BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 5th December 2024, commencing at 1:00pm
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 (1:00pm-1:15pm)							
1.	**24/25/237**	**13:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/238**	**13:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/239**	**13:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **7th November 2024.**	**D**	Read enclosure
4.	**24/25/240**	**13:19 (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.	**24/25/241**	**13:20 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**24/25/242**	**13:30 (5 mins)**	**Vision 2030 Strategy Update.**	K. Warriner/ J. Grinnell	To receive feedback from December's Strategy Board.	**A**	Verbal
7.	**24/25/243**	**13:35 (10 mins)**	**Cheshire and Merseyside System Wide Issues Update.**	D. Jones	To receive an update on the current position.	**A**	Presentation
Operational Issues							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
8.	**24/25/244**	**13:45 (30 mins)**	**Evidence of Our Performance:** • **Flash Report, M8.** • **Integrated Performance Report for M7, 2023/24:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions**	A. Bateman N. Askew A. Bateman A. Bateman M. Swindell D. Jones R. Lea Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A**	Read report
9.	**24/25/245**	**14:15 (10 mins)**	**ED Waiting Room.**	A. Bateman	For information and assurance.	**A**	Read report
10.	**24/25/246**	**14:25 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Unrivalled Experience							
11.	**24/25/247**	**14:35 (10 mins)**	**Digital, Data and Information Technology Update.**	K. Warriner	To receive an update on the current position	**A**	Read report
12.	**24/25/248**	**14:45 (5 mins)**	**PALS and Complaints, Q2.**	N. Askew	To receive the PALS and Complaints Report for Q2, 2024/25.	**A**	Read report
13.	**24/25/249**	**14:50 (5 mins)**	**Half Yearly Nurse Staffing Report.**	N. Askew	To receive a half yearly update.	**A**	Read report
14.	**24/25/250**	**14:55 (5 mins)**	**DIPC Report, Q2.**	A. Bass	To receive the DIPC report for Q2, 2024/25.	**A**	Read report
15.	**24/25/251**	**15:00 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 23.10.24.	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			the 20.11.24. - **Approved minutes from the meeting held on the 23.10.24.**				
Pioneering Breakthroughs							
16.	**24/25/252**	**15:05 (5 mins)**	**Futures Committee:** - **Chair's Highlight Report from the meeting held on the 26.11.24.** - **Approved minutes from the meeting held on the 30.9.24.**	A. Bateman/ J. Chester	To escalate any key risks, receive updates and note the approved minutes from the 30.9.24.	**A**	Read enclosures
Supporting our People							
17.	**24/25/253**	**15:10 (10 mins)**	**People Plan Highlight Report, including:** • **EDI update.**	M. Swindell	To receive an update on key areas and updates from the system on the workforce.	**A**	Read report
18.	**24/25/254**	**15:20 (5 mins)**	**People Committee:** - **Chair's Highlight Report from the meeting held on the 13.11.24.** - **Approved minutes from the meeting held on the 19.9.24.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 19.9.24.	**A**	Read enclosures
Strong Foundations (Board Assurance)							
19.	**24/25/255**	**15:25 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's Highlight Report from the meeting held on the 2.12.24.** - **Approved minutes**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 28.10.24, and to receive an update on the top key risks for 2024/25.	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			from the meeting held on the 28.10.24. - **2024/25 Top Key Risks, (M7).**				
20.	**24/25/256**	**15:30 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Items for Information							
21.	**24/25/257**	**15:35 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
22.	**24/25/258**	**15:39 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 9th January 2025, 9:00am, LT3, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in November 2024: 421: Second letter of intent.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M7, 2024/25	R. Lea

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

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

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Interim Chief Executive Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	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)
	Ms. J. Halloran	Deputy Development Director	(JH)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. R. Murphy	Senior Communications Manager	(RM)
	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 24/25/213	Ms. N. Palin	Associate Director of Transformation	(NP)
Observing:	Mr. A. Sharma	Member of the public	(AS)
	Ms. R. Thomas	Deputy Chair of the REACH Network	(RT)
Apologies:	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Mr. D. Powell	Development Director	(DP)
	Ms. J. Revill	Non-Executive Director	(JR)

Staff Story

The Chair welcomed members of the Finance team, the Head of EDI, and the chairs of the staff networks who had been invited to November's Board to share an overview of the work that they have been undertaking from an EDI perspective.

The presentation from members of the Finance team drew attention to what it means to build a culture where everyone belongs; what has been achieved to date, next steps, the feedback that they have received from various stakeholders on their work, and what needs to be done to embed EDI best practice Trust wide.

The chairs of the staff networks shared an overview of their EDI journey and provided an update on what's happening/next steps for the REACH staff network, LBGTQIA+ staff network, Armed Forces staff network, and the ACE staff network.

A request was made to the Board for its support in respect to the following:

- Approve the Trust's Anti-Racism Statement ahead of the launch.
- Make EDI training mandatory.
- *Inclusive recruitment* - Develop EDI Champions to sit on recruitment panels.

- *Reverse mentoring* – Executive and NED involvement in this.
- Development and Sponsorship Programme for the organisation's international staff.
- Develop training for managers and leaders to address unconscious bias.
- Protected time for staff who are involved in the staff networks.
- Ensure policies reflect network needs, eg staff involved with the armed forces are having to take five days' annual leave to participate in basic training.

The Board was advised that the Armed Forces staff network is accepting an ERS 'Gold Award' on behalf of the Trust on the 7.11.24. It was also reported that the Finance team were shortlisted for an HFMA award for diversity and inclusion.

The Chair offered thanks to everyone for their leadership and the work that has taken place and felt that the Board learnt a lot as a result of the presentations shared during the meeting. The Board offered its support in terms of the direction of travel and agreed to discuss the requests made by the chairs of the staff networks. It was confirmed that an update on the asks will be provided following discussion.

24/25/208 Welcome and Apologies

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

24/25/209 Declarations of Interest

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

24/25/210 Minutes of the previous meeting held on 26th June 2024 and 3rd October 2024.
Resolved:
The minutes from the meetings held on the 26.6.24 and the 3.10.24 were agreed as an accurate record of the meetings.

24/25/211 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 24/25/142.2: *Springfield Park (Liaise with Fiona Ashcroft to gain information on charities who arrange for groups of people to go out into the community to litter pick)* – Rachel Lea agreed to liaise with David Powell to address anything specific on the outcome of a discussion with the Friends of Springfield Park regarding litter picking in the park. **ACTION CLOSED**

Action 23/24/260.1: *System Wide Update (Liaise with the Chairs of CMAST to discuss as to whether transition will be dealt with under mental health via CMAST)* – It was confirmed that there is nothing formal to report. **ACTION CLOSED**

Action 24/25/148.1: *Workforce Equality, Diversity, and Inclusion Update (Discuss the issues relating to promotion across the Trust from an equal opportunity and fairness perspective)* – Audrey Chindiya has initiated a meeting to look at the issues that are standing in the way of equal opportunities and fairness. This group will drive the action plan forward for this area of work. **ACTION CLOSED**

24/25/212 Chair's and CEO's Update

The Chair advised of the appointment of Julian Hartley as the new Chief Executive of CQC and drew attention to the two reviews that CQC have welcomed which will help set their future direction: the final report of Dr. Penny Dash's review and the first report of the independent review by Professor Sir Mike Richards.

The Board was informed of the new organisational form that will start to emerge following the agreement of NHS Adult and Acute Specialist Providers to join a group model to develop a long-term strategy for healthcare services in Liverpool. It was pointed out that questions may be raised about how this will work, therefore it was suggested including an item on Ask the Execs and the Board agenda in due course.

The Interim Chief Executive, John Grinnell, advised of the system conversations that are taking place along with the refocus on Place and the urgent care system. Acute sector colleagues and commissioning services are experiencing pressures, and there are a number of areas that Alder Hey is being asked to participate in from a system perspective, for example, ICB operating models, how Place will operate, collaboratives, joint hospital alliance, etc. It was reported that the Trust will feedback on these matters in December with a lens on CYP and people.

Resolved:
The Board noted the Chair's and the Interim CEO's update.

24/25/213 2030 Transformation Programme Update

The Board received an update on the progress that has been made on the Vision 2030 strategic goals during the period from September 2024 to October 2024. A slide was produced in response to feedback from Non-Executive Directors requesting more detail on key highlights. Attention was drawn to the following points:

- The Trust is continuing to make progress and significant achievements in terms of milestones. The BAF risk score for the programme has decreased to 12 indicating improvements in programme governance and assurance. A key development of the programme is the Wellbeing Hub.
- It was reported that reflection took place during last week's Programme Board in respect to where the Trust is at and the direction it is heading in.
- A stock-take has been undertaken in collaboration with children and young people (CYP), and key stakeholders across Divisional, Executive, and Trust Board levels. This provided actionable insights that directly inform and will support the blueprint for the shape of Alder Hey by 2030 and the roadmap for 2025-30. It was reported that the Trust received lots of positive feedback from CYP during the stock-take. A Strategy Board session has been arranged for the 5.12.24 to receive the outcome of the stock-take.

  The themes collated in terms of the shape of Alder Hey 2030 to inform the next steps include:
  - Alder Hey being organised around 'Areas of Need'.
  - Alder Hey being the integrator, convenor, and pioneer for CYP.
  - More public health and prevention.
  - More care closer to home.
  - Expansion of super specialist services.

- Focus on Futures.
- Different workforce and skill mix than today.

- A second Clinical Leaders' Summit has been scheduled for the 15.11.24 to enable senior leaders to test the organisation's thinking and design of Alder Hey's Vision 2030, outcomes, and roadmap for getting there.
- It was reported that the feedback from the stock-take will help shape the programme for 2025/26 and the 5-year plan.

The Chair confirmed that there will be a focus on delivery of the 2030 Strategy during December's Strategy Board.

Resolved:
The Board received and noted the 2030 Transformation Programme update.

24/25/214 Evidence of Our Performance

Flash Report, M7

- Performance has increased in November, and activity is helping to reduce long waits. The Trust has reached a milestone with regard to patients waiting over 52 weeks for treatment or care; reduced to 400 patients which is a 50% reduction compared to six months ago.
- The Trust is making progress in terms of reducing the number of patients waiting for follow-up appointments.
- Elective recovery YTD is 104%, with a strong performance in Surgery.
- ED performance is at 81.7% in November due to an increase in patients that the department is seeing in the winter months. It was confirmed that the Trust is still above the national ED target of 78% for treating patients within 4 hours. The Board was advised of the challenges in maintaining performance levels due to the winter surge.
- The number of patients waiting for ASD/ADHD diagnosis continues to grow, and huge challenges are being experienced in terms of acquiring ADHD medication. Additional pharmacy/independent sector support is in place to try and alleviate the situation.
- The laboratory haematology/transfusion service is experiencing out of hours staffing issues. It was reported that work is taking place to mitigate this risk via recruitment and training.
- A decision has been taken to replace the Trust's CT scanner as it is coming to the end of its service life. It has also been decided to purchase a second scanner following the issue raised during the review of the major incident in Southport.

The Chair referred to the letter that Alder Hey received from the Secretary of State, Wes Streeting, and queried as to whether the Trust should approach Mr. Streeting to request support for the purchase of a second scanner. The Board confirmed their agreement of this suggestion.

24/25/214.1 Action: DJW

Integrated Performance Report for M6, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 6. An update was provided on the following areas of the IPR:

Outstanding Care and Experience – Safe and Caring

- There have been zero Category 2 pressure ulcers for the last nine months following the implementation of the Tissue Viability Action Plan.

Support our People

- The Trust has seen a spike in sickness absence in October 2024. It was confirmed that sickness absence will continue to be monitored.
- WTE continues to receive a lot of focus, with the target reducing from October 2024 as a result of the required CIP. Additional measures are being reviewed in order to deliver this.

Pioneering Breakthroughs

- A Business Case for Investment Zone funding (£4.1m) has been submitted. The bid will go to an external panel for assessment and approval in December 2024. An update on the outcome will be shared in due course.
- The Ambient AI LyreBird pilot has commenced with clinicians using the Ambient AI technology in clinic. The organisation is waiting to receive feedback from clinicians on the impact that the new technology has had.
- An AI coding opportunity with Phare Health has been identified. The Trust is in the process of discussing a collaboration agreement with Phare Health following two scoping sessions. It was reported that Alder Hey will be the first organisation to pilot this technology, if agreed.

Collaborate for CYP

- Work is taking place with Professor Rachel Isba, Consultant in Paediatric Public Health Medicine, to gain her expertise to determine what the Trust should measure itself against from a health inequality perspective. There is also a need to shape the wider inequalities agenda in order to embed it.
- A workshop is taking place to look at how the organisation can expand on social value.
- The Wellbeing Hub is now operational. It was suggested inviting the parents of a child who is receiving palliative care, to a future Board meeting to share their story in terms of how they were supported by the Wellbeing Hub.

24/25/214.2 Action: DJ/KMC

Financial Sustainability: Well Led

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

- Cheshire and Merseyside (C&M) System update.
- Alder Hey position;
  - Latest position as at M7 is a £2m deficit which is on plan except for the recent pay award pressure of £1.2m.
  - There is a requirement for surplus to hit the £3.3m plan (M8-M12), c£3m technical and NR release.
  - A financial improvement plan has been in place since June 2024 to close the £5m risk identified.
  - Divisional reviews took place at Finance, Transformation, and Performance Committee (FTPC) on the 28.10.24 to understand current position, forecast and any emerging risks.
  - Divisional performance mixed with Surgery driving high ERF, but there is a deterioration in Medicine, and a reliance on vacancies in Community and Mental Health Division.
  - There are four key themes emerging to drive financial efficiency as the organisation approaches winter and H2:
    - Workforce efficiency
    - Drugs costs
    - Activity plans

- Coding

- The Trust is awaiting further information with regard to the pay award pressure but there is currently no mitigation to off-set £2m in year.
- Proposal to focus on 4 key risks and opportunities over H2 with regular oversight through FTPC. Each area will have a designated lead reporting into the Financial Sustainability Delivery Group chaired by the Director of Finance.
- Ongoing monthly forecast reporting into FTPC with scenarios - best, most likely and worst during H2.

The Chair of the FTPC, John Kelly (JK), advised of the importance of focussing on the four key themes emerging to drive financial efficiency as winter approaches. Attention was drawn to the resources that are being spent on trial drugs and the lack of policy for this area of work. It was also pointed out that the demand for medication is increasing and starting to impact the Trust. JK felt that the Trust is under reporting productivity and drew attention to the importance of having multi-year transformational programmes that will determine benefits for 2026, 2027 and 2028. A discussion took place regarding trial drugs and it was emphasised that the Trust would need to have greater internal capacity before it could contemplate advancing this area of work.

Divisional Updates

Community and Mental Health Division

The Board was advised that ADHD will not meet its trajectory target of no CYP waiting over 104 weeks by October 2024. It was reported that the target has since been revised to a maximum of 117 weeks. Challenges continue to be experienced in terms of ADHD medication shortage and being unable to initiate medication for ADHD in line with ICB guidance. It was reported that the ASD/ADHD Transformation Programme is continuing with good engagement from teams and external colleagues with new pathway developments due to take place in October, and feedback from CYP is positive around the changes that Alder Hey is making to try and alleviate some of the issues.

The Chair asked as to whether the organisation needs to support the Community and Mental Health Division to develop different strategies and mechanisms to resolve this issue. The Board was advised that this is a national issue and there is a lot of work taking place at Alder Hey to manage the issue until it can be solved. It was felt that the output of the C&M work/data will provide assurance that the Trust is in a better position than some organisations.

JK suggested developing a dashboard/pipeline to show the progress that the Trust is making. It was reported that the organisation has the data to demonstrate that it is over performing in terms of what was commissioned.

A question was raised about whether there is any work taking place internationally that might help to address this risk. It was agreed to discuss this matter further outside of the meeting.

24/25/214.3 Action: JG/LC

Division of Medicine

A presentation was submitted to the Board to provide an update on the Neurology service provision. A number of slides were presented that provided information on the following areas.

- Background detail on the challenges experienced that has led to the need to transform the Neurology service. The '@ its best model' was initiated with the team and listening events noted several areas of concern. With support from the Executive team the Neurology Transformation Programme has commenced.
- Current workforce.
- Current service provision.
- The services that have currently paused.
- A summary of completed actions.
- Ongoing actions.

The Chair thanked the Director of Medicine, Urmi Das, for the update. It was reported that a meeting is taking place on the 8.11.24 with colleagues from Manchester and Specialist Commissioners to try and gain support for this issue. It was also pointed out that this risk is on the Board Assurance Framework and the Corporate Risk Register. The Chief Medical Officer, Alfie Bass, advised that the collective concern is around cover, workforce mismatch, and estates across the North West. It was agreed to provide an update on whether the proposed plan is accepted by Manchester and if not what the alternative might be.

24/25/214.4 Action: UD

A discussion took place around the national shortage of Paediatric Neurologists, the Trust's recruitment/training process that it is going to take forward to appoint to the service, the learning that can be taken from this issue, the possible launch of leadership cultural change sessions that will commence at consultant level, and having a prominent champion/external support who could help Alder Hey attract the best talent.

UD offered assurance that the Neurology team are very positive and working well together even though there are challenges within the service, and morale is improving following a number of actions that have been taken.

Division of Surgery

Highlights for the month include:

- Surgery has achieved 80% theatre TT utilisation in month which is the highest YTD with some clear improvements in inpatient theatres (Cardiac), Cardiology, Orthopaedics and Neurosurgery. This is due to a lot of actions that have been implemented by the team, job plans working, over recruiting, achieving higher activity, etc.
- Follow-up is a concern for the Division as there is a major challenge in aligning numbers with capacity.
- Modelling is underway to review required capacity to achieve 52 weeks wait by March 2025. The areas of challenge currently are ENT and Dental. Further clinical engagement will take place with teams, particularly dental. The main challenge is ENT therefore a number of options are being trialled to make the service as sustainable as possible.

The Chair offered thanks to the team for the work and improvements that have been made.

A suggestion was put forward about requesting resources from the Government in order to do something transformational in terms of reducing waiting lists, for example, no patient waiting over 39 weeks. It was reported that the only way to

grow is via speciality work. It will be necessary to invest in Spinal, Cardiac and Neurosurgery and fill theatre gaps with these high tariff specialities.

The chair asked that a discussion take place to look at whether the Trust is in a position to request funding for something that may create a transformational change.

24/25/214.5 Action: Execs

Resolved:
The Board noted the Flash Report for M7 and the content of the IPR for Month 6.

24/25/215 Alder Hey in the Park Campus Development Update

The Board was provided with an update on progress, budget controls, risks and actions on capital projects. The following points were highlighted:

- *Springfield Park* – Phase 1 of the park reinstatement has been completed and Phase 2 (swale) will be completed by December 2024. It was reported that the risk appertaining to the Springfield Park project has been reduced from a score of 12 to 8 to note the progress that has been made to conclude this project. The remaining site in terms of the Histopathology building and surrounding area will be completed in December 2025 as part of Phase 3.
- *Sunflower House* – Discussions are ongoing to try and resolve the issue of the sprinkler system in the under croft car park.
- It was confirmed that good progress is being made to deliver all projects.

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

24/25/216 Staff Influenza Vaccination Programme Update

The Board received an update on the seasonal vaccination programme approach for the 2024/25 winter. Attention was drawn to the following points:

- The vaccination team began this year's programme on the 7.10.24. Staff are able to book an appointment and drop-in for a vaccination.
- Following additional funding from the NHSE North West Immunisations team there is an inpatient CYP targeted flu and Covid vaccination programme for the Trust's vulnerable groups. This will be carried out in partnership with the staff vaccination work and other vaccination delivery in the Trust. It was confirmed that Covid vaccines will be available in the next two weeks for CYP and staff. There will also be an opportunistic approach taken over the Christmas period to offer vaccinations to CYP.
- It was reported that 32% (1,400) of staff have had a flu vaccine and 77 have had a Covid vaccine. A plea was made for managers to raise awareness of the importance of staff being vaccinated.
- *RSV;*
  - National rates are increasing but are currently behind previous seasons and on track with 2019 levels.
  - Alder Hey's season is delayed by a few weeks compared to last year.
- RSV age trend and vaccination rate;
  - The under 4 cohort are being diagnosed with RSV.
  - Grandparents to grandchildren is one of the biggest transmission rates of RSV.
  - On average there is a 25% vaccination uptake which is positive taking

into account the low level promotion of this vaccine.

Resolved:
The Board noted the Staff Influenza Vaccination Programme update.

24/25/217 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 25.9.24 were submitted to the Board for information and assurance purposes.

During October's meeting the Committee focussed on the Nuclear Medicine IRMER Improvement Plan, and diagnostic notifications.

The Chair raised a query about governor attendance at SQAC meetings. It was reported that of the six governors invited to the meeting, one governor has attended on a regular basis.

Resolved:
The Board noted the approved minutes from the meeting held on the 25.9.24.

24/25/218 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 September and October 2024.

It was reported that the 2024 staff survey has been circulated and is scheduled to close on the 29.11.24. To date, 2103 of 4425 colleagues (48%) have completed the survey. There is a real drive Trust wide to encourage staff to complete the survey.

EDI Improvement Plan Progress

The Board was provided with an update on the progress that has been made on the six high impact actions set out in the NHS EDI Improvement Plan, the planned action to support delivery, further improvements, and next steps.

Alder Hey's Anti-Racism Statement was presented to the Board and was approved for immediate internal and external launch.

Resolved:
The Board noted the updates and approved Alder Hey's Anti-Racism Statement.

24/25/219 Equality Act

The Board received the 2023/24 Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) for information purposes and final sign off. Attention was drawn to the themes that have been identified as areas that the Trust must focus on for improvement. Both reports have been discussed and scrutinised by the People Committee and it is felt that the organisation is progressing in the right direction.

It was pointed out that recruitment and opportunities for staff to develop and progress in their career has been identified in both reports as an area for improvement. A discussion took place about the type of support that could be

offered to help staff complete application forms and prepare for interviews/ promotion.

Reference was made to the presentations that were shared earlier in the meeting by the chairs of the staff networks and the requests that were made. It was suggested that the big items be discussed; recruitment, promotion, management training, but in terms of the smaller asks it was felt that these should be responded to point by point with a mini action plan underpinning this work. The Chair felt that it is really important to build trust and demonstrate that the organisation is listening and responding. A request was made to include reciprocal mentorship in the items to be discussed with a view to establishing a Reciprocal Mentorship Programme.

24/25/219.1 Action: Executive Directors

Resolved:
The Board received and approved the WRES and WDES reports for 2023/24.

24/25/220 Annual Report for the Armed Forces Network

The Board received the Armed Forces Network Annual Report as part of the VCHA on-going assessment and assurance process. The report provided an update on progress against each of the standards within the Veteran Aware requirements. Attention was drawn to the following points:

- Good progress has been made against year one objectives.
- There have been areas identified for continued improvement moving into year 2, including widening training across the workforce.
- Examples are included in the report in terms of increasing the visibility of the work of the forces within the Trust and through partnerships with local organisations.
- It was reported that the Armed Forces Network has achieved Gold status under the Defence Employment Recognition Scheme. Congratulations were offered to the team.

The Chair queried the process for enabling families to access services. It was reported that the Armed Forces charity SSAFA make contact with families but in terms of the Trust ensuring people are aware of this, this will be followed up when Phase 2 of the Wellbeing Hub is launched.

Resolved:
The Board received the Armed Forces Network Annual Report for 2023/24.

24/25/221 Audit and Risk Committee

The approved minutes from the meetings held on the 20.6.24 and the 11.7.24 were submitted to the Board for information and assurance purposes. Attention was drawn to the following two points:

- As part of considering potential training needs for Audit and Risk Committee (ARC) members, a presentation from the Trust's Finance Team on CIP and budget management has been requested. This will be available to all Non-Executive Directors (NEDs).
- There is no formal reporting from ARC to assurance committees on specific audits as updates are generally provided by the report owner, therefore an additional column has been included in the Internal Audit Plan to make a note of the committee that the report might be of interest to.

The Chair raised a query about governor attendance at ARC meetings. It was confirmed that two governors have attended on separate occasions.

Resolved:
The Board noted the approved minutes from the meetings held on the 20.6.24 and the 11.7.24.

24/25/194 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 30.9.24 were submitted to the Board for information and assurance purposes.

The Chair raised a query about governor attendance at the FTPC meeting. It was reported that the FTPC has offered governors the opportunity to receive a quarterly update rather than having to attend individual meetings, which governors welcomed. The first session took place on the 4.11.24 at 5:00pm.

Resolved:
The Board noted the approved minutes from the meeting held on the 30.9.24.

24/25/223 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 the relevant assurance committees are sighted on the Nuclear Medicine Action Plan that has been compiled to respond to the CQC Improvement Notice that the Trust received in relation to IRMER regulations 25, 61 and 65. The action plan will continue to be monitored by SQAC until all actions have been completed. It was reported that a lot of lessons have been learned as a result of this issue.
- The Board was advised that the Trust needs to ensure that it has oversight of services that have specific regulatory requirements.

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

24/25/224 Any Other Business

There was none to discuss.

24/25/225 Review of the Meeting

The Chair thanked everyone for their contributions during the meeting. It was felt that the presentation received from the Finance team and the Chairs of the staff networks were inspiring.

Date and Time of Next Meeting: Thursday 5.12.24 at 11:00am, 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
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for December 2024							
3.10.24	24/25/182.1	Integrated Performance Report for M5, 2023/24	Review the attendance list of risk meetings co-ordinated by the Governance team to ensure there is appropriate representation.	E. Saunders	5.12.24	On track Dec-24	
3.10.24	24/25/189.1	Liverpool Neonatal Partnership Governance	Meeting to take place between the Chair and CEO of Alder Hey and LWH to discuss the barriers being experienced in terms of interpreting data i.e. mortality and having access to reports for joint meetings e.g. LNP Board. Kerry Byrne agreed to attend this meeting in her capacity as lead NED for the LNP.	Dame Jo Williams/ J. Grinnell/ K. Byrne	5.12.24	On track Dec-24	
7.11.24	24/25/214.1	Evidence of our Performance	Write to the Secretary of State to request financial support for the purchase of a second CTC scanner.	Dame Jo Williams	5.12.24	On track Dec-24	
7.11.24	24/25/214.4	Integrated Performance Report	*Neurology Service* - Advise as to whether Manchester has accepted the proposed plan to help alleviate some of the issues being experienced by the Trust's Neurology service.	U. Das	5.12.24	On track Dec-24	
Actions for January 2025							
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	9.1.25	Jan-25	**22.8.24** - This action cannot be completed until the Trust has agreed its definition of culture. **3.10.24** - This action will be reviewed following December's Trust Strategy Board **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	9.1.25	Jan-25	**27.8.24** - A request has been made for this item to be included on September's RMF agenda. **27.9.24 -** A request has been made for this item to be included on December's RMF agenda. **ACTION TO REMAIN OPEN**
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	9.1.25	Jan-25	**22.8.24** - Following discussion with LUFT/LWH it has been agreed to arrange for this meeting to take place at a later date. **27.9.24** - An initial meeting is taking place between Erica Saunders and Daniel Scheffer ahead of arranging a Board to Board meeting. **6.11.24** - A further meeting has taken place in November. Arrangements are yet to be made for a Board to Board meeting. **28.11.24** - Arrangements are yet to be made for a Board to Board meeting. **ACTION TO REMAIN OPEN**
5.9.24	24/25/142.1	Alder Hey in the Park Campus Development Update	Provide an update on the resolution for the sprinkler system in the Under-Croft car park.	D. Powell	5.12.24	Jan-25	**27.9.24** - This item will be included on November's Board agenda. **3.10.24** - This action has been deferred to December as further work is required before an update can be submitted to the Board. **28.11.24** - This action has been deferred to January. **ACTION TO REMAIN OPEN**
3.10.24	24/25/183.1	Alder Hey in the Park Campus Development Update	Board discussion to take place on a partnership strategy for the Campus and the options available.	D. Powell	9.1.25	Jan-25	

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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
7.11.24	24/25/214.5	Integrated Performance Report	Discussion to take place to look at whether the Trust is in a position to request funding from the Government for something that may create a transformational change for Alder Hey and the NHS, for example, no patients waiting for treatment over 39 weeks.	Execs	9.1.25	On track Jan-25	
7.11.24	24/25/219.1	Staff Story (EDI)/ Equality Act	Discuss the recommendations made by the Chairs of the staff networks and provide feedback on the outcome following discussion by the Exec team - (It was suggested that the big items be discussed; recruitment, promotion, management training, but in terms of the smaller asks it was felt that these should be responded to point by point with a mini action plan underpinning this work. A request was made to include reciprocal mentorship in the items to be discussed with a view to establishing a Reciprocal Mentorship Programme).	Execs	9.1.25	On track Jan-25	
Actions for February 2025							
3.10.24	24/25/181.2	Alder Hey – Autumn and Winter Emergency Response Plan, 2024/25	*National debate on the Healthier Together App* - Set time aside to think about whether the Trust should continue with its established symptom checker which is to be promoted and further developed this winter, or whether Alder Hey should link in with the national initiative 'Healthier Together' and the options available.	A. Bateman	6.2.25	On track Feb-25	
7.11.24	24/25/214.2	Integrated Performance Report	Invite the family of a patient who were supported by the Wellbeing Hub, to a future Board meeting to share their story.	D. Jones/ K. McKeown	6.2.24	On-track	
Actions for June 2025							
6.6.24	24/25/83.1	2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement	Covering report sheet to be more specific to identify actions that are important versus business as usual.	A. Bass	Jun-25	On track Jun-25	
Actions for September 2025							
5.9.24	24/25/149.1	Wellbeing Guardian Dashboard	Integrate Freedom To Speak Up in the next iteration of the Wellbeing Guardian Report.	J. Revill	Sep-25	On track Sep-25	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
5.9.24	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	7.11.24	Closed	**5.6.24 -** This action is being progressed. An update will be provided during September's meeting. **5.9.24** - There hasn't been an opportunity to address this action therefore the action is to remain open. **7.11.24** - It was confirmed that there is nothing formal to report. **ACTION CLOSED**
5.9.24	24/25/140.1	Vision 2030 Strategy Deployment Update	Agenda item to be included on November's Strategy Board to discuss the outcome of the stock take exercise of the Trust's strategic goals to look at what is/isn't working in order to adapt the organisation's plans.	K. Warriner	5.12.24	Closed	**3.10.24** - The Trust Strategy Board has been deferred to the 5.12.24. **28.11.24** - This item has been included on December's Strategy Board agenda. **ACTION CLOSED**
8.2.24	24/25/142.2	Alder Hey in the Park Campus Development Update	Liaise with Fiona Ashcroft to gain information on charities who arrange for groups of people to go out into the community to litter pick.	Dame Jo Williams	7.11.24	Closed	**3.10.24** - A discussion has taken place with the CEO of the Charity and the Trust's Director of Development and it was suggested that the organisation engage with the Friends of Springfield Park to gain their input on this matter. A catch-up meeting is scheduled between the Trust and the Friends of Springfield Park w/c 7.10.24. David Powell agreed to provide an update on the outcome of the conversation with the Friends of Springfield Park. **7.11.24** - Rachel Lea agreed to liaise with David Powell to address anything specific on the outcome of a discussion with the Friends of Springfield Park regarding litter picking in the park. **ACTION CLOSED**
5.9.24	24/25/148.1	Workforce Equality, Diversity and Inclusion Update	Discuss the issues relating to promotion across the Trust from an equal opportunity and fairness perspective.	Dame Jo Williams/ J. Revill	7.11.24	Closed	**7.11.24** - Audrey Chindiya has initiated a meeting to look at the issues that are standing in the way of equal opportunities and fairness. This group will drive the action plan forward for this area of work. **ACTION CLOSED**
7.11.24	24/25/214.3	Integrated Performance Report	*ADHD trajectory/Medication shortages* - Discuss as to whether there is any work taking place internationally that may help the Trust resolve some of the issues relating to ADHD/medication shortages.	L. Cooper/ J. Grinnell	9.1.25	Closed	**28.11.24** - LC meets with the national team and CHA regularly to discuss continued ADHD medication shortages. Via the national call discussions regarding the international shortages are also included as this is a global issue. **ACTION CLOSED**

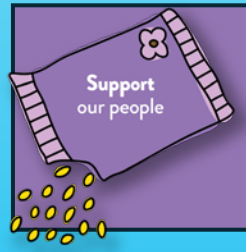
Flash Report November 2024

Alder Hey Children's NHS Foundation Trust

Performance is subject to change

1	0	89%	1
Severe/Fatal Incidents/Never Events	Number of Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections

73.5%	364	114%	95%
ED: % Treated within 4 Hours	Number of RTT Patients waiting >52weeks	Elective Recovery Volume vs 19/20	Diagnostic Performance



+112	10.5%	80.8%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed

VISION 2030

HIGHLIGHT

- 0 Patent Safety Incident Investigations
- Diagnostics achieved 95% performance
- 5th consecutive month with a reduction for RTT >52 weeks

UPDATE — Financial Sustainability

- M8 position £1.4m YTD, £0.6m relates to pay award remaining due to challenging month both activity and costs. Options to mitigate including releasing future benefit underway before external reporting
- Forecast remains to achieve £3.3m surplus subject to above

CHALLENGES

- Severe Incident – Review ongoing
- ED 4-hour performance was 73.5%, below national target of 77%
- Workforce estimated position +112 above plan

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: November 2024

Contents

VISION 2030

Our Journey To 2030

IPR Summary

The matrix below provides a summary of performance for the metrics presented in the Integrated Performance Report as SPC visuals. 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 and Level 1 patient safety training are consistently achieving target with an improving trend	RTT 52 weeks, Elective admissions per WTE, Severe/Fatal incidents, PALs resolved MSSA are inconsistently achieving target with an improving trend	Staff Turnover, PDRs completed and IHAs are not achieving Target but demonstrating an improving trend
	Common Cause	Category 3 & 4 Pressure Ulcers, Cancer (All), MRSA metric and Liquidity are achieving targets	Incidents 1,000 bed days, F&F, Complaints resolved, Sepsis, ED 4hr, WNB Rate, ERF, C.Diff, Staff Turnover, Sickness (All) and risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation, Diagnostics, Long Term Sickness and Medical Appraisal are not achieving targets and currently not demonstrating statistical improvement
	Special Cause - Concern		.	

