into 2024.
- Sickness absence overall continues to be stabilised and monitored for all long- and short-term sickness cases.
- Overpayments shows a positive reduction.
- Return to Work data remains challenging and senior leaders continue to manage and maintain across the organisation supported by HRBPs.

JW provided assurance to the committee noting the Brilliant Basics Team continue to work with divisions by putting trajectories in place to support with data reporting for executive assurance and oversight.

JW highlighted a positive celebration overall on the trusts mandatory training position which shows a statistical significance also noting by using the data in this way allows us to measure over time what has improved at a trust wide level.

- **Divisional Metrics**

Surgery Division

The Committee received the Surgery Division metrics report (June 2024) data. CL highlighted the following to the committee:

Staff turnover, sickness absence and mandatory training is making a significant improvement in terms of meeting trust targets.

- Theatres turnover data shows a significant improvement compared to the last 12 months and continues to move in the right direction. Action plans remain in place to keep service provisions stabilised.
- Time to Hire shows a decrease for the 4th month running with continued support from recruitment colleagues with lots of engagement with drop in sessions and continues to make progress.
- Return to work data; continue to run weekly meetings lead by Senior colleagues to review all return reports. Metrics shows a decline with there are action plans in place.
- BAME workforce remains in a higher percentage remaining at 18%. This remains as a standard agenda item at divisional board level and reviewed by the interview panel on how to implement better improvements.
- PDR has dropped slightly under trust target – trend is declining, and all teams continue to ensure colleagues are booked in for their PDR before deadline.
- Overpayments remains a focus in terms of Financial Sustainability Group supported by finance and HR colleagues in identifying those historical hot spots.
- HR Drop-in Sessions displays good visibility with HR in trying to extend those out to other areas across the trust and continue to look for ways to widen.
- Staff Survey continues to conduct big conversations and a teams channels has been created to share plans between areas and is presented monthly.

The division is activity working on the Anthony Walker foundation training that community division rolled out to staff recently.

JR advised this shows good work being achieved across the patch. The committee noted staff turnover figures show a really big change and is making great progress.

Resolved: The Committee received and noted the contents within the report.

Clinical Research Division

The Committee received the Clinical Research Division metrics report (June 2024) data and noted progress to date. SL pulled focus to the following:

- Mandatory Training remains above trust target and continues to be managed.
- PDR for band 7 and above is making good progress and continues to be monitored.
- Staff turnover is currently above trust target but the small number of staff within the CRD can change percentages quite significantly Feedback from the exit interviews from those staff leaving has been positive so no areas of concern to feedback to the Committee.
- Sickness absence reports a slight peek in short term sickness levels and shows an improvement in long term sickness.
- Big Conversation held in June which was utilised as a Wellbeing and Improvement Day was supported by JW/JP who conducted an improvement

work session focusing on 3 projects on our annual plan and a session in terms of stability and respect and was well received by the division.

SL formally thanked Megan Ainsworth and Brittany Simister from a Human Resources perspective for supporting the Clinical Research Division during the last few months.

JR asked if the training for managers around the recruitment process supported by JP will be an ongoing focus within the division. SL advised that the team had an away day earlier this year and conducted big conversations session with colleagues as a focus on development for all staff including Line Managers and will continue to review across the workforce. The divisional Annual Away Day has now been arranged and supported by HR.

KT asked if the Trust is taking steps to measure the uptake of exit interviews and their content. MS reminded colleagues of the detailed work underway by Katie Jones, HRBP for Surgery that is presented to People Committee regularly and includes a piece of work to review exit interviews and the process.

Resolved: The Committee received and noted the contents within the report.

Community & Mental Health Division

The Committee received the Community & Mental Health metrics report (June 2024) data and noted progress to date. RG highlighted the following:

- Sickness absence shows a slight rise driven primarily by in short term sickness. Action plans remain in place to address and stabilise across the division.
- OPD remains a challenging area. SALs, FTSU, HRBPs continue to provide support to all colleagues and managers.
- Return to work compliance remains challenging across services. The division remains focused on thinking about how we can support and improve as part of our process in line with trust guidance.
- Time to Hire remains challenging to fill vacancy posts. Senior Leaders continue to instil action plans and manage accordingly. Divisional induction process introduced as an opportunity to on-board colleagues into the organisation. Positive feedback has been received.
- HR Learning Sessions continue to run across the division as part of staff development and support.

JW highlighted a celebration success relating to the medical appraisals which are showing a good trend in improvement for the division. JW went on to ask if there are any key learning points that can be shared to support improvement across the divisions. RL commented that there are fewer medical staff within the Division but paid credit to the medical management for their support in this area.

FB noted Community and Mental Health is one of the areas that’s contributing to the overall increase in the proportion of BAME staff within the workforce and asked if there was anything particular that had been done to bring about this positive change. RG talked about a plethora of actions including interview panels are being balanced, a

suite of various EDI questions that have been mandated that all interviewees are asked and also EDI training within for all senior staff within the Division.

FB asked if any feedback on that completed training could be given. RG confirmed an evaluation has been circulated to colleagues who have done it as part of the divisional leadership team and is currently collating the rest of that information. The second module is due to start in September 2024.

Resolved: The Committee received and noted the contents within the report.

Medicine

The Committee received the Medicine Division metrics report (June 2024) data and noted progress to date. SC highlighted the following to the committee attention:

- Staff Turnover remains low; a positive position given the 'hard to recruit to' roles within the Division.
- Sickness absence shows a slight spike in short term cases with a further reduction in long term sickness cases. Overall remains below trust target.
- Mandatory Training figures reported 94% to date. Data inputting remains an area of focus relating to staff records once training has been completed and remains under review.
- In terms of return to work, the Division have conducted a deep dive into the data to identify any particular areas of concern. HRBPs continues to provide support to help with deadline completion and support for managers who manage a high volume of staff.
- Time to Hire has increased – division is working closely with KA in terms of occupational health support to ensure colleagues are fit for work and are supported accordingly.
- PDRs shows a reduction with plans in place to review the rest of 2024 to remain at trust target. Individuals who are due a PDR have been contacted to diarise with their manager.
- Big Conversations continue to take place across areas with a deadline of completion by the end of July 2024 with the aim to collate data in August to present at the next committee in September.

The Division will share results once data has been collated following completion.

The Medicine Division highlighted the second Health & Wellbeing week took place which gave opportunities for colleagues to get more involved and which helped to promote the division. Wellbeing packages were dropped into clinical therapy areas and continue to forward plan activities and share information across the organisation.

SC noted significant workforce challenges within transfusion, laboratory, and haematology which the Division are working to address through a longer-term workforce plan and training opportunities. Listening events remain ongoing along with benchmarking to enable a longer-term service review.

JR sought assurance that the Trust was consulting both regionally and nationally with colleagues regarding the 'hard to fill' roles. SC advised that we are working closely with local Trust's and have undertaken a benchmarking exercise with other paediatric Trusts in terms of rotas, on-call models etc. The Division have also contacted the Blood Transfusion Service (nationally) in relation to training packages and advice on how we build the service going forward.

FB was reassured by the mitigations taken and the approach taken in terms of the PDRs to keep the division on target.
FB went on to ask about the proportion of BAME staff within the Division which has seen an increase and asked if there was anything in particular that has brought about this positive change, or indeed if there were any concerns in maintaining this positive trend.
SB advised that during the year, the Division had held a number of international nurse recruitment campaigns along with a notable change in management and leaders from a BAME perspective. Recruitment panels are always representative of the BAME community and there is a lot of awareness raising and challenge encouraged in this space.

Resolved:
The Committee noted the divisional metrics for the Medical Division.

Corporate

The Committee received the corporate metrics report (June 2024) data and noted progress to date. ES pulled focus to the following highlights:

- Return to work compliance remains a focused agenda item on the corporate services collaborative meeting with plans for a deep dive supported by SO to ensure we are understanding all data.
- Time to hire corporate services is moving into the next financial period. Focus remains on all non-clinical roles taking into account the focus around all C&M guidance.
- Mandatory Training is showing a good trend – improved.
- PDR compliance is making good progress and continues to be monitored.
- Stay conversations requires some further work to bring in line and to regularise across all departments and how that's being conducted. A further review is being explored.
- Overall metrics remains stable and improving in some areas.

The Corporate Services Collaborative Meeting continues to take place on a monthly basis. All discussions remain focused on workforce metrics.

JR mentioned keeping that motivation and positivity going will be critical during this period. On the recruitment of BAME staff it will be interesting about the approach for your division you'll be taking that may need to be different, will be helpful to understand in a bit more detail.

