Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 5th September 2024, commencing at 9:00am
Lecture Theatre 4, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
1.	**24/25/134**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/135**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/136**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **4th July 2024.**	**D**	Read enclosure
4.	**24/25/137**	**9.19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**24/25/138**	**9:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**24/25/139**	**9:30 (10 mins)**	**Cheshire and Merseyside Update; including:** • **C&M financial position update.**	L. Shepherd/ D. Jones R. Lea	To receive an update on the current position.	**A** **A**	Verbal Presentation
7.	**24/25/140**	**9:40 (10 mins)**	**Vision 2030 Strategy Deployment Update.**	K. Warriner N. Palin	To receive an update on the current position.	**A**	Read report
Operational Issues							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
8.	**24/25/141**	**9:50 (45 mins)**	**Evidence of Our Performance:** • **Integrated Performance Report for M4, 2023/24:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions** • **Digital, Data and Information Technology Update.**	A. Bateman N. Askew A. Bateman A. Bateman M. Swindell D. Jones R.Lea Divisional Directors K. Warriner	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A** **A**	Read report Read report
9.	**24/25/142**	**10:35 (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
10.	**24/25/143**	**10:45 (10 mins)**	**Southport Incident Response.**	N. Askew	To receive a briefing on the recent incident.	**N**	Read report
Unrivalled Experience							
11.	**24/25/144**	**10:55 (5 mins)**	**Brilliant Basics Update.**	N. Askew	To receive an update on the current position.	**A**	Read report
12.	**24/25/145**	**11:00 (5 mins)**	**PALS and Complaints, Q1.**	N. Askew	To receive the PALS and Complaints Report for Q1, 2024/25.	**A**	Read report
13.	**24/25/146**	**11:05 (5 mins)**	**DIPC Report, Q1.**	A. Bass	To receive the DIPC report for Q1, 2024/25.	**A**	Read report
14.	**24/25/147**	**11:10 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 19.6.24.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			meeting held on the 24.7.24. - **Approved minutes from the meeting held on the 19.6.24.**				
Supporting our People							
15.	**24/25/148**	**11:15 (10 mins)**	**People Plan Highlight Report; including:** • **EDI Action Plan.**	M. Swindell	To receive an update on key areas and updates from the system on the workforce.	**A**	Read report
16.	**24/25/149**	**11:25 (10 mins)**	**Wellbeing Guardian Dashboard.**	J. Revill	For information and discussion.	**A**	Read report
17.	**24/25/150**	**11:35 (5 mins)**	**The People Committee:** - **Chair's Highlight Report from the meeting held on the 17.7.24.** - **Approved minutes from the meeting held on the 15.5.24.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 15.5.24.	**A**	Read enclosure
Strong Foundations (Board Assurance)							
18.	**24/25/151**	**11:40 (10 mins)**	**Re-appointment of Trust Chair and Well Led Assessment.**	E. Saunders	To receive and note the evidence and position against the well-led framework and Chair's Appraisal documentation in support of Dame Jo Williams' reappointment.	**N**	Read report
19.	**24/25/152**	**11:50 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 11.7.24.**	K Byrne	To escalate any key risks and receive an update from the meeting held on the 11.7.24.	**A**	Read enclosure
20.	**24/25/153**	**11:55**	**Finance, Transformation and**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 24.6.24 and	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(5 mins)	**Performance Committee:** - **Chair's verbal update from the meeting held on the 22.8.24.** - **Approved minutes from the meeting held on the 24.6.24 and the 29.7.24.** - **2024/25 Top Key Risks, (M4).**		the 29.7.24. To receive an update on the top key risks for 2024/25.	 **A**	
21.	**24/25/154**	**12:00 (10 mins)**	**Risk Appetite and Tolerances Proposal.**	E. Saunders	For discussion and approval.	**D**	Read report
22.	**24/25/155**	**12:10 (5 mins)**	**Board Assurance Framework Report; including:** • **Corporate Risk Register.**	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
23.	**24/25/156**	**12.15 (10 Mins)**	**Emergency Preparedness, Resilience and Response:** • **Policy and Business Continuity Management System Strategy Endorsement.** • **2024 Annual Report.**	N, Askew	To approve the EPRR Policy and endorse the Business Continuity Management System Strategy. To receive the EPRR Annual Report for 2024.	**D**	Read reports
Items for Information							
24.	**24/25/157**	**12:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
25.	**24/25/158**	**12:29 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Lunch (12:30pm-12:55pm)							

Alder Hey Children's NHS Foundation Trust

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)	Preparation
Date and Time of Next Meeting: Thursday, 3rd October 2024, 11:00am – 2:00pm, LT4, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust seal was used in August: • 418: Transfer deed for 69 East Prescot Road (Land Registry). • 419: Legal mortgage for land at Alder Road (Laidrah).

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M4, 2024/25	R. Lea
Mid-Year Review of Integrated Performance Report	A. Bateman

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 4th July 2024 at 11:15am**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/113	Ms. J. Halloran	Acting Deputy Development Director	(JH)
Observing:	Mr. A. Sharma	Member of the public	(AS)
Apologies:	Mrs. S. Arora	Non-Executive Director	(SA)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mr. D. Powell	Development Director	(DP)

Patient Story

The Chair welcomed the clinical manager of the Integrated Children's Community Nursing team (ICCNT), Julia Roberts, who had been invited to July's Board to talk about the benefits of the Virtual Ward for children and young people (CYP) and share Edward's story.

Edward is 2½ years old and was on the virtual ward for 4 weeks for continuation of IV therapy following an inpatient stay at Alder Hey. He was admitted to the virtual ward on the 19.12.23 which allowed him to go home for Christmas. Unfortunately he had to be referred back to Alder Hey for re-cannulation but was able to go home to continue his IV therapy.

Julia shared a number of slides that provided information on the following areas:

- Overview of the ICCNT Virtual Ward.
- Benefits of admission to the virtual ward;
  - Edward's parents continued to work and could also provide childcare for other siblings, making a stressful family situation more manageable.
  - Edward's parents had cost savings as a result of not having to travel to Alder Hey, not having to pay car parking fees or buy hospital food/snacks.

- Edward's family was able to spend time together at home aiding his recovery and minimizing separation anxiety for the whole family.
- Edward was in the comfort of his own home which reduced anxiety and disruption to his daily routine.
- Edward was able to spend Christmas at home with minimal disruption.

- Parent/family feedback;
  - The family were very grateful for the help, care and support they received whilst on the virtual ward.
  - Upon discharge, Edward's parents expressed their gratitude to the staff for the ability to be cared for in their own home.

Julia informed the Board that Edward is still a patient of Alder Hey but is doing well. The Chair thanked Julia and the team for the wonderful work they are doing out in the community and wished Edward and his family all the very best for the future.

24/25/106 Welcome and Apologies

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

24/25/107 Declarations of Interest

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

24/25/108 Minutes of the previous meeting held on Thursday 6th June 2024
Resolved:
The minutes from the meeting held on the 6th June were agreed as an accurate record of the meeting.

24/25/109 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

24/25/110 Chair's and CEO's Update

The Chair informed the Board of her attendance at various network meetings where discussions are taking place about the ICB's ambition for a long-term strategic approach, the thought that is being given in terms of doing things differently from a primary care/community perspective, and the consideration that is being given with regard to how services work together, their locations, and how they meet the needs of their communities. It was reported that a number of key documents and papers have been issued to set out the ICB's plans.

Louise Shepherd advised of the recovery programme that has been initiated by C&M which Alder Hey are to be involved with. It was reported that the C&M CYP Committee met on the 12.6.24 and have agreed to progress the Neurodiversity Programme and appropriate care in hospital or mental health for young people when experiencing a mental health crisis. Advancements are being made as a

result of networking and it has been decided as part of CMAST to drive forward the Virtual Ward role for CYP. Further support is also being offered to Places that require it.

The Trust has been notified that C&M have been selected by NHSE for intense scrutiny into the system's ability to deliver its plans in order to determine whether intervention is required. It was reported that the three systems in the North West along with six other ICBs will be reviewed in detail too. The outcome of the scrutiny will enable NHSE to provide the new Government with a picture of the current position and the overarching reasons for it. It was confirmed that the Director of Finance and Development, Rachel Lea, is attending all relevant meetings regarding this matter.

The Board was advised of the positive meeting that took place on the 26.6.24 with the Chief Executive of Liverpool City Council (LCC). Discussions took place about the Trust's ambitions for CYP in Liverpool and LCC's initiative for the establishment of a hub in the community to support local GPs and Primary Care Networks.

A conversation took place about the outcome of NHSE's scrutiny of C&M, possible solutions to address any gaps, and the concerns raised about preparing as a system for 2025/26 especially in terms of ensuring safety and quality for patients. It was reported that NHSE has advised that safety and quality are non-negotiable.

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

24/25/111 Liverpool University Foundation Trust (LUFT)/Liverpool Women's Hospital (LWH)/Alder Hey – Partnership Update

A meeting has taken place between the CEOs and Chairs of Alder Hey and LUFT/LWH about working in collaboration and partnership which culminated in a meeting with the CEOs and Medical Directors of both organisations. A transparent discussion was held about the work that needs to be undertaken to create a well-defined strategic direction for the Liverpool Neonatal Partnership (LNP) that has an oversight of the service as a whole. There was a commitment from all parties in terms of having joint oversight and a route for both Boards to be updated.

In terms of broader roles across the city, it has been agreed that the four organisations (Alder Hey, LWH, LUFT and Mersey Care) now need to establish a strong partnership that can prevent isolated procurement and different commissioning strategies that create fragmentation of community services, and explore how a partnership can be formulated to deliver improved family focused services in collaboration.

It was recognised that there are genuine challenges that need addressing. It is envisaged that there will be sufficient progress to meet as two Boards in September to receive updates on the key areas of collaboration, as detailed in the report, and to discuss the future shape of the joint governance that is being developed to oversee this work.

24/25/111.1 Action: ES/KMC

Liverpool Neonatal Partnership Governance Update

The Board was advised that there are four workstreams where work has been refreshed over the last six months and the output of this will be presented to a meeting of the two Executive teams in mid-July. The Associate Director of Strategy and Partnerships, Louise Weaver-Lowe, is currently working on a potential strategic direction/joint governance for the LNP which will be presented to both Exec teams during July's meeting.

It was reported that following the LNP Board on the 1.7.24 an Exec to Exec meeting took place with counterparts to discuss expectations going forward. Thanks were offered to Non-Executive Director, Kerry Byrne, for supporting this area of work and attending July's LNP Board. Kerry Byrne pointed out that it was her first meeting and asked for a briefing to be compiled to provide her with background information on the LNP.

24/25/111.2 Action: AB/ABASS

Resolved:
The Board received and noted the LUFT/LWH/Alder Hey Partnership update.

24/25/112 Evidence of Our Performance

The Board was advised of the work that is being undertaken to further develop/ progress the Integrated Performance Report (IPR) and ensure there are no gaps in the data. This will be an opportunity for Committee Chairs to review the IPR and confirm as to whether the report is fit for purpose. For the purposes of July's meeting it was confirmed that the report has been presented in its previous format. An updated version of the IPR will be submitted to the Board in September 2024.

Integrated Performance Report for M2, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 2. An update was provided on the following areas of the IPR:

Experience and Safety

- 92% of all PALS were responded to within 5 days despite the increased number of PALS received in recent months.
- 93% of formal complaints were responded to within 25 works days.
- There is a continuing upward trend in the Emergency Department (ED) Friends and Family Test (FFT) score, with 89% of respondents satisfied in May which is the highest score in 8 months,
- There is a very low number of Category 2 pressure ulcers due to the work undertaken by the Tissue Viability team. It was reported that this work will be rolled out to the rest of the organisation via a pilot.
- Metrics show an improvement in performance across the board.

Revolutionising Care

- *Elective Recovery* – It was confirmed that the Trust is ahead of plan; 119% YTD which includes June's figures.
- *Activity Plan* - June's activity plan suggests an achievement of 103% against plan. Elective and day case performance is at 97% for the month of June, and Outpatient appointments and procedures is at 106%,
- Theatre utilisation remains below the national target of 85%, achieving 77/78% for the fourth consecutive month. There is to be a focus on improving productivity in this area.

- ED performance achieved 86%, exceeding the national target of 78%. It was pointed out that the Trust will lose the use of the Paediatric Assessment Unit facility as a result of building the new Neonatal Unit. It was confirmed that there is some capacity in Critical Care to support this loss of space but it will be challenging.
- There are 6,002 patients waiting 2 years (or longer) for a follow up appointment. A plan is in the process of being compiled to address this challenging issue. It was confirmed that the Trust will achieve the national standard by March 2025 but it will take a lot of work to do so.

The Chair queried the plans for addressing theatre utilisation/productivity. It was pointed out that Specialist Children's Trusts struggle due to the specialised work that they do but there is an opportunity to address this matter. It was reported that work is taking place in theatres from a Brilliant Basics angle; a deep dive will be undertaken during July's Ops Board, and a productive theatres group is underway with clear workstreams to deliver increased activity in areas of opportunity and increase theatre utilisation.

Pioneering Breakthroughs

- The Trust is exploring the use of AI technology to reduce clinical time being utilised for administration tasks in outpatient clinics. It was reported that a contract has been signed with the respective company and updates will be provided as the trial progresses.
- *Research Capability and Funds* – The Trust is helping researchers grow, and from an innovation perspective is encouraging teams to come forward with problems or solutions.
- Via the Alder Hey Anywhere workstream, a patient and clinician portal is to be established to improve the experience of care. A stakeholder engagement exercise to collate end user requirements has concluded and a specification is being written in preparation for July's tender process.

It was queried as to whether there is anything being undertaken to incentivise people to identify innovations that are taking place outside of the Trust. It was reported that Strasys has created a Founders' Incentive scheme which it's felt will have a big impact for the Trust.

A question was raised about whether there are particular partners who the Trust could work with in terms of innovations that have already been tried and tested. The Board was advised of the difficulties in balancing home grown/co-created innovations and it was reported that the Investment Zone will provide Alder Hey with great opportunities in this field.

Support our People

- Turnover and sickness absence remain at or below target.
- It was confirmed that the workforce stability metric has been launched and includes backdated data.

Reference was made to the workforce stability metric and it was queried as to whether the Trust has been able to determine an appropriate standard for this metric yet. It was confirmed that a further piece of work needs to be undertaken before a metric can be agreed. A suggestion was made about having a separate metric for staff who move on.

Collaborate CYP

- *Health Inequalities and Prevention (HIP)* – The Trust's substantive Public Health Consultant, who is also the Chair of the HIP steering group, has been appointed.
- Work is taking place to determine a social metric target.
- It was reported that there is a consistent reduction in waiting times; number of children waiting more than 52 weeks for tooth extraction; right to treatment for LD waiters.

Financial Sustainability: Well Led

- There is a £1.5m deficit in month.
- The Trust is on plan for M3 with the exception of £232k in relation to industrial action costs incurred in month. The Board was advised that the forecast does not include costs of future industrial action.
- It was reported that there are some risks to the Trust's Efficiency Programme.
- £13.1m CIP has been identified which is in progress YTD with remaining due to be posted by Q4 to achieve plan in year. Internal mitigations/interventions are required as there are a number of risks in these schemes. This will be discussed by the Executive team during their meeting w/c 8.7.24.

Reference was made to the scrutiny work that has been initiated by NHSE to determine whether intervention is required to enable systems improve the likelihood of financial delivery in year. The Board was advised that time will be set aside during a forthcoming 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. It was confirmed that an update will be provided to the Board in September on the outcome of the exercise

24/25/112.2 Action: RL

Divisions

Community and Mental Health Division

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

Division of Medicine

- *Laboratories* – The service has recruited two new colleagues but there are still a number of staffing issues. It was confirmed that the acuteness of the staffing issue has reduced and work is taking place with the Brilliant Basics team to look at lean ways of working.
- *Urology* – With the support of Manchester, the Trust is training new colleagues.

Division of Surgery

- Despite performing against the activity plan, income achieved is lower in some speciality areas. A deep dive has taken place and it came to light that there are a number of coding issues which are in the process of being resolved.

Gender Development Service

The Board was provided with an update on the progress that has been made with the nationally commissioned Children and Young People's (CYP) Gender Service (North West). The following points were highlighted:

- Assessment appointments have been offered to all CYP who have transferred from the previous service provider. It was reported that a number

of patients have asked for their appointments to be deferred due to it being the holiday period or having exams.
- Was Not Brought (WNB) is at 13%. This is higher than expected therefore the service is reviewing the reasons for this.
- *Estates* – Staff within the service have started to be inducted into the new premises in Warrington, and it is expected that the building will be available for staff use within the next couple of weeks.
- *Registration* - The Trust is still liaising with CQC with regards to registering the premises in Warrington.
- A strategic risk for the Gender Service has been included on the BAF, and a formal update on the service's risks is being presented to the Audit and Risk Committee on the 11.7.24.

For noting
Following discussion, it was agreed that SQAC will receive operational updates on the Gender Service going forward and the Trust Board will receive updates by exception.

Resolved:
The Board:
- Received and noted the content of the IPR for Month 2.
- Noted the Gender Service update.

24/25/113 Alder Hey in the Park Campus Development Update

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

- *Park Reinstatement;*
  - It was reported that the final seeding to the football pitches has been completed and is now established.
  - Turfing and seeding to the majority of the park is now complete and areas are being opened for the community to access. It was pointed out that some of the areas are still patchy.
  - The pathways are to be tarmacked w/c 8.7.24.
  - A family fun day for the community is in the process of being organised by the Trust for the 31.7.24.
- The Base Camp project is progressing and is on track, as is the Police Station refurbishment.
- *Gender Service (new premises in Warrington)* – final issues regarding water and fire regulations were in the process of being resolved at Mandarin Court.

It was queried as to whether a name has been decided upon for the old Police Station. It was confirmed that the Trust is going to ask its CYP to put forward suggestions.

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

24/25/114 Learning from Patient Safety Incidents

The Board was provided with a summary of activity following the transition to the Patient Safety Incident Response Framework (PSIRF), including oversight of those incidents that have been reviewed in line with the Trust's Patient Safety Incident Response Plan (PSIRP), highlighting any identified areas of patient

safety learning and improvement for the reporting timeframe from the 1.6.24 to the 30.6.24. The following points were highlighted:

- 4 Duty of Candour responses were required during the reporting period. It was confirmed that the Trust is fully compliant with Duty of Candour.
- A total of 20 staff completed the bespoke PSIRF Engagement and Oversight training delivered by Consequence UK against the national service specification for staff involved in learning responses and action in Family Liaison roles.
- It was confirmed that all legacy Serious Incident investigations and subsequent actions have now been concluded.

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

24/25/115 Mortality Report, Q4

The Board received the Mortality Report for Q4. The following key points were highlighted:

- The Medical Examiner process has been implemented and the Trust is compliant with the regulatory requirements.
- The issue relating to a lack of administration support for the Hospital Mortality Review Group (HMRG) process has now been resolved and a full-time administrative post has been filled as of May 2024. The role has been modified to support both the HMRG and Child Death Overview process (CDOP) which will provide consistency and continuity in terms of having one person working on both processes.
- It was reported that there has been an increase in mortality due to a rise in sudden unexpected deaths outside of the Trust. This has been raised via the CDOP panel.
- In Q1 of 2023 statistics showed that the Trust exceeded the expected deaths in PICU, based on the software package. A deep dive took place into this reporting period with the outcome was shared with the national group, who were satisfied that is was due to the acuity of the patients.

Resolved:
The Board received and noted the content of the Trust's Mortality Report for Q4.

24/25/116 Use of the Mental Health Act (1983 and 2007) Annual Report, 2023/24

The Board received the 2023/24 Use of the Mental Health Act Annual Report for assurance purposes regarding activity in relation to the use of the Mental Health Act (1983 and 2007) for the reporting period from the 1.4.23 to the 31.3.24. The following points were highlighted:

- For the reporting period 1.4.23 to the 31.3.24, the Trust had 10 CYP detained under a section of the Mental health Act. It was confirmed that this is a decrease compared to 2022/23 when 17 CYP were detained under a section of the Mental Health Act.
- There has been a reduction in the applications for Deprivation of Liberty Safeguards Orders during 2023/24 in comparison to previous years. The majority of the applications relate to CYP being admitted into hospital due to there being no social placement for them.
- It was confirmed that the Trust is fully compliant in respect to Mental Health Act training across the respective services/Ward; Specialist Mental

Health Services, Ward 4C and the Emergency Department. In addition to annual Mental Health Act training, Mersey Care provide training regarding Mental Health Act administration to appropriate staff across the Trust as part of the service level agreement.

- An unannounced Care Quality Commission (CQC) Mental Health monitoring visit took place at Sunflower House on the 5.9.23. CQC concluded that they have no concerns regarding the use of the Mental Health Act and compliance with the Code of Practice in Sunflower House. A report was submitted to SQAC following the inspection.
- During the reporting period, one incident was reported in relation to the use of the Mental Health Act within Sunflower House. The incident related to documentation for the Mental Health Act. Under the Duty of Candour the Trust spoke with the respective family and a rapid learning review was undertaken which identified learning for Sunflower House which has been implemented.
- The Board was advised that Alder Hey commissions 'Real Advocacy' to provide advocacy support to CYP detained under the Mental Health Act within the Tier 4 Children's Inpatient Unit and acute paediatric wards. For the reporting period there were 12 CYP referred for advocacy support from the Trust's Tier 4 Children's Inpatient Unit and 3 CYP referred from Ward 4C.

Resolved:
The Board received and noted the contents of the 2023/24 Use of the Mental Health Act Annual Report.

24/25/117 Use of Restrictive Physical Interventions Annual Report 2023/2024

The Board received the 2023/24 Use of Restrictive Physical Interventions Annual Report for assurance purposes regarding activity in relation to the use of the restrictive physical interventions across the Trust for the reporting period from the 1.4.23 to the 31.3.24. The following points were highlighted:

- There has been a significant increase in the reporting of restrictive physical interventions in 2023/24. The increased reporting relates to 4 highly complex children on the Trust's Tier 4 Inpatient Unit who require planned restrictive physical interventions to provide safe care and treatment under Section 3 of the Mental Health Act.
- There has been a reduction in the use of restraint across the medical and surgical Divisions. This may be attributed to the reduction in CYP with complex and challenging behaviour who don't need to be admitted to the acute paediatric wards.
- During the reporting period, there were zero moderate or serious harm incidents reported regarding the use of restrictive physical intervention and clinical holding in relation to CYP, staff, or others.
- A total of 132 incidents involving low harm were reported which is an increase from 2022/23 and demonstrates improved incident reporting overall.
- The Trust continues to provide support and assistance to CYP and staff who are harmed following the use of restrictive physical intervention or clinical holding. This includes reflective practice, debrief sessions and access to health psychology support.
- The Trust provides Positive Behaviour Support (PBS) training for staff who are required to use PBS, restrictive physical interventions or clinical holding, with the focus on training being to avoid the use of, and alternatives to, restrictive physical interventions.

- It was reported that the Community and Mental Health Division recruited a Nurse Specialist (CALM trainer) and a Nurse consultant in January 2024 to review the restrictive intervention training provided and ensure a sustainable model going forward which recognises the different needs across the Trust.
- The Board was advised that the Trust is participating in the national 'Safewards' model. The Trust's Tier 4 Inpatient Unit has embedded and continues to promote 'Safewards' in line with best practice and guidance on the use of restrictive physical intervention and is the first paediatric unit to do this fully.

A number of questions were raised and responded to about whether Alder Hey is working with families to help them use the same techniques that the Trust uses, i.e. PBS, whether there is a clinical supervision model in place for patients who require restrictive physical intervention when receiving Nasogastric feeding as part of their care, and whether the Trust has been legally challenged from a human rights perspective in terms of detaining patients under the Mental Health Act.

Resolved:
The Board received and noted the contents of the 2023/24 Use of Restrictive Physical Interventions Annual Report.

24/25/118 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 22.5.24 were submitted to the Board for information and assurance purposes. It was confirmed that there was nothing to escalate to the Board.

Resolved:
The Board noted the approved minutes from the meeting held on the 22.5.24.

24/25/119 Futures Committee

Resolved:
The Board noted the approved minutes from the meeting held on the 16.4.24.

24/25/120 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 May/June 2024.

Workforce Equality, Diversity and Inclusion Annual Report for 2024

The Board received the Workforce Equality, Diversity and Inclusion Annual Report for 2024 and was provided with an overview of the activities that have taken place throughout the year. It was confirmed that the report is to be published on the Trust's external website.

The Chair of the EDI Steering Group, Garth Dallas, announced that the Trust has appointed a new Chair for the REACH staff network.

Resolved:
The Board:

- Received and noted the People Plan Highlight Report for May/June 2024.
- Received and noted the Workforce Equality, Diversity and Inclusion Annual Report for 2024.

24/25/121 Board of Directors Fit and Proper Persons Check

Resolved:

The Board noted the content of the Fit and Proper Persons Check report. It was recorded that the Fit and Proper Persons Test has been conducted for the 2023/24 period and all Board members satisfy the requirements. It was also noted that the Trust engaged the independent services of Gatenby Sanderson and Neotas to undertake additional checks, as per the new guidance for organisations on the appointment of a Board member.

24/25/122 Audit and Risk Committee

The approved minutes from the meeting held on the 18.4.24 were submitted to the Board for information and assurance purposes.

The Board was advised that the main focus of June's meeting was the Trust's 2023/24 Annual Report and Accounts. The Committee discussed the external auditors report for year ending the 31.3.24 and that a late conversation took place around transactions. A plan is in the process of being compiled to address complex transactions and will be monitored via the Committee throughout the year.

Resolved:

The Board noted the approved minutes from the meeting held on the 18.4.24.

24/25/123 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 23.5.24 were submitted to the Board for information and assurance purposes.

It was reported that a bottom up Divisional review of the financial outturn is in the process of taking place. During the next quarterly review session the Divisions will report on mitigations to close the gap. In terms of CIP, progress is being made via the efficiency programme to reduce the gap.

Resolved:

The Board noted the approved minutes from the meeting held on the 23.5.24.

24/25/124 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 confirmed that all risks have been scrutinised by the respective Assurance Committees.
- A strategic risk is to be included on the BAF relating to the Gender Service.
- A report on the outcome of the risk appetite work with the Assurance Committees will be submitted to the Board in September. A meeting is in the process of being scheduled with the Chair of the Futures Committee to discuss risk appetite and tolerance ideally ahead of the next Board meeting.

It was queried as to whether a risk relating to Neurodiversity is to be included in the BAF. It was confirmed that the risk is in draft form at the present time but will be incorporated in the BAF once approved.

It was suggested that a further review of the system and financial environment risk be undertaken.

24/25/124.1 Action: ES/RL

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

24/25/125 Any Other Business

There was none to discuss.

24/25/126 Review of the Meeting

The Chair drew the meeting to a close and thanked everyone for their contributions throughout the meeting. Attention was drawn to the powerful messages that had come about as a result of discussing critical issues during the Strategy Board session and focussing on the organisation's operational progress and assurance processes in the public Board meeting. The Chair advised that the governance work that is presently being undertaken is critical and will help Assurance Committee Chairs determine how they get the right flow of discussions in terms of Vision 2030 Strategy and regular Board meetings.

Date and Time of Next Meeting: Thursday 5.9.24 at 9:00am, LT4, Institute in the Park.

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for September 2024							
8.2.24	23/24/260.1	System Wide Update	Liaise with the Chairs of CMAST to discuss as to whether transition will be dealt with under mental health via CMAST.	Dame Jo Williams	6.6.24	Sep-24	**5.6.24 -** This action is being progressed. An update will be provided during September's meeting. **ACTION TO REMAIN OPEN**
Actions for October 2025							
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**
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	Oct-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	23/24/273.1	Freedom To Speak Up	Liaise with Jo Pottier to see if there is an opportunity via PAWC to link in with FTSU on the triangulation of discussions on culture and addressing concerns across the Trust. Compile a proposal and submit it to PAWC for approval.	K. Turner	6.6.24	Oct-24	**3.7.24** - A meeting is in the process of being arranged. An update will be provided in due course. **27.8.2**4 - A meeting is in the process of being arranged. An update will be provided in due course.**ACTION TO REMAIN OPEN**
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	Oct-24	27.8.24 - An update will be provided in October as this matter is not fully solved. **ACTION TO REMAIN OPEN**
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. **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	Oct-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.
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	On track Oct-24	
Actions for June 2025							
6.6.24	24/25/83.1	2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement	Covering report sheet to be more specific to identify actions that are important versus business as usual.	A. Bass	Jun-25	On track Jun-25	

Status	
Overdue	
On Track	

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
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
8.2.24	23/24/267.1	Learning from Patient Safety Incidents	Schedule a Board Development Session on PSIRF in April 2024.	N. Askew	6.6.24	Closed	**1.3.24** - This session will take place in September 2024. **22.8.24** - This session is scheduled for the 5.9.24. **ACTION CLOSED**
6.6.24	24/25/75.1	Cheshire and Merseyside System Wide Issues Update	Lisa Cooper offered her support to the Alliance's Mental Health workstream therefore it was agreed to have a discussion outside of the meeting.	L. Cooper/ L. Weaver-Lowe	5.9.24	Closed	**27.8.24** - This action has been addressed. **ACTION CLOSED**
6.6.24	24/25/79.1	Learning from Patient Safety Incidents	*September's Development Session on PSIRF* - Divide the session into two parts; 1. System changes. 2. The outputs from the learning review of two incidents.	N. Askew	5.9.24	Closed	22.8.24 - This action has been noted ahead of September's PSIRF development session. **ACTION CLOSED**
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	24/25/77.1	Gender Development Service	Hilary Cass is looking at the governance arrangements of the Gender Service programme and will be leading on the establishment of a provider collaborative. Work has commenced to look at a programme approach and governance arrangements for a provider collaborative and it was agreed to provide an update on the outcome of this work during September's Trust Board.	L. Cooper	5.9.24	Closed	**27.8.24** - Verbal updates will be provided to SQAC as this work evolves. **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**
4.7.24	24/25/111.2	Liverpool Neonatal Partnership Governance Update	*LNP Board* - Compile a briefing for Kerry Byrne to provide her with some background detail on the LNP.	A. Bateman/ A. Bass	5.9.24	Closed	22.8.24 - A pre-meet has been scheduled ahead of the next LNP Board in order to provide Kerry Byrne with some background detail on the LNP. **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**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

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

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

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description					Score
3.2	Strategy Deployment					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

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

The purpose of this report is to inform the Board of Directors about the current situation, benefits, and recommendations for future actions in delivery of our 2030 strategy. Additionally, this report will assess our governance and assurance practices to determine if we are achieving our objectives and delivering them in accordance with a culture that supports our people to thrive.

Recommendations to:

- Note the progress made to date, and review the detailed actions scheduled across the remainder of quarter 3-4 (24/25).

2. Background

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

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

3. Current Situation – Our Journey to 2030

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

Table 1: Key Highlights

Quadruple Aim	Strategic Goal – Highlights
Experience: Children, Young People & Families	**Outstanding Care and experience:** Virtual Tour set to launch Sept 24, aimed at providing an immersive experience for CYP and families. Our new starters induction now includes a section on what it means to receive an Alder Hey warm welcome as described by our children and young people. **Collaborating for CYP:** The Wellbeing Hub has entered a soft launch phase, with a more extensive go live event planned that will involve volunteer ward rounds.
Experience: Our People	**Futures**: Finalising the testing arrangements to support testing of Ambient Ai, with an aim of reducing administration burden and experience enhancements for CYPF. Approval of the Futures business case has allowed the recruitment process of key roles to begin.
Improved Outcomes	**Revolutionising Care:** Implementation of Neurology Transformation programme has commenced, and priority themes have been agreed. **Revolutionising Care:** The Proof of Concept for Personalised Care has progressed to the planning stage for an operational test of change, with the Community Nursing Team set to begin in Q3. This test will focus on assigning a named care coordinator to the most complex children identified through a detailed data analysis, aiming to assess the positive impact of having a single coordinator on CYP and families.
Efficiency	**Transformation:** Target 2024/25 £12.6m and YTD £6.4m posted Green, in efficiency plan. Improved position since May 24 (overall target £20m). **Our People**: Strengthening financial management and budget control.

4. Benefits

Reviewing the driver and watch measures across our strategic programmes is a key responsibility of the 2030 Programme Board and aligns with the benefit cases approved in April 2024 at FTP. A detailed review of the benefit measures is scheduled as part of the upcoming agenda at 2030 Programme Board in September.

Our benefit approach is aligned with the NHS Quadruple Aim, which emphasises a balanced focus on patient experience, population health, cost-efficiency, and staff well-being. This approach supports a holistic and sustainable framework for driving improvements across our programmes.

Table 2 outlines the key strategic driver measures that we aim to improve and sustain through our strategic goals and efforts.

Table 2: Strategic Benefits

Metric	April-24	May-24	June-24	July-24	Target	Average (23/24)	Variance	Assurance
Proxy Measure: F&F Test - % Recommend the Trust *Development of effort score in 24/25	93%	94%	92%	93%	95%	93%		
Incidents of harm per 1,000 bed days (rated Minor harm and above)	8	14	13	13	14	13		NA
Number of Incidents rated No Harm and Near Miss per 1,000 bed days	55	44	46	45	46	46		NA
Staff Thriving Index	*** Due July 24 ***							
*Number of staff benefiting from capacity and capability support, seed funding	0	0	0	12	TBC	TBC	NA	NA
Increase activity IP /EL – ERF Value %	120.9%	121.6%	121.2%	127.8%	117.1%	TBC		
~~Improving Clinical Outcomes~~ Get Me Well	*** In Development ***							
Social Value Generated	-	-	£52,545 (Q1)	TBC	TBC	TBC	NA	NA
Strategic Transformation: Financial Benefits *Forecast recurrent delivery (Green+Amber rated schemes)*	£7.2m	£8.1m	£6.4m	£6.4m	£12.6m	NA		

As outlined in table 2, the metrics available are at differing levels of maturity.

In Development: Two of the strategic measures are currently under development, with performance being monitored through the watch measures in the meantime. The deployment of the Thriving measure has fallen behind the original timescales; however, a successful test of the measure has been completed, and the data capture method is being finalised, with deployment expected in Q3.

Established and Achieving: A sustained level of activity which continues to hit targets alongside the first assessment of social value in Q1.

Financial Improvement: During July there has been a greater focus on "in year" savings, to ensure we remain on track with the overall £20m efficiency target for the year. With regard to strategic benefits realisation, at end of July we are forecasting recurrent delivery of £6.4m against the original £12.6m target assigned to transformation. Whilst this represents a significant improvement compared to 2023/24, it also reflects the scale of the challenge and financial risk going into the autumn months which needs to be addressed. Particular attention is required relating to savings from workforce efficiencies (noting MARS scheme has now been closed and outcomes will be included in August financial reports) and regarding the target for external investment and non-NHS income.

5. Governance

Our assurance and governance processes are crucial in determining whether we are achieving our set objectives and delivering them in the right way. Since April 2024, our 2030 Programme Board (2030 PB), has met monthly and reports directly into FTP.

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

Programme Governance: As detailed in Table 3, effective programme management is a core component of the Trust's 2030 programme management approach. The overall shape of the programme is assessed as part of a standard report to the 2030 Programme Board (2030-PB) and table 3 details some of key messages around the effectiveness of the maintenance of the programme management standards.

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

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

Benefit Cases	All strategic programmes for 2024-2026 are expected to have a completed benefits case and for those that are well established a Q1 benefits review will also take place. The year-to-date progress is as follows: • 11 out of 17 benefit cases have been completed. The remaining benefit cases are scheduled for completion during quarter 3. • 3 out of 11 have undergone a Q1 benefits review with the remaining due for completion in early September and a full benefits assessment will be submitted to 2030 Programme Board and subsequently FTP.
Scope Definition	The phase 2 scope for Outstanding Care and Experience was approved at 2030 PB (2030), with 5 workstreams approved aligned to our CYP Promises. a. Closing the Consultation and Feedback Loop b. Right Information, Right Time c. Addressing Areas of Variation in Experience d. Personalised Care e. CYPF Voice
Resource	Allocation of DMO resource was approved at 2030 PB (July 24), was approved to support the delivery of the Financial Improvement Sprints. Short-term maternity cover vacancies and an upcoming permanent Senior Programme Manager vacancy (from September 24) pose a potential risk to our ability to deliver on current strategic programmes. Recruitment efforts are underway to mitigate this risk and ensure continuity in our strategic goals. A resource review is scheduled for September to assess our current allocation and ensure that resources are utilised effectively to maximise impact and achieve the best possible outcomes.
Milestones	Milestones have been defined at the strategic goal level, though gaps remain at programme level.

Programme Governance	Good programme governance is reflected in the internal governance and assurance ratings for the Strategic programmes below, with identified opportunities to enhance compliance against programme standards on Securing New Investment.

	#	Deliverable / Strategic Programmes	Performance Rating	Governance Rating
Outstanding Care & Experience	1.1	Safety Culture	9	8
	1.2	CYPF Engagement & Experience	7	7
Support Our People	2.1	Thriving @ Alder Hey	7	7
	2.2	Professional Development Hub	Scheduled Q3	Scheduled Q3
	2.3	Future Workforce	Scheduled Q3	Scheduled Q3
Pioneering Breakthroughs	3.1	Creating Clinical Capacity	Scheduled Q3	Scheduled Q3
	3.2	Secure New Investment	4	8
Revolutionise Care	4.1	Get Me Well (Medicine)	Scheduled Q3	Scheduled Q3
	4.2	Treat More Children	7	9
	4.3	Home First	6	6
	4.4	Digital Transformation: New Models of Care	-	-
Collaborate for CYP	5.1	Drive Net Zero	8	6
	5.2	Reducing Health Inequalities	9	9
	5.3	Corporate Services Collaboration	-	-

6. BAF Risk: 3.2 Strategy Deployment

Due to continued financial challenges needing to be addressed this year and the reallocation of programme resources towards financial efficiencies, the risk of failing to execute the 2030 vision and make a positive impact on children and young people has increased. The BAF score has risen to 15 as of August, up from 12 earlier in the year. This highlights the ongoing pressures of the financial environment, which reinforces the urgency of delivering the level of change envisioned through Vision 2030, while remaining mindful of the importance of bringing our people along with us.

In line with good practice, this risk is reviewed regularly as part of the 2030 Programme Board's rhythms and routines. A key aspect that will be explored in more detail at the next Programme Board meeting is the balance between longer-term transformations and in-year process optimisation programmes to ensure a well-balanced portfolio.

Conclusion

This report provides a comprehensive overview of our current position and outlines clear actions to drive further improvements. We look forward to discussing these plans in more detail at the upcoming Strategy Board meeting (October 24).

Recommendations

0028
To note the progress made to date, and review the detailed actions scheduled across quarter 3.

Next Steps

1. Review programme milestones and associated resource plans to ensure these are sufficient and balanced to support success.

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

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

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: August 2024

Contents

VISION 2030

Our Journey To 2030

IPR Summary

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

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Mandatory Training, Level 1 patient safety training and Liquidity are consistently achieving target with an improving trend	Low Harm & above incidents, Severe/Fatal incidents, Cat 2 Pressure Ulcers, MSSA are inconsistently achieving target with an improving trend	IHAs are not achieving Target but demonstrating an improving trend
	Common Cause	Category 3 & 4 Pressure Ulcers, Mandatory Training, Cancer (All) and MRSA metrics are achieving targets	No Harm incidents, Complaints/PALs, Sepsis, ED 4hr, RTT 52wks, ERF, C.Diff, 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, F&F ED, Long Term Sickness and PDRs are not achieving targets and currently not demonstrating statistical improvement
	Special Cause - Concern		.	

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

- We are consistently passing 25.6%* of our metrics.
  55.8% of the evaluated SPC metrics achieved the target in the month of July 2024.
- We are achieving 58.1% of our metrics inconsistently.
- We are not achieving the target for 16.3% 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*

VISION 2030

BRILLIANT BASICS

Integrated Performance Report | August 2024

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

100% of formal complaints responded to within 25 working days. Sustained decrease in category 2 pressure ulcers

Areas of Concern:

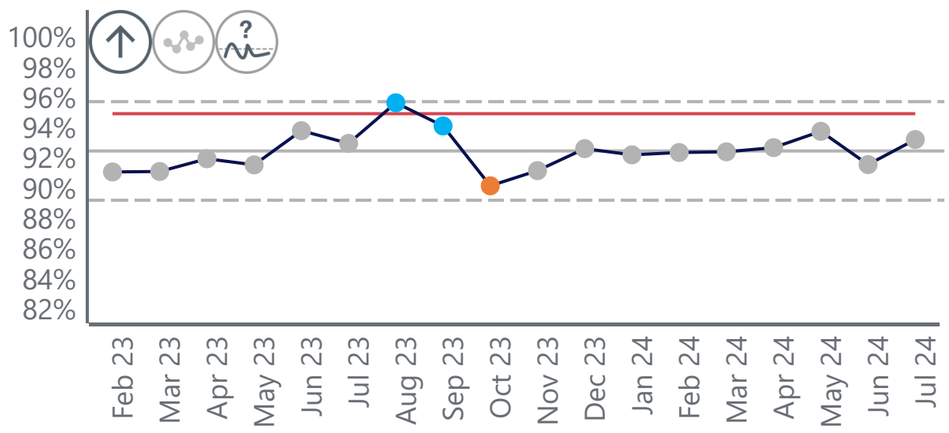
A Never Event occurred in July. Incident under investigation in line with the PSIRI Framework and a Learning Review has taken place; positive feedback from the staff involved in the learning process so far.

Forward Look (with actions)

Increased trend of PALS concerns raised continues; a Family Hub is being implemented in the Trust which will provide a one-stop-shop approach to resolving issues

F&F Test - % Recommend the Trust

Target: Statutory



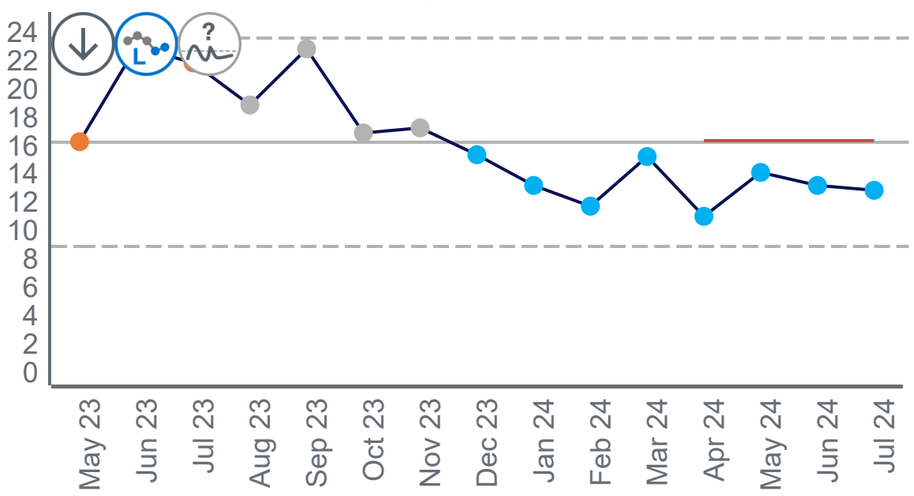
Technical Analysis:

Consistently not achieving the 95% target. July performance of 93.3% represents an increase from June performance of 91.6%. 7 out 8 previous months have been above 92% performance.

Actions:

Consistently achieving above 92% compliance; review of FFT process underway

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



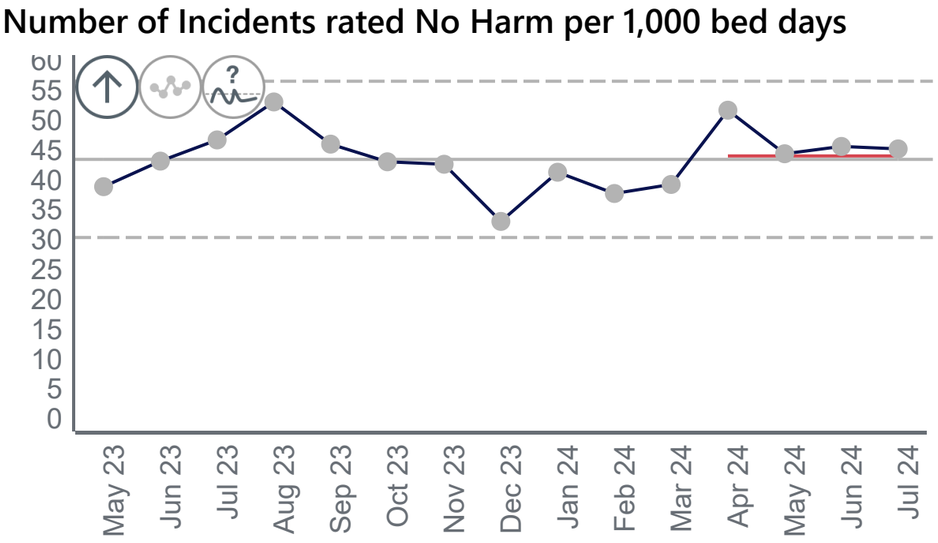
Technical Analysis:

Common cause variation has been observed with performance of 12.9 incidents of harm per 1,000 bed days, with a monthly average of x16 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 16.4. The period illustrated covers from May-23 only, the month the trusts risk management

Actions:

Positive downward trend in incidents resulting in harm. Staff encouraged to keep reporting as a decrease in incidents reported in the summer months related to holiday season

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



Technical Analysis:

Common cause variation observed with 45.3 incidents of no harm per 1000 bed days, with a monthly average of 44. This incluces 52 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

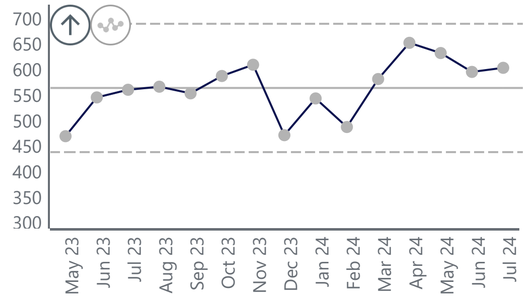
0033

Integrated Performance Report | August 2024

NHS
Alder Hey Children's
NHS Foundation Trust

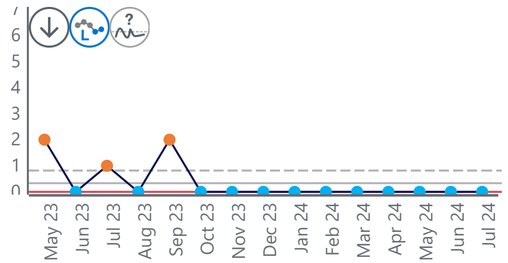
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



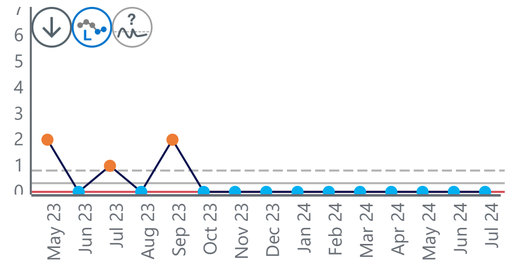
Severe or Fatal Incidents – Physical only

Target: Internal

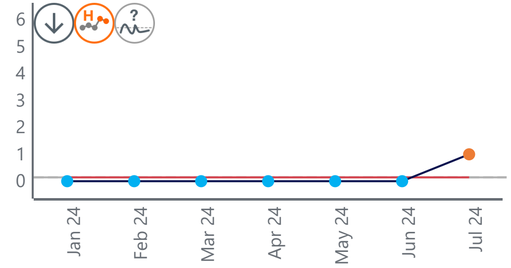


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

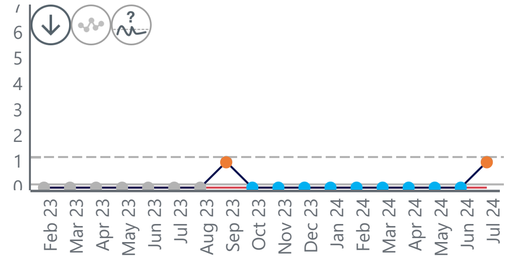


Number of PSIIs (Patient safety incident investigation) undertaken



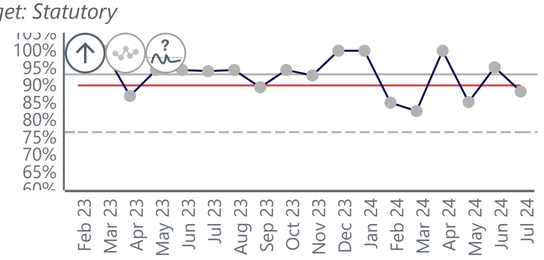
Number of Never Events

Target: Internal



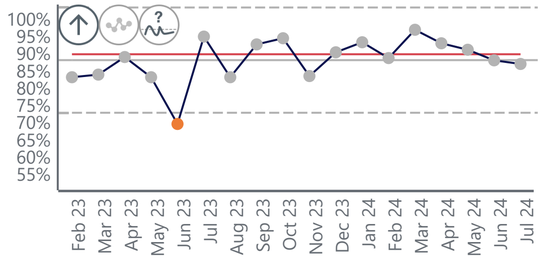
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

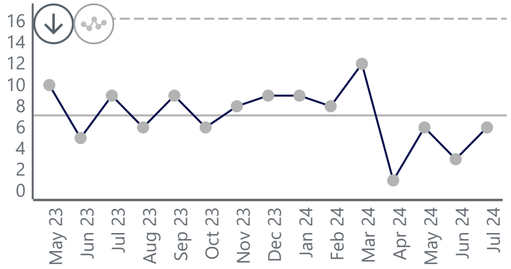


Sepsis % Patients receiving antibiotic within 60 mins for ED

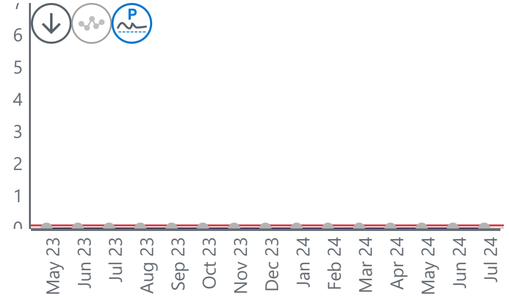
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

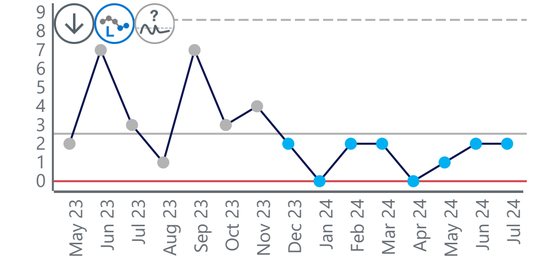


Pressure Ulcers Category 3 and 4

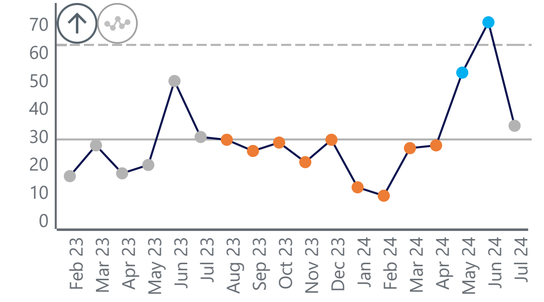


Pressure Ulcers Category 2

Target: Internal

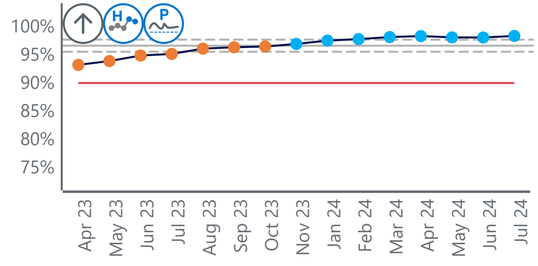


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



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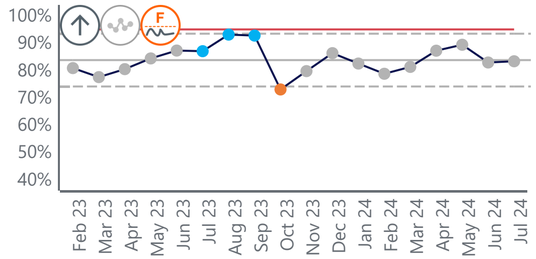
Integrated Performance Report | August 2024

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

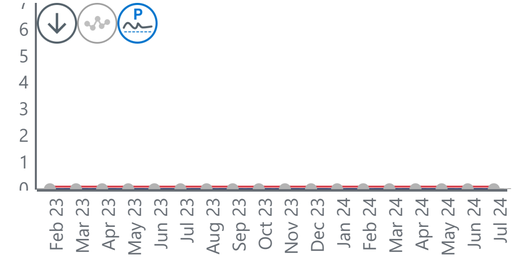
F&F ED - % Recommend the Trust

Target: Internal



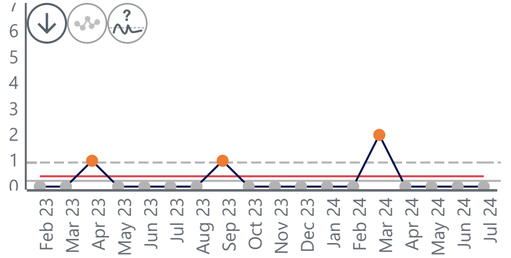
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



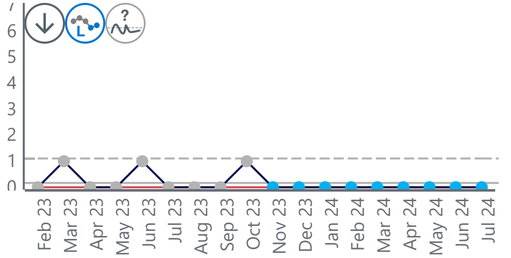
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



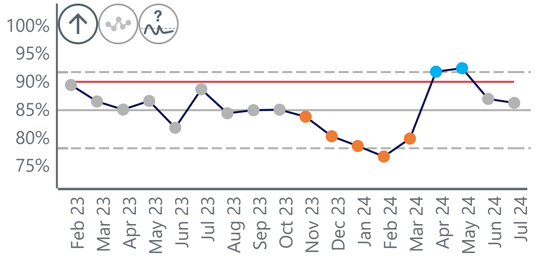
Hospital Acquired Organisms - MSSA

Target: Internal



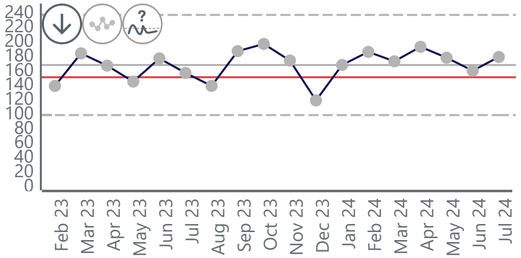
% PALS Resolved within 5 Days

Target: Internal



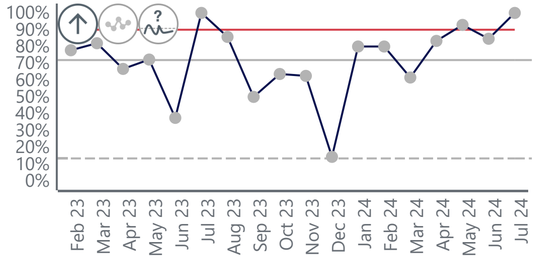
Number of PALs contacts

Target: Internal



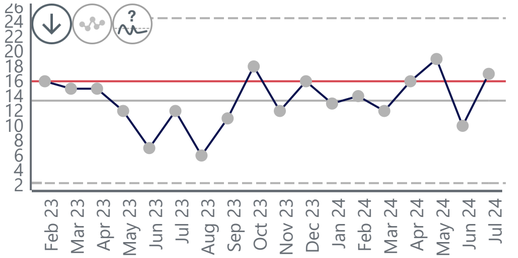
% Complaints Responded to within 25 working days

Target: Internal

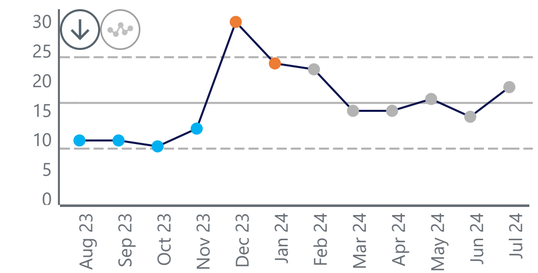


Number of formal complaints received

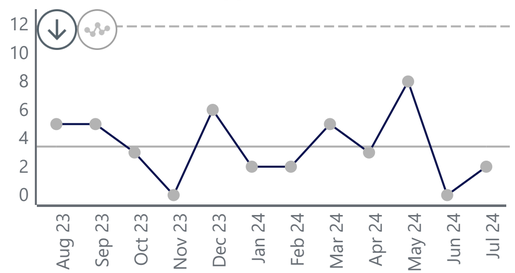
Target: Internal



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



Number of patients deteriorating from HDU admitted to PICU



Integrated Performance Report | August 2024

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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

Highlights:

- ED performance achieved 88%, exceeding the national target of 78%
- 100% compliance remains for access to cancer services, exceeding national standard
- 657 patients waited over 52weeks for treatment against an external trajectory of 743
- The number of patients waiting 2 years for their follow up reduced from 6,158 to 5,911
- Improvement in number of IHA assessments within 20 days has sustained, achieving 98%

Areas of Concern:

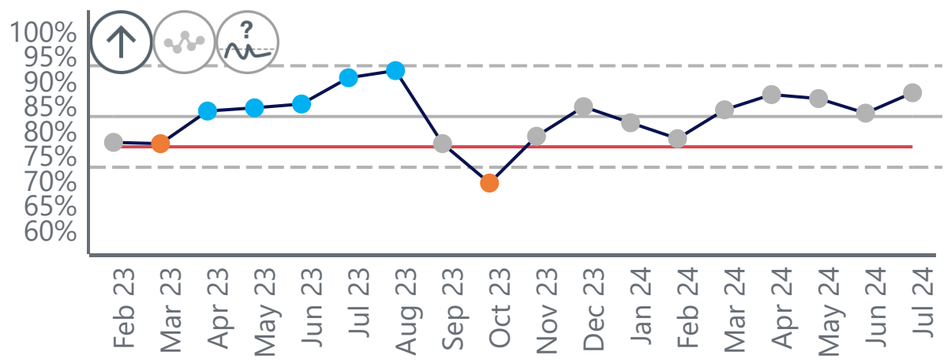
- DM01 performance decreased from 88% in June to 84% in July, and remains below national target of 95%
- Theatre utilisation remains below the national target of 85%, with a slight increase to 78%
- The number of patients waiting for ASD or ADHD diagnosis continues to grow, now 2,826 patients are waiting

Forward Look (with actions)

- A business case to address the overdue follow up appointments is in development, and the weekly Task & Finish Group continues to meet to oversee progress
- Trajectory for sleep studies to be completed to forecast DM01 compliance
- New models of care metric due for inclusion September 2024 and '% of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks' due for reporting in October 2024 paper.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

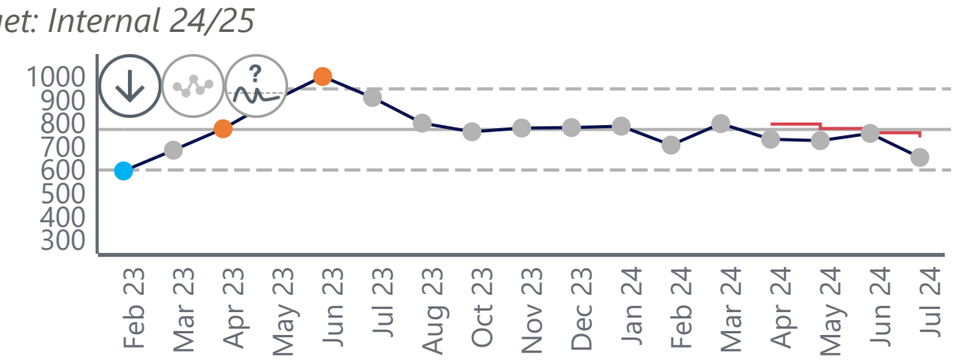
Trust is achieving the national target (>77%) in July-24. Common cause variation has been observed with performance of 87.9%. Improvement from June-24 (83.8%). July-24 performance is -3% compared to July-23 (90.9%), although July-24 seen +443 attendances compared to July-23.