From an overall perspective the headline analysis summary based on all metrics:

- 59.6% of all metrics have achieved target in the month of October 2024.

From an SPC perspective the headline analysis summary based on attributed metrics:

- We are consistently passing 19.2%* of our metrics.
- We are achieving 63.8% of our metrics inconsistently.
- We are not achieving the target for 17% 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 YTD and those with 24/25 targets set only*

VISION 2030

BRILLIANT BASICS

Integrated Performance Report | November 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:

•94% of PALS concerns responded to within 5 working days and 92% of formal complaints responded to within 25 working days
•No hospital acquired MRSA (BSI), MSSA or C-diff

Areas of Concern:

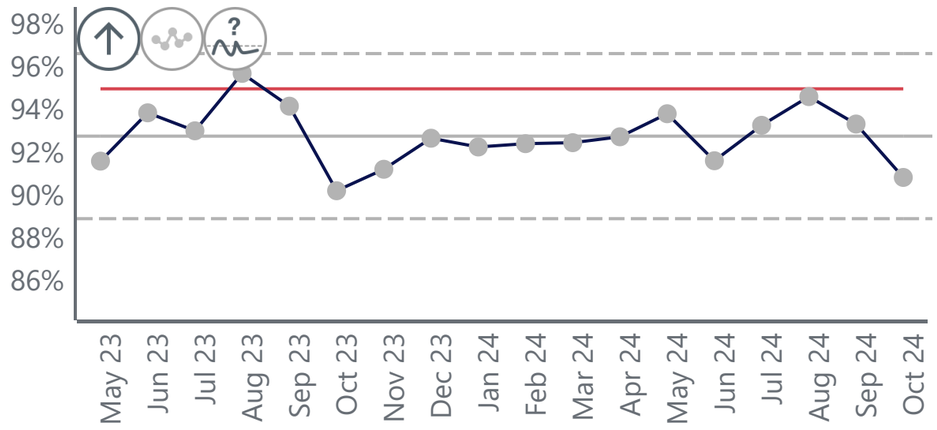
•Decrease in compliance with administration of antibiotics for sepsis: 83% in inpatients and 82% in ED
•91% of families would recommend the Trust and 82% would recommend ED
•Consistent number of patients admitted to Critical Care unexpectedly

Forward Look (with actions)

Divisions to review cases where antibiotics not given within 60 minutes for sepsis in collaboration with the Sepsis team and identify any actions for improvement

F&F Test - % Recommend the Trust

Target: Statutory



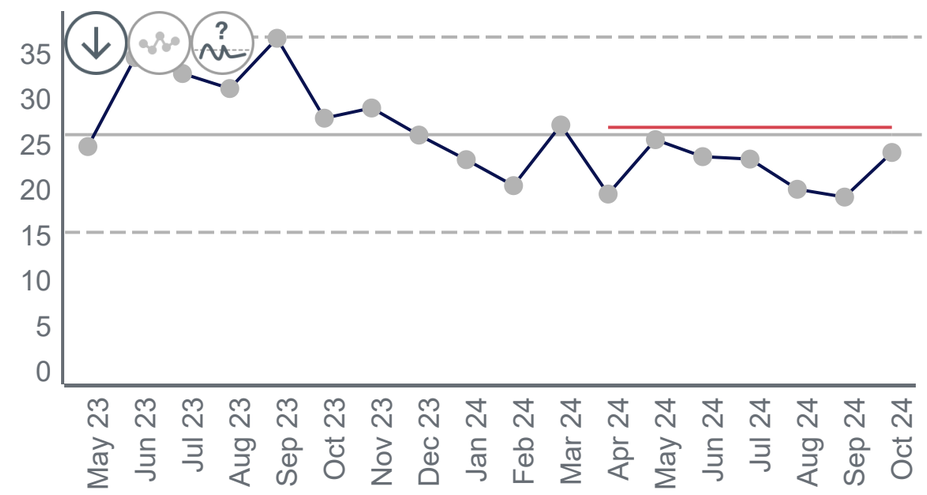
Technical Analysis:

Consistently not achieving the 95% target. October performance of 90.9% represents a decrease from September performance of 93.4%. Lowest performance since October 2023. 2nd consecutive month with a decrease.

Actions:

Review of FFT system undertaken and questions reviewed

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



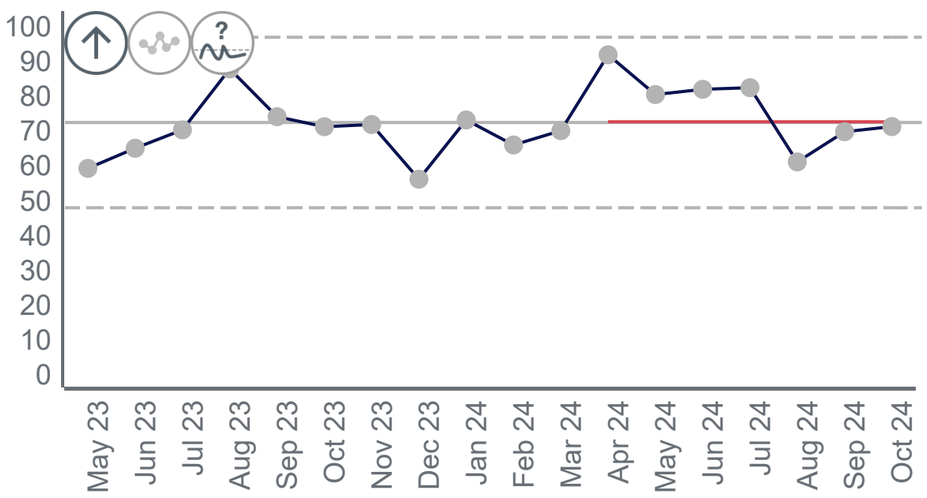
Technical Analysis:

Common cause variation has been observed with performance of 24 incidents of harm per 1,000 bed days, with a monthly average of x26 incidents during the period. Incidents are assessed on Physical and Psychological Harms. The target is set on a 5% reduction of 23/24, with a monthly target of 27.

Actions:

All incidents reviewed by Divisional governance team and selected incidents nominated for discussion at weekly Patient Safety Meeting. Incidents reported as Moderate harm or above reviewed at weekly PSIRI panel

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



Technical Analysis:

Common cause variation observed with 71 incidents of no harm per 1000 bed days, with a monthly average of 73. This incluces xx 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 71.

Actions:

All incidents reviewed by Divisional governance team and selected incidents nominated for discussion at weekly Patient Safety Meeting. Incidents reported as Moderate harm or above reviewed at weekly PSIRI panel

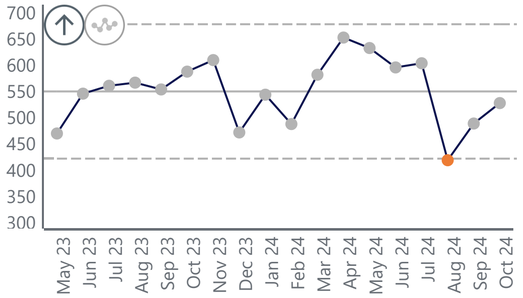
0024

Integrated Performance Report | November 2024

Alder Hey Children's NHS Foundation Trust

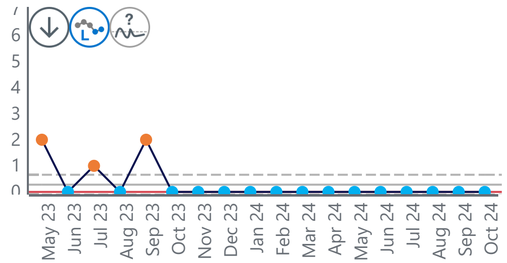
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



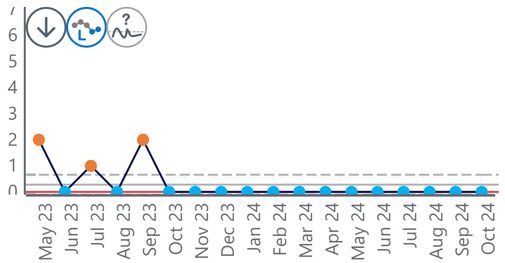
Severe or Fatal Incidents – Physical only

Target: Internal

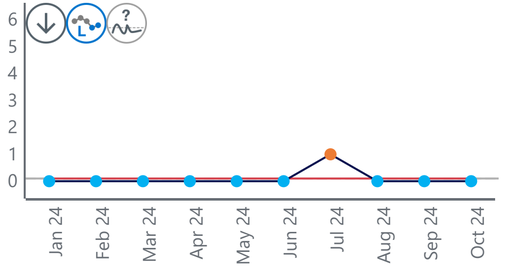


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

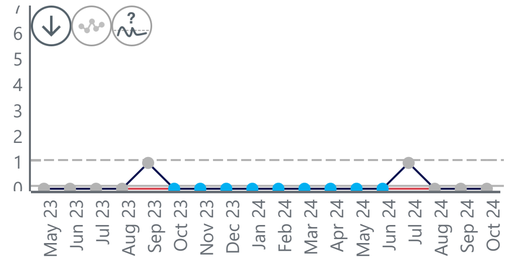


Number of PSIIs (Patient safety incident investigation) undertaken



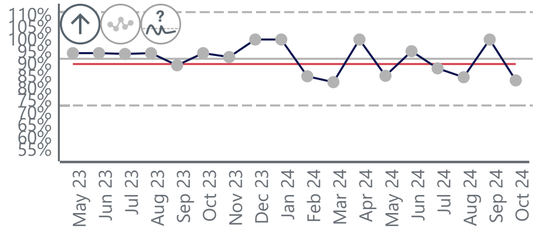
Number of Never Events

Target: Internal



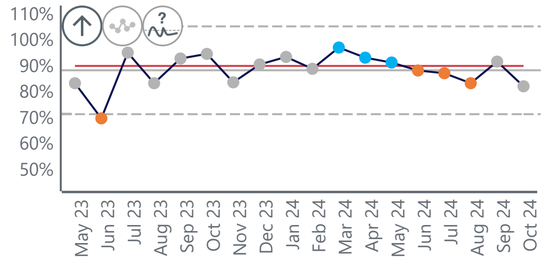
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

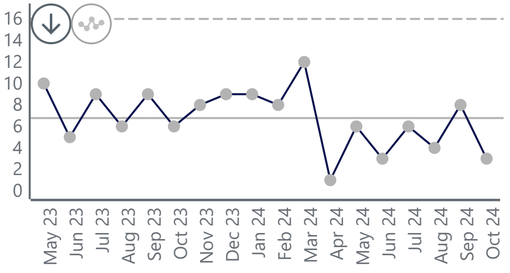


Sepsis % Patients receiving antibiotic within 60 mins for ED

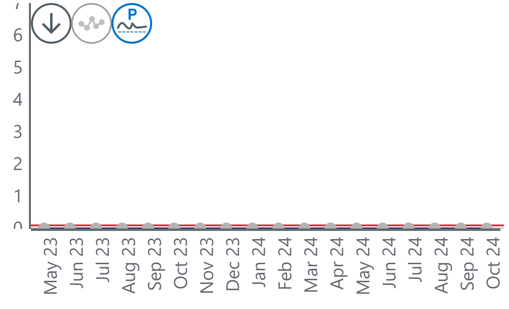
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

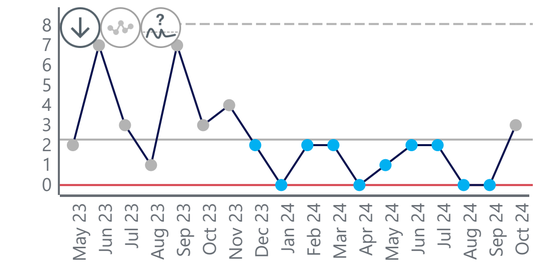


Pressure Ulcers Category 3 and 4

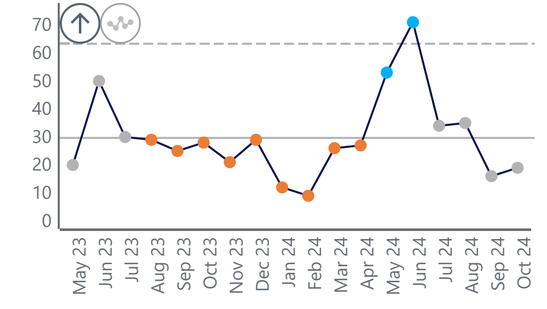


Pressure Ulcers Category 2

Target: Internal

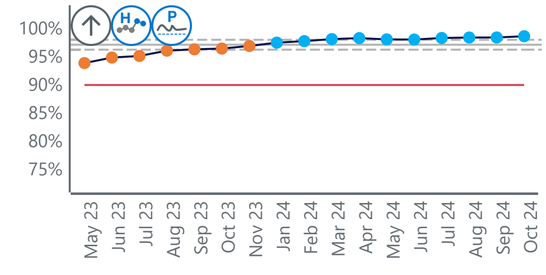


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



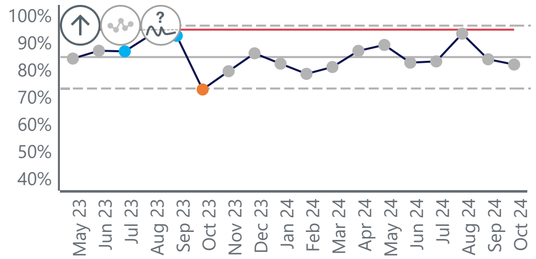
Integrated Performance Report | November 2024

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

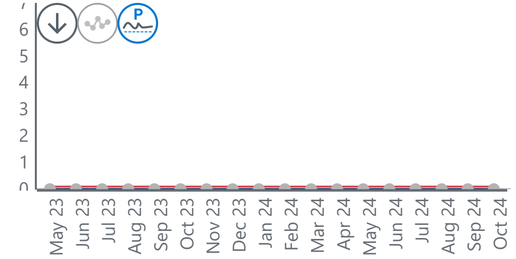
F&F ED - % Recommend the Trust

Target: Internal



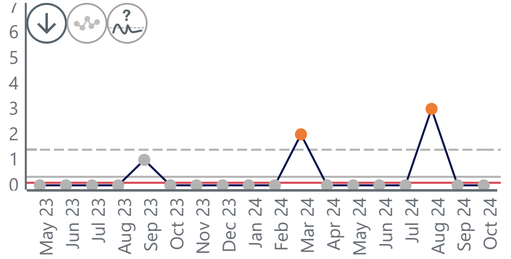
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



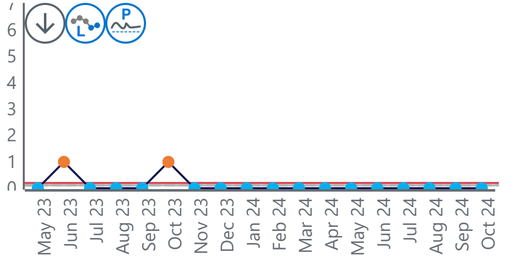
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



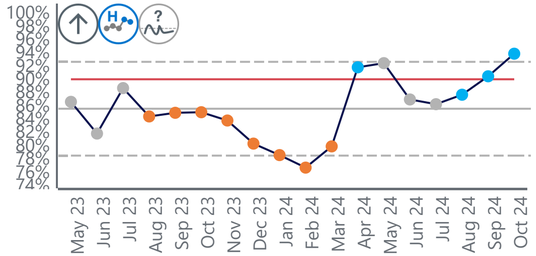
Hospital Acquired Organisms - MSSA

Target: Internal



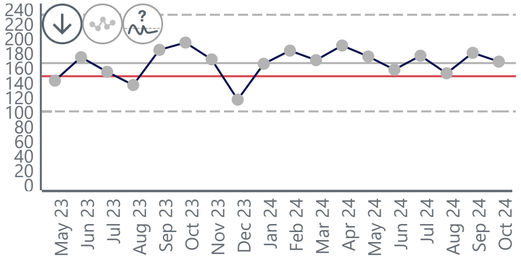
% PALS Resolved within 5 Days

Target: Internal



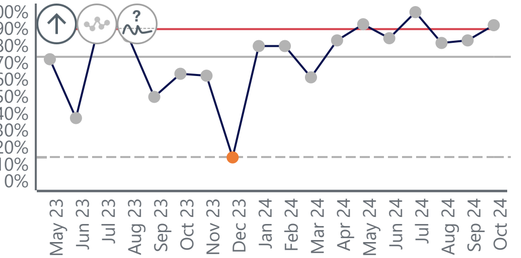
Number of PALs contacts

Target: Internal



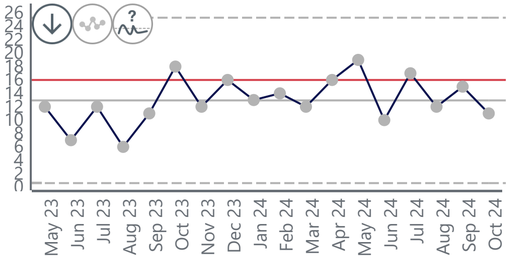
% Complaints Responded to within 25 working days

Target: Internal

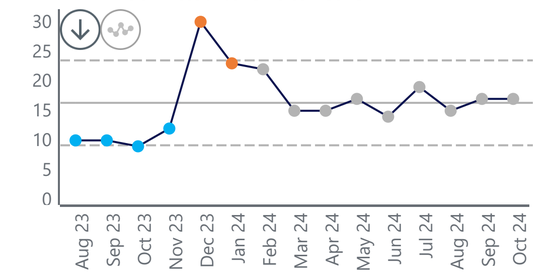


Number of formal complaints received

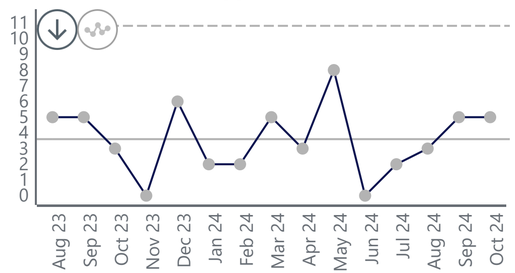
Target: Internal



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



Number of patients deteriorating from HDU admitted to PICU



Integrated Performance Report | November 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:

• % recovery for DC & ELEC activity 121% in month. Some consistent case mix changes which are converting a higher volume of patients to DC from IP. This is reflected in the YTD performance of DC (104%) and EL (95%). OP New & OPROCs consistently above activity plan with YTD performance at 103% • Achieved 91% DM01 compliance in month which is the highest YTD. Throughout October, the compliance has increased by 7%, and the backlog of patients waiting >6 weeks has reduced by a third. • Despite underperforming against the national target, in month TT utilisation remained at 80% which is the highest performance YTD. Inpatient TT utilisation continues to improve with in month performance of 84%. • Further reduction in the number of overdue follow-ups by 31st March 2025.

Areas of Concern:

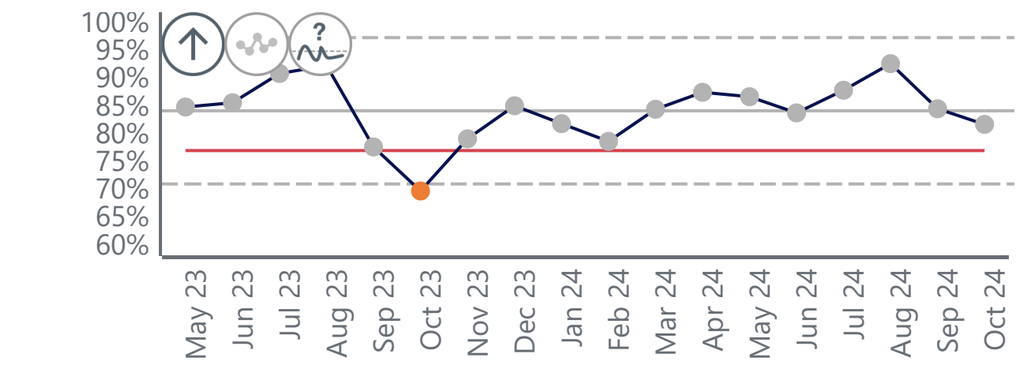
• WNB rate continues to be above trust target.
• ASD & ADHD assessment waiting times are below the target of 95%. In October, 14% of patients received an outcome in under 65 weeks. A transformation programme is established with focused workstreams

Forward Look (with actions)

• The WNB Predictor Tool and the current process for contacting families before outpatient appointments is being reviewed. • The ability to record clinical validation on Aldercare is now active, and the clearance rate for overdue follow-ups by March 2025 is expected to increase. • A two-week shadowing of inpatient theatres during October identified SMART actions that will reduce delays in theatre starting on time. Further shadowing of day case theatre finish times is planned for December.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

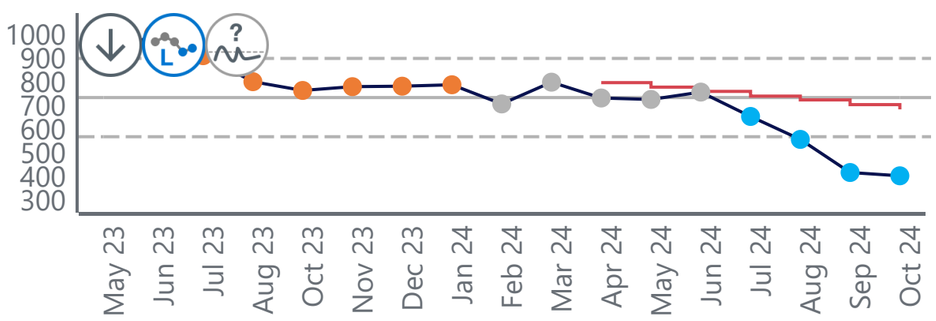
Trust is achieving the national target (>77%) in September-24. Common cause variation has been observed with performance of 81.7%. Decrease from Sept 24 (84.5%). Oct-24 performance is +12% compared to Oct-23 (69.7%) whilst Oct-24 seen only on average 8 less attends per day compared to Oct-23. 2024/2025 performance to date is 86.1%

Actions:

Performance monitored weekly through Care Group Leadership/Winter Planning Meetings. Senior decision maker capacity within ED continues to be a challenge into winter and will be proactively managed with the use of alternative workforce groups to support where possible. Key actions: • Launch of Clinically Ready to Proceed (CRtP) • Maximising use of primary care streaming within the UTC • Amending current escalation plans.

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

Target: Internal 24/25



Technical Analysis:

Demonstrating special cause variation of improving nature with number of patients waiting > 52 weeks at 406 for Oct 2024 against a trajectory of 687. Further decrease from Sept 2024 position of 420 and the 4th consecutive month with a reduction. Top 3 services with waiters >52 weeks: Dentistry (n= 198), ENT (n=59) & Neurology (n=52). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

Actions:

The Trust is focused upon reducing the number of patients over 52 weeks by March 2025. It is expected that this will be achieved in all but 4 specialties across both Medicine and Surgical Divisions

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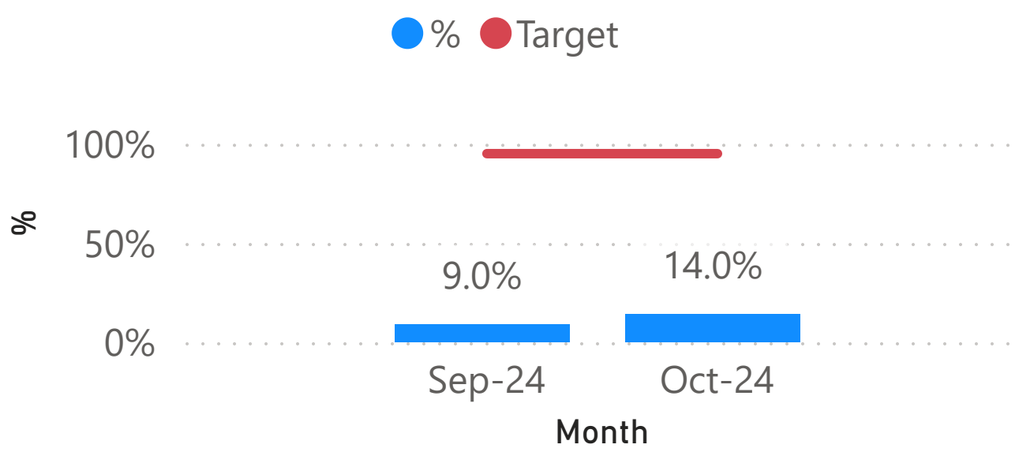
Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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



Technical Analysis:

At the end of October the longest wait to complete an ASD diagnosis was 138 weeks and for ADHD 145 weeks. Of those still waiting, 97% of the ADHD waiting list and 99% of ASD is within 104 weeks.

Actions:

The ASD and ADHD pathways continue to focus on those children and young people who have waited the longest. The transformation programme is established with workstreams focussing on digital improvements, workforce and training and the development of a new clinical model. The improvement programme is working alongside the Cheshire and Mersey ND improvement programme to ensure that the work aligned.