NA stated in reflection on this section it was good to see Brilliant Basics coming to future People Committee meetings. NA reported that when this was done with patient safety and in relation to work in SQAC, how data was provided in advance, it allowed for creation of space for conversation for exploration.

The next Corporate Services Collaborative Meeting will take place on Tuesday 30th July 2024.

Resolved: Committee received and noted progress made to date from each division.

24/25/026 **Corrective Pay – Average Pay During Annual leave**

The committee received the Corrective Pay Report. ND highlighting the following for the committee's attention:

ND explained how this issue had arisen, and that a negotiation was agreed nationally with Trade Unison to resolve the payment issues.

Alder Hey has now implemented an automated system to address payment issues going forward, and this will be the final year where payments of this nature are processed manually.

MS formally thanked ND for this detailed report.

Resolved: The Committee noted the progression of all developments which remains on course.

24/25/027 **Volunteering Update**

The Committee received the Volunteer Update and noted the contents. AD drew focus to the following:

Volunteer Week was celebrated to show appreciation and value to members which was a successful day.

Alder Hey have 154 active volunteers to date who are currently completing a minimum of 4 hours per week and 50 in probation period and 80 new potential candidates. There are two recruitment sessions scheduled within 2024 with a total of 65 booked in.

The volunteering Team continues to support our warm welcome as part of 2030 strategy and the new "call me" incentive is now actively running.

NA formally thanked the team for this paper which shows good impact across the organisation.

Resolved: The Committee noted the contents of the Volunteer report.

24/25/028 **Nursing Workforce**

The Committee received the Nursing Workforce report and noted the contents. PO'C drew the committee attention to the following highlights:

The nursing workforce report was submitted to Trust Board in June 2024.

135 band 5 nurses were employed in 2023 which included 38 international nurses plus additional 7 registered nurse apprentice graduates. 9 out of 106 who were offered a position at Alder Hey failed to commence in post bringing the attrition rates down from 30% to 8.5% with a vacancy rate less than 2% showing a year-on-year trend.

NA commented that we remain highly dependent on our higher education institutes to recruit a diverse student cohort; twice a year each year we welcome 65 white female student nurses to the organisation and we are working with the university to encourage the recruitment of a more diverse workforce. KB noted following a recent conversation with the Dean at Edge Hill around their access and participation plan they have APP targets around widening that participation.

Resolved: The Committee received and noted the Nursing Workforce Report.

24/25/029 **Annual Health & Safety Report**

The Committee received the Annual Health & Safety Report and noted the contents.

The Annual Health & Safety report shows a good overview on activity over the last 12 months with continued support from the Health & Safety Team.

Resolved: The Committee received and acknowledged the Annual Health & Safety report and noted progress to date.

24/25/030 **Non-Clinical Claims Report (Inc Incidents)**

The Committee received and noted the content of the Non-Clinical Claims Report.

Clinical and non-clinical claims management will come together from September 2024 and continue to have scrutiny within the Audit & Risk Committee Meeting. All non-clinical claims will continue to be investigated and supported by the Health & Safety Team.

JW informed the committee the brilliant basics team are working on a piece of work in connection with incidents reported through violence and aggression around safe and respectful behaviours and asked the committee to receive this in September to show we are demonstrating support for our colleagues in managing this during a difficult process.

Action: The Committee will receive an update at the next meeting in terms of current progress to demonstrate support is being provided across the organisation relating to managing violence and aggression against our colleagues.

24/25/031 **Equality, Diversity & Inclusion Plans – Monitoring Process**

The Committee received the Equality, Diversity and Inclusion plans report and noted the contents. SO drew the committee's attention to the following:

The EDI agenda and action plans continue on course and there is a lot of activity across the divisions.

Staff Network Leads continue to progress activity across the patch. SO announced Audrey Chindiya was welcomed into the role as Chair for the REACH network. EDI Training will commence aligned to what divisions are doing and will be rolled out in due course.

Resolved: The committee noted the contents of the report.

24/25/032 **Board Assurance Framework – monitoring of strategic workforce risks**

The Committee received and acknowledged the Board Assurance Framework Report.

The committee noted the positive feedback following the Audit and Risk Committee meeting which took place in July 2024 noting the review of the 3-workforce people risks that are taking place and thanked MS/SO.

The risk appetite continues to make good progress related to the various assurance committees including People Committee. Following Trust Board submission in September 2024 there will be a more detailed profile around appetite in relation to our workforce risks with NED input welcome.

Resolved: The Committee received and noted the Board Assurance Framework

24/25/033 **Policies for ratification**:

- **The Security Policy**

The Committee received the security policy that provided a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Security Policy

- **Flexible Working Policy**

The Committee received the Flexible Working Policy that provided a detailed overview of recent developments / updates and was approved by the membership following minor amendments:

- Update to include new legislative changes.

Resolved: The Committee APPROVED the Flexible Working Policy

24/25/034 **LNC Minutes**

The Committee received the approved minutes of the LNC meeting held on (April 2024)

24/25/035 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the EGC meeting held on (April 2024)

24/25/036 **Equality, Diversity & Inclusion Steering Group (EDISG) Minutes**

The Committee received the approved minutes of the EDISG meeting held on (March 2024)

24/25/037 **Any Other Business**

Supporting Medical Trainees

KB informed the committee we have established a working group programme that will look at medical trainee's experience across Alder Hey and have received comments back from some external quality reviews identifying some re-occurring themes. Not all findings relate to education so the team are continuing to work closely with divisions to raise awareness for committee assurance and oversight and will bring a report to the next people committee.

Action: KB will provide an update to the committee in September 2024 in relation to improving the working lives of junior doctors in training at Alder Hey.

24/25/038 **Review of Meeting – Chair's Report to Board**

Strategy Update:
Progress of the People Plan continues to progress forward in line with vision 2030. Good achievements being made in terms of culture.

Divisional Metrics:
Divisional metrics reports continue to be managed and maintained. All senior leaders continue to stabilise across service provisions.

Trust Wide Metrics:
The Trust Metrics remains consistent with June's reporting data and continues to be monitored.

Mitigation remains in place to review manage and maintain.

Policies for Ratification: APPROVED
The Security Policy
Flexible Working Policy

The Chair noted good progress being made across all areas.

Date and Time of Next meeting.
Thursday 19th September 2024 at 2pm onsite: Room 7 (Mezzanine)

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	Freedom to Speak Up quarterly update
Report of:	Kerry Turner, FTSU Guardian
Paper Prepared by:	Kerry Turner, FTSU Guardian

Purpose of Paper:	Decision ☐ Information ☐ Assurance ☑ Regulation ☐
Action / Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this paper is to provide the Board with a summary of FTSU activity in the last quarter together with future plans
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None identified at present

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description				Score
BAF 2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families				9
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Not Assured** Evidence indicates poor effectiveness of controls

1. Purpose

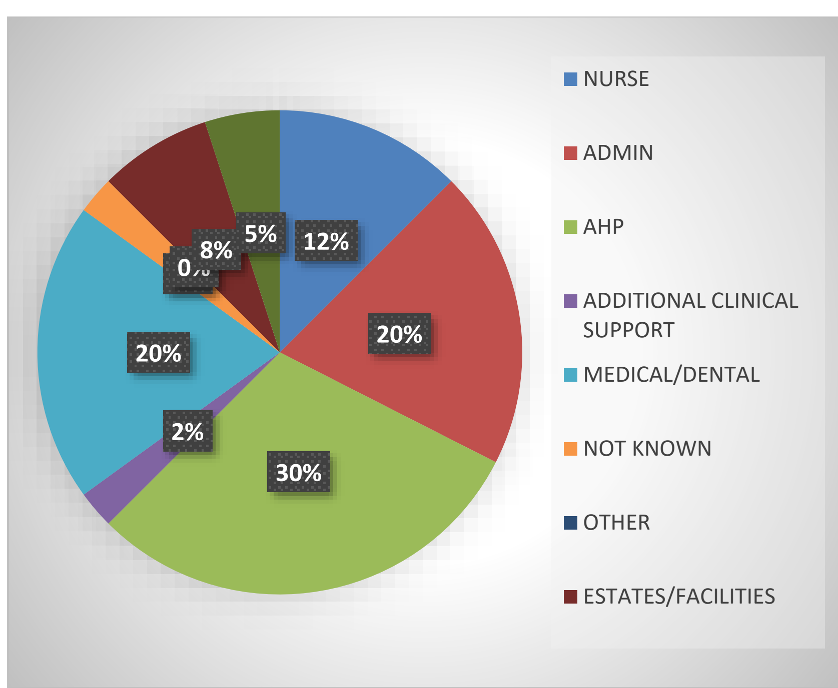
The purpose of this paper is to provide the Board with a summary of the activities of the FTSU team for the Q2 data and to outline the actions planned for the coming period.