Actions:

ED have a set an internal target of 85% for 2024/25. Department is currently performing well; however, there will be a loss of PAU and EDU beds from August 2024 – March 2025. A mitigation plan has been approved

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

Target: Internal 24/25



Technical Analysis:

Demonstrating common cause variation with number of patients waiting > 52 weeks at 657 for July 2024 against a trajectory of 743. This is a decrease from June 2024 position of 760. The top 3 services with waiters >52 weeks: Dentistry (n= 281), ENT (n=127) & Plastics (n=83). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

Actions:

Both Medicine and Surgery Division now submit weekly updates against trajectory. The organisation is focused on achieving zero 65 week waits by September 2024, with dental as the main area of concern.

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NHS
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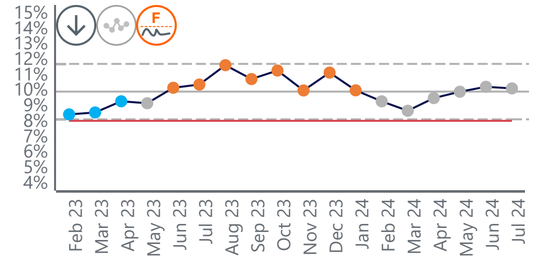
NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

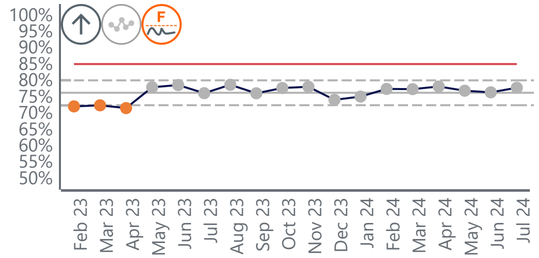
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

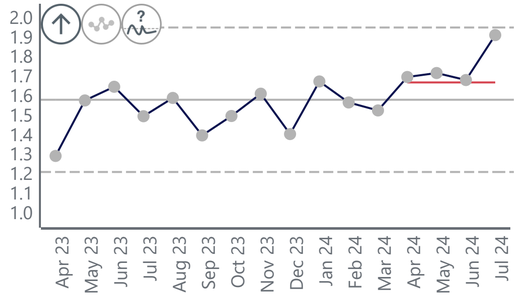


Theatre Utilisation (Capped Touch Time)

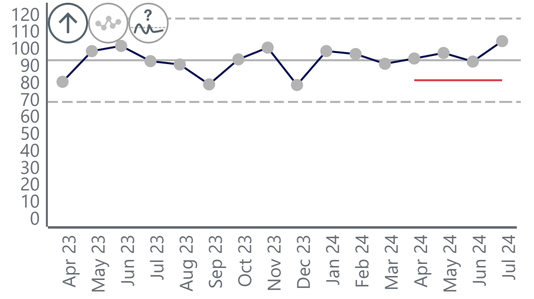
Target: Internal



Elective admissions (IP & DC) per clinical WTE

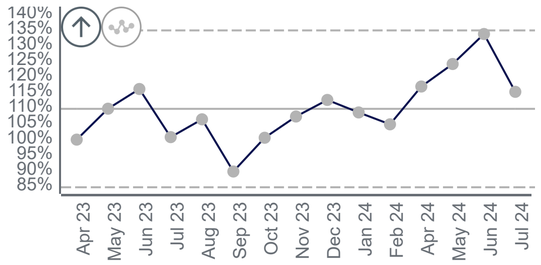


Outpatient attendances per Consultant WTE



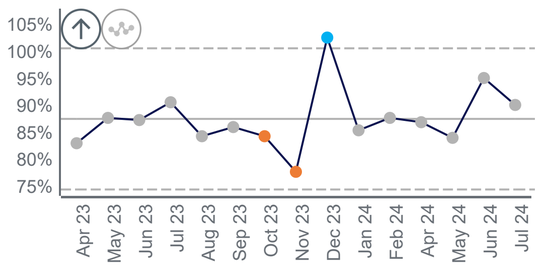
% Recovery for Daycase Discharges

Based on 19/20 baseline



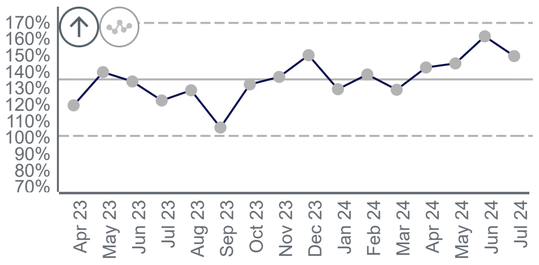
% Recovery for Elective Discharges

Based on 19/20 baseline

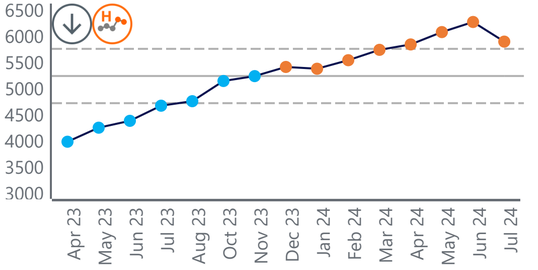


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

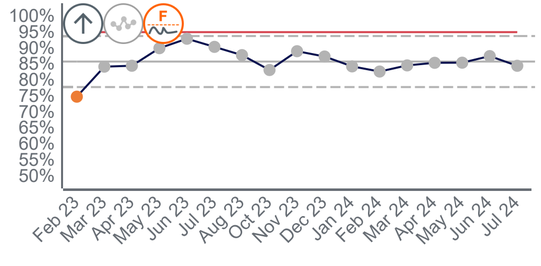


Reduce overdue Outpatient Follow Up Waits - 2 years & over

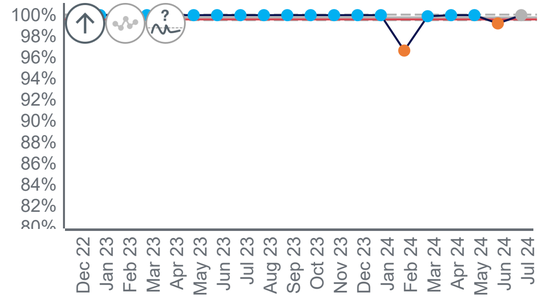


Diagnostics: % Completed Within 6 Weeks of referral

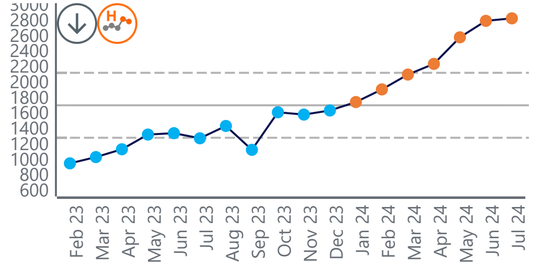
Target: Statutory



ADHD & ASD: % Referral to triage within 12 weeks



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



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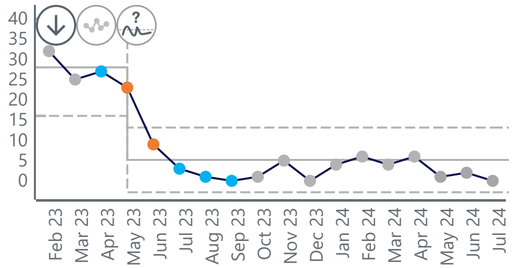
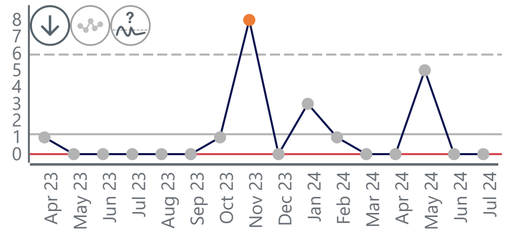
Revolutionise Care - Effective & Responsive - Watch Metrics

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



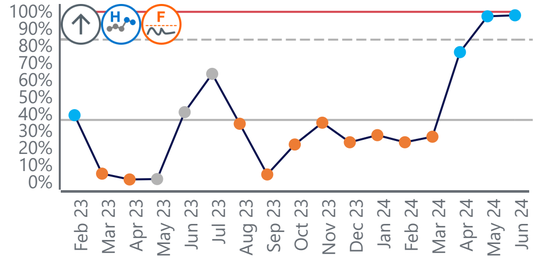
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



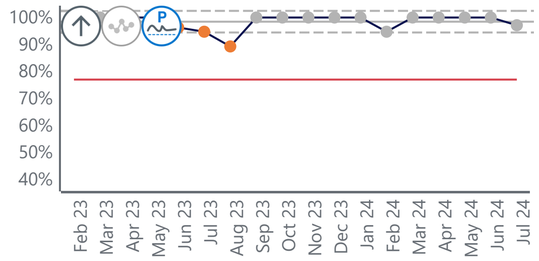
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



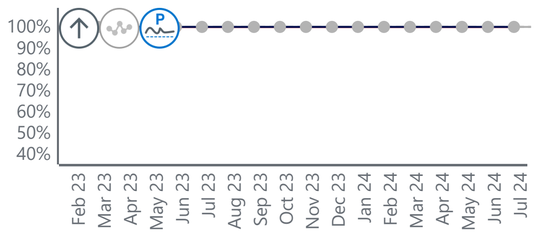
Cancer: Faster Diagnosis within 28 days

Target: Statutory



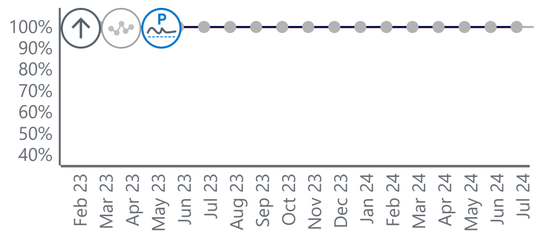
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

Target: Internal (Stretch)



Integrated Performance Report | August 2024

Alder Hey Children's NHS Foundation Trust

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 July 2024 is below

Areas of Concern:

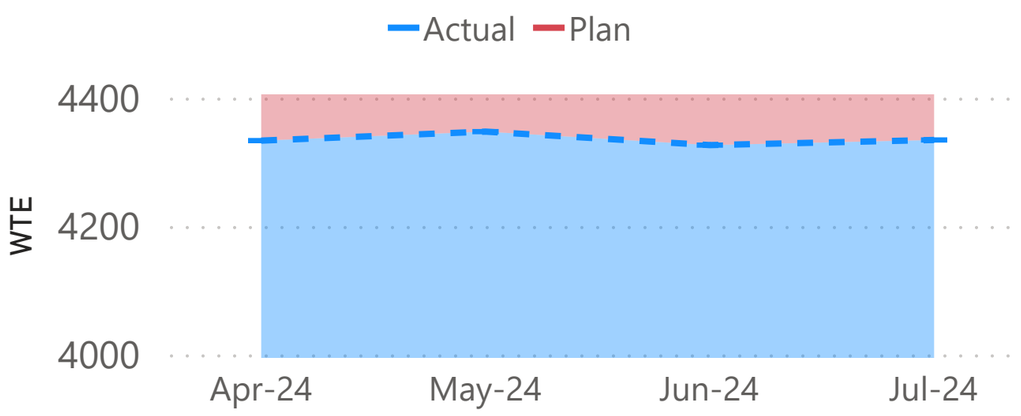
- The medical appraisal rate is challenging; the position is being monitored, and has seen improvement

Forward Look (with actions)

- PDR completion has remained below 90%; there are specific concerns with B7+ PDR compliance which were due to be completed by 31st July. Compliance is being reported regularly to managers for action.
- While total workforce is below plan in July 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.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

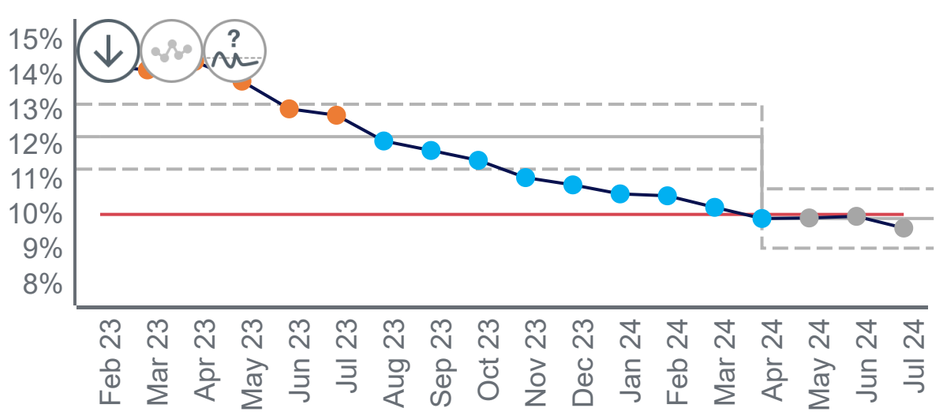
Total workforce for the end of July 2024 was 5.9 WTE below plan. Actual WTE was 4333.77 against a plan of 4339.67. 24/25 year end plan is set at 4311.45 WTE.

Actions:

Total workforce is the WTE staff in post, plus agency and bank usage (as WTE). While total workforce is below plan in July 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:

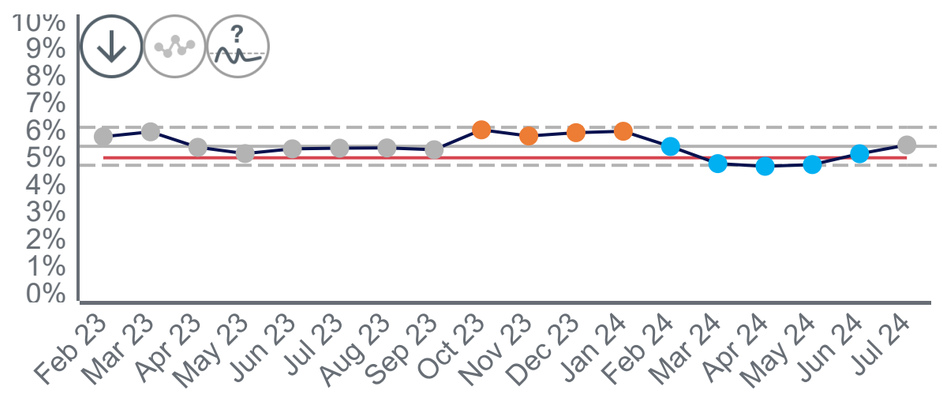
Staff Turnover is demonstrating common cause variation with performance of 9.6% in July 2024. This is the 4th consecutive month under the 10% target in 2024/2025.

Actions:

Following a significant period of reduction, turnover has remained at or below 10% in month. Ongoing analysis and external benchmarking remain in place.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in June 2024 is 5.49% which is above the 5% target. An increase from June 2024 at 5.15%. July 2024 performance comprises STS at 2.00% and LTS at 3.49%. Still demonstrating common cause variation, 2nd consecutive month above the target in 24/25.

Actions:

Sickness absence remains slightly over 5% in July 2024 following previous improvement. The following is in place with discussions at divisional board, wellbeing activities, focus on long term sickness and return to work discussions.

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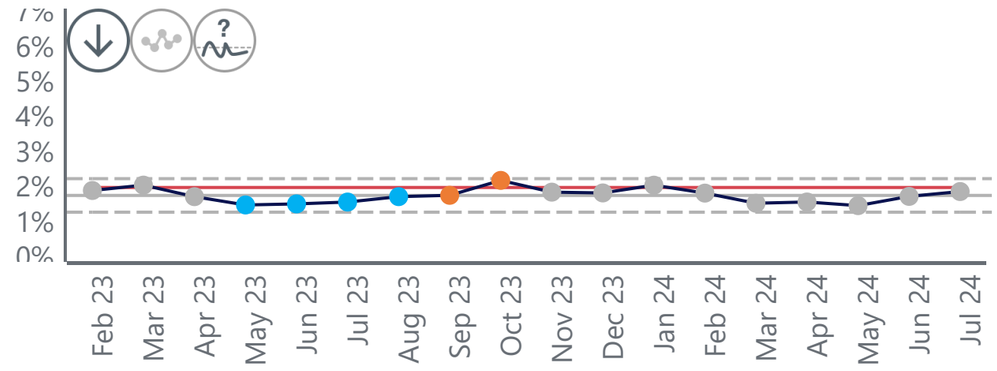
Alder Hey Children's NHS Foundation Trust

Supporting Our People - Watch Metrics

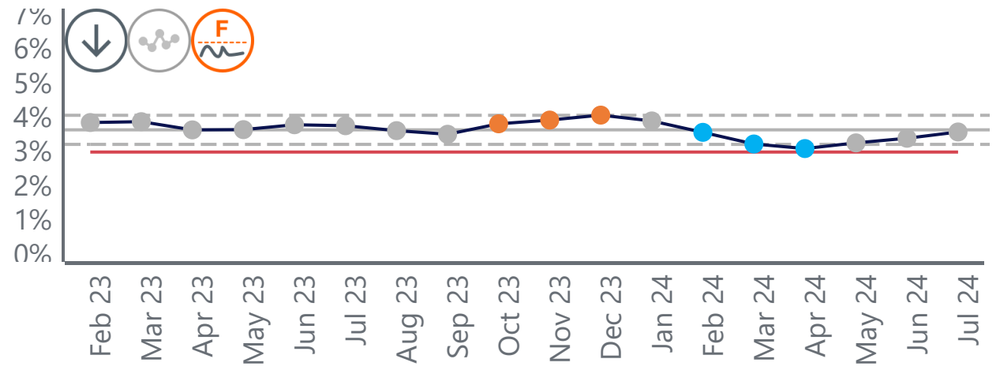
Short Term Sickness

Target: Internal



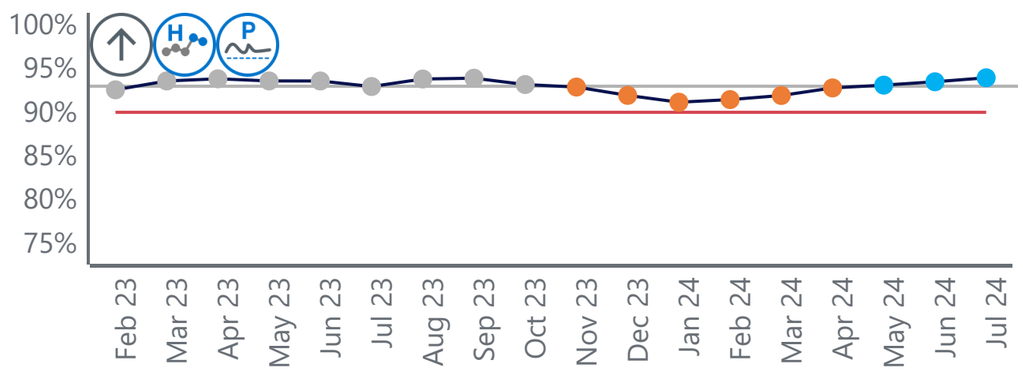
Long Term Sickness

Target: Internal



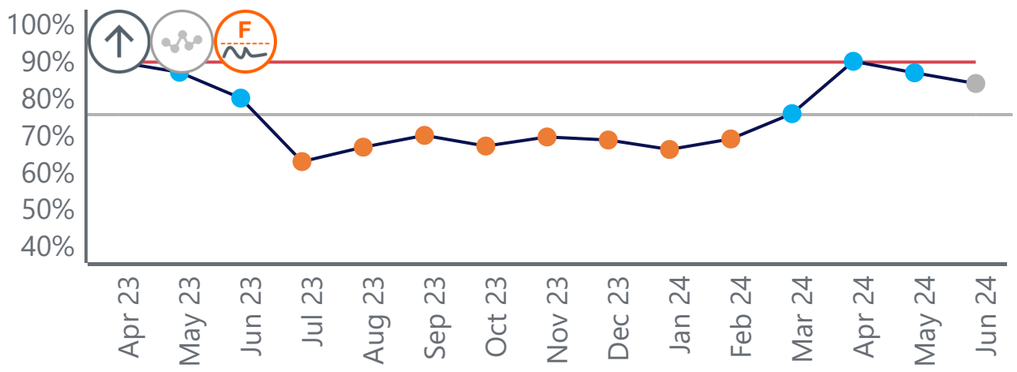
Mandatory Training

Target: Internal



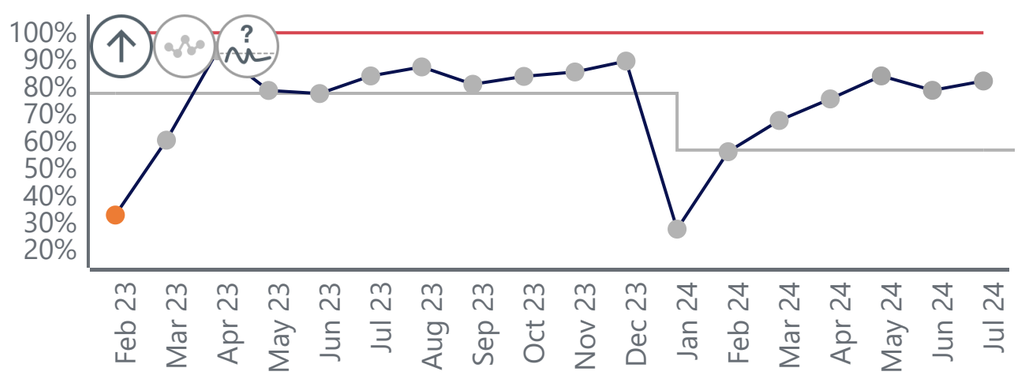
% PDRs Completed (Rolling 12 Months)

Target: Internal

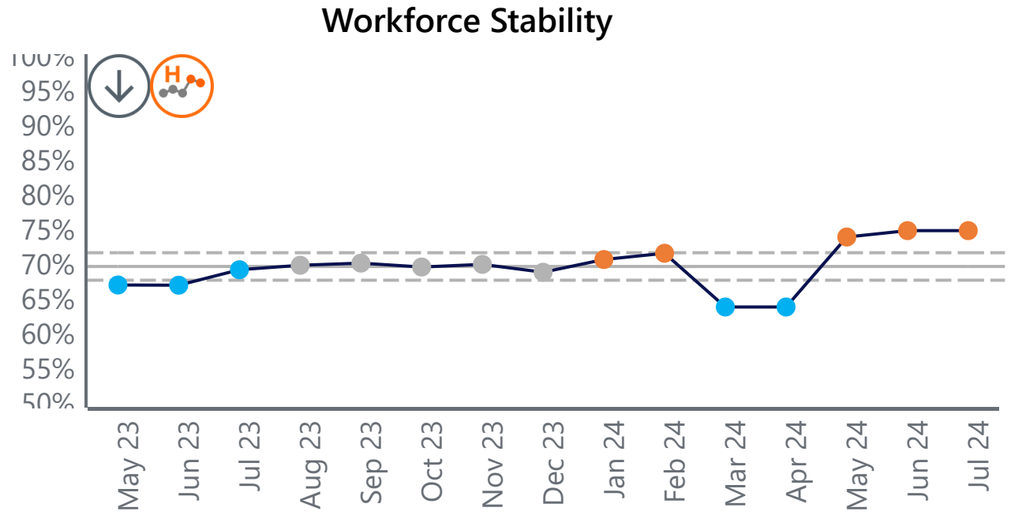


Medical Appraisal

Target: Internal



Workforce Stability



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:

• New bid coordinator appointed to oversee horizon scanning for external funding opportunities and capture of funding application data (submissions and successes) • Cost neutral business case for Futures infrastructure developed • Investment zone case underway for £4m funding over 5-year period (planned September submission) • Commercial forecast for commercial contract research activity ahead of target at end of M04 • Capacity building funding call for Starting Well (in conjunction with Liverpool Women's) is live and close in September

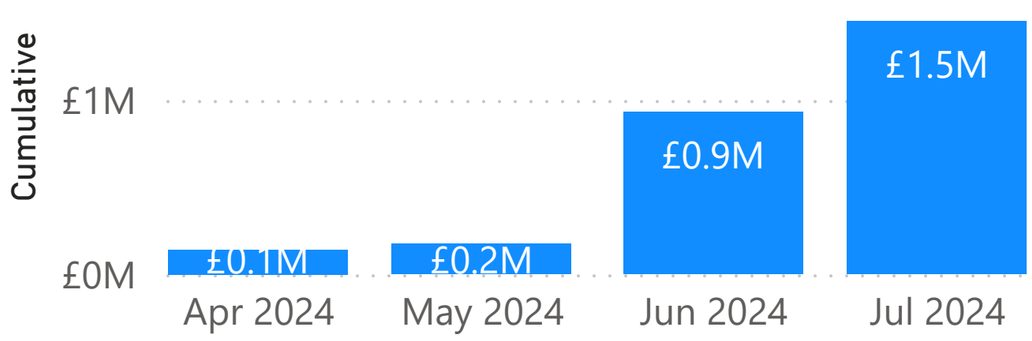
Areas of Concern:

• Vacant posts in innovation (including Senior Innovation Consultants and Head of Automation) restricting ability to drive forward Futures implementation plan • Gaps in leadership particularly relating to building external partnerships restricting ability to bring in additional external investment

Forward Look (with actions)

• Futures business case to be reviewed by Execs in August • Interviews for Senior Innovation Consultant taking place in August • Head of Automation JD awaiting job matching

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



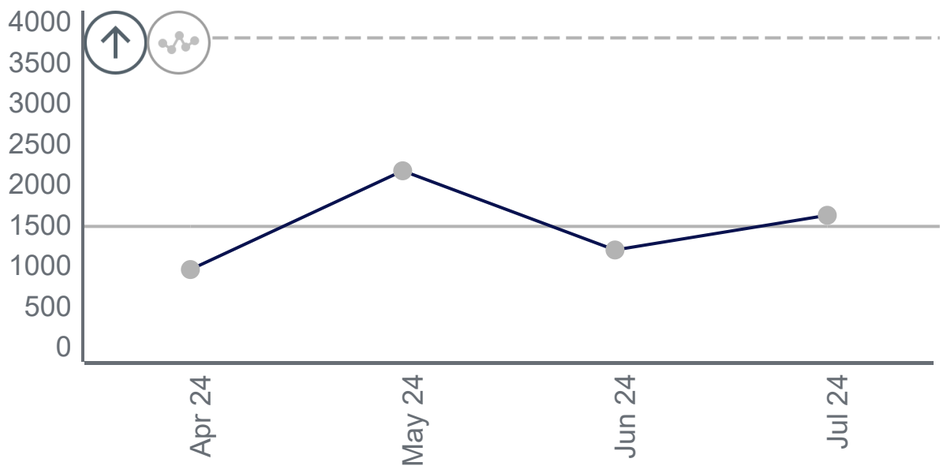
Technical Analysis:

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

Actions:

New Innovation Consultant/Bid Coordinator has been appointed to work across Futures (started in July) and has been tasked with horizon scanning to identify appropriate opportunities and collating and reporting on grant submissions and awards.

Manual Hours Saved through automation solutions

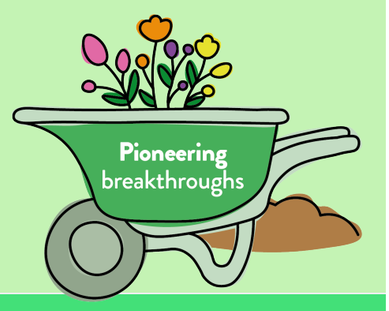


Technical Analysis:

This data is based on our current RPA solutions.

Actions:

Automation workshop planned for 29th August to review progress with current projects and assess future capacity.
Ongoing discussions with Ambient AI company regarding launching a pilot in Q3 in 2024/25.

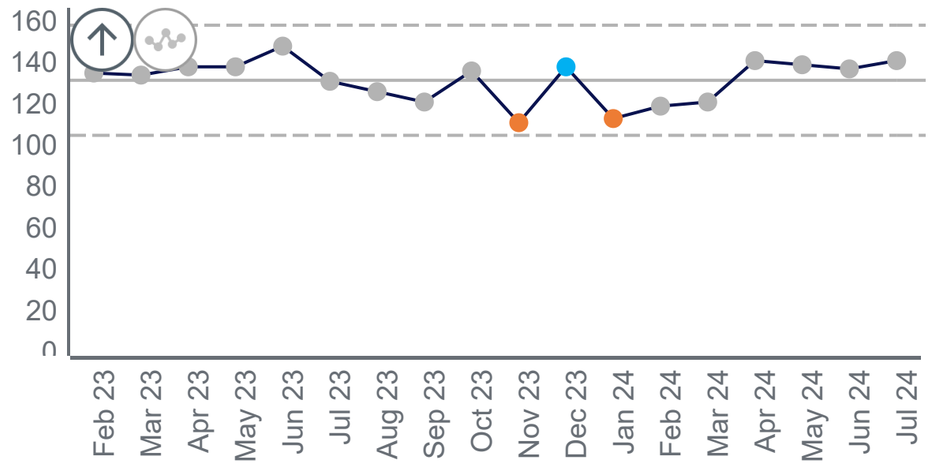


Integrated Performance Report | August 2024

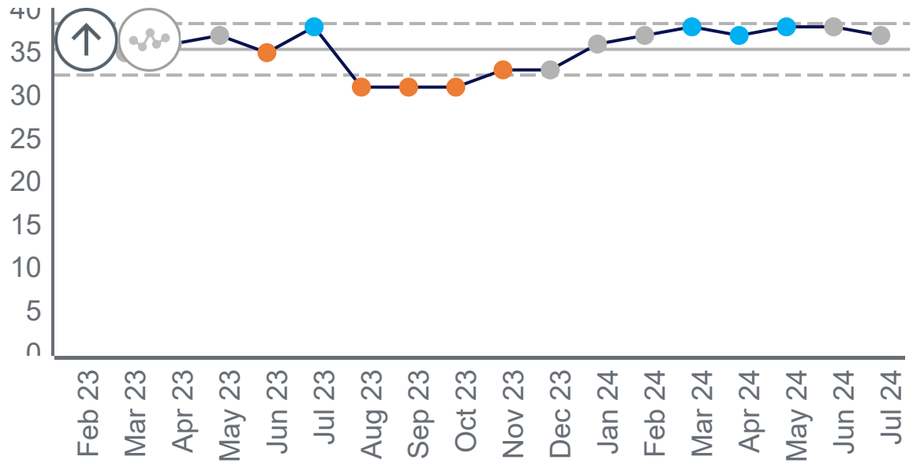
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

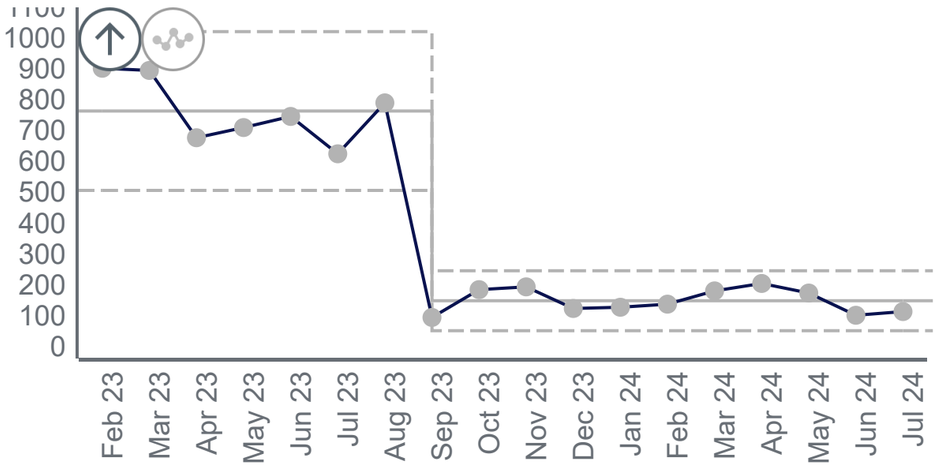
Number of Active (Open) Studies - Non Commercial



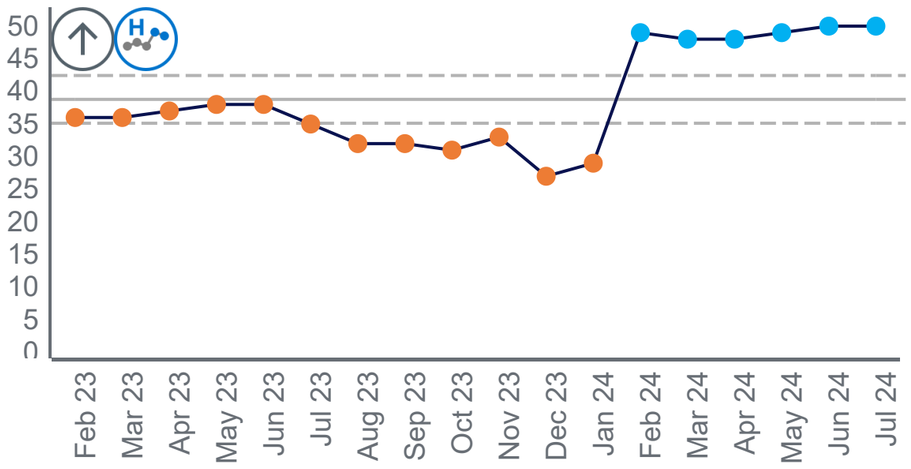
Number of Active (Open) Studies - Commercial

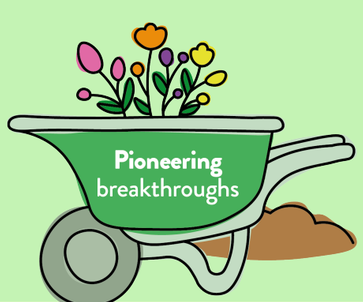


Number of Patients Recruited into Research Studies



Number of Chief Investigator led studies





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Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

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

Highlights:

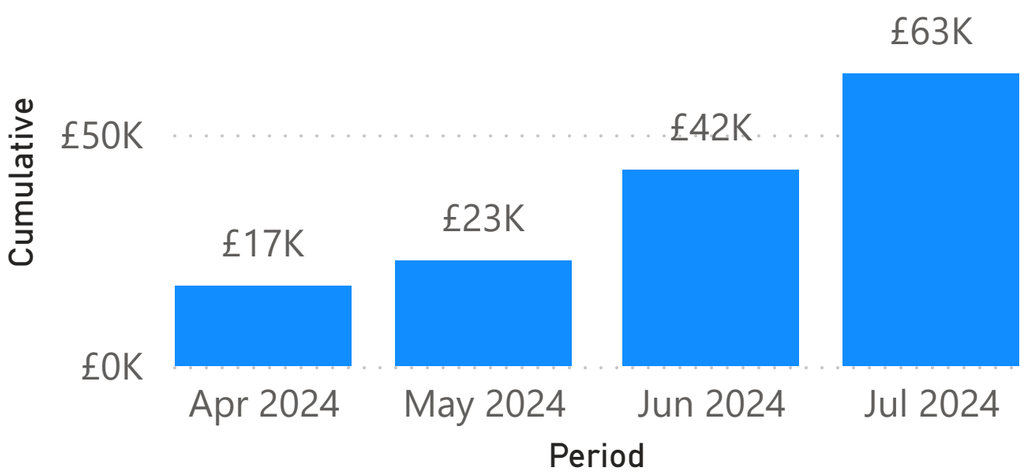
- Social Value now being captured across two key domains of the National SV Framework
- Capacity within widening participation team expanded from June 24
- Partnership with The Prince's Trust continues 24/25

Areas of Concern:

Forward Look (with actions)

Need to develop organisation wide approach to capturing social value

Social Value Generated - Cumulative



Technical Analysis:

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

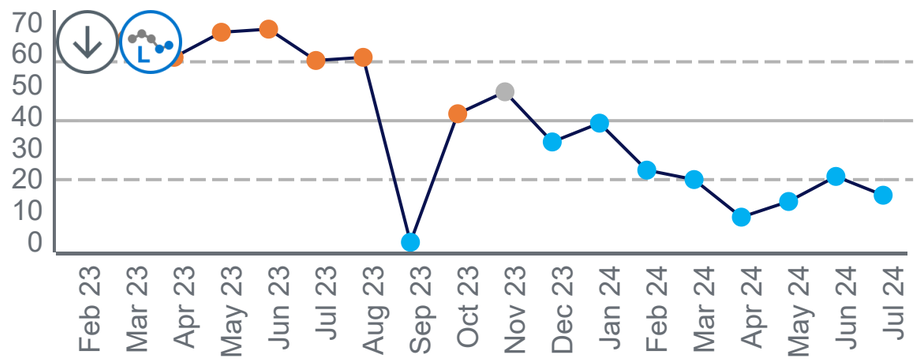
Integrated Performance Report | August 2024

Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

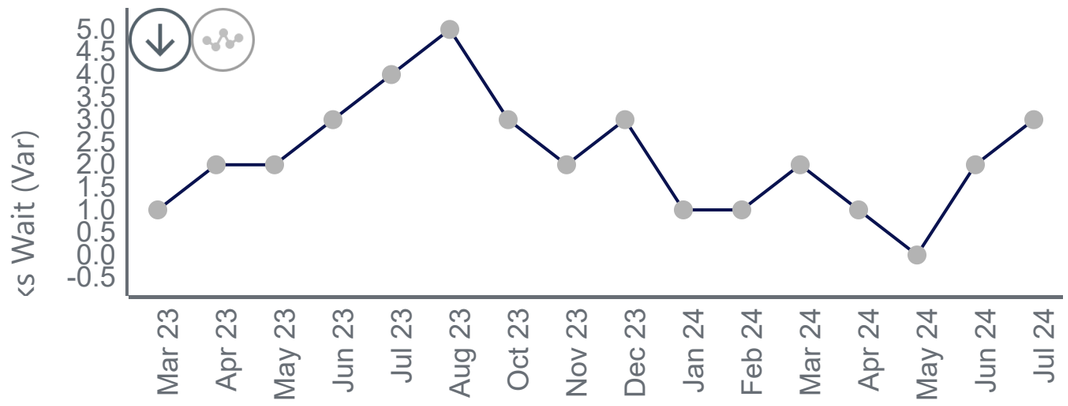
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

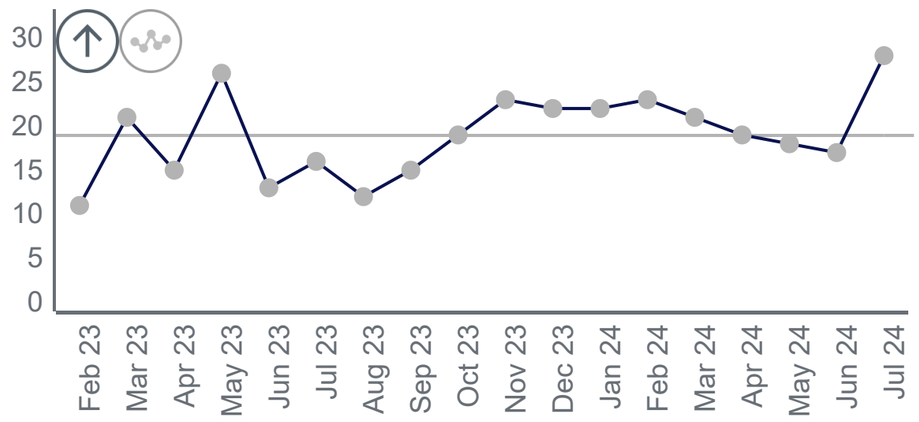


Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD

Sept-23 Unavailable



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



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Alder Hey Children's NHS Foundation Trust

Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

In July (M4), the Trust is reporting a position £0.4m away from plan (£3m deficit against a plan of £2.6m). This is due to industrial action. Forecasting to achieve £3.3m surplus following a reforecast exercise and launch of the financial improvement plan, however divisional forecasts have highlighted significant challenges and risk. CIP on plan in M4 and overall, £9.5m CIP has been transacted in year, with £11m 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 £83k 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:

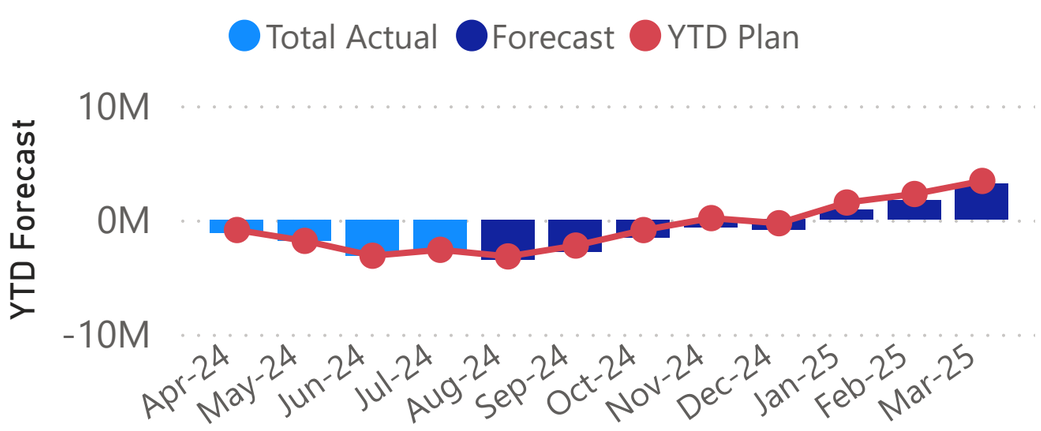
Work is ongoing to deliver full savings of £19.9m and significant progress has been made to date resulting in £8m of savings recurrently posted in M4. Divisional forecasts have highlighted significant financial and operational challenges, however divisions have been asked to provide mitigation plans. 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.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

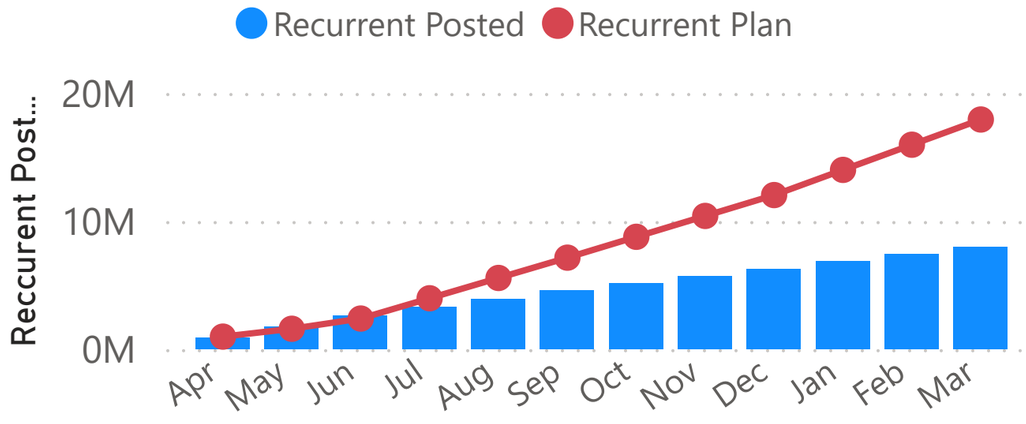
Current plan is £3.3m surplus however initial forecast has highlighted significant challenge. Risks to delivery of this is linked to achievement of CIP still in progres

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.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

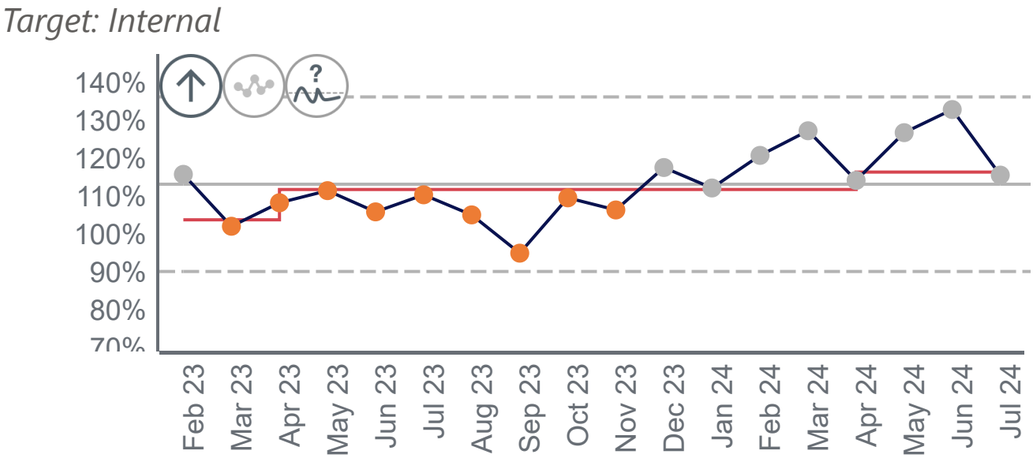
In year CIP identified and in progress is £14.3m whilst recurrent CIP is £13m

Actions:

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

% ERF Value (Income)

Target: Internal



Technical Analysis:

July performance estimated at 123%.

Actions:

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

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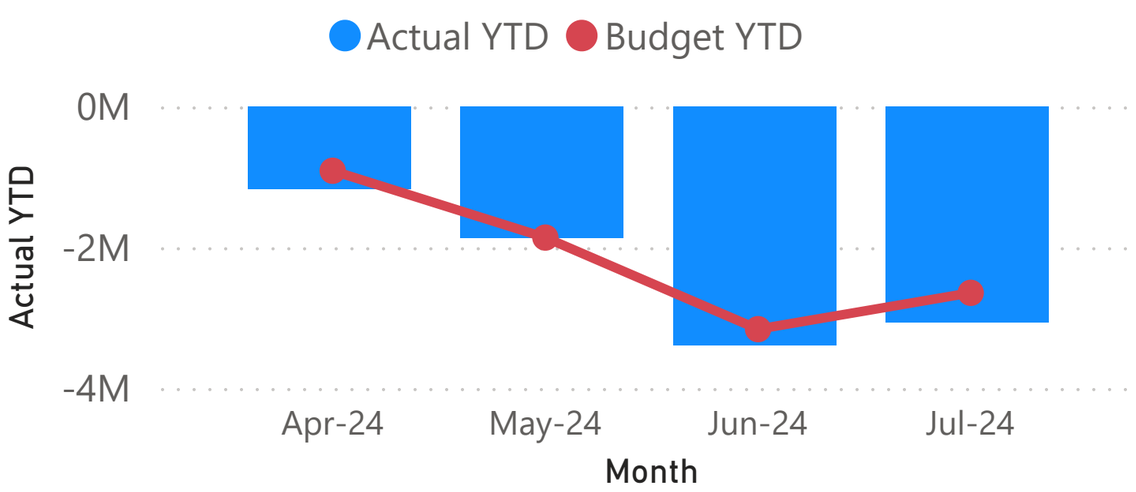
Alder Hey Children's NHS Foundation Trust

Financial Sustainability: Well Led - Watch Metrics

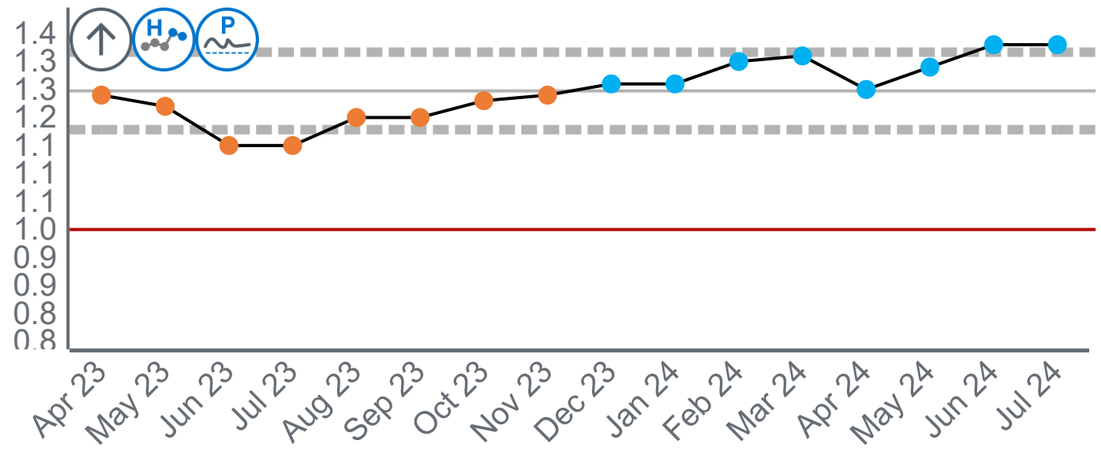
I&E distance from target (cumulative YTD)

Target: Internal

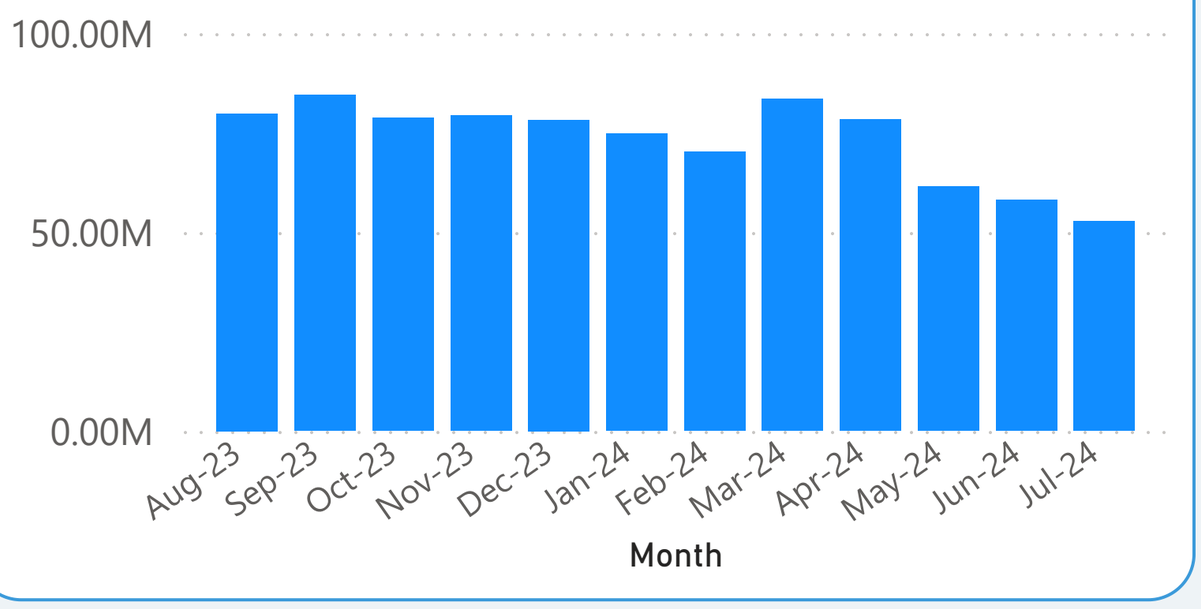


Liquidity

Target: Internal



Cash In Bank



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Decrease in number of high risks reported for July 24

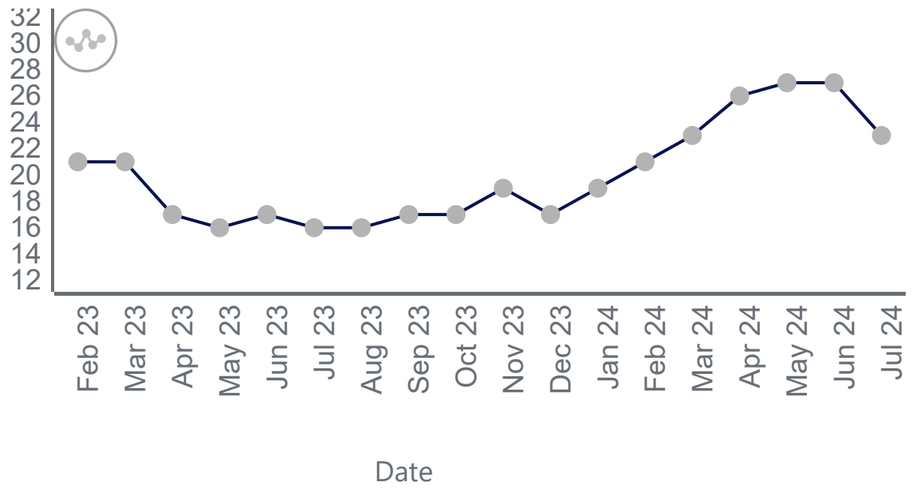
Areas of Concern:

Despite requests and emails limited involvement remains at risk oversight meetings from all risk owners –currently being monitored.