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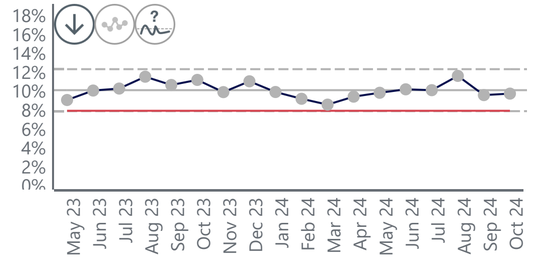
Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

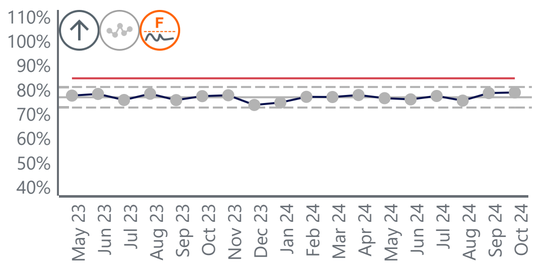
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

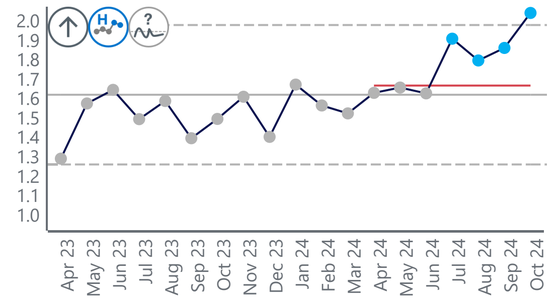


Theatre Utilisation (Capped Touch Time)

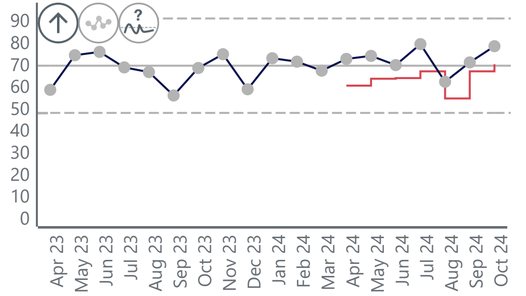
Target: Internal



Elective admissions (IP & DC) per clinical WTE

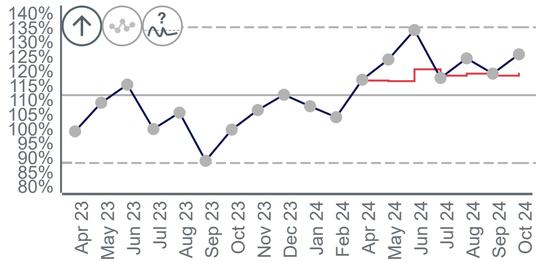


Outpatient attendances per Consultant WTE



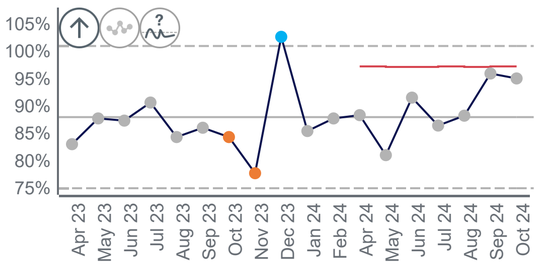
% Recovery for Daycase Discharges

Based on 19/20 baseline



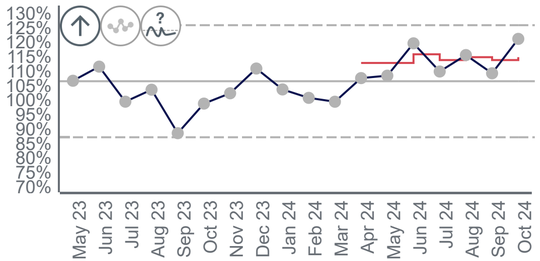
% Recovery for Elective Discharges

Based on 19/20 baseline



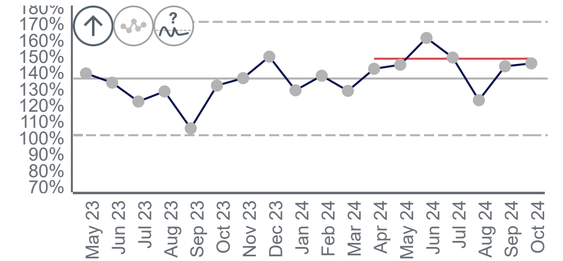
% Recovery for DC & Elec Activity Volume

Based on 19/20 baseline



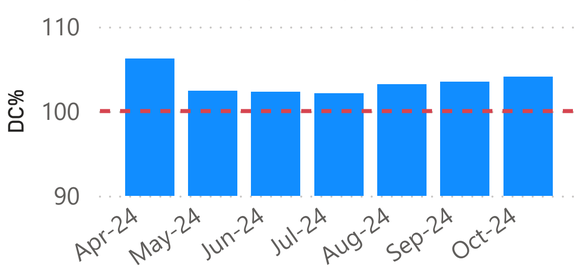
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline



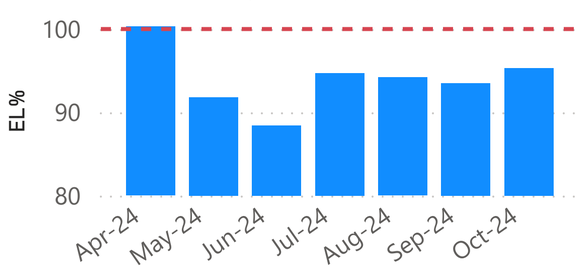
Daycase Activity vs Plan (YTD Position)

SLAM Performance (Volume)



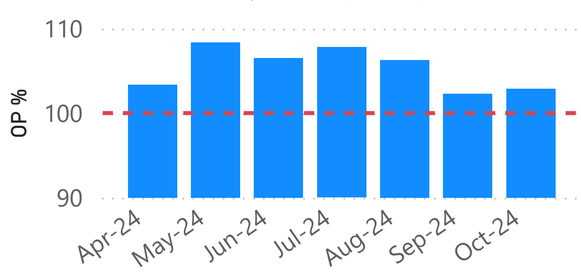
Elective Activity vs Plan (YTD Position)

SLAM Performance (Volume)

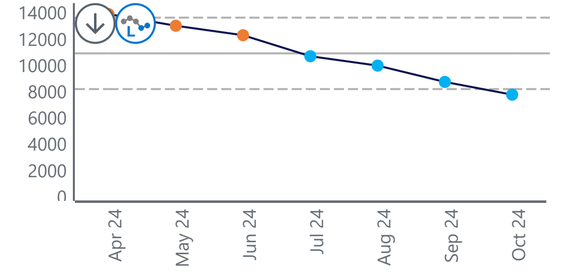


OP New & OPPROC Activity vs Plan (YTD Position)

SLAM Performance (Volume)



Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



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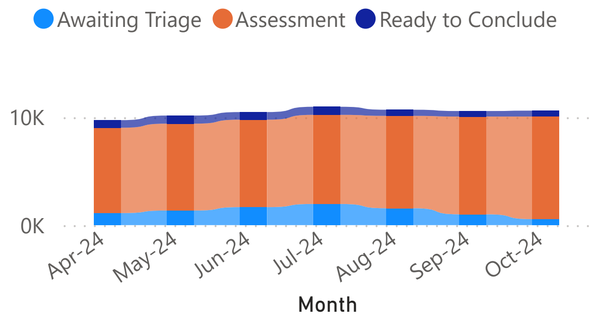
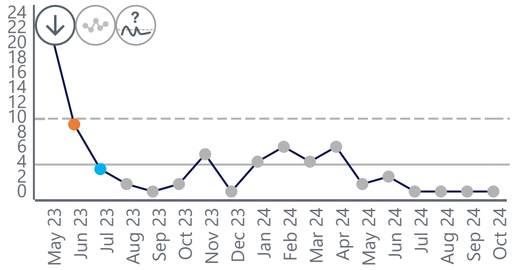
Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

ADHD/ASD Diagnosis Status

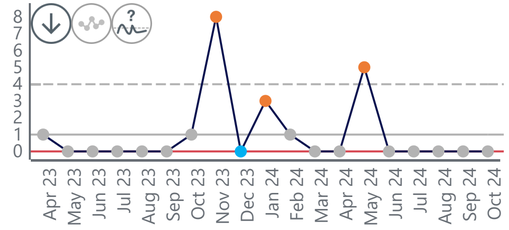


CAMHS: Number of children & young people waiting >52weeks



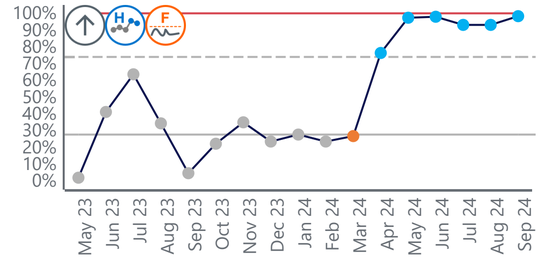
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



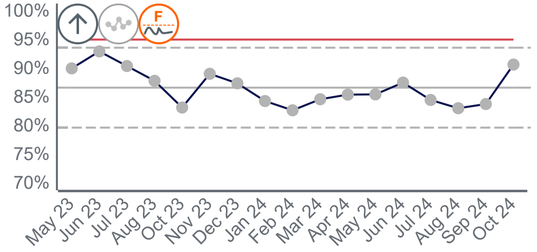
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



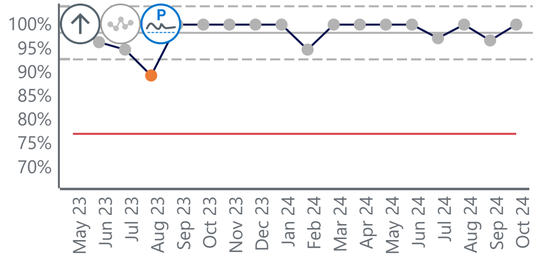
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



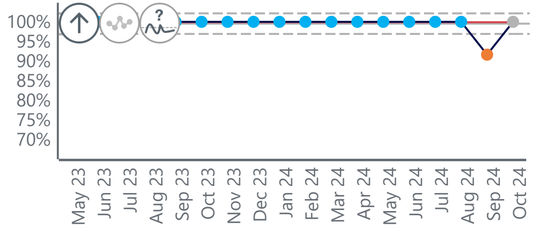
Cancer: Faster Diagnosis within 28 days

Target: Statutory



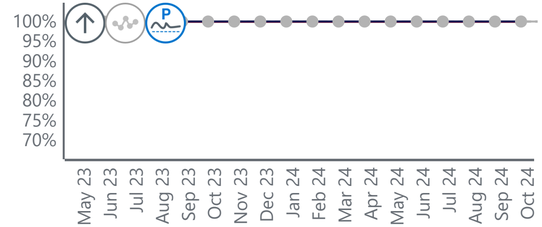
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

Target: Internal (Stretch)



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Alder Hey Children's NHS Foundation Trust

Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training completion remains over 90%

Areas of Concern:

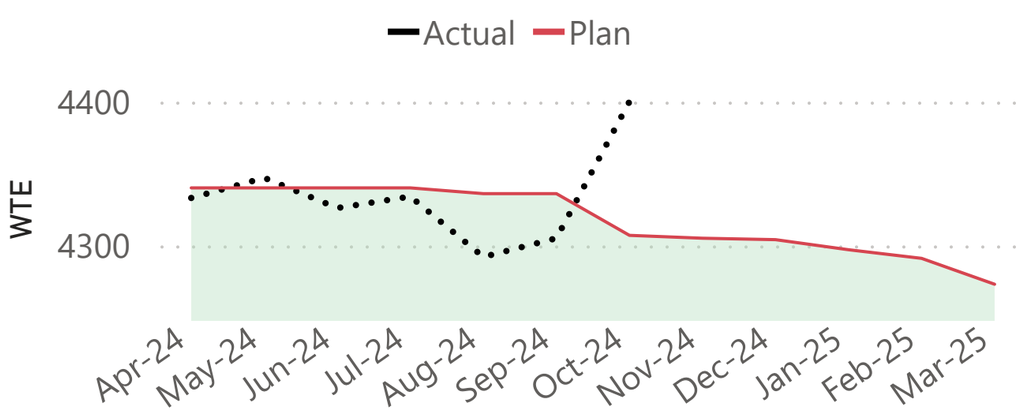
• PDR completion has remained below 90%; there are specific concerns with B7+ PDR compliance which were due to be completed by 31st July.
• Sickness absence has seen an increase; actions are in place.
• WTE remains a challenging plan, exceeded for the first time in October, due to an increase in temporary workforce usage (+14.86 WTE), increase in substantive workforce (+74.9 WTE) which includes the bulk nurse recruitment, and a reduction in plan (-29 WTE) due to the impact of CIP.

Forward Look (with actions)

• The WTE plan continues to be challenging, as the WTE plan reduces further (by -34 WTE) to March 2025 to account for CIP. Actions are being reviewed.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

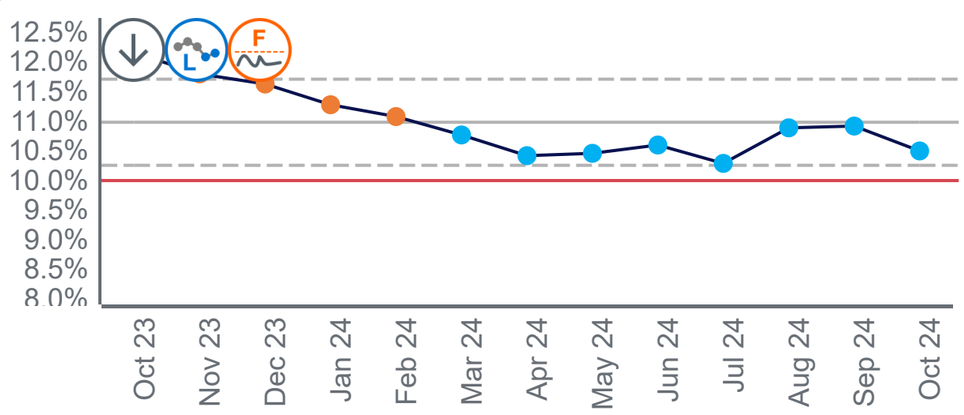
Total workforce for the end of October 2024 was 93 WTE above plan. Actual WTE was 4400 against a plan of 4307. 24/25 year end plan is set at 4273.4 WTE.

Actions:

When comparing September to October, there was an increase in temporary workforce usage (+14.86 WTE), increase in substantive workforce (+74.9 WTE), and a reduction in plan (-29 WTE) due to the impact of CIP. Actions are being reviewed.

Staff Turnover

Target: Internal



Technical Analysis:

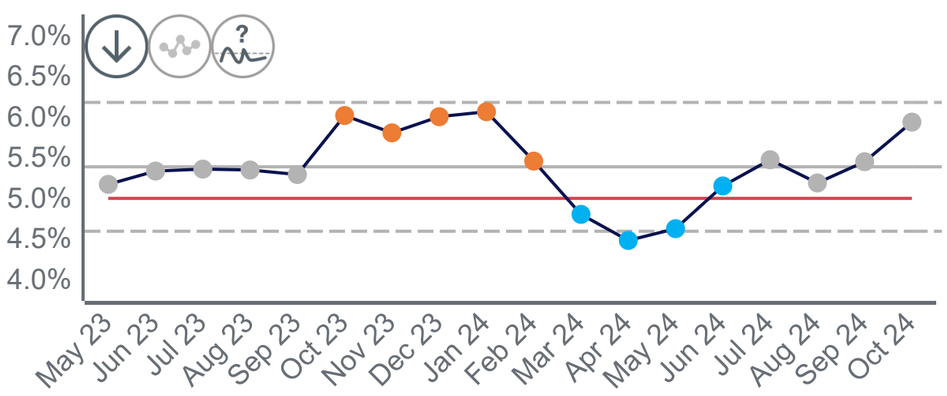
Staff Turnover is demonstrating special cause variation of improving nature with performance of 10.5% in October 2024.

Actions:

While staff turnover is reporting above the 10% target, however the significant improvement seen across the previous 18 months has been broadly sustained.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in October 2024 is 5.97% which is above the 5% target. An increase from September 2024 at 5.47%. October 2024 performance comprises STS at 2.26% and LTS at 3.68%. Still demonstrating common cause variation, 5th consecutive month above the target in 24/25.

Actions:

We have seen the proportion of sickness due to cold/flu significantly increase from August to October. Sickness due to anxiety/repression etc. has remained broadly level. Actions include the development of the Support for our People Toolkit focused on wellbeing and support strategies.

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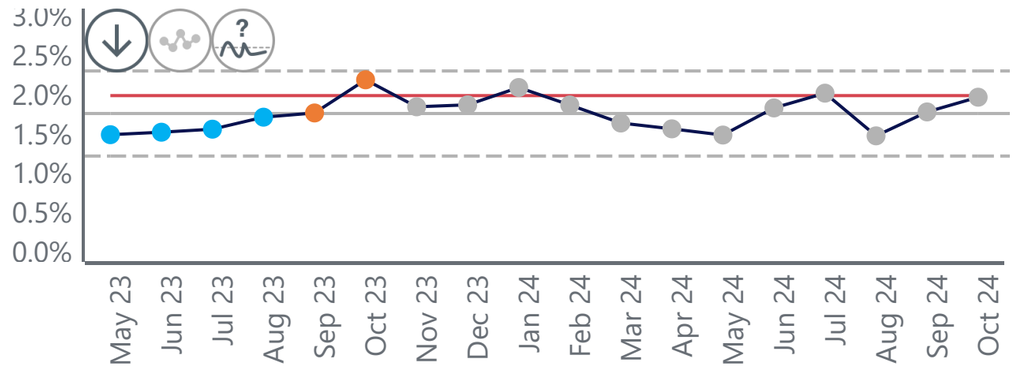
Alder Hey Children's NHS Foundation Trust

Supporting Our People - Watch Metrics

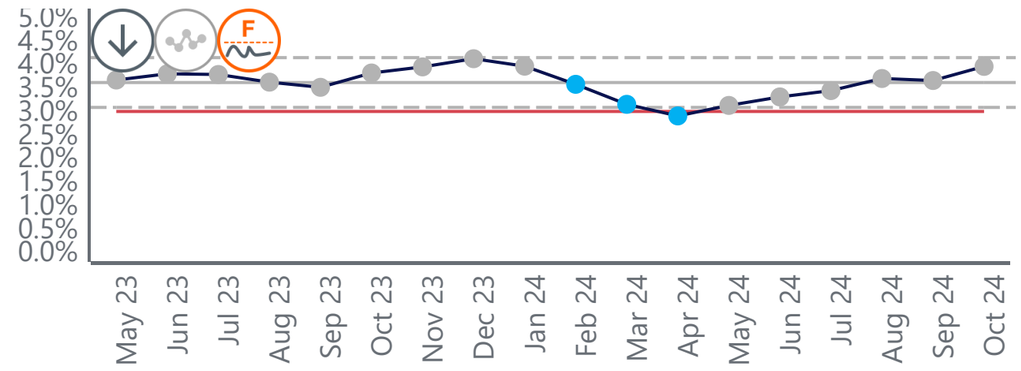
Short Term Sickness

Target: Internal



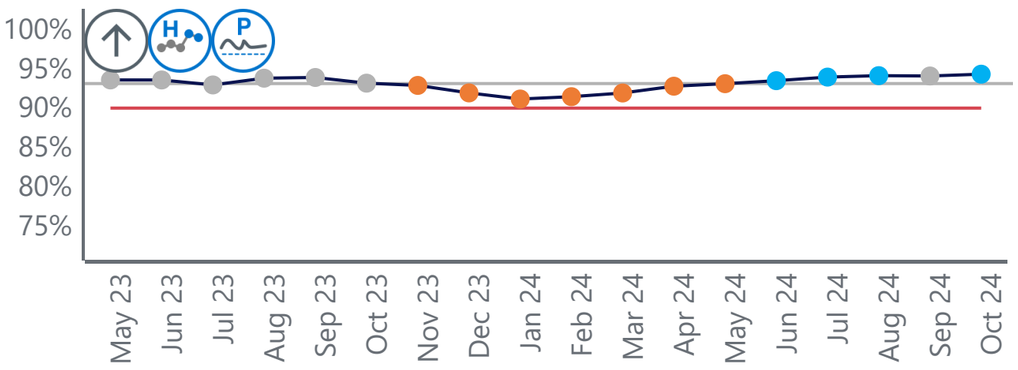
Long Term Sickness

Target: Internal



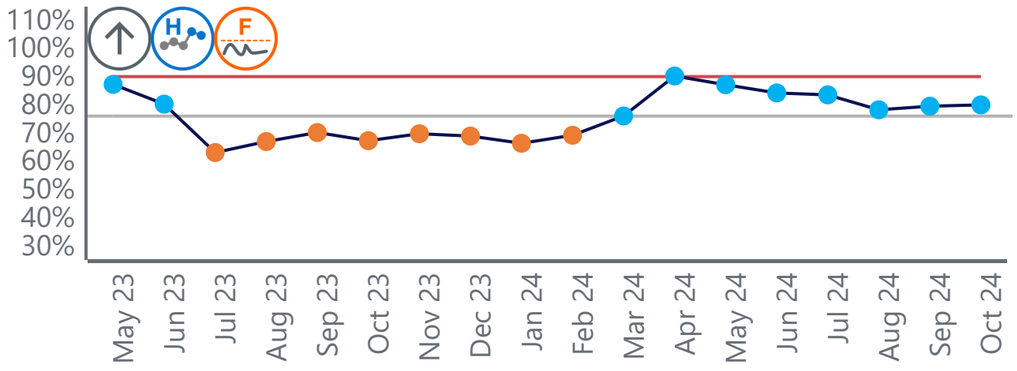
Mandatory Training

Target: Internal



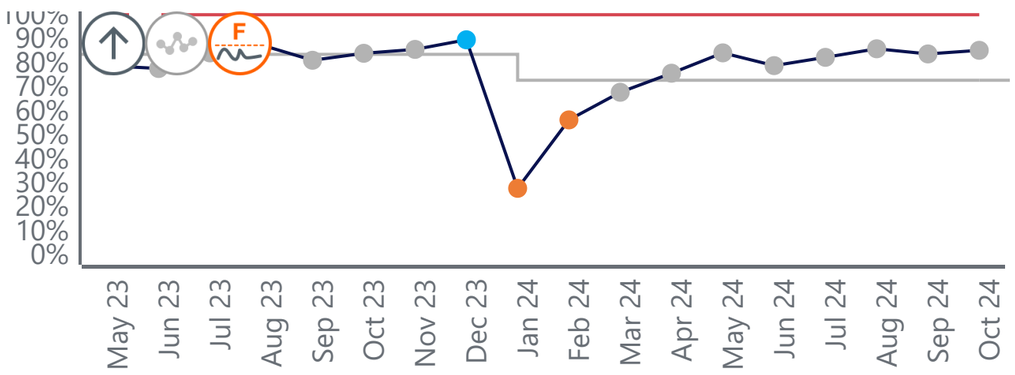
% PDRs Completed (Rolling 12 Months)

Target: Internal

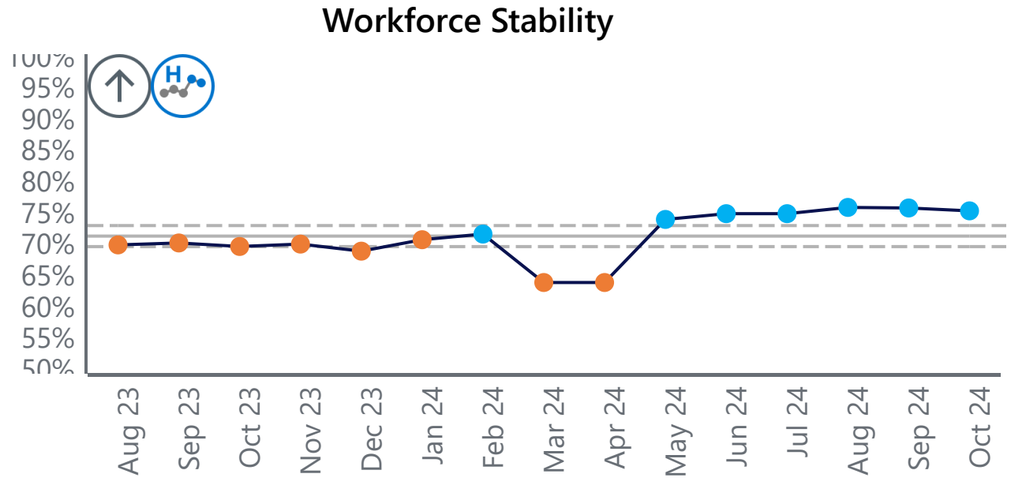


Medical Appraisal

Target: Internal



Workforce Stability



Integrated Performance Report | November 2024

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:

- Mobile Research Unit now on site and ready for use to extend our research into the community – can be used for all outreach activities not just research related
- 3rd MRI scanner (funded by NIHR Capital call) now operational
- Commercial research income remains ahead of target at end of M7
- Outline business case to Combined Authority for Paediatric Open Innovation Zone (£4.1m) under review
- Lyrebird Ambient AI pilot now live
- Trustwide RPA prioritisation exercise complete with monthly review agreed

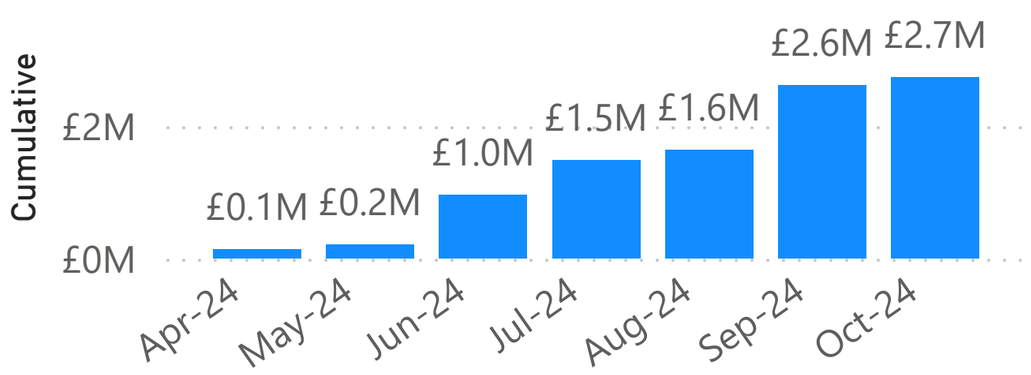
Areas of Concern:

- Innovation underperforming against external income target – work ongoing to identify opportunities

Forward Look (with actions)

- Internal funding call in preparation for Dec release for expenditure from April 2025 aligned with Futures Discovery themes
- Agreement with Phare Health for AI Coding proof of concept work under review
- Meeting with UCLan to identify stronger partnership planned for 11th November

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



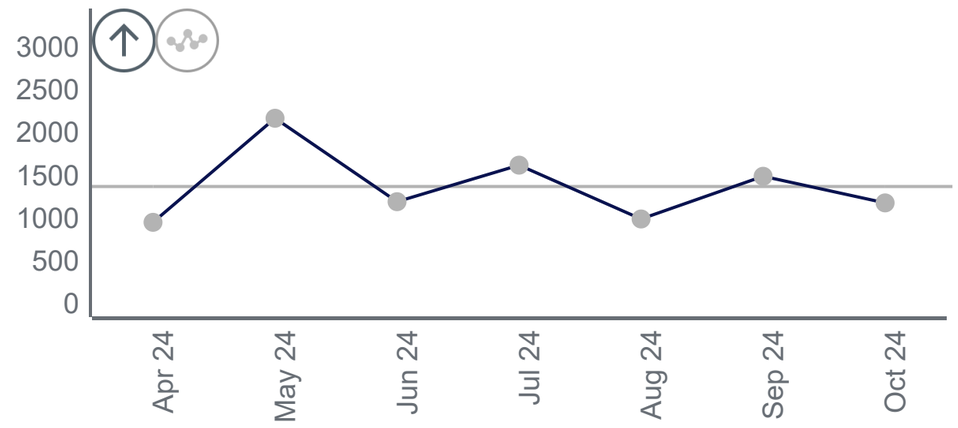
Technical Analysis:

This includes commercial and non-commercial income to research and innovation (cumulative total)

Actions:

Research income is ahead of target at M7. Innovation income is behind target – opportunities are under review.

Manual hours saved through automation solutions - Monthly

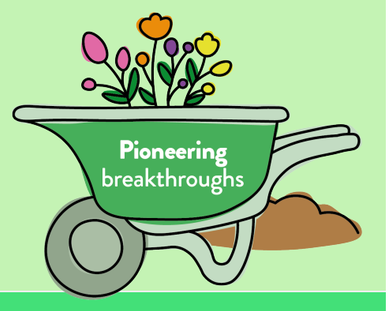


Technical Analysis:

This relates to fully implemented RPA solutions

Actions:

A Trustwide prioritisation exercise has taken place to ensure the RPA team are on track to meet the needs of the Divisions and Corporate services and deliver against the approved business case. A monthly prioritisation review has also been implemented.



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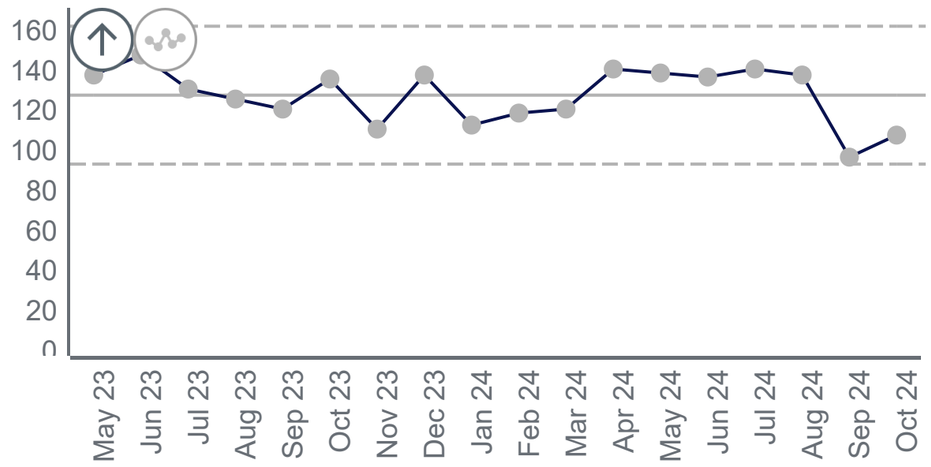
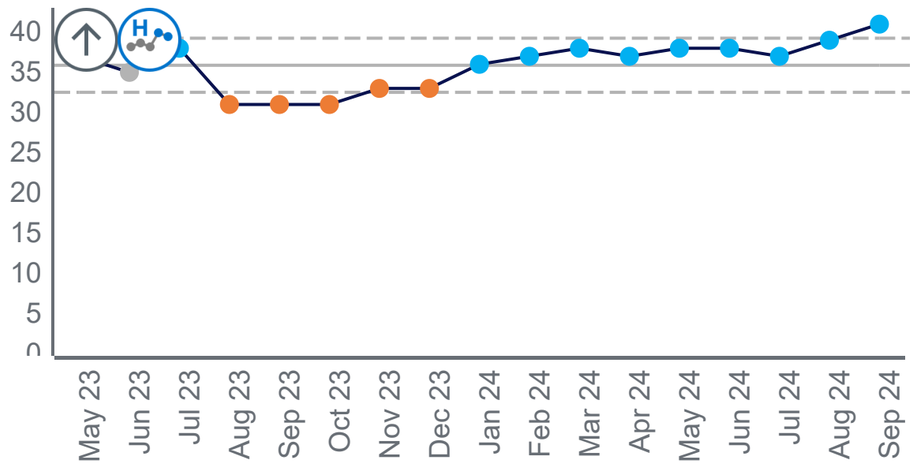
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

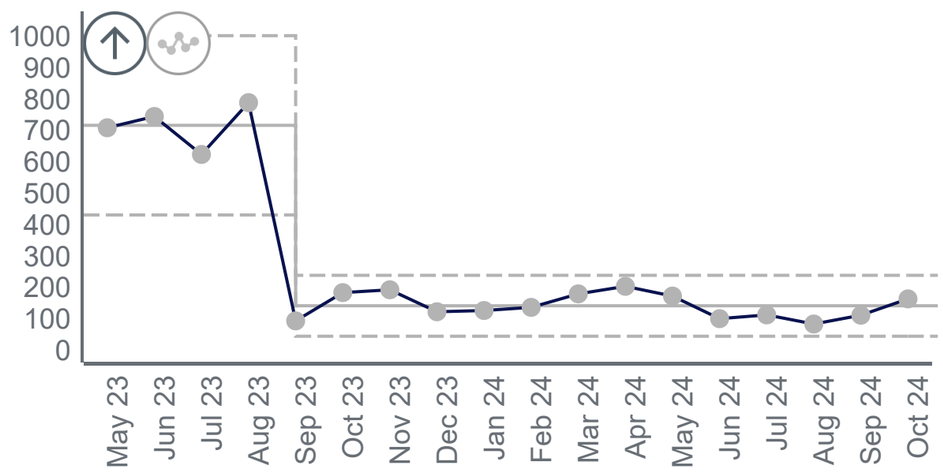
Number of Active (Open) Studies - Academic



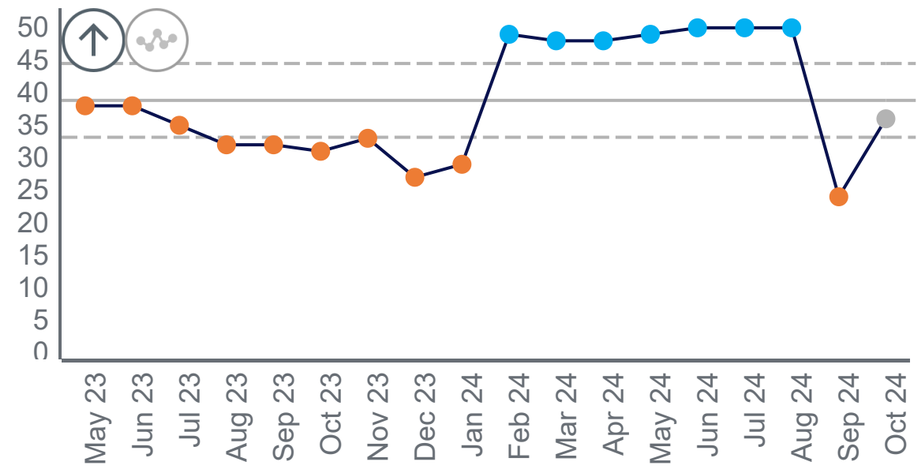
Number of Active (Open) Studies - Commercial

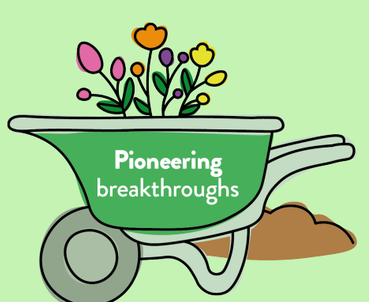


Number of Patients Recruited into Research Studies



Number of Chief Investigator led studies





Integrated Performance Report | November 2024

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:

• Health & Wellbeing Hub: officially launched 11th November 2024. Referrals are being taken from ward 3C, cleft palate team, respiratory and PALS. 16 referrals received by 15th November. • Health inequalities and prevention: referrals for the Vaping Clinic being taken from respiratory and pre-op clinic.
• Screened more than 600 patients, inputted into nearly 100 management plans for vaccination, and vaccinated 20 children. • Vaccination has been contraindicated in 5 children. Referred one patient (and their unvaccinated sibling) to the vaccination anaphylaxis service.