2. Recommendation

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

3. FTSU Q2 Activity

Q2 Data



Contacts by Professional Groups

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

Recording Cases and

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

Theme	Open	Closed	Total
Patent Safety and Quality	1	0	1
Worker Safety and Wellbeing	0	0	0
Inappropriate Attitudes and Behaviours	22	1	23
Policies, Processes, Procedures, Systems	12	4	16
Infrastructure/Environment	0	0	0
Cultural	0	0	0

Leadership			0
Senior Management Issue			0
Middle Management Issue			0
Total	35	5	40

*Speak Up cases often contain multiple themes; therefore, data sets do not always equate together. Issues are recorded under the worker's own description. In cases relating to Inappropriate attitudes and Behaviours, it should be considered that there will potentially be an element of staff safety.

Of the 35 cases that remain open in Q2:

- 1 concern relating to patient safety remains open, however mitigation has been put in place to reduce the risk and a meeting with senior leads scheduled.
- 7 are related to a single concern; there is a meeting scheduled to look at potential ways in which an informal resolution can be reached, without compromise to service, but ensuring, that those staff who have raised the concern, have been listened to.
- 3 remain open, as the individuals have received coaching and are keen to take the concern forward themselves, closure will occur once a resolution is reached.
- 15 remain open and are related, these cases should conclude once the FTSUG has carried out a follow up meeting.
- 1 remains open, as although a resolution has been attained, it is unsure as to whether this is a sustainable resolution, therefore it will remain open until the scheduled review has been carried out.
- 3 cases remain open relating to inappropriate behaviours, currently those staff that have raised these concerns are unsure on whether they would like to proceed. The FTSUG has scheduled regular monthly meetings with the staff to provide support and guidance, where appropriate
- 7 cases remain open, but have proposals to address the concerns, however meetings have not yet taken place with the staff members concerned.

Patient Safety and Quality
The single case relating to patient safety, was escalated to the senior leaders within that area, assurance had been provided that mitigation was in place and therefore patient harm reduced. The concern related to training and development and the apparent lack of a robust process in managing/monitoring staff capability. This is scheduled to be reviewed.

Inappropriate Attitudes and Behaviours
There were 23 issues raised in Q2 in this category, these are related to the breakdown in relationships between staff members, with this and poor behaviours not being challenged and addressed by leadership teams, a lack of adherence to Trust values and an absence of good communications strategies. Of the concerns raised, a high proportion of staff involved, expressed a desire to progress the concerns informally, expressing that the apparent lack of an informal route had curtailed earlier escalation. Staff are supported throughout this process by the FTSUG and signposted to SALS.

Policies, Processes, Procedures, Systems
There were 16 issues or concerns raised in this category in Q2. A high proportion of these concerns were in relation to Organisational Change, the process adopted and the negative impact on the individuals involved.
There is currently a review of the Organisational Change Policy and a working group has also been established to review the policy, take feedback and consider how best to make changes to the policy and/or the managers' tool kit.

Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again scoring the process highly in terms of satisfaction. Staff response to the question '*when people speak up in this organisation, things*

change' were indicating by 33%, that this was not the case, this had decreased to 16.7% and currently has decreased further, to 11.5%.

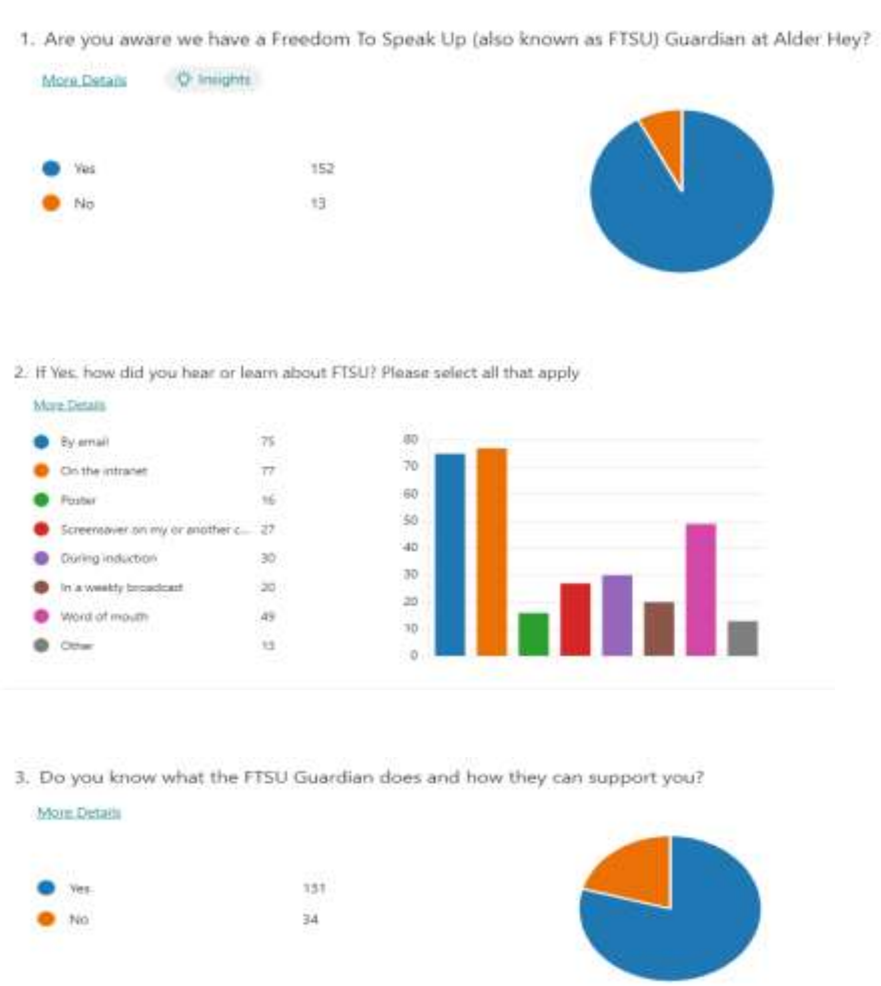
To view results from the questionnaire post closure please click on the link below:
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=OVmEMfpVb8x8dRhYPVxLZDFdyaHIx6lu&id=G888R1c5sE6Cur6KaqH2Sri2S89zA4NJtHQSSVjh0UBUQktJNk5OWUNCN01YUVNOWjlSTkVQSFBDMC4u