Forward Look (with actions)

Request to Education group for consideration of inclusion of Introduction to risk management training for all staff. Overview and assurance of mitigation/progression with high risks continue to be undertaken as a standing agenda item at Risk Management Forum.

Number of High Risks (scored 15 and above)



Technical Analysis:

A decrease in reported high risks from 27 reported on July 24

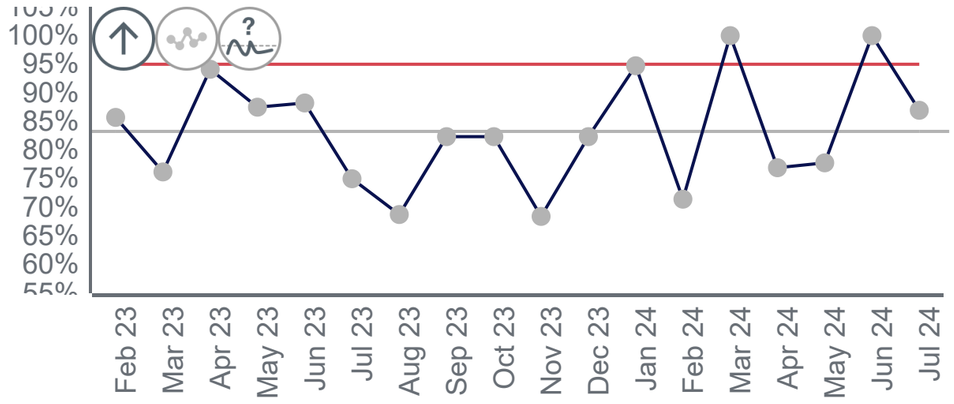
Actions:

23 high risks reported in July 24 a decrease from previous reporting period. Risks themed as follows:

Quality/ Safety (9 risks) Workforce (3 risks), Compliance/regulatory (5 risks), Financial (3 risks), Quality/Effectiveness (1 risk), 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 87% in July 2024. 2nd consecutive month above the monthly average in the period of 83%.

Actions:

87% of high risks within review date. 3 risks overdue. All overdue risks continue to be escalated directly with risk owners

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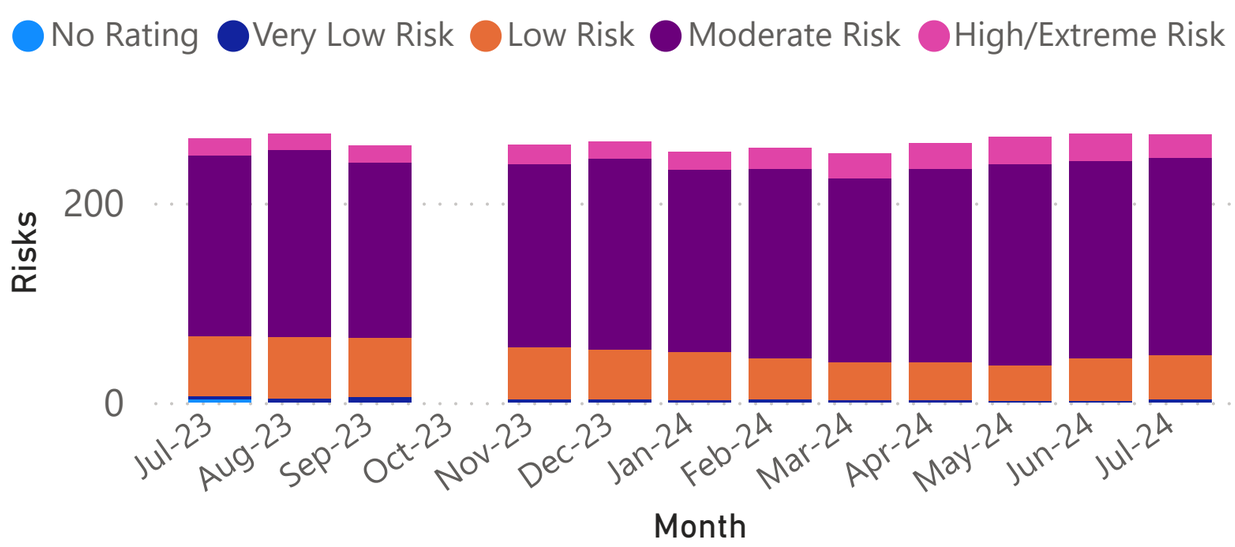
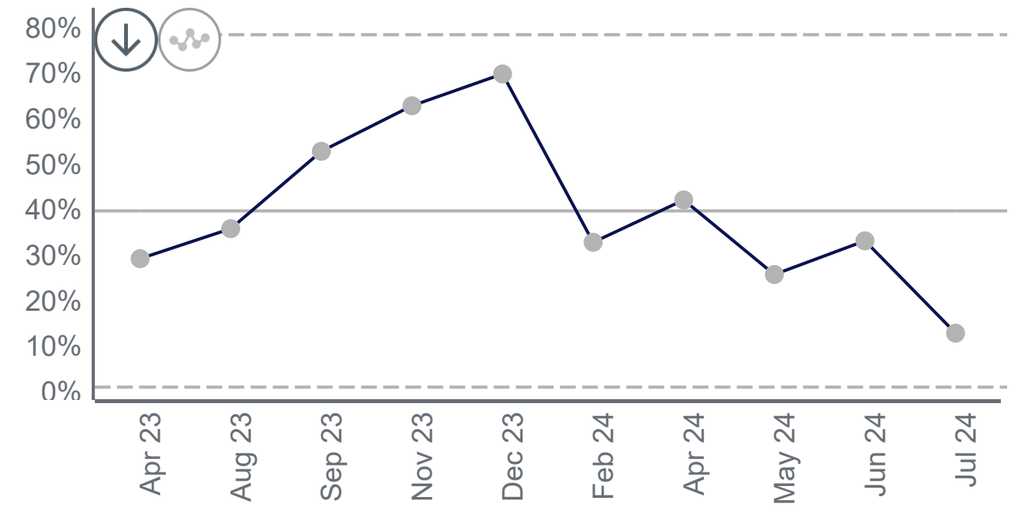
Alder Hey Children's NHS Foundation Trust

Well Led - Risk Management

Trust Risk Profile



% of high risks with actions past expected date of completion



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

- Reduction in incidents rated no harm / near miss (95)
- 100% of complaints responded to within 25 days
- Increase in the number of families who would recommend outpatients (96%) and mental health services (100%)
- Was not Brought rate reduced in July
- Improved RTT position for Eating Disorder Service (96%) – despite a continued increase in referrals
- Sustained improvement in waiting times to access community dietetics (83%), and reduction in longest wait.
- Longest waits to access SALT have improved. RTT has improved slightly compared to previous month (68%) – significant increase in referrals since 2021/22

Areas of Concern

- Work continues on data reporting for Mental Health Services via MHSDS due to data quality issues impacting on submissions. This has been escalated to executive team and BI team who lead this work.
- Outpatient Fracture/Dermatology programme of works has been further delayed until August 2024
- Continued increase in referrals for Eating Disorder Team in July 2024, with particular increase around referrals for ARFID
- Liverpool CAMHS: referral to help (first assessment) waiting times remains lower than target (36% within 6 weeks of referral) – demand and capacity work has commenced
- Capacity for Psychiatry appointments (Liverpool CAMHS) outstrips demand, demand and capacity work is ongoing
- 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)

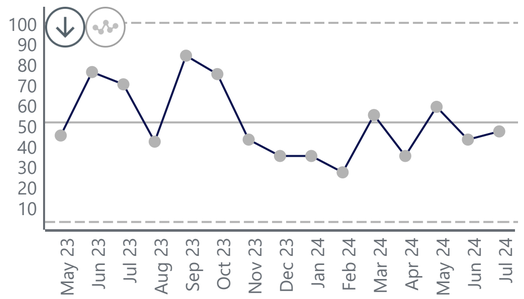
- Demand and capacity work commenced for Community Dietetics to reach 92% RTT
- Demand and capacity work for ARFID referrals commenced
- Demand and capacity work ongoing for Liverpool Psychiatry
- Continued work ongoing to improve Mental Health data reporting– annual data re-submitted for 2023/24, awaiting feedback. Expected improvement in the number of data errors in MHSDS.
- Capacity and Demand planning work for Speech and Language Therapies has been completed. Work to review waiting times and improvement plan is ongoing, with trajectory for improvement being developed

Integrated Performance Report | August 2024

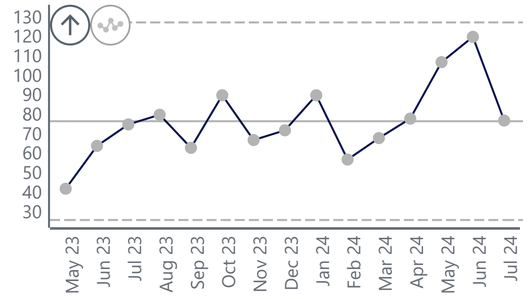
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

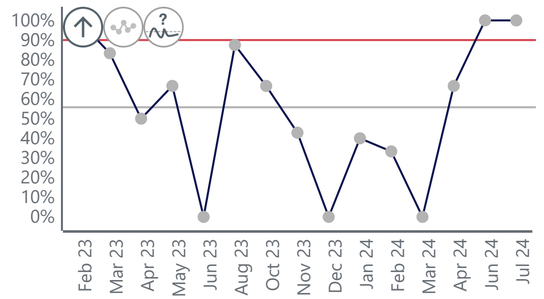
Patient Safety Incidents rated Low Harm & Above



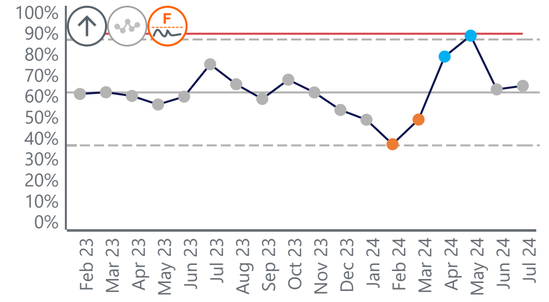
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

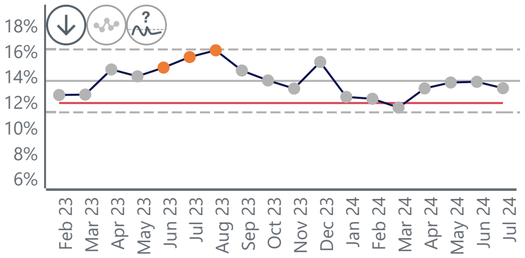


% PALS Resolved within 5 Days

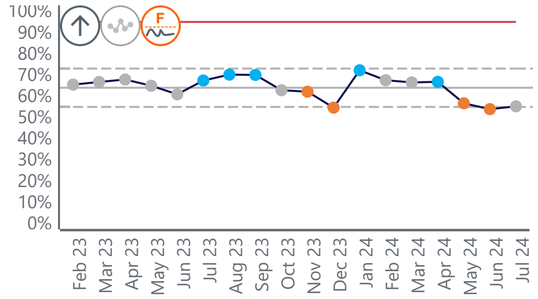


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

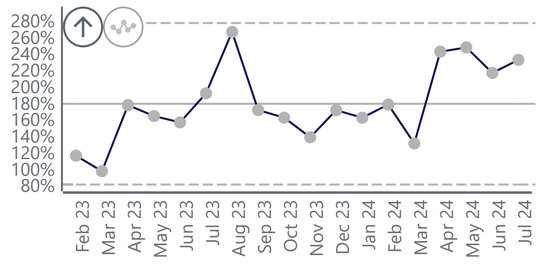


% of Clinical Letters completed within 10 Days

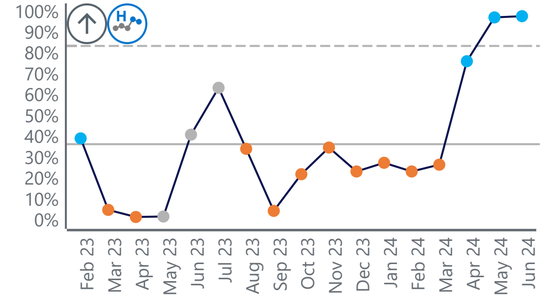


% Recovery for OP New & OPPROC Activity Volume

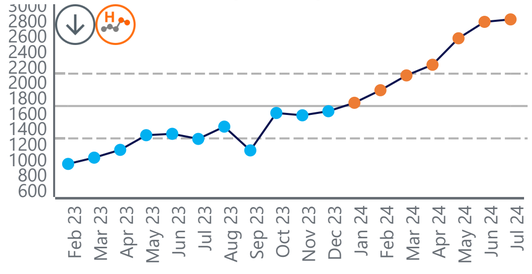
Based on 19/20 baseline



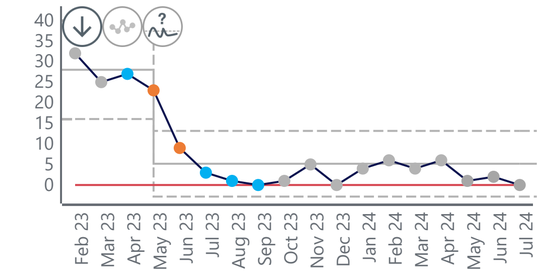
IHA: % complete within 20 days of referral to Alder Hey



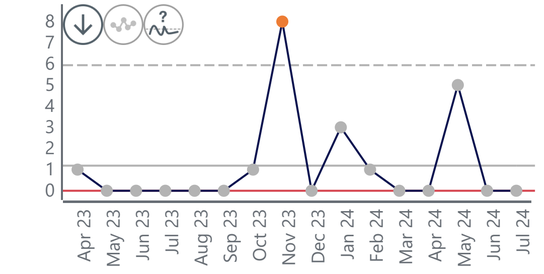
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



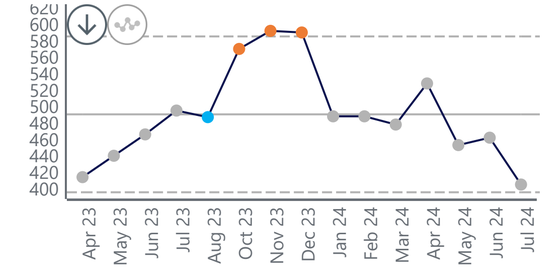
CAMHS: Number of children & young people waiting >52weeks



Number of Paediatric Community Patients waiting >52 weeks



Reduce overdue Outpatient Follow Up Waits - 2 years & over



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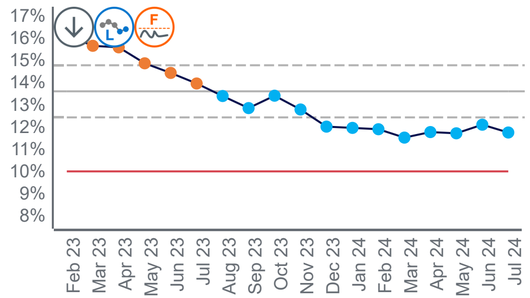
Integrated Performance Report | August 2024

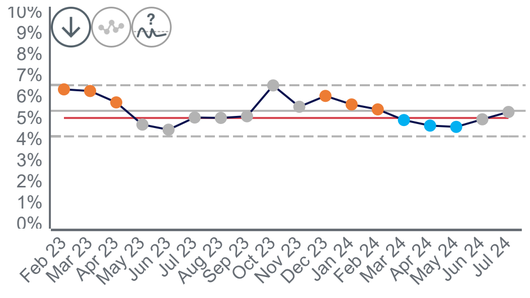
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

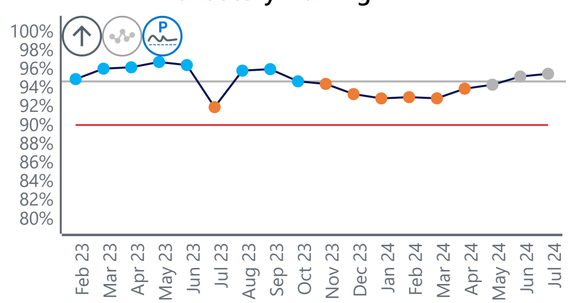
Staff Turnover



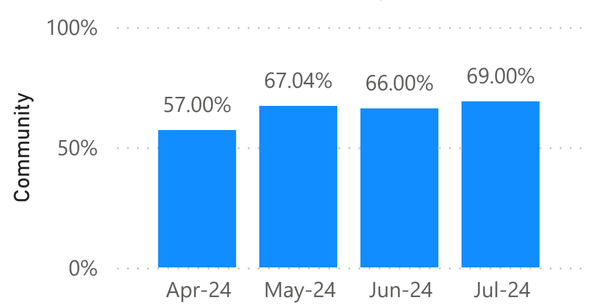
Sickness Absence (Total)



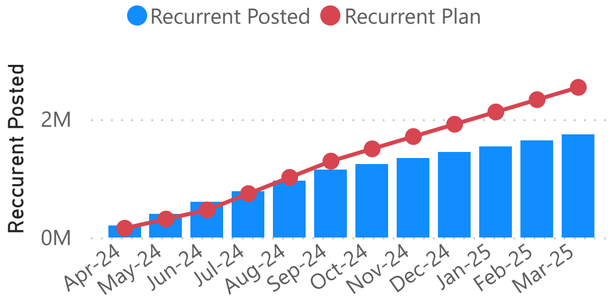
Mandatory Training



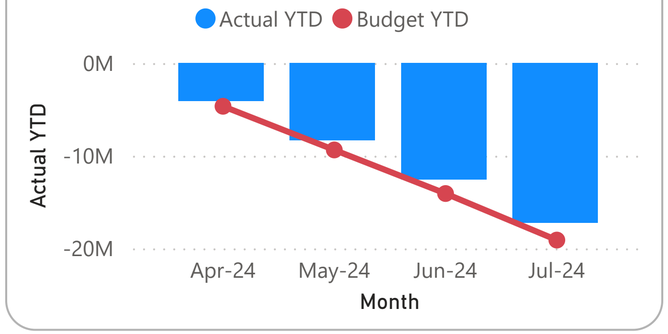
Workforce Stability



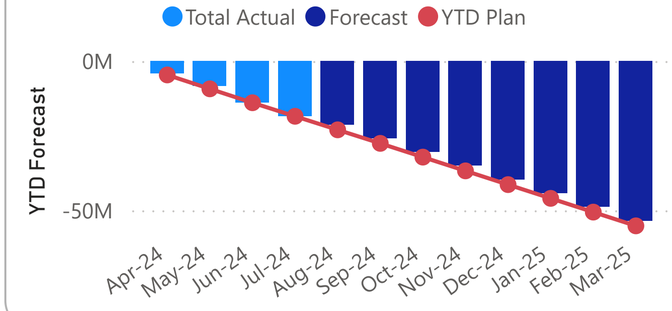
Recurrent Efficiency Plans Delivered (Forecast)



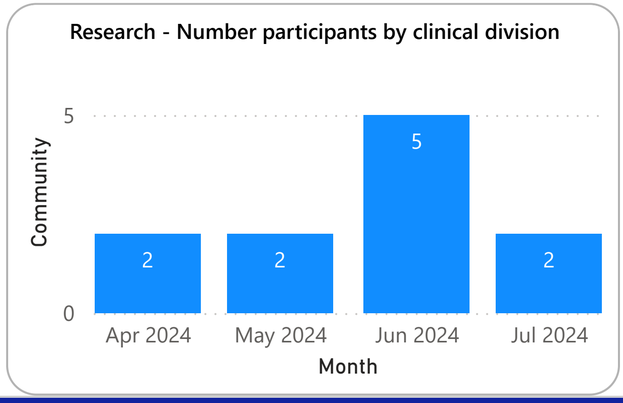
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division

Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• The EDU and PAU bed closure occurred successfully with the services relocating to 4C to support with the NICU and SDEC build development

• ED improved 4 hours performance achieving 88% in month

• 100% response rate for formal complaints for 8th consecutive month

• Reduction in patients waiting over 52 weeks to receive treatment

• Reduction in overdue follow ups following speciality focus

• 94% compliance in mandatory training

• Further reduction in staff turnover, 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

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

• Slight increase in sickness absence however remains below trust 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

• 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)

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

• 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 focus on delivering CIP in a financially sustainable manner

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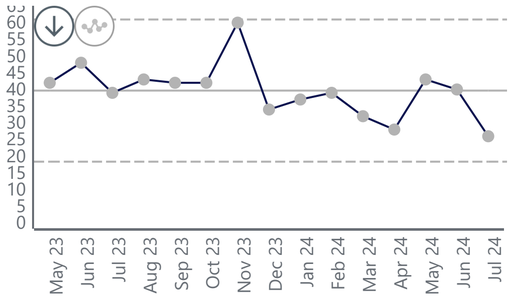
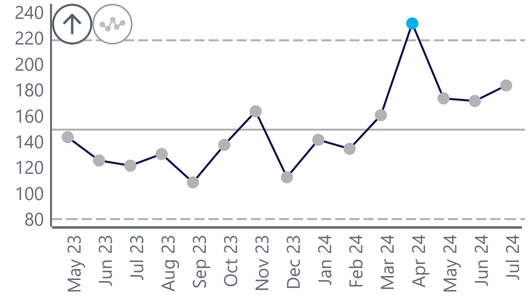
Divisional Performance Summary - Medicine

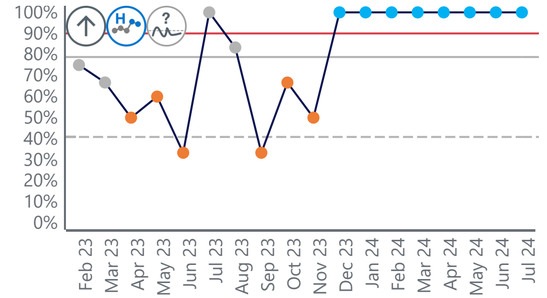
Patient Safety Incidents rated Low Harm & Above



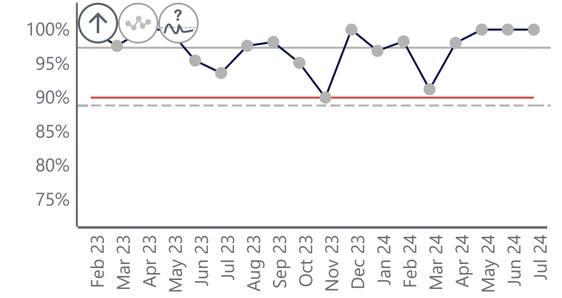
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

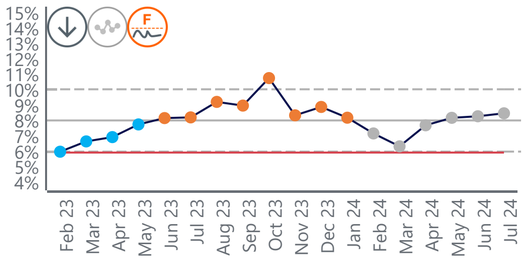


% PALS Resolved within 5 Days

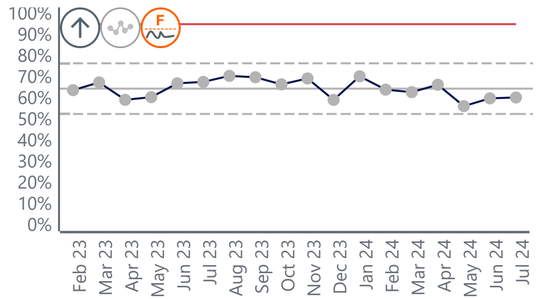


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

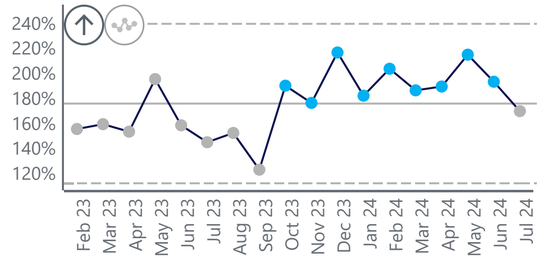


% of Clinical Letters completed within 10 Days

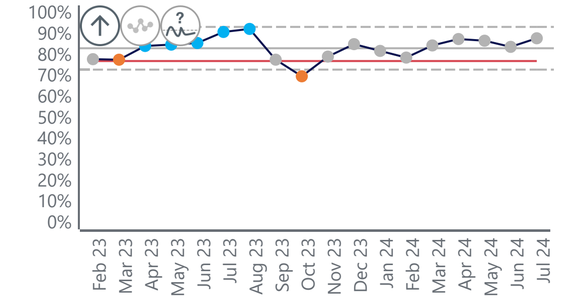


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

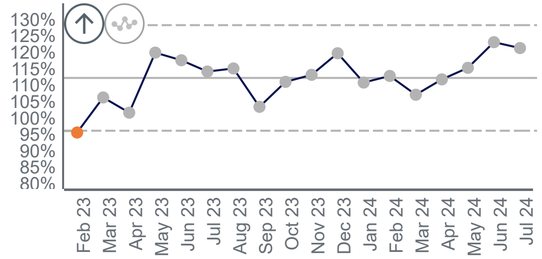


ED: % treated within 4 Hours

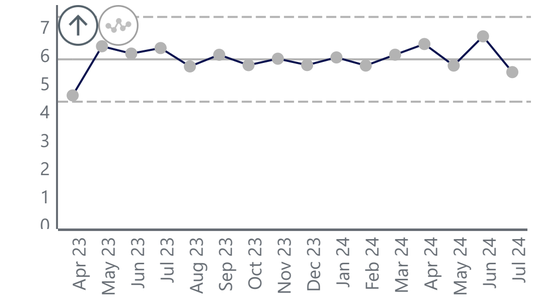


% Recovery for DC & Elec Activity Volume

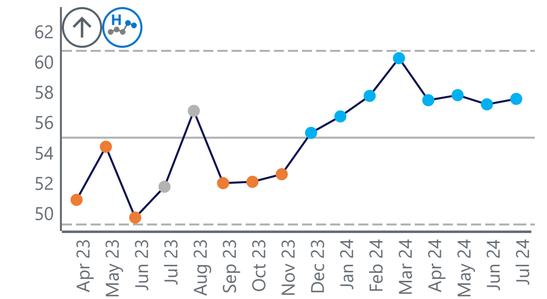
Based on 19/20 baseline



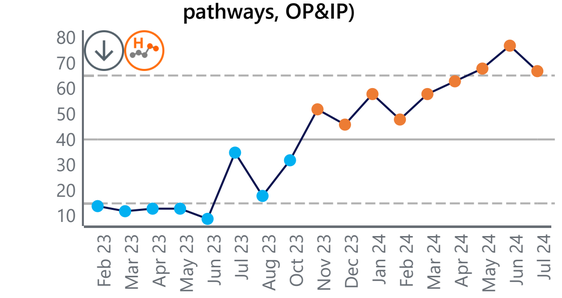
Inpatient Discharges per working day



Day Cases per working day



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



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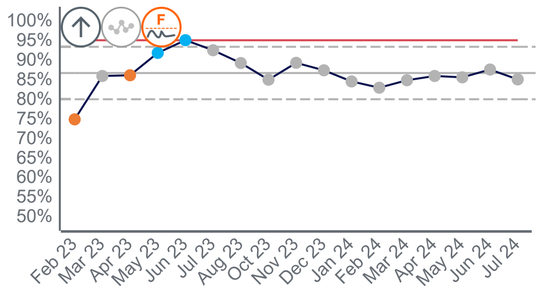
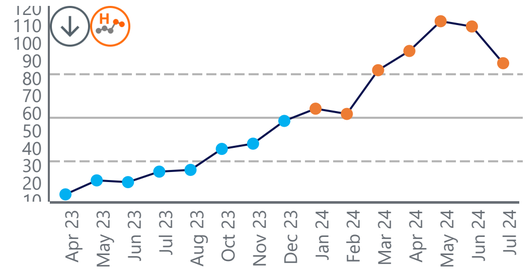
Divisional Performance Summary - Medicine

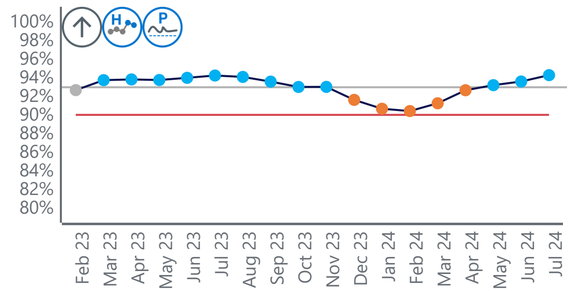
Diagnostics: % Completed Within 6 Weeks of referral



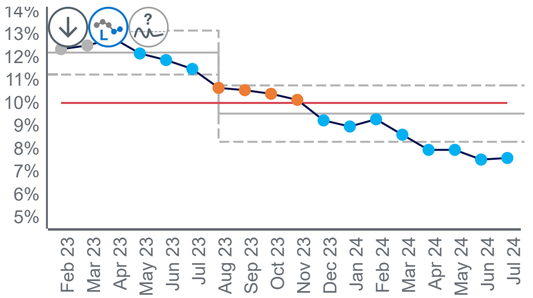
Reduce overdue Outpatient Follow Up Waits - 2 years & over



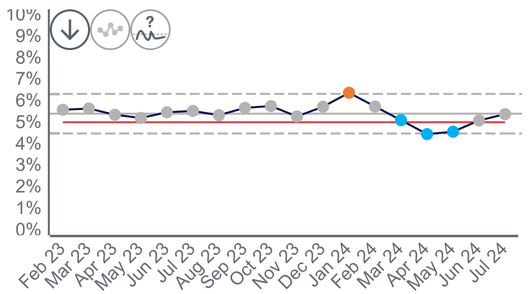
Mandatory Training



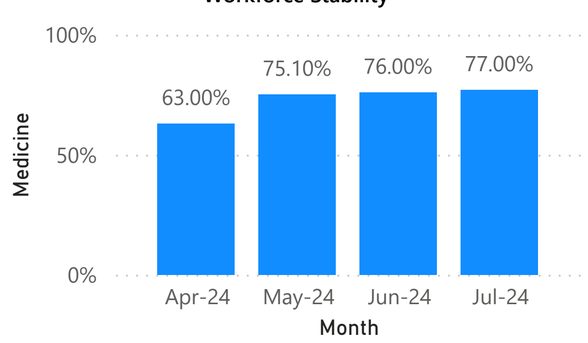
Staff Turnover



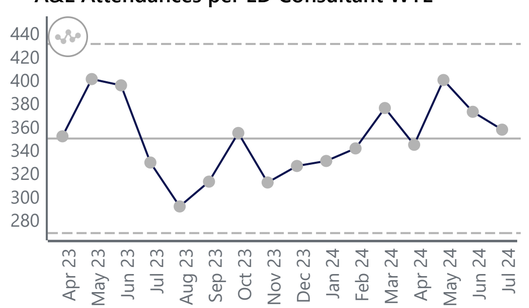
Sickness Absence (Total)



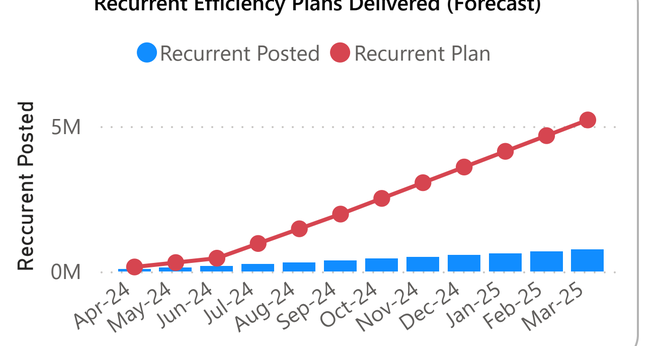
Workforce Stability



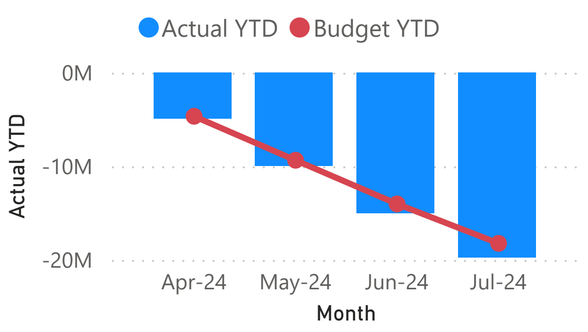
A&E Attendances per ED Consultant WTE



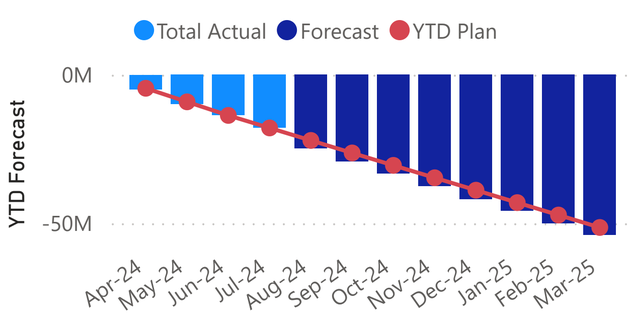
Recurrent Efficiency Plans Delivered (Forecast)



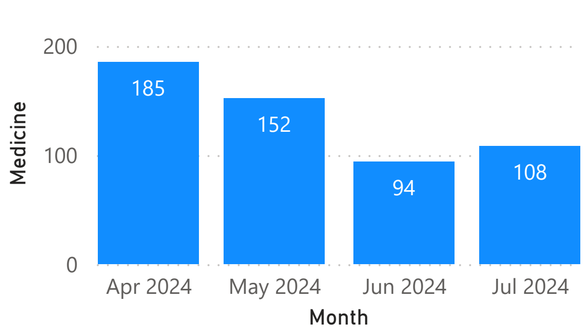
I&E distance from target (cumulative YTD)



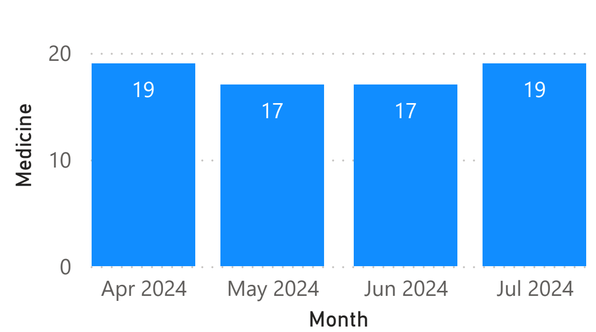
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

- Number of patients waiting <65 and <52 weeks continues to reduce.
- Division on track for 0 > 65 weeks by end of September 2024.
- Achieved 130% for OPNEW and OPROC recovery
- 100% complaints responded to within 25 working days.
- Mandatory training compliance continues to increase for the 5th consecutive month.
- Staff Turnover rates continue to decline and are at Trust target.
- Overdue follow ups have decreased following ongoing targeted improvement work.
- Review undertaken of specialties who have performed against activity plan but have not achieved expected income.

Areas of Concern

- Overdue follow up appointments continue to be a concern, although have seen a decrease in month, numbers still significantly high and specialty plans being worked through.
- WNB remains above target for the Division.
- Financially our forecast looks challenging with a significant issue within non-pay.

Forward Look (with actions)

- Productive theatres group focusing on increasing touch time utilisation in September. Eg. Late starts.
- Productive Outpatients group focusing on 3 specialties with highest WNB rate consistently.
- Ongoing actions in place to achieve 0 CYP waiting over 52 weeks by March 25.
- Coding sprint ongoing and further opportunities identified.

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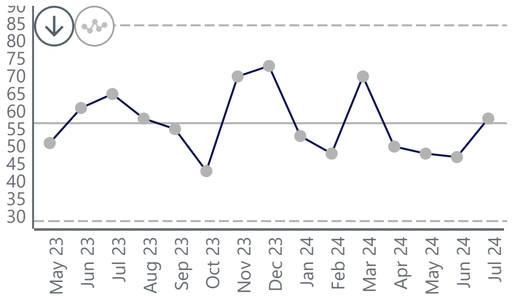
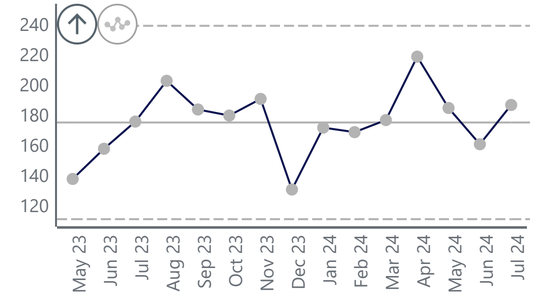
Divisional Performance Summary - Surgery

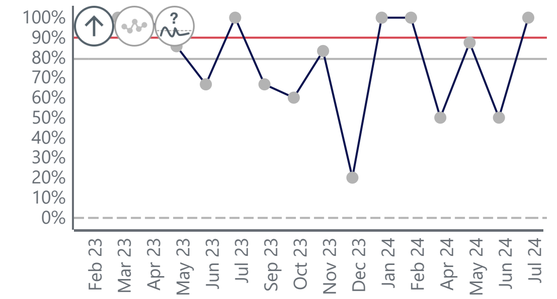
Patient Safety Incidents rated Low Harm & Above



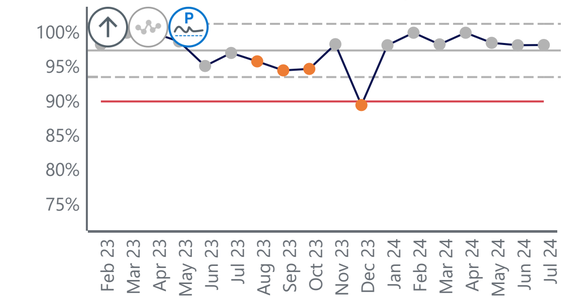
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

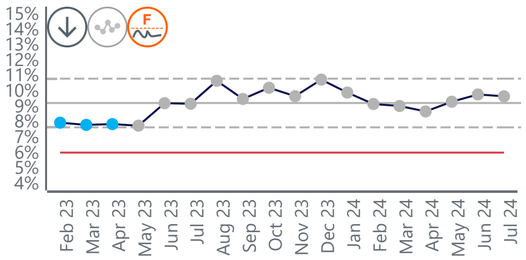


% PALS Resolved within 5 Days

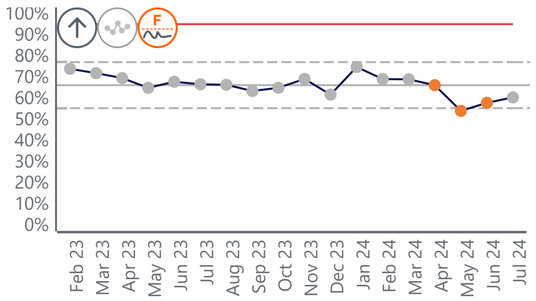


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

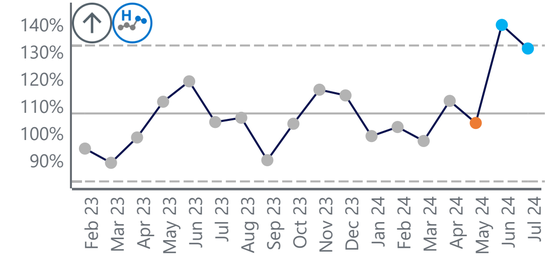


% of Clinical Letters completed within 10 Days



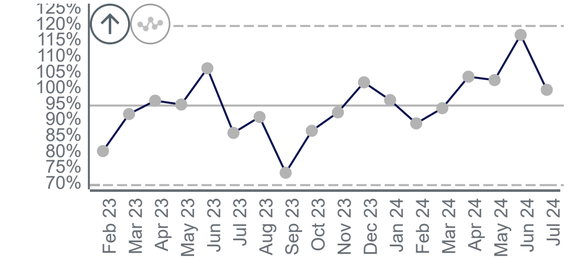
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

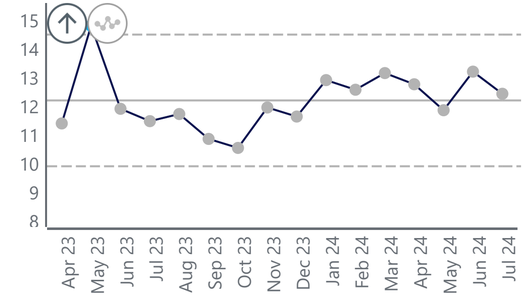


% Recovery for DC & Elec Activity Volume

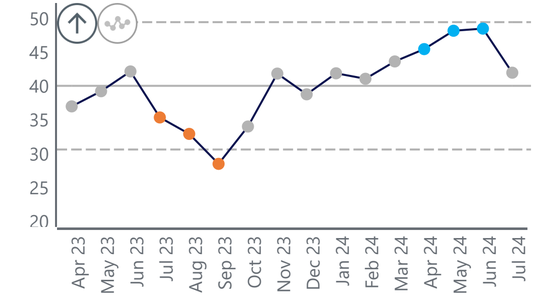
Based on 19/20 baseline



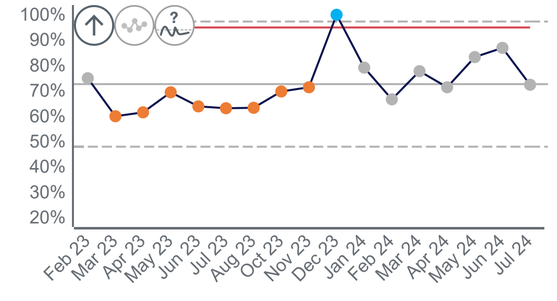
Inpatient Discharges per working day



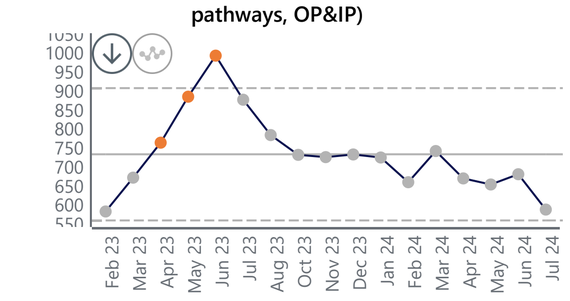
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



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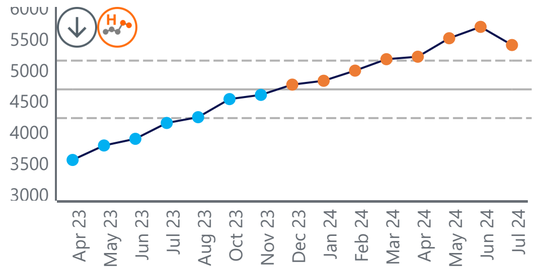
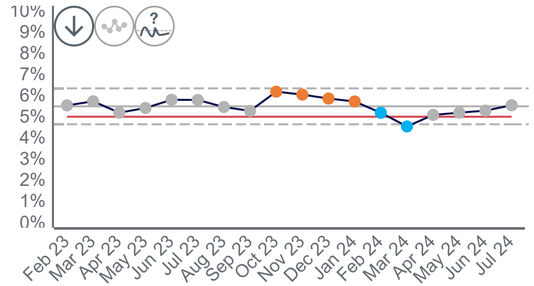
Divisional Performance Summary - Surgery

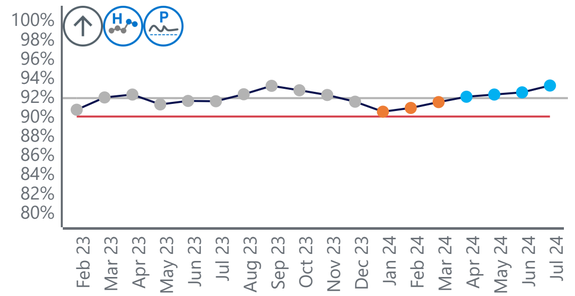
Reduce overdue Outpatient Follow Up Waits - 2 years & over



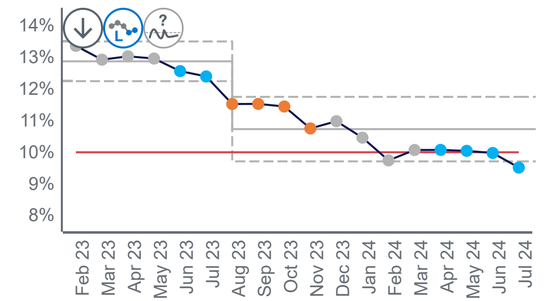
Sickness Absence (Total)



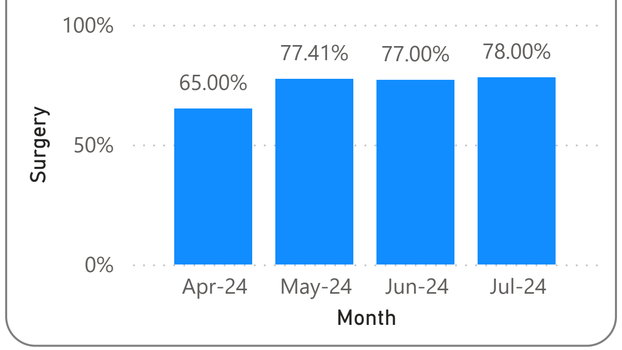
Mandatory Training



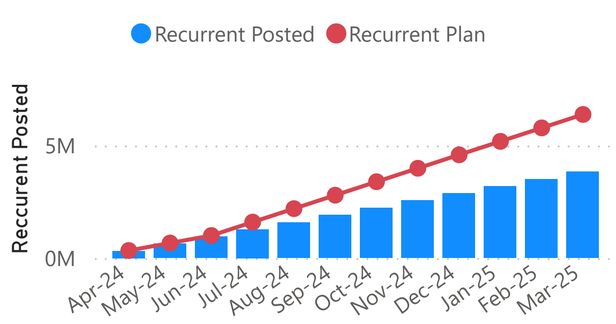
Staff Turnover



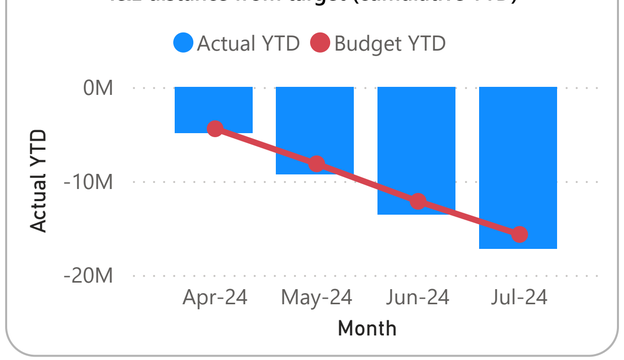
Workforce Stability



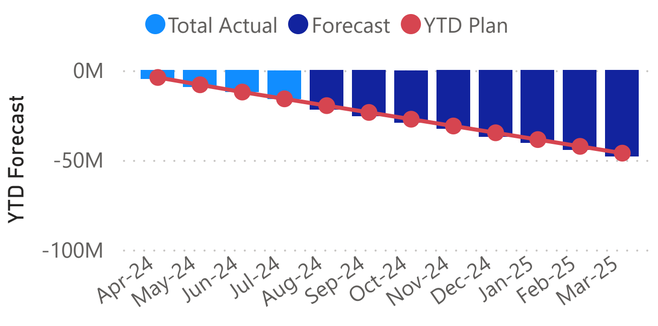
Recurrent Efficiency Plans Delivered (Forecast)



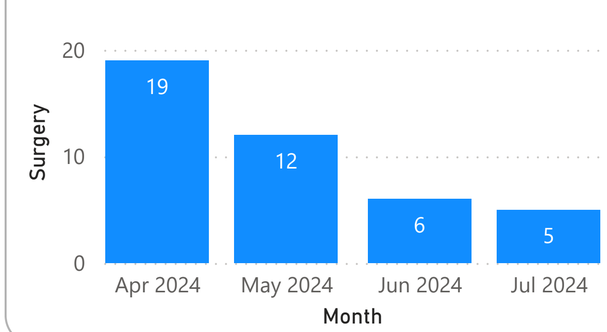
I&E distance from target (cumulative YTD)



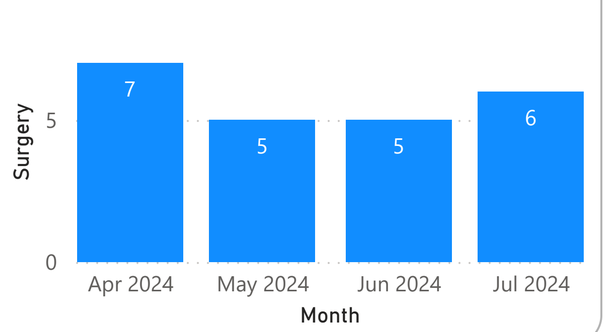
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• Confirmation of allocation of Mobile Research Unit to Alder Hey (one of 4 across the North West Coast and only dedicated paediatric unit – delivery expected in late October 2024

• Funding for NIHR Alder Hey Clinical Research Facility extended until 2029 and annual report submitted

• Alder Hey funding from Clinical Research Network (will become Regional Research Delivery Network from 1st October) will remain stable until 31st March 2026

• Alder Hey staff and parent champion attended national Clinical Research Facility conference and presented multiple posters.