Areas of Concern:

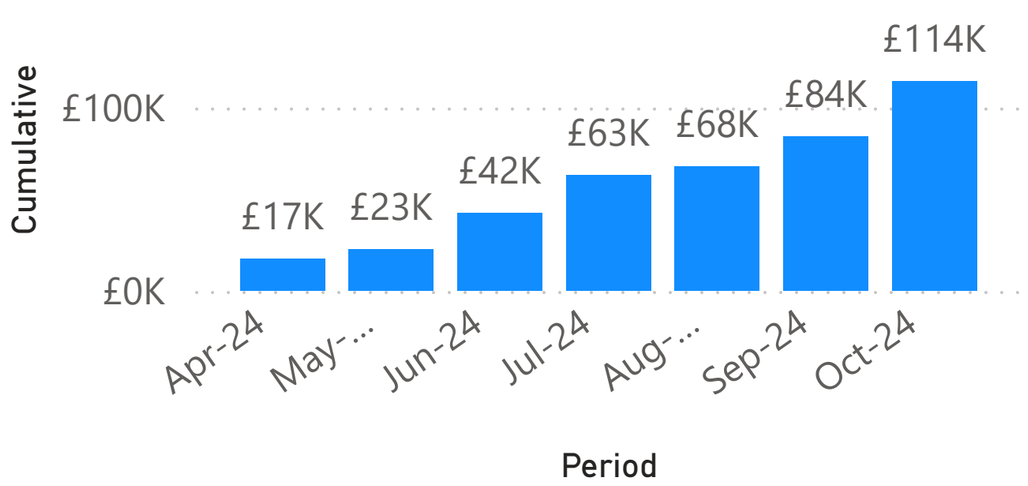
A phased approach is being used for the launch of the Health & Wellbeing Hub as there is concern that demand may exceed the capacity of the team. Referral activity will be monitored, evaluated and then further roll out will be undertaken.

Forward Look (with actions)

Vaping Clinic will see its first patients in December.

Collaborating for CYP's year 2 priorities have been agreed by the SRO and workstream leads, revised PIDS to be developed.

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.

Actions:

A range of careers events in secondary schools have been held this month, including introduction to the range of NHS careers and mock interviews. A range of group events have been held, including an event for young people with care experience.

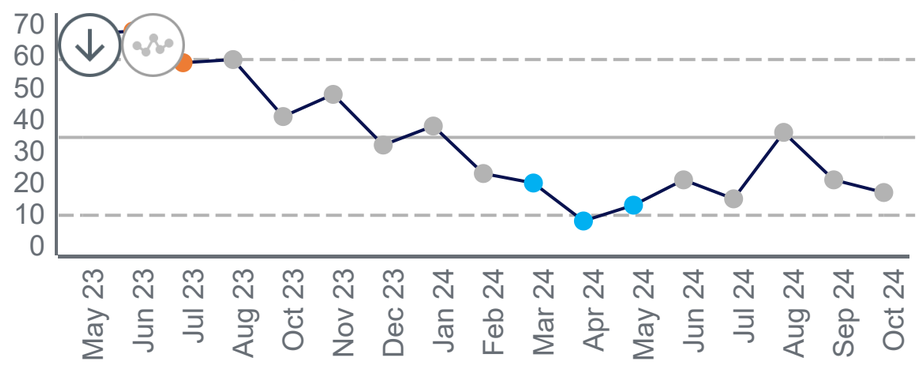
Integrated Performance Report | November 2024

Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

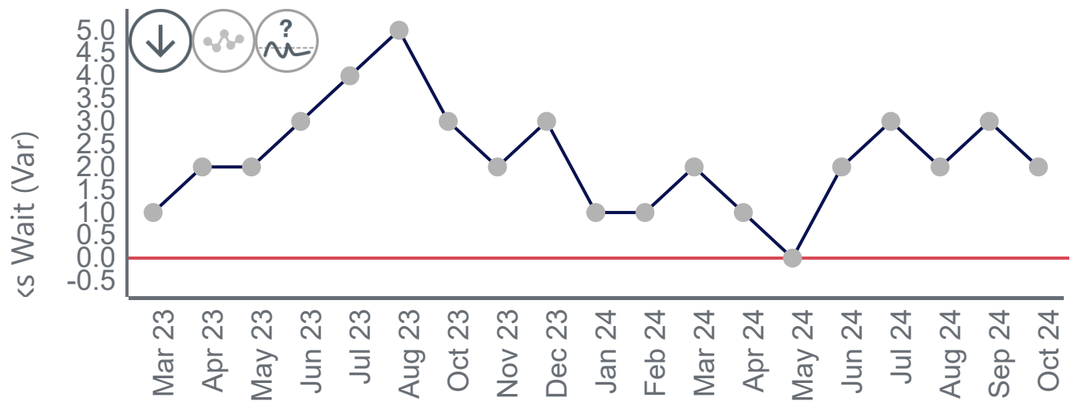
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

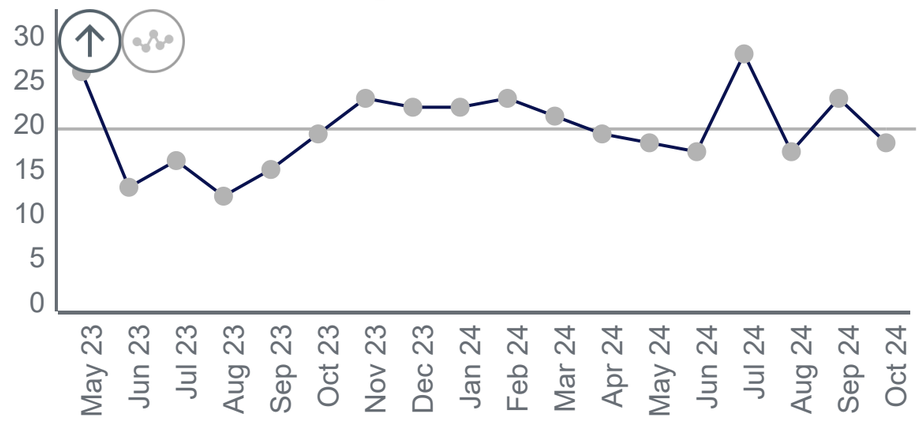


Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD

Sept-23 Unavailable



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



Integrated Performance Report | November 2024

Alder Hey Children's NHS Foundation Trust

Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

• £1.6m deficit, which is off plan by £0.7m YTD due to pay award impact • Forecasting to achieve £3.3m surplus, however, the Trust are carrying £1.2m pay award risk that we will endeavour to mitigate through internal stretch • Divisional forecasts continue to highlight challenges and risk and have deteriorated between month 6 and 7 by circa £1.7m (primarily medicine and digital). That being said, the financial improvement plan has resulted in some significant savings, primarily through technical workstreams which has given the trust assurance to continue to forecast to plan albeit with the known stretch target of £1.2m as set out above • CIP was above plan in M7, £14.7m CIP has been transacted in year, with £5.2m in progress and opportunity • Cash remains high, although slightly lower than plan due to high levels of accrued income as awaiting payment of YTD ERF • Capital broadly on plan YTD however forecast has been updated to £1.5m favourable to plan, following movement of Neonatal expenditure moving to 25/26 in agreement with the ICB.

Areas of Concern:

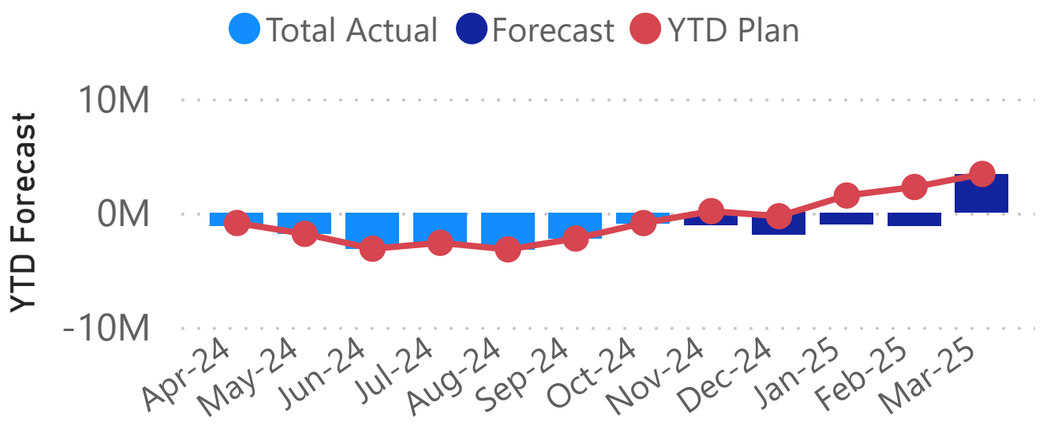
Work is ongoing to deliver full savings of £19.9m and significant progress has been made to date resulting in £12m of savings recurrently posted in M7. Divisional forecasts continue to highlight significant financial and operational challenges with medicines forecast deteriorating by £2.7m since Q1. SDG meetings will now be focusing on 4 key priorities (Workforce, Drugs, Coding and Activity) with a view to deliver savings to support the position. 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. ICB are now requiring all Trusts to hold gold command meetings with an intense focus on finance and improving run rate. Once mobilised this will to be managed through execs.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

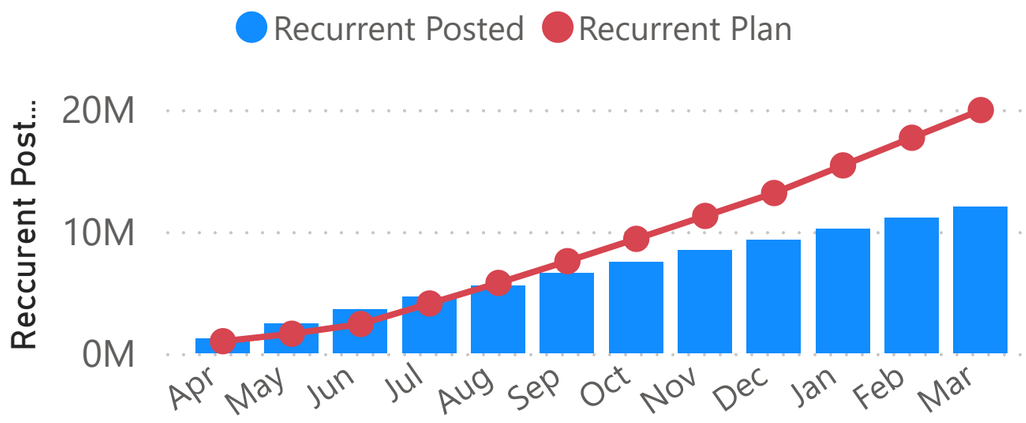
Current plan is £3.3m surplus (£1.2m pay award risk) however, initial forecast continues to highlight significant challenge. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through SDG meeting and divisional deep dives. SDG meetings will now be focusing on 4 key priorities (Workforce, Drugs, Coding and Activity) with a view to deliver savings and achieve the full year forecast.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

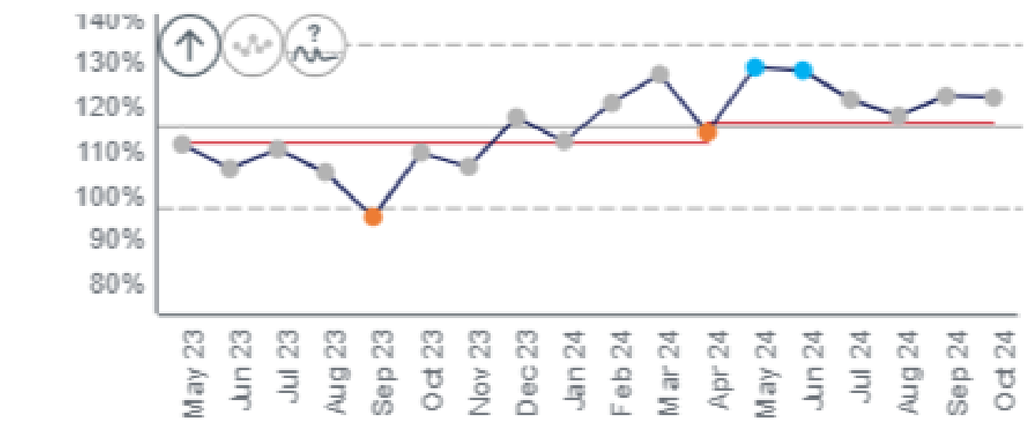
In year CIP identified and in progress is £18.3m whilst recurrent CIP is £14.4m

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:

October performance estimated at 123%.

Actions:

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

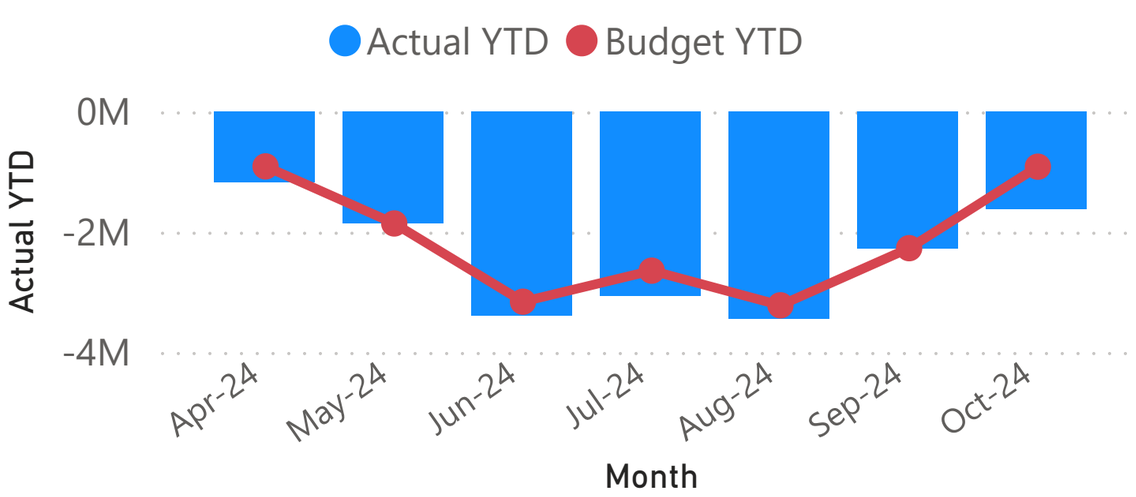
Integrated Performance Report | November 2024

Alder Hey Children's NHS Foundation Trust

Financial Sustainability: Well Led - Watch Metrics

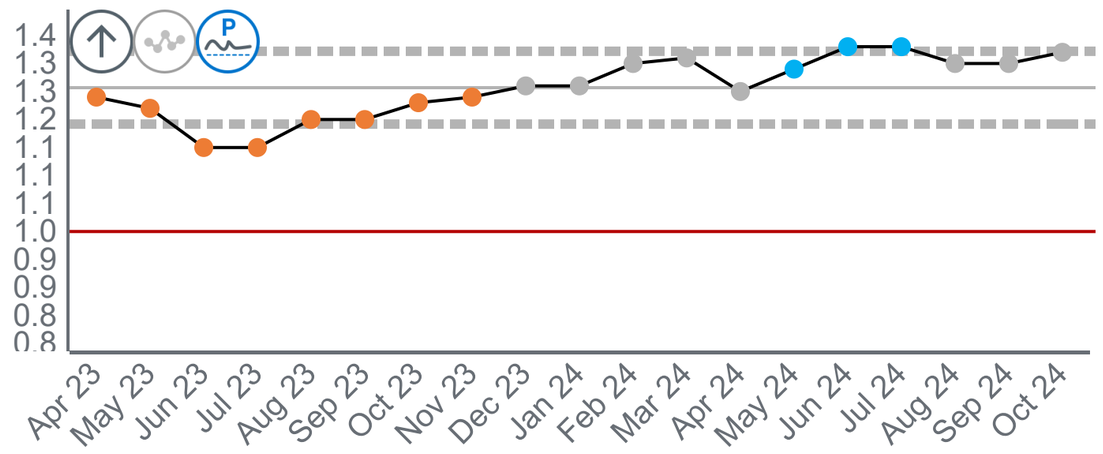
I&E distance from target (cumulative YTD)

Target: Internal

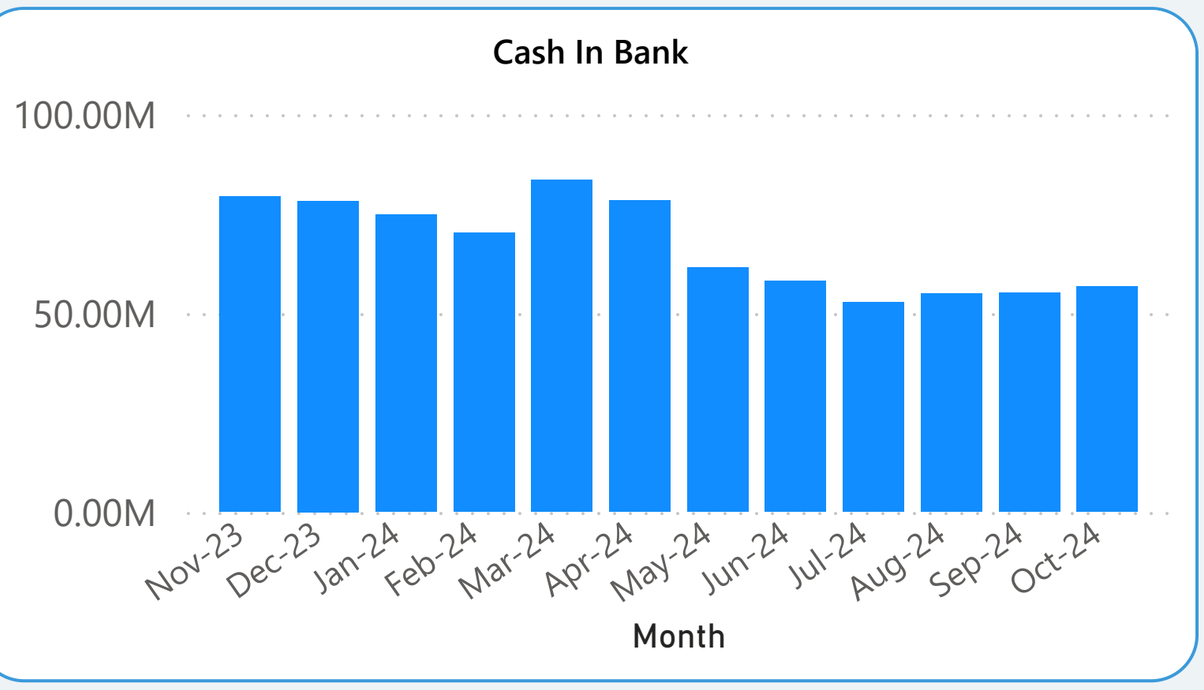


Liquidity

Target: Internal



Cash In Bank



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Positive engagement with teams at risk oversight meeting continues

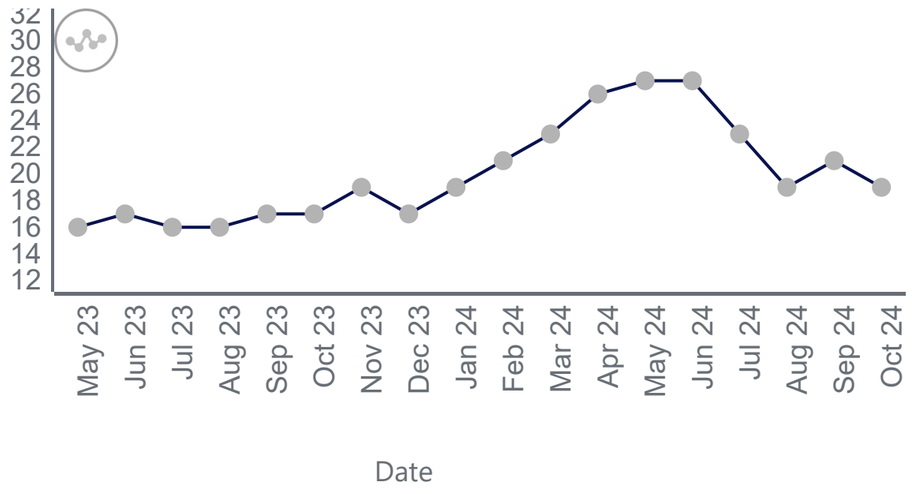
Areas of Concern:

No concerns of note

Forward Look (with actions)

• Positive dialogue with service/risk owners to start to review risks in line with approved risk appetite agreement. • Proposal for risk management training to be included in suite of mandatory training requirements being submitted to Education Committee Dec 24. • Deep dive into long standing high moderate risk (score 12+ and on risk register > 12 months) being undertaken at next Risk Management Forum

Number of High Risks (scored 15 and above)



Technical Analysis:

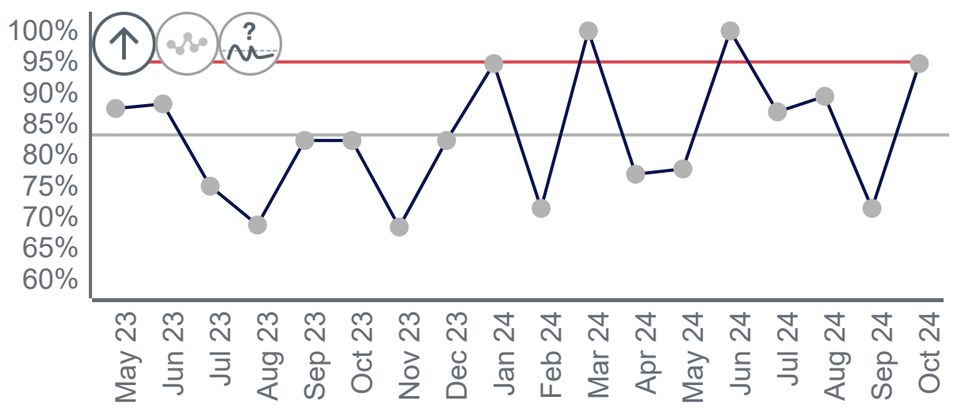
19 high risks reported on risk register as of end October, a slight decrease in high risks from the previous reporting period of 21.

Actions:

Risks themed as follows: • Quality – Safety = 8 • Workforce = 2 • Workforce – Sustainability = 3 • Compliance and Regulatory = 4 • Financial = 1 • Reputational = 1

% of High Risks within review date

Target: Internal



Technical Analysis:

% of High Risks within review date is demonstrating common cause variation with performance of 89% in October 2024.

Actions:

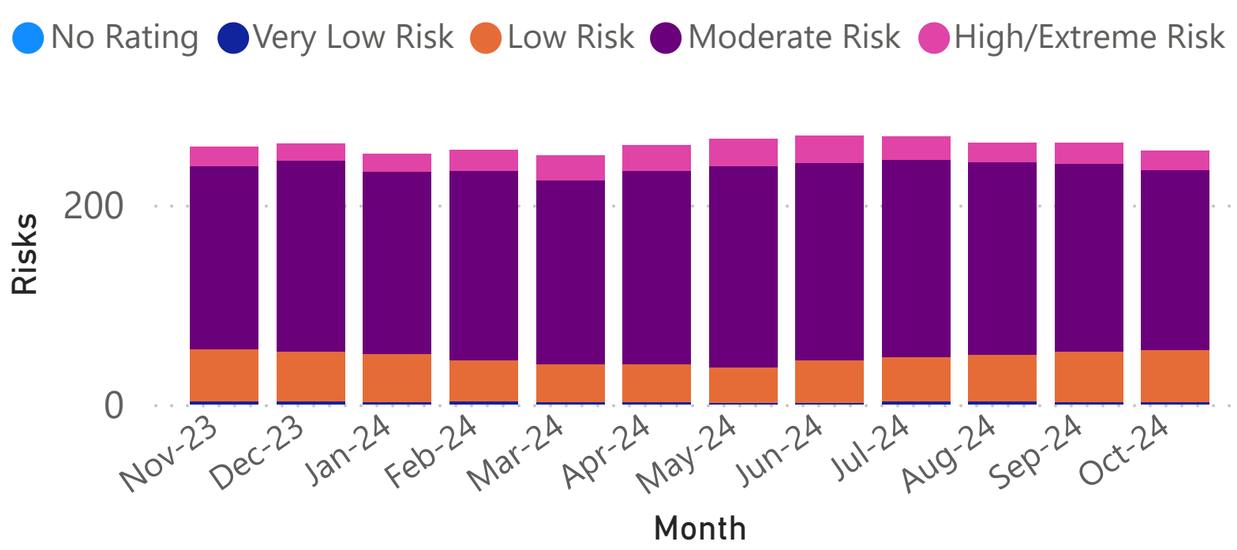
94.7% (18/19) risks within expected review date. 1 overdue risk has been escalated to risk owner/manager for immediate review and update

Integrated Performance Report | November 2024

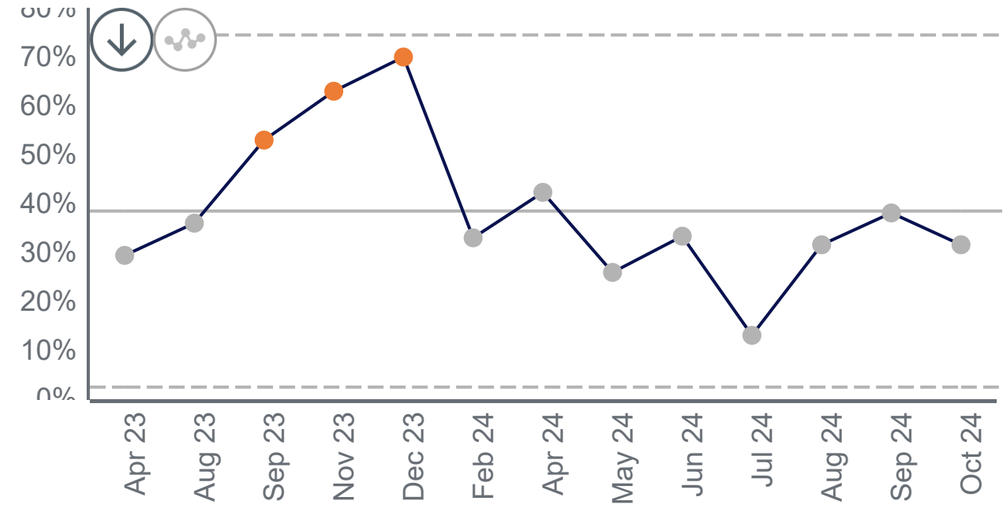
Alder Hey Children's NHS Foundation Trust

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

- 98% Initial Health Assessments completed within 20 days of receiving referral (87% IHAs completed within 20 days of starting in care)
- Mandatory training compliance remains above Trust target (96%)
- No children and young people waiting over 52 weeks for CAMHS, community paediatrics and therapies.
- Reduction in the number of formal complaints received (2)
- Improvement in number of PALS responded to within 5 days (86%) and complaints responded to within 25 days (80%)
- Continued reduction in number of children and young people waiting 2+ years for a follow up (reduced from 1325 to 80)
- 165% virtual ward occupancy
- RTT for SALT Sefton has continued to improve (91%).

Areas of Concern

- Increase in urgent Eating Disorder referrals – with decrease in RTT (88% - 1 breach)
- Sickness absence has increased (7%) with slight increase in short term sickness (2%)
- Outpatient Fracture / Dermatology work has commenced. Delays with redevelopment work which is impacting on ability to reduce clinic room waiting list.
- Work continues regarding data reporting for Mental Health Services via MHSDS due to data quality issues impacting on submissions. MHSDS Improvement Steering Group to be introduced November 2024.
- Continued challenges with ADHD medication shortage – unable to initiate medication for ADHD in line with ICB guidance

Forward Look (with actions)

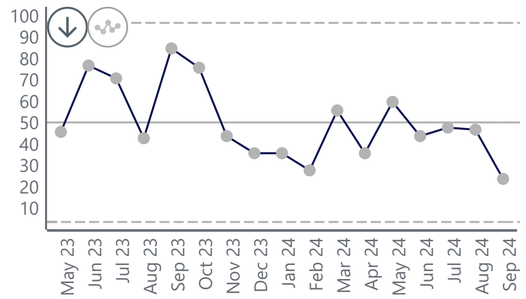
- Virtual ward / virtual care activity accepted for Meditech development sprint Nov 2024.
- CAMHS PIFU discharge pathway – information leaflets and SOPs have been approved. Go live November 2024.
- ASD / ADHD transformation programme continuing with good engagement from teams and external colleagues. Staff listening events completed in October 2024, with demand and Capacity analysis for treatment pathway to be completed November 2024
- Work ongoing with Victim Support to provide psychological support to children impacted by the Southport critical incident.
- Sunflower House Meditech development work completed, testing to be arranged for November/December.
- Continued work ongoing to improve Mental Health data reporting. Annual data re-submitted for 2023/24, awaiting feedback.
- Steering Group for Phlebotomy and H&W work streams established.