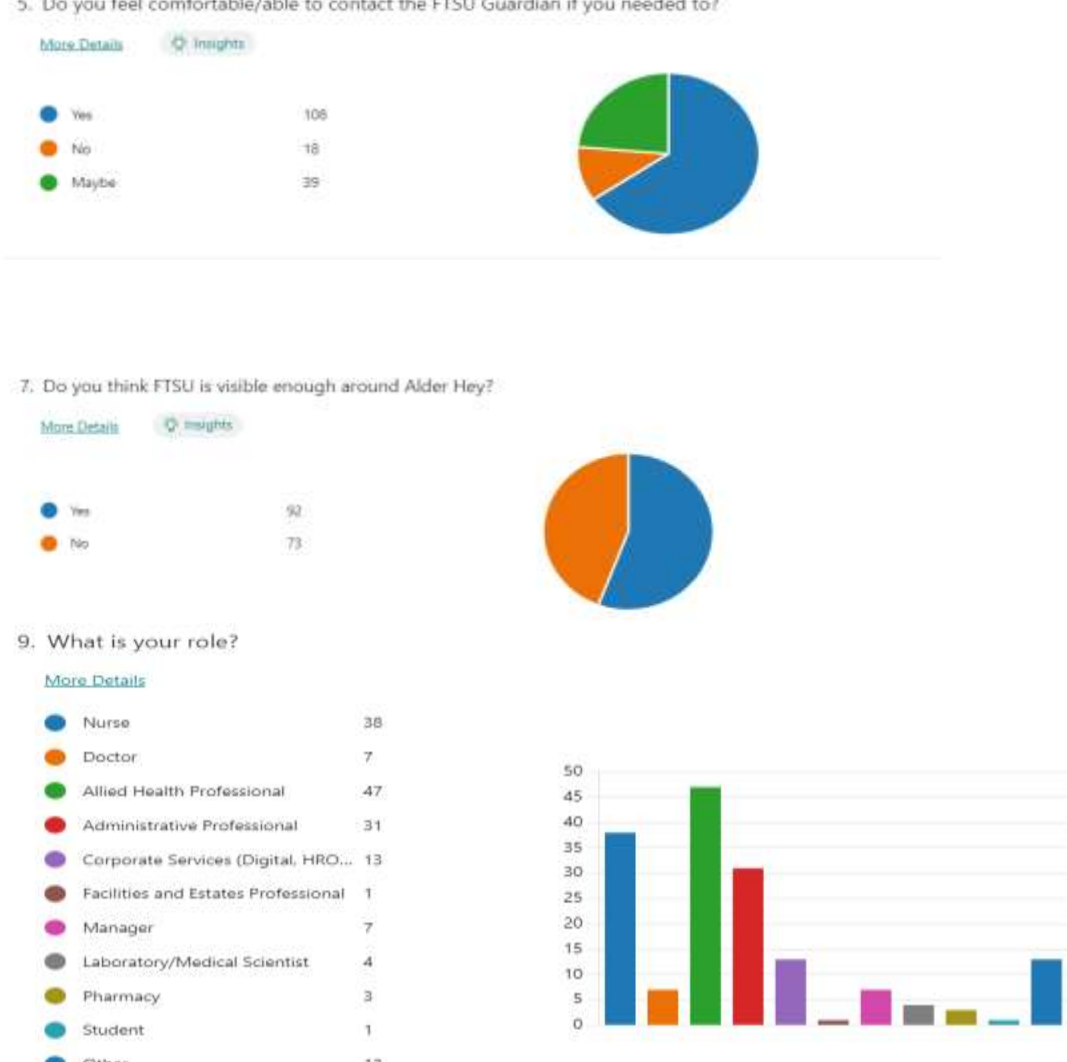
4. Lessons Learnt

From the concerns raised in Q2 and previously, consideration should be given to the development of an informal framework so that a resolution can be reached, without the need to progress formally, which is potentially creating a barrier to staff raising concerns. As previously described, a review of the Organisational Change Policy is underway, the vision for this is to create a pathway to change that reduces the negativity currently associated with this process. Other lessons learnt relate to the continuing education and development, for managers and leaders, regarding reasonable adjustments and the application of these, the ACE network, alongside HR colleagues, should be considered in developing and promoting this piece of work. In terms of concerns raised, where there is an element of poor communication between managers and staff, it would be beneficial if all managers/leaders were mandated to attend the Strong Foundation course as a way to enhance communication styles.

5. FTSU Survey results

In order to understand how FTSU is perceived across the organisation, we conducted a FTSU survey over a 3-month period, below are a selection of responses. This survey has provided FTSU with some valuable intelligence that will inform how we advertise the service, so that staff know what it is, where it is and how to contact FTSU. There is a requirement to look at the barriers staff may have in raising concerns and why they would not feel safe.





6. FTSUG Visibility Programme

The FTSUG visibility programme continues to be well received across the organisation and a key component to the FTSU communication plan. Recently Kerry Byrne NED lead for FTSU, attended with the FTSUG to a visit on 4C, where she was able to see the improvements being made by the nursing leadership team and how these improvements translated for the staff by engaging with them during the visit.

John Grinnell , Managing Director, has also attended PICU with the FTSUG as part of the programme and has scheduled monthly attendance, going forward. Both visits were well received by staff working within the areas, who engaged openly and honestly with both John and Kerry. In addition to this and after meeting with the Network Chairs, a collaborative approach has been agreed for part of the FTSU visibility programme. This will see the FTSUG being accompanied on the visit with one of the Chairs, the aim being to raise the profile of the Chairs and help reduce any barriers for staff in raising concerns by demonstrating collaboration.

7. Staff induction

The FTSUG and FTSU Champion Joe Fitzpatrick, Internal Communication manager, continue to be part of the Trust's new staff induction programme. Recently, time has been allocated to the FTSU service at the Trainee Doctors' Induction programme, providing an opportunity to promote the service and what it can provide. In addition to staff induction, the FTSUG has been requested to present at a

number of staff meetings, again this has enabled the service to be promoted and for staff to raise questions. Recently there has been attendance at Research and Innovation, both were well received and there have been requests from staff in these areas to become a FTSU Champion.

8. Mandatory training

Uptake of the Speak Up training continues to be good, as of the 4th September compliance stood at 94.8%. There remaining 2 modules Listen Up, Follow Up, will be rolled out when the ESR system has been adjusted to allow managers and leaders to be identified.

9. FTSUG Development

In order to remain an active FTSUG, there is a requirement by the National Guardians Office, that annual refresher training be completed, this has been actioned and the FTSUG is compliant. In addition to this training the FTSUG has also attended lunch and learn sessions, delivered by the NGO. Recent sessions include Martha's Rule, barriers speaking up and also participation in a review of the Guardian job description.

10. Speak Up Month

Speak Up month takes place every October, with the theme for this year being Listening. There will be a range of communication across the Trust during the month and in addition to this FTSU and the Networks have come together and will be in the atrium every Monday through October, promoting FTSU, all the networks and asking staff to commit to not being silent in raising concerns, as they will be listened to, heard and their concerns acted upon. FTSU and the network chairs will continue after October by attending our community sites.

11. FTSU APP Development

Due to the demands on the innovation team, the development of this app has been paused, but is scheduled to restart in October, however progress has been made within the development environment, as the ability to submit requests has been developed and should be ready for testing in October. Open cases, escalated cases and post closure cases are still in skeleton form but with the submission of cases being developed, expanding these shouldn't be difficult. With the introduction of the FTSU app, will come the ability for staff to raise concerns anonymously. Currently we do not have the availability of a system for staff to do this with confidence and this could potentially be viewed as a barrier for some staff in raising concerns. The capability of InPhase in this functionality remains part of the phase 2 plan for the roll out of the modules not yet in active use.

Kerry Turner
Freedom to Speak Up Guardian

Finance, Transformation and Performance Committee
Minutes of the meeting held on Thursday 22nd August 2024 at 13:00, Via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Dame Jo Williams	Non-Executive Director	(JW)
	Shalni Arora	Non-Executive Director	(SA)
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:			
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Jane Halloran	Acting Deputy Development Director	(JH)
	Ellen Matthews	Head of Service Development and Performance	
	Andy McColl	Deputy Director of Finance	(AMC)
	Melissa Swindell	Director of HR & OD	
	Gary Wadeson	Associate Finance Director, Income	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)

24/25/74 Apologies

Apologies were noted from:

John Grinnell	Managing Director / CFO	(JG)
Nathan Askew	Chief Nurse	(NA)
Adam Bateman	Chief Operating Officer	
Emily Kirkpatrick	Deputy Director of Finance	(EK)
Natalie Palin	Associate Director Transformation	(NP)
Erica Saunders	Director of Corporate Affairs	(ES)

24/25/75 Minutes from the meeting held 29th July 2024

The minutes were approved as a true and accurate record.

24/25/76 Matters Arising and Action log

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

24/25/77 Declarations of Interest

There were no declarations of interest.

24/25/78 Top 5 Risks

1. **Immediate financial performance including system position (RAG HIGH)**
   M4: reported in line with plan except for industrial action (c£0.4m). No guidance on how IA will be treated in 24/25.
   Forecast risk of c£5m flagged at M3 related to in year CIP delivery – improvement plan developed with c50% mitigated to date with residual £2.5m risk being worked up through improvement plan and sprints.

2. **Capital Programme (RAG HIGH)**
   Capital Management Group continue to provide oversight for 24/25. YTD spend at M4 is above plan slightly but due to profile and is expected to remain in line with plan by end of the year.

   Risk emerging for 25/26 and beyond on medical equipment replacement due to scale of replacement and inability to replace, update to be received at FTPC next month.

3. **Efficiency Programme (RAG HIGH)**

AMc highlighted £9.6m of savings in year, £8m is recurrent, forecast is delivery of £14.3m with £13m recurrent. Next months update will include the approved applications from MARS. Outstanding is a £7m gap recurrent gap, whilst this will be reduced it is unlikely this will be met.

AMc shared a slide comparing the recurrent position this time last year noting this year has positively improved.

4. **Benefits realisation, governance and prioritisation of change programme to 2030 (RAG MEDIUM)**

The last Programme Board had been held on 15th August KW highlighted currently the only challenging programme is Securing new investment (£10m club).

BAF risk has been increased mainly due to resources. This will be included within the review.