• Rocket-orbit trial – first interventional dermatology study for a long time – recruited to time and target

• Commercial forecast for commercial contract research activity ahead of target at end of M04

• No concerns with metrics mandatory training, turnover and stability metrics

Areas of Concern

• Incidents have been reviewed and actions taken

• Sickness levels within team causing some concern particularly for research delivery

Forward Look (with actions)

• Continued focus on improving study performance to ensure 80%+ studies are recruiting to time and target

• Strong links being developed between new bid coordinator and Liverpool Joint Research Office

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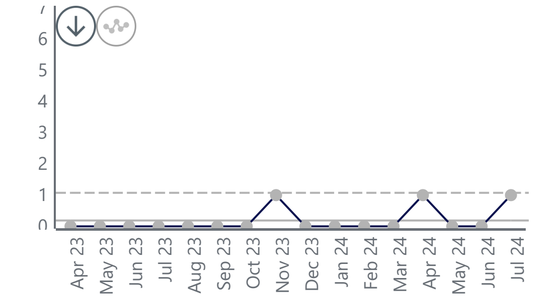
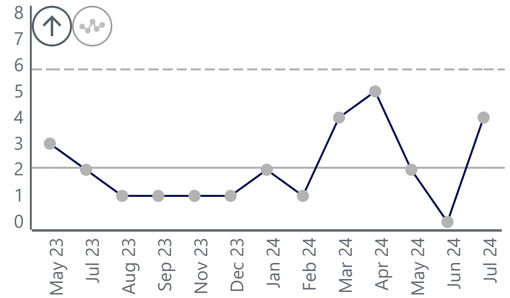
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

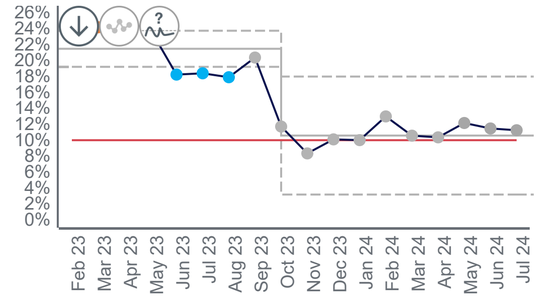
Patient Safety Incidents rated Low Harm & Above



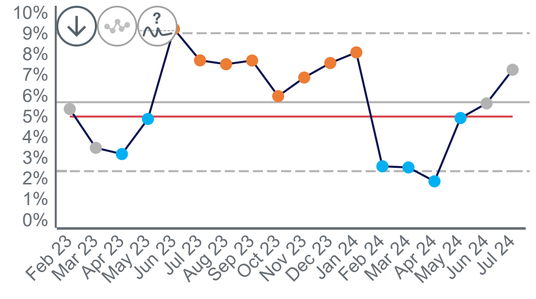
Patient Safety Incidents rated No Harm



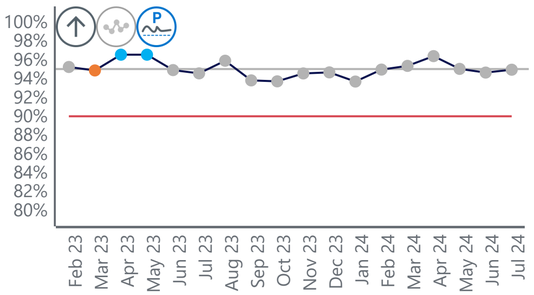
Staff Turnover



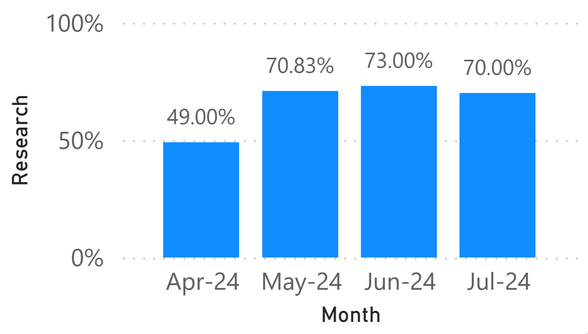
Sickness Absence (Total)



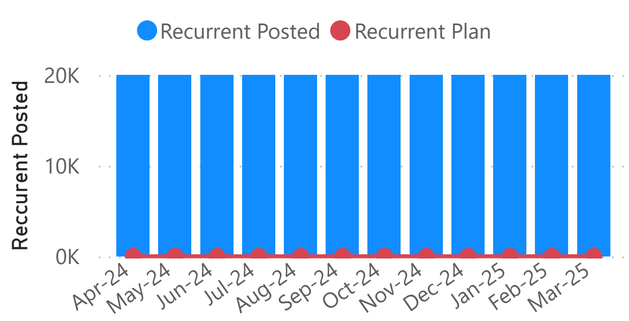
Mandatory Training



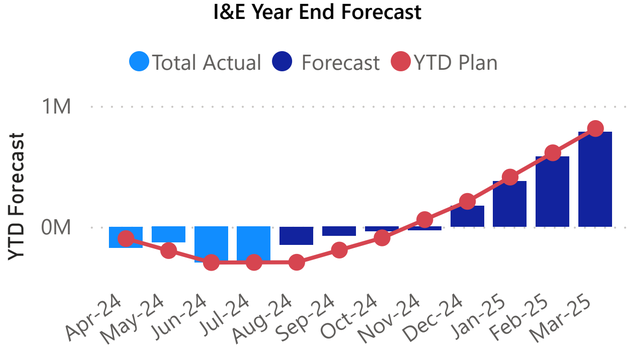
Workforce Stability



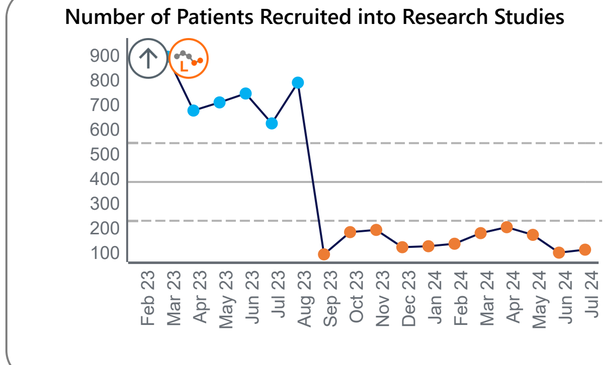
Recurrent Efficiency Plans Delivered (Forecast)



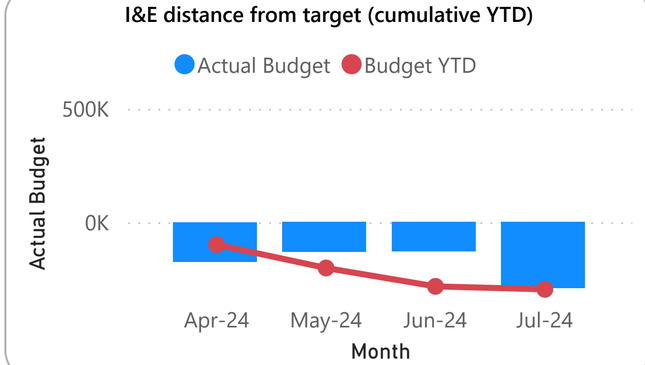
I&E Year End Forecast



Number of Patients Recruited into Research Studies



I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

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

• Positive engagement in all service areas in monthly review of risks and actions required regarding any overdue risks. 86% of Corporate Risks in date as at 25th July 2024.

• Short term sickness absence remains below target at 1% in-month.

• Income slightly ahead of plan at M03.

• 72% of CIP already identified and/or delivered at M03.

• All relevant BIG conversations have taken place including: Digital, Nursing & Quality, Finance and HR.

• Zero Tolerance

Policy now complete and due for ratification through Patient Safety Board and People Committee.

Training now commenced but requires resourcing long-term.

Areas of Concern

• Band 7 PDR completion rate currently sitting at 34% this position is thought to be directly linked to the July deadline and it is hoped that an increase will be seen next month.

• Return to Work compliance has increased from 56% to 68%.

• All PDR completion rate has decreased from 90% to 88%.

• Time to hire remains above the 30-day target and is sitting at 38 days.

Forward Look (with actions)

• Return to work compliance has been a specific area of focus and work is ongoing to increase compliance to meet Trust target. Weekly reports now being issued to management to highlight absences where RTWs have not been recorded with a call to action.

• Focus on financial position, system finance and opportunities.

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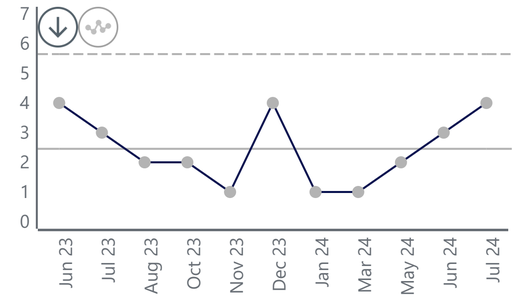
Integrated Performance Report | August 2024

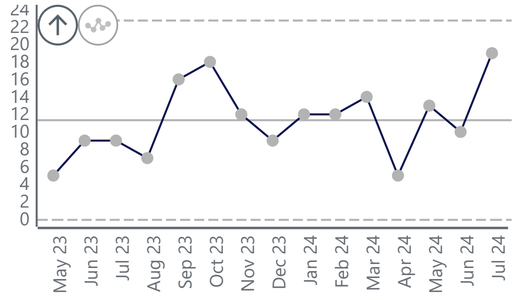
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

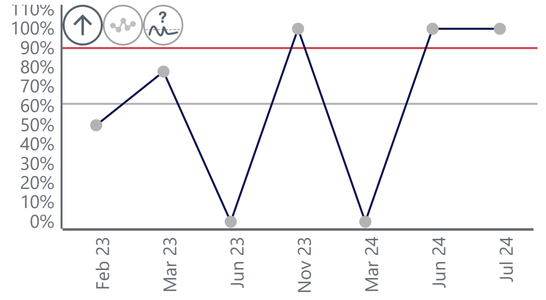
Patient Safety Incidents rated Low Harm & Above



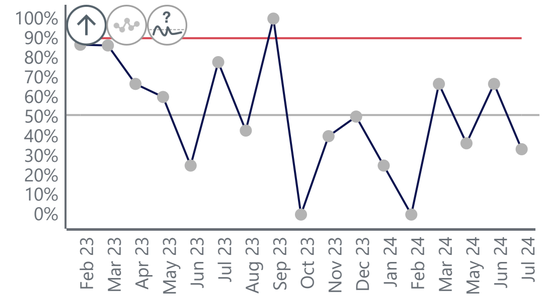
Patient Safety Incidents rated No Harm



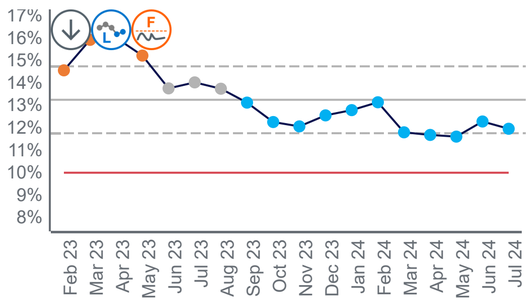
% Complaints Responded to within 25 working days



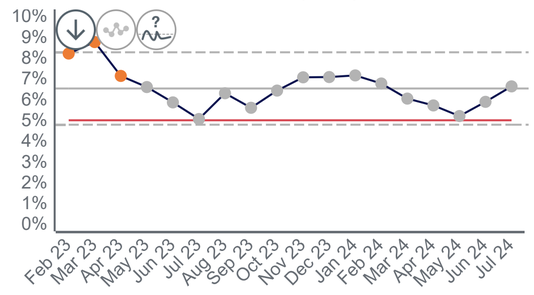
% PALS Resolved within 5 Days



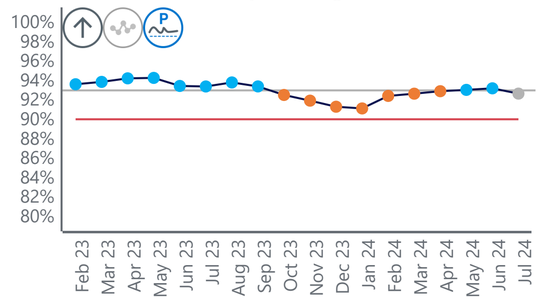
Staff Turnover



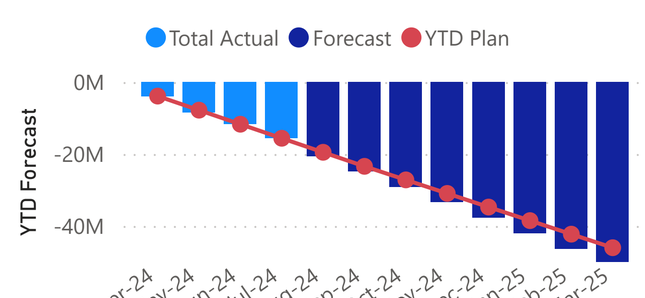
Sickness Absence (Total)



Mandatory Training



I&E Year End Forecast



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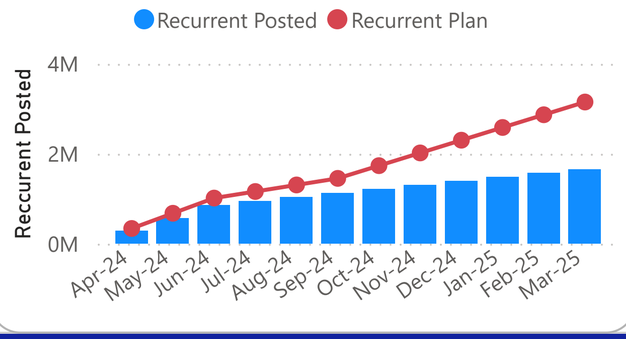
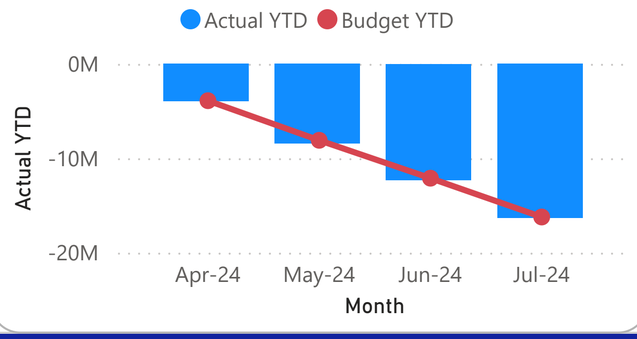


I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

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

April

	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	109%	-	98%	-	221	10.1	13.5	-1.30	-8.00%	0.00	0%	0.00	0.00%	0.00	0.00%	9.52	1.79%	0.00	0.00%	1	41	0	1	4	100%	0	0
HDU	80%	141%	80%	153%	368	24.5	30.9	-5.65	-7.40%	2.72	51%	1.00	1.22%	0.00	0.00%	181.97	7.40%	0.61	0.78%	8	124	0	3	4	100%	0	0
ICU	93%	66%	92%	56%	564	31.2	30.9	4.63	2.90%	2.17	52%	0.61	0.39%	0.00	0.00%	268.68	5.65%	0.00	0.00%	12	186	0	1	5	100%	1	0
Ward 1cC	90%	86%	94%	94%	858	8.7	13.2	-4.09	-6.90%	-0.70	-13%	0.00	0.00%	0.00	0.00%	86.09	4.63%	25.56	14.14%	7	84	0	18	15	93%	1	1
Ward 1cN	75%	8%	67%	-	189	17.3	19.4	0.57	1.60%	1.43	59%	0.00	0.00%	0.00	0.00%	19.76	1.90%	0.00	0.00%	1	59	0	9	1	100.00%	0	0
Ward 3A	97%	92%	96%	154%	804	10.1	10.8	-3.71	-7.70%	1.62	10%	1.92	3.63%	0.00	0.00%	113.41	7.14%	58.82	13.52%	6	67	0	18	33	96.67%	1	0
Ward 3B	82%	100%	89%	-	323	16.9	11.9	-1.02	-2.40%	1.56	30%	0.00	0.00%	0.00	0.00%	47.59	3.56%	27.60	24.73%	20	105	0	9	6	67%	2	0
Ward 3C	99%	109%	85%	159%	753	12.2	10.08	-4.14	-6.70%	2.26	23%	0.00	0.00%	0.00	0.00%	144.29	7.24%	11.04	4.79%	7	114	0	6	10	100.00%	0	0
Ward 4A	93%	59%	86%	110%	848	10.2	10.8	-7.68	-11.50%	0.80	14%	0.00	0.00%	0.00	0.00%	124.02	5.56%	0.00	0.00%	6	70	1	5	32	94%	0	0
Ward 4B	61%	84%	56%	75%	499	14.3	11.3	4.69	10.70%	2.34	6%	1.00	2.55%	0.00	0.00%	87.24	7.52%	131.83	12.64%	5	110	0	6	10	90%	0	0
Ward 4C	99%	101%	91%	107%	808	10.2	12.4	5.03	8.80%	2.24	19%	0.00	0.00%	0.31	3.31%	52.97	3.40%	3.15	1.18%	17	231	0	6	12	100.00%	1	1

May

	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	102%	-	100%	-	87	26.5	13.5	-1.30	-8.00%	1.00	50%	0.00	0.00%	0.00	0.00%	14.68	2.61%	4.00	12.90%	0	41	0	1	7	100%	0	0
HDU	79%	135%	77%	162%	326	27.8	30.9	-5.65	-7.50%	2.72	51%	0.00	0.00%	0.00	0.00%	172.61	6.85%	19.01	23.47%	12	136	0	3	1	100%	0	0
ICU	87%	86%	85%	77%	680	27.1	30.9	6.32	4.00%	2.17	52%	2.61	1.67%	0.00	0.00%	246.08	5.08%	0.00	0.00%	10	196	0	1	3	100%	1	0
Ward 1cC	93%	86%	91%	91%	606	12.5	13.2	-4.15	-7.00%	-0.70	-13%	0.00	0.00%	0.00	0.00%	52.76	2.75%	15.13	8.10%	7	91	1	19	11	91%	1	0
Ward 1cN	73%	14%	80%	-	254	14.7	19.4	0.49	1.40%	1.43	59%	0.00	0.00%	0.00	0.00%	22.79	2.12%	0.00	0.00%	5	64	0	9	3	100.00%	0	0
Ward 3A	95%	126%	96%	100%	816	9.2	10.8	-4.71	-8.70%	1.62	10%	0.00	0.00%	0.00	0.00%	159.98	9.82%	64.97	14.59%	0	67	0	18	24	100.00%	1	0
Ward 3B	95%	126%	99%	-	446	13.9	11.9	-1.02	-2.40%	0.56	11%	1.00	2.22%	0.00	0.00%	76.09	5.47%	30.92	24.29%	10	115	0	9	6	100%	0	0
Ward 3C	102%	124%	87%	189%	772	13.1	10.08	-3.14	-5.00%	2.26	23%	1.00	1.52%	0.00	0.00%	159.08	7.75%	19.72	8.28%	8	122	0	6	8	100.00%	0	0
Ward 4A	91%	49%	88%	97%	794	11.0	10.8	-6.84	-10.20%	0.80	14%	1.84	2.48%	0.00	0.00%	97.63	4.23%	21.16	13.91%	4	74	0	5	33	94%	1	0
Ward 4B	65%	91%	63%	77%	584	13.2	11.3	5.61	12.90%	1.34	4%	0.92	2.41%	0.00	0.00%	59.59	5.01%	112.61	10.42%	6	116	0	6	9	100%	0	0
Ward 4C	98%	95%	98%	111%	811	10.3	12.4	5.03	-8.80%	1.24	11%	0.00	0.00%	0.00	0.00%	58.95	3.67%	12.23	4.10%	14	245	1	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 both April and May is based on March 2024 data which is the latest reported information from the model hospital. Those areas highlighted red fall below this benchmark.

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 month 4.

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, however, are still below the National Benchmark for CHPPD. The increase in HCA's is due to 1:1 requirement following risk assessment.

Surgery

Within the Division 1 ward falls below the standard fill rate:

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.

3A: The overfill on the HCA line is attributable to an increase in 1:1 requirement and compounded by 1.32 WTE LTS within this staff group.

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

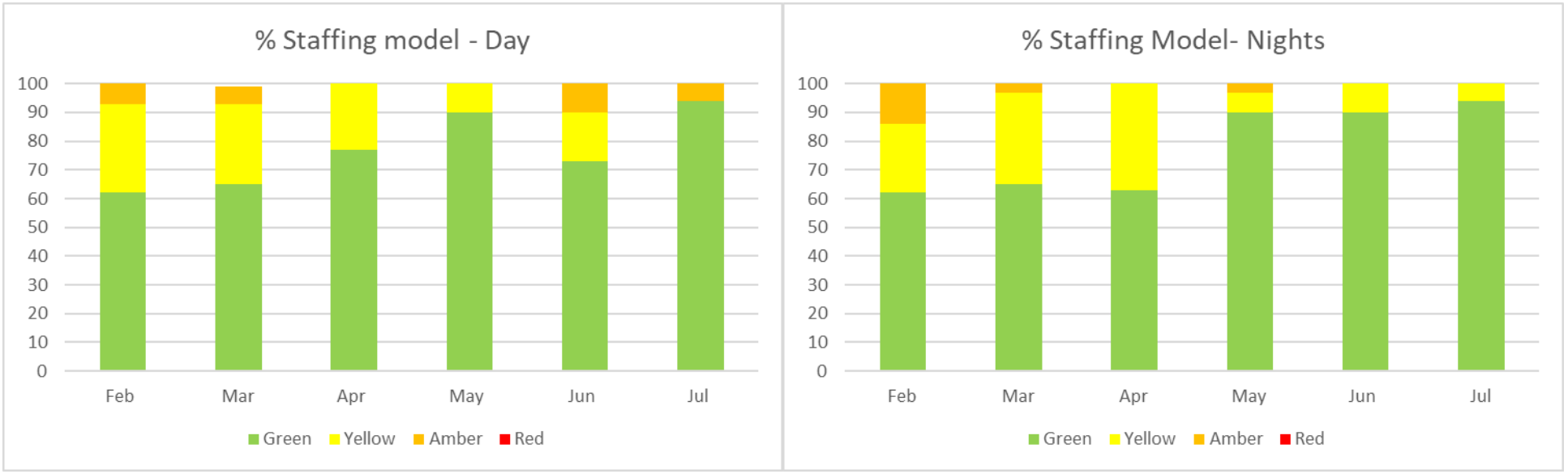
Summary

Alder Hey are below the National Benchmark for CHPPD in 5 wards/departments for April 2024 (highlighted on the data set) which is a less positive position than the previous month, whilst the other areas are either comparable or above this. 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 February – July 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 94% of shifts in July. This was in part due to decreased occupancy within the wards.



Electronic Roster KPI Report

July Board Paper

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

Summary Narrative

Steady improvement in July. 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 compliance shown below. The main areas for improvement this month relates to sickness and absence.

July Roster KPI Table

RosterPerform 11 Overview															
KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owes)		The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shifts in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days (24th June - 21st July)	% 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)	56	23.53%	80.00	578.75	0.00%	0	1	31.57%	9.83%	7.98%	0.00%	2.51%	0.00%	20.30%
Accident & Emergency - Nursing (912201)	44	32.42%	720.00	230.08	15.64%	1765.42	0	14.24%	11.29%	1.98%	1.31%	9.51%	7.17%	31.81%
Burns Unit (915208)	44	15.65%	140.00	15	2.45%	54.25	0	4.41%	15.64%	3.12%	1.31%	2.25%	0.00%	24.87%
Critical Care Ward (913208)	44	16.46%	1200.00	598.23	1.53%	263.5	0	22.05%	18.83%	0.51%	0.26%	5.14%	3.23%	27.98%
High Dependancy Unit (HDU) (913210)	44	27.15%	640.00	262.26	7.34%	610.5	0	21.58%	13.62%	3.68%	2.20%	7.82%	9.80%	37.21%
Medical Daycase Unit (911314)	47	27.64%	50.00	-44.97	1.74%	19	3	17.03%	17.00%	0.00%	0.00%	1.44%	0.00%	18.44%
Outpatients (916503)	44	47.87%	420.00	1081.65	16.42%	991.25	26	45.09%	11.89%	0.36%	2.21%	20.37%	4.28%	39.22%
Sunflower House (912310)	20	41.59%	190.00	759.67	26.56%	1085	27	18.45%	8.69%	0.00%	0.05%	14.37%	6.05%	29.89%
Surgical Daycase Unit (915418)	44	48.74%	85.00	414.66	11.71%	353	2	29.65%	14.42%	2.15%	1.01%	14.29%	0.00%	31.86%
Theatres - Cardiac & Cardiology (915405)	44	38.44%	130.00	-2.75	6.01%	133	1	6.26%	11.26%	0.72%	6.25%	6.11%	0.00%	24.34%
Theatres - Emergency (915420)	44	26.12%	230.00	11.25	3.40%	68.5	0	4.48%	9.48%	4.42%	0.00%	12.77%	0.00%	31.01%
Theatres - IP Anaesthetics (915423)	44	27.00%	82.00	-12.92	4.02%	131.75	5	2.15%	14.39%	1.44%	2.11%	8.94%	6.08%	32.96%
Theatres - IP Porters (915435)	39	48.00%	101.00	32	12.80%	200.5	0	9.18%	5.77%	0.00%	0.53%	14.46%	0.00%	26.17%
Theatres - IP Recovery (915422)	44	37.38%	103.00	-27.7	8.25%	125.25	0	11.94%	16.67%	0.10%	6.83%	10.50%	0.00%	34.11%
Theatres - IP Scrub (915424)	44	32.38%	128.00	2	16.39%	322.25	4	9.58%	12.75%	0.37%	1.80%	8.71%	0.00%	28.88%
Theatres - Ortho & Neuro Scrub (915436)	44	28.15%	37.80	0.5	3.29%	426	5	4.86%	14.96%	0.32%	1.83%	8.96%	4.59%	30.66%
Theatres - SDC Anaesthetics (915429)	44	32.46%	58.40	-6.58	38.17%	387.5	0	6.17%	13.31%	0.00%	3.36%	1.06%	17.67%	35.39%
Theatres - SDC Recovery (915430)	44	36.02%	177.30	-75.27	11.02%	146	11	9.28%	16.34%	0.00%	5.90%	8.79%	0.00%	31.02%
Theatres - SDC Scrub (915421)	44	33.92%	532.00	4.5	9.90%	255.5	11	12.90%	14.78%	0.55%	3.36%	15.28%	0.00%	33.96%
Ward 1C Cardiac (913307)	44	27.78%	361.00	499.54	4.51%	298.17	1	18.39%	15.76%	3.51%	1.39%	5.73%	7.25%	35.15%
Ward 1C Neonatal (913310)	40	35.48%	556.00	741.25	0.48%	23	0	21.06%	14.05%	2.65%	1.54%	2.90%	4.04%	30.19%
Ward 3A (915309)	44	28.23%	371.00	69.41	9.92%	736.5	17	8.65%	11.58%	3.26%	1.11%	9.94%	5.79%	33.25%
Ward 3B - Oncology (911208)	41	29.98%	555.00	195.28	16.02%	911.58	55	9.64%	13.21%	0.86%	0.61%	10.62%	6.04%	37.49%
Ward 3C (911313)	42	32.10%	607.00	1905.13	18.25%	1673.75	94	16.11%	14.59%	3.00%	1.72%	5.44%	3.72%	31.28%
Ward 4A (914210)	41	29.42%	634.00	511.93	9.05%	732	52	20.42%	14.74%	3.64%	0.83%	8.75%	5.05%	35.37%
Ward 4B (914211)	45	36.07%	533.00	450.65	13.46%	1193	3	23.95%	11.13%	5.52%	1.91%	8.81%	6.45%	33.90%
Ward 4C (912207)	45	23.82%	280.00	-182.04	9.87%	732.08	9	8.74%	13.43%	3.15%	0.80%	6.11%	1.47%	28.17%
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

Key challenges remain with sickness which has a knock on effect on total unavailability. Some key areas of improvement include Changes since approval where the KPI is less than 25%, but we have improved from 38% in February to 32% in July. Additional duties has seen an improvement from 425 in June to 326 in July, a much-improved position from 468 in May. A reflection of an improved staffing position and greater grip re safer staffing and bank.

Across the Divisions, in Medicine changes in approval has improved from 32% in June to 29% in July. Additional duties have improved in month from 198 shifts down to 164 in July. Most being created on ward 3C (94) and 3B (55). Study leave remains over the 2% KPI, with 4B continuing to allocate over the target.

In Surgery, KPIs remain stable and on target with specific improvement being seen in additional duties where there has been a reduction from 188 in June to 109 in July. Bank hours are down from 6820 to 5267 in July, albeit that the percentage of shifts filled by temporary staff remains static at 10%.

In the Community Division, Lead times have improved to 32 days from 30, but still outside the KPI of 42 days. Roster changes are still a challenge at 45% outside the target of 25%. OPD sickness pressures increased additional duties from 39 to 53. Consequently, bank usage increased from 19 to 21%. Annual Leave, Study Leave & Other leave remain within the agreed KPI target. Total unavailability was improved from 37% down to 34.56%. Net hours increased again from 1519 to 1841 with the majority of these being in Outpatients. A member of the E Roster team is working with the Outpatients senior team to review. Sickness increased from 13.91% to 17.37%, with the majority of this being in Outpatients The management team continue to work with HR to manage this huge and consistent pressure in OPD, which impacts greatly on the overall sickness position in Community.

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.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	Digital, Data and Information Technology Update
Report of:	Kate Warriner, Chief Digital and Information Officer
Paper Prepared by:	Kate Warriner, Chief Digital and Information Officer; Ian Gilbertson, Deputy Chief Digital and Information Officer

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Digital and Data Futures Strategy Vision 2030
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:	None

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
4.2	Digital and Data Strategic Development & Delivery	12

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

Alder Hey Digital, Data and Information Technology Update

1. Executive Summary

The purpose of this report is to provide the Board of Directors with an update on progress against the Digital and Data Futures Strategy. It reports on the overall service, key areas of transformation and operational performance.

Key headlines include:

- Digital Maturity Assessment 2024
- Good progress with Digital and Data Futures/2030 strategy
- Good Operational performance

The Board of Directors is asked to receive the report and note good progress to date.

2. National and Regional Updates

2.1 Digital Maturity Assessment (DMA) 2024

The DMA process at Alder Hey has now been submitted. The questionnaire has been answered in full and a series of multi-disciplinary workshops were undertaken to validate answers with Digital, clinical and operational colleagues.

NHSE have been actively involved in open conversations with Alder Hey regarding validation in areas including:

- Check and challenge to regional colleagues
- Significant changes from 2023 DMA
- Top 10% nationally

Each Trust was also paired with another organisation as part of the DMA peer review process. Alder Hey were matched with Liverpool Women's Hospital for the provider peer review and this peer review took place through the process. Next steps, include awaiting the publication of the data in September, before reviewing this collaboratively with other providers across the ICS.

2.2 Liverpool digital collaboration

Alder Hey continue to work with the ICB around joined up digital programme opportunities across Liverpool. A weekly meeting has been established which is attended regularly by the Alder Hey CTDO and any progress will be reported back to the Trust through the relevant committees.

3. Digital and Data Futures Progress

3.1 Digital Children, Young People and Families

A specification has been developed for the procurement of a Patient Portal. This has been shared with key stakeholders for input and approval. Work is currently underway with procurement to prepare for a tender exercise, assessing the market for suppliers

who meet the agreed criteria. Key stakeholders will then participate in system demonstrations before selecting a preferred supplier.

Work is also underway to review and optimise the Trust's online symptom checker prior to scoping out future phases. There are also ongoing discussions around how the use of ISLA care can be expanded across the organisation

3.2 Outstanding Records and Safe Systems

The External Advice application is now live across a number of specialties, which gives clinical teams the ability to record advice and guidance for patients being cared for in other provider organizations. This will then become part of the Alder Hey patient record.

Good progress has been made with AlderCare Optimisation and a wide range of system developments have been delivered to date. To support the programme the team have now adopted 'Quality Assurance Rounds' where they will visit individual specialties and gather valuable feedback on challenges but also recognizing what works well. Physiotherapy and Emergency Department sessions have been completed and found valuable by all involved.

Scoping work is currently underway for the new Infection Prevention control system. A plan for delivery will be developed shortly with a proposed 6 month timescale for deployment.

3.3 Healthier Populations through Digital, Data and Analytics

Work is underway in developing the Business Case to support the transition to a new Data Warehouse and this is expected to be shared in September. This is a foundational piece of work which will give the Trust a solid platform to deliver its Insights vision, which is a key part of the 2030 strategy.

The team are also working on several revised national datasets, as part of our statutory reporting obligations. These include Mental Health, Commissioning and Emergency Department datasets.

Productivity work remains ongoing. The scope has now increased following engagement with Divisional colleagues and the next version is due to be available in September.

3.4 Technical roadmap and Operational Service Excellence

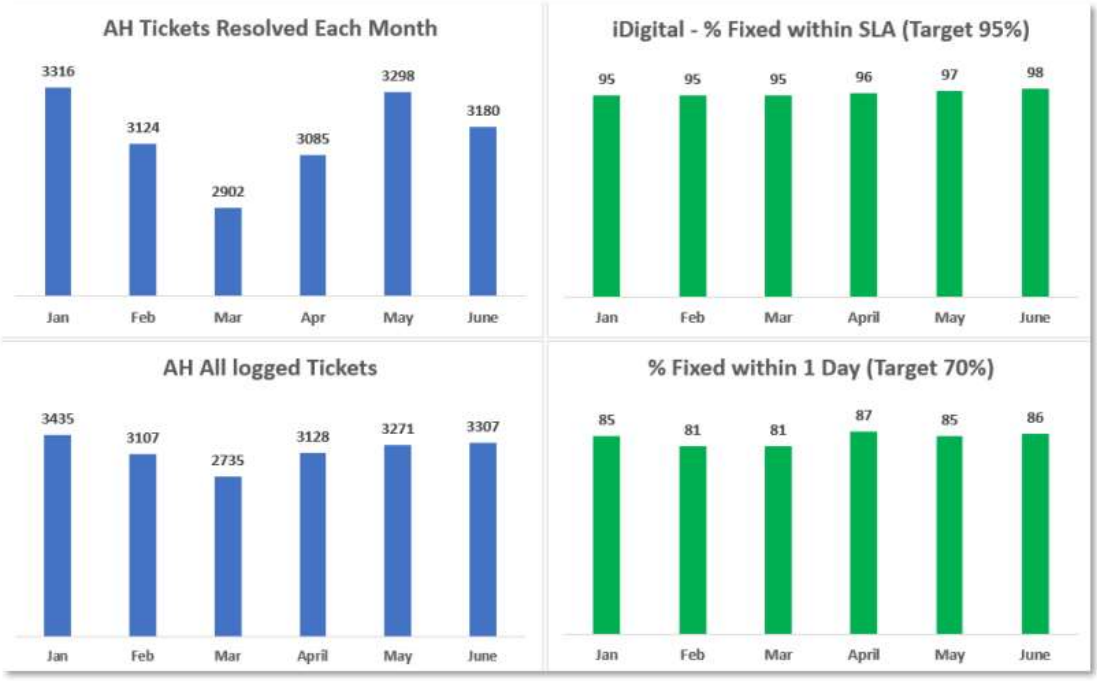
Progress has been made in stabilizing the Trusts internet connectivity however, there is further work scheduled throughout September to increase resilience even further. Plans are also being developed to increase the resilience of our telephony systems and options being explored to modernize the current bleep system.

Multi factor authentication has been successfully deployed across the Trust by the National deadline.

3.4.1 Operational Performance

9069
The graphs below provide performance from July 2024. Key highlights include:

- Key Performance Indicators met consistently for previous 6 months.
- Tech Bar resolved 211 tickets.
- 86% of tickets resolved in 1 day



4. Summary and Recommendations

In summary, progress with digital and data developments and delivery at Alder Hey remain positive and the mobilisation and delivery of the new strategy continues well.

The Board of Directors is asked to receive the report and note good progress to date.

BOARD OF DIRECTORS

Thursday, 5th September 2024

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

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

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

Campus Development Report on the Programme for Delivery

September 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
- Base Camp

2024/25 Q3 & Q4:

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

2025/2026 Q3:

- Neo-Natal & UCC/SDEC

Key Achievements to Report:

Springfield Park

The main works including the play areas are complete. Final levelling and drainage works around the Alder Centre and Swale will complete mid-September 2024.

Gender Development Service

The building was handed over to the Trust 14.08.24. Staff occupied the new facilities from 19.08.24 with patient go live from 22.08.24.

Beech House (Police Station Refurbishment)

This building was handed over to the Trust and occupation commenced as planned 25.07.24. All moves are complete.

Fracture/Dermatology Outpatients

Construction works started on site 12.08.24.

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.

Project	Manager	Open Risks	Low	Med	High (15+)
Park	KO	6	3	3	
Eaton Road Frontage	KO	3	2	1	
Fracture/ Dermatology OPD	KO	6	1	5	
Police Station Refurb	TJ	5	1	4	
Neonatal & UCC	JOB	18	3	15	
Gender Development Service (GDS)	JVH/JG	2	0	2	

The Development Team will undertake the next quarterly review of all risks in September. Those projects highlighted in grey are complete with 12 month defect processes in place.

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
Park	Failure to deliver long term vision for park	BAF 3.1	12	Programme continually assessed for mitigations/improvement.
Neonatal & UCC	Affordability	Not assigned	12	Development team 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	Trust has responded to CEs and associated correspondence received. Briefing presentation held 18.06.24 for Executive/Non-Executive Directors.

3. Construction Programme Delivery Timetable (Critical Path)

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

4. Construction Programme Delivery Timetable (Associated Projects)

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

5. Project Updates

Neonatal and Urgent Care Centre

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Programme: • Draft services Deed of Variation (lifecycle & maintenance) received; this is being worked through with Bevan Brittan. • Hoarding installation with vinyl visuals to complete September.		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: • EDU decant to Ward 4c completed. • Trust is working with Morgan Sindall Construction to look at opportunities to open the new Ground Floor as quickly as practicable. • Ground Floor (GF) shell space review meetings commenced 03.06.24 to agree final design.		Potential decant costs. Potential budget & programme impact of GF reconfiguration changes.	Agree decant plan ED waiting. Agree GF design.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Trust meetings with contractor held 06.03.24, 09.04.24 & 21.05.24. • A briefing presentation was held for Executive/Non-Executive Directors 18.06.24. to update on latest position and next steps.		Possible contract claim.	Continued oversight via Finance Transformation & Performance Committee.
Sprinkler System Under-Croft Car Park: • Cost quotes received from two potential contractors		Fire compliance. Budget TBC.	Briefing paper being prepared for September ’24 Executive Director’s meeting.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation: Executive Directors approval obtained 30.05.24 to address immediate priorities: • Permanent solutions for those staff currently accommodated on a 'temporary' basis. • Alternative accommodation for teams/services currently based in the Histopathology building, to allow demolition of the building. • Potential increased scope: meeting rooms and storage.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for works/kit.	Full staff engagement exercise to agree final desk allocation, move dates and operational logistics. Budget and scope of works to be finalised.
Former Police Station Refurbishment (Beech House): • Building handed over to Trust and moves complete. • 3SM dismantled and removed from site.			Management of snags and building defects. After Care meetings in place to monitor post move snags, defects & priority additional works (eg: replacement carpets & blinds).

Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Community Communications: Works in Progress • Community Day – Community Day 31.07.24 to be rescheduled.		Inconsistent communications.	Continued and maintained input & communications from all key stakeholders. Quarterly newsletters and regular website updates.
Completion Works: • The ground levelling and path works around the Alder Centre will complete 13.09.24. • Works to complete the Swale will conclude 13.09.24.		Resistance to swale from some elements of the community.	Trust discussions on-going with LCC to confirm and gather required documentation for the handover of Springfield Park to LCC.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Work ongoing in line with programme. • Start on Site: 12.08.24. • Construction Completion: 06.12.24. • 'Go Live' 20.12.24.		Delay to completion, impact on operational running of the services. Mitie PM resources.	Regular meetings. Close monitoring of critical risks. Capacity management plan to accommodate patient activity during works.

Mini Master Plan for Eaton Road Frontage / Master Site Planning

Deliverable	RAG	Risks/Issues	Actions/Next Steps
High level programme to be fully agreed – 5-year proposed plan developed: • Master Site Planning presentation to Trust Board 06.06.24. • Informal 9-month key stakeholder engagement.		Budget TBC.	On-going site tidy. Approval of priority and immediate works. Clinical model / estates strategy to be developed.

Elective Surgical Day Case

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Design Team appointments completed. Indicative costs received and being assessed for all work packages.		Programme, available budget. Mitie PM resources.	Review indicative costs and assess programme.

Gender Development Services (GDS) – Estates Solution

sDeliverable	RAG	Risks/Issues	Actions/Next Steps
• The building was handed over to the Trust 14.08.24. • Staff occupied the new facilities from 19.08.24. • Patient go live from 22.08.24.		Water results 2 no. taps – isolated to avoid access by staff/patients.	Regular snag/defect 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 and site set up have concluded under the Letter of Intent with the contractor. Several unexpected issues have been discovered on site including fire stopping and water safety compliance. Further survey works and site investigation exercises are scheduled over the next 3-4 weeks. Impact on design and cost plan will be assessed alongside this to develop a proposed mitigation plan. Work is continuing to agree the main contract for the project.		Programme, available budget.	Consultation and staff move plan. Develop Phase 2 business case. Develop wider site master planning.

6. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 5 September 2024.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Alder Hey Response to the Southport Major Incident**
Report of:	Nathan Askew Chief Nurse
Paper Prepared by:	Nathan Askew Chief Nurse

Purpose of Paper:	Decision	☐	Information	☐
	Assurance	☑	Regulation	☐
Action / Decision Required:	To note	☑	To approve	☐
Summary / supporting information	This paper provides an overview to the Trust Board of the initial response to the Southport Major incident, the ongoing care and support of families and the support of staff both immediately after the incident and through the subsequent civil unrest.			
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:	Note the intent for future funding request for relevant resources to EPRR			

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

Introduction
This paper provides an overview to the Trust Board of the initial response to the Southport Major incident, the ongoing care and support of families and the support of staff both immediately after the incident and through the subsequent civil unrest.

Background
The Trust, as a category 1 responder under the Civil Contingencies Act can be called upon to respond to significant incidents. In the event of a major incident NWAS contact the Trust and the Major Incident is formally declared.

It is known now that on the 29th July, 2024, shortly before midday a male, armed with a knife, entered a holiday dance club in Southport and proceeded to attack a number of children and adults present at the event.

Initial Incident Response

Incident Timeline

12.08	Trauma phone call to ED from trauma cell received Major Incident from NWAS due to a stabbing incident in Southport Reported at the time: 12 casualties, 3 fatalities
12.11	Internal 2222 Trauma call placed by ED
12.21	Trust declared Major Incident
13.21	First patient arrived via ambulance to ED
17.24	Major Incident Stood down

The Trust initially received 5 patients. Three children were sent to other local hospitals and one to the Royal Manchester Children's Hospital. Alder Hey repatriated children from local hospitals within the first 24 hours. We sadly received a further two children who were laid to rest in our mortuary. In total the Trust cared for 11 children and their families.

The Trust Major Incident response plan was activated and the command and control structure put in place, linking through Strategic command to the ICB and interagency response.

To facilitate the urgent care and treatment required the Trust cancelled a number of elective patients on the day and the following day as additional theatre capacity was required for those affected by the major incident.

Throughout the incident our ED and non-elective services continued to provide urgent care and treatment to children and young people attending the hospital, and our workforce continued to provide care to those children, young people and families who were already in our care. Staff from across the organisation should be commended for maintaining our level of service provision.

Ongoing care

All children affected by the incident were discharged by the evening of 5th August, each will receive ongoing care as indicated by their clinical case.

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.

Alder Hey charity facilitated the public donations which were received and have been able to release the money to families for immediate needs, working closely with those involved to ensure financial stability at this challenging time.

The families of the three children who died as a result of their injuries are being supported through our Snowdrop team for initial bereavement care. They are all aware of the longer term offer from the Alder Centre and will transition to that service at the right time for them as a family.

Staff Support

It should be recognised that our staff involved in providing care to these families have witnessed some very traumatic events. They have all been provided with initial support through our SALs and clinical health psychology services, proactively reaching out to teams and staff involved. Hot debriefs were undertaken with all teams involved in the response.

A technical tactical debrief was held on 9th August and facilitated by colleagues from CWP. The event recognised a range of good practice and learning which would help facilitate and improve any future response to a major incident of this nature. This will be collated and report through EPG to SQAC following the usual governance process.

In the wake of the incident, large scale civil unrest was seen, with appalling acts which were racially motivated. As a Trust we were mindful of the safety of all our colleagues but particularly those from our BAME communities. Our REACH network worked with senior managers to develop a range of support for our colleagues from the global majority which included provision for transport, car sharing and peer support. The shuttle bus service was reinstated to our off-site parking areas and additional security was put in place to ensure safety. We shared any intelligence of planned demonstrations with all staff and ensured that managers were able to be flexible with requests for changes of shift to maintain our staff's safety. We provided individualised support as required through SALs.

Summary

Alder Hey provided a robust response to the tragic events in Southport on 29th July 2024. These types of events are rare, and rarer to involve children and young people. The Trust will be involved in the ongoing care of the bereaved families, and the survivors for considerable time to come.

The incident will result in the need to consider the areas for learning and improvement and the Board will be presented with requested additional resources in due course.

Recommendation

The Board are asked to:

- Note the contents of this report
- Recognise the robust response provided by our team across Alder Hey
- Note the intent for future funding request for relevant resources to EPRR

Nathan Askew
Chief Nursing, AHP and Experience Officer
Accountable Emergency Officer

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Brilliant Basics Update**
Report of:	**Nathan Askew, Chief Nurse, Brilliant Basics SRO**
Paper Prepared by:	Jennie Williams, Head of Improvement

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This report provides assurance on: - progress of the Brilliant Basics Delivery Plan 2024/2025 - Alder Hey involvement in Cheshire and Merseyside Improvement Network
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	None

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
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 aim of this paper is to provide Trust Board assurance on:

- progress of the Brilliant Basics (BB) Delivery Plan 2024/2025
- Alder Hey involvement in Cheshire and Merseyside Improvement Network

There are **no risks** to escalate to Board.

The key message in this report is that accumulative progress continues to be made towards the development of a culture of continuous improvement.

2. Background and current state

Progress on BB Delivery Plan 2024/2025

Trust Board approved the BB Delivery Plan (March 2024) and receives biannual updates for assurance against progress.

Table 1 below details progress against the driver metric. The staff survey data is updated annually and will therefore be updated for the BB end of year report.

Driver	Target
NHS Staff Survey Involvement Question: The degree to which staff feel that they are involved in making improvements within their organisation.	Brilliant Basics will **contribute** to increasing the numerical value of the survey results.
Current Data & Insight	
Graph 1. Pulse Survey Metrics  Graph 1 illustrates the end of year position for the NHS staff survey involvement metric. This data and graph will be updated at the end of 24/25 and will be included in the end of year BB report. Data source: Model Hospital. Comparator: Staff survey benchmarking group. Category: Involvement (Q10,E,F). Analysis: 0=low, 10=high.	

Appendix 1 contains the approved BB Delivery Plan 2024/2025 and progress against the plan.

Progress has been made against three of the four objectives with a clear plan for focus on the fourth objective in the second half of the year.

The SRO has been accountable for all decisions regarding progress and change control during 2024/25. BB governance is being enhanced through the reinstatement of a quarterly BB Development Group.

Alder Hey involvement in Cheshire and Merseyside Improvement Network

Cheshire and Merseyside Improvement Network (CaMIN) was convened in November 2023 and continues to meet monthly.

The Associate Medical Director for Cheshire and Merseyside and NHS England Deputy Director for System Improvement have been welcomed to Alder Hey to demonstrate the progress and impact of implementation of the Brilliant Basics Improvement System. This was a positive meeting where we agreed to support NHS

Cheshire and Merseyside to develop their internal capacity and capability for continuous improvement. This is in early development and further details will be contained in future reports.

3. Conclusion and Recommendations

Brilliant Basics continues to go from strength to strength in its delivery of a culture of continuous improvement in a systematic and consistent way.

In accordance with working in a continuous improvement manner, we will continue to seek feedback, incorporate learning, and maintain an agile approach to delivery.

The board is asked to:

1. Note the report and confirm the assurance gained on embedding the Brilliant Basics Improvement System.

Alder Hey Children's NHS Foundation Trust

Appendix One: 2024/2025 Plan Assessment.

OBJECTIVES	DELIVERED THROUGH	KEY OUTCOMES	PROGRESS
Bringing what matters most to life at all levels of the organisation so you can see and feel it, collectively and accumulatively delivering the outcomes desired in a systematic and consistent way.	Strategy deployment	• Strategic initiatives that are directly translated into local implementation • Ward to board reporting with clear measures of improvement locally contributing to the driver metric	Specific and intentional strategy deployment will be the focus for the second half of 24/25 utilising personalise my care as the test of change.
Leaders developing problem solving using A3 thinking and coaching conversations during 'go, see' with frontline teams.	Leader Standard Work	• A shift from command and control to humility and coaching style • Teams that are empowered to make improvements • Unblocking barriers to improvement at the frontline	Leadership capability offer established: ➢ Managers essentials (Improvement) mean evaluation 4.7/5 ➢ Frontline visibility planning at Execs 12/9/24
Effective and productive meetings using standardised meeting hygiene.	Meeting Hygiene Standard work	• Effective use of time in sub-board committees • Succinct and clearly written papers • Assurance and improvement evident throughout	People committee: Data led discussions enabling focus on progress and improvement CEOG: Time series data illustration and report streamlining in progress
Supporting priority teams/services to deliver productivity improvements using Brilliant Basics methodology.	BB Improvement System; tools, routines, behaviours	• A3 thinking used throughout • Teams that are empowered to make improvements • Productivity improvement in priority teams / services	➢ Supporting Divisions with 3 productivity priority areas; detailed process mapping completed and change ideas left with teams for testing ➢ NEW! Lean sessions: supporting the organisation to identify and remove waste

ENDS

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Quarter 1 Complaints, PALS and Compliments report**
Report of:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

Purpose of Paper:	Decision	☐	Information	☐
	Assurance	☑	Regulation	☐
Action / Decision Required:	To note	☐	To approve	☑
Summary / supporting information	The purpose of this paper is to provide Trust Board with an update and assurance on the performance against complaints and PALS targets in Q1 2024/25, and identify the themes This paper uses the Brilliant Basics reporting principles; feedback from Trust Board on this format and content requested to ensure the new format meets the needs of the Board and provides the appropriate level of assurance			
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:	Review required to achieve compliance with PHSO NHS Complaints Standards in training			

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

Compliments, Complaints and PALS Report – Q1 2024/25: Trust Board 5th September 2024

Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q1 2024/25 and a thematic analysis of the top reasons for complaints and PALS
Vision and Goals	The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. Where care and treatment does not meet the standard of care expected, the Trust has a duty to listen to their concerns, wherever possible resolve at the first point of contact, investigate concerns, and provide a full, appropriate, and compassionate response.

Strategic Objective	To reduce the number of PALS concerns and formal complaints by increasing the number of issues that are resolved at the first point of contact
Driver Metric	• PALS concerns responded to within 5 working days • Formal complaints acknowledged within 3 working days • Formal complaints responded to within 25 working days
Graph Key	Medicine Surgery Community & Mental Health Corporate

Figure 1: Complaints received in Q1 by Division

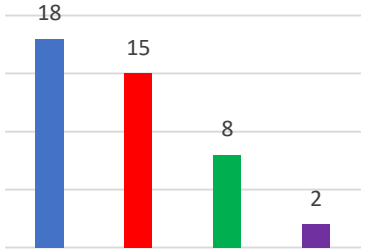


Figure 2: Total number of complaints rolling 12 months (not inclusive of withdrawn)

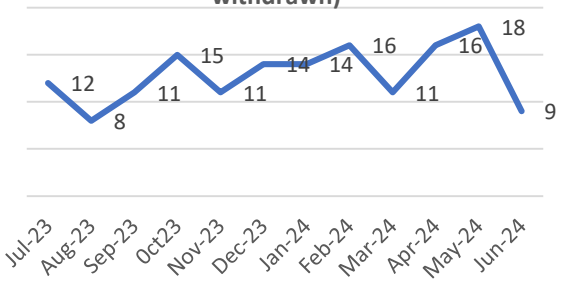


Figure 3: Primary category of complaints

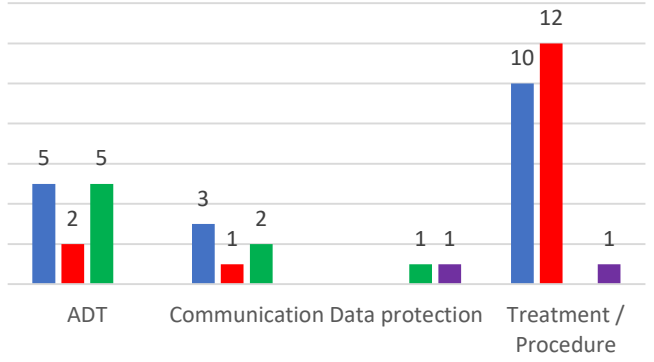


Figure 4: Trust overall compliance with 3 day acknowledgement of complaints rolling 12 months

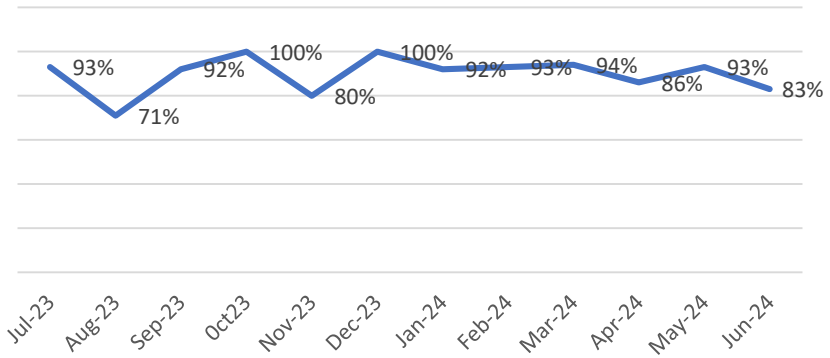


Figure 5: Trust overall compliance with 25 day response to complaints rolling 12 months

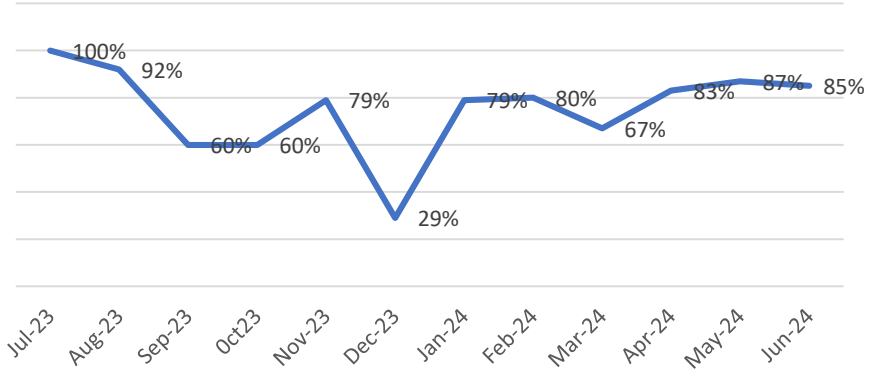
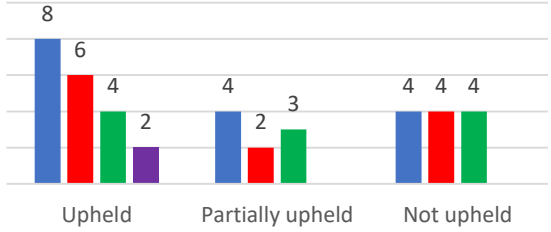


Figure 6: Outcome of complaints responded to in Q1



Complaints: In Q1, 47 complaints received, 4 withdrawn therefore 43 new complaints. Main reason continues to be treatment and procedure accounting for more than half of complaints received (53%). Trust overall not compliant with the 3 day acknowledgement; average 87% compliance. 43 complaints investigated and responded to. Trust overall not complaint with the 25 working day response; average 85% compliance. 20 complaints fully upheld (49%), 9 partially upheld (22%), and 12 not upheld (30%) (2 awaiting recording of outcome). 5 complaints were re-opened at second stage. One ongoing investigation by PHSO (Division of Surgery).

Compliments, Complaints and PALS Report – Q1 2024/25

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Figure 7: PALS received in Q1 by Division

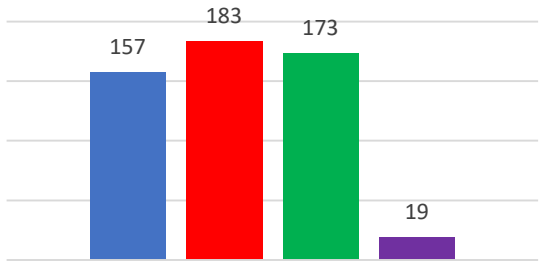
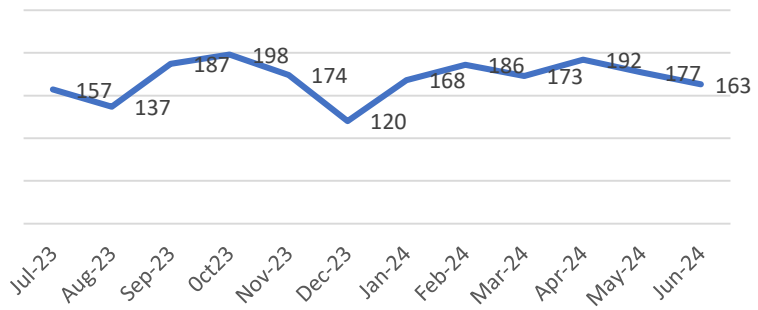


Figure 8: Total number of PALS rolling 12 months



PALS: In Q1, 532 PALS concerns were received. The main themes continue to be access to appointments and communication. Improvement in compliance with the 5 working day response; average 91% compliance. 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 only achieved 56% compliance indicating a lack of oversight.