Integrated Performance Report | November 2024

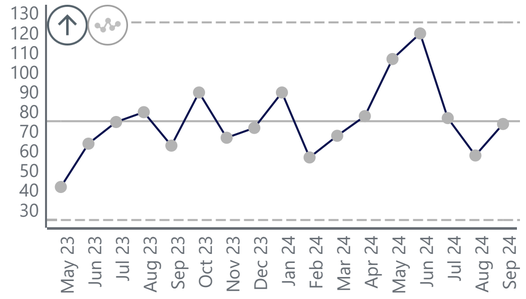
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

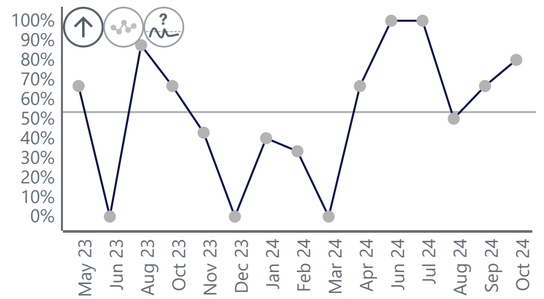
Patient Safety Incidents rated Low Harm & Above



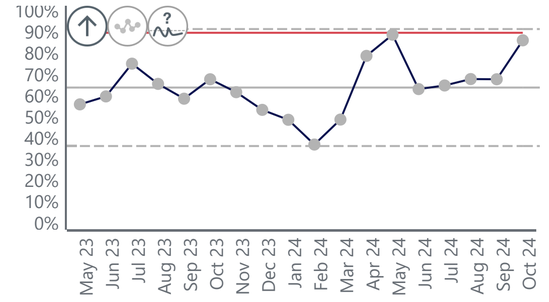
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

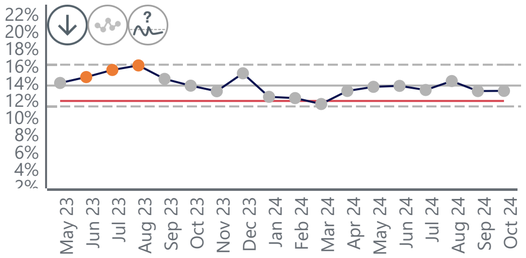


% PALS Resolved within 5 Days

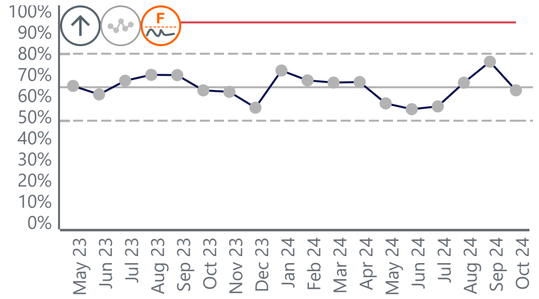


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

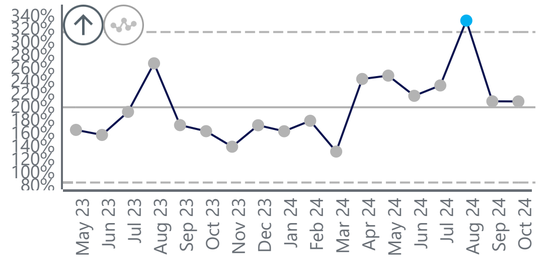


% of Clinical Letters completed within 10 Days

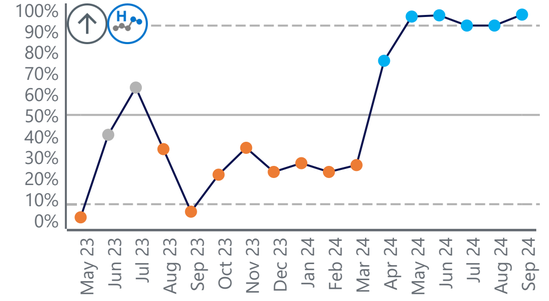


% Recovery for OP New & OPPROC Activity Volume

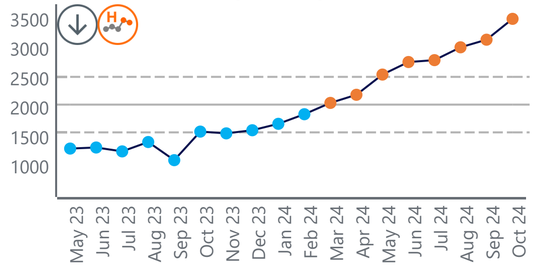
Based on 19/20 baseline



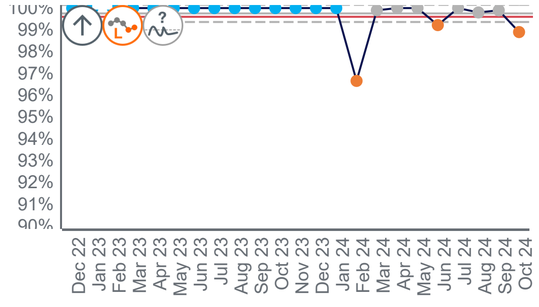
IHA: % complete within 20 days of referral to Alder Hey



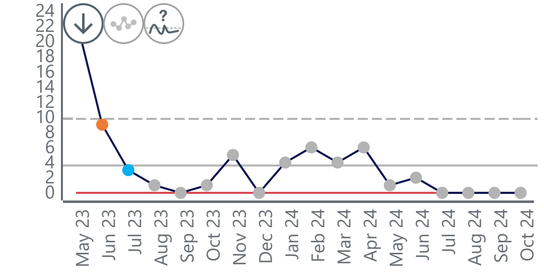
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



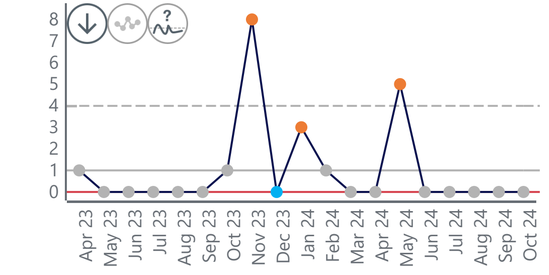
ADHD & ASD: % Referral to triage within 12 weeks



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



Number of Paediatric Community Patients waiting >52 weeks



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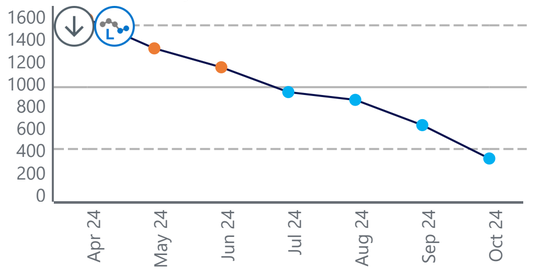
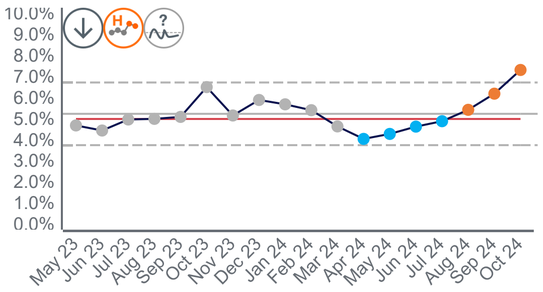
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

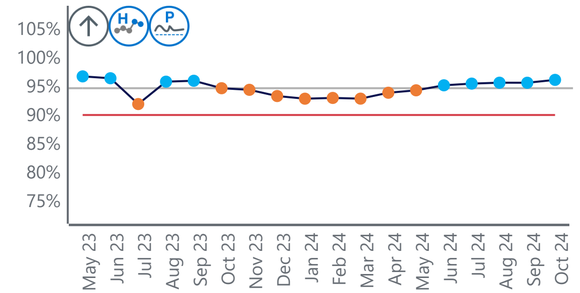
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



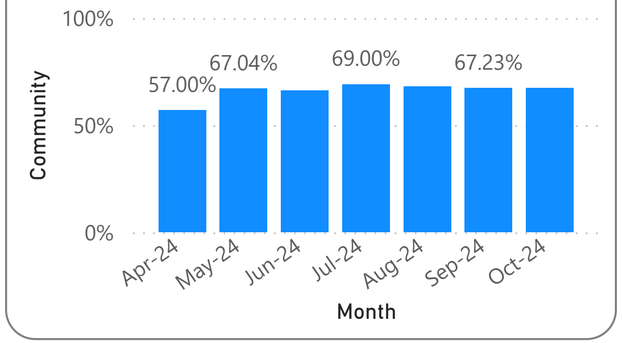
Sickness Absence (Total)



Mandatory Training

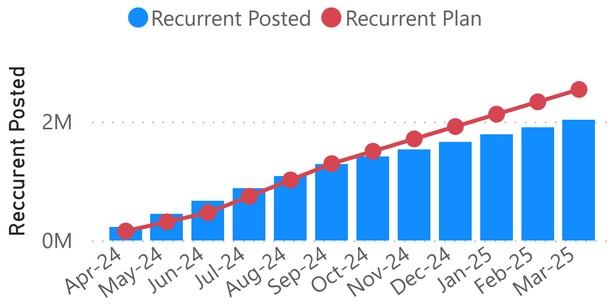


Workforce Stability

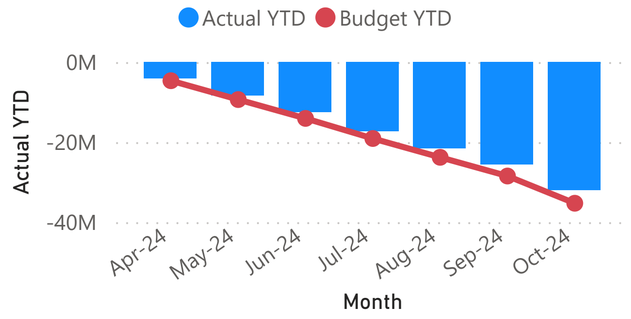


Staff Turnover

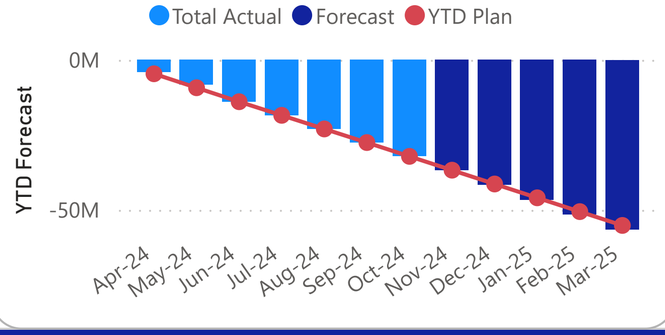
Recurrent Efficiency Plans Delivered (Forecast)



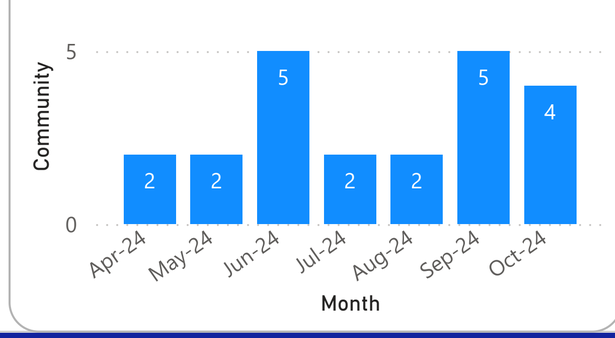
I&E distance from target (cumulative YTD)



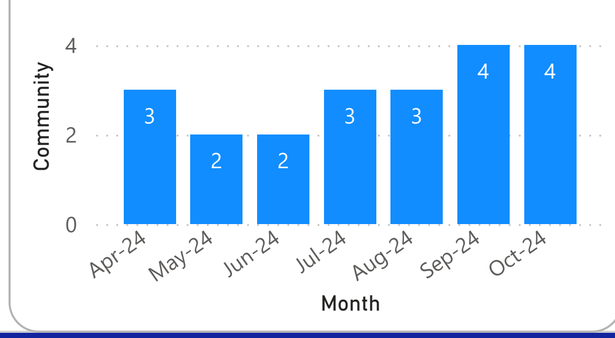
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Improvement in DMO1 performance, achieving 91% only 4% away from the national standard, plans in place to achieve 95% in December

•100% response rate for formal complaints for 11 consecutive month

•100% compliance in PALS for 5 months

•Maintained reduction in WNB rate following focused efforts in key specialities

•Improvement in activity recovery for both Outpatient appointments, Elective and Day Case

•Further reduction in children overdue follow up care, maintained month on month reduction for 6 months

•Sickness rates below 5%

•Maintained high performance in mandatory training compliance

Areas of Concern

•Challenges experienced in achieving 4 hour ED standard compared to previous months. Maintained above 78% standard; however, anticipation that this KPI will be challenged over coming weeks

•Reduction in the volume of Day cases per working day, analysis shows this is likely owing to an increase in OPROCs instead

•Slight increase in children waiting over 52 weeks for treatment, primary area of concern being neurology

•Challenging financial position, owing to reduction in forecast income anticipated and increase in non-pay spend, resulted in worsening end of year forecast position

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

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

•Challenges in achieving ED Sepsis compliance, case by case review under way

Forward Look (with actions)

•DMO recovery plan in place to achieve 95% in December

•Extended winter planning actions in place in attempt to support increased attendances through ED and to prepare for any anticipated RSV surge

•Plans to ensure no child is over due their follow up appointment by over two years by the end of March 2024

•Additional resource options under analysis to understand further options to support neurology by providing additional capacity to reduce waiting times

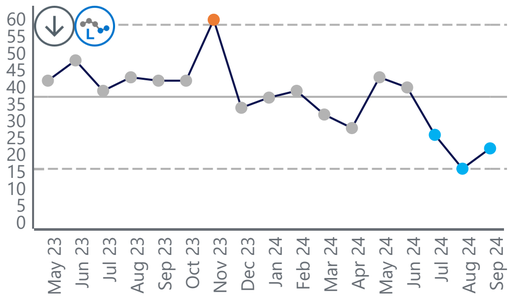
•Divisional health and wellbeing occurring in November to support staff during one of the busiest times of the year within the division

Integrated Performance Report | November 2024

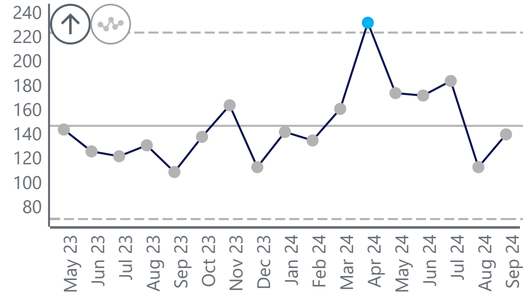
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

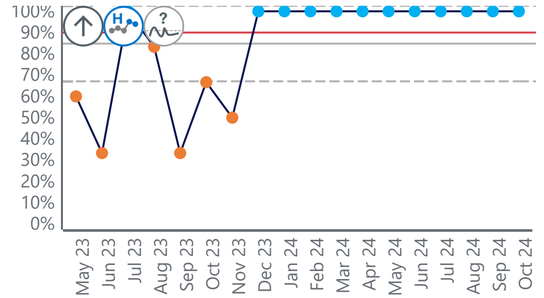
Patient Safety Incidents rated Low Harm & Above



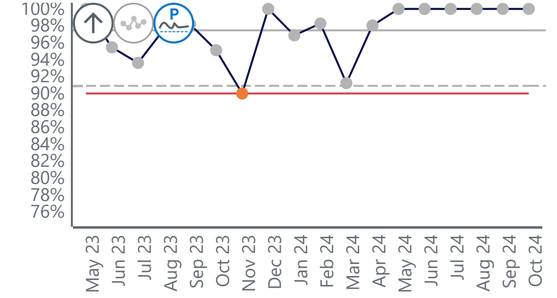
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

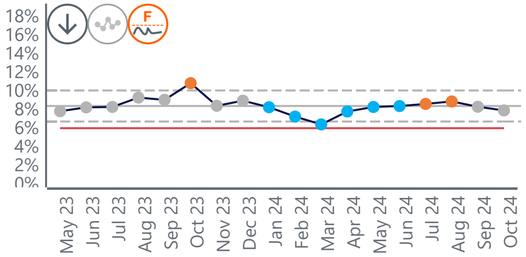


% PALS Resolved within 5 Days

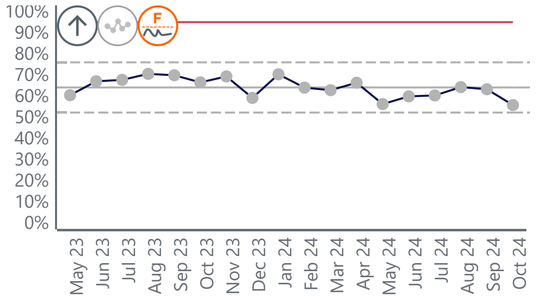


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

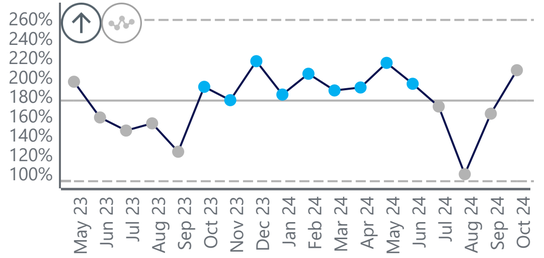


% of Clinical Letters completed within 10 Days

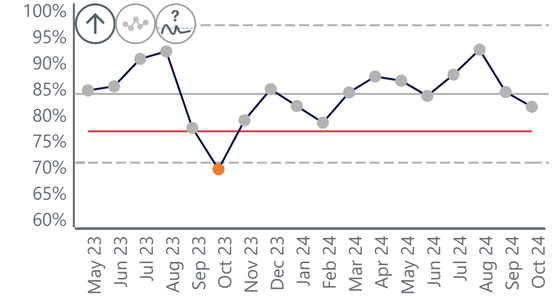


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline



ED: % treated within 4 Hours



% Recovery for DC & Elec Activity Volume

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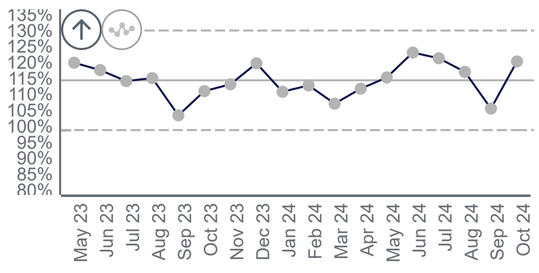
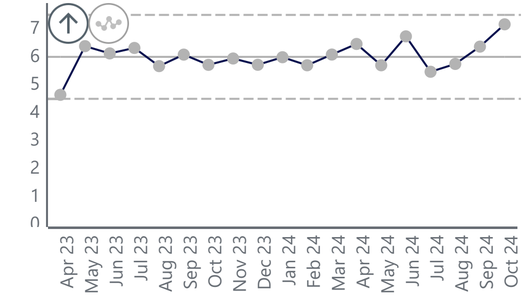
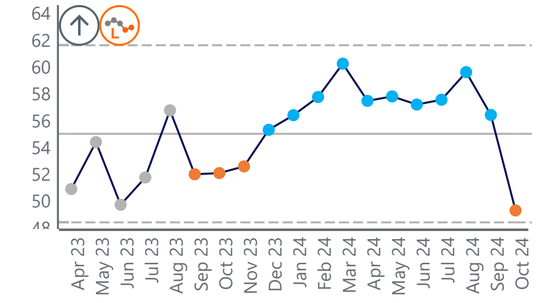


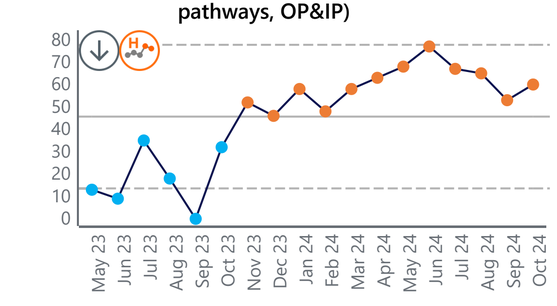
Inpatient Discharges per working day



Day Cases per working day



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



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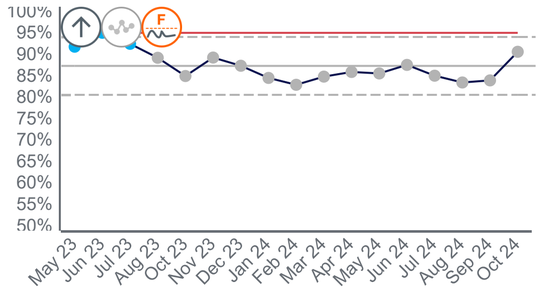
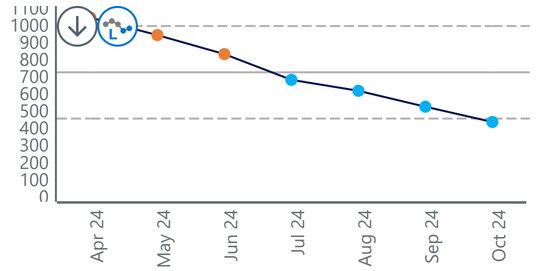
Divisional Performance Summary - Medicine

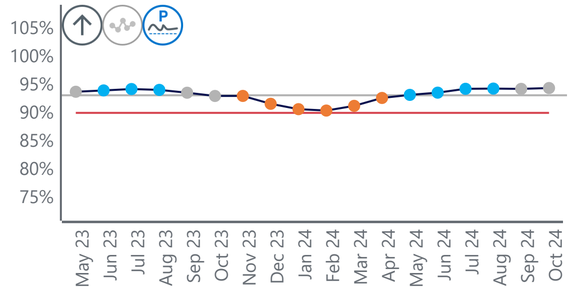
Diagnostics: % Completed Within 6 Weeks of referral



Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025

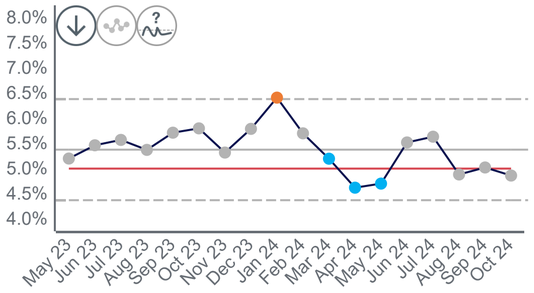


Mandatory Training

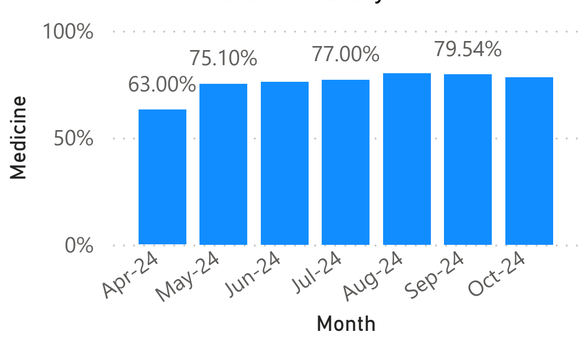


Staff Turnover

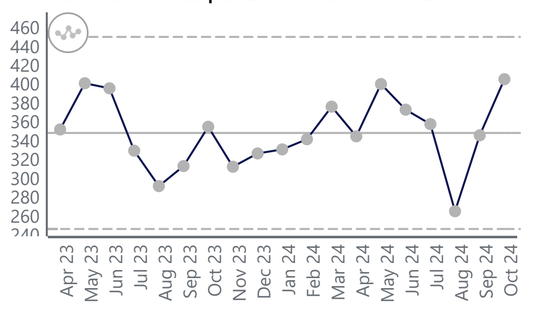
Sickness Absence (Total)



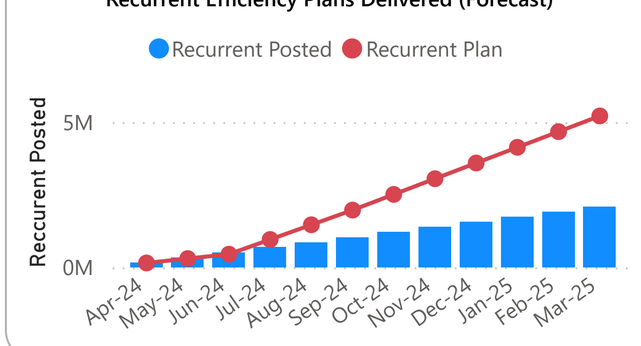
Workforce Stability



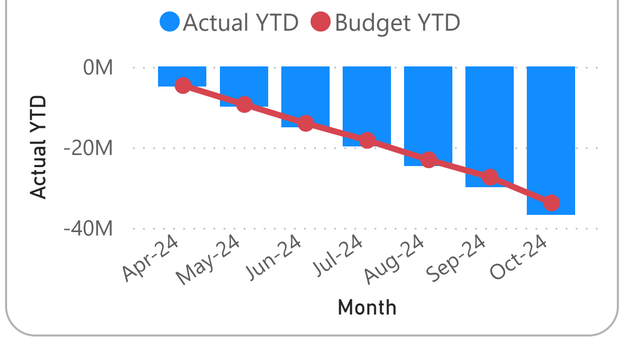
A&E Attendances per ED Consultant WTE



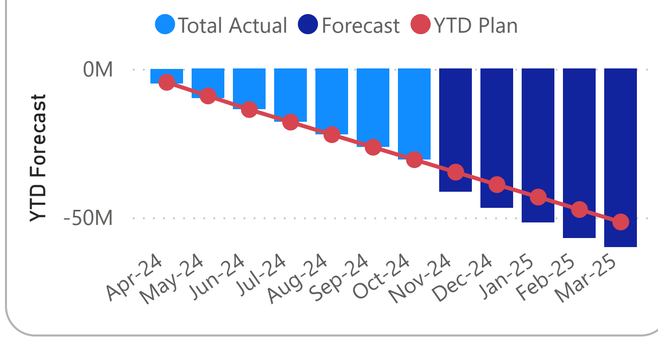
Recurrent Efficiency Plans Delivered (Forecast)



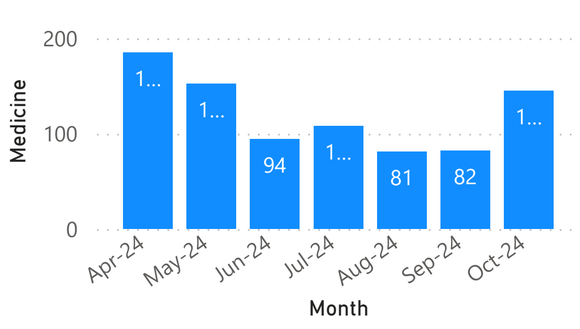
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



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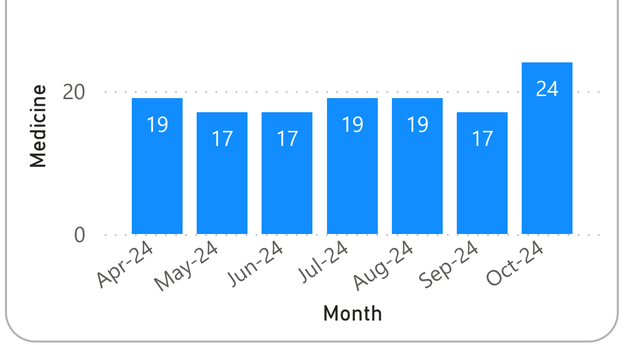

Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

•Significant overperformance in elective recovery- DC & IP volume at 122%

•Overperformance in OPNEW/PROC recovery at 113%

•Increase in DC per working day aligned to productive theatres programme

•DM01 compliance significantly improved for 3rd consecutive month at 93%

•Continued reduction in number of CYP waiting over 52 weeks for treatment

•Mandatory training compliance continues to be over target

•Maintained 100% compliance with PALS and formal complaints responses

•Although FU waits remain a challenge, continued decrease in volume waiting over 2 years

Areas of Concern

•Sickness increased significantly in month which is in line (slightly less) with winter seasonal trends. In month increase in STS and reduction in LTS. STS top reasons were cold and flu and most pressured areas were in theatres and 1C.

•WNB rate remained above target in month

Forward Look (with actions)

•Trajectory completed with action plan to support additional capacity required to continue improvements with DM01 position

•Ongoing work to improve WNB rates which includes: review of use of the AI predictor tool, 2 pilots underway within productive outpatient group – to have standard overbooking rules & a trial in Gynaecology to utilise a WNB F2F appointment to directly contact the patient via telephone.

•Further work planned within productive theatres to shadow DC finish times to review opportunity- similar to previous 'starting on time' shadowing.

•Ongoing work within the safe follow up programme and at specialty level to ensure clear action plans for backlog and future ways of working

• Winter People Plan launched at Surgery people committee- further work planned to enhance wellbeing of staff across all groups

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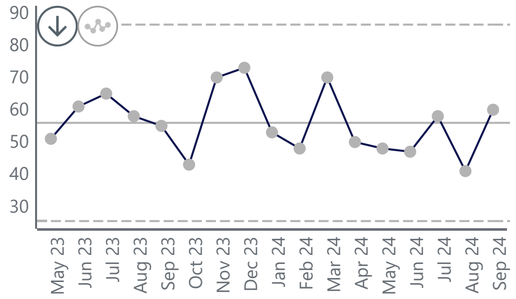
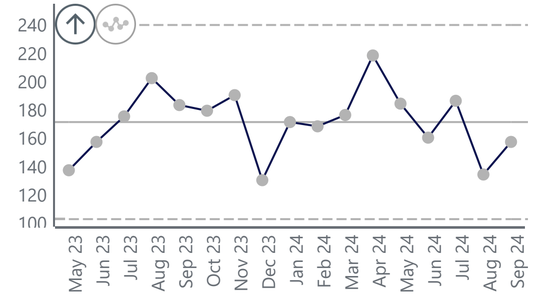
Divisional Performance Summary - Surgery

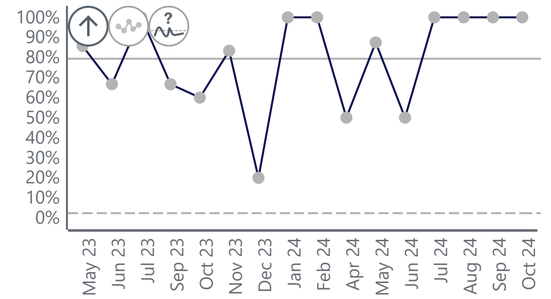
Patient Safety Incidents rated Low Harm & Above



Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days



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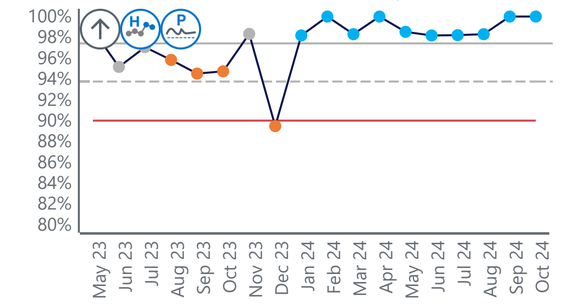
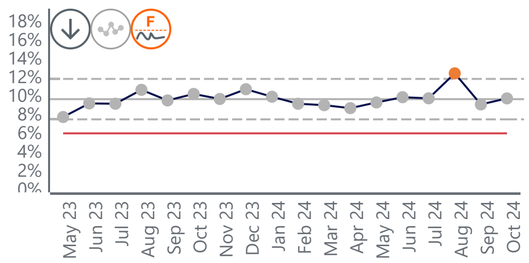
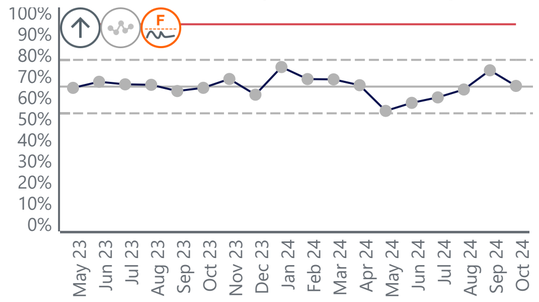


% Was Not Brought Rate (All OP: New and FU)

Target: Internal



% of Clinical Letters completed within 10 Days



% Recovery for OP New & OPPROC Activity Volume

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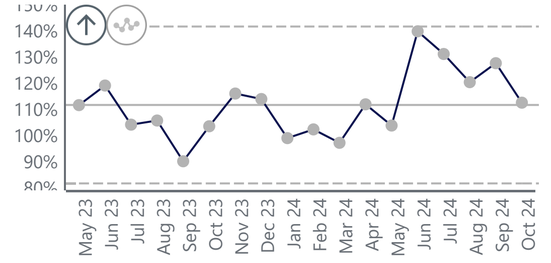

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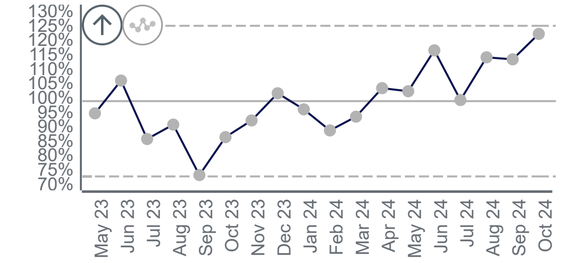
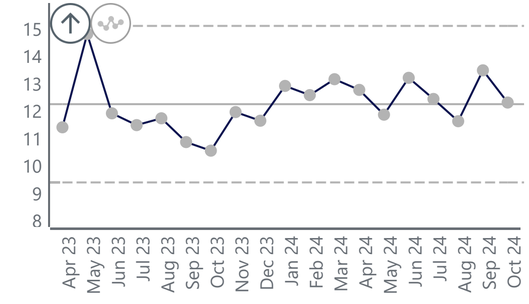
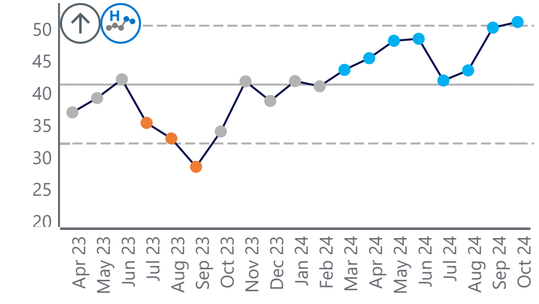


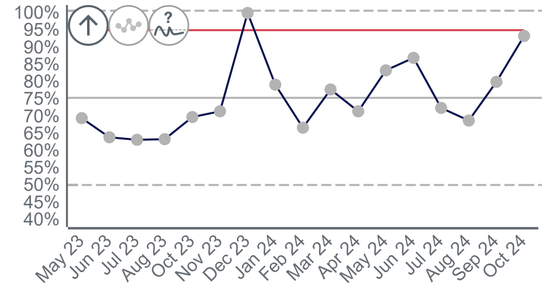
Inpatient Discharges per working day



Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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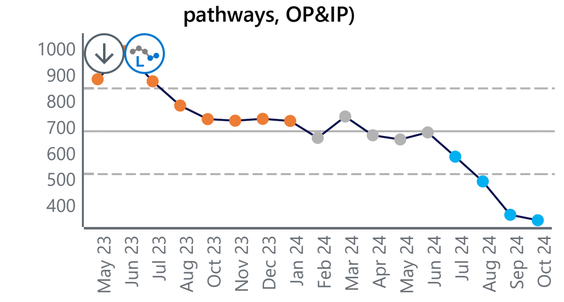