5. **The campus & Park developments (RAG MEDIUM)**

JH highlighted:

- Beech House (Police station) is now fully occupied.
- Fracture/Dermatology Outpatients construction work has commenced and is due to be completed December 2024.
- Gender Development Service Patients have started to be seen today.
- Park Main works are complete with final completion in relation to the Alder Centre and swale is to be completed by the middle of September.

The Chair referred to an ED walkaround noting the main concern had been the new Neonatal build. JH noted the risk review piece that was in place and would be updated on in September.

24/25/79 **Finance Report**

Month 4 Financial Position

AC highlighted a £0.3 surplus position, Year To Date (YTD) deficit of £3m.

Income is £3.7m ahead of plan due to consultants pay award, LNP expected commissioner payments, drugs & devices above plan usage, R&D and HEE income all largely offset in pay and non pay.

Pay is £0.2m ahead of plan YTD due to vacancies and a sustained reduction in temp spend due to improved sickness rates within the clinical divisions. However, this is offset by industrial action.

Divisional performance continues to be varied:

Surgery report a positive position this is largely due to ERF income.

Medicine reporting a deficit position largely due to undelivered CIP.

The Community division continues to be in surplus due to vacancies. The M4 position shows Surgery (£0.1m), Medicine (£0.5m) and Commercial (£0.1m) are adverse to plan, offset by a favourable position in Community Mental Health (£0.5m) and Corporate (£40k).

SA queried the WTE Run Rates slide querying the bank and vacancies numbers don't appear to be linked particularly in relation to NHS Infrastructure (non-clinical staff). RL advised that this has been highlighted through workforce meetings with divisions and a further piece of work is on-going so this is clearer in the future.
Action: RL/AC

KW agreed with the above action to provide a clearer understanding of non-clinical vacancies and bank staff next month, noting when this has previously been reviewed Play Specialists had been included as non-clinical when they should be categorised as supporting clinical staff.

Resolved:
FTPC received and noted the M4 Finance report.

24/25/80 **Month 4 Integrated Performance Report**
EM noted the main points to highlight from the report was as the 2 strategic metrics below are being reviewed they have not been included this month and would be re-included after the review in M5:

- Improving Clinical Outcome metrics looking to include patients benefited from new models of care.
- ADHD Metric

The Chair noted the main areas of concern highlighted in the report have been the same as previous months. EM agreed the main areas are:

- Scope
  Extra capacity has been approved within Theatres, expected to see reduction in waiting times by October.

- DM01/Sleep Studies
  Working towards compliant by the end of March 2025.

- ADHD
  Waiting times linked to drug shortage, Community continue to look at other options.

A discussion was held around the current financial position, how this is felt throughout the Divisions and being clear with communications. AMc agreed with this noting disconnect can be felt with having restrictions on areas to support the strategy.

Resolved:
FTPC received and noted the M4 Integrated Performance report.

24/25/80 **External Finance Review**
RL highlighted:

- PWC have now completed the 4 week review focusing on financial plans, governance, controls, reporting and efficiency programme.
- A draft report has been received from PWC for Alder Hey which was overall positive, with 9 recommendations, none of which are deemed significant and a number that are already included in the financial improvement programme.

- NHSE have also recently allocated a lead to C&M to undertake an assessment on the latest financial plans and seeking risk adjusted forecasts and mitigations.

Resolved:
FPTC received and noted the PWC and NHSE review.

24/25/82 Campus update
Resolved:
An update on the campus had been received under Top 5 risks.

24/25/83 2030 Programme update
Resolved:
An update on 2030 Programme had been received under Top 5 risks.

24/25/84 Board Assurance Framework
Resolved:
FTPC noted risks within the Board Assurance Framework.

24/25/85 National Cost Collection
Resolved:
The post submission report had been circulated for information.

24/25/86 Any Other Business
No other business was recorded.

24/25/87 Review of Meeting
The Chair noted the positive financial month 4 and Benefit Programme position.

Date and Time of Next Meeting: Monday 30th September at 1pm, via Teams.

24/25 Key Risks – September Position

Alder Hey Children's NHS

	Initial Risk	Initial RAG	Latest Position	RAG M5
Financial Performance including system position	Challenging 24/25 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	Month 5 position reported in line with revised trajectory forecast submitted in August except for industrial action (c£0.4m). IA funding agreed to be allocated to systems, not yet known individual provider impacts. Forecast for year remains in line with plan £3.3m surplus however still looking to achieve in year benefit from finance improvement sprints with focus on any recurrent savings to reduce CIP gap going into 25/26. PWC review concluded, system summary shared with recommendations. Phase 2 now being scope at system level with target to close residual gap by 9th October ahead national meeting. Weekly gold command to be put in place by all providers reporting into ICB, key metrics focus on workforce. AH responding with 4 areas focus and enhanced data/dashboards to provide insight.	High
Capital Programme	Limited CDEL allocation in 24/25 Significant capital investment required and prioritisation required.	Medium	Capital Management Group continue to provide oversight for 24/25 and reporting in to ops board. In year forecast remains in line with plan and some benefit from VAT review and closed Pos with CDEL being redirected to medical equipment as priority. 5 year capital plan initiated included in agenda.	Medium
Efficiency Programme	Plan assumes delivery of £19.3m recurrent savings. Highest level set in any one year. Managing of message to organisation alongside delivery of 2030 vision.	High	M5 reporting in line with plan and forecast to achieve in full in year. Gap remans recurrent. RAG rate reduced to recognise in year forecast but recognise the challenge remains recurrently. Work ongoing for 25/26 efficiency programme and key themes.	Medium
Benefits Realisation	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	Medium	Benefit review included as separate pack	Medium
Campus	Complex campus programme across multi sites.	Medium	No issues to escalate – paper reported in pack	Medium

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	**Board Assurance Framework Report (August 2024)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Monthly BAF Reports
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
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 August 2024.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2024/25

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 15 principal risks aligned to the Trust's strategic objectives and delivery of Vision 2030.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

BAF Risk		Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Finance, Transformation and Performance Committee Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Finance, Transformation and Performance Committee
1.4	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	Finance, Transformation and Performance Committee Safety & Quality Assurance Committee
1.5	Lack of visibility at Board level across the Gender Service	Trust Board
1.6	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Finance, Transformation and Performance Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	Finance, Transformation and Performance Committee
3.4	Financial Environment	Finance, Transformation and Performance Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People	Futures Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Finance, Transformation and Performance Committee

3. Summary of the BAF at 12th September 2024

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	FT&P / SQAC	**4x5**	3x3
1.3 AB	Building and infrastructure defects that could affect quality and provision of services	FT&P	4x3	2x3
1.4 LC	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	FT&P / SQAC	**3x5**	3x3
1.5 LC	Lack of visibility at Board level across the Gender Service	Trust Board	4x2	4x1
1.6 LC	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board	**4x4**	4x2
STRATIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People Cttee	3x4	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Cttee	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	FT&P	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	FT&P	**5x3**	4x2
3.4 JG	Financial Environment	FT&P	**4x4**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	**4x4**	3x3
STRATEGIC OBJECTIVE: Pioneering breakthroughs				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Futures	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	FT&P	3x4	2x4

4. Summary of August 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  Risk 1.1 has been reviewed and remains unchanged. Monitoring continues through SQAC.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  BAF risk reviewed, actions updated and documents uploaded for assurance. Risk score to remain the same.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC). NEW***
  Risk #70 - 'Risk of children and young people not being able to access ADHD medications during periods of national shortage' closed on the system due to this BAF risk covering the same issue. Open actions moved over to the BAF risk.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in August maintains above the national standard of 78%, achieving 92.6%.

  There has been a slight decline in DM01 performance in month, reducing from 84.4% in July to 83% in August. Nationally, the target remains to achieve 95% by March 2025, however Cheshire & Merseyside ICB have challenged Trusts to achieve this by December 2024.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. The trust had one patient waiting longer than 78 weeks at end of August 2024. The number of patients waiting over 65 weeks at end of August was 54, with the majority of patients waiting for dental treatment. The requirement for zero 65 weeks set by NHS England has been extended to 30th September 2024.

  Risk remains for achieving 65-week cohort regarding cancellation of agreed appointments, but these patients are being closely monitored by services.

- ***Building and infrastructure defects that could affect quality and provision of services (AB).***
  A further update has been requested from project Co reps regarding corroded pipework and ongoing plans. The Project Co Manager is currently on leave which is delaying a response.

  An updated report has been received regarding amber status pipework repairs. This will be uploaded to the risk.

  Internal AH staff pipework meetings have taken place.

  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. Booster pumps installed on the hot water system have proved effective and this will now be discussed as to introduce to cold water.