Compliments: The Division of Community and Mental Health continue to record the largest number of compliments on InPhase

Figure 9: Category of PALS

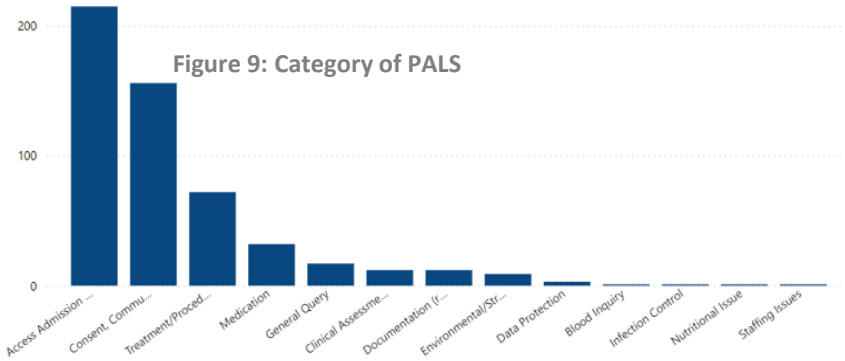


Figure 10: Trust overall compliance with 5 day response to PALS rolling 12 months

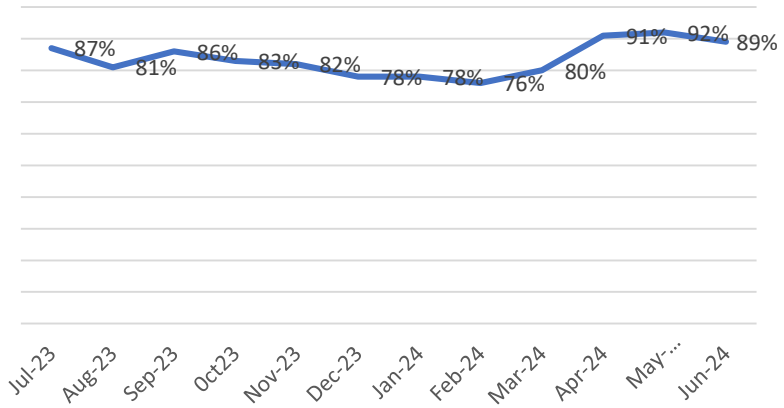
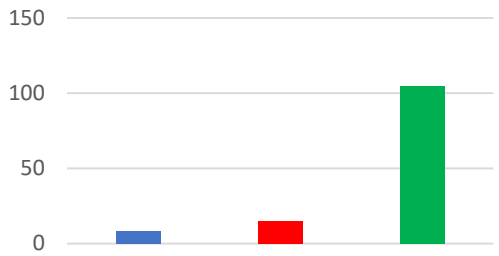


Figure 11: Compliments recorded in Q1 by Division



Success Highlights	• 85% of formal complaints responded to within 25 working days however there is significant toom for improvement to ensure families receive a response in a timely manner • Continued excellent compliance in the Divisions of Medicine and Surgery in PALS response compliance and significant improvement in compliance in Community and Mental Health Division
Feedback and lessons learnt	• Divisions capturing actions and sharing learning at the Patient Experience and Engagement Group
Escalations and Risks	• The PHSO set out the NHS Complaints Standards in December 2022; the Trust is not currently compliant with the training requirement set out in the standards. A review is underway to address action required to achieve compliance • Corporate services consistently failing to achieve 100% compliance in responding to the concerns of families in a timely manner. A review is underway to improve the oversight and ownership

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	Infection Prevention & Control Quarterly Report Quarter 1, April – June 2024/2025
Report of:	Infection Prevention & Control Team
Paper Prepared by:	Dr Beatriz Larru Director of Infection Prevention & Control

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

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

1. Introduction

The purpose of this report is to provide the Trust Board with oversight of Infection Prevention Control (IPC) activity and reporting for the Q1 period (1st April – 30th June 2024) ensuring the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

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

2. Infection Prevention & Control Department

During Q1, the IPC committee received reports from the following subgroups.

2.1 Clinical Advisory Group: no meetings held in Q1 with ongoing discussions into how to best transform CAG into steering groups focused on the prevention of HAI bacteraemias, ventilatory associated pneumonia and catheter- associated urinary tract infections.

2.2 IPC Champions Group: On 30.04.24., 28.05.24 and 25.06.24 the group have met to discuss transmission-based precaution isolation and PPE and continue to update the group on any infectious diseases where there is high transmission within the community. We have continued to provide sessions in line with the NHSE IPC Educational Framework. The group brought up several challenges like the lack of representation from all wards / areas in the IPC Champions Group. *Action:* Requested an updated list of attendees for each area. Rolled out the Glove Smart Campaign in May 2024 and collaborated with the Antimicrobial Stewardship (AMS) team to comply with the IPC educational framework. *Action:* for September 2024 to collaborate with the decontamination team.

2.3 Antimicrobial Resistance Steering Group: On 11.04.24, 09.05.24 and 13.06.24 the group met to discuss with AMR the workstreams initiated to promote judicious use of antimicrobials across the Trust. The ongoing workstreams focus on 1) De-labelling penicillin allergies, 2) Promote IV to PO administration of antimicrobials, 3) Promote nursing role in AMS, 4) Understand health inequities and antimicrobial resistance, 5) Promote diagnostic stewardship by limiting unnecessary blood cultures in ICU, 6) Understand behavioral change science in antibiotic prescribing and 7) Surgical prophylaxis.

2.4 Hand Hygiene Improvement Group: no meeting held in Q1, but work is ongoing; meetings with Innovation team to move forward automatic methods of monitoring hand hygiene compliance to effectively promote behavioral change through auditing results.

2.5 Environmental Cleanliness Group: On 16.04.24 and 21.05.24 the discussions centered around roles and responsibilities for cleaning & decontamination of frequently used items. Action: SharePoint page developed with instructions for cleaning and decontamination of items, in accordance with the National Standards of Healthcare Cleanliness 2021. On 18.06.24 the group continued to discuss how to best implement Hospital Cleaning policy RM49 across the Trust and need for a new system for cleaning audits. Action: new electronic auditing system being procured.

2.7 High Consequences Infection Diseases (HCID Steering Group): NHSE & EPRR leads visited on 29.07.24 and we have now become an accredited airborne HCID Centre. On-going HCID training programme for staff and local SIM and induction sessions continue on 3C, ED & PICU. *Action:* simulation planned for 02.09.24

2.8 Sharp Safety Group: no meetings held in Q1 as there are still ongoing discussions with Health & Safety about appropriate leadership for this operational group.

3. Infection Prevention & Control Metrics

3.1 Bacteraemia Surveillance

3.1.1 Healthcare-associated Gram-negative Bloodstream Infections

A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA (UK Health Security Agency) is shown below in Table-1. During Q1, 6 patients had healthcare-associated Gram-negative blood stream infections. Cases were identified in Neonatal (1), Cardiac (2) Oncology (2) and Critical Care (1) units.

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

All of these patients had central vascular catheters in place when they developed bacteraemia so the workplan to reduce Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)) across the Trust has continued during Q1, with a closer collaboration between IPC and the Microbiology laboratory to include in our PIR all significant blood stream infections (not just those subject to mandatory UKHSA reporting such as *E. coli, Pseudomonas* or *Klebsiella*) to engage with all stakeholders in the development of the CLABSI steering group.

***E. coli* bloodstream infections**

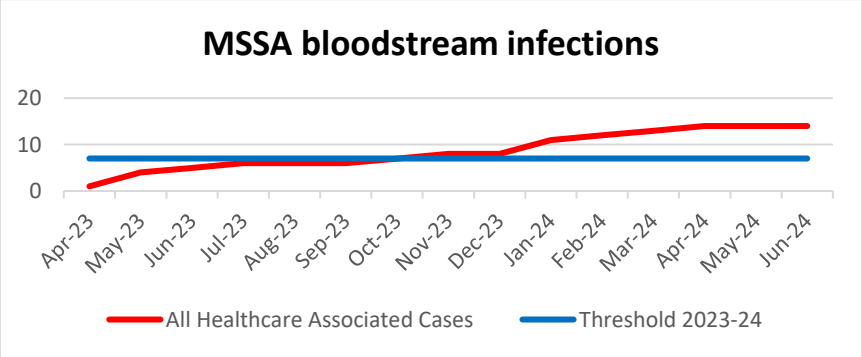
***Klebsiella spp*. bloodstream infections**

***P. aeruginosa* bloodstream infections**

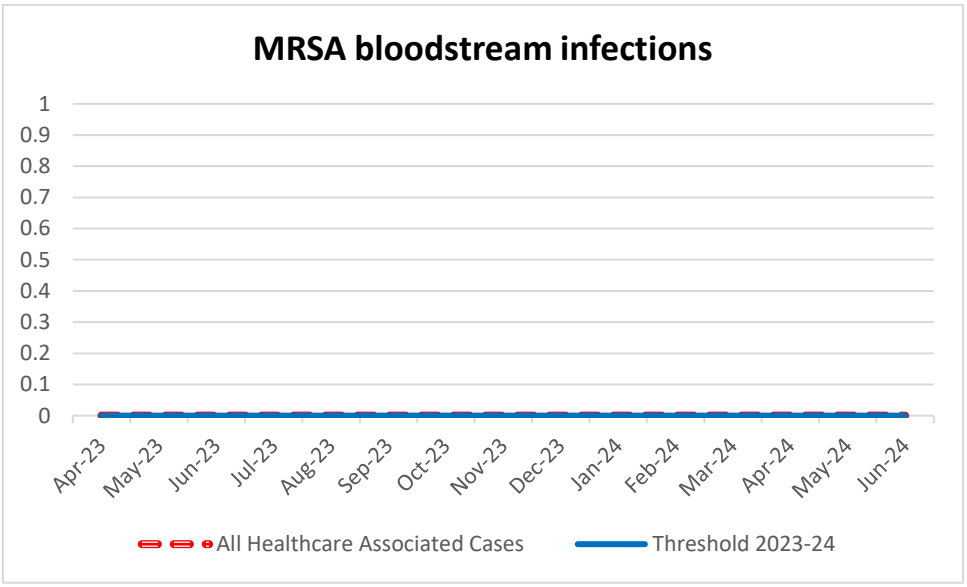
Table-1: UKHSA HAIs monthly tables for Gram-negative bloodstream infections.

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

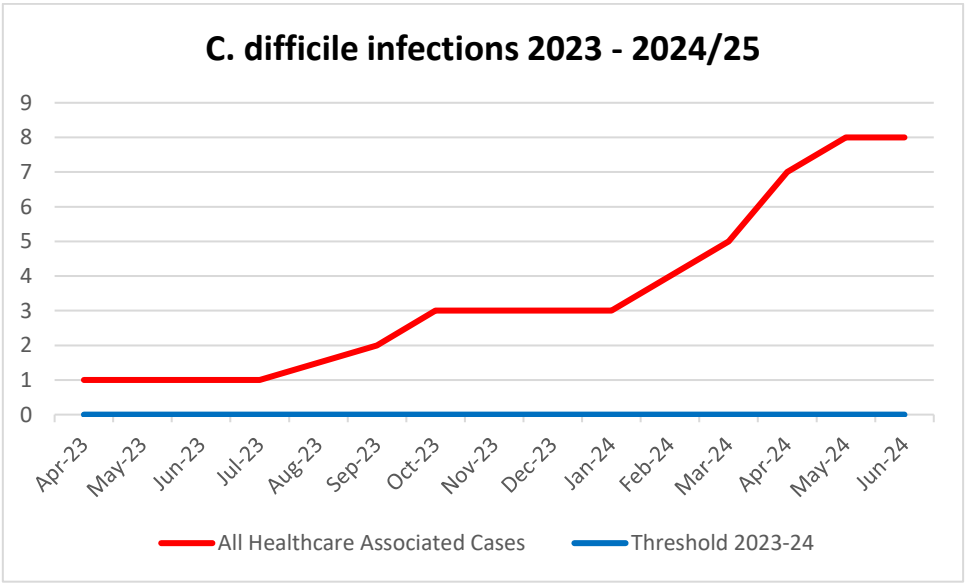
3.1.2 Healthcare-associated *Staphylococcus aureus* bloodstream infections



During Q1, 1 patient had a healthcare associated MSSA blood stream infection: was admitted in the cardiac ward.



3.1.3 *C. difficile* Infection



During Q1 there were 3 healthcare associated Clostridium difficile infections identified. One was from Oncology and two were from General Surgery. PIR for the cases identified that there were no identified lapses in care, all cases were long-term/ regular hospital attenders, and all had exposure to multiple broad-spectrum antibiotic treatments. One of these 3 cases was likely a colonised patient with no clinical symptoms, in which testing was not indicated. Learning from PIRs - education to staff to isolate based on symptoms and send off samples at the earliest possibility and to ensure adequate/appropriate documentation (utilising the Bristol stool chart) of patient stool/output in patients' records.

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

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

3.2 Healthcare acquired viral infections.

3.2.1 Respiratory viral infections

During Q1, we continued to see that a large proportion out of the positive respiratory viral tests analyzed in the microbiology laboratory, were obtained on patients admitted for longer than 3 days (*i.e*., viral healthcare acquired infection). We report these rates to the ED team to ensure appropriate use of diagnostic resources across the Trust.

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

- Lack of staff awareness to use PPE accordingly to patient's symptoms, not just testing results.
- Lack of staff awareness of the burden of nosocomial viral infections in hospitalised paediatric patients
- Previous visits from a friend or relative with symptoms
- Frequent contact outside the ward in families with long-term patients (particularly in 1C cardiac ward).
- Patients being frequently exposed to multiple visitors.
- Cubicle doors not being kept closed.
- Lack of education for parents and visitors being given on admission.
- Long hospital admission stays for patients with complex needs who have outside careers.

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

3.2.2 Gastrointestinal viral infections

During Q1, there were 3 cases of healthcare associated *Norovirus* on 3C, 4A and 4C. No outbreak declared because of these cases – no further patients or staff affected.
There was 1 case of healthcare associated Sapovirus on the Oncology ward.

3.3 Other Notable Infections

3.3.1 Group A *Streptococcus*

3 cases of healthcare associated Group A *Streptococcus* were identified during Q1 24/25 without any epidemiological link identified between them.

3.3.2 Measles

There were 2 positive measles cases reported during Q1 24/25- both found to be MMR vaccine related. There was an increase in patients presenting to ED with suspected measles requiring contact tracing (27 cases Apr-June 2024). BI has developed and automatic contact tracing dashboard which allows IPC to promptly identified significant exposures. The IPC department and DIPC closely collaborate with Liverpool City Council, NHSE and UKHSA to develop a collaborative approach to enhance MMR vaccination rates in the community and increase awareness of healthcare workers to promptly recognise measles cases.

4. Infection Prevention & Control Associated Risks

See Appendix 1 at the end of report.

5. Discussion and next steps

During Q1, the IPC department has continued to maintain their increase visibility across the Trust through daily isolation ward rounds a monthly steering group meetings despite significant low staff capacity within the Team with only two infection preventionist and one project coordinator actively working alongside the DIPC and deputy director of AHP for the majority of Q1. However, two new IPC practitioners have successfully been recruited into the IPC team, which will allow us to continue transforming the IPC department into a highly effective data driven program.

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

Funding of ICNet has been secured with ongoing plans for implementation under the Digital team. Risks remain largely unchanged due staff absence and the priority on clinical care and safety.

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Appendix 1: Infection Prevention & Control associated Risks

Risk Number InPhase ID	Ulysses ID	Risk Description	Initial Risk score	Target risk score	Risk score Q1 24/25	Risk movement	Mitigations in place Q4
00000148		Rising tide infectious disease (measles) overwhelming Trust preparedness. Preparedness requirements for and management response of suspected and / or confirmed measles cases across the Trust	12	3	6	↓	NEW RISK Originally assigned to EPRR transferred to IPC 29.4.2024. Bi-weekly meetings held to monitor progress of preparedness and Infectious diseases plan developed. Tracking plan developed with BI support.
00002713	2747	Inability to maintain IPC standards due to limited availability of curtains and lack of timely response to the rapid cleaning pathway Risk transferred to the Associate Chief Operating Officer, Corporate Services and Head of Facilities	9	4	9	↔	The Business case has been approved for the replacement of window curtains but risk remains open as not yet fully implemented. Replacement of internal bed dividing curtains still outstanding.
00002714	2748	IPC Policies are not up to date and not reflective of current IPC practice	9	4	6	↓	The recovery plan remains in place and on track. Remaining policies were due for presentation at IPCC in May and SQAC in June for ratification. However this was delayed and so risk remains static

							and will be reviewed after next IPCC.
00002715	2749	Lack of advanced data skills within the IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data	12	3	12	⟷	Funding secured for ICNet. Action closed. New action for the implementation of ICNet will take some months, no change to score at present until implementation commences. Implementation group formed to action.
00002710	2744	Non delivery of IPC standards due to insufficient IPC staffing levels	12	6	12	⟷	Significant staffing challenges remain, 2 band 6 IPC practitioners left in May 2024. Posts at shortlisting stage and intewrview date to be arranged. Band 4 Assistant Practitioner remains off sick. Service remains in a vulnerable position but is safe due to the Clinical oversight of the remaining staff and processes by DIPC .Prioritization of work and streamlining of processes by DIPC and DD of AHPs (Allied Health Professionals) remains in place.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 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 24th July 2024, along with the approved minutes from the 19th June 2024 meeting.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐

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

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

0101 **1. Executive Summary**

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

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

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

- SQAC received the positive Patient Safety Strategy update. SQAC was pleased to note the clear progress and good documentation on the workstreams scrutinised in month.
- SQAC received the Sepsis Quarterly update with good discussion held. SQAC noted the progress regarding the Sepsis dashboard and noted the challenges regarding training and a shift to a different approach.
- SQAC received the ED monthly report, ED@ its best update, positive update received, SQAC noted that ED are continuing to make good use of data.
- SQAC received the Patient Safety learning review report with helpful discussion and review, with thoughtful review of a difficult incident and learning.
- SQAC received the Drugs & Therapeutics Quarterly Report/Annual Report
- SQAC received the Fuller Inquiry Action Plan Quarterly Report
- SQAC received the Safeguarding Children Annual Report
- SQAC received the Board Assurance Framework
- SQAC received the NICE Compliance update
- SQAC received the Clinical Audit Assurance Report
- SQAC received Data Triangulation/Canary charts update
- SQAC received the Confidential enquiries/national guidance report
- SQAC received the Clinical Effectiveness & Outcomes Group Chairs Highlight report
- SQAC received the Liverpool Neonatal Partnership Integrated Governance Report
- SQAC received the Healthcare Transition update
- SQAC received the Divisional updates
- SQAC received and Ratified the Parental Nutrition Policy
- SQAC received the Absconsion Policy – Policy was reviewed offline to ensure that it is in a finished format, Policy was ratified offline by SQAC chair.
- SQAC received and Ratified C35 – Tracheostomy Policy

4. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on Wednesday 19th June 2024
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing, AHP & Experience Officer, Chair (ACCN)	(NA)
	Lisa Cooper	Divisional Director – Community & Mental Health Services	(LC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Bea Larru	Director of Infection Prevention & Control	(BL)
	Gerald Meehan	Non Executive Director	(GM)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RP)
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	(JP)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)

In Attendance:

24/25/54	Will Weston	Medical Services Director	(WW)
24/25/58/59/60/67	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	(NO)
24/25/65	Jennifer Deeney	Head of Neonatal Nursing/Liverpool Neonatal Partnership	(JD)
24/25/66	Jayne Guy	Head of Nursing & AHP's for Diagnostics & Clinical Services	(JG)
	Peter White	Chief Nursing Information Officer	(PW)
	Natalie Palin	Director of Transformation and Change	(NP)
	Ian Gilbertson	Deputy Chief Digital and Information Officer	(IG)
	Ellen Matthews	Head of Service Development & Performance	(EM)
	Jill Preece	Governance Manager	(JPr)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)

Apologies:	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	PB)
	Kerry Byrne	Non Executive Director	(KB)
	Laura Rad	Head of Nursing - Research	(LR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS)

24/25/50 **Welcome and Apologies**
The Chair welcomed everyone to the meeting.

24/25/51 **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.

24/25/52 **Minutes of the Previous Meeting**
The Committee members were content to APPROVE the notes of the meeting held on 22nd May 2024.

24/25/53 **Matters Arising/Review of Action log**
The action log was reviewed and updated.

Assurance on Key Risks
24/25/54 *Delivery of Outstanding Care*
Safe

Patient Safety Strategy update
WW presented the Patient Safety Strategy update

- Patient Safety Strategy Board had applied careful scrutiny to workstreams 1, 6, 7, 8, and 10.
- Workstream 1 Suite of Safety Metrics – changes in reporting which shows Psychological and Physical harm separately. Emerging work using canary charts was explained to SQAC.
- Workstream 6 - Negligence and litigation - all milestones had been achieved and following approval of a closure report the intention is to move this to business as usual.
- Workstream 7 – Children Young People & Families as Patient Safety partners – it was identified that further project management support would be required, with plans in place to fill this gap.
- Workstream 8 – Education & Training – over 98% of staff had completed level 1 training, with the next steps to move onto level 2 training which would be included in the Trusts prospectus.
- Patient Safety Strategy Board received an update regarding Unacknowledged notices.
- WW alluded to the metrics and referred to a new way of reporting based on an updated criteria which allows for comparison of governance over time. All the metrics are currently Green, with the aim to score higher at the next review in August 2024.
- The new Patient Safety Investigation co-ordinator is due to commence in post week commencing 24.6.2024, with the investigators due to commence in post in a couple of months.
- WW advised that he is pleased overall with the continued improvements demonstrated. WW stated that he and Patient Safety Strategy Board colleagues are grateful for the ongoing support and challenge from members of the SQAC. WW stated that this update would be his last update until 2025 and that both CT and JR would be providing future Patient Safety Strategy Board updates to SQAC.

NP alluded to the Canary charts and stated that these charts would be extremely useful. NP sought clarity whether colleagues had incorporated how the Trust considers soft intelligence alongside the data. WW thanked NP for her comments and stated that there is further refining required and that colleagues would like to include other metrics i.e. the thriving index, potentially staff safety culture. WW stated that there is definitely options for the softer metrics. WW stated that this would just be an indicator whereby there may be a concern and does not replace the need for discussions and interactions with the specialties.

FB stated that she liked the concept of the 'canary chart' and advised that she could see that there is a great deal of further development. FB stated that it is important to not just display items that are easy to measure and to ensure that there is a holistic approach including the soft factors that are much more difficult to display in this way.

UD alluded to the importance of ensuring that the information is captured and provided for each specialty, to chart this information alongside the soft intelligence. WW stated that during his update to Executive Team on 27.6.24 that this detail would be specific to each specialties and information would be drilled down into certain areas.

NA welcomed the ongoing progress and formally thanked WW for ongoing support.
NA alluded to the Unacknowledged notices and stated that with the exception of Community & Mental Health Division that unacknowledged notices are not on trajectory and sought clarity when SQAC would receive an update on the current position. WW stated that Unacknowledged notices are on the Patient Safety Strategy workplan and that WW would review the workplan to ascertain when the next update is due to Patient Safety Strategy Board.
Resolved: SQAC to receive update on Unacknowledged notices at October 2024 SQAC meeting.

FB expressed her thanks to WW for his ongoing support provided to SQAC and acknowledged the significant improvements made by WW. FB conveyed her best wishes to WW and welcomed WW return in 2025.

Resolved: SQAC welcomed the progress made in month and **NOTED** the continuous improvement across an array of patient safety workstreams.

24/25/55 **Quarterly IPC update**
SQAC received the Quarterly IPC Update

Resolved: SQAC received and **NOTED** the Quality IPC update

24/25/56 **Annual IPC update**

SQAC received the Annual IPC update which detailed a comprehensive update regarding the Infection Prevention Control Team, progress made in the service alongside challenges.

- BL advised of the staffing challenges with IPC and advised on the reduced number of practitioners within IPC team.
- IPC colleagues had been undertaken daily isolation rounds and participate actively with the measles outbreak response which the Trust embedded from January 2024-end of April 2024.
- IPC colleagues are updating all IPC policies and are liaising with staff in this regard, there are a number of policies which would be presented to July SQAC meeting.
  BL provided an overview of the various IPC Steering Groups and sub groups.
- BL alluded to the gram negative infections in the short gut in oncology children they are not represented in the adult targets, IPC are working with other paediatric settings to try and set targets specifically for paediatrics.
  The Trust had seen MSSA cases IPC colleagues had worked
  with Cardiac, Orthopaedics and Neurosurgical divisions to manage patients when the come into the hospital.
- Nationally there had been on increase of 400 cases of C Difficile across the country, particularly in the North West, the Trust had seen an increase, particularly in oncology patients and short gut children who are highly affected. The North West had commissioned ICB work to try and prevent C Difficile.
- Focus, particularly over the last winter related to preventing hospital acquired viral infections, IPC review all incidents, IPC colleagues meet with ward managers, and instil good practices.
- The Trust had seen reduced norovirus cases, and any previous norovirus outbreaks had been well managed.
- The Trust had not seen an increase on Group A Streptococcus cases in year, but have seen an increase in Measles cases. ED had worked to quickly isolate patients despite building works.
- BL advised that a Pertusis update would be provided in the next IPC report as the Trust had seen a significant amount of Pertusis and significant Pertusis exposure for healthcare workers.
- IPC Team had secured the funding for ICNet, with plans for implementation in the new financial year.

FB expressed her thanks to BL for the comprehensive Annual report. FB stated that she appreciated the structure which is in place which details the IPC forums and interactive behaviours within IPC team which is extremely important. FB advised that SQAC note the staff challenges, and that IPC could do even more if the IPC staff team was stabilised.

RP alluded to the reports, and stated that the Divisions are reporting within the Integrated Performance Dashboard 0 level of hospital acquired infections or healthcare acquired infections however this does not correlate with this report, with a mismatch of data across the Divisional and IPC information.

BL stated that the Trust does report nationally to the UKHSA and advised that this report does match the UKHSA mandatory surveillance reporting. BL stated that she is happy to review this offline with RP.

Resolved Offline discussion to be held with RP and BL to discuss discrepancy

GM alluded to the MSSA screening prior to surgery and queried whether the neurosurgical model referred to has had an impact. BL stated that the impact on orthopaedics change in screening had not been measured yet as this had only just commenced (3 months ago), with Cardiac being implemented soon. BL alluded to neurosurgery and advised this had been implemented in Neurosurgery and as a consequence there is no MSSA infections in neurosurgical patients since implemented: Most infections after surgery happen because of bacteria's that the patient has prior to surgery, and it makes sense to swob patients prior to surgery to determine any bacteria and to decolonise. There is a national mandate for MRSA but not MSSA. BL stated that the rules to help control MRSA now need to apply to MSSA. BL advised that the guidance is extremely clear for adults and that when Cardiac and Orthopaedics have implant surgery they are mandated to undertake MSSA but not for children, the Trust want to update this.

JP expressed her thanks to BL for ongoing support regarding IPC
NA suggested that Q4 and the annual report are combined in for next year. This combined approach was welcomed.

NA requested support from BI colleagues to enable an appropriate solution regarding the inconsistencies regarding the data, IG confirmed that BI colleagues would liaise with BL and RP regarding this to enable an appropriate solution.

Resolved: SQAC received and **NOTED** the Annual IPC update.
Resolved: Quarter 4 and IPC Annual Report to be combined in the future.

24/25/57 **ED monthly report: MH attendances and ED@its best report**

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

- ED attendees continue to be higher this year, in comparison to May 2023 – the Trust has an increase by 6% in May 2024 and the trust maintained 86.7% of CYP seen in the four hour standard against a target of 78%
- UTC utilisation is still below plan, colleagues are continuing to work on this, this continues to be 30% of the total patients who attend, and colleagues continue to over deliver on the activity plan, with work ongoing.
- Maintained improvements from March 2024 regarding time to triage, remain at 15 minutes, although a slight improvement, there is continued focus. ED are developing and moving to the Manchester triage model all senior staff had attended training CW envisaged an impact over the next 3 months, once training had been completed.
- Median time to clinical assessment for April was 73 minutes, 13 minutes higher than the national standard of 60 minutes. With challenges during the evenings 6pm – 10pm continuing, colleagues are continuing to review the workforce required to manage these peak times. CW envisaged that colleagues would see a difference regarding workforce during the busy/peak times during the winter period.
- There had been an increase in ED Friends & Family Test results with 89% of families recommending the Trust.
- Emergency Department Sepsis – (delivering antibiotics within 60 minutes) - compliance for May 2024 was 93%.
- Colleagues are working on data regarding length of stay on PAU to split the PAU length of stay from the rest of the inpatient stay, this is in progress.
- There is focus on ambulance handover, with some challenges regarding rerecording handover within the 30 minute standard.

Key improvement actions

- Colleagues continue to review the mitigations for EDU/PAU move due to NICU Estates work with an options appraisal to be presented to Executive Team in June 2024.
- Review of Medical and ACP cover on PAU and correlation between activity levels, with support from Brilliant Basics Team – July 2024

FB alluded to handover compliance and requested if CW could provide clarity on the difference of a compliant ambulance handover and a handover that happens within 30 minutes.

FB alluded to the figure within the graph regarding handover compliance and a separate figure for handed over within 30 minutes and sought clarity regarding ‘what is compliance’ and whether this is a checklist completed for every handover or what it actually refers to.
CW stated that compliance relates to the checklist required from the ambulance staff on arrival and the handover within 30 minutes is the standard for the Trust to measure.
FB acknowledged the need to improve the procedures and the data compliance.

NA alluded to the Was Not Brought rates for ED and stated that although there were numerous children returning to ED in March 2024 it appears a really good month with regards to reducing the Was Not Brought rate and sought clarity whether colleague understand what went well in March 2024 to enable the reduced Was Not Brought rates.

CW stated that there is increased focus within the division and children are being followed up in a more timely manner, colleagues are starting to text the patients if they had not arrived/attended as planned, this is not reflective in the data given this has only recently commenced. CW confirmed that going forward colleagues would be receiving texts and messages sent to families who do not arrive.

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

24/25/58 **Quarter 4 Safeguarding Report (1st January 2024-31st March 2024)**

NO presented the Quarter 4 Safeguarding Report

- Level 3 safeguarding training compliance remains under the compliance rate of 90% with ongoing work undertaken to improve compliance.
- There were 53 cancelled Safeguarding training places within this quarter.
- Safeguarding team continue to see a high demand in relation to the multi agency safeguarding hub (MASH) requests. In Quarter 4 there were 719 requests from social care colleagues which was in relation to 1,448 children
- Overall there were 3,040 MASH requests in the last financial year, relating to 6,174 children resulting in a significant demand on the Safeguarding team time.
- Safeguarding team had seen a significant increase in demands from Knowsley, and Safeguarding colleagues. NO advised that colleagues usually see this when social care partners change there ways of working and triaging referrals. Safeguarding team colleagues continue to work with colleagues in this regard.
- Sexual Safety in NHS work is ongoing
- Fuller Inquiry - Safeguarding Team continue to work with Medicine Divisional colleagues regarding strengthening assurance in relation to Safeguarding arrangements within the Mortuary.
- Challenges in Quarter 4 continue to be the same challenges as reported in previous quarters regarding Safeguarding level 3 training compliance, having the Statutory Safeguarding key roles, and gaps within he team and the continued demand from safeguarding children partnerships and Local Authority colleagues in their improvement journeys as they work with their Ofsted improvement plans.
- Achievements include recruitment following successful business cases; work regarding the Child Death Policies, and ensuring all of the key teams across the Trust have had opportunities to comment on the multi agency protocols and policies, specifically regarding the Sudden Unexpected Death Childhood (SUDiC) for Children 0 to under 18 and the Acute Life-Threatening Event (ALTE) protocol and ensuring those colleagues have had opportunities to comment on protocols; ongoing work regarding the Fuller Inquiry and the Sexual Safety in NHS work
- Work would continue within Quarter 1 to review and develop Trust policies and protocols in relation to those areas which incorporate multi agency protocols, with ongoing work to modernise the policies and Standard Operating Procedures. Achievement also include the recruitment of the Named Doctor for Safeguarding and Named Nurse commenced in role within Quarter 1.

FB stated that she had recently attended a Safeguarding Quality Assurance round with the Safeguarding team and had noted all of the ongoing work being undertaken, with great progress made with regards to addressing key risks. FB acknowledged the significant ongoing work regarding modernising policies, whilst also recognising the key workload challenges given the significant increase in MASH referrals. FB expressed thanks to the Safeguarding team for ongoing work.

GM made a Declaration of interest that he worked for Liverpool City Council in this area.
GM stated that he is fascinated by 66% increase in MASH referrals which is extremely significant and is likely to be relating to Liverpool and Sefton both are intervention and Knowsley have had significant difficulties which is predictable.GM alluded to previous years and sought clarity whether Safeguarding colleagues had seen a difference in the nature or quality of the referrals and whether they are appropriate from a safeguarding perspective.
NO alluded to Alder Hey referrals into the MASH processes and stated that Alder Hey Safeguarding team do have oversight of the quality of those referrals and that there are quality audits on those. NO referred to the requests from the MASH back to Alder Hey to provide information, NO stated that she has been in post for two years and that prior to NO commencing in post the Safeguarding Team

had not been collecting the data. NO advised that the Trust currently have data for a 18 months period, the Safeguarding Team have seen a significant increase in requests. NO advised that often Safeguarding colleagues are seeing that the number of children attached to requests have increased, regarding the complex contextual safeguarding and regarding criminal exploitation and sexual exploitation with an increase in referrals in where there are a number of children of interest relating to one enquiry.
Knowsley have changed their processes within this last quarter and safeguarding colleagues had seen a significant increase.
Sefton had recently introduced a different way of referrals, and had moved from written referrals to a verbal conversation. Safeguarding colleagues continue to map and monitor how this impacts on demand. Safeguarding colleagues are involved in the improvement discussions and NO attends the Liverpool meetings regarding the improvement plan for Children's social care.
NO stated that the quality of information requested is really good, MASH nurse had visited the different MASH hubs to enhance relationships and better improve the quality of information provided.
NO advised that feedback received regarding the quality of information that is provided by the Safeguarding team at Alder Hey is high quality, in comparison to other providers.
GM stated that as a committee it is important to focus and monitor this going forward, given the major demand on resources within Safeguarding, as the team are operating at the highest level of risk.
FB stated that this was observed during the Safeguarding Quality Assurance Round.
Resolved: FB suggested an offline discussion with NA and NO regarding how to reflect this within the Quarter 1 report 2024/25

NA thanked NO for the excellent report. NA and NO had a short discussion on the challenges with level 3 safeguarding training and agreed to meet offline to discuss potential ways to move this forward.

Resolved: NO to ensure that the list is shared with ACN's to ensure that the required staff are booked onto the training, with the roster updated to reflect. After a 4 week period charge to be introduced for non attendance.

FB stated that overall the Mandatory training charts looks in an improved position compared to various updates, whilst noting the ongoing improvements required to improve compliance for level 3 training.

Resolved: SQAC received and **NOTED** the Quarter 4 Safeguarding Report

24/25/59 **Merseyside Joint Agency Protocol Acute Life-Threatening Event (ALTE)**
NO presented the Merseyside Joint Agency Protocol Acute Life- Threatening Event (ALTE) which had been developed by five of the Children Safeguarding Partnerships which guide staffs responses regarding children with Acute Life Threatening event and is closely linked with the Sudden Unexpected Death Childhood (SUDiC) for children aged 0 to undner 18 protocol.

NO sought approval for this protocol to be uploaded onto the DMS system to ensure that Alder Hey are in line with Merseyside approach to ALTE.

Resolved: SQAC were supportive of this approach and approved the Merseyside Joint Agency Protocol Acute-Life Threatening Event (ALTE) being uploaded onto the DMS

24/25/60 **Merseyside Joint Agency Protocol Sudden Unexpected Death Childhood (SUDiC) for Children aged 0 to under 18 years**
NO presented the Merseyside Joint Agency Protocol Sudden Unexpected Death Childhood (SUDiC) for Children aged 0 to under 18 years, which had been developed by five of the Children Safeguarding Partnerships which guides staff responses regarding a Sudden Unexpected Death.

FB alluded to Appendix E - the Liverpool Women's flowchart, and sought clarity whether the LNP had also indicated is going to remain in operation.
NO replied that RP had stated that this had been listed for discussion at their governance meeting.

FB stated it is good to know that this discussion is taking place and that some clarity is going to emerge, whilst understanding that the Trust cannot have one single policy for both organisations, given the difference in structures and cultures.
NA alluded to the significant sections regarding the pro forma and queried whether there is an opportunity to prioritise this to include within the EPR system given that it is not just the safeguarding team that use it and whether this could be a first step into digitalisation. IG stated that there is a planned meeting with Safeguarding colleagues on 21.6.24 to assess and agree priorities to enable an appropriate transformation plan to be established.
FB alluded to the Alder Hey policy and stated that there is a great deal of detail within the protocols, and sought clarity whether it would be the intention for the Alder Hey policy supplements only where it is necessary and replicates as much as possible.
NO stated that Safeguarding colleagues are mindful that a number of Safeguarding policies and protocols are extensive. NO stated that she had met with Dr. Holt regarding whether the Bereavement Policy and Child Death Policy could be combined and safeguarding colleagues would be signposting people to the relevant sections of the policies and wherever possible the easy read flow charts to guide staff at a glance would be included, NO confirmed that colleagues would aim to minimise the policies whenever possible.
FB thanked NO and the Safeguarding Team for the ongoing work and support.

Caring
Effective

24/25/61 **Board Assurance Framework**

SQAC received the Board Assurance Framework.
FB advised that the key risks are unchanged.

- SQAC noted Risk 151 – Expanse Referral Process
- SQAC noted Risk 70 – National ADHD medication shortage – LC advised that she had met with JG and NA on 17.6.24 to discuss this, with a further meeting scheduled on 21.6.24 to review a number of actions and review whether the scoring is correct. LC stated that it is likely that this score would be increased.
  NA stated that this is likely to be included in the Board Assurance Framework in its own right, as this is complex and acknowledging the longevity.

IG advised that there is a report regarding the Expanse Referral risk which has been developed regarding the mitigation action plan, with 4-6 weeks work required, once this had been completed this would reduce the risk, IT are actively monitoring and working on this action plan.

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

24/25/62 **Aggregate Analysis of Incidents, Complaints, Patients Advice and Liaison Services (PALS), Claims and Inquests Quarter 3 and Quarter 4 (October 2023-March 2024)**

JR presented the Quarter 3 and Quarter 4 report, which detailed analysis, themes and trends.
for this year to provide assurance compliance NHS Quality Contract, very prescriptive report based on quality contract requirement

- A Total of 4, 324 incidents were reported in Quarter 3 and Quarter 4 2023/24
- 93.5% of all incidents were reported as low and non physical harm in Quarter 3 and Quarter 4.
- 0.43% of all incidents were recorded as moderate physical harm in Quarters 3 and Quarter 4
- No incidents resulted in severe or fatal (death) harm in Quarter 3 and Quarter 4 2023/24
- Duty of Candour (CQC Regulation 20) – 100% compliant with statutory regulation for initial verbal & written notifications for Quarter 3 and Quarter 4 2023/24.
- Top 5 Incident Categories in Quarter 4 2023/24 were: Medication, AATD, Documentation, Infrastructure and Treatment / Procedure.
- A total of 81 complaints were received in the 6 month reporting period, which is a slight increase from 71 in Quarters 1 and 2, with the main themes of complaints relating to treatment and procedure, and allegation of failure of delivery of medical care

- A total of 1,019 formal PALS were received in the six month period which is a slight increase from 974 in Quarter 1 and Quarter 2, with themes continued to be reported regarding appointing waiting times, delays in communication, and alleged failure in medical care.
- There were 8 new claims within the last 6 month period, which is a similar trend to Quarters 1 and 2, themes related to alleged failure in care and delay in treatment and diagnosis.

JR advised that colleagues had commenced working with business intelligence colleagues and colleagues within Brilliant basics to determine whether the data that is provided could be presented throughout the report in SPC charts to demonstrate any special cause effect, and subsequently any potential areas of focus for quality improvement. This data would also be used to proactively to inform the next iteration of the Patient Safety profile which is in line with the national Patient Safety Strategy and the Trusts' PSIRF plan.

Resolved: SQAC **NOTED** the content of the Aggregate Analysis of Incidents, Complaints, Patients Advice and Liaison Services (PALS), Claims and Inquests Quarter 3 and Quarter 4 (October 2023-March 2024 and **NOTED** the assurance that the Trust is fully compliant with NHS Quality Contract reporting requirements. SQAC **NOTED** and welcomed the offer from Brilliant Basics to support improvements in reporting with the addition of SPC Charts into future reports.

24/25/63 **Quarterly Mortality Report/Mortality Annual Report**

SQAC received the Quarterly Mortality Report/Mortality Annual Report.

NA stated that this is an extremely comprehensive report, which details the successes and challenges. NA stated that he is happy to share any feedback to ABA and JG once they had returned from leave.

GM alluded to Page 2 of the Mortality report and the higher death rates this year, GM stated that he had tried to look at other Children's Hospital data and sought clarity whether there were any particular cases that have distorted the figures, or whether there are any trends. NA stated that within the Mortality report that there is a comparison to similar other centres to Alder Hey, and that Alder Hey are in the mid range. NA stated that an update would be required from AB & JG once they had returned from leave.

Resolved: SQAC received and **NOTED** the Quarterly Mortality Report/Mortality Annual report.

24/25/64 **Clinical Effectiveness and Outcomes Group Chairs Highlight report**

JR presented the Clinical Effectiveness and Outcomes Group Chairs Highlight report from the meeting held on 7th June 2024.

- JR has had discussions with North West ODN regarding benchmarking of Twist and Shout Testicular Torsion report, the pathway had been developed by the National Lead who is a consultant at Alder Hey, this is on the list to be discussed at the ODN network, and this is being progressed locally.
- There had been a recent appointment of a clinical governance lead for the Medicine division – this individual would now be engaged with CEOG work.
- The first clinical audit masterclass is due to be held on 24/06/2024 and is fully booked.
- A decrease in Policy/document compliance is **NOTED,** JR stated that this is likely to be due to user error, therefore drop in sessions for staff had been arranged, there is an action plan in place and governance colleagues had already met with the Medicine division with a significant number of policies have since been updated and are now in date.
- Epilepsy 12 noncompliance of data – JR formally requested colleagues within the Medicine Division to share with her the letter that had been sent externally with the full action plan to include within the report.
- JR advised that there is a meeting scheduled on 19.6.25 with JD regarding LNP regarding policies and protocols

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

24/25/65 Liverpool Neonatal Partnership Quality Assurance update

JD presented the Liverpool Neonatal Partnership Quality Assurance update.
JD advised that the data within the report related to April 2024 as the report is 1 month behind given the timing on input from colleagues
Key achievements

- 17 Band 5 had been recruited, 3 Band 6, 2 8B ANNP's and 3 consultants

Key challenges

- Challenges remain regarding performance metrics and ensuring that there is sight at LWH of the neonatal babies at Alder Hey, JD is working with IG and IT team to ascertain the best method to extract this information.
- Recruitment of SALT - not successful at 8a, JD advised that she had liaised with Commissioners regarding how to possibly reuse this money to support a different AHP, whilst determining an appropriate plan for SALT.
- Operationally it had been a busy month across both sites, bed occupancy run level is approximately 82% across both sites.
- JD alluded to the dashboard and stated that there are still issues that are being worked though specifically the recording of data regarding parents being seen within 24 hours
- Blood stream infections had also been included within the report – 20 in February 2024, 15 in March 2024 and 8 in April 2024.
- Staff turnover is reducing, there is an increase in 1C which is due to internal promotion.
- There is good incident reporting, with the majority of the incidents reported as low harm or no harm
- The Risk Register had been reviewed, JD confirmed that all of the risks are currently up to date and are relevant and work is on going in this area.
- JD had consulted with Chair of CEOG re policies. JD is due to meet with JR on 19.6.24, A heatmap has been created and would be shared within the July LNP update.
- There was 1 shared incident during the reporting period relating to a baby with a TGA who was delivered at LWH and unfortunately there was not a bed at Alder Hey, communication on both sides was not as robust as it should be, the team had met and had agreed an escalation plan with a robust process is now in place for the future.
- There had been no complaints within LNP partnership.
- Positive friends and families responses received
- Quality Improvement plans and audits are in place
- There was no NICE guidance reported within the reporting period

FB stated that the Trust Board are sighted on the complexities regarding working across the two organisations, particularly with regards to the different ways the risks are scored and colleagues are aware of this.

Resolved: JR requested a copy of the triple 5 paperwork to be shared with her.

NA stated that in May 2023 there was compliance rate of 100% of parents being seen within 24 hours and this had since been extremely variable. NA sought clarity regarding how this is being addressed. JD advised that there is a Quality Improvement Project in place to try and address this issue which is an issue for both LWH and Alder Hey. JD advised that this is a tick box within badger, and colleagues had requested Badger whether this could be made into a mandatory box as colleagues cannot move on without ticking the box to confirm that you had spoken with the parents, this is a national key performance indicator and something which has to be ticked, there had been significant training regarding this.
JD provided an update on the NICU Operational Preparedness

- Build trajectory is on plan
- Budget is not on trajectory
- Workforce – recruitment within budget is slightly over plan, colleagues are in discussions with commissioners with regards to the medical workforce. Positive recruitment of the medical workforce ANNP is a challenge - approval had been received by commissioners to run a hybrid post, with the aim of increasing the out of hours cover for doctors from August on the Alder Hey site upto 10.00 pm or midnight which is a twilight shift which people are happy to do to ensure a full 24/7

team on the Alder Hey site with 1C having its own medical cover 24/7 from a neonatology perspective.

- Nurse recruitment is green, as there are 46 nurses on 1C already, there are nurses that will come from LWH that are already in post and there would be posts within PICU where the neonates that come out of PICU will all fill in the gap. There are 9 WTE to recruit to at Band 5, these posts are due to go out to advert on 22.6.24. These 9 nurses would commence on a rotation within paediatrics at Alder Hey on the paediatric wards for a 6 month period over the winter period and would start their Foundation in Neonatal Nursing after this.

FB stated it is good to receive this update regarding how the LNP is developing, FB stated that this may not be needed monthly, however this would be discussed offline, and JD would be updated as appropriate.

Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership monthly update

24/25/66 **Divisional Update and Deep Dive regarding Patients deteriorating to critical care and deep dive regarding the Trust approach to implementation of Martha's Rule**

Division of Surgery -

RP expressed her apologies as the Division had not included the data regarding the incident and risk history for the past year, this would be rectified for the July update.

- The Division continue to see good compliance with actions and reporting on the Risk Register, colleagues within the Division are feeling assured that the new process is working well.
- Challenges regarding the variation in policies across the LNP and Alder Hey neonatal services colleagues are working collaboratively to address this.
- Ongoing digital risk with regards to referrals as colleagues are still seeing numbers of minor, moderate and severe harms in terms of follow up's with ongoing work taking place to address this
- The Division had seen a downward trajectory with regards to Sepsis training due to the unavailability of the module for a period of time which was a national issue which had impacted the Division.
- There had been 2 moderate harm incidents reported in month, both incidents had been downgraded following a rapid review and detailed action plan in place.
- RP alluded to the IPC data and confirmed that she would follow this offline with IPC and would correlate for the July report.
- The Division have 1 high risk regarding capital which is being managed through the Capital Sub Group and the Trust Capital Steering Group.

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

- Ongoing challenge regarding ADHD medication shortage, frequent meetings take place to review this and there are various action plans in place. JP alluded to the BAF risk to ensure that this is documented in its fullest, as this is continuing to be a significant pressure.
- Challenge regarding lack of a clear process for electrocardiogram (ECG) traces to be recorded on the electronic patient record (EPR) as these are stored in image now with challenges regarding searching and finding the ECG as this data is not visible on the patients record, this issued had been raised at Patient Safety Strategy.
- The Named Doctor for Safeguarding had been appointed and is expected to commence in post in October 2024.
- Neurodevelopmental transformation programme had commenced, with the second meeting of the Board due to meet at the end of this week.
- Data – initial health assessment data is looking really healthy with positive ongoing work
- SQAC **NOTED** all of the new risks that had been added with regards to the gender service as they would now be monitored as a couple of the risks are scored quite high.

Medicine – CW provided the Divisional update

- CW provided an overview regarding a patient from Ukraine who had been nursed on 3B, patient arrived at Alder Hey in 2022 as the treating hospital in Ukraine had been bombed. CW detailed how staff caring for this patient had provided exceptional care and compassion to this traumatised patient who was unable to speak English. CW described how staff ensured wrap around support for this patient and her family with regards to supporting with language, signposting regarding

accommodation needs, gaining links to the community, ensuring that the child was sheltered from any loud noises as she was traumatised by loud noises and staff ensuring that she was shielded from any further trauma. The family are truly grateful to Alder Hey and to Liverpool for the exceptional support received. Child is now in a local school and is learning English and is being supported.

- Challenge regarding staffing crisis within haematology and transfusion/labs due to the unavailability of trained staff, due to significant sickness. This risk was at 25 and the risk is being reviewed this week by triumvirate and the labs, colleagues are hoping this risk score could be reduced to 20 with the mitigations that had been put in place.
- Division continue to ensure increased focus regarding sepsis. There had been no access to sepsis training for the last 5 week period, which had resulted in a decline in sepsis training compliance within the Division and across the Trust.
- The Division are reviewing all low harm incidents, with education with staff regarding grading.

Resolved: SQAC **NOTED** the significant challenges and would keep this under review at July 2024 meeting.

Research Division - JP presented the Research Divisional update

- Division had been celebrating the work of the orthopaedic research team this month who had received excellence reports from clinical team but also have recruited the highest number of patients in the CRAFFT study that has now reached its national target and is closed to recruitment.
- Concerns - Division have had a number of occasions in the last 2 months where the CRF had been occupied overnight by staff who have left before staff arrived but left dirty linen and wet towels. This has been escalated to estates and Response team and we have left signs on the CRF entrance, however it has delayed patients been seen for the first appointments as we had to get rooms cleaned. No further episodes since highlighting.
- Division are having to take a reduction of DMD studies for 3 months, due to two members of the team being on long term sickness absence, to ensure the safety of patients and to ensure continuity with the one other nurse, the division have paused active recruitment of new patients- no patients currently waiting for access to the trials so this shouldn't have a big impact.
- Progress is being made with updating the Research Patient Experience Survey to better be able to extract FFT data.
- There are no concerns or themes from study adverse events in month, the Division had one event with a consultant recruiting a patient to study without being signed onto delegation log, this had since been rectified and training had been addressed with the individual involved.

Deep Dive – regarding Patients deteriorating to critical care

JG presented the first Deep Dive report regarding Patients deteriorating to critical care, following review over the last 6 month period.

- From December 2023 - end of May 2024 there had been a total of 142 episodes of deterioration requiring transfer into critical are care, this includes 26 patients that clinically deteriorated on HDU requiring transfer to PICU. Of these episodes there were 111 patients, with 11 patients requiring repeat admission.
- The data that is supplied as part of the integrated performance report includes both patients that deteriorate within the inpatient ward and also patients that go from HDU to ICU. The HDU team evaluate all of those patients that deteriorate within there are and require ICU admission.
- Challenge remains regarding PEWS recording and accurately recording this as part of the patient observations, this had been highlighted in previous RCAs. A meeting is planned with JG, and other Senior Nurses including the Head of Nurse Education are meeting imminently to review how this could be addressed in line with the implementation of the national PEWS, the Trust is currently derogated as part of the DETECT study and there would reach a point that the Trust needs to align with national PEWS system.

Trust approach to implementation of Martha's Rule

JG presented an overview of the Trust approach of Martha's Rule

- Alder Hey expressions of interest had been granted and Alder Hey is one of the pilot sites across the Country implementing Martha's rule, Alder Hey is 1 of 7 Trusts within C&M and Alder Hey are collaborating with those other hospitals.
- Alder Hey currently have a response team on site 24/7 to provide assessment of patients where a Martha's Rule review had been activated, They will be first point of access.
- A What's app platform has been developed which includes a QR code and chat bot function to enable triaging of contact from patient, parent, family member of staff with the Response Team
- Inphase had been aligned to ensure a thorough governance process.
- Communication materials had been developed to share with partners across C&M, to ensure a consistent approach, delivery is currently awaited.
- Meetings are due to be set up with Health Innovation North West Coast to support through the implementation of Phase 1.
- Information sessions had commenced for all ward areas including staff and ward managers undertaken by the Response Team.
- An update is due to be provided at the Ask the Execs lunchtime briefing on 26.6.24
- Medical escalation flow chart is being finalised
- Aim to be launching on 1st July 2024.

NA stated that it is great to review this data, NA advised that the use of predictability and preventability is extremely helpful.
NA alluded to the reason for transfer from 1C to HDU when there are 10 HDU beds on 1C and sought clarity regarding the detail regarding movement of patients.

RP referred to the provision on 1C cardiac and stated that the 1C cardiac majority of HDU level 2 as they are on inotropes, support and hadn't reached the need for ventilation. RP stated that colleagues did discuss regarding whether to look at non invasion ventilation CPAP, BIPAP, non-invasive ventilation on 1C cardiac, however the feedback from colleagues and cardiac team is that given that they are on single organ support which is making them HDU, if moving to a second organ support then they should be in a more PIC standard unit in terms of a general HDU which means that patients do move back and forth, but in terms of the infrastructure and the medical modelling and provision regarding the support the model is set up on HDU to be there for that dual support rather than on 1C cardiac.

NA stated that there is a need to re review the BI data as the Trust should not be counting HDU patients going to PICU as a deterioration as they are already in critical care, and that these should be excluded from the numbers.
NA requested JG to clarify the measure as the measure previously used regarding readmission to PICU was within 24 hours and not 72 hours to ensure that the Trust is counting similarly to other organisations.

NA stated that it is helpful to include the transfers out of hours to PICU and HDU as this often signifies either poor planning during the day or significant pressure out of hours, this would be a good metric to include the detail regarding how the flow is being managed.

JG stated that she does have this data. JG alluded to the readmission and stated that this would be reviewed.

FB sought clarity from NA with regards to a follow up report. NA stated that Patient Safety Strategy Board are required to receive regular reports on the work regarding the Deteriorating Patients and Martha's Rule. SQAC would receive updates if needed, but would be routinely monitored via Patient Safety Strategy Board. would receive to SQAC should it be needed.

FB alluded to Marthas' rule and the response team making any judgements with regards to whether it is a risk regarding deterioration. FB sought clarity regarding how colleagues would know whether the correct decisions are being made and that the correct outcomes are being recorded. JG stated that she had discussed a set of metrics which would be established, and that the response team would be undertaking this in conjunction with other colleagues.