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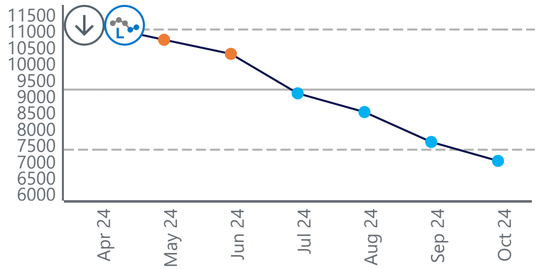
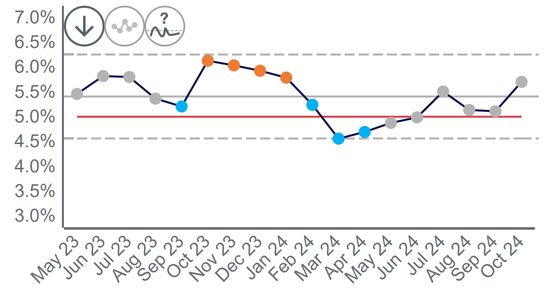
Divisional Performance Summary - Surgery

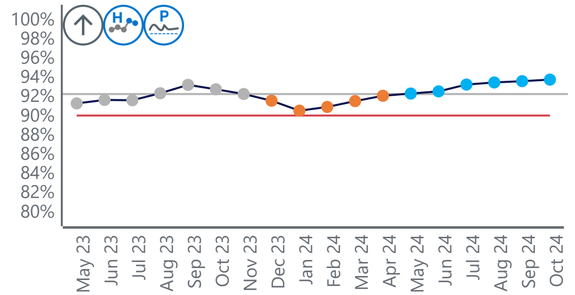
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



Sickness Absence (Total)

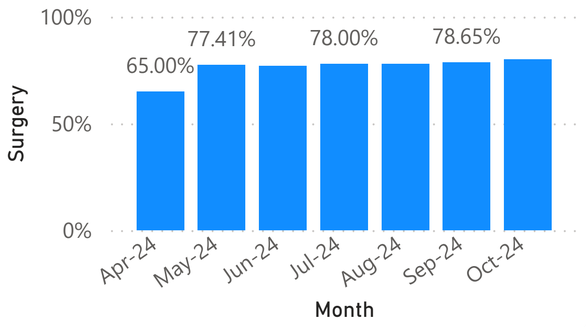


Mandatory Training

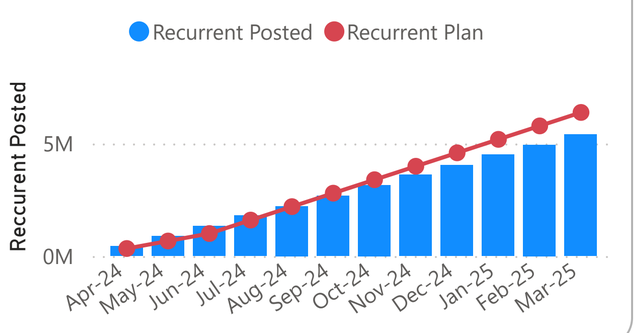


Staff Turnover

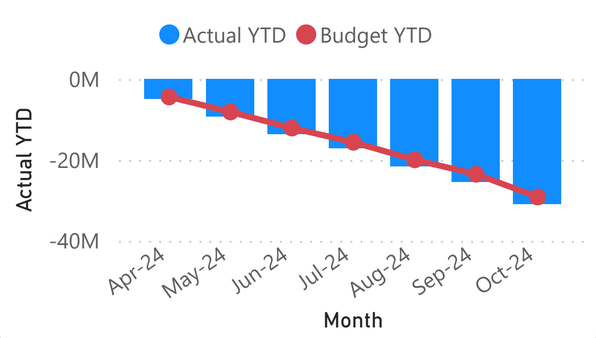
Workforce Stability



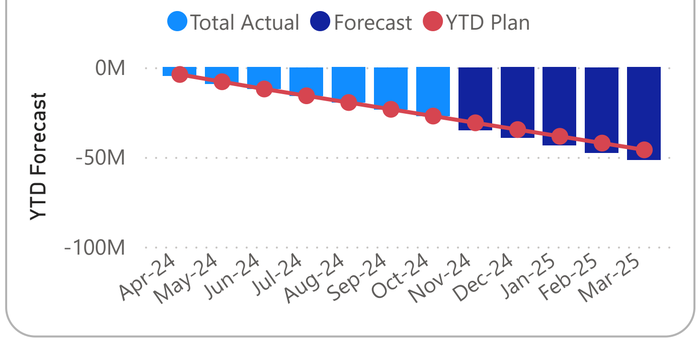
Recurrent Efficiency Plans Delivered (Forecast)



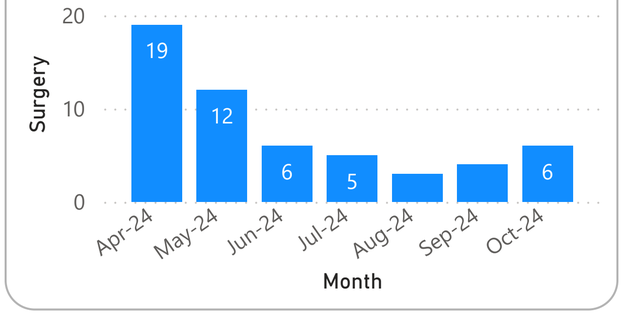
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



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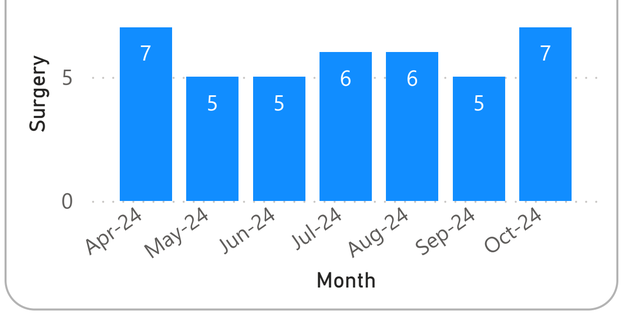

Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- The Mobile Research Unit is now on site and ready to use for outreach activities – call for ideas currently live
- Commercial research income remains ahead of target with more studies in the pipeline
- First UK participant recruited to GPIX-Surmount study (Dr Senthil Senniappan)
- Mandatory training remains on track
- Sickness absence has reduced and is now on target
- Innovation have joined regular research roundtable meetings with clinical specialties to increase Futures MDT working

Areas of Concern

- Some band 7+ PDR recording issues need to be corrected to reflect 100% completion
- ED research staffing model at risk due to decrease in study activity and associated income (bridging funding identified for Jan-Mar 25)

Forward Look (with actions)

- Partnership meeting with UCLan planned for 11th November to strengthen research links
- Liverpool Life-course Bioresource Development Stakeholder Meeting scheduled for 21st November

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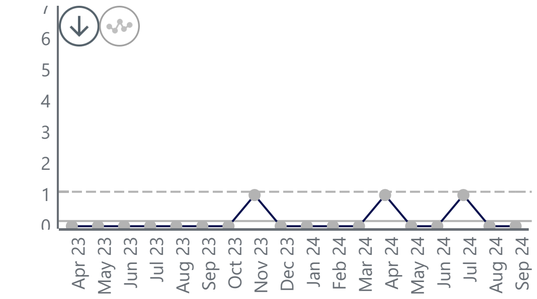
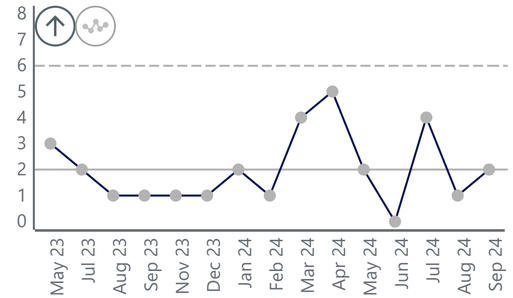
Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

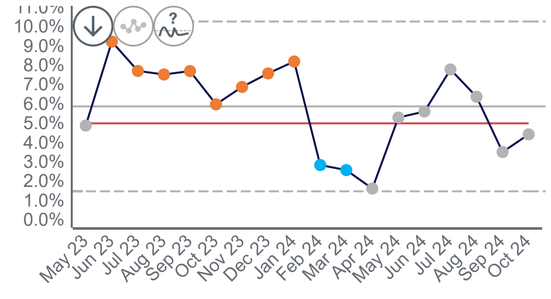


Patient Safety Incidents rated No Harm



Staff Turnover

Sickness Absence (Total)



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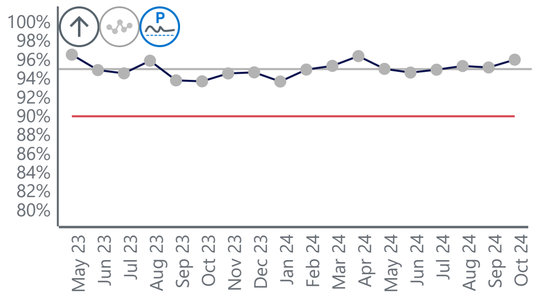
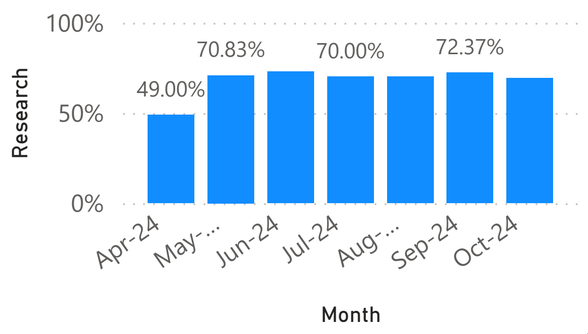


Workforce Stability



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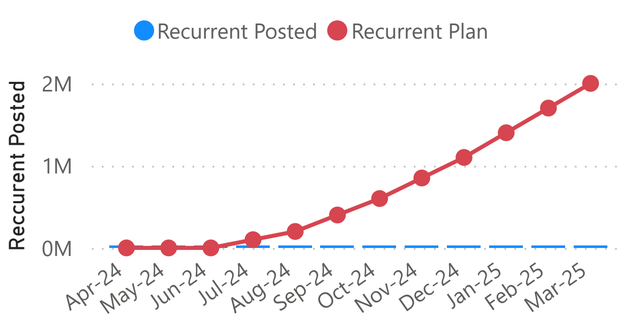
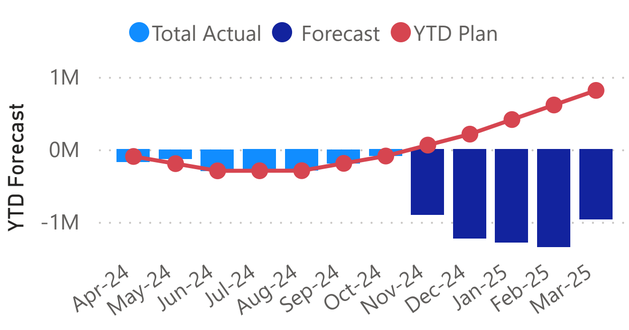
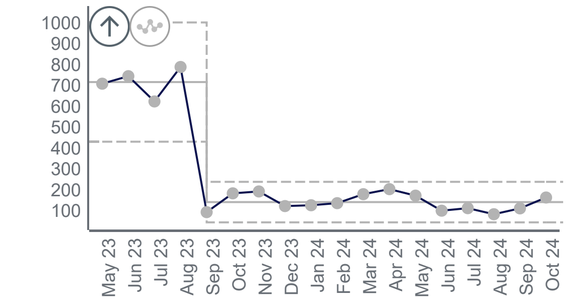


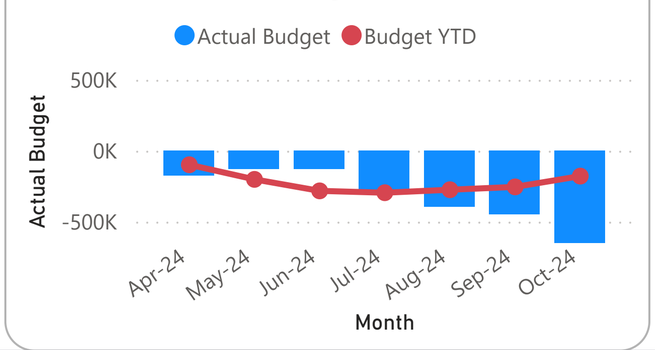
I&E Year End Forecast



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

The Corporate Services Collaborative did not formally meet in November – this was due to a new meeting cycle being agreed which will commence from December 2024.

Highlights from the October corporate data include:

- Mandatory training remains stable at 93%.
- Short term sickness absence remains within Trust target at 2%.
- Proportion of BAME staff in workforce is currently sitting at 7%.
- Long term sickness has remained at 5% from the previous month.
- Staff survey completion rates for corporate services is 65%.
- 94% of CIP already identified and/or delivered at M07.

Areas of Concern

- Return to work completion has increased slightly from previous month to 76% (from 71%) but remains a key focus. Reports are being sent to divisional managers to escalate for non-compliance.
- PDRs for B7+ is currently sitting at 72%.
- PDRs for all staff is currently sitting at 85%.
- Overall sickness has increased to 7.3% from 6.6% in previous month.
- I ncome behind plan at M07 but forecast expected will be an overachieved position.
- Risk management compliance saw a worsened position with 6/52 risks overdue review.

Forward Look (with actions)

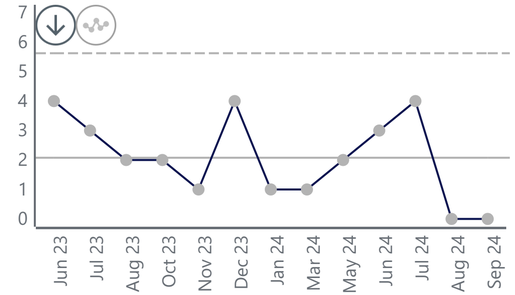
- PDRs – HR Advisors are picking up conversations with Managers to ensure completion as priority. Bi-monthly 'deep dive' reports continue to be received at Corporate Services Collaborative to enable a focus on hotspot areas.
- Continued focus on financial position, system finance and opportunities.
- Risk owners asked to ensure all overdue risks are reviewed as a priority.

Integrated Performance Report | November 2024

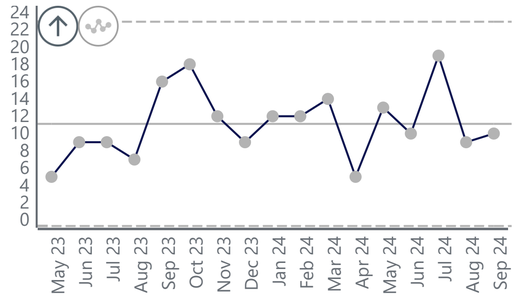
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

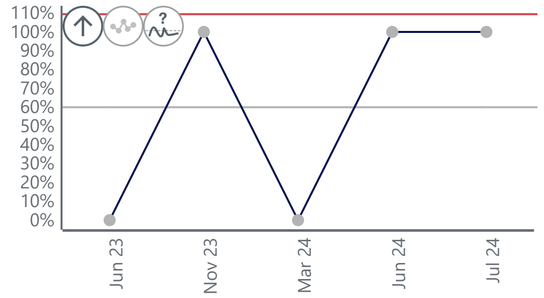
Patient Safety Incidents rated Low Harm & Above



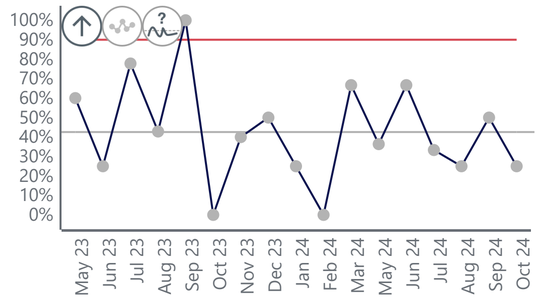
Patient Safety Incidents rated No Harm



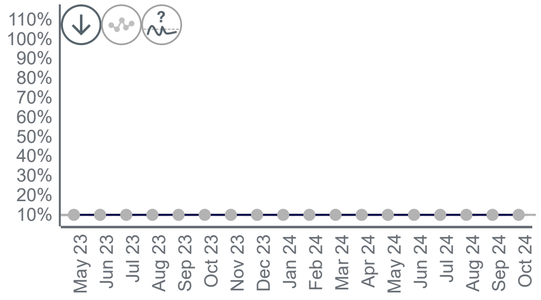
% Complaints Responded to within 25 working days



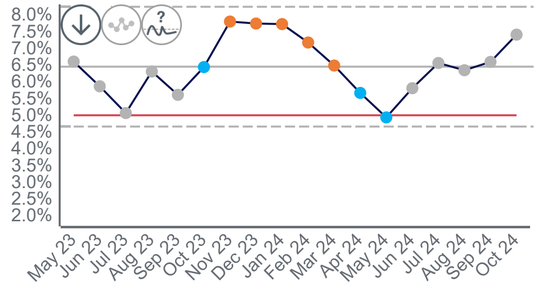
% PALS Resolved within 5 Days



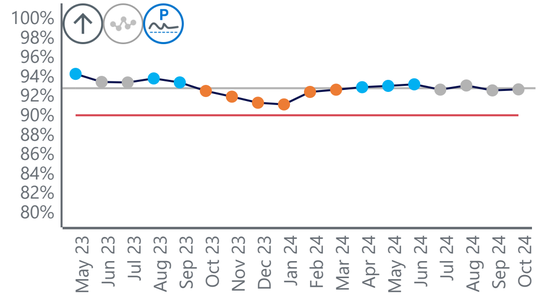
Staff Turnover



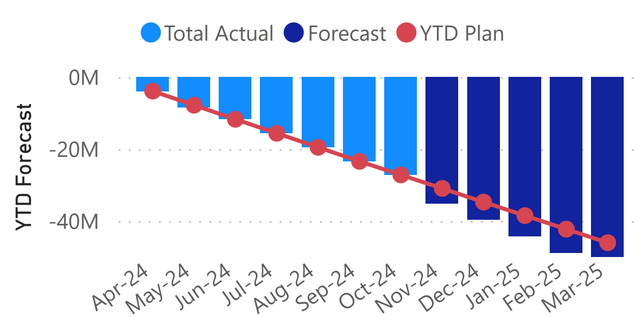
Sickness Absence (Total)



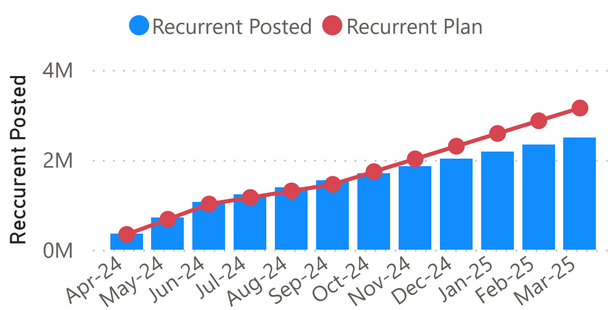
Mandatory Training



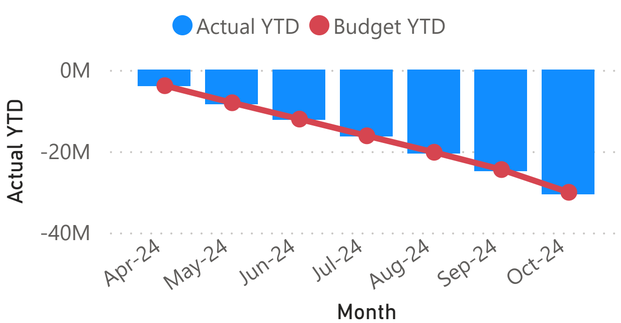
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

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

	Day		Night		Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate		RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of response	% Very good and good		
Burns Unit	101%	-	100%	-	90	21.9	21.61	-1.30	-8.00%	0.00	0%	0.00	0.00%	0.00	0.00%	6.15	1.13%	0.00	0.00%	2	45	0	1	2	100%	1	
HDU	79%	40%	81%	77%	186	43.6	37.53	-2.51	-3.00%	3.33	62%	0.00	0.00%	0.00	0.00%	94.59	4.00%	0.00	0.00%	9	167	0	3	1	100%		
ICU	86%	47%	86%	27%	547	30.8	36.36	9.14	6.00%	2.17	52%	0.92	0.60%	0.00	0.00%	231.73	5.06%	0.00	0.00%	10	231	0	1	1	100%	1	1
Ward 1cC	92%	87%	93%	86%	594	12.4	14.58	-3.40	-6.00%	0.30	6%	0.00	0.00%	0.00	0.00%	153.92	8.30%	20.40	13.53%	13	131	6	26	9	88.89%		
Ward 1cN	86%	0%	94%	-	221	18.1	18.57	2.61	7.00%	1.43	59%	0.00	0.00%	0.00	0.00%	53.97	5.52%	0.00	0.00%	2	83	0	9	1	100%		
Ward 3A	96%	86%	97%	154%	699	11.5	12.61	-5.09	-10.00%	2.55	16%	0.00	0.00%	0.00	0.00%	78.21	4.81%	22.24	5.52%	5	81	0	18	26	96.15%	1	
Ward 3B	97%	88%	97%	-	371	14.7	15.41	-0.69	-1.50%	1.36	26%	0.00	0.00%	0.00	0.00%	54.08	4.04%	0.00	0.00%	5	138	0	9	5	100%	1	
Ward 3C	95%	91%	86%	123%	730	11.8	12.81	0.74	1.00%	2.26	23%	0.00	0.00%	0.00	0.00%	74.47	4.01%	14.88	6.46%	3	145	0	7	21	95.24%		1
Ward 4A	84%	63%	89%	89%	704	11.5	12.28	-0.63	-0.90%	0.80	14%	4.76	6.74%	0.00	0.00%	199.53	9.35%	0.00	0.00%	9	100	0	5	20	100%	1	
Ward 4B	67%	81%	59%	95%	610	12.8	15.32	-3.81	-11.00%	13.78	28%	0.00	0.00%	0.00	0.00%	58.20	5.18%	99.73	9.18%	7	138	1	7	11	100%	1	
Ward 4C	90%	88%	87%	103%	506	14.7	14.32	6.26	11.00%	-0.52	-4%	1.00	1.94%	0.00	0.00%	119.39	7.74%	9.00	2.51%	9	283	1	9	26	94.44%	1	

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. Fill rates are produced by setting out the planned number of hours required for Registered Nurses across days and nights and the same for Health Care Assistants (HCA) for a full month period and is captured daily. The electronic roster produces the percentage fill for the month and accurately reflects the hours worked against the planned number. The percentage fill rates include any hours worked by bank staff. The benchmark for CHPPD for the above tables is based on August 2024 data, this is the the latest information from the model hospital so may not be comparable in relation to capacity and acuity of the wards and departments within Alder Hey in September. Those areas highlighted red fall below this reported benchmark.

Summary

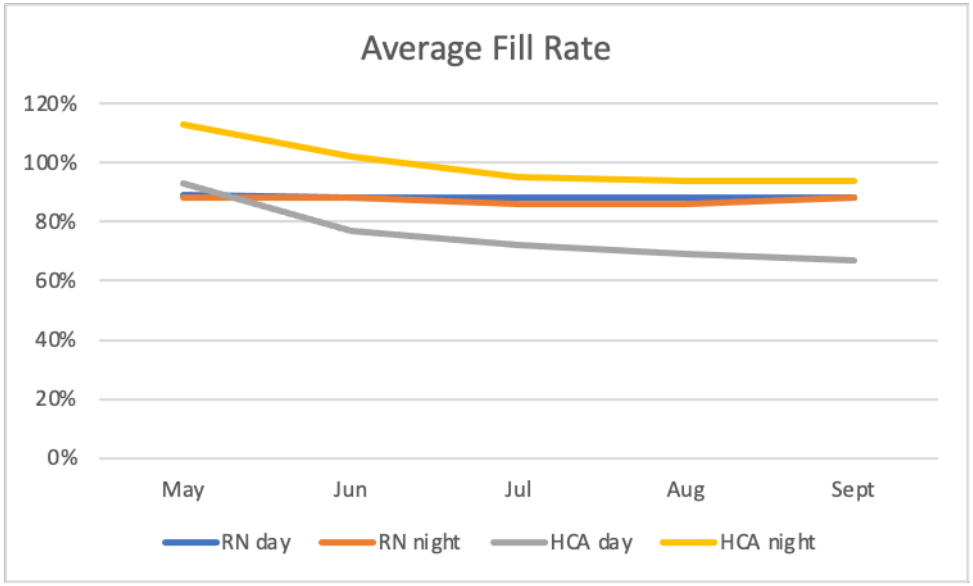
Medicine

1 ward (4B) within the Division of Medicine falls below the 80% standard for fill rate for registered nurses. Additional beds opened and model changes contribute to this.

Surgery

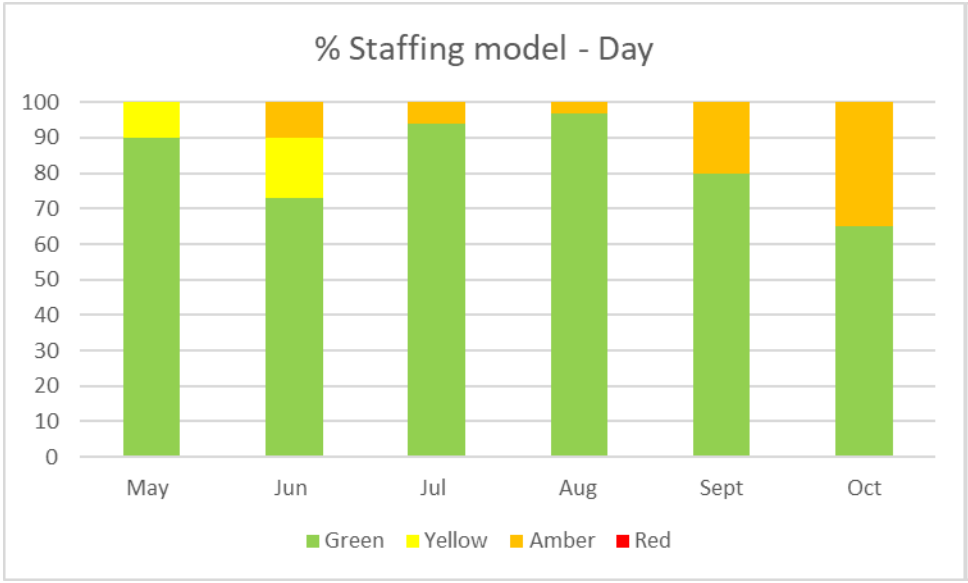
Only HDU fell below 80% fill rate for registered nurses during September.

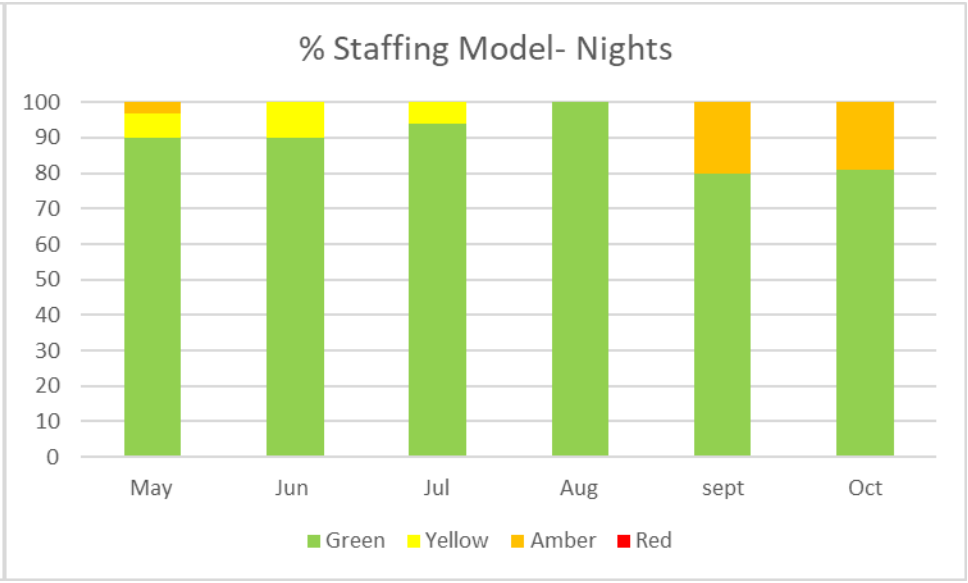
An overall improved position in relation to fill rates across day and nights has been noted sine May 2024. The HCA fill rate for night duty for two of the areas is higher than the planned establishment at 154% and 123%. Predominantly this is due to the continuous need for additional HCA resources a result of those patients who require 1-1 and enhanced supervision as well as those with challenging behaviour or safeguarding need., There are vacancies within HCAs across the trust which impacts on the fill rate reported in some areas.



Summary of Staffing models May – October 2024

There has been an increase in an amber staffing model being reported during day shifts in October which correlates to higher acuity and increased capacity across the wards. Night shift reporting is consistent with the previous month. To note we continue to see no red staffing days in the month of October and for the reporting period May -October 2024.





NHSP Bank Spend January – October 2024

Temporary staffing is monitored closely with weekly oversight from Workforce Efficiencies group attended and represented by senior staff from various disciplines including nursing. This group produced trust and divisional dashboards to support the monitoring of bank and agency use across all areas and has oversight from executives. Weekly monitoring of bank and agency occurs in each division as well as daily oversight from Safe Staffing Chair and Senior Clinical Site Practitioner out of hours. There has been a consistent reduction in the use of bank hours over this period and future reports will include data which allow this to be tracked.

Electronic Roster KPI Report

October 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.