Joint water safety workshops continue. It seems that the dosing system may not be the best course of action after several discussions over the last few weeks and with the improvement of the booster pumps this may well be the better option.

Only one remaining skylight to be replaced. Due for completion late Sept/early October.

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

Green roof final works are under way.

- ***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).***
  Risk reviewed and actions updated. Remains the same due to issues with MHDS not resolved currently.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  Risk and actions reviewed. No change to 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. Controls updated to reflect safety culture progress and need for inclusion in Patient Safety Board. Actions reviewed and progress noted with timescales amended where appropriate. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risk reviewed in month. No change to score. Gaps and actions reviewed and updated.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed - no change to score. Works to complete the Swale are scheduled to conclude end September 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 (KW).***
  The risk has been reviewed by the 2030 Programme Board, and there was an acknowledged risk that the current near-term gap in the financial efficiency programme and the relocation of programme resources necessitate an increased risk in the strategic deployment. It is understood that this is a short-term risk, given the intention for the financial efficiency programme to run a series of sprints over a 12-week period. Additionally, there is an upcoming risk related to the resources in the Delivery Management Office due to upcoming vacancies and maternity leave. While there is a plan for additional recruitment, a residual gap is likely to remain. An assessment of benefits and wider change resources is underway to ensure resources are allocated to priority areas.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (JG).***
  Risk reviewed and no changes to score. Financial improvement plan is progressing internally with actions to be completed to mitigate risk of non-delivery in year. CIP remains a focus with plans to be developed as we enter into planning stage for 25/26.

- ***System working to deliver 2030 Strategy (DJ).***
  No change to risk score in-month. All actions remain on track within estimated completion dates.

- ***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).***
  Full review of progress towards actions. Cost neutral business case for Futures signed off by Execs in August. Progress with implementation plan including new Futures posts (using repurposed funds) and commercial forecast ahead of target but no change to risk score this 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 ongoing and significant progress has been made against the priority issues within the programme. Workforce proposal approved by Executive Committee and now working with HR on next steps. Cyber Assurance Framework is underway and will be aligned to annual Data Protection and Security Toolkit assessment from 2025.

5. Corporate risks (15+) linked to BAF Risks (as at 9th September 2024)

There are currently 20 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	5x3	Business Support	4.2	May 2024	May 2024
2487	Disruption in patient's supply of medication and / or treatment ***(NEW)***	4x4	Community		Apr 2023	July 2024
212	Reduced staffing in Plaster Room	3x5	Community	2.1	May 2024	July 2024
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service. ***(NEW)***	4x4	Community	1.6	Jun 2024	Jun 2024
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	2.1	Apr 2023	June 2024
27	Fragility of Inherited Metabolic Disease Service (IMD) ***(NEW)***	4x4	Medicine		Jun 2023	July 2024
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties	3x5	Business Support		Mar 2024	Mar 2024
2623	Then there is no access to CT scans for the entire trust. the trust is unable to provide CT scans for all patients, including major trauma patients, deterioration inpatients, elective patients, forensic patients and ED attendances.	5x3	Medicine		Apr 2022	Mar 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
197	Legal proceedings related to the Gender Service	4x4	Community	1.5	May 2024	May 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
140	Anaesthetic cover out of hours - ward based issues	5x3	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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2677	We are now in Year 7 since the Alder Hey in the park building became operational. Most of the Trusts Medical Devices were purchased or replaced at this time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 years. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital equipment. This year (22/23) we had planned to replace £6.3m of this capital equipment. However, external capital expenditure restrictions have been placed upon the Trust by the ICS which means we only have £2.3m allocated for device replacements. the remaining £4m is "at risk" and will roll over into next year's replacement budget which will then stand at £9.5m	4x4	Surgery	3.4	Aug 2022	Feb 2024
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4	Dec 2019	*Apr 2023
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
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
111	Anaesthetic cover out of hours	5x3	Medicine	1.2, 2.1 & 2.2	Nov 2023	Nov 2023
189	EPRR Assurance Non-Compliance	3x5	Business Support		Jul 2024	Jul 2024
212	Reduced staffing in Plaster Room	3x5	Community		May 2024	May 2024
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)						
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.4	Jul 2021	*Apr 2023
117	Safe follow up care	4x4	Business Support	1.1, 2.1 & 2.2	Dec 2023	Dec 2023
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (3x5=15)						
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1	Dec 2019	*Apr 2023
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2	Jul 2021	*Apr 2023
1.5 Lack of visibility at Board level across the Gender Service (4x2=8)						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
197	Legal proceedings related to the Gender Service	4x4	Community	1.2	May 2024	May 2024
1.6 Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (4x4=8)						
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service. ***(NEW)***	4x4	Community	1.2	Jun 2024	Jun 2024
STRATEGIC OBJECTIVE: Support our people						
2.1 Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (3x4=12)						
2450	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
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
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
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	1.1	Apr 2023	June 2024
212	Reduced staffing in Plaster Room	3x5	Community	1.1	May 2024	July 2024
2.2 Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (3x3=9)						
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1	Feb 2023	*Apr 2023
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.1	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.1	Dec 2023	Dec 2023

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)						
	None					
STRATEGIC OBJECTIVE: Collaborate for children and young people						
3.1 Failure to fully realise the Trust's vision for the Park and Alder Hey campus (3x4=12)						
	None					
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (3x4=12)						
	None					
3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x4=16)						
2677	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
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)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (3x4=12)						
151	Expanse Referral Process	5x3	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	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	Safety & Quality Assurance Committee

Description
Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

Sep 2024	
Control Description	Control Assurance Internal
The Trust has a quality improvement programme 'Brilliant Basics', where quality improvement is at the heart of everything we do and provides staff with the skills, knowledge and confidence to learn, lead and deliver in an improvement style.	Formal and informal training and coaching available to support departments to make positive changes. Outcomes shared through the SharePoint site and reported to board bi-annually against agreed plan.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through CQSG, learning bulletin produced and learning from RCA's shared at the meeting
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC

Gaps in Controls / Assurance

1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis
2. Robust reduction programme in the number of medication incidents and near misses
3. Impact of Industrial action in the safe delivery of care and progress against recovery
4. The CQC will move to a new oversight framework which may reduce our CQC ratings
5. The 2030 vision sees a shift to a consumer focussed experience with 5 workstreams with key deliverables for year 1, without any additional resource
6. The new models of care workstream will need to redefine the delivery of services whilst maintaining the principles of the strategy
7. Alder Care (Expanse) has been implemented across the organisation which poses risks until stabilisation.

Action	Description	September 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	Outstanding care and experience

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Responsive		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
20	9	Finance, Transformation & Performance Committee

Description
Capacity and Demand modelling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care, and risk to achieve the national standard of eliminating waits >65 weeks by March 2024. Our challenged specialties include ENT, Dental, Spinal Surgery, ASD/ADHD and CAMHS. In addition, unprecedented demand for urgent care has increased the wait for clinical assessment and reduced the percentage of patients treated within 4 hours. These factors combine to create a risk that waiting times for elective and urgent care will exceed national standards, with potential detriment to experience and outcomes for Children, Young People and their families.

Sep 2024	
Control Description	Control Assurance Internal
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	Daily reports to NHS England -@ Daily Performance summary -@ monthly Performance report to Operational delivery group -@ Performance reports to RABD Board Sub-@Committee -@ bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	Corporate report and divisional Dashboards -@ Performance reports to RABD Board Sub-@Committee -@ Use of electronic patient pathway forms to signify follow-@up clinical urgency and time-@frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	Significant decrease in waiting times for Sefton SALT -@ Corporate report and divisional Dashboards -@ Performance reports to RABD Board Sub-@Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	monthly Performance report to Operational delivery group -@ Corporate report and divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	monthly oversight of project delivery at Programme Board -@ bi-@monthly transformation project update to SQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - SDG forum to address challenged areas and approve cases for investment where access to care is challenged.
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

Gaps in Controls / Assurance
1. Reduce to zero the number of C&YP waiting over 65 weeks for treatment to reduce the long-wait backlog for planned care 2. In urgent and emergency care, consistently exceed national standard of 76% of patients treated within 4 hours (aspire to 85%) and a time to clinical assessment of 60 minutes

Action	Description	September 2024	
		Due Date	Action Update
Reduce the long-wait backlog for planned care	Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	30/09/2024	Deadline extension to achieve zero 65 weeks extended by NHSE to 30th September 2024. Vast majority of services have already reached this target but concern remains in Paediatric Dentistry and Paediatric Neurology. Whilst there is capacity in dentistry within the month of September to meet target there is a risk due to to patient cancellations or was not brought that the target may not be met. Within the Paediatric Neurology service there are concerns regarding capacity which are being reviewed by the service, currently a risk of 7 patients not meeting the 65 week target.
Urgent and Emergency Care Standards	Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	31/01/2024	Actions implemented to date have led to improved access to A&E, which is now exceeding the 85% national standard

Building and infrastructure defects that could affect quality and provision of services	
Risk Number	**Strategic Objectives**
1.3	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

RM03 Risk Rating		
Actual	**Target**	**Assurance Committee**
12	6	Finance, Transformation & Performance Committee

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

Sep 2024	
Control Description	**Control Assurance Internal**
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations. Review of the action plan takes place monthly to ensure all remains on track.	
Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.	
Regular oversight of issues by Trust committee (FT&P)	Monthly report to 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	September 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	Outstanding care and experience

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

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	9	Finance, Transformation & Performance 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.