RP alluded to the invigorated Alder Hey Ethics and colleagues had discussed the cross over between acuteness of Martha's rule, the Clinical Case Support Service and the Alder Hey Ethics Service, and whether there is space for some signposting should the team decide that it is an acute immediate need and could be to provide a broader discussion of the clinical care of that patient more holistically if this is supportive to colleagues. JG stated this is extremely positive.
FB welcomed the suggestion and suggested JG and RP discuss this offline
FB stated that there are significant grey areas potentially regarding understanding choices, and ensuring parents are fully involved in the exploration and discussion/choices and advice/clinical opinion.

Resolved SQAC received and **NOTED** the Divisional updates and the deep dives regarding Patients deteriorating to critical care and the deep dive regarding the Trust approach to implementation of Martha's Rule.

24/25/67 *Well Led*
Responsive

Children in Care Policy
NO presented the Children in Care Policy, which is a Trust wide policy for oversight and management of Children in Care.
FB queried whether this Policy is drawing on national best practice, any approach is in relation to children in care. The statutory title is looked after children – all work set out standard
NO stated that the Policy is in line with statutory guidance in conjunction with local authority colleagues. NO advised that this Policy had been discussed at the Safeguarding and Statutory assurance group which is chaired by LC. NO stated that this policy had also been discussed within the Divisional Policies and Procedures sub group**.**

FB sought clarity regarding communication and next steps. NO advised that the Named Nurse for children in care which is a statutory role continually works with the relevant teams within the statutory service.
There are weekly teaching sessions and reflective sessions for staff who specifically work with this cohort of children in relation to the statutory health requirements, there would be ongoing work across the Trust. NO advised that part of the level 3 safeguarding training includes children in care and all of the statutory requirements regarding this.
The Named Nurse for Children had also been undertaking significant work regarding how the Trust should receive children in care, with ongoing work with admin staff as there had been some incidents with breaches regarding demographic information, as children in care attend appointments with foster carers and sometimes with their biological parents, with ongoing work to ensure that staff feel that they understand their roles and responsibilities regarding children in care.

GM sought clarity whether there is any linkage to the children in care councils that each Local Authority have and ensuring that there is cross reference. NO confirmed that the Trust had been undertaking significant work with social care partners regarding improving the communication between Alder Hey statutory service team and working with social workers, there are weekly meetings with each of the Local Authorities – Liverpool, Sefton and Knowsley to discuss each of the children referred in for specific statutory assessment work or for fostering and adoption advisor work.
Safeguarding team had been trying to strengthen links with corporate parenting boards.
Safeguarding Team have tried to engage with the Children in Care Councils, who have different names across the different Local Authorities. The Safeguarding had only been successful in engaging with the Sefton group. NO advised that there are some foster carers who are working with the Trust to strengthen the Trust approaches to meeting the needs of children in care, with ongoing work to strengthen communication channels, with success regarding the fostering service, particularly in Merseyside who are often in the atrium at Alder Hey. There is a lot of work to do to engage with the Children in Care Councils.

Resolved: SQAC, received, **NOTED** and Ratified the Children in Care Policy.

24/25/68 **Any other business -** None.

24/25/69 **Review the key assurances and highlights to report to the Board.**

- SQAC received a positive Patient Safety Strategy update. SQAC was pleased to note the clear progress and good documentation on the workstreams scrutinised in month.
- SQAC received the Quarterly IPC update with significant assurance received.
- SQAC received the Annual IPC update which provided significant assurance on Infection Prevention Control, IPC reports were extremely clear. SQAC received an update on the presence of IPC colleagues on the wards and strong attendance at Infection Prevention Forum, those aspects are working well. SQAC noted the ongoing pressures within the Infection Prevention Control team.
- SQAC received the ED monthly report: MH attendances and ED@its Best. ED continue to see high attendances, with challenges with regards to time to triage and time to clinical assessment. SQAC noted the ongoing work regarding heatmaps to address this issue. SQAC received an update on new work regarding PAU length of stay.
- SQAC received the Quarter 4 Safeguarding Report, SQAC noted the staffing pressures that the Safeguarding team had experienced. SQAC noted the focus being made on policies. SQAC noted the extremely high increase of MASH referrals into Alder Hey, SQAC agreed this would be kept under review with regards to the resources available to address this. SQAC acknowledged the good work by the team and good awareness within the Executive Team regarding the pressures that the Safeguarding team are experiencing.
- SQAC received and adopted the Merseyside Joint Agency Protocol Acute Life -Threatening Event (ALTE).
- SQAC received and adopted the Merseyside Joint Agency Protocol Sudden Unexpected Death Childhood (SUDiC) for Children aged 0 to under 18.
- SQAC received the Board Assurance Framework. SQAC noted the risks regarding Expanse referrals and the Risk with regards to ASD and ADHD regarding the availability of medication, with ongoing work with regards to this risk, with a view to having this as a stand alone Board Assurance Risk, given that the medication shortage is not going to be resolved imminently.
- SQAC received the Bi annual Aggregated Analysis Report, this was a clear report on the main themes and Trust performance in addressing and responding to the different kinds of reports, with assurance received.
- SQAC received the Quarterly Mortality Report/Mortality Annual Report with assurance received.
- SQAC received the Clinical Effectiveness & Outcomes Group Chairs Highlight Report with assurance received.
- SQAC received the Liverpool Neonatal Partnership Integrated Governance Report with relevant risks raised.
- SQAC received the Divisional updates and noted the very high risk relating to medicine/labs and noted that mitigations are in place to address this high risk, however this issue does remain a concern.
- SQAC noted the deterioration in performance regarding sepsis within the Medicine and Surgery divisions due to the absence of training package.
- SQAC received the Deep Dive into Patients deteriorating to critical care which was extremely useful.
- SQAC received the Trust approach to the implementation of Martha's Rule. Offline discussion would be held to ensure that this receives continued attention, SQAC recognized that this would become business as usual within the general committees and that SQAC would only receive details regarding concerns in the future.
- SQAC received, Noted and ratified the Children in Care Policy

23/24/70 **Date and Time of Next Meeting:** 19th June 2024 9.30 – 11.30 am via Microsoft teams

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

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

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during July/August 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 July and August 2024.

2. Current Position

2.1 Workforce Metrics

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

Key highlights from the workforce metric data:

Sickness-

The sickness absence target for 2024 is 5%, which comprises 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 set at 3%.

Sickness absence in July was 5.4% and above Trust Target of 5%, which is a slight increase from the previous month.

Sickness absence continues to be driven largely by long term sickness absence at 3.49%, with 2% 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 July was 10%, achieving Trust target. Retention initiatives are proving successful in reducing high levels of turnover, as Turnover has seen sustained reduction and achieving target each month. Turnover has remained at target since the start of 2024/25.

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. Compliance is being reported regularly to managers for action, via the Head of Learning and Development.

Total Workforce WTE

Total Workforce WTE (whole time equivalent) has become an increasingly prominent metric, both internally and externally with the ICB and is now reported in the IPR as one of the front three people metrics. 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 workforce efficiencies programme is also in place, reporting through SDG (as was), focusing on workforce spend and potential efficiencies for 2024/25. The measure is currently being broken down to a divisional level.

2.2 Agenda for Change Pay award.

The government have confirmed an uplift of 5.5% to the agenda for change payscale, to be paid in October 2024, backdated to 1st April 2024*.

In addition, from 1st April 2024, for those in band 8a-9 an intermediate pay point has been added 2 years into the band. This will also be paid in October and colleagues will automatically receive it where they have achieved the required pay progression in previous years.

The Senior Salaries Review Body (SSRB) report recommends an increase of 5 per cent for all ESMs and all VSMs in the NHS in England from 1 April 2024, which the government has accepted.

Consultants salaries to be uplifted by 6 per cent on a consolidated basis. SAS doctors salaries to be uplifted by 6 per cent on a consolidated basis. Resident doctors (doctors in training/juniors): a 6 per cent consolidated increase plus an additional consolidated uplift of £1,000 to all the pay points.
No uplifts in Local Clinical Excellence Awards (these remain frozen)

There is no automatic uplift to spot salaries or locally agreed payscales.

**There will again be an option for colleagues to spread the arrears over 6 months (the remainder of the financial year), which can be particularly beneficial to colleagues in receipt of universal credit. This offer will be communicated to across the Trust shortly.*

2.3 Industrial Action

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 19 August until 11.59pm on 15 September. The offer consists of:

- The Government will invest an average of a further 4.05% into 2023-24 pay scales for junior doctor (on top of the uplift already paid to total a cumulative uplift of 13.2% on average)
- For 2024/25, an uplift to each Nodal Point by 6% plus £1000, on a consolidated basis, with an effective date of 1st April 2024.

There are additional measures in the offer aimed at improving experience of junior doctors, including amendments to the exception reporting process.

The BMA's junior doctor committee in Wales have accepted the Welsh Government's pay offers after members voted in favour of the deals. Of note, there is an active dispute between the government and General Practice colleagues.

2 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. The measure is currently being broken down to a divisional level.
- Communication to be imminently issued in respect of the pay award, particularly the impact of arrears payments for some groups of staff.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 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 in relation to Equality, Diversity, and Inclusion (ED&I) during July/August 2024.

2. Supporting our Staff – Specific to the events following the tragic incident in Southport.

The response from Alder Hey staff during the tragic events that took place in August saw us all come together supporting each other through a very difficult time. Staff responded to the tragic events with care, compassion, and professionalism. Our Staff Advice and Liaison Service (SALS) took immediate action offering additional support and guidance to all our staff who were affected. The subsequent events that followed had a massive impact on our communities and some of our staff experience harassment and discrimination, feeling scared and unsafe. As an organisation we took immediate urgent action and came together to provide support to our staff, standing strong together. The REACH staff network was pivotal in helping the executive team coordinate support, ensuring staff had a space to share their worries and concerns. The team held two online safety and support listening sessions and one face to face session for staff. The REACH staff network arranged extra meetings for network members to come together to share their feelings and fears. We were able to gather information and resources to help staff who felt unsafe and needing support. We communicated our position regarding Zero Tolerance and will continue to ensure that we are clear in our approach towards any form of discrimination. We provided a manager briefing, offering information, guidance, and support to managers. As an organisation we all came together, supporting each other. Our executive team worked closely with our external partners to ensure that extra support was available for our staff if needed. This shocking incident has highlighted the need to ensure that robust support systems are in place and that our policies, processes, and actions continue to provide a safe and caring environment for all our staff.

3. North West BAME Assembly Anti-Racist Framework Update

In 2023 we committed to implement the North West BAME Assembly's Anti-Racist Framework. The framework is a tool designed to support NHS organisations to become intentionally anti-racist by tackling structural racism and discrimination through collaboration, reflective practice, and accountability. We recognise that our commitment to this journey will require continuous review of our progress and our intentional actions for change. The framework is organised into three levels of achievement: Bronze, Silver, and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

We are working towards applying the frameworks 5 key drivers:

0122
- **Leading from the front**: appointment of an executive/director level EDI sponsor with a commitment to advancing anti-racism
- **Anti-racism as mission critical**: we are currently developing an anti-racist statement in collaboration with the REACH staff network and members of the wider workforce
- **Actions not words**: setting and publishing one stretch goal that goes beyond legal or NHS assurance
- **We do this together**: demonstrate the progress we are making regarding reducing an identified health inequality. We have several projects which support this key driver which we can use as evidence
- **Zero tolerance**: communicating our zero-tolerance approach to racist abuse from service users or staff members. We will be launching our new and revised policy which confirms our position and the action we take in regard to any form of racist abuse.

Once we are confident that we have made significant progress and can evidence this we will apply to the assembly for bronze status, whilst continuing to work towards silver status. We hope that we can apply for bronze status at the next submission date which will be April/May 2025.

4. NHS EDI Improvement Plan progress update

In June 2023 NHS England introduce the NHS EDI Improvement plan. The aim of this plan is to improve equality, diversity, and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience. The plan prioritised six high impact actions to address the widely known intersectional impacts of discrimination and bias. We have mapped out our current progress against each success metric and identified further actions and opportunities need to ensure that we embed the improvement plan. We are making good progress and will continue to monitor our progress in relation to implementing each of the six high impact actions.

5. 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'.

- In July we took part in the Liverpool PRIDE march. It was a great event led by our LGBTQIA+ staff network and supported by our staff. We marched together with many of the Liverpool city NHS hospital Trusts. The staff network continues to work with the Head of EDI to ensure that we are working to achieve the recommendations agreed on receipt of the Navajo Charter mark. We continue to make improvements in this area and will continue to monitor our progress to ensure we are implementing the required recommendations to enhance the experiences of staff from LGBTQIA+ community.
- ACE - Disabilities and Long-Term conditions staff network have been actively working with HR to promote ESR, raising awareness of the importance of declaring disabilities on ESR. September will be the start of monthly HR & EDI drop-in sessions which will see the networking with HR colleagues to support

0123 staff, providing them with information about how to access ESR. The staff network has also been working closely with our HR business partners to provide feedback on policies and will become integral members of the Employment Policy Review Group. The members are currently examining the actions needed to progress Alder Hey to 'Disability Confident Leader'. Disability Confident has three levels that have been designed to support organisations: Level 1: Disability Confident Committed. Level 2: Disability Confident Employer. Level 3: Disability Confident Leader. Alder Hey is currently a Disability Confident Employer.

- Plans are being put in place for Remembrance Day service which will take place on Monday 11th November in the Atrium 10:30am – 11:30am. We will be joined by the local armed forces cadets who will support the event. The staff network has developed a workplan which they are working towards implementing, this includes the developed of a policy to support Alder Hey veterans, Service Leavers, and Military spouse/partners.
- The REACH staff network is holding a celebration event on Friday 30th August to mark the 1-year anniversary of the staff network. The celebration event will reflect on the progress made over the year and future. We are honoured to be joined by Michelle Cox. Michelle has 30 years' experience in the NHS, and 26 years as a registered nurse. 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 understandings around Equality Diversity and Inclusion ensuring that challenges are addressed, and learning embedded throughout NHS organisations. It came as no surprise to hear of Michelle's landmark win at an Employment Tribunal, February 2023, taking on her employer for race discrimination, harassment, victimisation, and detriments for whistleblowing. A fight she describes as a win for all global majority staff in the NHS experiencing discrimination. Michelle will share some of her experiences in relation to her lived experiences and how staff networks can have a positive impact on staff experiences. We will also be joined by 'Grace Wellness CIC Community Group' who will be sharing information regarding a project they are taking part it that aims to promote awareness of Sickle Cell disease and the need for more blood donations from Black communities.

6. Learning and Development

Our new EDI training has now been launched on the ESR system. This exciting training provides staff with bitesize modules related to EDI and these inclusive Active Bystander Training, Allyship, Anti-Racism, Microaggressions, Culture, to name a few. This exciting new training will be hosted on ESR and available to all staff. We have also launched Introduction to Equality, Diversity and Inclusion Course for Leaders and Managers. The latest Strong Foundations – Management Essentials offering for leaders and managers 'Introduction to Equality, Diversity and Inclusion' is now available for staff to book on to. An Introduction to Equality, Diversity, and Inclusion will allow leaders to consider the benefits of positive equality, diversity, and inclusion (EDI) action by embedding inclusive leadership practice, commitment to

promoting equal opportunity and fairness. We have co-produced the training with our Staff Networks to ensure we are acting on their lived experiences and developing strategies to improve staff experience based on their valuable insight.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
August 2024

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Wellbeing Guardian: Dashboard**
Report of:	**Wellbeing Guardian**
Paper Prepared by:	Jo Revill, Jeanette Chamberlain, Jo Potier and Sarah Robertson

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Paper presented to the Board
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:	None

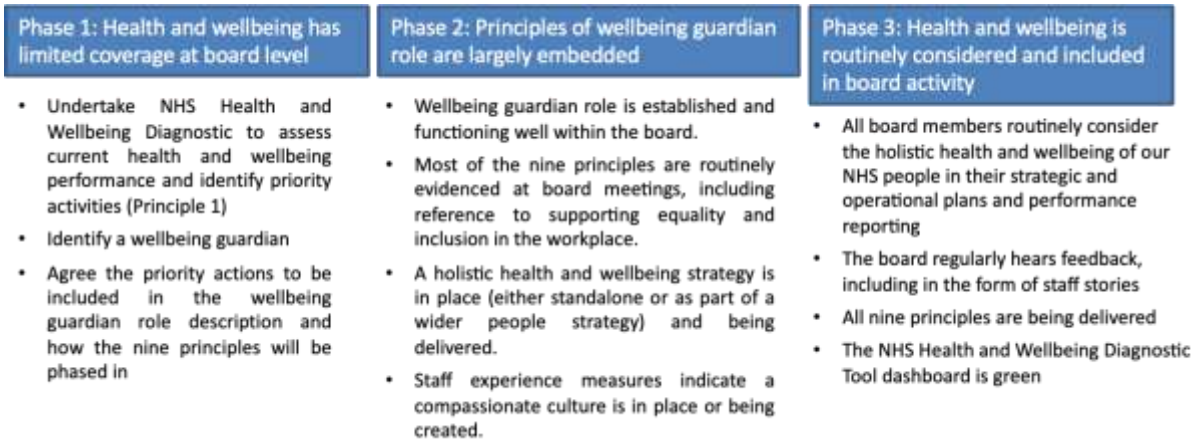
1. Introduction

This paper is an update to the Board by the Wellbeing Guardian on the current progress of the Wellbeing Guardian Nine Principles with the action plan attached to this paper.

2. Background

The Wellbeing Guardian (WBG) is a Non-Executive Director who:

There are nine Board principles supported by the WBG and the recommended approach to implementation is:



Alder Hey's appointed WBG, Jo Revill, is working with SALS, Organisational Development and HR to advance and oversee the implementation of the nine Board principles. The Board was previously advised that the NHS Health & Wellbeing Diagnostic had been completed for Alder Hey, and the Board formally approved the priority actions and the move to Phase 2 of implementation.

The Wellbeing Steering Group created a Dashboard to summarise the action plan for the nine principles supported by the WBG, which was initially presented to the Board at its meeting on 29th September 2022. The attached version of the Dashboard for September 2024 demonstrates the good progress that has been made to implement the nine principles of the Wellbeing Guardian.

PAWC will monitor the Dashboard and action plan, as we are moving into Phase 3, with the aim of approving the of implementation of the nine principles of the Wellbeing Guardian.

Attached to this summary is the current action plan and next steps that the team are currently working on.

The Board is therefore asked to:

(i) Note the actions and
(ii) Approve the current action plan and comment where required.

Health & Wellbeing Strategic Group

	Wellbeing Principle Description	Currently in Place	Initiatives	RAG	Progress	Next Steps	Lead(s)
Principle One	The health and wellbeing of our NHS people and those learning and working in the NHS should not be compromised by the work they do for the NHS.		Development of SALS PALs Network, we now have over 100 SALS Pals. Strengthening me session offered to teams to support awareness of mental health. Lunch and learn in mental health offered. Attending Trust briefings. 7 minute briefings shared. Revised and reviewed intranet.		SALS Pals project completed and reported back via PAWC. Next phase of SALs PALS to be launched with meetings with each divison planned for a rollout across the trust of SALS Pals.	**The Staff Advice and Liaison Service embedded within organisation. Network of SALS Pals now within the Trust (101 trained SALS Pals). SALS Pals only funded for a period of time by NHSE & next steps include going out divisonally to talk about next steps to deliver SALS Pals across the organistion. Paper signed off at PAWC.**	**SALS**
Principle Two	Where an individual or team is exposed to a particularly distressing clinical event, board time should be made available to assure the board and the wellbeing guardian that the wellbeing impact on those NHS staff and learners has been checked.		Debriefing SOP developed and shared. Debriefing after traumatic clinical incidents. Reflective practice spaces being offered to teams that request it. Major incident response plan has now been developed.		Jo Potier is part of the Patient Safety Board to help drive and inform how we support staff through distressing clinical events. Good links and visible Freedom to speak up Guardian who also is approachable in terms of supporting staff through difficult incidents. Evidence of this includes recent response to the Major Incident where there was a comprehensive trauma informed staff support plan implemented to ensure that the wellbeing of all involved directly and indirectly were checked in on and attended to.	**Jo Revill to pick this up in terms of Board Time for this item**	**SALS/Jo Revill**
Principle Three	Regular assurance will be provided to the wellbeing guardian to ensure that wellness induction (previously wellbeing 'check-in') are being provided to all new NHS people on appointment and to all learners on placement in the NHS, as outlined in the 2019 NHS Staff and Learners' Mental Wellbeing Review's recommendations.				Health and Wellbeing Conversation for New Starters has been devised, and developed. This forms part of the new induction policy which has now been ratified at PAWC. We have also developed a Health and Wellbeing Conversation around Menopause which is part of the menopaise policy & the PDR paperwork has a Health and Wellbeing conversation Attached. Physical health and workstream progressing. Menopause Support group	**Complete.**	**Jeanette Chamberlain/Darren Shaw**
Principle Four	The wellbeing guardian will receive assurance that all our NHS people and those learning in the NHS have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.				Staff can be referred to Occupational Health by their Line Managers and also make a self referral	**No futher action**	**Occuapational Health/H&W forum**
Principle Five	The death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.e death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.		Reviewed NHS Employers postvention guidance and toolkit shared within SALS and HR.		National Postvention toolkit to be shared within the organisation which would guide us in the event of a death by suicide. A local Alder Hey guide will be written to support postvention intervention within the Trust. Bespoke work from SALS/OD around National Suicide Prevention day in 2024.	**Local Guidance to be written**	**Jo Potier/Sarah Robertson**
Principle Six	The NHS will ensure a supportive, safe environment to promote psychological and physical wellbeing		Health and Wellbeing Forum brings together all starff involved in Staff Support across the Trust to collaborate and share ideas. Forum also includes leaders from the Trust enabling initiatives to be shared aross the Organisation. Staff networks well established and promoted within the Trust. SALS available for staff to access for emotional support, also supported by a network of SALS Pals. Collaboration between OD/SALS and Clinical Health Pyschology to develop a debriefing SOP which is now used in terms of suporting any teams who need additional support following distressing or traumatic events. Patient Safety Board established to ensure staff are supported through difficult incidents and events that may occur.		Established wellbeing forum which is well attended within the Trust, which is developing a staff support handbook to support staff accessing the right support at the right time. Staff are able to access a range of support including SALS. Debriefing SOP implemented and teams are able to request and access support when required. Patient Safety Board is now established and staff safety considered as part of this.	**Ongoing**	**Wellbeing forum which all staff involved in staff suport and wellbeing attend.**
Principle Seven	The NHS will ensure that the cultural and spiritual needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.		EDI lead in post and overseeing several of the staff networks which all look at promoting the spiritual and the cultural needs of our organisation.		Evidence can be collated, reviewed and enacted, via staff survey, EDI, WRES data. Staff networks are now established. Strong Foundations focusses on cultural and spiritual needs of the organisation. Partnership working between all areas of staff support across the organisation, including networks, chaplaincy, EDI lead, SALS, OD, HR to ensure inclusivity.	***EDI lead now in place and making good progress in establishing networks as well as a EQI Board of which Jo Potier attends.***	***EDI/SALS/OD***
Principle Eight	The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).		EDI lead to input. REACH network developed and set up. Reasonable Adjustments Policy developed.		REACH Network developed.	**EDI lead now in place and making good progress in establishing networks as well as a EQI Board**	**(EDI lead/HR/SALS)**
Principle Nine	The wellbeing guardian will provide suitable challenge to the board to be assured that the organisation is working with system leaders and regulators, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment.		Evidence from Board here		Good progress, conversations flowing through to Baord level.	**No further action**	**WB Guardian to report**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	People Committee
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 17th July 2024, along with the approved minutes from 15th May 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

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:

- Looking after each other
- Creating a sense of belonging
- Learn and grow for the Future.
- Embrace new ways of working.

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 in terms of the cultural journey aligned to 2030.
- The Committee received the Trust Wide people metrics report which shows an overall stable position. Return to Work compliance remains challenging and there was positive recognition of progress relating to mandatory training.
- 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 Corrective Pay Report (average pay during annual leave) and noted the contents.
- The Committee received the Volunteering Report which shows a positive improvement in volunteering experience which has resulted in some permanent/temporary employment opportunities.
- The Committee received the Nursing Workforce Annual Report 2023/24.
- The Committee received the Health & Safety Annual Report 2023/24.
- The Committee received the Non-Clinical Claims Annual Report 2023/24
- The Committee received the Equality, Diversity & Inclusion Plan, showcasing good activity across the EDI networks. A new Chair has been appointed into the REACH network.
- The Committee received the Board Assurance Report and held a good discussion regarding the Risk Appetite on key risk.
- The Committee received and ratified the following policies for ratification: Security Policy and the Flexibility Working policy.
- The Committee received the LNC Minutes for information.
- The Committee received the EGC Minutes for information.
- The Committee received the EDI Steering Group Minutes for information.

3. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

People Committee
Confirmed Minutes of the last meeting held on 15th May 2024
Tony Bell Boardroom, Institute Building

Present:

Jo Revill	Non-Executive Director **(Chair)**	(JR)
Nathan Askew	Chief Nursing Officer	(NA)
Adam Bateman	Chief Operating Officer	(AB)
Garth Dallas	Non-Executive Director	(GD)
Erica Saunders	Director of Corporate Affairs	(ES)
Melissa Swindell	Chief People Officer	(MS
Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
Sarah Leo	Head of Research – Clinical Research	(SL)
Jo Potier	Associate Director of Organisational Development	(JP)
Katherine Birch	Director of Alder Hey Academy	(KB)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Chloe Lee	Associate COO – Surgery	(CL)

In attendance:

Kathryn Allsopp	Head of Operational HR	(KA)
Jill Preece	Governance Manager	(JP)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Alison Mellor	Workforce Systems & Information Manager	(AM)
Nicola Osborne	Associate Director for Safeguarding	(NO)
Sarah Robinson	Clinical Phycologist – CAMHS	(SR)
Gill Foden	Head of Learning & Development	(GF)
Phil O'Connor	Deputy Director of Nursing	(PO)
Rachael Pennington	Associate Chief Nurse – Surgery	(RP)
Clair Finnigan	Operational HR Manager	(CF)
Tommy Curran	Health & Safety Risk Assessor	(TC)
Jeanette Chamberlain	Staff Advice & Liaison Manager	(JC)
Audrey Chindiya	Finance Manager	(AC)
Angela Ditchfield	EDI Lead	(AD)
Darren Shaw	Head of Organisational Development	(DS)
Kerry Turner	FTSU Guardian	(KT)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Alfie Bass	Chief Medical Officer	(AB)
Sharon Owen	Deputy Chief People Officer	(SO)
John Kelly	Non-Executive Director	(JK)
Fiona Beveridge	Non-Executive Director	(FB)
John Chester	Director of Research & Innovation	(JC)
Urmi Das	Director, Division of Medicine	(UD)
Rachel Hanger	Associate Chief Nurse – Surgery	(RH)
Natalie Palin	Director of Transformation	(NP)
Jason Taylor	General Manager, Research	(JT)
Cath Wardell	Associate Chief Nurse – Medicine	(CW)
Julie Worthington	Staff Side Chair	(JW)
Pauline Brown	Director of Nursing	(PB)
Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
John Grinnell	Managing Director	(JG)

Jacqui Pointon	Associate Chief Nurse	(JP)
Clare Shelley	Associate Director of Operational Finance	(CS)
Maisie StJohn	Service Manager	(MSt)
Adrian Hughes	Deputy Medical Director	(AH)
Lisa Cooper	Director of Community & Mental Health Services	(LC)
Neil Davies	HR Business Partner	(ND)
Jacqui Lyons-Killey	Associate Chief Nurse – Research	(JLK)

23/24/001 **Declarations of Interest**

No declarations were declared.

23/24/002 **Minutes of the previous meeting held on 20th March 2024.**

The minutes of the last meeting were approved as an accurate record.

23/24/003 **Matters Arising and Action Log**

Action log was updated accordingly.

23/24/004 **Updated Terms of Reference**

MS introduced the Committee Terms of Reference now incorporating the changes discussed at the last meeting in relation to the Public Sector Equality Duty.

MS went on to inform colleagues that in agreement with the Chair, the Committee would be known as the 'People Committee' going forward.

Consideration would be given to include something explicitly around the Trust Values.

The Committee membership agreed all changes will be applied to the terms of reference document. **Action:** TJ to update.

Resolved: The Committee APPROVED the Terms of Reference and Work Plan for 2024/25.

23/24/005 **Monitor Progress against the People Plan –**

MS was pleased to report that the People Plan continues to progress and that some real improvements are now being seen in terms of our journey and how we think about our culture. There has been a positive shift in terms of the people metrics and how we are using data more effectively specifically in relation to experience. Conversations continue to take place across the organisation in terms of the continuing development (years 2 & 3) of the People Plan and a further update will be provided to June Trust Board.

Staff survey shows that generally staff are having a good experience.

Our Culture Evolution

JP introduced a presentation: 'Our Culture Evolution' outlining Alder Hey's culture journey which aims to achieve better consistency in our vision for both children and young people, and staff, in line with our 2030 Vision.

One of the main messages from the presentation was celebrating the things

we already do really well and being consistent in continuing to deliver these.

Attention was drawn to the gaps between the current state of play and achieving what we want for staff and Children and Young People in terms of their experience. An exercise would now be undertaken to re-visit our Values to ensure they are articulated and understood by our staff. Data in relation to safety culture would also be a key focus in this initial piece of work.

The Chair thanked JP for the clear and concise presentation which clearly demonstrates the huge amount of work ongoing and welcomed the 'consistency type' approach and links with the Trust Strategy.

KT asked what makes this approach different to what Alder Hey has tried before. JP stated this development strategy aims to provide a sense of 'showing' and 'not telling' piece of work to provide a sense of assurance and confidence. MS added this will be developed into how we launch this culture journey.

GD referred to the negative comments displayed within the presentation and asked for assurance on how we are ensuring people are being heard. MS commented she had met with Deputy Director of Communications & Marketing and Internal Communications Manager to formulate a plan and methodology on how we communicate with colleagues throughout the organisation to provide assurance so that everyone feels a part of this workstream. MS added, we have rich data that will give us enough analysis to ensure we communicate back to provide hope and assurance to showing a change is happening and continues to happen.

Resolved: The Committee noted the contents of the presentation.

Metrics development:

- **Staff Thriving Index**

DS introduced a report setting out the progress against developing a staff thriving index at Alder Hey to give an overall idea of staff wellbeing on a regular basis.
He explained that following a pilot on the proposed questions, the Thriving working group established to look at this workstream agreed to utilise the foundations of the 'Gallup Net Thriving' methodology that asks two questions on a scale of 1-10 to measure whole of life wellbeing, but instead expand to six questions to capture both working life and non-working life experiences.

The next stage of the process is to develop a more effective method of rolling the questions out by June 2024 to ensure it reaches all staff including all grades, staff groups and locations and is able to dynamically provide support to staff based on their responses.

KB welcomed the report and stressed the need to use this risk data effectively and trying to be proactive.

NA commented would be good to see this data over time and how we can

continue to impact our colleagues experience and have ways to support our staff in other ways. NA suggested might be good to see this as part of our divisional data to try and identify areas and reasons where thriving is lacking for a deeper understanding and to offer support.

This work is to commence in May, with the aim of releasing the questionnaire in June and providing the first set of data in July 2024.

- **Workforce Stability Metric**

KA introduced a report which provided an overview of the new workforce stability measure developed as part of the work on the People Plan.

She explained that workforce stability will be reported from April 2024, and it is recommended for the first 12 months that a target is not attached to the metric.

23/24/006 **Monitor Progress against the People Plan**

- **Divisional Metrics**

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (April 2024). RG highlighted the following key points:

- Sickness has seen a continued reduction sitting at 4.7% overall and 3% for long term sickness absence.
- Return to work compliance has increased in-month and continues to make good improvements.
- Turnover remains stable at 12% - improved.
- PDR compliance rate reports 89% with continued focus on ensuring deadlines are met.

Divisional Leadership sessions continue to take place supported by HRBPs and Deputies.

Resolved: The Committee received and noted the contents within the report.

Medicine

The Committee received the Medicine Division metrics report (April 2024) data and noted progress to date. SC highlighted the following:

- Sickness reported 4.4% which shows an improvement for short- and long-term sickness. Senior Leaders continue to work with HRBPs to ensure colleagues are supported to remain in the workplace.
- Time to Hire has increased and continues to recruit to fill gaps across services. A deep dive is being conducted to explore all data and provide the committee with a further update at the next meeting.
- PDR compliance was just below target at 86%. All areas are given

expectations and continues to be monitored regularly.
- Big Conversations continue to take place throughout the organisation in connection to the Staff Survey to showcase impact and actions taken.

The Medicine Division is working to align Health & Wellbeing into service provisions and continues to be incorporated.

Resolved:
The Committee noted the divisional metrics for the Medical Division.

Surgery Division

The Committee received the Surgery Division metrics report (April 2024) data. CL highlighted the following:

- Turnover remains static and below target with no particular themes identified for staff leaving.
- Sickness was reported at sitting below trust target at 5.1%. An increase in short term sickness was reported with a focus on hot spot areas. Long term sickness was reported at 3% showing significant improvement.
- In terms of return to work, a new process has been established in respect of weekly return to work meetings for Nurses and AHPs which has shown an improvement in terms of compliance. Senior Leaders continue to identify areas with gaps and monitor accordingly.
- Mandatory Training remains above trust target and continues to be stable.
- PDR Compliance remains above target at 91% on 30 April 2024. Senior Leadership continue to run sessions with the Senior Nursing Teams.
- Staff survey big conversations are underway within the Division.
- Theatres: Plastics experienced various challenges of gaps in establishment which continues to be controlled through the divisional board. Sickness and return to work show improvement and continues to be monitored.

CL went on to report that the Division had established a People Committee which had been very well received. The forum will be used to relaunch some of the previous programmes, initiatives, and celebrations for staff.

AC commented on the reduction in sickness absence within the surgical division which was having a positive impact financially.

A conversation ensued regarding the positive proportion of BAME staff in the surgical workforce, but it was noted that this was a particularly high figure due to the targeted international nurse recruitment which takes place annually.

KT challenged the continuously low return to work position across all divisions and talked about the benefits of these conversations for colleagues owho sit within the disability groups. In response to a question around this being a potential system issue, KA responded that she felt the process was minimal but offered support if needed.

Resolved: The Committee received and noted the contents within the report.

Clinical Research Division

The Committee received the Research Division metrics report (April 2024) data and noted progress to date. SL highlighted the following:

- Return to work showed 100% compliance.
- Sickness absence was reported at 2%– senior leaders continue to manage.
- PDR compliance remains in a good place sitting at 97% overall.

Clinical Research will hold a Divisional Big Conversation event in June 2024 supported by the Brilliant Basics Team. Details will be feedback to the committee and details of the event will be shared accordingly.

Resolved: The Committee received and noted the contents within the report.

Corporate

The Committee received the corporate metrics report (April 2024) data and noted progress to date. ES highlighted the following:

- Sickness shows a slight increase compared to the previous month reporting at 6.1%. Plans are in place to manage both long and short term sickness absence and remain standard agenda items at the Corporate Services Collaborative in order to understand the rise.
- Return to work compliance remains steady and continues to be monitored.
- Mandatory Training was sitting at 93%. ES referred to the 'hard to achieve' topics which remain a focus and continues to be monitored and managed accordingly. Bi-monthly deep dives have now been scheduled into the workplan for the Corporate Services Collaborative.
- PDR compliance (95%) continues to see an increase in reporting figures.

The next Corporate Services Collaborative Meeting will take place in May 2024.

Resolved: Committee received and noted progress made to date from each division.

GD referred to the overpayments displayed across departments which continues to be well managed and added good to see that data and formally thanked all areas.

Trust Wide Metrics

The Committee noted the contents of the trust metrics containing April's data.

23/24/009 **Freedom to Speak Up**

The committee received the Freedom to Speak Up report and noted the contents. KT highlighting the following:

- Annual activity has increased over the last year. In terms of themes of concerns, they relate to policies and procedures and attitude and behaviours, these are consistent with the national picture and will remain a focus. Inapposite attitude and behaviours will be monitored.
- Staff Survey showcased 26% of colleagues do not feel safe to raise concerns and 34% reported not feeling confident concerns will be addressed. Colleagues continue to raise concerns through FTSU in confidence and data will continue to be monitored accordingly.
- The FTSUG Visibility Programme remains ongoing with development and is making good progress with good conversations being held with managers around the role of the service.
- The MIAA Audit of the FTSU service received an overall assessment of 'substantial assurance' and received 5 recommendations which are actively being addressed.
- FTSU champions continue to play a key part to help support and promote the principles of FTSU. Recruitment remains ongoing to ensure they are reflective of our organisation's diverse population.
- The FTSU App remains in development stage to implement a private and secure way of raising concerns that allows this to happen anonymously supported by the Innovation Team. Work remains ongoing to launch the InPhase module.

Next Steps:
A Deputy FTSU Guardian role will go out to advert in due course which is a new role that will work closely alongside with the FTSU Guardian.

The Chair was encouraged by development of the FTSU App and the Committee looks forward to seeing this feature progress and go live. GD referred to the 28% of staff who do not feel safe to raise a concern, but this is acknowledged and supported through the EDI network chairs perspective.

Resolved: The Committee noted the progression of all developments which remains on course.

23/24/010 **Internal Communications Update**

The Committee received the Internal Communications Update and noted the contents. JF drew the committee's attention to the following:

The launch of Vision 2030 has been a key focus during the last six months consisting of new posters and reinforcing digital resources launched to increase communication and spread awareness. A repository is available for staff on the intranet.

Alder Care has introduced the "you said" "we did" to create and show a sense of change is happening and teams continue to explore better ways of engagement.

In partnership with HR colleagues, the Communications Team have delivered a recognition campaign for retirements during 2024.

The Chair thanked JF for the detailed report which showcases good efforts of change is happening within Alder Hey. JR asked for assurance on measuring engagement

levels to help track data analysis to identify the elements where colleagues need the most support as part of our awareness and oversight. JF stated that there are variety of analytics that are measured regarding staff interaction. A harder to measure area is whether or not staff are reading emails containing key messages, but this is work in progress.

Resolved: The Committee noted the contents of the Internal Communications report.

23/24/011 **Sexual Safety NHS Charter**

The Committee received the Sexual Safety NHS Charter and noted the contents. NS drew the committee attention to the following highlights:

In November 2023 Alder Hey agreed to sign up to the Sexual Safety NHS Charter which commits to a zero-tolerance approach for unwanted or inappropriate sexual behaviour towards our workforce.

NS reminded colleagues that this year's NHS staff survey included a question relating to whether colleagues had experienced any unwanted behaviour of a sexual nature in the workplace which resulted in 1% of our staff reporting that they had. A further deep dive into that 1% will be explored to identify any themes.

In addition, a working group has been formed with extended invitations to include all Nursing, Governance, SALS and HR colleagues with a comprehensive action plan to ensure assurance is given and oversight is captured.

The Committee discussed implementing a new standalone Policy outlining our commitment to sexual safety and after some discussion agreed to incorporate sexual safety into our existing policies ensuring all points are captured and highlighted accordingly.

Work was ongoing with communications around acceptable behaviours in the workplace.

Action: NS confirmed further work will be undertaken to incorporate sexual safety into relevant workforce policies with a view to reviewing its effectiveness and feedback to the Committee for assurance and oversight.

Resolved: The Committee received and noted the Sexual Safety NHS Charter Report.

23/24/010 **Workforce Equality, Diversity & Inclusion Annual Report 2024**

The Committee received the Workforce Equality, Diversity and Inclusion Annual Report and noted the contents. AD highlighted the following achievements:

Significant progress over the last 12 months particularly in relation to the WDES/WRES, staff survey and gender pay gap. Forward planning will involve impacted actions and achievements.

The Chair commented good to see the achievements being made and is set out well in terms of reporting.

Resolved:
The Committee received and acknowledged the Equality, Diversity and Inclusion Annual Report and noted progress to date.

23/24/011 **DBS Update**

The Committee received the DBS Update and noted the contents. KA highlighted the following for the Committees attention:

- The Recruitment Team continues to undertake 3 yearly checks on all DBS records for colleagues who are employment at Alder Hey.
- Alder Hey's current position reports at 95% compliance. Additional capacity has been put in place to ensure completion rates are stable when conducting data analysis.
- Challenges remain in certain areas due to minor errors of dropping off the system and needing to opt back – all teams acknowledge and there are plans in place to address and manage.

Alder Hey continues to push forward for completion of as many checks as possible to ensure assurance across the organisation's all checks are obtained and updated on our reporting system for each individual employment at the organisation.

The Chair welcomed the detailed overview and assurance that all checks are obtained and dealt with securely and timely.

Resolved:
The Committee received and acknowledged the DBS update and noted progress to date.

23/24/012 **Committee Annual Report 2023/24**

The Committee received and noted the content of the Annual Report which details the huge amount of work the Committee has undertaken.

KB suggested that education and development to feature more going forward. JR agreed to pick this up outside of the meeting in terms of assurances coming through to the Committee.

23/24/013 **Board Assurance Framework – monitoring of strategic workforce risks.**

The Committee received and acknowledged the Board Assurance Framework Report.

No BAF risks relating to workforce were rated 15 or above.

EDI Risk will undertake a further review and discussion on how to manage and maintain.

Resolved: The Committee received and noted the Board Assurance Framework

Alder Hey Children's NHS Foundation Trust

23/24/014 **Risk Appetite**

The Committee received the Risk Appetite presentation. ES drew the committee's attention to the following:

ES reminded colleagues that the Trust Board had set appetite statements in 2021/22 applying tolerances against different categories set by the Good Governance Institute.

The risk appetite levels for workforce/people risks were:

Workforce - sustainability	MEDIUM (10-12)
Workforce - EDI	MEDIUM (10-12)
Workforce - culture	MEDIUM (10-12)

Work had been undertaken to define risk descriptors for the workforce/people categories which had not already been defined, the Committee was asked to consider if these were appropriate along with the suggested tolerances.

ES reminded colleagues of the theory behind setting risk appetite levels being that should the risk fall below the set appetite level, it can be closed.

Next Steps:
The Risk Appetite will be submitted to ARC in July 2024 then put forward for Trust Board submission in September 2024.

Action: The Chair asked the Committee members to review the contents and feedback to ES within 3 weeks for comments / approval prior to Board submission.

Resolved: The committee noted the contents of the Risk Appetite presentation.

23/24/015 **Policies for ratification**:

- **The Induction Policy**

The Committee received the Induction Policy which has been recently updated in accordance with the policy renewal date. An overview had been submitted to the Committee detailing the suggested changes for assurance and oversight.

Resolved: The Committee APPROVED the Induction Policy

- **Medical Staff Covering Absent Colleagues & Vacancies Policy**

The Committee received the Medical Staff Covering Absent Colleagues & Vacancies Policy which has been recently updated in accordance with the policy renewal date. An overview had been submitted to the Committee which had previously been through the Local Negotiation Committee and MIAA colleagues.

Resolved: The Committee APPROVED the Medical Staff Covering Absent

Colleagues & Vacancies Policy.

23/24/016 **Health & Safety Committee (HSC) Minutes**

The Committee received the approved minutes of the HSC meeting held on (January 2024)

23/24/017 **Joint Consultative and Negotiation Committee (JCNC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on (March 2024)

23/24/018 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the JCNC meeting held on (February 2024)

23/24/019 **Any Other Business**

No further business was raised.

23/24/020 **Review of Meeting – Chair's Report to Board**

Terms of Reference:
The Committee Approved the terms of reference document.

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 April's reporting data and continues to be monitored.

Mitigation remains in place to review manage and maintain.

Policies for Ratification: APPROVED
The Induction policy
Medical Staff Covering Absence Colleagues & Vacancies Policy

The Chair noted good progress being made across all areas.

Date and Time of Next meeting
Wednesday 17th July 2024 at 2pm via MS Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Re-appointment of Trust Chair and Well Led Assessment**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Governance Manager Director of Corporate Affairs

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Guidance for NHS trusts and foundation trusts: assessing the well-led key question.
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
BAF 2.1	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.					3x4
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Alder Hey Children's NHS Foundation Trust

Well-Led Assessment – Assurance Report

1. Executive Summary

The Board will be aware that Trust Chair, Dame Jo Williams' current term of office comes to an end in February 2025. Dame Jo was re-appointed as Chair at Alder Hey in 2022 for a second three-year period having originally taken up the post in 2019.

Under the NHS Foundation Trust Code of Governance (provision C.4.3) *'Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be* ***subject to rigorous review****.*'

Dame Jo has formally confirmed her intention to seek re-appointment for a final twelve-month period, to February 2026.

The purpose of this report is to provide assurance to the Board and to NHS England in respect of the Well Led Framework jointly issued by them and the CQC to support Dame Jo's reappointment.

2. Well Led Framework – Performance Evidence

Board Leadership
The Board's current composition demonstrates an exceptionally good balance of skills with a broad range of experience highly relevant for delivery of the 2030 Strategy. The Trust's Strategy reflects the wider local and national context and is underpinned by a robust plan for its delivery supported by appropriate governance arrangements and clear accountability for each component of the delivery plan.

Structures and processes are in place to support effective decision making at Board level and below, as well as active collaboration with other providers to tackle shared challenges. All assurance committees undertake an annual review of its effectiveness against their terms of reference which are reported to the Audit and Risk Committee by way of assurance that there is a robust system of internal control.

The Board exercises effective and visible leadership, including clinical leadership, across the Trust through a variety of mechanisms including Quality Assurance Rounds, key committees, corporate governance and communications and programmed visits.

All Directors continue to declare that they are Fit and Proper and meet the fundamental standards required to perform the decision-making functions of a Board Member. This year, the Board have considered the six competency domains within the new Leadership Competency Framework further supporting the Fit and Proper Person assessment for individual Board Members.

How does the Board manage risk?
The Board have a collective understanding of the strategic risks that may affect the delivery of Vision 2030. Non-Executive Director Committee Chairs utilise the Board assurance Framework (BAF) to drive the agendas and for decision making where appropriate. Risks to delivery of the

2030 Strategy are clearly articulated in the Board Assurance Framework which is received by the Board and its assurance committees each month along with annual deep dives into each of the BAF risks. Non-Executive Directors present constructive challenge in terms of gaining assurance on the progression of actions taken to address any gaps in controls and ensure that quality of care is sustained.

The Trust has a robust financial governance framework and actively engages with system partners to support delivery of system-wide financial balance. Dame Jo has elected to join the Trust's Finance, Transformation and Performance Committee at the current time in recognition of the financial challenges faced by the Cheshire and Mersey system.

Non-Executive Director Accountability
The Non-Executive Directors are held to account individually and collectively for the performance of the Board by the Council of Governors. During the year, a bespoke face-to-face training session was facilitated for the Trust's governors by NHS Providers which focused on accountability and holding to account, ensuring governors are equipped with the skills and knowledge they require to hold the Board to account. Training and development opportunities remain flexible and responsive to meet the needs of the governors.

Governors are actively encouraged to observe Board Meetings and are aligned to specific assurance committees and again, encouraged to attend where possible to allow them to gain a better understanding of how Non-Executive Directors hold the Executive to account in terms of the process of challenge, support and scrutiny. Board papers are routinely made available to the Council of Governors.

Executive and Non-Executive Directors attend the Council of Governors' meetings and report on the work of their committees and the Chair and Chief Executive report on the Trust's performance and on key strategic and operational issues and developments. This ensures that the agendas of the two bodies remain closely interlinked and appropriate decisions taken by each in accordance with its Standing Orders.

Dame Jo holds regular informal meetings with governors and provides them with a written briefing after each Board meeting. This presents the opportunity for governors to ask any questions or raise any issues in a timely way. Feedback from the Chair's appraisal is that she actively encourages interaction between the NEDs and the Council and ensures all voices are heard, taking great care not to dominate and that she facilitates a collaborative and collegiate environment.

3. Chair's Appraisal

In line with the latest guidance from NHS England, a range of key stakeholders were invited to contribute to Dame Jo's appraisal for 2023/24 against the components of the NHS Leadership Competency Framework.

The volume of positive comments was immense and they were by any measure, exceptional. The main themes that emerged were around the Chair's personal style; leadership style; ability to maintain strategic focus and engage in constructive challenge; visibility and accessibility and advocacy for children and young people, particularly within the complexities of the wider system.

Dame Jo's most recent appraisal describes her as:

- An inspirational leader, chair and role model who has the ability to balance strategic and operational issues ensuring that the organisation's focus remains on children and young people and their families.
- Someone who cares deeply about staff and their wellbeing and who leads with compassion, gravitas and integrity, encouraging a just and safe culture in which to raise concerns freely.
- Not afraid of making difficult decisions.
- Having a huge impact within the system and has become increasingly influential locally and nationally in ensuring the children and young people's agenda is prioritised.

- One who sets the right tone and culture for the organisation and is said to exemplify NHS values.
- A fantastic and powerful advocate for Alder Hey, children and young people, children's services and for championing the inequalities agenda.

Where areas of development were provided by respondents, they were not fundamental weaknesses nor suggested changes to Dame Jo's approach, but enhancements to her existing leadership skills.

4. Conclusion

From the evidence above and Alder Hey's overall performance both in terms of financial 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 deliver as an organisation, but how it is delivered.

5. Recommendation

The Board is asked to note the evidence and position against the well-led framework and Chair's Appraisal documentation in support Dame Jo Williams' reappointment.

Erica Saunders
Director of Corporate Affairs

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Chair's Report from the Audit & Risk Committee (ARC) meeting on 11 July 2024**
Report of:	**ARC Chair**
Paper Prepared by:	ARC Chair

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action / Decision Required:	To note ☑ To approve ☐
Summary / supporting information	ARC minutes and papers from the meeting that took place on 20 June 2024
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐
Resource Implications:	None

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board and provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

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

The main focus of the July meeting is risk management and oversight of key risks. ARC received the following documents / updates:

- Presentation of risk management within Community & Mental Health Service (CAHMS) including Gender Development Service risks
- Update on introduction of Risk Appetite and Tolerances
- Board Assurance Framework
- Update from the Risk Management Forum including the Corporate Risk Register
- Trust Risk Management Report
- Quarterly reports from on Data Protection Act and Freedom of Information Act delivery and compliance
- Third Party Assurance Report – ELFs Payroll Service
- Annual Assurance Reports and Forward Plans for Clinical and Non-Clinical Claims
- Forward Plan on Implementation of Phase 2 of InPhase
- Update on Shareholders Register
- Update on Action Plan for Property Valuation Processes
- Conflicts of Interest Policy (for approval)

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

None.

4. Positive highlights of note

The Committee received a presentation from the Director for CAHMS on the development of BAF and operational risks for the Gener Development Service.

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Finance, Transformation and Performance Committee
Confirmed Minutes of the meeting held on Monday 24th June 2024 at 13:00, Via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	(SA)
	Dame Jo Williams	Non-Executive Director	(JW)
	Adam Bateman	Chief Operating Officer	
	John Grinnell	Managing Director / CFO	(JG)
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nurse	(NA)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Jane Halloran	Acting Deputy Development Director	(JH)
	Emily Kirkpatrick	Deputy Director of Finance	(EK)
	Andy McColl	Deputy Director of Finance	(AMC)
	Natalie Palin	Associate Director Transformation	(NP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item: 45	Ellen Mathews	Head of Performance	
48	Katie Tootill	Chief Procurement Officer	
48	Richard Jolley	Head of Procurement	
51	Alex Pitman	Green Project Director	
52	Graeme Dixon	Head of Building Services	

24/25/38 **Apologies**

Apologies were noted from:
Melissa Swindell Director of HR & OD

24/25/39 **Minutes from the meeting held 23rd May 2024**

The minutes were approved as a true and accurate record.

24/25/40 **Matters Arising and Action log**

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

The Chair asked for an update in relation to community and mental health metrics. KW advised the teams are working through the details and this will be presented at a later FTPC.

24/25/41 **Declarations of Interest**

There were no declarations of interest.

24/25/22 **Top 5 Risks**

1. **Immediate financial performance including system position (RAG HIGH)**

M2 reported inline with plan, following an opportunity to reprofile CIP plans and resubmit. C&M are also on plan due to reprofiling and resubmitting plans.

For C&M the agreed Year End Position is £150M deficit target.

A Divisional forecast was carried out at M2 due to the challenging year ahead. Risk came out as around £3.5m, this would mean a breakeven position rather than the surplus agreed. Divisions have now been tasked to see if any cost reduction schemes can be brought forward. RL went through a number of risks that have not yet been fully tested with plans on them being carried out over the next few months.

A discussion was held on the quarterly divisional FTPC's being useful to see how divisions are progressing. JG noted the importance of the Quarter 1 check in and using this month to identify further opportunities. RL noted a number of opportunities that have been discussed i.e. looking at discretionary spend.

RL noted that alongside the Divisional update next month an overall Trust position would also be included.
Action: RL/EK

2. **Capital Programme (RAG HIGH) –**
Following a review of the above risk it was now RAG rated as high due to capital reporting. RL provided further detail noting capital plans had been included in 23/24 accounts, following the external audit a request has been made to take this out as there is not enough evidence to support, this is largely in relation to the eating disorder scheme.

RL noted from M3 further detail would be included in the Capital report clearly stating any slippage within schemes.
Action: EK

3. **Efficiency Programme (RAG HIGH)**
Plan for delivery is £19.3m forecast is currently £12m recurrently. Work continues to look at reducing gaps that are not recurrent.

4. **Benefits realisation, governance and prioritisation of change programme to 2030 (RAG MEDIUM)**
The Chair's report from the 2030 Programme Board Meeting,13 June 2024 had been included with the pack. NP noted one of the main challenges currently is looking at the current position whilst also trying to achieve a long term plan.

JG said it would be helpful to see where programmes are in terms of at the beginning or nearly completed.

5. **The campus & Park developments (RAG MEDIUM)**
An update on the programme would be received under the agenda item.

24/25/43 **Finance Report**

Month 1 Financial Position

M1 reported a £0.7m deficit in May (M2), and £1.8m deficit year to date which is on plan. This is largely due to the reprofile of CIP (£385k), following an opportunity to re-submit the plan in June.

Income is £0.8m ahead of plan due to consultants pay award, LNP expected commissioner payments, drugs & devices above plan usage, and R&D income. ERF income is marginally above plan YTD.

Pay is £0.2m ahead of plan due to vacancies and an ongoing reduction in temp spend due to improved sickness rates within the clinical divisions. However, historic pressures have continued, specifically within HCA 1-2-1, Junior doctors, High Dependency Unit (HDU) and Critical Care nursing, Theatres and non-delivered CIP.

Non Pay is £1.3m behind plan with c.£0.5m largely offset by income, however, inflationary pressures have continued within drugs, clinical supplies , Theatres and non-delivered CIP continue to be drivers of the adverse position.