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Org.Units/Metrics	Roster Approval (Full) Less Time Days (16th September - 13th October	% 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 (312201)	47	43.40%	80.00	513.72	0.00%	0	0	**31.84%**	**2.64%**	**8.02%**	0.71%	**14.99%**	0.00%	26.37%
Accident & Emergency - Nursing (312201)	43	35.30%	720.00	374.86	16.04%	1717.42	1	11.86%	**11.40%**	3.11%	1.66%	**9.73%**	8.54%	35.84%
Burns Unit (315208)	44	20.35%	140.00	151.25	1.69%	42	1	2.94%	13.50%	3.46%	0.40%	**3.50%**	0.00%	23.78%
Critical Care Ward (313208)	44	22.21%	1200.00	665.24	5.37%	386.23	3	**15.73%**	**13.76%**	4.24%	0.38%	**4.91%**	4.05%	27.34%
High Dependancy Unit (HDU) (313210)	44	18.36%	640.00	173.52	0.72%	57.5	0	**26.61%**	11.13%	**5.63%**	1.05%	**5.73%**	8.45%	32.90%
Medical Daycase Unit (311314)	43	35.20%	50.00	-21.22	0.90%	3.5	4	13.61%	**11.15%**	1.71%	1.37%	**5.77%**	0.00%	20.60%
Outpatients (316503)	**41**	44.07%	420.00	652.38	14.30%	374.5	13	**37.94%**	13.36%	0.32%	1.63%	**10.42%**	2.78%	28.12%
Sunflower House (312310)	**25**	41.36%	190.00	1054.85	15.91%	581.75	3	**30.72%**	3.90%	0.48%	1.64%	**3.56%**	6.03%	31.56%
Surgical Daycase Unit (315418)	44	44.34%	85.00	-25.5	7.61%	258.08	0	**20.36%**	11.69%	0.00%	1.83%	**5.07%**	0.00%	18.58%
Theatres - Cardiac & Cardiology (315405)	44	26.16%	130.00	-1	5.16%	110.5	3	8.21%	**11.21%**	0.78%	**5.84%**	**10.33%**	0.00%	28.15%
Theatres - Emergency (315420)	44	23.05%	230.00	58	10.11%	211	0	2.57%	**15.43%**	2.50%	0.19%	**7.09%**	0.00%	25.27%
Theatres - IP Anaesthetics (315423)	44	19.81%	82.00	112.58	2.57%	82.75	0	1.14%	13.15%	0.23%	3.86%	**6.45%**	4.51%	28.20%
Theatres - IP Porters (315435)	**44**	32.93%	101.00	30.86	2.12%	30.5	3	7.55%	11.58%	0.00%	0.00%	**0.00%**	0.00%	17.83%
Theatres - IP Recovery (315422)	44	23.44%	103.00	-27.2	9.43%	152.75	0	2.82%	6.97%	**0.06%**	**6.91%**	**6.43%**	0.00%	20.37%
Theatres - IP Scrub (315424)	44	19.91%	128.00	-2	16.10%	270.75	1	15.75%	8.36%	0.36%	3.81%	**17.13%**	0.00%	41.34%
Theatres - Ortho & Neuro Scrub (315436)	44	38.31%	37.80	-2.5	14.38%	324	1	7.37%	**8.13%**	0.00%	2.63%	**14.05%**	4.00%	34.84%
Theatres - SDC Anaesthetics (315429)	44	51.07%	58.40	-11.05	22.94%	372.25	1	5.13%	**8.17%**	1.17%	0.00%	**14.52%**	16.25%	45.16%
Theatres - SDC Recovery (315430)	44	21.60%	117.30	-1.62	5.06%	83	4	4.23%	11.03%	0.84%	0.78%	**3.92%**	0.00%	16.88%
Theatres - SDC Scrub (315421)	44	42.35%	532.00	-30.03	8.98%	249.5	5	6.66%	10.87%	0.00%	2.86%	**13.25%**	0.00%	35.01%
Ward 1C Cardiac (313307)	44	27.50%	361.00	602.46	3.11%	681.25	0	**6.59%**	11.69%	3.16%	1.03%	**3.17%**	5.07%	30.27%
Ward 1C Neonatal (313310)	**41**	35.65%	556.00	432.88	1.33%	100.5	0	**12.83%**	12.57%	**5.40%**	0.33%	**4.49%**	3.50%	36.42%
Ward 3A (315309)	41	28.70%	371.00	68.53	11.21%	876	28	8.35%	13.17%	2.86%	1.31%	**7.14%**	7.41%	32.81%
Ward 3B - Oncology (311208)	**41**	21.33%	555.00	463.03	7.08%	360.5	40	18.25%	13.30%	3.13%	2.14%	**6.50%**	4.35%	35.31%
Ward 3C (311313)	40	30.32%	607.00	1464.02	14.50%	1274.5	56	**17.45%**	**7.85%**	**5.22%**	1.30%	**5.38%**	6.33%	28.02%
Ward 4A (314210)	34	28.20%	634.00	314.31	10.41%	832.25	26	**17.17%**	**9.76%**	**4.05%**	1.01%	**11.65%**	5.45%	34.33%
Ward 4B (314211)	**41**	30.00%	533.00	626.29	12.30%	1123.83	23	**20.02%**	12.45%	**2.97%**	1.37%	**6.71%**	7.75%	31.44%
Ward 4C (312207)	**45**	30.24%	280.00	136.78	7.43%	561.5	15	8.13%	**11.36%**	1.79%	1.35%	**5.13%**	2.33%	28.38%

Trust Summary

- Lead time (Roster sign-off) remains within the KPI target of minimum 42 days. Currently 42.5 days.
- Net hours have reduced from 9703 to 7376 with 19 out of the 27 units within KPI.
- Bank / Agency has reduced again from 11462 hours to 10640 hours for the month of October. To note we have seen a consistent decrease and is the lowest since January 2024.
- Unfilled roster has continued to consistently improve and for the first time since January has achieved KPI of < 15%.
- Annual leave being allocated to staff although improving remains low in many areas with the average being 10.9%. KPI is 15% but buffers run from 11-17%. Low annual leave may result in some departments facing challenges in accommodating all staff annual leave by the end of the financial year.
- We have seen an increase in sickness at 8.29 % for the month of October. This is outside our agreed KPI of 5 %.

Monthly roster review meetings are now in place across the trust occurring in each division, led by Heads of Nursing and in conjunction with health roster team. Both ward managers and matrons attend these meetings. This meeting has proved to be successful and supports each ward to work within a set of Key Performance Indicators (KPI) which includes the important element of rosters being finalised by managers in a timely manner allowing staff to plan their personal life more easily around work. In addition, these meetings have been beneficial in highlighting where there are increased number of additional shifts as well as the requirement and utilisation of NHSP and Agency shifts. The meeting encourages the ward managers to track the range of KPI focusing on improvements within their own area. Reports are circulated monthly to the ACN and HON to share with their respective teams and take forward any agreed actions.

BOARD OF DIRECTORS

Thursday, 5th December 2024

Paper Title:	**ED Waiting Room**
Report of:	**Adam Bateman, Chief Operating Officer**
Paper Prepared by:	Nikita Pickard, Senior Divisional Manager, Division of Medicine

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper outlines the upcoming reconfiguration of the ground floor space due to the ongoing construction work for the new NICU SDEC build requiring closure of the current ED waiting area.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Implications:	Capital Expenditure Contingency of £10,000 identified for changes required Revenue Expenditure Expected increase of £283,101 in staffing costs for the duration of the changes based upon the current proposed dates.

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
Legacy Risk 003	Children and young people waiting beyond the national standard for planned and urgent care	20

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

As part of the wider NICU SDEC new build, the current ED waiting area is required to be handed over to Morgan Sindall Construction (MSC) to enable key works activities to proceed on programme. This paper outlines the changes and associated risks with the commencement of this change which will take place on 7th January 2025 and continue until MSC are able to hand the building back for occupation which is expected to be early December 2025.

2. Background and Current State

As part of the wider NICU SDEC new build, the current ED waiting area will be handed over to Morgan Sindall Construction (MSC) to enable key works activities to proceed on programme.

Over recent months a detailed options appraisal has been complete, containing 7 initial options, all of which were reviewed against current constraints, risks, and opportunities.

Previous communications indicated the operational impact may be as late as March 2025 however, the current contractual position states MSC will require the area from early January 2025.

At a site meeting held August 21, 2024, it was informally agreed that several of the options were no longer viable, and a revised proposal was put forward named Option A as indicated below, for the purpose of this report Option A is the only consideration.

3. Proposed Changes

The identified changes are:

- Current ED waiting to be closed.
- Current Radiology waiting area to move to the performance space within the atrium.
- ED Waiting area to be created wihtin the existing Radiology waiting area space and adjacent corridor space.
- ED reception to move to share a joint reception desk with Radiology witin the atrium
- ED Nurse streaming to be co-located with the new reception area.

This is a change in available waiting room capacity for ED:

	Current	**Proposed**
ED Waiting Space	83	55
Radiology Waiting Space	26	26 (potential to be more)

A full drawing outline of this proposal can be found in appendix 1.

4. Implications

There are several implications of this proposal which have been outlined below. A full risk matrix outlining the challenges is also provided in appendix 2.

Who is affected by the proposal?

At time of writing, the below list are considered as key stakeholders:

- ED Service
- Radiology Service
- Site Security
- Children, young people and families
- Infection Prevention and Control
- Charity
- All users of th Atrium

The above list of stakeholders have been consulted with exception of CYP and families, and will need further engagement to finalise logistics once dates have been confirmed.

Operational Impact
There will be a significant reduction in capacity for ED which may affect the ability to deliver our urgent and emergency care access standards. This will be closely monitored for the duration of the changes.

Clinical Impact
Clinically there are a number of risks that have been identified within this option that require mitigation. These are fully outlined in the risk assessment in appendix 2 and are being worked through as part of a mobilisation group for the changes. Key pathways for consideration are:

- Patients requiring decontamination
- Patients suspected of High Consequence Infectious Disease (HCID)
- Acutely unwell/deteriorating patients
- Immunocompromised patients
- Overarching infection prevention and control principles

Additional staffing requirements have been identified to support mitigation of these risks.

Security Impact
Due to the relocation of the waiting area and reception desk, it will requiring the atrium being open to the general public 24/7 which is a change to current practice. This has been considered and additional resources identified to mitigate any security implications of this.

Financial Impact

Capital

The capital impact at this time has been identified as ‘potential risk. After a programme review, the opportunity to target float has been identified which may result in a nil cost to the capital works contract. However, this will require a formal instruction to revise the programme date and will remain a risk until project completion. If a delay is realised, this could incur prolongation and additional prelim costs of approx. £56,000.

It is also assumed that a small works contingency of £10,000 may be required for reconfiguring access control and CCTV on site.

Revenue

After consultation with key stakeholders, it is anticipated that additional staffing costs will be required to mitigate risks identified in the risk matrix below. The additional revenue cost has been highlighted below:

ED staff	£4,726.43 per week
Security staff	£1,297 per week
Total	£6,023.43 per week

With the 7th January confirmed, this presents an additional revenue cost of £54,207 over and above the previously reported date of mid-March, and a total pressure of £283,101 for the full duration of the project, assuming a Go Live in early Dec 2025 (47 weeks).

5. Conclusion

The relocation of the ED waiting area is a fundamental requirement to continue the current construction work for the new NICU/SDEC build. Several options were explored with only one identified as suitable in line with the available estate, health and safety restrictions and fire regulations. There are operational, clinical, security and financial implications of the proposed changes. These have been outlined and mitigated where possible. Work is ongoing with a weekly mobilisation meeting to ensure a successful transition on 7th January 2025 and further mitigation of the identified risks.

6. Recommendations & proposed next steps

The Board is recommended to note the upcoming changes impacting the organisation.

Appendix A: Proposed Changes

Following discussions on site on 21.08.2024, the previous Trust Options 1-7 were discussed and the new Option A favoured as follows:

1. Existing ED Waiting Area Closed (Within Contractor's Site Demise)
2. Entrance to ED via North Entrance & Atrium
3. Radiology Waiting Area relocated to Atrium
4. Existing Reception used for both Radiology & ED
5. ED Waiting Area 1 (former Radiology Wait)
6. ED Waiting Area 2 (existing Seating)
7. Triage Rooms in Former Cubicles
8. Existing Reception used for Low Acuity Area
9. ED Waiting Area 3 (Low Acuity Wait)
10. Treatment Rooms in former Consult/Exam Rooms for Low Acuity Patients

Approximate waiting area numbers provided (exact numbers will be dependent on exact seating size and layout):

Radiology	41No Spaces
ED Department	55No Spaces Area 5: 37No (24No existing + 13No new) Area 6: 8No (existing) Area 9: 10No (new)

Appendix B: Risk Assessment Matrix

Risk	Ref.	Inherent risk	Controls	Likelihood	Consequence	Score (LxC)	Mitigation actions/controls to be established	Likelihood	Consequence	Score (LxC)
Financial	**1**	Increase in capital costs due to programme prolongation.	Programme review held and negotiated position to target programme float.	**4**	**3**	**12**	Based on 7th Jan, this puts the Trust 'at risk' of £28k per week for 2 weeks (£56k total).	**4**	**3**	**12**
	2	Increase in ED staff levels	Staffing review undertaken	**5**	**3**	**15**	Based on 7th Jan, this adds £4,726 per week until project completion.	**5**	**3**	**15**
	3	Increase in Security presence required	Staffing review undertaken	**5**	**3**	**15**	Based on 7th Jan, this adds £1,297 per week until project completion.	**5**	**3**	**15**
	4	Increase in Radiology staff levels	Staffing review undertaken	**5**	**3**	**15**	No additional cost identified during review. Use of Volunteers for Waiting room.	**2**	**3**	**5**
Patient or Staff safety	**5**	Remote waiting area and clinical oversight of deteriorating patients	Clinical review of area undertaken to understand mitigation	**5**	**5**	**25**	Additional staffing identified as per the above	**2**	**5**	**10**
	6	Patients have open access to the atrium 24/7 and potential other areas of the Trust out of hours. Radiology areas need to be always closed and Swipe access for staff and Patient safety.	Review with security of options to manage	**5**	**3**	**15**	Additional security needs identified.	**5**	**2**	**10**

Risk	Ref.	Inherent risk	Controls	Likelihood	Consequence	Score (LxC)	Mitigation actions/controls to be established	Likelihood	Consequence	Score (LxC)
	7	Patients with infectious diseases have open access to the atrium 24/7	Clinical review with Radiology and ED team as to pathways and mitigation options.	**5**	**3**	**15**	Will review options to use sub-waits within ED to limit exposure but limited capacity	**3**	**3**	**9**
Clinical Effectiveness	**8**	Insufficient capacity to meet peek demands within the waiting room.	Exploring digital options to support patients being managed in different ways	**5**	**4**	**20**	No solution identified as yet	**5**	**4**	**20**
	9	Inefficient flow and process impacting upon the ability to work efficiently and deliver 4-hour standard	Additional ED walk through scheduled wc 4th November to identify options	**5**	**4**	**20**	No additional mitigations identified so far	**5**	**4**	**20**
Care	**10**	Poor Patient Experience for ED and Radiology	Patient representatives to be engaged and volunteers to look as to how to improve this during period of the move	**4**	**4**	**16**	No additional mitigations identified so far	**4**	**4**	**16**
Responsiveness	**11**	Ability to respond to an acute deterioration due to remote location	Options to be explored to manage this	**4**	**5**	**15**	Defib trolley to be located easily accessibly – location to be confirmed. Process outstanding to be confirmed to reduce likelihood further	**3**	**5**	**15**

0065 VISION 2030

NHS Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th December 2024

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

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

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
BAF Risk 3.1	Failure to Fully Realise the Trust's Vision for the Park					2x4
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

December 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 Phase 1 Concluded

2024/25 Q3 & Q4:

- Social Prescribing Base Camp
- Springfield Park Phase 2
- Fracture/Dermatology Outpatients
- Elective Surgical Hub
- Alder Park Phase 1

2025/2026 Q3:

- Neo-Natal & UCC/EDU/PAU/SDEC
- Springfield Park Phase 3

Projects listed for completion by Q4 2024/25 are planned to complete within this timeframe. The two remaining projects, Neo-Natal/UCC and phase 3 Springfield Park are on target for completion and handover by December '25, as scheduled. Refer to Section 4 of this report.

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+)
Springfield Park	KOT	5	1	4	
Site Tidy/ Master Planning	KOT	9	3	6	
Fracture/ Dermatology OPD	KOT	8	3	5	
Neonatal & PAU/EDU/UCC/SDEC	JG	17	3	14	
Alder Park: Phase 1	KOT	8	3	5	
Elective Surgical Hub	JVH	6	1	5	

Regular meetings remain in place with Mitie and the SPV to check, challenge and manage any implications associated with projects in the main hospital building. Additional Mitie PM resources are in place, and early indications are positive. Progress is noted within Section 4 of this report.

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Springfield Park	Failure to deliver long term vision for park	BAF 3.1	8	Phase 1 complete. New planning application submitted. Phase 2 on target for completion Dec '24. Phase 3 detailed plan being developed.
Neonatal & SDEC	Affordability	Not assigned	12	Development team managing mitigation plan for SPV/other costs. Draft services Deed of Variation received and being worked through with Bevan Brittan.
SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Informal discussions have resumed between the contractor and the Trust to establish the contractor's position.

3. Construction Programme Delivery Timetable

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	
Springfield Park	Phase 1: Main Park																									
	Phase 2: Swale																									
	Phase 3: Park Handover																									
Neo-Natal & SDEC	Main Construction Period																									
SFH/Catkin	Sprinkler System Solution																									
Site Completion/ Master Planning	Phase 1 Enabling (scope TBD)																									
	Phase 2+ Site Plan (scope TBD)																									
Base Camp	Install																									
Alder Park: Lyndhurst Building & Site Plan	Phase 1 Refurbishment (EDYS, Therapies & SALT)																									
	Phase 2 Construction TBC (Sefton CAMHS)																									
Elective Surgical Hub	Refurbishment																									
Fracture/ Dermatology OPD	Refurbishment																									

4. Project Updates

Neonatal and SDEC

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Programme – Completion 20.10.25: • RIBA Stage 5 Design Review/Sign Off by technical & clinical teams. • Completion of service disconnections (EDU/PAU & ED) by Mitie.		Completion of main construction works. Increased construction & SPV costs. Delay to unit opening.	Formal monthly Construction Progress meeting. RIBA Stage 5 sign off.
Costs and Operational Coordination: • Draft services Deed of Variation (lifecycle & maintenance) being worked through with Bevan Brittan. • ED Waiting decant plan approved at 21.11.24 Ops Board. • Ground Floor shell space design being progressed.		Potential budget & programme impact of GF reconfiguration changes.	Agree shell space design 29.11.24. Agree Services DOV – target Aug '25. Equipment & Furniture requirements confirmed and costed – target 30.11.24. Draft Move & Commissioning plan.

Catkin & Sunflower House Building

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Finalising Contract Position: • Informal discussions have resumed between the contractor and the Trust to establish the contractor's position. The details of this are subject to legal privilege.		Possible contract claim.	Continued oversight via Finance Transformation & Performance Committee.
Sprinkler System Under-Croft Car Park: • Challenge with budget from quotes received from tender process. • Potential options discussed at 26.09.24 and reported at 28.10.24 Finance, Transformation & Performance Committee.		Fire compliance. Budget.	Proposals to be finalised.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Work ongoing in line with programme: • Construction Completion: Phase 1 completed, rooms handed over 22.11.24. Phase 2 completion Jan '25.		Delay to completion, impact on operational running of the services.	Regular meetings remain in place to track construction completion and occupation dates.

Modular/Office Buildings

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Space Utilisation & Working Environment: • ***Demolition of Histopathology Building*** (to complete Springfield Park Phase 3): Staff re-location has commenced; proposals developed for alternative accommodation for remaining services. • ***Improved Environment Institute in the Park***: carpet replacement to be progressed, general tidy, consideration re: purchase of meeting pods and improved space allocation. • ***Desk & Meeting Room Allocation***: space management policy under consideration.		Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for works/kit.	Full staff engagement exercise to agree final desk allocation, move dates and operational logistics. Budget and scope of works to be finalised. Proposal prepared for discussion with Executive Directors.

Springfield Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Completion Works: • Phase 1 Main Park: completed. • Phase 2 Swale: Soiled, seeded, trees planted and stonework completed. Full path loop, signage and benches installed. Heras fencing remains around the football pitches. LCC pre-handover site walkabout 02.12.24. • Retrospective planning application submitted to LCC on 15.10.24. • Phase 3 Full Site Handover (Dec '25): programme of works and supporting costs being developed.		Completion and funding of all remaining works.	Planning approval end Jan '25, tbc.

Site Completion / Master Site Planning

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Site Completion/Tidy: • Priority works to be finalised. Master Site Planning: • Informal key stakeholder engagement underway.		Budget TBC.	Clinical model / estates strategy to be developed.

Elective Surgical Hub

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Priority Major Schemes: • Indicative construction programme received from Mitie. Mitigations being explored to conclude Endoscopy Room construction by end Mar '25. • Updated budget cost report issued and being assessed, in particular costs not yet advised / tbc inc mechanical & electrical, a high-cost risk.		Programme, available budget.	Equipment & Furniture requirements confirmed and costed.

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

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Main Construction: • LOI extended ahead of contract signing early Dec '24. • Challenges to identify affordable fire stopping and ventilation design solutions (as directed by the Trust's Authorised Engineers), and to accommodate Water Safety Group recommendations (NHS Estates Technical Bulletin 3) has impacted programme completion. Mitigations have been identified with a view to construction completing end Mar '25.		Programme, available budget.	Contract signing. Equipment & Furniture requirements confirmed and costed.

5. Conclusion

Trust Board is requested to receive and acknowledge the update provided as of 5 December 2024.

BOARD OF DIRECTORS

Thursday, 5th December 2024

Paper Title:	**Digital, Data and Information Technology Update**
Report of:	**Kate Warriner – Chief Transformation and Digital Officer**
Paper Prepared by:	**Kate Warriner – Chief Transformation and Digital 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	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

1. Executive Summary

The purpose of this report is to provide the Board of Directors with an update on progress relating to Digital and Data and its contribution to Vision 2030. It reports on the overall service, key areas of transformation and operational performance.

Key headlines include:

- Liverpool Place Update
- Good progress with Digital programmes within Vision 2030
- Update on AlderCare Phase 2

The Board of Directors is asked to note progress to date.

2. National and Regional Updates

2.1 Digital Maturity Assessment 2024

All aspects of the Digital Maturity Assessment for 2024 have now been completed. The data is now available to view through the NHSE platform. A workshop has taken place with Cheshire and Merseyside colleagues to review the results collectively as an ICB and provide feedback to the DMA team ahead of next year's assessment.

2.2 Liverpool digital collaboration

Progress is being made across Liverpool Acute and Specialist Providers (LAASP) with the 5 adult trusts converging to a single Electronic Patient Record (EPR) provider. It has now been agreed Alder Hey and Merseycare will not be an active part of the programme however, there will be a focus on how interoperability can ensure the two organisations can digitally connect with those in the LAASP programme.

Alongside the above, Alder Hey will continue to work strategically with all providers across Liverpool to ensure any future decisions or initiatives are in the best interests of all Trusts across the region. Finally, with Alder Hey about to renew its EPR contract, it will align the term with the Liverpool EPR contract, which will give flexibility should Alder Hey wish to join the programme at a later date.

3. Vision 2030 – Digital Update

3.1 Revolutionising Care

Work has commenced on the optimisation of the Online Symptom Checker, with the inclusion of additional symptoms currently being added. Discussions are ongoing relating to the implementation of a clinician view which is aiming to commence in January 2025.

The Pre-Op Dental service is now live with Islacare, enabling questionnaires to be sent out digitally in advance of dental surgery. Work is ongoing to integrate the platform with Meditech. The Islacare Waiting List Management pilot has been completed which resulted in a reduction in waiting lists.

3.1.1 AlderCare Update

The number of P1s has reduced significantly and 2 of the remaining P1s have a delivery date of the solution by November 2024. If testing is successful solutions will be fully delivered by end of Jan 2025.

As the Optimisation programme has developed, the governance structure has become well embedded. The refresh of the new Quality Rounds has been well received by the clinical and operational teams. Feedback from these rounds identified issues around technical set ups within the Outpatient Rooms, which are now being fed into a new project established to create the optimum Outpatient Clinic Room of the future.

3.2 Outstanding Care, Experience and Safety.

The project implementing a new Infection Prevention control system has begun and a plan for delivery has been developed with a proposed six-month timescale for deployment.

A Project Board has also been established to govern and manage the Integrated Observation work. Once established, this will replace the DETECT system and enable automatic transfer of observations into Meditech saving nursing time and reducing manual error. It will also help the Trust become further compliant with Martha's rule.

3.3 Pioneering Breakthroughs

Demonstrations with stakeholders and suppliers have taken place for a new Patient Portal. Stakeholder feedback is currently being collated and there are plans to also engage patients in the process. Once completed, all feedback will be reviewed and assessed prior to selecting the supplier and awarding the contract. The plan aims to have the first phase live in Quarter 4 of 24/25.

The replacement Data Warehouse Business Case has been finalised and is aiming to be presented to Capital Management Group on 27th November. If approved, plans will be refined and agreed for the work to commence.

The Trust are currently piloting Lyrebird which is an Ambient AI solution to support efficiencies in clinic. Scoping on current processes is now complete and work is ongoing with the supplier to explore integration options with Medisec. The pilot clinicians have been testing in real clinics with positive feedback so far regarding the benefits of the solution. Next steps include widening the pilot further ahead of making a decision on which use cases to explore next.

4. Digital Centre of Excellence and Performance

Regional PACS work is progressing well and is on track for the transition in early 2025. In preparation there is further by work scheduled on 24th September and 8th October.

A Telephony Business case has been developed to address the risk identified of running a critical communications platform on aged hardware. This business case also included an option to move the current emergency and non-emergency bleep platform to a cloud hosted service, which brings greater resilience and enhanced feature set.

Several technical workshops have been held exploring the future of the shared Meditech server environment. The purpose of these workshops is to explore short term options (12-24months) whilst regional discussions around EPR are concluded. Additionally, these discussions have explored what a 5-year roadmap would look like for the technology used, this will allow for an infrastructure strategy to be developed in line with the Trust strategic objectives.

The trust has rolled out Tanium which is a solution to help with patching compliancy and third-party patching for all user end points and servers in the Trust. This will help with the Trusts national MDE scores and improve Cyber resilience.

4.3 Data and Analytics

A dashboard has recently been released providing oversight into the current workforce controls around Bank and Agency usage, workforce expenditure and headcount. Additionally, priority work ongoing with Neurology transformation, Clinical Coding, MHSDS validation and support of commissioning datasets below.

The data engineering team have completed enhancements to a number of major national datasets recently, including the Commissioner Data Set, Emergency Care Data Set and Acute Faster Data Flows. The team are currently prioritising the Mental Health Services Data Set, Community Faster Data Flows, and the collation of data for the Federated Data Platform (FDP) theatres application.

5. Summary and Recommendation

In summary, progress with digital developments and delivery at Alder Hey remain good and on track against plans. There are several challenges however all have mitigation plans in place.

Board of Directors is asked to note progress to date.

Compliments, Complaints and PALS Report – Q2 2024/25: SQAC 5th December 2024

0076

Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q2 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 Q2 by Division

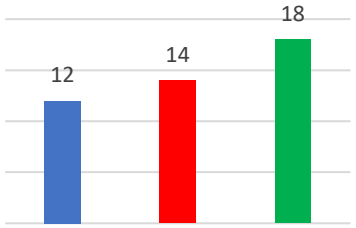


Figure 2: Number of complaints rolling 12 months

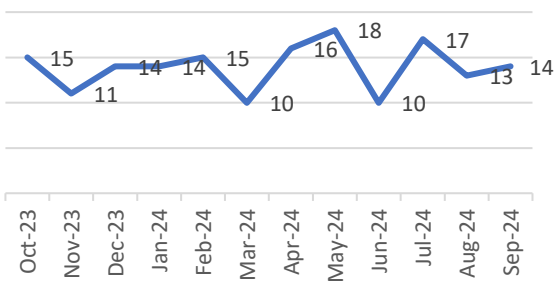


Figure 3: Primary category of complaints

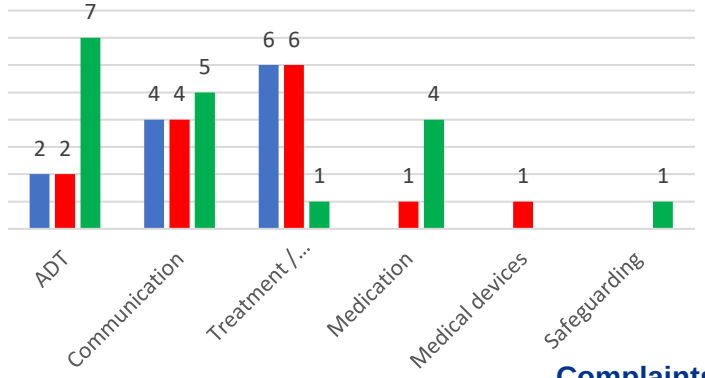


Figure 4: Compliance with 3 day acknowledgement of complaints rolling 12 months

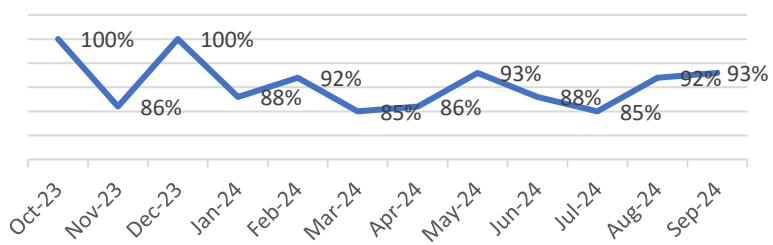


Figure 5: Compliance with 25 day response to complaints rolling 12 months

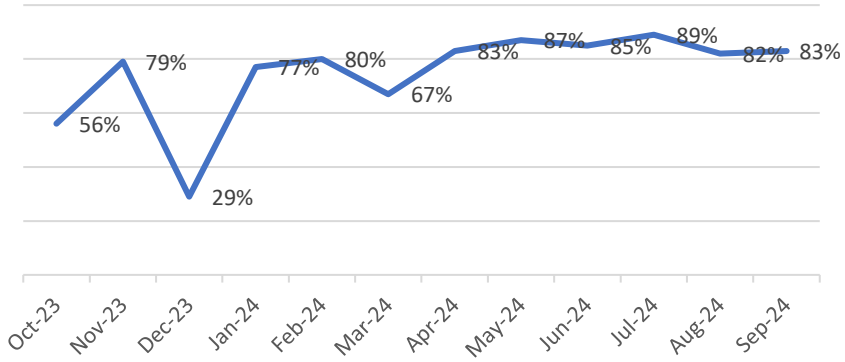
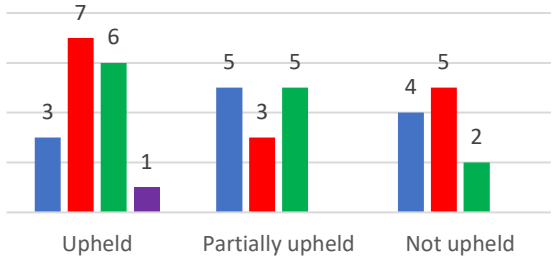


Figure 6: Outcome of complaints responded to in Q2



Complaints: In Q2, 47 complaints received; 3 withdrawn therefore 44 new complaints. Top 3 reasons continued to be treatment and procedure (29%); communication (29%); and ADT (25%). These 3 categories account for 84% of all formal complaints. Trust overall not compliant with the 3 day acknowledgement; average 90% compliance. 41 complaints investigated and responded to. Trust overall not complaint with the 25 working day response in Q2; average 85% compliance. The Divisions of Medicine and Surgery both achieved excellent compliance of 100%; Community and Mental Health achieved 37% compliance. 17 complaints fully upheld (41%), 13 partially upheld (32%), and 11 not upheld (27%). 8 complaints were re-opened at second stage.