Sep 2024	
Control Description	Control Assurance Internal
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is is now being fully implemented.	Business case (attached)
Weekly performance monitoring in place for operational teams which includes: • Weekly Tuesday/Wednesday meeting with PCOs • Divisional Waiting Times Meeting each Thursday • Trust Access to Care Delivery Group each Friday This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: • Monthly contract statements • Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software

Gaps in Controls / Assurance
1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to legacy waiting times and recruitment issues as a result of national workforce shortages.

Action	Description	September 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	31/12/2024	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/10/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/12/2024	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
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/12/2024	
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	31/10/2024	

Lack of visibility at Board level across the Gender Service

Risk Number	Strategic Objectives
1.5	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
Safe Responsive		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
8	4	Trust Board

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

Sep 2024	
Control Description	Control Assurance Internal
Dedicated communications lead and communications plan in place to manage internal and external communications and media.	Internal and external communications plan
Monthly Operational and governance meeting to be in place to review service delivery and escalate key issues to Division and Trust Board.	Divisional governance meeting minutes
All identified risks within the Gender Service are reflected on the risk register. Appropriate controls and actions are in place and are reviewed on a fortnightly basis with Gender Service Senior Leadership Team.	risks on InPhase being managed closely

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

Action	Description	September 2024	
		Due Date	Action Update
Escalation of Key Issues to Divisional Integrated Governance Meeting	Key Issues to be reported to Divisional Integrated Governance Meeting on a monthly basis.	25/06/2025	
North Programme Delivery Board	Reports and issues to go back to monthly North Programme Delivery Board, chaired by CEO of Alder Hey NHS Foundation Trust and/or Director of Operations, Manchester Foundation Trust.	31/12/2024	

Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	
Risk Number	**Strategic Objectives**
1.6	Outstanding care & experience

CQC Domains	Linked Risks	Owner
Effective Safe Responsive		Lisa Cooper

RM03 Risk Rating		
Actual	**Target**	**Assurance Committee**
16	4	Trust Board

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

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

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

Action	Description	September 2024	
		Due Date	**Action Update**
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	31/10/2024	
Risk 236 - Action 2	Increase capacity to the prescription rota to cover the additional work.	31/07/2024	
Risk 236 - Action 3	Engagement with the youth forum requested to help with messaging.	31/07/2024	
Risk 236 - Action 4	Escalation Regionally to ICB via Divisional Director and nationally via CEO	31/07/2024	
Risk 236 - Action 5	Two additional telephone lines ordered and awaiting installation to support the increased demand	31/07/2024	
Risk 236 - Action 6	Plan for a “Super Saturday” with clinical teams and Pharmacy	31/07/2024	
Risk 236 - Action 7	Plan for Psychiatry support to increase number of complex assessment conclusions using voluntary additional hours	31/07/2024	
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	31/10/2024	
Risk 236 - Action 9 (carried over from Risk #70)	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary	30/09/2024	

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	Support our People

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

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	People Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation. 3. Not developing inclusive recruitment and talent management practices to improve workforce diversity

Sep 2024	
Control Description	Control Assurance Internal
Monthly Ops Board monitoring	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
People Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Apprenticeship Strategy implemented	Annual update to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to Board and PAWC
Nursing Workforce Report	Reports to PAWC, SQC and Board
Nurse Retention Lead	Bi-monthly reports to PAWC
Recruitment Strategy currently in development	progress to be reported PAWC
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Lack of robust talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation

Action	Description	September 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. As at May 24 overall trust compliance was 93.00%. Areas of concern are highlighted, discussed and supported with subject experts. The current area under review is SEPSIS.
2. Sickness absence levels higher than Trust Target	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	Action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased. A Business Case has been shared with Exec Team - outcome awaited.
6. Lack of inclusive 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	Support our People

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

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	People 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.

Sep 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthyl reporting to PAWC
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on Trust Intranet and accessible for staff
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2023 Staff Survey Report - main report, divisional reports and team level reports
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Thriving Leadership Programme	Strategy implementation as part of the People Plan
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at People and Wellbeing Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PAWC
Alignment of staff safety and patient safety work via developing safety culture training and developing Restorative Just & Learning culture strategy	Patient Safety Board minutes
Monthly Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Associate Director of Organisational Development and enables shared thinking about teams in need of support and joint working where indicated.	

Gaps in Controls / Assurance
- lack of embedded safety culture across the organisation - lack of understanding about a just and restorative culture approach - lack of consistent compassionate leadership - Inconsistent application of Trust values and behavioural framework - insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas - insufficient OD resource available to fully address all culture tensions and challenges when they arise

Action	Description	September 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.	30/09/2024	Culture presentation given at June Trust Board and broadly supported with agreement to move into next steps/agreeing and defining actions. Further meeting to be held with MD and CPO to agree actions with comms and engagement plan. Will inform reporting
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/03/2025	Meeting with Director of Transformation on 4th April to discuss @its Best MDT model and underpinning resource. Output to be reviewed with Head of OD. Consider next 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.	29/09/2025	No further progress with this action. Proposal still with execs and resource to be agreed for the delivery of the training. Meeting held to look at integration of safety culture training and STAT programme running in theatres. Further meeting to be arranged by Patient Safety lead to be confirmed
Thriving Leaders framework	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focussed review and development and Operational Leaders programme.NHSE Board level leadership competencies published with full appraisal process to follow in autumn 2024. All leader competencies to be developed based on same principles with reference to NHSE line manager competencies and other published leadership competencies.	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.
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	Support our People

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

RM03 Risk Rating		
Actual	**Target**	**Assurance Committee**
12	4	People Committee

Description
- Failure to have a diverse and inclusive workforce which represents the local population. - Failure to take steps to become an inclusive work place where all staff feel their contribution as an individual is recognised and valued. - Failure to provide equal opportunities for career development and growth. - Non-compliance with the public sector equality duties

Sep 2024	
Control Description	**Control Assurance Internal**
Establishment of 4 x Staff Networks	All networks have appointed chairs, supported by Head of EDI. members of EDI Steering Group and report bi-monthly
Education and Training in EDI	Mandaotry EDI Training for all staff. current compl;iance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
PAWC Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PAWC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	monitored through PAWC
People Policies	People Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
NHS England Improvement Plan supported by Trust Board, and associated actions into action plan	NHSE EDI Improvement Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 3 of delivery, continues to include a focus on inclusive leadership
EDI Steering Group established - Chaired by NED	Minutes reported into PAWC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People and Wellbeing Committee

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

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

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

Risk Number	Strategic Objectives
3.1	Collaborate for childern & young people

CQC Domains	Linked Risks	Owner
Responsive		Rachel Lea

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Finance, Transformation & Performance Committee

Description

The Alder Hey long term vision for the Alder Hey Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale and in partnership with the local community and other key stakeholders as a legacy for future generations

Sep 2024

Control Description	Control Assurance Internal
CEO Campus Highlight Update Report	Fortnightly Report
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board and RABD Stakeholder events / reported to Trust Board and CoG
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
Development Team monthly meetings	Outputs reported to RABD via Project Update
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision.
Weekly Programme Check.	The Development Team run a weekly programme check.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
Exec Design Group	Quarterly Minutes of Exec Design Reviews
Programme and plan (agreed with LCC and LPA) to return the park back by March 2024 (phase 3).	Updates on progress through Campus report .
Meetings held with Liverpool City Council at key stages	public meetings held
Planning application for Neonatal and Urgent Care	Full planning permission gained
Neonatal Programme Board	monthly meeting
Strategic Estates and Space Allocation Group	Chaired by Exec, meets quarterly

Gaps in Controls / Assurance

PARK:
1. Adoption of the SWALE by United Utilities
2. Park Handover
3. Weather conditions causing potential delays

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

Action	Description	September 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	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	8	Finance, Transformation & Performance Committee

Description
Risk of failure to: - translate the 2030 Vision into operational plans and systematically execute. - deliver on the strategic ambitions to make a difference to CYP impacting on the delivery of the NHS Long Term Plan and Trust’s reputation.