In month Divisional performance continues to be varied with Surgery and Medicine reporting a deficit position largely due to temp spend and non pay pressures. The Community division continues to be in surplus due to vacancies.

The Chair noted the change from the end of 23/24 in surplus to the beginning of 24/25 deficit. FTPC agreed going forward details of the underlying position would be useful.
Action: EK

DJW asked for details on progress against the 1:1 Health Care Assistant programme. NA advised that the programme is currently being supported with bank staff, in line with 2030 vision to reduce the number of bank staff this is under review.

Resolved:
FTPC received and noted the M2 Finance report.

24/25/44 **Month 1 Integrated Performance Report**

AB highlighted the following challenges:
Junior Doctor Industrial Action starts on Thursday, 170 out patient appointments have been rescheduled as well as 40 operations.
In relation to night Laboratory cover has been reduced having an affect on activities that can be carried out.
Performance:
ADHD and Neurodiversity both have long waiting lists particularly ADHD due to the medication shortage. AB went through a number of options being reviewed.
Follow up pilot is due to start contacting patients ensuring appointment is still needed.
52 week waits biggest areas are ENT and Dentistry. Approval has been given to increase capacity in both areas with plans for this to be cleared by March 2025.
Number of patients are waiting over 65 weeks in these area, a recovery plan has been agreed for these patients to have been seen by September 2024.
Positive:
ED performance remains high. Working through plans for ED to be disturbed as little as possible during Neonatal build.
Virtual Ward is being used and is receiving positive feedback.

SA asked for detail on sleep studies declining within the month. AB advised this comes under diagnostics to be performed under 6 weeks. Options including performing further tests are being looked into.

Resolved:
FTPC received and noted the M2 Integrated Performance report.

24/25/45 **Productivity Dashboard**

Ellen Matthews gave a presentation on the revised draft Productivity Dashboard providing data from the current financial year compared with 2019/20. FTPC were asked if the right metrics were being provided.

SA asked for details on cost per staff. EM advised this was a subtraction on the WTE. AMc advised that inflation hasn't been included at this stage.

Divisional productivity slide was shared with FTPC.

Next steps included:
Looking at other options for data other than SLAM.
Review Staff in posts as currently not included.
Divisional deep dives.
SA said the WTE increased by 28% vs 27% for clinical noting it would be good in the future to see the areas broken down. FTPC noted this was a first draft and further detail would be included in future versions.

JG queried that FTPC is content with measures and achievements being looked at.

DJW said for external purposes following the external hospital standards would be required.

Resolved:
FTPC received and noted progress to date against the Productivity Dashboard.

24/25/46 **Campus update**

JH highlighted areas completed or close to as:

- Draft to be returned from SPV on Neonatal project with final agreement to take place in September 2024.
- Confirmation to be received this week on occupying the first floor for Gender Development service at Warrington.
- Park football pitches drainage has now been completed.

JH noted project delays including the challenges.

JK asked if there are any updates in relation to the nursery. JH said there have been some delays with a completion date of May 2025.

Resolved:
RABD received and noted the Campus update.

24/25/47 **Digital and Information Technology**

KW highlighted from the circulated report:

- Submission of Digital Maturity Assessment 2024 has been completed.

KW reported on a cyber security incident that took place earlier in June at a laboratory in London. As Alder Hey have sent samples to the laboratory an incident meeting has been held this morning and CQC are aware. No further samples are currently being sent.

An AlderC@re strategic session was held with Meditech on 18th June 2024. Meditech are keen to support with a number of challenges for Alder Hey, further follow ups are to be worked through.

Resolved:
FTPC noted progress to date as well as the cyber security incident on the laboratory in London.

24/25/48 **Procurement**

KT went through the report providing detail on 18 schemes delivered and savings as of May 2024.

GOJO Soap and Gel - Due to the national issue of GOJO going into administration the trust has agreed to transition to a new supplier of hand hygiene products (SC Johnson).

Cheshire Wirral Partnership reached out to HPL to support with a number of strategic projects on an interim 12-month basis from 01st June 2024. This opportunity has been discussed through the procurement Board and it was agreed that HPL would be able to support for a period of 12 months. CWP will fund the additional Procurement roles required to deliver the service.

DJ queried the best social value model approach. KT agreed to contact DJ to discuss further.
Action: KT/DJ

KT reported on working with the finance team to work through areas of increased spend. Currently looking into a Deep Dive of standardising ordering from same providers across Alder Hey. JG asked for a future FTPC to provide details on spending over the last five years.
Action: KT/RJ

JK noted increase on non-staff pay within the Surgery Division in relation to stock and asked for extra focus on this within the deep dive.

24/25/49 Board Assurance Framework

ES highlighted the procurement risk is not currently visible within the BAF. All other risks have been covered in earlier items.

Resolved:
FTPC noted risks within the Board Assurance Framework.

24/25/50 Risk Appetite

ES presented slides on the worked examples. FTPC was asked to review the proposed risk appetite statements and risk tolerances in practice.

KW asked if transformational change should be included. As well as having an open risk appetite on Technology whether cyber security should also be added as a safety element.

The Chair queried the minimal risk appetite in relation to the financial risk and whether this should be higher.

Next steps included presenting feedback from all subcommittees at the Audit and Risk Committee in July and Trust Board in September 2024.

SA asked when the Future Committee risk tolerances would be discussed suggesting the Trust Strategy Board. ES agreed this would be a good starting point with it being a new committee.

Resolved:
FTPC reviewed and responded on the risk appetite suggestions for FTPC.

24/25/51 Green update

AP presented slides on year to date results against delivering net zero. AP highlighted the building is now working close to as it was designed.

AP is due to commence a new role for the ICB on the wider environmental strategy. AP will continue to be based at Alder Hey.

Resolved:
FTPC noted year to date progress against green project.

24/25/52 **PFI**

GD went through energy initiatives including installation of LED lights across the multi-storey car park in July/August.

Working through with Mite on their performance reports as financial miss reporting has been noted with them. Mite are looking into correcting the reporting and will be refunding the financial difference one the amount has been approved.

Further report on pipework is to be received.

Resolved:
FTPC received and noted progress against PFI.

24/25/53 **Any Other Business**

No other business was recorded.

24/25/54 **Review of Meeting**

The Chair noted new input that raised a number of questions that will hopefully be worked through the divisional FPC.

Date and Time of Next Meeting: Monday 29th July at 1pm, Innovation Park, Rooms 2/3 Edge Lane.

Alder Hey Children's NHS
NHS Foundation Trust

Finance, Transformation and Performance Committee
Confirmed Minutes of the meeting held on Monday 29th July 2024 at 13:00, Via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	
	John Grinnell	Managing Director / CFO	(JG)
	Rachel Lea	Deputy Director of Finance	(RL)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nurse	(NA)
	Jenny Dalzell	Associate Director of Strategy and Partnerships	(JD)
	Emily Kirkpatrick	Deputy Director of Finance	(EK)
	Andy McColl	Deputy Director of Finance	(AMC)
	Natalie Palin	Associate Director Transformation	(NP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)

24/25/56 Apologies

Apologies were noted from:

Melissa Swindell	Director of HR & OD	
Dame Jo Williams	Non-Executive Director	(JW)
Dani Jones	Director of Strategy and Partnerships	(DJ)
Jane Halloran	Acting Deputy Development Director	(JH)

Due to a major incident in Southport today the following members/attendees sent their apologies:

Adam Bateman	Chief Operating Officer	(AB)
Chloe Lee	ACCO Surgery	(CL)
Sian Calderwood	ACCO Medicine	(SC)

24/25/57 Minutes from the meeting held 24th June 2024

The minutes were approved as a true and accurate record.

24/25/58 Matters Arising and Action log

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

24/25/59 Declarations of Interest

There were no declarations of interest.

24/25/60 Top 5 Risks

1. **Immediate financial performance including system position (RAG HIGH)**
   M3: reported in line with plan except for industrial action (c£0.2m). No guidance on how IA will be treated in 24/25. Forecast risk of c£5m related to in year CIP delivery – improvement plan developed and being implemented at pace to ensure risks can be mitigated.

2. **Capital Programme (RAG HIGH) –**
   24/25 plan agreed in line with CDEL allocation.
   Risk emerging for 25/26 and beyond on medical equipment replacement due to scale of replacement and inability to replace. Full assessment underway and update in September FTPC.

3. **Efficiency Programme (RAG HIGH)**

Plan for delivery is £19.3m forecast is currently £12m recurrently. Work continues to look at reducing gaps that are not recurrent.

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

5. **The campus & Park developments (RAG MEDIUM)**
   Police Station has now been renamed as Beech House. Further update under agenda item.

24/25/61 **Finance Report**

Month 3 Financial Position

£1.5m deficit reported for M3 with a £3.4m deficit year date, off plan due to industrial action.

ERF is favourable year to date by £200K, some areas overachieving and some areas under achieving against planner to date.

Elective is underachieving year to date by around £300K, that's offset by outpatient procedures and outpatient imaging.

Deep dives around procurement and what we can do there and also just managing inflationary risks.

Surgery and medicine off plan being offset by community and being favourable year to date.

Bank and agency spend continues, which mainly relates to HCA and covering for sickness. EK noted a finance improvement piece of work is to include bank and agency spend.

The Chair queried headcount numbers and asked that this is looked into at a later date. Part of this was in terms of Community Division.

Link between FTPC and People Committee needs to be stronger working through.

GW provided an update on work being carried out on coding internally and also able to benchmark externally. KW said a paper on coding is due to be presented at Executive Committee and will then be presented at a later FTPC.
Action: KW/Karl Edwardson: To confirm once coding update has been presented to Executive Committee and will be presented at FTPC.

Resolved:
FTPC received and noted the M3 Finance report.

24/25/63 **HFMA Sustainability Audit and ICB Expenditure Control**

EK referred to the two above papers that had been shared in the pack noting good progress against both audits. Procedures now included/updated following the audits are; ledger hierarchy, re-instating Capital Steering Group, development of the productivity dashboard and Executive Vacancy Panel.

Policies updated include; Nursing Standing Order Procedure and Medical Staff Covering Absences.

Action plan for areas that are being worked through; SFI's updated to include changes to Executive functions, Development of longer financial plan, retrospective review of business cases.

There is a further checklist for all Trust's to complete as requested from PWC. This will be presented at September FTPC with an update from outstanding actions as noted above. EK advised that the checklist was similar to previous evidence requested.
Action: EK to present a further checklist as requested from PWC at September FTPC with an update on any outstanding actions.

SA asked how Alder Hey compared against other Trust's. EK said she would provide these details to SA outside of the meeting.
Action: EK

Resolved:
FTPC received and noted progress to date against ICB Costs.

24/25/64 **Month 3 Integrated Performance Report**

JG highlighted:

- ED performance achieved 84%, exceeding the national target of 78%
- 100% compliance remains for access to cancer services, exceeding national standard.
- 760 patients waited over 52weeks for treatment against an external trajectory of 763.
- The number of Paediatric Community patients waiting >52 weeks reduced from 5 to 0.

Areas that continue to be reviewed and supported include over 2,000 patients waiting over 2 years for a follow appointment and patients awaiting ADHD and ASD diagnosis.

The winter plan is being developed and will be presented at a later FTPC.

Resolved:
FTPC received and noted the M3 Integrated Performance report.

24/25/65 **Medicine Division**

Resolved:
As Sian Calderwood, ACCO Medicine was supporting a major incident the presentation would be taken as read.

24/25/66 **Community Division**

RG highlighted:
£1.5m forecast. Activity overperforming in most areas.
SA asked if there had been any benefits from CYP as one. RG said in terms of the app it gives patients detail of the services. RG agreed to look into the benefits and include in the October Divisional update.
Action: RG to provide details on benefits from the CYP as One application.

ADHD/ASD Diagnosis waiting times
RG went through the comprehensive improvement programme that has been previously presented at Executive Committee and Trust Board on reducing the number of patients waiting for ADHD and ASD diagnosis. The programme includes

workstreams reviewing capacity and demand models of care. One option being looked into is supporting further capacity within these services.

Vacancies
RG went through the challenges being faced in reference to the number of vacancies across the division. Opportunities being looked into for new staff to recruit and retain include joint roles, time set aside for research studies or clinical developments.

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

24/25/67 **Surgery Division**
Resolved:
As Chloe Lee, ACCO Medicine was supporting a major incident the presentation would be taken as read.

24/25/68 **Campus update**
Resolved:
As Jayne Hollaran was unable to attend FTPC the paper was taken as read.

24/25/69 **Liverpool Neonatal Partnership**
Resolved:
As Chloe Lee had been unable to attend today the paper would be taken as read.

24/25/70 **Benefit Realisation**
NP updated FTPC on the last Programme Board that had been held on Thursday 25th July and had been observed by members of PWC, feedback from them is awaited. NP highlighted the following points from the meeting:

- Risk management and financial challenge, resource allocation and program management progress and future plans.
- Current scoring of BAF perspective of strategic deployment was discussed and will be reviewed in accordance with discussions at the meeting.
- Introducing a different level of risk into the delivery of our programme due to moving some of our resources from a programme management to support the delivery of the Sprint programme. In terms of resource allocation, there will be meetings with each of the SRO's to review what their needs are.
- In short term and medium term there is short term constraints from a resource perspective, approval at a recent executive meeting was given to put into place mitigations around additional recruitment.

Resolved:
FTPC noted progress to date and ongoing challenges within Benefit Realisation Programme.

24/25/71 **Board Assurance Framework**
ES highlighted BAF risks had been covered with in the Top 5 risks item.

For September Trust Board an update will be provided on any gaps in relation to the overall broad financial risk, particularly around the detail that may be coming out of the PWC review.

Resolved:

FTPC noted risks within the Board Assurance Framework.

24/25/72 **Any Other Business**
No other business was recorded.

24/25/73 **Review of Meeting**
The Chair noted new input that raised a number of questions that will hopefully be worked through the divisional FPC.

Date and Time of Next Meeting: Thursday 22nd August at 1pm, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Finance, Transformation and Performance Committee – 2024/25 Key Risks (M4)**
Report of:	**Chair of the Finance Transformation, and Performance Committee**
Paper Prepared by:	Deputy Director of Finance

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

24/25 Key Risks – August Position

Alder Hey Children's NHS

	Initial Risk	Initial RAG	Latest Position	RAG M3
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 4 position 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. National external review undertaken by PWC concluded with feedback due asap. Further review undertaken by NHSE nominated lead and system RAG rating all providers based on risk of delivery. AH green with an ask if more can be achieved to support system gap – to be picked up in agenda.	**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. 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. Full assessment underway and update in September FTPC and TB	**Medium**
Efficiency Programme	Plan assumes delivery of £19.3m recurrent savings. Highest level set in any one year. Managing of message to organisation alongside delivery of 2030 vision.	**High**	Overall target increased to £19.95m, including ICB stretch target for non-clinical pay savings. M4 position similar to M2, reporting on plan YTD but gap for the full year as per above with improvement plan developed to mitigate and close gap.	**High**
Benefits Realisation	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	**Medium**	Chair report included from programme board in pack.	**Medium**
Campus	Complex campus programme across multi sites.	**Medium**	GDS and community building both now handed over with teams taking	**Medium**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	Risk Appetite and Tolerances Update
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Jill Preece, Governance Manager

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	This paper provides the current position in relation to the Risk Appetite and Risk Tolerance work within the organisation.
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/s	Risk Description				Score
	This paper refers to all risks on the risk register				
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Alder Hey Children's NHS Foundation Trust

Board of Directors

Risk Appetite and Tolerances Update

1. Purpose

The purpose of this paper is to provide the Board with an updated position with regard to the work undertaken in the last 12 months within the 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.

2. Introduction

Risk is inherent in the provision of healthcare and services. It is necessary for the Trust to understand and agree the level of risk that it is willing to accept to achieve its strategic objectives.

The purpose of a Risk Appetite Statement is to articulate what risks the Board is willing or unwilling to take in order to achieve those objectives.

In setting out its approach to and appetite for risk within a Risk Appetite Statement, the Board is defining its strategic approach to risk-taking by setting its boundaries and risk tolerance thresholds.

The purpose of articulating the Board's appetite for risk is to feed into the Trust's wider risk management process and in particular the on-going development of the Trust's Risk Management reporting by informing the agreement of target risk scores.

3. Background

The UK Corporate Governance Code states that '*the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'*. This means that at least once a year, the Board should consider the types of risk they may wish to exploit and/or can tolerate in the pursuit of its objectives. This helps demonstrate to our regulators, services users, and other stakeholders that there are clear and effective processes for managing risks, issues, and performance across the Trust.

Alder Hey's initial risk appetite statement was presented to the Board in March 2021 setting out the proposed risk appetite for the Trust using the *Good Governance Institute's Risk Appetite for NHS Organisations Matrix*. A further review was undertaken in 2022 to assess whether any changes to appetite levels are required to support decision making, particularly in the context of the Covid-19 pandemic; and to overlay the suggested risk appetite with associated risk tolerance thresholds.

4. Proposed risk appetite and thresholds

Risk Appetite is the level of risk within which the Trust **aims** to operate.
Risk Tolerance is the level of risk within which the Trust is **willing** to operate.

Alder Hey recognises that its long-term sustainability depends upon the delivery of its strategic objectives

and its relationships with its patients, staff the public and strategic partners. As such the Trust will not accept risks that provide a negative impact on patient safety.

However, Alder Hey has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has greatest appetite to pursue clinical innovation opportunities that will accrue long term benefits in terms of sustainability and growth.

5. Current position

Over the last 12 months the main assurance committees were invited to:

- consider the Risk Appetite Statements and Risk Tolerances for risks within their remit and confirm that they either support the Board's proposal or suggest any changes to be fed back to Board.
- agree where action is required to reduce score/s for any for risks within their remit that scored higher than the tolerances.
- for those risks where the impact descriptors do not exist, define the descriptors.

Following initiation of the risk appetite work in early 2023, the Board will recall that a new risk management system, InPhase was implemented (May 2023) which, presented a number of challenges in relation to reporting functionality. This meant that the risk appetite work was paused until these could be resolved.

In February this year, we recommenced this work through the assurance committees with the exception of the Futures Committee to allow time for its evolution. An exercise was undertaken to re-profile the Trust's current risks against the eleven risk categories linked to appetite which provoked some thoughtful and insightful discussions around the degree of risk we are willing to accept, and more practically when applying the tolerances how this may change the Trust's risk profile. The discussions at various committees acknowledged both the changes to the NHS landscape and Alder Hey's strategic outlook since the risk appetite levels were initially proposed in 2021 which has resulted in a number of suggested changes (detailed below).

There were some instances where risk descriptors had not already been defined, these are also detailed below (highlighted in blue).

In summary, there was acceptance of the proposed tolerance levels across the majority of the eleven categories from each of the assurance committees with the following proposals:

Safety and Quality Assurance Committee - clinical risks

- acceptance that the Trust has NO appetite for risks that compromises patient safety.
- acceptance that the Trust has MINIMAL risk appetite for risks that may compromise the delivery of outcomes for our patients.
- applying an exception to 'quality-safety' risks that cannot be reduced to a score of less than the threshold of 4 i.e., 1x5=5 (catastrophic & rare) despite all mitigations and for these to remain active and reviewed on a three-monthly cycle, with a view to undertaking a robust review every 12 months.

People Committee

- acceptance that the Trust has a CAUTIOUS appetite for risk that may threaten the sustainability of its workforce, in terms of numbers, skill, health and wellbeing.
- acceptance that the Trust has a CAUTIOUS appetite for risk which may compromise its plans to develop a more diverse and inclusive workforce.
- add a new (twelfth) category called 'workforce-culture' with a proposed CAUTIOUS appetite for risk (MEDIUM 10-12).
- Agreed the impact descriptors for 'workforce-EDI' and 'workforce-culture' categories (see appendix A).

Finance, Transformation and Performance Committee

- Acceptance that the Trust has:
    - a MINIMAL appetite for risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.
    - An OPEN appetite for risk to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level.
    - An OPEN appetite for investments which may grow the size of the organization.
    - a CAUTIOUS appetite for actions and decisions that whilst taken in the interest of ensuring quality and sustainability of the patients in our care, may affect the reputation of the organisation.
    - an OPEN appetite for risks related to the Trust's estate and infrastructure **except** where they adversely impact on patient safety and regulatory compliance.
    - an OPEN risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users.
- Suggestion to split the 'Technology' category out as follows: one that explicitly references transformational change with an OPEN risk appetite, and one that explicitly references cyber security with a MINIMAL risk appetite.
- Suggestion that the 'financial' category should be lower than OPEN given the current environment, deliverability of high-risk cost improvement and overall level of risk the Trust is faced with in delivering against an agreed Plan.
- A change to the 'systems and partnerships' category risk appetite from HIGH (15-25) to MEDIUM (10-12) given that so much of delivering Vision 2030 is predicated on how we work in the system.
- Agreed the impact descriptors for 'financial-investment' and 'commercial' categories (see appendix A).

Futures Committee

- A short discussion took place at the Finance, Transformation and Performance Committee in June where there was agreement to allow time for the Futures Committee to evolve over the coming months and hold initial conversations regarding (clinical) innovation risk appetite at Strategy Board in the first instance. The timing for this is yet to be agreed.

6. Proposed Risk Appetite Statement

Considering all of the suggested changes from the assurance committees, the proposed Risk Appetite Statement for Board approval is as follows (highlighted in blue):

Category	Proposed Risk Appetite Statement	Risk appetite level	Risk score threshold
Compliance and Regulatory	• Alder Hey has is a **MINIMAL** risk appetite for risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	LOW	4-6
Financial	• Alder Hey has a **MINIMAL** risk appetite to financial risk in respect of meeting its statutory duties.	LOW	4-6
	• Alder Hey has an ~~**OPEN**~~ **MINIMAL** appetite for risk to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level.	~~MEDUIM~~ LOW	4-6
Commercial	• Alder Hey has an **OPEN** appetite for investments which may grow the size of the organisation.	MEDIUM	10-12
Quality – Safety	• Alder Hey has **NO** appetite for risk that compromises patient safety.	NONE	1-3
Quality – Effectiveness	• Alder Hey has a **MINIMAL** risk appetite for risks that may compromise the delivery of outcomes for our patients.	LOW	4-6
Workforce	• Alder Hey has a **CAUTIOUS** risk appetite for risk that may threaten the sustainability of its workforce, in terms of numbers, skill, health and wellbeing.	MEDIUM	8-9
	• Alder Hey has a **CAUTIOUS** risk appetite for risk which may compromise its plans to develop a more diverse and inclusive workforce.	MEDUIM	8-9
	• Alder Hey has a **CAUTIOUS** risk appetite for risk which may compromise the ongoing development and sustainability of an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families.	MEDIUM	8-9
Reputation	• Alder Hey has a **CAUTIOUS** risk appetite for actions and decisions that whilst taken in the interest of ensuring quality and sustainability of the patient in our care, may affect the reputation of the organisation.	MEDIUM	8-9
Systems & Partnerships	• Alder Hey has a ~~**SEEK**~~ **CAUTIOUS** risk appetite for system working and partnerships which will benefit our local population.	~~HIGH~~ MEDIUM	8-9
Clinical Innovation	• Alder Hey has a **SEEK** risk appetite for clinical innovation that does not compromise quality of care.	HIGH	**15-25**
Environment	• Alder Hey is committed to providing patient care in a safe environment and has an **OPEN** risk appetite for risks related to the Trust's estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	10-12
Technology	• Alder Hey has a **MINIMAL** appetite for risk relating to exposure or loss resulting from a Cyberattack.	LOW	4-6
	• Alder Hey has a **CAUTIOUS** risk appetite in relation to delivering transformational change aligned to the Trust's Strategy.	MEDIUM	8-9

Risk Levels (consequence)	
AVOID (NO)	Avoidance of risk and uncertainty is a key organisational objective ALARP (As little as reasonably possible)
MINIMAL	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
CAUTIOUS	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
OPEN	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
SEEK	Eager to be innovative and choose options offering potentially higher business rewards despite greater inherent risk

7. Next steps in terms of risk appetite

- ✓ Associate Director of Nursing and Governance to work with Divisional Governance Leads to apply risk appetite level consistently to existing and new risks.
- ✓ Discuss tolerances at Divisional Governance meetings for practical application.
- ✓ Test levels of mitigation for existing risks with a view to further reducing risk scores.
- ✓ Risk Management Forum to oversee implementation and report to ARC on progress.
- ✓ Risk Management Strategy to be updated to reflect Risk Appetite Statement.

8. Recommendation

The Board is asked to approve the risk appetite statement as detailed in the table above and note the next steps in terms of practical application.

Jill Preece
Governance Manager

Appendix A – Impact Descriptors

Category	Risk appetite & Tolerance	Maximum acceptable risk (IxL) expressed using the I & L descriptions
Compliance & Regulatory	LOW 4-6	**3x2** Single breach in statutory duty OR Challenging external recommendations / improvement notice with a likelihood of this risk occurring of "Probably won't occur (not expected to happen, but definite potential exists – unlikely to occur) 1-10,000 chance". **2x3** Breach of statutory legislation OR Reduced performance rating if unresolved with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance".
Financial – compliance	LOW 4-6	**3x2** Loss of 0.25–0.5 per cent of budget OR Claim(s) between £10,000 and £100,000 with a likelihood of this occurring of "Probably won't occur (not expected to happen, but definite potential exists – unlikely to occur) 1-10,000 chance". **2x3** Loss of 0.1–0.25 per cent of budget OR Claim less than £10,000 with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance".
Financial – investment	LOW 4-6	**4x3** Loss of £1m - £5m directly attributable loss / unplanned cost / reduction in change related benefits with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance". **3x4** Loss of £100k - £1m directly attributable loss / unplanned cost / reduction in change related benefits with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-100 chance".
Commercial	MEDIUM 10-12	**4x3** Commercial Strategy not fully articulated. Possible losses arising from business partners / market uncertainties / suppliers / commercial innovation with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance". **3x4** Commercial Strategy not fully articulated. Possible losses arising from business partners / market uncertainties / suppliers / commercial innovation with a likelihood of this risk occurring of "Probably will occur (strong possibility that this could occur – likely to occur) 1-100 chance".
Quality – Safety	NONE 1-3	**3x1** Increase in length of hospital stay by 4-15 days OR an event which impacts on a small number of patients with a likelihood of this risk occurring of little chance of occurrence (can't believe this event would happen – will only happen in exceptional circumstances) 1-100,000 chance. **1x3** An event which impacts a small number of patients with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance".

Category	Risk appetite & Tolerance	Maximum acceptable risk (IxL) expressed using the I & L descriptions
Quality – Effectiveness	LOW 4-6	**3x2** Treatment or service has significantly reduced effectiveness OR Formal complaint (stage 2) OR Local resolution (with potential to go to independent review) OR Repeated failure to meet internal standards OR Major patient safety implications if findings are not acted on with a likelihood of this risk occurring of "Probably won't occur (not expected to happen, but definite potential exists – unlikely to occur) 1-10,000 chance." **2x3** Overall treatment or service suboptimal OR Formal complaint (stage 1) OR Local resolution OR Single failure to meet internal standards OR Minor implications for patient safety if unresolved OR Reduced performance rating if unresolved with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance".
Workforce – sustainability	MEDIUM 10-12	**4x3** Uncertain delivery of key objective/service due to lack of staff OR Unsafe staffing level or competence (>5 days) OR Loss of key staff OR very low staff morale OR No staff attending mandatory/ key training with a likelihood of this risk occurring of "*May occur* (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance". **3x4** Late delivery of key objective/ service due to lack of staff OR Unsafe staffing level or competence (>1 day) OR Low staff morale OR Poor staff attendance for mandatory/key training with *a likelihood of this risk occurring of "Probably will occur* (strong possibility that this could occur – likely to occur) 1-100 chance".
Workforce – EDI	MEDIUM 10-12	**4x3** Failure to have a diverse and inclusive workforce which represents the local population OR non-compliance with the Public Sector Equality Duties OR failure to provide diversity without inclusion where all staff feel recognised, valued and respected with a likelihood of this risk occurring of "*May occur* (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance". **3x4** Failure to promote equality, diversity and inclusion OR non-compliance with the Public Sector Equality Duties OR failure to provide diversity without inclusion where all staff feel recognised, valued and respected with a likelihood of this risk occurring of *"Probably will occur* (strong possibility that this could occur – likely to occur) 1-100 chance.
Workforce – culture	MEDIUM 10-12	**4x3** Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision OR lack of adherence to the Trust values and behavioural framework leading to a decline in performance OR failure to create a working environment and cultures where every individual can feel safe to speak up with a likelihood of this risk occurring of "*May occur* (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance"

Category	Risk appetite & Tolerance	Maximum acceptable risk (IxL) expressed using the I & L descriptions
		3x4 Failure to sustain the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision OR inconsistent application of the Trust values and behavioural framework leading to a decline in performance OR staff not feeling safe or confident to speak up with a likelihood of this risk occurring of *"Probably will occur* (strong possibility that this could occur – likely to occur) 1-100 chance".
Reputation	MEDIUM 10-12	**4x3** National media coverage with <3 days service well below reasonable public expectation with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance". **3x4** Local media coverage – long-term reduction in public confidence with a likelihood of this risk occurring of "Probably will occur (strong possibility that this could occur – likely to occur) 1-100 chance".
Systems & Partnerships	MEDIUM 10-12	**4x3** The risk of direct or indirect loss as a result of a failure to deliver on our partnership obligations with a likelihood of this risk occurring of "This is expected to occur frequently (In most circumstances – more likely to occur than not) 1-1000 chance". **3x4** The risk of direct or indirect loss as a result of a failure to deliver on our partnership obligations with a likelihood of this risk occurring of "This is expected to occur frequently (In most circumstances – more likely to occur than not) 1-100 chance".
Clinical Innovation	HIGH 15-25	**Not yet discussed (Strategy Board/Futures Committee)**
Environment	MEDIUM 10-12	**4x3** Loss/interruption of >1 day. Major impact on environment e.g., major medical equipment at end of life with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance". **3x4** Loss/interruption of <1 day. Moderate impact on environment with a likelihood of this risk occurring of "Probably will occur (strong possibility that this could occur – likely to occur) 1-100 chance".
Technology – transformational change	MEDIUM 10-12	**4x3** Failure to invest in core tech systems and skills that support innovation and transformation and the fast-evolving needs of the organisation required for the 2030 Strategy with a likelihood of this risk occurring of "May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance". **3x4** failure to successful implement core tech systems and skills that support innovation and transformation and the fast-evolving needs of the organisation required for the 2030 Strategy with a likelihood of this risk occurring of "Probably will occur (strong possibility that this could occur – likely to occur) 1-100 chance".
Technology – cyber security	LOW 4-6	**3x2** Loss of >1 day. Inability to maintain key patient services resulting from a cyber-attack or data breach with a likelihood of this risk occurring of "Probably won't occur (not expected to happen, but definite potential exists – unlikely to occur) 1-10,000 chance."

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Category	Risk appetite & Tolerance	Maximum acceptable risk (IxL) expressed using the I & L descriptions
		2x3 Disruption to service due to exposure or loss resulting from a cyber-attack with a likelihood of this risk occurring of “May occur (may occur occasionally, has happened before on occasions – reasonable chance of occurring) 1-1000 chance”.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**Board Assurance Framework Report (July 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 July 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. ***(NEW)***	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 5th August 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. ***(NEW)***	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.	PC	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	PC	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	PC	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	3x4	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 July 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF 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 and actions updated.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC). NEW***
  No change to medication shortage actions continue.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in July maintains above the national standard of 78%, achieving 87.9%.

  Continued improvement plans are in place for Sleep Studies (sickness) and Gastro (some increase in availability of theatres identified, more sessions required) to improve the Overall DM01 compliance, achieving 84% for June 2024 against a national target of 95% by March 2025.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. The trust achieved zero 78 weeks at end of June 2024. The number of patients waiting over 65 weeks at end of June was 86, and increase from May 2024, 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. Focus on most challenged areas (Dental, ENT, Spine and Neurology) will continue to meet this target with the internal aim to reach 60 weeks by end August 2024. Trajectory is in place and this is being monitored weekly.

  Risk remains for achieving 65 week cohort regarding cancellation of agreed appointments, potential doctors strikes but these patients are being closely monitored by services. In addition challenges with Radiology cover for additional clinics are faced by dental team, service reviewing needs and additional options to mitigate this.

- ***Building and infrastructure defects that could affect quality and provision of services (AB).***
  An update regarding corroded pipework and ongoing plans was been requested from Project Co. 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, and later this year we will introduce a chemical dosing system across the site.

  Joint water safety workshops continue and we are awaiting further details on the dosing system. This has been escalated several times due to the length of time Project Co are taking in resolving. The Trust are informed that progress is being made on water temperature works.

  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 remains the same and elements of national reporting remain under review via MHDS issues at present.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  Review of actions to mitigate gaps in assurance undertaken. No change to risk score, albeit improvements in some areas, (sickness absence % and turnover% creating improved stability. All actions to be addressed through the actions of the people plan as presented to Board in July 2024.

- ***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, all actions on track - no change to risk score,

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Actions plan in place - and are aligned to the NHSE 6 High impact changes. Actions on track.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed - no change to score. All main park works complete and open to the public. All remaining actions regarding the Swale are being progressed in line with timescales.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (KW).***
  The 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 the risk score, remains at 16 as whilst in year reporting in line with plan, risks emerging on delivery of 24/25 efficiency programme and also challenges within C&M system. Oversight through Finance, Transformation & Performance Committee with actions underway to mitigate risks. Finance improvement sprint over 12-week period in train to report through SDG with exec lead for each workstream.

- 0170 ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; no change to score in month and all actions updated.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  Review undertaken in-month and no change to risk score or current position.

- ***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, which now includes Quality Assurance Rounds. Workforce proposal approved by Executive Committee and now working with HR on next steps. Cyber Security plans remain in progress.

5. Corporate risks (15+) linked to BAF Risks (as at 30th July 2024)

There are currently 23 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	5x4	Business Support	4.2	May 2024	May 2024
212	Reduced staffing in Plaster Room ***(NEW)***	3x5	Community	2.1	May 2024	July 2024
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer. ***(NEW)***	4x4	Medicine	2.1	Apr 2023	June 2024
70	National ADHD medication shortage	4x4	Community		Sept 2023	May 2024
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties	3x5	Business Support		Mar 2024	Mar 2024
2623	When the CT breaks, this causes disruption to other services who rely heavily on CT and patients receiving their treatment.	4x4	Medicine		Apr 2022	Mar 2024
178	Major Incidents disrupting the Trusts ability to maintain statutory duties	5x3	Business Support		Apr 2024	Apr 2024
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	4x4	Community	2.2	Feb 2023	*Apr 2023
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	4x4	Business Support	1.2, 2.1 & 2.2	Feb 2024	Feb 2024
117	Safe follow up care	4x4	Business Support	1.2, 2.1 & 2.2	Dec 2023	Dec 2023
2677	We are now in Year 7 since the Alder Hey in the park building became operational. Most of the Trusts Medical Devices were purchased or replaced at this time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 years. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital equipment. This year (22/23) we had planned to replace £6.3m of this capital equipment. However, external capital expenditure restrictions have been placed upon the Trust by the ICS which means we only have £2.3m	4x4	Surgery	3.4	Aug 2022	Feb 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	allocated for device replacements. the remaining £4m is "at risk" and will roll over into next year's replacement budget which will then stand at £9.5m					
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4	Dec 2019	*Apr 2023
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
226	Inpatient admission errors	4x4	Surgery	3.4	Jun 2024	Jun 2024
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	3x5	Medicine	2.1 & 2.2	Nov 2022	*Apr 2023
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	2.1 & 2.2	Jan 2020	*Apr 2023
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	2.1	Feb 2023	Mar 2024
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	3x5	Community		May 2022	*Apr 2023
111	Anaesthetic cover out of hours	5x3	Medicine	1.2, 2.1 & 2.2	Nov 2023	Nov 2023
189	EPRR Assurance Non-Compliance ***(NEW)***	3x5	Business Support		Jul 2024	Jul 2024
212	Reduced staffing in Plaster Room ***(NEW)***	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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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)						
197	Legal proceedings related to the Gender Service ***(NEW)***	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)						
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	4x4	Business Support		Feb 2024	Feb 2024
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.2	Nov 2022	*Apr 2023
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.2	Jan 2020	*Apr 2023
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	1.1	Feb 2023	Mar 2024
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 ***(NEW)***	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)						
2100	Risk of inability to provide safe staffing levels	4x4	Business Support	1.1 & 2.1	Jan 2020	*Apr 2023
140	Anaesthetic cover out of hours - ward based issues	4x4	Business Support		Feb 2024	Feb 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	4x4	Medicine	1.1 & 2.1	Nov 2022	*Apr 2023
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1	Feb 2023	*Apr 2023
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.1	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.1	Dec 2023	Dec 2023
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)						
	None					
STRATEGIC OBJECTIVE: Collaborate for children and young people						
3.1 Failure to fully realise the Trust's vision for the Park and Alder Hey campus (3x4=12)						
	None					
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
226	Inpatient admission errors	4x4	Surgery	1.1	Jun 2024	Jun 2024
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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)						
2694	Delayed growth plan (strategy KPIs)		Business Support (Innovation)	5x3	Sept 2022	Apr 2024
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (3x4=12)						
151	Expanse Referral Process	5x4	Business Support	1.2	16 May 2024	May 2024

* risk movement data not available pre-move to InPhase

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

Erica Saunders
Director of Corporate Affairs

Inability to deliver safe and high quality services	
Risk Number	Strategic Objectives
1.1	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.

Aug 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	August 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 and 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.

Aug 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	August 2024	
		Due Date	Action Update
Reduce the long-wait backlog for planned care	Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	31/03/2024	All services working towards zero 65 week waiters by 31st March 2024. Particular concern in ENT, Dental and Spine where additional investment continues in insourcing and theatre time protection for services.
Urgent and Emergency Care Standards	Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	31/01/2024	Actions implemented to date have led to improved access to A&E, which is now exceeding the 85% national standard

Building and infrastructure defects that could affect quality and provision of services	
Risk Number	Strategic Objectives
1.3	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Finance, Transformation and Performance Committee

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

Aug 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	August 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 and 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.

Aug 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	August 2024	
		Due Date	Action Update
Continued workforce planning	Continued workforce planning including: - introduction of new roles - continued representation at C&M workforce meetings - review of all job descriptions and person spec to ensure consistency and ability to progress - development of preceptorship/development pathway	30/09/2024	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/07/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	30/09/2024	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	30/09/2024	
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	31/08/2024	

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, Effective, Responsive, Caring, Well-Led		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.

Aug 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	August 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	
Lunch and Learn	I will deliver a lunch and learn session to the Trust on 29 July to increase visibility and understanding of the service.	29/07/2024	
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 and experience

CQC Domains	Linked Risks	Owner
Safe, Effective, Caring, Responsive, Well-Led		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.

Aug 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	August 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	

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

Aug 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	August 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.

Aug 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	August 2024	
		Due Date	Action Update
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards.	30/09/2024	Staff Thriving Index pilot complete and implementation plan being developed. Thriving Teams MDT up and running with work planned to develop metrics for identifying vulnerable teams as part of this process. Discussed with CPO. Methodology to be agreed and to incorporate work already done by Director of Medical Services in discussion with MD
Culture strategy development to include governance framework supporting culture work	Culture strategy to be developed and to include review of governance framework and reporting processes for culture work including via Patient Safety Strategy Board and People and Wellbeing Committee.	28/06/2024	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	31/07/2024	Meeting with Director of Transformation on 4th April to discuss @its Best MDT model and underpinning resource. Output to be reviewed with Head of OD. Consider next stepts in terms of building capability across HR and other supportive People functions.
Safety culture training	Safety culture training to be developed and implemented with teams to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	31/07/2024	Safety culture and human factors training pilot delivered with all PICU staff (completed March 2024). Pilot review to be arranged with Patient Safety training and leadership team to determine feasibility of and agree next steps for roll out across the organisation.
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

Aug 2024	
Control Description	Control Assurance Internal
Establishment of 4 x Staff Networks	All networks have appointed chairs, supported by Head of EDI. members of EDI Steering Group and report bi-monthly
Education and Training in EDI	Mandaotry EDI Training for all staff. current compl;iance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
PAWC Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PAWC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	monitored through PAWC
People Policies	People Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
NHS England Improvement Plan supported by Trust Board, and associated actions into action plan	NHSE EDI Improvement Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 3 of delivery, continues to include a focus on inclusive leadership
EDI Steering Group established - Chaired by NED	Minutes reported into PAWC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People and Wellbeing Committee

Gaps in Controls / Assurance
Multi-factoral issues spanning training and education, sufficient EDI resources to support the agenda, cultural awareness and understanding

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	
Risk Number	Strategic Objectives
3.1	Collaborate for children and young people

CQC Domains	Linked Risks	Owner
		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

Aug 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	August 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 and 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.

Aug 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	August 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 and 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.

Aug 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	August 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 and 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.

Aug 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	August 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	31/08/2023	Now have agreement for a Children's Board under the Cheshire & Mersey ICS which will include a children's health network. This will include key stakeholders from across the region with the ability to influence and transform children's services. It will act as a Forum for sharing information across the system to help us keep abreast of the changing landscape.

Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.					
Risk Number			Strategic Objectives		
4.1			Pioneering Breakthroughs		
CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
Well-Led		John Chester	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.

Aug 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	August 2024	
		Due Date	Action Update
1. Integration of R&I activities into Futures	Completion of Research Strategy. Strategy approved by R&I Committee in Jan 24 subject to minor amendments. Amendments made and shared with new Futures Committee in April. Production of final version with design company complete.	31/03/2024	Starting
2a. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2025	
2b. Activity Levels	Review of CRD trials portfolio. Activity levels currently stable and building capacity to increase AH led research.	31/03/2025	
3a. Financial Model	Case for internal and multi-sector inward investment. Plans underway through £10m club to secure external funds for internal investment to grow through Futures. 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 commence in May 2024	31/03/2025	
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	
5. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy. New post agreed (CRD funded) to support marketing and comms for Futures - est start date Sept 24	31/03/2025	

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

CQC Domains	Linked Risks	Owner
		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.

Aug 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	August 2024	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2025	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/08/2024	Programme to commence Nov 2023
Cyber Security	Completion of Cyber Essentials Plus Collaborate with Clatterbridge to share learning and best practice	14/05/2024	
Experienced Resources	Assess workforce and develop options appraisal for impacted services	14/05/2024	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th September 2024

Paper Title:	**EPRR Policy & BCMS Strategy Endorsement**
Report of:	**Nathan Askew**
Paper Prepared by:	Jacob Gray

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	EPRR Policy BCMS Strategy
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
173	Business Continuity Incidents disrupting the Trusts ability to maintain statutory duties	15

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

0198

1. Executive Summary

Following ratification at August SQAC 2024. The Trust board is requested to note and endorse the following two documents:

- Emergency Preparedness, Resilience & Response Policy
- Business Continuity Management System Strategy

2. Document Distribution

As with all EPRR documents, the named policy and strategy have been consulted on with subject matter experts and stakeholders prior to approval and ratification.

The EPRR Policy will be uploaded to DMS, the following as outlined within the policy will receive direct notification via the Trusts EPRR Team.

Distribution List		
Role / Location	**Organisation**	**Format**
Document Management System	AHCFT	Electronic copy - (primary source)
Executives	AHCFT	Electronic copy
Senior Managers	AHCFT	Electronic copy

The BCMS Strategy will be uploaded to DMS, the following as outlined within the strategy will receive direct notification via the Trusts EPRR Team.

Distribution List		
Role / Location	**Organisation**	**Format**
Document Management System	AHCFT	Electronic copy - (primary source)
Associate Chief Operating Officers	AHCFT	Electronic copy
Corporate Leads	AHCFT	Electronic copy

3. Recommendation

To note and endorse the Trusts EPRR Policy following ratification at August SQAC 2024.

To note and endorse the Trusts Business Continuity Management System Strategy following ratification at August SQAC 2024.

Alder Hey Children's NHS Foundation Trust

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

Document Properties	
Version:	2.0
Name of Ratifying Committee:	Safety and Quality Assurance Committee (SQAC)
Date Ratified:	21/08/2024
Name of Originator/Author:	Emergency Preparedness, Resilience & Response Manager
Name of Approval Committee:	Emergency Preparedness Group (EPG)
Date Approved:	18/07/2024
Executive Sponsor:	Chief Nursing Officer, Accountable Emergency Officer
Date Issued:	21/08/2024
Review Date:	30/08/2027

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
2.0	July 2024	EPRR Manager	Current	Updated following Core Standards review
1.1	May 2022	EPRR Manager	Archived	Updates to appendix A
1	June 2022	EPRR Manager	Archived	Replaces Major Incident Policy and Business Continuity Policy

Record of changes made to EPRR Policy – Version 2.0			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
7.6	9	Removal of resilience officer roles and responsibilities	Position no longer fulfilled
7.10	9	Division of SMOC and EOC roles and responsibilities	Clearer role differentiation
12	13	Inclusion of lessons identified ownership and reporting processes.	Review into governance, continuous improvement requirements
13.1	15	Inclusion of minimum number aspiration of trainers for ED PRPS training.	Review into HazMat CBRNe Training resource.

Distribution List		
Role / Location	**Organisation**	**Format**
Document Management System	AHCFT	Electronic copy - (primary source)
Executives	AHCFT	Electronic copy
Senior Managers	AHCFT	Electronic copy

Any outdated version of this document will be destroyed via confidential waste/archived from online listings and replaced with the most up to date ratified version.

Contents

1. Introduction

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 (as amended).

This policy describes the Trusts overarching EPRR management processes and duties on compliance with with the CCA 2004, NHS England EPRR Framework 2022, HM Government Emergency Response and Recovery Non-Statutory Guidance (2013), NHS EPRR Standard Contract, National Occupational Standards, Minimum Occupational Standards, National Risk Register, Cheshire and Merseyside Local Risk Register, Clinical Guidelines for Major Incidents and Mass Casualty Events, Chemical, Biological, Radiological and Nuclear Incidents: Clinical Management and Health Protection Handbook.

2. Definitions

ACOO – Associate Chief Operating Officer
AEO – Accountable Emergency Officer
AHCFT – Alder Hey Children's NHS Foundation Trust
BCM – Business Continuity Management
BCMS – Business Continuity Management System
BCP – Business Continuity Plan
BIA – Business impact Analysis
CBRNE – Chemical, Biological, Radiological, Nuclear & Explosives
CCA 2004 – Civil Contingency Act 2004
C&M – Cheshire and Merseyside
CNO – Chief Nursing Officer
COO – Chief Operating Officer
CRF – Cheshire Resilience Forum
CRR – Community Risk Register (Cheshire & Merseyside Risk Register)
DMS – Document Management System
EPG – Emergency Preparedness Group
EPRR – Emergency Preparedness, Resilience & Response
MOS – Minimum Occupational Standards
MRF – Merseyside Resilience Forum
NHSE – NHS England
ICB – Integrated Care Board
ICS – Integrated Care System
IRP – Incident Response Plan
LHRP – Local Health Resilience Partnership
LRF – Local Resilience Forum
NRR – National Risk Register
PRPS – Powered Respirator Protective Suit

RA – Risk Assessment
RD – Resilience Direct
SMOC – Senior Manager on Call
SQAC – Safety & Quality Assurance Committee
TNA – Training Needs Analysis

3. Purpose

This policy provides the framework for Alder Hey Children's Hospital NHS Foundation Trust (AHCFT) to meet the statutory requirements of the Civil Contingencies Act (CCA) (2004), NHS Act 2006 (as amended by the Health and Social Care Act 2022), NHS Standard Contract and NHS England EPRR Framework (2022).

This document describes the principles the organisation will follow in its duty to appropriately prepare for, respond to, and recover from incidents and emergencies.

This includes the framework and delivery of Business Continuity Management (BCM) via Business Continuity Management System (BCMS).

This policy is aligned to the vision and strategic aims of AHCFT and is informed by the AHCFT Strategic Plan 2019/24.

The objectives of the Trust's EPRR Policy are:

- To enable the organisation to prepare for the common consequences of emergencies rather than for every individual emergency scenario;
- To enable the organisation to have flexible arrangements for responding to emergencies, which can be scalable and adaptable to work in a wide range of specific scenarios;
- To supplement arrangements with specific planning and capability building for the most concerning risks in the Cheshire and Mersey Community Risk Register (CRR) and the National Risk Register (NRR);
- To ensure that plans are in place to recover from incidents and to provide appropriate support to those affected.

4. Scope

This policy is a trust-wide policy and applies to all members of staff, either permanent, temporary and to those working within, or for, the trust under contracted services.

5. Duties

Alder Hey Children's NHS Foundation Trust (AHCFT) is a designated Category 1 responder under the Civil Contingencies Act (CCA) 2004. As a result it is expected to fulfil the following civil protection duties as underpinned by the CCA:

a. Assess the risk of emergencies occurring and use this to inform contingency planning;
b. Put in place emergency plans;
c. Put in place business continuity management arrangements;

d. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
e. Share information with other local responders to enhance co-ordination;
f. Cooperate with other local responders to enhance co-ordination and efficiency.

In addition to the duties outlined; the Trust will endeavour to align with the requirements listed within the NHS England Core Standards for EPRR and the NHS Standard Contract, which are in accordance with the CCA (2004) and the NHS Act 2006 (as amended). The Trust will also work in accordance with the underpinning Principles for EPRR:

Preparedness and Anticipation	AHCFT will endeavor to anticipate and manage consequences of incidents and emergencies by identifying risks and understanding the direct and indirect consequences, where possible. All individuals that may have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. AHCFT should be able to demonstrate clear training and exercising schedules that deliver against this.
Continuity	AHCFT will endeavor to respond to incidents through processes grounded within its existing functions and its familiar ways of working.
Subsidiarity	Decisions should be taken at the lowest appropriate level, with coordination at highest level necessary.
Communication	AHCFT will endeavor to ensure good two-way communication is in please as required to any effective response. Reliable information must be passed correctly without delay between those who need to know, including the public.
Cooperation and Integration	Effective coordination should be exercised within AHCFT and other organisations via local, regional, and national tiers of a response. Mutual aid can be activated across the organisation, UK, and international boundaries, as appropriate.
Direction	Clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident to effectively prioritise and focus the response.

6. Roles & Responsibilities

6.1. Chief Executive (CEO)

The Chief Executive has overall responsibility for ensuring that the AHCFT is able to provide an effective response to major incidents. The Chief Executive will ensure that

suitable incident plan(s) is/are developed, implemented, and tested to enable the organisation to respond to a major incident effectively, at any time.

6.2. Chief Nursing Officer (CNO)

The NHS Act 2006 (as amended) places a duty on relevant service providers to appoint an individual to be responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO).

AHCFT's Chief Nursing Officer is the Trust AEO. Acting as the executive authority with responsibility for ensuring the Trust complies with its legal obligations.

As AEO, they will provide assurance to the Board regarding present policy, procedures, plans, strategies, systems and training are in place and appropriate in order for the Trust to respond in the event of an incident. The AEO will be aware of their legal duties to ensure preparedness to respond to an incident within the Trust's remit to maintain the public's protection and maximise the NHS response.

The AEO will additionally be responsible for:

- The AEO will chair the emergency preparedness group (EPG) and ensure it has an appropriate governance structure, to support the oversight and delivery of EPRR core standards across the organisation;
- Ensuring that the organisation, and any sub-contractors, is compliant with the EPRR requirements as set out in the CCA 2004, the NHS Act 2006 (as amended) and the NHS Standard Contract, including the NHS England Emergency Preparedness, Resilience and Response Framework and the NHS England Core Standards for EPRR;
- Ensuring the organisation is properly prepared and resourced for dealing with an incident;
- Ensuring that the organisation, any providers commissioned, and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this;
- Ensuring that the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and partner organisations in the local area served;
- Ensuring that the organisation complies with any requirements of NHS England, or agents thereof, in respect of the monitoring of compliance;
- Providing NHSE with such information as it may require for the purpose of discharging its functions;
- Providing NHSE with such information as it may require for the purpose of discharging its functions;
- Ensuring that the organisation is appropriately represented by director level engagement with and effectively contributing to any governance meeting, sub-groups or working groups of the local health resilience partnership (LHRP) and/or local resilience forum (LRF), as appropriate.

6.3. Non-Executive Director (NED)

A Non-Executive Director will be nominated to support the AEO by:

- Endorsing assurance to the Board that the organisation is meeting its obligations with respect to EPRR and relevant statutory duties under the CCA 2004 and the NHS Act 2006 (as amended). This will include assurance that the organisation has allocated sufficient experienced and qualified resource to meet these requirements.

6.4. Chief Operating Officer (COO)

The Chief Operating Officer will provide or delegate to a suitably nominated person the strategic response to incidents during working hours.

6.5. Emergency Preparedness Resilience & Response Manager

The Trust will employ and suitably resource an EPRRM to support the development and delivery of the EPRR work plan.

The EPRRM will be responsible for:

- Providing assurance to the CNO on compliance with NHS England Core Standards for EPRR, and highlighting areas of risk by undertaking the Trusts annual self-assessment against EPRR core standards;
- Developing, writing, and supporting Trust EPRR related policies, plans, procedures, and reports to Trust Groups, Forums, and Committees, as required.
- Producing an annual EPRR report and maintaining the EPRR Risk Register;
- Working with colleagues at all levels to promote and embed EPRR across the Trust footprint, building EPRR capability, knowledge, and resilience;
- Assessing training needs and delivery of EPRR training to staff across all levels of the organisation;
- Ensuring EPRR plans are tested, exercised, and validated in line with the NHS England EPRR Framework (2022) and associated guidance to maintain and develop organisational resilience;
- Ensuring appropriate debriefing sessions are carried out after incidents to capture lessons identified and notable practice. The request of debriefs will be the responsibility of the ACOO's;
- Providing specialist knowledge to AHCFT as required;
- Working with senior managers across AHCFT to assess training needs and delivery of EPRR training to staff across all disciplines and all levels of the organisation;
- Supporting local business continuity planning arrangements are in place, maintained and tested appropriately;
- Establishing and maintaining Incident Coordination Centre facilities for response to incidents;
- Highlighting areas of risk in relation to EPRR to the CNO, and COO;
- Providing support to the Strategic, Tactical and Operational Command and Control structures in the event of an emergency;
- Participating and representing AHCFT in Cheshire & Mersey Multi-Agency Exercises, as and when required;
- Working with the wider Cheshire & Mersey EPRR Network to work as a system partner and peer support.