Sep 2024	
Control Description	Control Assurance Internal
Collaborating in Communities is a key theme in the 2030 Change Programme: assurance received through Strategy Leadership Group and Strategy Board	
2030 Vision: Alder Hey strategy refresh - Q4 23/24 - delivery of brochure and final comms collateral	Council of Governors strategy session (full overview) (Jan 2023) Strategy 2030 - Approved at Trust Board (March 2023) Strategy 2030 wider Staff Launch (May 2023)
CYP System update report to Strategy Board, incorporating partnership assurance periodically throughout the year.	Building upon Growing Great Partnerships report
Operational Plan incorporates Vision 2030 deliverables (2024/25)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
SRO Group established	
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	

Gaps in Controls / Assurance
1. Completion of 2030 Vision communication collateral 2. 2030 delivery programme and plan in development 3. Failure to develop capacity for delivery 4. Failure to build capacity and skills within our workforce to deliver the ‘new’ aspects’ of the 2030 Strategy 5. Failure to deprioritise to enable requisite focus on areas of need and transformational change 6. Risk of ‘mission creep’ associated to the Strategy

Action	Description	September 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	Collaborate for children & young people

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

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	12	Finance Transformation & Performance Committee

Description

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

Sep 2024

Control Description	Control Assurance Internal
Organisation-wide financial plan.	Monitored through IPR and the monthly financial report that is shared with FT&P and Trust Board.
NHSi financial regime, regulatory and ICS system.	- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FT&P) - Attendance at ICB DoF Group
Financial systems, budgetary control and financial reporting processes.	Daily activity tracker to support divisional Performance management of activity delivery -@ Full electronic access to budgets &@ specialty Performance results -@ Finance reports shared with each division/@department monthly -@ Financial in-month and forecast position reported through SDG, Exec team, FT&P, and trust Board -@ Financial recovery plans reported through SDG and FT&P -@ Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend. Updated 5 year capital plan shared with FT&P and Trust Board.
Divisional performance discussed at FT&P with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through FT&P with divisional leads ('3 at the Top')
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / FT&P and SDG for the relevant transformation schemes.
FT&P deep dive into any areas or departments that are off track with regards to performance and high financial risk area	FT&P Agendas, Reports & Minutes
Financial Review Panel Meetings	Any area/division that is off plan is expected to attend a financial review panel meeting with DOF with action plan detailing mitigation to bring back into budget.
Financial Improvement - SDG Meetings - Oversight of Plan delivery	Minutes from SDG

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations and overall financial position of Trust.
2. Long Term tariff arrangements for complex children shows underfunding of c£3m for Alder Hey
3. Devolved specialised commissioning and uncertainty impact to specialist trusts
4. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
5. Funding models not aligned to 2030 creating a shortfall.
6. Deliverability of high risk recurrent CIP programme
7. Increasing inflationary pressures outside of AH control
8. Divisional budget positions are not achieved due to emerging cost pressures and impact of Industrial Action.

Action	Description	September 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	Collaborate for children & young people

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.

Sep 2024

Control Description	Control Assurance Internal
Membership of CMAST & MHLDC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST Committee in Common in place and working CMAST - CYP alliance established. MHLDC committed membership from Alder Hey and establishment of a CYP workstream.
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	Beyond Programme recurrently funded by ICS. Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board.
Impact of changing NHS finance regime, commissioning intentions (described in BAF 3.4)	See BAF 3.4 (financial environment)
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.
Joint development of new models of care on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board and Strategy Leadership Group
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings
Maintain effective existing relationships with key system leaders and regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually).
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Reporting through Strategy Board
Implementation of Vision 2030 is dependent on building capability and capacity to deliver in the new system environment. This requires both additional capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	Assessment of central team capacity along with a 24/25+ plan to address gaps to be undertaken with MD & CSPO in December 23. Linked with COO and divisions for wider capacity and capability across clinical teams.

Gaps in Controls / Assurance

1. Uncertainty over future commissioning intentions (see BAF 3.4 re finance)
2. Future delegation of Specialist Commissioned services into ICSs – shadow arrangements under definition
3. Executing the comprehensive Stakeholder Engagement Plan
4. National mandates forcing us to prioritise unexpected programmes of work
5. System finance and productivity challenges creating risk of short notice reprioritisation of system level work and resource

Action	Description	September 2024	
		Due Date	Action Update
3. Partner Engagement	Complete partner engagement	01/10/2024	
4. Horizon Scanning	4. Horizon scanning	01/10/2024	
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	01/10/2024	
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)	01/10/2024	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	30/09/2024	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	Pioneering Breakthroughs

CQC Domains	Linked Risks	Owner
Well-Led		John Chester

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	6	Futures Committee

Description
Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries. Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities. Risk of exposure to ethical challenges and national and international reputational risks.

Sep 2024	
Control Description	Control Assurance Internal
Resource and Business Development Committee (RABD) Additional oversight of financial and commercial aspects of R&I activity	Reports to Trust Board
Research Management Board and Innovation Management Board (and subsidiary committees - Sponsorship Oversight Committee, Data Access Panel etc) Delivery and performance measurement of various R&I activities	Reports to R&I Committee
Clear management structures and accountability within each of CRD and IC	Reports to Operational Board
Protection +/- exploitation of intellectual property	Reports to R&I Committee
Strategic commercial partnerships with industry partners and commercial vehicles	Reports to Strategy Board and RABD
Staff probity - via online declaration of interests portal (gifts & hospitality, sponsorship etc.)	Adherence to Trust Policies, Declarations of Interest Register and digital audit trail to audit committee
External communications via internet, social media etc facilitated through Marketing and Communications team	Communications Strategy and Brand Guide
Data governance via Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOP
Risk registers	Reports to Risk Management Forum

Gaps in Controls / Assurance
1. Integration of R&I activities into Futures not yet fully determined. 2. Levels of activity targeted at maintaining and enhancing reputation not yet sustainable. 3. Financial model and levels of income not yet consistent with growth and sustainability. 4. Capacity and capability of clinical staff and services to participate in R&I activities. 5. Comms Strategy for Futures not yet fully described.

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

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

CQC Domains	Linked Risks	Owner
Effective Responsive		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Finance, Transformation & Performance Committee

Description
Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.

Sep 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	September 2024	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2025	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/08/2024	Programme to commence Nov 2023
Cyber Assurance Framework	This has replaced the action around Cyber Essentials +. The Trust are partway through completing the Cyber Assurance Framework, Part C and D were completed in 23/24 and Part A is scheduled to be completed before the end of 2024. For 25/26, Cyber will now become a key part of the Data Protection and Security Toolkit which is completed annually and assurance will be sought through this assessment. Results of the next annual DSPT will be received in July 25.	31/07/2025	
Experienced Resources	Assess workforce and develop options appraisal for impacted services	14/05/2024	

BOARD OF DIRECTORS

Thursday, 3rd October 2024

Paper Title:	**Summer 2024 Governor Election Results**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	**Governance Manager**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide the Council with the outcome of the summer governor election round.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	The cost of running the summer election round is estimated at £7,300. The cost of running the by-election is £2,000.

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. Executive Summary

The purpose of this report is to provide the Council of Governors with the outcome of the summer governor election round.

2. Background and current state

In July 2024 the Trust issued election notifications for the following governor seats:

Constituency:

- Public: Merseyside (1 to elect)
- Public: North Wales (1 to elect)
- Staff: Medical and Dental (1 to elect)

Following a successful election process which concluded on Monday 9th September 2024 we would like to welcome the following Governors to the Council:

Elected unopposed:

Staff: Medical and Dental – Su De *(re-elected)*
Public: North Wales – Lowri Smith *(re-elected)*

Elected via a public vote

Public: Merseyside – Emma Freeman

Staff Governor Update

The Council will be aware that Staff Governor, Mike Mander representing 'clinical – other clinical staff' resigned from his role recently and a by-election to fill this seat was initiated immediately. Three nominations have been received from interested candidates. Staff sitting within this constituency will have the opportunity to vote for their preferred candidate until 5pm on Friday 27th September 2024.
The Trust will be informed of the outcome of the election on Monday 30th September 2024.

Erica Saunders
Director of Corporate Affairs