6.6. EPRR Project Management Support Officer

- Support and coordinate individual projects the EPRR Team undertake

6.7. EPRR Administrate Officer

- Support the administrative requirements of the EPRR Team

6.8. Clinical Lead/CBRN-HazMat

- Promoting and championing EPRR in line with legislation and best practice, working with clinical directors and colleagues;
- Providing specialist advice and support to the EPRRM on the clinical aspects of EPRR, underpinned by emergency preparedness theory and experience;
- Proposing policy change to EPRR plans as and when identified;
- Researching and developing the clinical elements of EPRR training and exercising;
- Participating in AHCFT and multi-agency EPRR training and exercises to provide clinical input;
- Ensuring that there is a continuous program of learning by the implementation and formulation of recommendations from national, local and AHCFT EPRR events;
- Assisting with the regular review of the Major Incident and supporting incident plans in line with NHS and national guidance;
- Work closely with the EPRRM to prepare information and evidence for EPRR audits;
- Lead on emergency department arrangements to support the Trusts 24/7 response capability for decontamination in response to CBRNe / HazMat incidents.

6.9. Executives On-Call (EOC)

In addition to the AHCFT On Call Manager Policy all staff on the EOC will:

- Ensure they are contactable during the agreed-on call period;
- Make the appropriate decisions for the agreed level of incident management;
- Promote EPRR methodologies and ways of working during incidents;
- Facilitate debriefing sessions following EPRR incidents;
- Maintain awareness of Trust Incident Response Plans and their duties associated to them
- Attend relevant training and exercises to keep their knowledge and skills related to EPRR up to date.

6.10. Senior Managers On-Call (SMOC)

In addition to the AHCFT On Call Manager Policy all SMOC staff will:

- Ensure they are contactable during the agreed-on call period;
- Make the appropriate decisions for the agreed level of incident management;
- Promote EPRR methodologies and ways of working during incidents;
- Facilitate debriefing sessions following EPRR incidents;

- Maintain awareness of Trust Incident Response Plans and their duties associated to them;
- Attend relevant training and exercises to keep their knowledge and skills related to EPRR up to date.

6.11. Associate Chief Operating Officer (ACOO) (or nominated Deputy)

Each department/division is responsible for:

- Ensuring that EPRR is part of everyday culture, and promoted and embedded across the Division;
- Ensuring the present Policy is followed and implemented within their areas of responsibility;
- Ensuring EPRR Core Standards relevant to individual Division are implemented at a local level, and there are appropriate records in place to support Trust governance and audit process;
- Developing action plans to strengthen compliance, and or, to address areas of non-compliance;
- Ensuring that adequate resources are made available for the response to incidents and emergencies;
- Ensure that there is appropriate and active representation at the EPG and related EPRR working groups as required;
- Ensure training needs analysis is undertaken and that an appropriate level of training and exercising for EPRR is delivered within their areas of responsibility, and appropriate governance records are maintained;
- Requesting EPRR support to facilitate debriefing sessions following incidents;
- Be responsible for any divisional actions highlighted as a result of the debriefs and learning to ensure continuous organisational development.

6.12. All Trust employees and sub-contractors

- Familiarising themselves with and adhering to all relevant EPRR policies, procedures and plans designed to minimise the impact of disruption to service provision;
- Cooperating and participating in the implementation of EPRR activities and take part in appropriate, related training and exercising.

6.13. Emergency Preparedness Group (EPG)

The EPG is a multi-disciplined group that will:

- Maintain a strategic oversight of all Trust matters relating to Emergency Preparedness, Resilience and Response (EPRR);
- Ensure the Trust meets its legislative and statutory requirements related to the Civil Contingencies Act (2004);
- Act as group to facilitate and support the Trust's compliance with NHS England Core Standards for EPRR;
- Provide a group where EPRR related concerns can be raised and addressed;

- Issue EPRR policies, plans, and procedures to Safety and Quality Assurance Committee (SQAC), who will report to the Trust Board on EPRR arrangements as required.

7. Incident Response Plans

Incident Response Plans (IRP's) will all follow the standard Trust template for Plans and Policies. The Trust is required to produce IRP's to mitigate the impact of common consequence incidents occurring that may impact the Trust or population it serves.

All IRP's will be reviewed annually, IRP's may be reviewed earlier in the event of changes to legislation or published guidance, they may also be reviewed earlier in the event of activation and post incident learning.

IRP version control will maintained within the Trusts Policy standards, with the addition of EPRR requirements this includes:

- Version numbering;
- Trigger / plan activation;
- Incident roles;
- Communication methods;
- Resources required;
- Stand down procedures;
- Debriefing requirements;
- Date and year identification;
- Archive and destruction of previous digital and hard copies;

Where IRP's are updated, the version number will be increased by 0.1 for minor changes and 1.0 for major changes.

7.1. Service Incident Response Plans

Service and local incident response plans where required will be established and implemented by the local service leads and signed off through divisional governance processes. They will require being presented to the EPG and EPRR Manager to ensure compliance with IRP and Trust Policy procedures.

8. Business Continuity Management System Strategy

The Trust Board will endorse the Trusts Business Continuity Management Strategy, to ensure business resilience. The board will be appraised on the Trusts key and critical service delivery areas and their levels of Maximum Periods of Tolerable Disruption in order to sponsor and endorse the Trusts overall BCMS Strategy and Programme of work.

The Trusts Business Continuity Planning arrangements will be developed and aligned in accordance with:

- NHS England Business Continuity Toolkit 2022
- ISO 22031
- ISO 22313
- NHS EPRR Core Standards

- Expectations and Indicators of Good Practice

The Trust acknowledges that despite proactive BCM efforts, residual risk may remain. Minimal acceptable risk beyond a threshold which could cause potential impact on Trust pre-identified levels of disruption. As a part of the BCMS Strategy such residual risks will undergo continuous monitoring.

Additional risk associated with business continuity, including those related to long terms planning, climate change, and adaptation processes will be reported in alignment with all EPRR risks.

9. Risk Assessment & Management

Risks relevant to EPRR will be managed in accordance to the Trusts Risk Assessment Policy and Risk Management Strategy. EPRR risks are acknowledged to hold high-risk scores, this is due to their impact to when reviewed in relation to the National Risk Register (NRR), and the Cheshire and Merseyside Community Risk Register (CRR).

Trust service leads are responsible for identifying and managing risk locally, this includes escalation of risk awareness within the service and to the EPG as appropriate.

The Trust will endeavour to mitigate against and reduce the impact of EPRR related risk where possible. In certain instances, the Trust may accept levels of risk where mitigation may be disproportionately high in relation to the probability and potential impact of the risk occurring, or where risks have control measures that reduce residual risk to as low as reasonably practicable.

The EPRRM will produce an assessment of risks relating to CRR and ensure appropriate controls are in place. Identified risks will be included into the Trusts EPRR working cycle.

10. Training & Exercising

The Trust will establish a Training and Exercising Program linked to the Trusts TNA and MOS, Trusts IRP's and related risks. Specific and dynamic response capabilities may also be trained and exercised outside of this, as determined by levels of required readiness.

The EPRR Training and Exercising Program will be updated annually in accordance with IRP cycles, risk profiles, and post-training and exercise feedback.

10.1. Training

The Trust will have processes in place to ensure that training for all staff included within IRP's, this will be undertaken in accordance with the EPRR Training Needs Analysis (TNA) and based upon individual roles as set out within the NHS England Minimum Occupational Standards (MOS) for EPRR.

This will ensure targeted training will be met for the following roles:

- AEO;

- Executives on Call;
- EPRR Manager;
- Senior Managers on Call;
- Service Leads and named roles within IRP's;

Training type and training frequency will be based on the TNA that will inform an annual training program in order to ensure roles can be carried in alignment with competency standards in the MOS.

Training records will be maintained through the EPRR Team, all training undertaken directly or indirectly by the Trusts EPRR team will be captured on this record.

10.2. Exercising

The Trust will ensure that EPRR response plans are tested regularly using a variety of processes, as appropriate.

Processes, functions and roles within plans, not individuals, will be exercised to ensure they are fit for purpose and fulfil all necessary functions and actions that may be required during an incident.

All exercises carried out by the Trust must have:

- Aim and objectives;
- Target mode;
- Target group;
- Link to plan / risk;
- Risk assessment to reduce disruption to organisation;
- Debriefing and lessons identified method.

The Trust where possible will consider exercising with partner agencies and contracted services where the identified risks and the involvement of partner organisations is appropriate.

Exercising records will be maintained through the EPRR Team, all training undertaken directly or indirectly by the Trusts EPRR team will be captured on this record.

11. Lessons Identified & Continuous Improvement

In order to identify lessons from any incident or exercise it is important to capture as much detail about the incident or exercise and the experiences of those involved as soon as is reasonably practicable.

AHCFT has a Debrief Guidance document, established by the EPRR and Staff Advice and Liaison Service (SALS) Team. The document provides comprehensive guidance on how a debrief will be delivered and how improvements will be identified and shared.

Lessons Identified from EPRR incidents will be owned by incident leads, service managers, and Trust senior management. Their completion will be monitored and reviewed by the EPRR Team and reported to the EPG Bi-Monthly.

12. EPRR Resource

The Trust will allocate suitable financial resource for EPRR to ensure effective compliance in proportion to criteria set out under the EPRR Core Standards, this includes financial resourcing to adequately account for depreciation of EPRR equipment, including recertification and replacement of PPE, PRPS, and associated decontamination facilities and additional equipment etc.

12.1. CBRNe / HazMat Decontamination Resourcing

The Trust holds 24 Powered Respirator Protective Suits (PRPS) these are maintained through the Trusts EPRR Budget and coordinated maintenance through Respirex International.

The built-in decontamination unit located within emergency department is considered as part of the Trust main hospital, compliance and the operability of the decontamination unit resides with Mitie, the Trusts hospital maintenance provider.

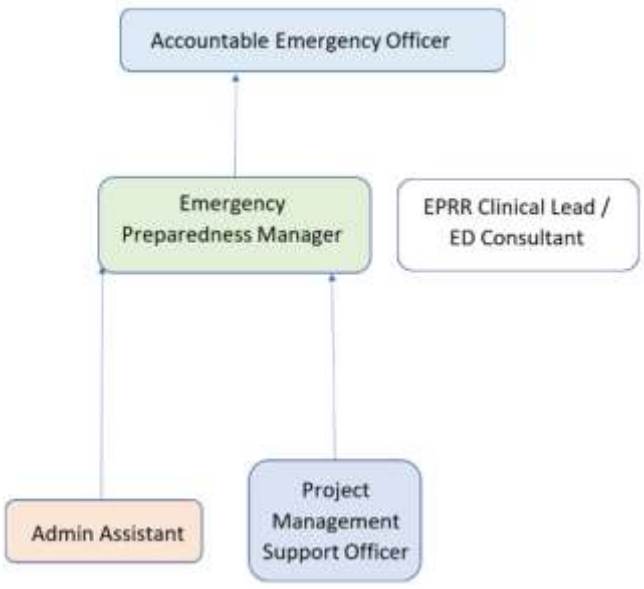
The Trust will seek to maintain 9 Trained PRPS HazMat CBRNe trainers to support the Emergency Departments training capability, audit, and preparedness.

12.2. Incident Response Resource

In the event of an incident being declared members of the SMOC team have authorisation to spend against the EPRR budget as required, this will be monitored, and detail of spending captured post incident review

13. EPRR Team Structure

The EPRR Team is comprised of an EPRR Lead, EPRR Clinical Lead, Project Management Support Officer, and an Administrative Assistant reporting to the Accountable Emergency Officer.



14. EPRR Governance Reporting Structure

The work of the EPRR Team and programs of work outlined within this policy will be reported quarterly to the Safety and Quality Assurance Committee. A report will be presented annually to the Trust Board.

All Trust level documents created and maintained as part of the EPRR and Business Continuity programme will be subject to the Trusts governance arrangements, circulated with all internal and external stakeholders as required, and held on the Trusts Document Management System (DMS) as the central repository.

The Trust EPRR Policy and Major Incident Plan will be endorsed by the Trust Board, all other Trust level documents created will be ratified by SQAC.

14.1. Trust EPRR Representation

14.1.1. *Local Resilience Forum*

NHS Cheshire and Merseyside AEO attends the Cheshire Resilience Forum (CRF) Executive Board and Merseyside Resilience Forum (MRF) Executive Group to support the health sectors contribution to the Local Resilience Forum (LRF). These groups are responsible for agreeing the LRF aim and objectives and drive the EPRR agenda at a Strategic level.

14.1.1. *Local Health Resilience Partnership*

The Trusts AEO represents AHCFT at Local Health Resilience Partnership (LHRP) Strategic meetings, in the event the AEO is unavailable a suitably nominated senior manager within the Trust may represent on their behalf.

The Cheshire and Merseyside ICB EPRR Lead or nominated deputy will represent the Trust at the Local Resilience Forum (LRF). Actions or relevant information for the Trust

will be fed down into LHRP Strategic (attended by AEO) and Tactical (attended by EPRR Manager) meetings.

NHS Cheshire and Merseyside have EPRR Management representation on behalf of the the ICB and wider health economy at the LRF Tactical and Operational Groups.

ICB EPRR Managers are responsible for cascading information with relevant health partners and inviting them to appropriate training, exercising or workshops to develop and promote local relationships and interoperability.

15. External Contractors & Suppliers

Where the Trust receives services or supplies that are key and / or essential to the acceptable level of Trust's usual operational delivery, the service lead of such supplier or contractor will assure themself in alignment with the Trusts overall BCMS that any supplier or contractor it is able to meet agreed contractual obligations under the departments local BCP and BCM arrangements.

BCP's of any supplier / contractor may be requested for any service delivery that is deemed business critical.

Where appropriate, local service business continuity exercising should offer to include representation from essential suppliers or contractors.

16. Monitoring

Monitoring	Lead Responsible	Frequency	Responsible Committee
Policy compliance	EPRR Manager	Annually	EPG

17. References & Further Information

Civil Contingencies Act 2004 - Civil Contingencies Act 2004
Health and Social Care Act 2012 - Health and Social Care Act 2012
Health and Care Act 2022 - Health and Care Act 2022
Expectations and Indicators of Good Practice Set for Category 1 and Category 2 Responders - Expectations and Indicators of Good Practice
NHS England EPRR Core Standards Guidance - Core Standards Guidance
NHS England EPRR Framework 2022 - EPRR Framework
NHS England Business Continuity Management Toolkit - BCM Toolkit
NHS England minimum Occupational Standards for EPRR - Minimum Occupational Standards
Trust Major Incident Plan (Mass Casualty)
Trust Business Continuity Plan
Trust Incident Response Plan
Trust Business Continuity Management System (Strategy)

18. Checklist for Approval of EPRR Plans/Policies

		Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear that the document is a Trust policy?	Yes	
2.	**Rationale**		
	Are reasons for development of the policy stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Is the plan linked to the local risk register?	Yes	
4.	**Content**		
	Is the aim and objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
	Are activation/escalation process' included?	N/A	
	Is the Command-and-Control structure included?	N/A	
	Are internal and external communication requirements included?	N/A	
	Are 24/7 capabilities included?	N/A	
	Are staff welfare factors included?	N/A	
	Does the plan include the stand down/recovery/debriefing process?	N/A	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		

		Yes/No/ Unsure	Comments
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/exercising to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document include version history and identify key changes since the last approved version?	Yes	
	Have previous versions (digital and physical been removed/destroyed)	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	N/A	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable (Default is 3 years)?	Yes	
11.	**Equipment**		
	Does the plan outline equipment requirements?	Yes	
12.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

19. Equality Impact Assessment

Initial Equality Impact Assessment (EIA) Form	
This section must be completed at the development stage i.e. before approval or ratification. For further guidance please refer to the Equality Impact Assessment (EIA) Policy on DMS.	
Part 1	
Name and Job Title of Responsible Person(s): Jacob Gray	**Contact Number:** 07790 976 815
Department(s): Emergency Preparedness, Resilience & Response	**Date of Assessment**: 20/06/2024
Name of the policy / procedure being assessed: EPRR Policy	
Is the policy new or existing? New ☐ Existing ☑	
Who will be affected by the policy (*please tick all that apply*)? Staff ☑ Patients ☐ Visitors ☐ Public ☐	
How will these groups / key stakeholders be consulted with? Click or tap here to enter text.	
What is the main purpose of the policy? To outline the Trusts overarching EPRR management processes and duties in compliance with the CCA 2004, NHS England EPRR Framework 2022, HM Government Emergency Response and Recovery Non-Statutory Guidance (2013), and NHS EPRR Standard Contract.	
What are the benefits of the policy and how will these be measured? Click or tap here to enter text.	
Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes ☑ No ☐ *If yes, please give brief details:* Trust Incident Response Plans and SOPs, On Call Manager Policy, Staff Absence Policy, Risk Management Policy, Risk Management Strategy, Business Continuity Management System Strategy.	
What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? *Please use the **Equality Relevance** guidance (see on DMS) to specify who would be affected (e.g. patients with a hearing impairment, staff aged over 50).* *Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)*	

Protected Characteristic	Tick either positive, negative or no impact			Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact		
Age	☐	☐	☑		
Sex	☐	☐	☑		
Race	☐	☐	☑		
Religion or belief	☐	☐	☑		
Disability	☐	☐	☑		
Sexual orientation	☐	☐	☑		
Pregnancy and maternity	☐	☐	☑		
Gender reassignment	☐	☐	☑		
Marriage and civil partnership	☐	☐	☑		
Other (specify)	☐	☐	☑		
If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) Click or tap here to enter text.					
Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? Yes ☐ No ☑ *See **Equality Relevance** guidance (on DMS) for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal)*					

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete a Full Equality Impact Assessment. Please speak to the Head of Equality, Diversity and Inclusion and see the Full Equality Impact Assessment (EIA) Form on DMS			
Action	**Lead**	**Timescale**	**Review Date**
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.

Declaration	
I am satisfied this document / activity has been satisfactorily equality impact assessed and the outcome is:	Tick one box
Continue – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken	☑
Justify and continue – EIA has identified an adverse impact but it is felt the policy cannot be amended. ***You must complete a Full Equality Impact Assessment (EIA) Form before this policy can be ratified***.	☐
Make Changes – EIA has identified a need to amend the policy in order to remove barriers or to better promote equality ***You must ensure the policy has been amended before it can be ratified.***	☐
Stop – EIA has shown actual or potential unlawful discrimination and the policy has been removed	☐
Name: Jacob Gray	Date: 20/06/2024

Approval & Ratification		
Policy Author:	Name: Jacob Gray	Job title: EPRR Manager
Approval Committee:	EPG	Date approved: 18/07/2024
Ratification Committee:	SQAC	Date ratified: 21/08/2024
Person to Review Equality Analysis:	Name: Jacob Gray	Review Date: 20/06/2024
Comments:	No comments to add.	

Alder Hey Children's NHS Foundation Trust

BUSINESS CONTINUITY MANAGEMENT SYSTEM STRATEGY

Document Properties	
Version:	1
Name of Ratifying Committee:	Safety and Quality Assurance Committee (SQAC)
Date Ratified:	21/08/2024
Name of Originator/Author:	Emergency Preparedness, Resilience & Response Manager
Name of Approval Committee:	Emergency Preparedness Group (EPG)
Date Approved:	18/07/2024
Executive Sponsor:	Chief Nursing Officer, Accountable Emergency Officer
Date Issued:	21/08/2024
Review Date:	30/08/2027

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	July 2024	EPRRM	Draft	New Document

Record of changes made to BCMS Strategy – Version 1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
		New Docuemnt	Formalisation of Trusts BCMS arrangements

Distribution List		
Role / Location	**Organisation**	**Format**
Document Management System	AHCFT	Electronic copy - (primary source)
Associate Chief Operating Officers	AHCFT	Electronic copy
Corporate Leads	AHCFT	Electronic copy

Any outdated version of this document will be destroyed via confidential waste/archived from online listings and replaced with the most up to date ratified version.

Contents

1. Introduction

This document describes the strategy of the Trusts Business Continuity Management System (BCMS) to support the continuous delivery of critical services during disruption.

In alignment with Emergency Preparedness, Resilience and Response Framework (2022) and Business Continuity Management Toolkit (2023), the Trust must prepare for, respond to, and recover from incidents whilst maintaining critical functions.

2. Scope

This document is for:

- Executives
- Strategic Commanders
- Senior Managers
- Tactical Commanders
- Incident management Staff
- Clinical Leads
- Heads of Service
- Operational Leads
- Communications staff

3. Aim

The aim of this BCMS is to set out the processes in the creation and monitoring of Business Continuity Plans (BCP's) and Business Continuity Planning compliance.

4. Objectives

The Trust Board recognises that the implementation of an effective BCMS Strategy is essential to the contribution and delivery of the Trusts vision and overall objectives.

The objectives of this BCMS are to:

- Support the identification, creation, and maintenance of BCP's
- Support stakeholders in creation and maintenance of BCP's
- Outline resources available to support the wider business continuity programme of work
- Align the Trust with NHS England EPRR Framework

5. Definitions

AEO – Accountable Emergency Officer
ARC – Audit and Risk Committee
BC- Business Continuity
BCM – Business Continuity Management
BCMS – Business Continuity Management System
BCP – Business Continuity Plan
BIA – Business Impact Analysis
EPG – Emergency Preparedness Group

EPRR – Emergency Preparedness, Resilience and Response
EPRRM – Emergency Preparedness, Resilience and Response Manager
NHSE – NHS England
ICS – Integrated Care System
IRP – Incident Response Plan
ISO – International Organisation Standard
RPO – Recovery Point Objectives
RTO – Recovery Time Objective
SME – Subject Matter Expert
SQAC – Safety and Quality Assurance Committee

6. Risk assessment

Risks relevant to BC will be managed in accordance with the Trusts Risk Assessment Policy and Risk Management Strategy. BC associated risks like EPRR risks are acknowledged to hold high-risk scores, this is due to their impact to when reviewed in relation to worst case scenario.

Trust service leads are responsible for identifying and managing risk locally, this includes escalation of risk awareness within the service and to the EPG as appropriate.

The Trust acknowledges that despite proactive BCM efforts, residual risk may remain. Minimal acceptable risk beyond a threshold which could cause potential impact on Trust pre-identified levels of disruption.

The Trust will endeavour to mitigate against and reduce the impact of BC related risk where possible. In certain instances, the Trust may accept levels of risk where mitigation may be disproportionately high in relation to the probability and potential impact of the risk occurring, or where risks have control measures that reduce residual risk to as low as reasonably practicable.

7. Business Impact Analysis

BIA’s will be conducted and updated by all required Trust services annually to ensure up-to-date information and relevance. They will be reported through divisional forums and collated via divisional EPG reports.

BIA’s will be used to inform BCP’s by identifying:

- Critical activities
- Resource requirements
- Recovery time objectives
- IM&T alignment to backup systems

BIA’s will be conducted using the NHSE adopted excel template.

8. Business Continuity Plan

8.1. BCP Document Control & Storage

Trust BCP's will be maintained in a restricted SharePoint portal. Access will be made to BCP Authors, and Trust Commanders. Hard copies of BCP's will be held within local versions will be held in their respective areas.

Any outdated BPC versions will be destroyed via confidential waste/archived from online listings and replaced with the most up to date ratified version.

8.2. BCP Requirements

Business continuity plans across the Trust will be created at three levels:

- Organisational
- Divisional
- Service

All BCP's should follow the Trust standard BCP Template that includes the following:

- Cover Document
    - Identifiers

- Plan Administration and Maintenance
    - Version Control
    - Distribution List
    - Document Author
    - Review Date
    - Exercising schedule
    - Plan Approval

- Introduction
    - Aim
    - Objectives
    - Scope
    - Legal and regulatory requirements
    - Linked plans

- Roles and responsibilities
    - Identification of key roles
    - Prompts for action and escalation

- Link to Business Impact Analysis
    - Prioritised activities including Recovery Time Objectives (RTO)
    - Resource requirements for priority services:
        - Staff
        - Service / Supplier Disruption
        - Loss of Premises
        - Loss of Data

- Plan Activation

  - Activation triggers
  - Activation procedures
  - Escalation procedures
  - Stand down procedures

- Incident Response
  - Command and control/Incident response procedure
  - Incident response structure
  - Action cards / checklists
  - Decision making requirements

- Recovery
  - Recovery strategies
  - Debriefing, lessons learned capturing, incident reports, action planning

- Communications
  - Internal and external stakeholder comms procedures
  - Warning and informing of the public
  - Sharing information in alignment with any Information Governance (IG) requirements
  - Media / press arrangements

- Annexes
  - Reference to BIA's
  - Contact directory (internal and external stakeholders)
  - Internal and external interdependencies
  - Templates, agendas, proformas
  - Mutual aid agreements

9. Training

BCP Authors will be invited to attend NHSE adopted BCP Workshops delivered by the Trust EPRRM. The workshop will support authors by covering the following topics:

- Overview of Business Continuity Management and Cycle
- Legal aspects and NHS England Core Standards
- Business Impact Analysis
- Business Continuity Strategy Outcomes
- Business Continuity Incident Response Plans
- Exercising, Maintaining & Reviewing

Workshops will be held 4 times a year to support the continuous support of new services and/or authors. These will be included in the Trusts EPRR Training and Exercising programme of work.

All workshop attendees' records will be maintained by the EPRR Team, these will be included into assurance reporting through EPG, SQAC, and Trust Board as outlined in section 13. Feedback from workshops will be collated through Microsoft Forms to evaluate and improve content.

The Trusts EPRR Mandatory Training for all employees will include a dedicated section highlighting the requirements of local business continuity planning.

10. Exercising

Exercises will be coordinated within each division. Each BCP is required to be exercised once annually. The BCP author / lead will identify and include stakeholders in exercises as required by the individual BCPs requirements, risk assessments, previous incidents, changes to the service, infrastructure, or role within the Trust.

Exercises should be concluded with a hot-debrief to capture good practise, learning, and areas of improvement.

Exercise themes, attendance records, debrief material, and action plans will be monitored within the division and highlight included into divisional reporting to the EPG, and collated within the Trusts EPRR BCM Assurance Database.

11. External Suppliers & Contractors

BCP or BC planning arrangements should be requested during the initial stages of engagement with suppliers providing essential or critical services, these should ideally be included within any bidding submissions or equivalent.

BCPs should be reviewed by relevant SME's, Risk Management, and EPRRM.

- Supplier BCP's should be reviewed and approved before awarding of contracts. Acceptable assurance sought for should include:
- Current BCP
- Evidence of testing
- Evidence of BCP outlining supplier maintains sufficient resources and/or arrangements to maintain service delivery during disruptions.
- Alignment to ISO 22301

12. Governance & Audits

12.1. Documents within BCMS Scope

Documents within the BCMS scope will be approved at local divisional level and ratified at EPG. Reviews, updates and re-approval as a part of the cycle of learning will be maintained within the division and status reported to EPG.

12.2. Board Assurance

The board will receive an annual assurance report containing the compliance levels of divisions BCM programmes of work and the Trusts overall BC compliance.

12.3. Action Plans

Action plans derived from exercises, audits, or incidents are monitored using a lessons identified log and reported to the EPG through divisional assurance reports.

12.4. Oversight & Support

The AEO and EPRRM will provide strategic oversight and ensure the BC program has adequate resource, including sufficient workshops and training and exercising resource.

12.5. Audit within BCMS Scope

BCP Audits will be undertaken by the Trusts EPRR Team. All audits will be conducted in alignment to ISO 22301, the full audit can be found within Appendix 1.

One internal audit per division will be conducted each year.

The Trust will seek to conduct external audits every 3 years to validate internal findings and provide additional assurance and/or recommendations.

Audit results will be included into the Trusts BCM Programme of work, this will be reported to EPG bi-monthly, SQAC quarterly, ARC annually, and the Board Annually.

12.6. Business Continuity SharePoint

The Trusts EPRR SharePoint maintains a library of BC resources to support all aspects of BC requirements:

- Business Impact Analyses Template
- Business Continuity Plan Template
- Exercising materials
- BC Workshop enrolment
- Local checklist templates

The SharePoint site is regularly and continuously updated to reflect the latest developments and feedback.

13. Monitoring

BCMS Strategy will be monitored via:

Monitoring	Lead Responsible	Frequency	Responsible Committee
Exercising	Divisional Leads	Bi-Monthly	EPG
Divisional BCP Compliance	Divisional Leads	Bi-Monthly	EPG
BCP Audit / Compliance	EPRR	Semi-Annually	EPG / SQAC
BC Workshop Training Attendance	EPRRM	Bi-Monthly	EPG
Trust Overall BCP Compliance	EPRRM	Annually	Trust Board
Trust BCP Compliance	EPRRM	Annually	EPG / SQAC

14. Further Information

- Civil Contingencies Act (2004)
- ISO 22301
- NHS England Business Continuity Management Toolkit (2023)
- NHS England EPRR Framework (2022)
- BCI Good Practice Guidelines (2018)
- NHS Digital Data Security Protection Toolkit

15. Appendices

Appendix #	Title
1	BC Audit Template

Appendix 1 – BC Audit Template

Audit Date			
Auditor Name			
Plan Title			
Department / Division			
Risk Assessment			
Is there a documented risk assessment	Yes	No	
Does the risk assessment identify potential threats	Yes	No	
Are controls clearly outlined	Yes	No	
Is the risk in date	Yes	No	
Additional Comments			
Business Impact Analysis			
Is there a documented BIA	Yes	No	
Has BIA been reviewed within last 12 months	Yes	No	
Are RTO's and RPO's clearly defined	Yes	No	
Has BIA been referenced within BCP	Yes	No	
Additional Comments			
Business Continuity Plans			
Are BCP's in place for all critical functions	Yes	No	
Has BCP been reviewed within last 12 months	Yes	No	
Are roles and responsibilities clearly defined within BCP	Yes	No	
Are BCP's available electronically and local hard copies	Yes	No	
Additional Comments			
Exercising			
Has an exercise been held within last 12 months	Yes	No	
Has exercise learning been applied to BCP	Yes	No	
Are exercise records available	Yes	No	
Additional Comments			
External Suppliers and Contractors			
Have supplier BCP's been reviewed	Yes	No	N/A
Have suppliers provided adequate assurance	Yes	No	N/A
Additional Comments			
Document Control			
Does the BCP follow the Trust template	Yes	No	
Is the document correctly security marked	Yes	No	
Have updates been recorded in the documents record of changes	Yes	No	
Is the BCP held in the secure SharePoint	Yes	No	
Summary and Recommendations			
Overall assessment	Fully assured	Partially assured	Not assured
Recommendations			

16. Checklist for Approval

		Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear that the document is a Trust policy?	Yes	
2.	**Rationale**		
	Are reasons for development of the policy stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document include version history and identify key changes since the last approved version?	Yes	
9.	**Process for Monitoring Compliance**		

		Yes/No/ Unsure	Comments
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable (Default is 3 years)?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

17. Equality Impact Assessment

Initial Equality Impact Assessment (EIA) Form	
Part 1	
Name and Job Title of Responsible Person(s): Jacob Gray EPRR Manager	**Contact Number:** 07790 976815
Department(s): Emergency Preparedness, Resilience & Response	**Date of Assessment**: 31/05/2024
Name of the policy / procedure being assessed: BCMS Strategy	
Is the policy new or existing? New ☑ Existing ☐	
Who will be affected by the policy Staff ☑ Patients ☐ Visitors ☐ Public ☐	
How will these groups / key stakeholders be consulted with? Stakeholder consultation email	
What is the main purpose of the policy? To formalise the trusts Business Continuity Management System Strategy and processes in alignment to NHSE framework 2022	
What are the benefits of the policy and how will these be measured? Support Trust resilience to disruptive events, compliance recorded and reported through Trust EPRR Annual Core Standards.	
Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes ☑ No ☐ *If yes, please give brief details:* EPRR Policy, Business Continuity Plan, Risk Management Policy, Risk Management Strategy	
What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? *Please use the **Equality Relevance** guidance (see on DMS) to specify who would be affected (e.g. patients with a hearing impairment, staff aged over 50).* *Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)*	

Protected Characteristic	Tick either positive, negative or no impact			Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact		
Age	☐	☐	☑		
Sex	☐	☐	☑		
Race	☐	☐	☑		
Religion or belief	☐	☐	☑		
Disability	☐	☐	☑		
Sexual orientation	☐	☐	☑		
Pregnancy and maternity	☐	☐	☑		
Gender reassignment	☐	☐	☑		
Marriage and civil partnership	☐	☐	☑		
Other (specify)	☐	☐	☑		
If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)					
Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? Yes ☐ No ☑ *See **Equality Relevance** guidance (on DMS) for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal)*					

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete a Full Equality Impact Assessment. Please speak to the Head of Equality, Diversity and Inclusion and see the Full Equality Impact Assessment (EIA) Form on DMS			
Action	**Lead**	**Timescale**	**Review Date**
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.

Declaration	
I am satisfied this document / activity has been satisfactorily equality impact assessed and the outcome is:	Tick one box
Continue – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken	☑
Justify and continue – EIA has identified an adverse impact but it is felt the policy cannot be amended. ***You must complete a Full Equality Impact Assessment (EIA) Form before this policy can be ratified***.	☐
Make Changes – EIA has identified a need to amend the policy in order to remove barriers or to better promote equality ***You must ensure the policy has been amended before it can be ratified.***	☐
Stop – EIA has shown actual or potential unlawful discrimination and the policy has been removed	☐
Name: Click or tap here to enter text.	Date: Click or tap to enter a date.

Approval & Ratification		
Policy Author:	Name: Jacob Gray	Job title: EPRR Manager
Approval Committee:	EPG	Date approved: 18/07/2024
Ratification Committee:	SQAC	Date ratified: 21/08/2024
Person to Review Equality Analysis:	Name: Jacob Gray	Review Date: 30/05/2027
Comments:	No Comments to add.	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 5th September 2024

Paper Title:	Emergency Preparedness, Resilience and Response, Annual Report 2024
Report of:	Nathan Askew - Chief Nursing, AHP and Experience Officer (Accountable Emergency Officer)
Paper Prepared by:	Jacob Gray - Emergency Preparedness, Resilience & Response Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ■
Background Papers and/or supporting information:	Alder Hey Children's EPRR Annual Core Standards.
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:	

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
189	The risk is the non-compliance in statutory requirement to formally assure NHS England with the Trusts readiness to respond to emergencies, provided through the EPRR annual assurance process.					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

This report summarises the Trusts overall preparedness in reference to NHS England Emergency Preparedness, Resilience & Response (EPRR) Core Standards. It highlights emergencies and disruptive events, Business Continuity, and EPRR Training and Exercising.

Last year the Trust reported a non-compliant return in alignment with NHS England North's check and challenge process. Although the Trust has seen significant improvement in its overall compliance the level of assurance which relating to all domains across the EPRR portfolio, this is due to much more stringent check and challenge processes into each individual standard.

This year the Trust reports its self-assessment against the Core Standards as non-compliant, with a compliance standard of 51% submitted to the ICB. This exceeds projected expectations of 40% compliance following the 2023 compliance submission at 8%.

The check and challenge process for 2024 has been reviewed and amended from 2023. This years check and challenge process will now be led by Cheshire and Merseyside NHS ICB EPRR colleagues and peer-reviewed with EPRR colleagues across Cheshire and Merseyside Trusts.

Whilst the Trust is confident in its compliance level, the change in check and challenge processes for 2024 could see a compliance reduction, to which the Trust Board will receive an amended position statement and action plan.

2. Purpose

This report is to provide an annual assurance report to the Board of Directors on the current position of the Alder Hey Children's NHS Foundation Emergency Preparedness Resilience and Response (EPRR).

It also provides information of the year to date for EPRR including the assurance rating against the NHS England Core Standards for EPRR.

3. Background

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006, and Health and Care Act 2022 underpin EPRR for Health.

The Civil Contingencies Act 2004 places statutory duties on the Trust, which is classed as Category 1 responder, as such the full set of civil protection duties apply, requiring it to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place business continuity management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;

- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency.

Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England Guidance.

4. EPRR Resource

The Trusts EPRR Manager is currently supported by NHSP resource, who support project support and administrative duties, a business case has been submitted to support full time positions to support the Trusts EPRR portfolio. The Trust also currently funds a Consultant Programmed Activities (PA)to support clinical EPRR requirements.

5. Significant incidents and Events

The Trust has responded to a number of incidents within the last 12 months. It should be noted that whilst it is essential that the EPRR team are involved in these significant events, this has impacted on delivery of some aspects of the work plan against the core standards.

Declarations have been made for 3 incidents.

Incident	Scenario	Type	Date
M53 Crash	Overturned bus resulting in multiple casualties	Major Incident	29/09/2023
CT Scanner Downtime	Urgent CT downtime resulting in no CT capacity for prolonged period	Business Continuity Incident	23/07/2024
Southport Stabbing	Knife attack on multiple people including children	Major Incident	29/07/2024
Industrial Action	Planned reduction of staff	Not Declared	Numerous
CrowdStrike failed update	Global disruption to multiple IM&T systems and services	Not Declared	19/07/2024

5.1. Incidents and Events reported by divisions internally

All divisionally reported incidents highlighted below are reported into the Trusts Emergency Preparedness Group, many required no further action of the group and were included for information only. All items are categorised under the three recognised incident domains as Major Incident, Critical Incident, and Business Continuity Incident, with Business Continuity Incident further broken down to, Loss of staff, Service/Supplier Disruption, Loss of Data, Loss of premises. Some incidents and events reported carried over for a number of months as a part of divisional reporting.

A full list of themes from these incidents can be found in Appendix. 1.

Medicine	Total
Sep-Dec - 2023	2
Period 1 - 2024	2
Period 2 - 2024	3
Period 3 - 2024	0
Period 4 - 2024	N/A
Total events	7

Surgery	Total
Sep-Dec - 2023	2
Period 1 - 2024	2
Period 2 - 2024	1
Period 3 - 2024	5
Period 4 - 2024	N/A
Total events	10

Community	Total
Sep-Dec - 2023	16
Period 1 - 2024	5
Period 2 - 2024	14
Period 3 - 2024	3
Period 4 - 2024	N/A
Total events	38

Estates & Facilities	Total
Sep-Dec - 2023	2
Period 1 - 2024	0
Period 2 - 2024	1
Period 3 - 2024	0
Period 4 - 2024	N/A
Total events	3

Digital	Total
Sep-Dec - 2023	3
Period 1 - 2024	5
Period 2 - 2024	10
Period 3 - 2024	0
Period 4 - 2024	N/A
Total events	18

Research	Total
Sep-Dec - 2023	2
Period 1 - 2024	0
Period 2 - 2024	0
Period 3 - 2024	0
Period 4 - 2024	N/A
Total events	2

6. Policies, Plans, Procedures

The Trusts Policies, Plans and Procedures are maintained on the Trusts Document Management System (DMS).

- There are currently 5 plans out of date, these are included into the EPG annual work plan and are expected to be completed by during 2025. . Many of the plans had previously been a part of a 3 year update cycle, this cycle has been reviewed and reduced to a 1 year cycle following the 2023 check and challenge process.
- Updating, planning, resourcing, coordination, collaboration, and embedding of all plans by the EPRR Team during 2024 has not been achieved due to the significant changes made across the plans to date.
- Some plans require co-authoring as used during incidents, require subject matter expertise from leads across the Trust.
- 4 additional plans have been identified as being required, these are in their draft stages and included into the EPG annual work plan and are expected to be in place by the dates listed within the review period as final drafts ahead of ratification. .

Name	Document Type	Review Date
Adverse Weather Plan	Plan	29/08/2025
Bomb Threat Plan	Plan	23/09/2024
Business Continuity Management Strategy	Guidance	30/05/2026
Business Continuity Plan	Plan	14/08/2024
Emergency Preparedness, Resilience and Response Policy	Policy	12/07/2025
HAZMAT and CBRNE Incident Management Plan	Other / Miscellaneous	14/08/2024
Hospital Evacuation Plan	Plan	31/10/2023
Incident Response Plan	Plan	31/07/2025
Incident Communications Plan	Plan	18/07/2025
Incident Coordination SOP	Standard Operating Procedure	18/05/2025
Lockdown Policy	Policy	18/01/2026
Major Incident Command and Control Plan for Mass Casualties	Plan	31/05/2023
On Call Manager Policy	Policy	25/05/2025
Pandemic Plan	Plan	26/04/2024
Excess Fatalities Plan	Plan	Final Draft - 26/12/2024
Protected Individuals Plan	Plan	Final Draft - 26/12/2024
Countermeasures Plan	Plan	Final Draft - 23/01/2025
Lockdown Plan	Plan	Final Draft - 28/11/2024

6.1. Divisional and Departmental Business Continuity Planning

Changes to the divisional and departmental business continuity plans (BCP's) through the BCMS is allowing a reset of all BCP's as they undertake an enhanced process to bring them in alignment.

The Trusts EPRR Team has created a repository of resources for BCP owners, established workshops, and set tabletop dates to test and review plans. In 2025 we will review how the learning from Business Continuity incidents is captured and shared across the Trust.

Medicine	Total
BIA's Conducted	0
# of BCP's	10
BCP's Exercised	10
BCP's in Date	1

Surgery	Total
BIA's Conducted	0
# of BCP's	16
BCP's Exercised	0
BCP's in Date	0

Community	Total
BIA's Conducted	0
# of BCP's	8
BCP's Exercised	0
BCP's in Date	0

Divisional Compliance	%
Medicine Compliance	0
Surgery Compliance	0
Community Compliance	0
Estates & Facilities Compliance	0
Digital Compliance	0
Research Compliance	0
Corporate Services Compliance	0
Misc Compliance	0
Overall Compliance	0

Estates & Facilities	Total
BIA's Conducted	0
# of BCP's	7
BCP's Exercised	0
BCP's in Date	1

Digital	Total
BIA's Conducted	0
# of BCP's	5
BCP's Exercised	0
BCP's in Date	0

Research	Total
BIA's Conducted	0
# of BCP's	1
BCP's Exercised	0
BCP's in Date	0

Overall	Total
BIA's Conducted	0
# of BCP's	55
BCP's Exercised	10
BCP's in Date	2

Corporate Services	Total
BIA's Conducted	0
# of BCP's	7
BCP's Exercised	0
BCP's in Date	0

Misc	Total
BIA's Conducted	0
# of BCP's	1
BCP's Exercised	0
BCP's in Date	0

7. Training Compliance

The Trust has an established EPRR training needs analysis (TNA), with a complimenting annual training and exercising programme.

Many of the below listed training modules have been introduced during 2024 to support commanders. Staff who have been identified for the additional training have been booked on the respective courses as they become available. Executive on-call Incident Response Training is at 100% and Senior Manager on Call Incident Response Training is at 75.68%.

Tactical Commanders receive a compliance report update monthly to direct resources, training opportunities, and self-led learning to support their compliance. This model is due to be expanded to support Strategic Commanders on a quarterly basis by end of year 2024. All current compliance is reported to the Emergency Preparedness Group on a bi-monthly basis.

These metrics prevent the Trust from achieving 2 core standards as part Training and Exercising Domain, which currently remain partial and require significant improvement during 2025, this will be a key component of the EPG workplan moving forward.

All training sessions are designed in alignment with Minimum Occupational Standards for Emergency Preparedness, Resilience and Response.

EPRR Training is coordinated through the Trusts EPRR SharePoint and database maintained locally within the EPRR Team.

	AEO Only	Strategic / EOC			
Training	**AEO - Role and Expectations**	**Principles of Health Command - Strat**	**Executive on-call Incident Response**	**Commander Portfolio Workbook**	**Media Training**
Frequency	2 yearly	3 yearly	3 yearly	1 yearly	2 yearly
EPRR Mandatory or Optional	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Total Staff to be trained	2	12	12	12	13
Total staff trained	0	2	12	0	0
%	0.00%	16.67%	100.00%	0.00%	0.00%

ICB Colleagues have created a AEO Training package that can be delivered locally by the Trusts EPRR Manager to The Trusts AEO, and Deputy AEO. These training sessions have been scheduled in to be conducted in September 2024.

	Tactical/SMOC			
Training	**Principles of Health Command - Tac**	**SMOC Incident Response**	**Commander Portfolio Workbook**	**Commander CBRNe HazMat Awareness**
Frequency	3 yearly	3 yearly	1 yearly	3 Yearly
EPRR Mandatory or Optional	Mandatory	Mandatory	Mandatory	Mandatory
Total Staff to be trained	37	37	37	37
Total staff trained	13	28	0	0
%	35.14%	75.68%	0.00%	0.00%

			Tactical & Strategic		
Training	**Legal Awareness Training**	**Working with your Loggist Training**	**Incident Coordination Centre familiarisation (ICC)**	**JESIP Training/Awareness**	**Resilience Direct**
Frequency	3 yearly	3 years	2 Years	2 yearly	Once
EPRR Mandatory or Optional	Optional	Mandatory	Mandatory	Mandatory	Optional
Total Staff to be trained	49	49	49	49	49
Total staff trained	0	2	1	2	2
%	0.00%	4.08%	2.04%	4.08%	4.08%

Selected executives have registered on to an ICB Led Legal awareness Training Course, certification and accreditation for this has not yet been released, as such the Trust has no evidence to support the Legal Awareness Training session to date.

	Other	
Training	**Loggist Training**	**Business Continuity**
Frequency	3 yearly	3 yearly
EPRR Mandatory or Optional	Optional	Mandatory
Total Staff to be trained	25	TBC
Total staff trained	5	N/A
%	20.00%	N/A

While the Trust is embedding its newly established Business Continuity Management System Strategy (BCMS) figures to support Business Continuity Workshops is ongoing. The 2024 review into Divisional and Departmental BCP's identified over 100 total plans with approximately 80 individual Authors. The BCMS programme of work will continue into 2025 with individual invites going to authors to support their business continuity awareness.

	EPRR					
Training	**Structured debrief training**	**Senior Emergo Instructor**	**L3 Teaching**	**CBCI**	**DIPHEPPR**	**Loggist Instructor**
Frequency	5 years	Once	Once	Once	Once	Once
EPRR Mandatory or Optional	Mandatory	Optional	Mandatory	Mandatory	Mandatory	Mandatory
Total Staff to be trained	1	1	1	1	1	1
Total staff trained	1	1	1	0	1	1
%	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%

Trust
EPRR Overview Mandatory Training
3 Yearly
Mandatory
Whole Trust
N/A
93.23%

Divisions						
Academy	Alder Hey in the Park	Capital	Community & Mental Health	Digital	Executive	Facilities
97.14%	69.23%	94.12%	93.04%	98.75%	92.59%	92.93%
Finance	Human Resources	Innovation	Marketing & Comms	Medical Services	Medicine	Nursing & Quality
95.35%	90.32%	83.33%	100.00%	75.00%	94.33%	94.25%
	Other	Planning	Research & Development	Strategy	Surgical Care	
	100.00%	100.00%	98.59%	92.68%	91.65%	

8. Exercising

Exercises during 2024 have tested several areas and documents as shown below. Learning from exercises is presented to EPG.

Title	Description	Plan Tested	Type	Date
Exercise Hermes	ICB Communications exercise	Switchboard Cascade	Communication	13/03/2024
Exercise MICAS	Switchboard cascade exercise	Switchboard Cascade	Communication	15/04/2024
Exercise DeconSim	HazMat Decontamination	HazMat CBRN	Live	02/05/2024
Exercise Toucan	ICB Communications exercise	Switchboard Cascade	Communication	23/05/2024
Medicine BC	Medicine Division BC – Loss of Staffing	Renal, MDU, Cancer Services, ED, UC, 3C, 4C, 4B, 3B, Dietetics BCP	Tabletop	28/06/2024
Planned Exercises for 2024 Year End				
Surgery BC	Surgery Division BC – Premises Loss	Theatres, PICU, HDU, 1C, 4A, Burns, Medical Engineering	Tabletop	23/08/2024
Exercise Ortho	Response to unplanned HCID patient	Incident Response Plan / HCID Plan	Tabletop	26/11/2024

9. Core Standards Compliance

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	1	10	0
Command and control	2	2	0	0
Training and exercising	4	2	2	0
Response	7	6	1	0
Warning and informing	4	2	2	0
Cooperation	4	3	1	0
Business Continuity	10	4	6	0
Hazmat/CBRN	12	5	7	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	32	30	0

10. Conclusion

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 this document highlights progression the Trust is making with the EPRR portfolio it is essential to acknowledge there are areas that require further and sustained development. Challenges identified with individual standards are reported to EPG and escalated to the AEO as required through the bi-weekly meetings.

Although the core standards submission remains non-compliant, the Trust has exceeded its projected level of compliance against the core standards workplan.

11. Recommendations

The Alder Hey Children's NHS Foundation Trust Board of Directors is requested:

To note the annual EPRR assurance report and self-assessment assurance rating of non-compliance in line with the NHS England EPRR core standards for 2024.

To note and endorse the Trusts Business Continuity Management Strategy.

To note and endorse with the Trust EPRR Policy.

12. Appendix 1 - Incidents and Events reported by division breakdown

Medicine:

Date	Description	Category of Incident
Sep-23	Microbiology walk in fridge/freezer failure	Service/Supplier disruption
Sep-23	Issues with water supply, made dialysis machine malfunction	Service/Supplier disruption
Jan-24	Generator failure during blackstart exercise	Service/Supplier disruption
Feb-24	Generator failure (blackstart) - CL3 safety facilities shutdown	Service/Supplier disruption
Mar-24	CT scanner fault	Service/Supplier disruption
May-24	Images taken since installation of new fluoroscopy cant send to PACS	Service/Supplier disruption
May-24	Alder Hey AAH account cannot accept more orders until payment received.	Service/Supplier disruption

Surgery:

Date	Description	Category of Incident
Sep-23	All scopes decontaminated with water - outside acceptable range for endoscopy decon	Service/Supplier disruption
Oct-23	M53 Major Incident	Service/Supplier disruption
Jan-24	M53 Major Incident	Major Incident
Feb-24	M53 Major Incident	Major Incident
May-24	M53 Major Incident	Major Incident
Jul-24	M53 Major Incident	Major Incident

Community:

Date	Description	Category of Incident
Jul-23	Lift failure at Sefton Carers Community Site for OT & Physio	No EPRR Escalation Required
Jul-23	Fire door on the corridor of level 1 OPD will not stay closed	No EPRR Escalation Required
Jul-23	Ongoing leak in CAMHS MTD office - due to heavy rain - had to move equipment	No EPRR Escalation Required
Aug-23	MHST office in Thornton's Centre too hot to work in	No EPRR Escalation Required
Aug-23	Failure in delivery of water to modular building from catering	No EPRR Escalation Required
Aug-23	Tire problems when parking at temporary car park	No EPRR Escalation Required
Sep-23	MHST office in Thornton's Centre too hot to work in	No EPRR Escalation Required
Sep-23	False fire alarm in SFH	No EPRR Escalation Required
Sep-23	Printers not working at Netherton & Southport centres	No EPRR Escalation Required
Sep-23	Accident in temporary car park - tripped on uneven ground	No EPRR Escalation Required
Sep-23	SARC medical equipment issues	No EPRR Escalation Required
Oct-23	Printers not working at Southport outpatient hub	No EPRR Escalation Required
Oct-23	Telephone divert in SaLT due to absence of admin in Ainsdale office	Loss of Staff
Oct-23	False fire alarm in 3SM	No EPRR Escalation Required
Oct-23	Unsafe building security - main door locking system not working	Loss of Premises
Oct-23	Unsuitable base in Thornton centre for NHST team	Loss of Premises
Nov-23	No heating in SFH overnight	Service/Supplier disruption
Nov-23	Security guard not available from 9:30am onwards for 2 nights	Loss of Staff
Dec-23	Modular building heating not working	Service/Supplier disruption
Dec-23	Heating in Thornton's centre not working	Service/Supplier disruption
Dec-23	ADHD nursing team unable to prescribe medication due to staff shortage	Loss of Staff
Feb-24	Fire call to modular building	No EPRR Escalation Required
Feb-24	No security guard in SFH overnight	Loss of Staff
Feb-24	Automatic intermittent fire alarm continuously sounding	No EPRR Escalation Required
Feb-24	ID badges for SFH not working	Loss of Data

Feb-24	Fire alarm false alarm - food burning in microwave	No EPRR Escalation Required
Feb-24	Telephone lines down at Burlington Contact engaged tone	Service/Supplier disruption
Mar-24	Not receiving inbound calls to CAHMS crisis care	Service/Supplier disruption
Mar-24	Door to Thornton Wellbeing broken after attempt to lock up	Service/Supplier disruption
Mar-24	Fobs to southport centre stopped working	Service/Supplier disruption
Mar-24	Prank calls made to CAMHS Crisis Care team numerous times	No EPRR Escalation Required
Mar-24	Teams crashing / not recording work completed	Service/Supplier disruption
Mar-24	update applied to trust logging system, caused disruption to DHCP services	Service/Supplier disruption
Apr-24	Printer broken in NHC - off for 2 weeks +	No EPRR Escalation Required
Apr-24	Printer broken at Netherton HC	No EPRR Escalation Required
May-24	Poor internet access at Sunflower House meant unable to access interpreting service for patient	No EPRR Escalation Required
Jun-24	unable to print resource, referrals and reports, or scan at Sefton Carers Centre due to printer outage	No EPRR Escalation Required
Jun-24	Unable to print patient resources due to MFD printers not working	No EPRR Escalation Required

Estates & Facilities:

Date	Description	Category of Incident
Aug-23	Catering walk in fridge failure	Service/Supplier disruption
Oct-23	Beech water strike - loss of water to Alder Centre	Service/Supplier disruption
Jun-24	Electrical strike	No EPRR Escalation Required
Jun-24	Electrical strike	No EPRR Escalation Required

Digital:

Date	Description	Category of Incident
Sep-23	Telephone system failure	Service/Supplier disruption
Oct-23	External telephone lines hardware fault	Service/Supplier disruption
Oct-23	Alder care issue - hardware fault	Service/Supplier disruption
Oct-23	External telephone lines hardware fault	Service/Supplier disruption
Oct-23	Alder care issue - hardware fault	Service/Supplier disruption
Jan-24	Bleep failure	Service/Supplier disruption
Feb-24	Vitals outage	Service/Supplier disruption
Feb-24	Bleep failure	Service/Supplier disruption
Mar-24	Bolton data centre had issues due to lack of load testing, old connections reactivated to restore service.	Service/Supplier disruption
Mar-24	trust's web filtering appliances are failing - cant handle demand. To be replaced by a new firewall soon.	Service/Supplier disruption
Apr-24	New certificate issued to Meditech, a change made in system by supplier reverted this back	Service/Supplier disruption
Apr-24	A database log issue required System C to resolve, restoring access. Post-firewall migration, communication between Detect and CareFlow systems was offline.	Service/Supplier disruption
Apr-24	The trust's outdated web filters caused service issues, prompting a migration to new firewalls.	Service/Supplier disruption
May-24	A new security certificate issued to remote desktop solution which caused issues with access	Service/Supplier disruption
May-24	Issue with printing transfusion documents / lab labels from Meditech.	Service/Supplier disruption
May-24	The trust experience an extended period of intermittent disruption to Meditech web client.	Service/Supplier disruption
May-24	New trust firewalls caused slow or unresponsive access to web applications like O365.	Service/Supplier disruption
Jul-24	disruption of the Bleep system experience on two occasions for prolonged periods	Service/Supplier disruption
Jul-24	Issue with Microsoft Azure services, an international issue with cloud-based systems (Cloudstrike)	Loss of Data