Compliments, Complaints and PALS Report – Q1 2024/25

0077

Figure 7: PALS received in Q2 by Division

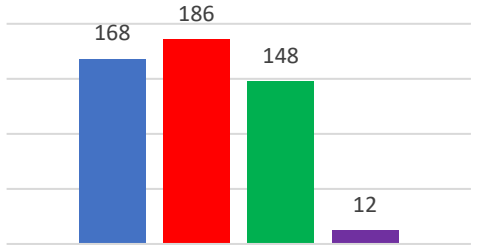
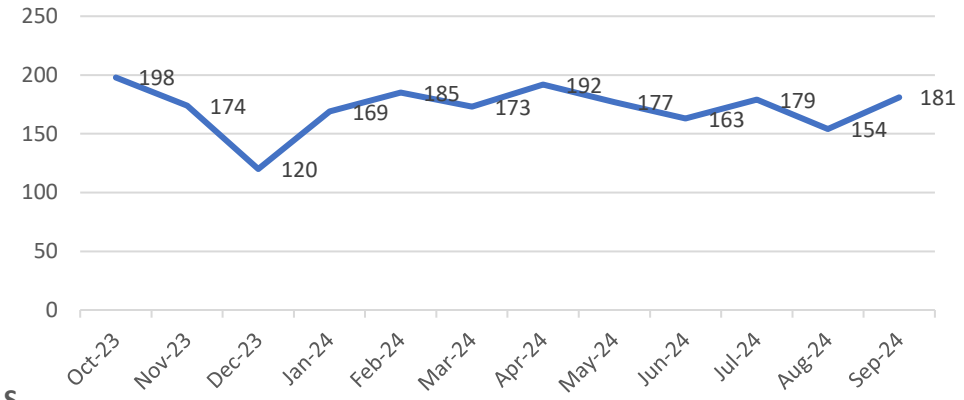


Figure 8: Total number of PALS rolling 12 months



PHSO: There are 2 ongoing PHSO investigations in the Division of Surgery (both commenced in Q1 2024/25). One new investigation confirmed in Q2 in Surgery. One PHSO investigation closed with no further action in the Division of Medicine (from Q3 2023/24). 3 new enquiries and requests for documentation in each Division; update awaited as to whether the cases will progress to PHSO investigation

PALS: In Q2, 514 PALS concerns were received. The main themes continue to be access to appointments and communication which is consistent with themes of formal complaints. Sustained position in compliance with the 5 working day response; average 90% compliance. The Divisions of Medicine and Surgery both achieved excellent compliance: 100% in Medicine and 99% in Surgery. Community and Mental Health achieved a sustained improvement in compliance of 72%. Corporate services only achieved 47% compliance indicating a lack of oversight.

Figure 9: Categories of PALS

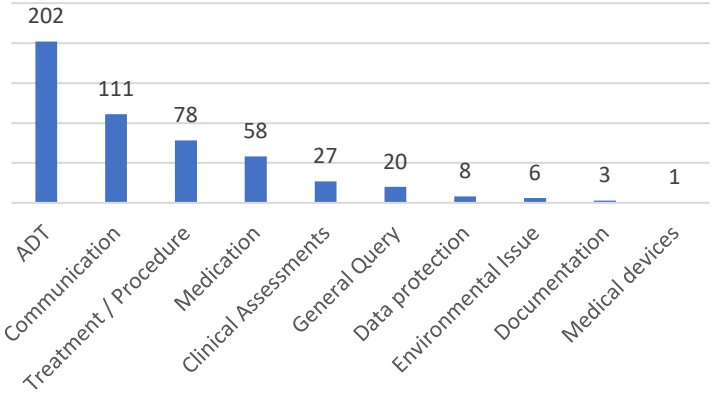


Figure 10: Trust overall compliance with 5 day response to PALS rolling 12 months

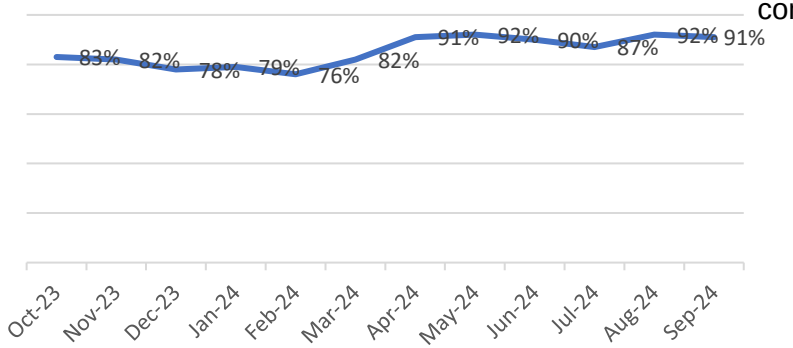


Figure 11: Compliments recorded in Q2 by Division

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

Success Highlights	• 85% of formal complaints responded to within 25 working days with excellent compliance in the Divisions of Medicine and Surgery. There is room for improvement in the initial acknowledgement of formal complaints received • Continued excellent compliance in the Divisions of Medicine and Surgery in PALS response compliance and sustained 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 fully 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

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VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 5th December 2024

Report of:	Chief Nurse
Paper Prepared By:	Director of Nursing
Subject/Title:	Mid year Nursing Workforce Report 2024/2025
Background Papers:	• How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Developing Workforce Standards: Supporting providers to deliver high quality care through safe and effective staffing: NHSI, 2018 • NHS Long Term Workforce Plan, June 2023
Purpose of Paper:	This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing. This report demonstrates compliance with the NQB guidance with a focus on right staff, right skills and right place and time.
Action/Decision Required:	The Board of Directors are asked to approve the following: The content of the report and assurance that appropriate information is being provided to meet national and local requirements. The information on safe staffing and the impact on quality of care
Summary/Supporting Information	Annual staffing report
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Impact:	none

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score
2.1	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality cate for children and young people	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	Y☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Introduction

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

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

In October 2024, the Trust took part in a nursing workforce review with NHSE and ICB leads; the review was attended by the Chief Nurse and senior colleagues from nursing, HR and Finance. Positive feedback and assurance was received from NHSE and ICB partners.

This report will outline the Trust compliance with the triangulated approach to determining safe staffing requirements as set out in the National Quality Board guidance and compliance with the three expectations of Right Staff; Right Skills; and Right Place and Time. Meeting NQB guidance is key to compliance with the CQC fundamental standards on staffing.

2. NQB Expectation 1: Right Staff

Focuses on:

- Evidence-based workforce planning
- Professional judgement
- Compare staffing with peers

In line with the Trust's *Nursing and Health Care Support Worker Workforce Plan 2021-2025*, significant progress has been made in the implementation of evidence-based acuity tools to support workforce planning and establishment setting.

The following Safer Nursing Care Tools (SNCT) are available and applicable to wards and departments at Alder Hey:

Table 1	
Ward / Department:	**SNCT:**
Ward 1C Cardiac	CYP (Children and Young People)
Ward 3A	CYP
Ward 3B	CYP
Ward 3C	CYP
Ward 4A	CYP
Ward 4B	CYP
Ward 4C	CYP
Sunflower House	MHOST (Mental Health Optimal Staffing Tool)
ED	ED (Emergency Department)

The following wards and departments continue to follow the relevant national staffing standards as there is not an SNCT applicable (the tools cannot be adapted for use):

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Table 2	
Ward / Department:	**SNCT:**
Ward 1C Neonatal	BAPM (British Association of Perinatal Medicine)
PICU	PICS (Paediatric Intensive Care Society)
HDU	PICS
Burns Unit	RCN (Royal College of Nursing)
Renal Unit	RCN
EDU / PAU	RCN
SDCU	RCN
MDU	RCN
OPD	RCN

In October 2023, senior nursing and AHP staff undertook training facilitated by NHSE to support the implementation of the CYP SNCT. In October 2024, senior staff from ED attended the ED SNCT, and senior staff from Sunflower House attended the MHOST SNCT training. All staff who attended training had to complete an inter-rater reliability assessment and the Chief Nurse received confirmation that all staff successfully passed their assessment.

Patient acuity data was collected twice in year (February and July 2024) for 20 days for all patients on the ward in line with SNCT guidance on all inpatient wards who met the criteria for the CYP SNCT (as shown in Table 1). Data was validated by senior staff who are not the budget holder for that ward. Going forward, the annual cycle will involve data collection for 30 days in January and June; Sunflower House and ED will undertake their first data collection in January 2025.

The patient acuity data can be used as part of establishment setting by populating the CYP SNCT Ward Multipliers tool, however it is recommended that the data is collected a minimum of three times before it is used to set establishments, therefore the senior team used the data during the 2024 round of establishment reviews in shadow form. The Safer Staffing Faculty at NHSE have been extremely supportive and on hand to assist the team with any questions to support our phased implementation.

It remains essential that professional judgement is considered when using SNCT and the senior team are reviewing the impact of a high number of side rooms on the ward and the impact that any empty beds has had on the suggested WTE from the Ward Multipliers tool as empty beds were not scored.

Quality metrics, key performance indicators, outcomes and incidents were all reviewed as a core component of the safe staffing principles.

All establishment reviews, with the exception of Out Patients Department, have been conducted in 2024 between August and October. A multi disciplinary team approach including Finance and HR was used. Reviews were based on achieving compliance with the national requirements (RCN / BAPM / PICS), patient acuity, professional judgement, benchmarking using the NHSE Model Health System, and review of compliance with key quality metrics and a review of CYP SNCT ward multipliers.

The annual planning cycle will include establishment reviews being undertaken in July and August going forward in line with the Trust budget setting planning.

The Trust benchmarks against peers and reports Care Hours per Patient Day (CHPPD) monthly in the Safe Staffing and Patient Quality Indicator Report in the Integrated

Performance Report. Data is compared and benchmarked with CHPPD figures from comparative wards enabling investigation to understand any significant variation and to make sure the right staff are being used in the right way in the right numbers. CHPPD includes total staff time spent on direct patient care including clinical time such as preparing medicines, documentation, and safeguarding. Comparative data from April to August 2024 can be found in Appendix I; Wards / departments highlighted in Red fall below the benchmark of the Model Health System (formerly Model Hospital). There has been significant improvement in benchmarking within the last 3 months, with all areas Green in August 2024.

3. NQB Expectation 2: Right Skills

Focuses on:

- Mandatory training development and education
- Working as a multi professional team
- Recruitment and retention

The Trust welcomed 51 new nurses in October who, with the exception of new nurses on PICU, have successfully completed their induction and supranumery period on the wards. The Trust undertakes Trust-wide Band 5 recruitment twice a year aligned to the university graduation points; in May (for commencement in September) and October (for commencement in February). 48 new nurses have been appointed who are due to qualify in February 2025. The Trust are supporting 7 staff members who are undertaking the Registered Nurse Degree Apprenticeship (RNDA) programme and are due to qualify in September 2025.

Each recruitment cycle has 2 opportunities for recruitment to ensure candidates who are unsuccessful initially can receive feedback and action this for the second opportunity. We deliver a recruitment preparation session in advance of any advert being released and also attend all local universities with graduating students. All shortlisted candidates are invited to the recruitment event on the same day; they undertake a medication assessment and if successful, progress to interview. Successful candidates are informed which ward / department they will be posted on six weeks after notification that they have been employed. Keep in touch events are facilitated before they commence in post and their ward / department base is confirmed to maintain effective communication, preparation, visits to their allocated ward, and reduce attrition rates. Upon commencement all candidates complete a one week induction programme facilitated by the nurse education team to ensure consistency and foster peer support mechanisms. A Professional Nurse Advocate (PNA) session has been introduced at the end of each day during induction.

Over the past 5 years the Trust has successfully recruited 190 internationally educated nurses (IEN) and completed the international recruitment plan. The focus now is to support IEN's in their progression within the organisation which includes:

- A recruitment support session
- Career guidance through explanation of PDR
- Inclusive Band 6 development programme
- Training needs analysis organisational funding opportunities
- Nurse education representation at REACH network meetings
- Ensured the nursing career pathway meets the needs of the whole nursing workforce
- Supported 21 IENs to undertake Florence Nightingale Foundation IEN online leadership programme

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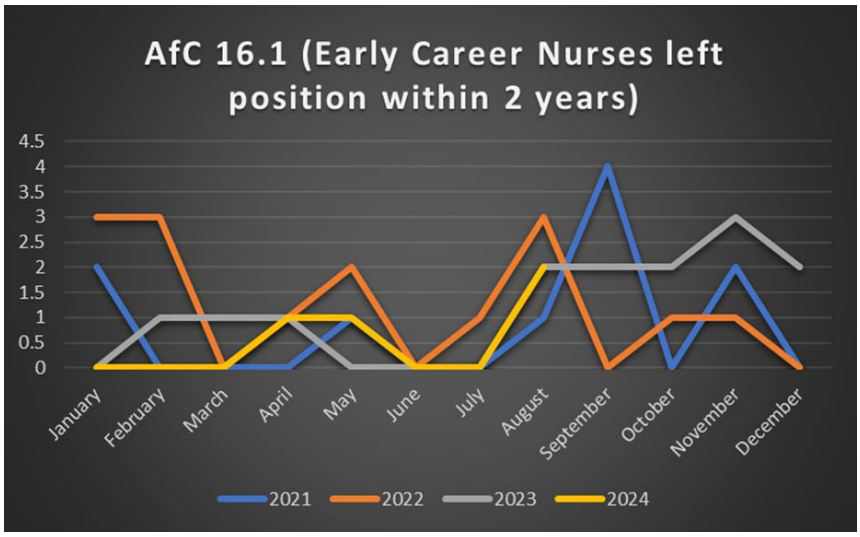
- Supported 4 IENs to complete the BSc Integrated Children and Young Peoples practice to 'top up' to degree level
- Supported 3 IENs to undertake and successfully complete PNA Training. Further one in training and 5 awaiting to commence
- Ensuring Job Descriptions are applicable to IEN's for Band 6 roles
- Established an IEN forum

To enhance recruitment of Health Care Support Workers (HCSW), the Trust has been involved in an NHSE project with NHSP to create a unique programme. The Clinical Support Worker Development programme enables candidates with no clinical experience to undertake a 12 week placement via NHSP; during this time they are supported to complete the care certificate and gain clinical experience. Upon successful completion, candidates can be recruited into substantive posts or supported to continue to access bank only work.

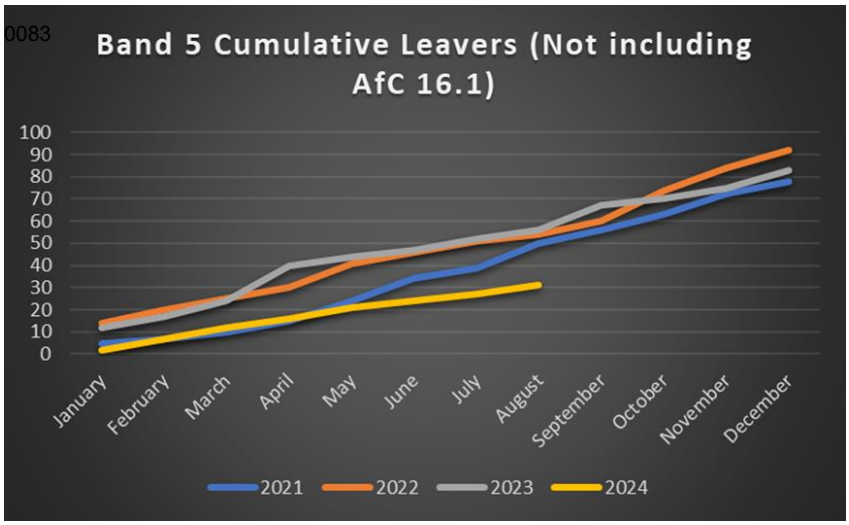
Retaining our nursing workforce is a key priority and the Trust is currently seconding a Lead for Nurse Retention (Fixed for 12 months) to focus on three key pillars of action to ensure monitoring, governance, sustainability, and retention improvement for early career nurses. The Three pillars are:

1. Preceptorship
2. Professional Nurse Advocate
3. New starter attrition rates

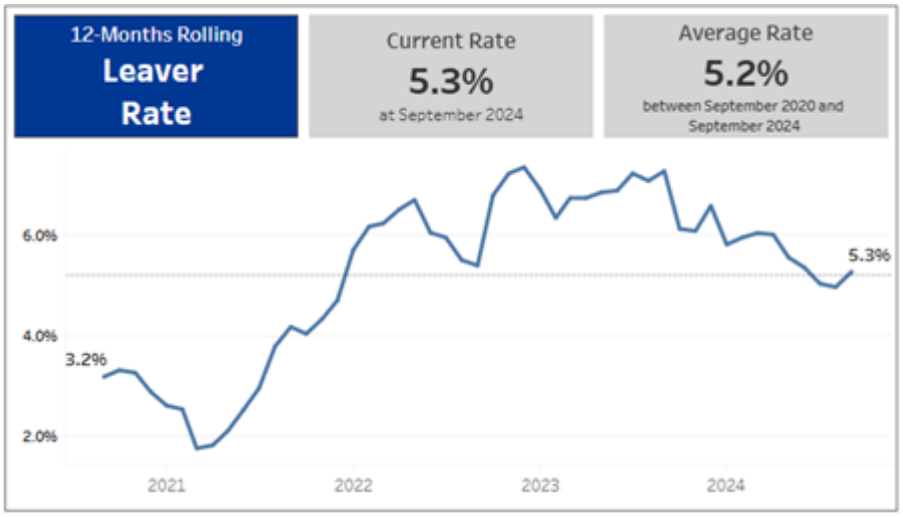
The Trust has trained 17 PNA's and an additional 4 in training; the training plan is to support 8 candidates per year. PNA intervention and the Trust Preceptorship Plan has specifically focussed on Preceptees / early career nurses (<2 years post Registration). By utilising 16.1 AFC spinal point we can determine preceptee/early career nursing leavers



The Internal Transfer Process (ITP) offers existing Alder Hey Band 5 nurses the opportunity the relocate within the organisation. The ITP creates a framework for Band 5 nurses to identify a new area they would prefer to work, and for the Trust to support relocation where possible, without the need for formal recruitment processes. Band 5 leavers data for nurses who are more than 2 years registered, demonstrates further work required to retain. Whilst early career attrition now appears to be plateauing, experienced Band 5 attrition continues to increase. Some of this will be due to promotion and transition however further work is required to determine the reasons for leaving.



The current leaver rate is 5.3%.



4. NQB Expectation 3: Right Place and Time

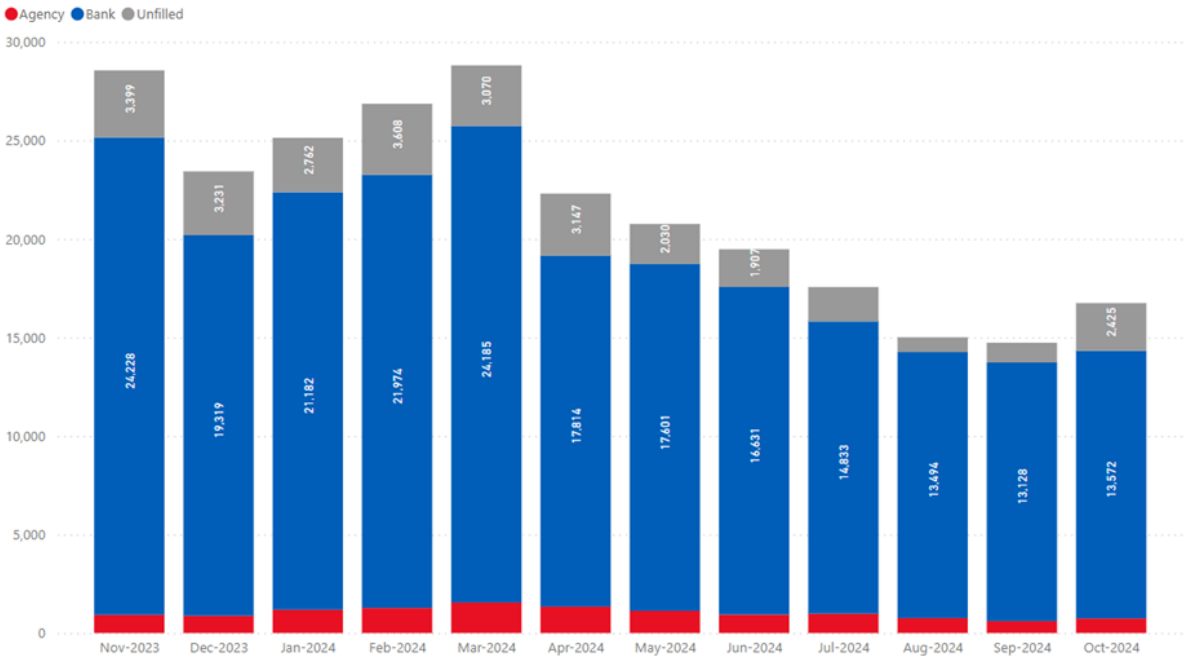
Focuses on:

- Productive working and eliminating waste
- Efficient deployment and flexibility
- Efficient employment and minimising agency

Workforce data for October 2024 shows a budget of 868.16 WTE as can be seen in Appendix II. There are 896.99 in post which is 28.8 WTE over budget however maternity leave is currently very high at 48.57 WTE.

Staffing RAG rating data has continued to show improvement with zero red shifts within the wards and departments thus far in 2024/25.

The senior nurse / AHP team have increased the oversight and scrutiny of bank shifts through the Trust's daily Safer Staffing meeting. The graph below shows the decreasing trend of temporary staffing usage



Compliance with NHS price caps is consistently below the 60% regional KPI. The Trust has utilised agency staffing specifically in Theatre as a result of the Trust increasing activity in line with the elective recovery programme and in the Crisis Care Team. The number of agency nurses in Theatre has decreased to 4.75 WTE with a plan to decrease to 2.75 WTE by the end of December when we will only require agency support for Orthopaedics and Spinal. Agency staff will be in place in Theatre until substantive staff commence in post and complete supernumerary training periods; it is anticipated that agency support will not be required in Theatre in the next financial year.

Summary

Trust Board are asked to approve the content of this assurance report and support the ongoing safer staffing developments.

Appendix I: Care Hours per Patient Day (CHPPD) report April to August 2024

	April 24		May 24		June 24		July 24		August 24	
	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark
Burns Unit	10.1	13.5	26.5	13.5	16.7	16.7	15.9	15.88	21.6	15.88
HDU	24.5	30.9	27.8	30.9	34.1	31.67	39.9	37.81	38.1	37.81
ICU	31.2	30.9	27.1	30.9	26.8	29.23	31.4	33.55	35.8	33.55
Ward 1C C	8.7	13.2	12.5	13.2	13.3	13.3	12.4	12.36	14.6	12.36
Ward 1C N	17.30	19.4	14.7	19.4	18.7	18.73	17.3	17.33	18.6	17.33
Ward 3A	10.1	10.8	9.2	10.8	9	9.3	9	9.31	12.7	9.31
Ward 3B	16.9	11.9	13.9	11.9	15.2	15.2	14.7	14.67	15.4	14.67
Ward 3C	12.2	10.08	13.1	10.08	12.8	11.55	13	12.01	12.9	12.01
Ward 4A	10.2	10.8	11	10.8	10.1	9.75	10.7	10.3	12.1	10.3
Ward 4B	14.3	11.3	13.2	11.3	15.9	15.9	15	13.98	15.7	13.98
Ward 4C	10.2	12.4	10.3	12.4	10.3	10.26	11.1	11.08	14.3	11.08

Appendix II: Care Hours per Patient Day (CHPPD) report April to August 2024

	Assignment Status FTE						In Month Vacancy FTE		In Month Gap	12m Rolling Turnover					12m Rolling Sickness %			In Month Sickness FTE Days Lost			PDR	MT
Department	Acting Up	Active Assignment	Internal Secondment	Maternity & Adoption	Out on External Secondment - Paid	Total FTE	FTE Budgeted	FTE Variance	FTE Gap	Starters FTE	Leavers FTE	Avg FTE	LTR FTE %	Churn %	Short Term	Long Term	Overall	Short Term	Long Term	Overall	Reviews Completed %	Compliance %
411 Sunflower House (912310)		10.33	1.00	1.00		**12.33**	14.73	2.40	4.40	2.00	4.64	12.10	38.35%	54.88%	4.03	3.16	7.20	15.00	24.80	39.80	**87.50**	**96.44%**
411 Outpatients Level 2 (916503)		13.70		0.51		**14.21**	15.33	1.12	1.63	0.76		13.60	0.00%	5.59%	2.16	17.76	19.92	39.20	15.71	54.91	**87.50**	**97.89%**
411 Children's Community Nursing Team (912406)		14.73		1.00		**15.73**	13.25	-2.48	-1.48	1.00		15.08	0.00%	6.63%	1.02	6.97	7.98	0.00	62.00	62.00	**100.00**	**98.26%**
411 Medical Daycase Unit (911314)		6.79				**6.79**	6.04	-0.75	-0.75			6.29	0.00%	0.00%	1.06	0.00	1.06	4.04	0.00	4.04	**100.00**	**98.43%**
411 Ward 3B Oncology (911208)		40.79		2.45		**43.24**	43.95	0.71	3.16	4.60	2.00	41.18	4.86%	16.03%	3.02	2.53	5.55	42.27	75.32	117.59	**71.79**	**93.87%**
411 Ward 3C (911313)		60.18	0.20	4.53		**64.91**	62.65	-2.26	2.47	3.00	3.92	63.43	6.18%	10.91%	2.88	3.56	6.44	48.68	28.52	77.20	**69.35**	**98.33%**
411 Ward 4B (914211)	2.00	30.00	2.00	3.61		**37.61**	33.67	-3.94	3.67		3.92	39.94	9.82%	9.82%	3.20	2.80	6.00	26.67	0.00	26.67	**97.44**	**97.29%**
411 Accident & Emergency (912201)	0.65	82.18	1.00	6.80		**90.63**	83.67	-6.96	1.49	11.00	5.00	83.37	6.00%	19.19%	3.89	3.80	7.69	115.89	115.16	231.05	**87.65**	**96.31%**
411 Ward 4C (912207)		52.73	2.00	2.61		**57.34**	57.68	0.34	4.95	9.92	7.84	57.59	13.61%	30.84%	2.93	1.92	4.86	43.70	38.80	82.50	**74.47**	**96.97%**
411 Burns Unit (CHP) (915208)		17.66				**17.66**	16.84	-0.82	-0.82			17.15	0.00%	0.00%	1.24	0.59	1.82	9.75	0.00	9.75	**40.00**	**97.29%**
411 Ward 1C (913307)		58.41	1.48	3.84		**63.73**	58.43	-6.30	0.02	2.52	2.38	62.13	3.83%	7.89%	2.55	1.87	4.42	99.43	72.97	172.40	**53.33**	**95.76%**
411 Ward 1C Neonatal (913310)		36.52		1.00	1.00	**38.52**	35.21	-3.31	-1.31	10.53	6.45	35.53	18.16%	47.80%	2.76	1.04	3.80	2.89	19.01	21.91	**28.57**	**96.41%**
411 Critical Care (913204)		12.51				**12.51**	12.57	0.06	0.06			12.51	0.00%	0.00%	1.58	1.18	2.76	5.00	0.00	5.00	**57.14**	**93.79%**
411 Critical Care Ward (913208)		151.55	0.92	6.53		**158.99**	161.87	2.88	10.32	18.92	14.44	158.39	9.12%	21.06%	2.20	2.77	4.97	160.35	128.49	288.85	**69.93**	**94.86%**
411 High Dependency Unit (HDU) (913210)		73.41		6.84		**80.25**	75.67	-3.66	2.26	4.92	7.07	80.53	8.77%	14.88%	3.36	2.42	5.78	84.19	70.23	154.41	**89.04**	**96.83%**
411 Ward 4A (914210)		67.69		2.92		**70.61**	67.53	-2.92	-0.16	3.84	7.97	69.25	11.51%	17.06%	2.74	3.26	6.00	94.03	61.95	155.97	**72.46**	**93.72%**
411 Ward 3A (915309)		50.48	1.92	3.92		**56.32**	49.23	-8.09	-1.25	4.00	5.07	56.01	9.05%	16.19%	3.76	3.37	7.13	71.56	31.00	102.56	**72.55**	**96.77%**
411 Surgical Day Case Ward (915418)		15.50				**15.50**	16.94	1.44	1.44	2.00		16.54	0.00%	12.09%	3.20	6.11	9.32	27.56	0.00	27.56	**33.33**	**95.12%**
411 Theatres - Emergency (915420)		12.35				**12.35**	12.54	0.19	0.19	2.00		11.35	0.00%	17.63%	0.80	2.36	3.16	5.00	10.00	15.00	**63.64**	**97.99%**
411 Theatres - IP Anaesthetics (915423)		1.00				**1.00**	1.00	-1.00	0.00			1.00	0.00%	0.00%	0.00	0.00	0.00	0.00	0.00	0.00	**50.00**	**95.83%**
411 Theatres - IP Recovery (915422)		7.75				**7.75**	10.68	2.93	2.93	1.00	1.00	7.35	13.60%	27.20%	1.81	7.27	9.08	11.00	8.80	19.80	**87.50**	**98.15%**
411 Theatres - IP Scrub (915424)		8.40				**8.40**	7.14	-1.26	-1.26	2.00		6.95	0.00%	28.76%	0.83	2.12	2.95	0.00	43.16	43.16	**100.00**	**97.83%**
411 Theatres - SDC Anaesthetics (915429)		1.76		1.00		**2.76**	3.13	1.37	1.37			2.26	0.00%	0.00%	1.81	8.54	10.35	2.00	23.56	25.56	**100.00**	**100.00%**
411 Theatres - SDC Recovery (915430)		7.83				**7.83**	8.41	0.58	0.58	1.00		7.23	0.00%	13.84%	3.29	5.09	8.38	15.00	0.00	15.00	**75.00**	**97.00%**
	2.65	**834.25**	**10.52**	**48.57**	**1.00**	**896.99**	**868.16**	**-29.75**	**33.91**	**85.01**	**71.70**	**876.77**	**8.18%**	**17.87%**	**2.79**	**3.16**	**5.95**	**923.20**	**829.48**	**1,752.67**	**72.62**	**96.08%**

BOARD OF DIRECTORS

Thursday, 5th December 2024

Paper Title:	Infection Prevention & Control Quarterly Report Q2 July – September 2024
Report of:	Infection Prevention & Control Team
Paper Prepared by:	Dr Beatriz Larru Director of Infection Prevention & Control

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

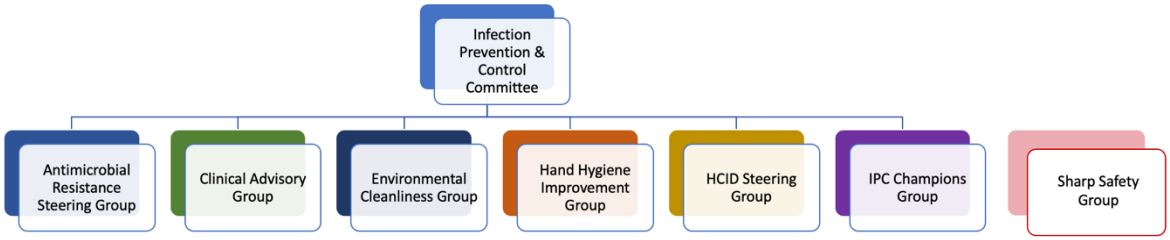
1. Executive Summary

The purpose of this report is to provide the Trust Board with oversight of Infection Prevention Control (IPC) activity and reporting for the Q2 period (1st July – 30th September 2024/2025) 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. Background and current state

During Q2, the IPC committee received reports from the following subgroups.



Clinical Advisory Group: No meetings held in Q2 as this group meetings has been suspended at present while working on its transformation into HAIs steering groups.

IPC Champions Group: On 24.09.24 the group met and discussed infectious diseases where there is high transmission within the community. We have continued to provide sessions in line with the NHSE IPC Educational Framework. Rolled out the Glove Smart Campaign 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- Action Completed - Decontamination lead scheduled to chair the November meeting (26.11.24)

Antimicrobial Resistance Steering Group: On 10.07.24 and 18.09.24 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 behavioural change science in antibiotic prescribing and 7) Surgical prophylaxis.

Hand Hygiene Improvement Group: no meeting held in Q2, but work is ongoing; meetings with Innovation team to move forward with automatic methods of monitoring hand hygiene compliance to effectively promote behavioural change through auditing results.

Environmental Cleanliness Group: On 16.07.24 and 17.09.24 the discussions centred around roles and responsibilities for cleaning & decontamination of frequently used items. The group have also continued to discuss how to best implement the Hospital Cleaning policy RM49 across the Trust and the need for a new system for cleaning audits.
Action: new electronic auditing system being procured.
Action: SharePoint page developed with instructions for cleaning and decontamination of items, in accordance with the National Standards of Healthcare Cleanliness 2021.

High Consequences Infection Diseases (HCID Steering Group): NHSE & EPRR leads visited and we have now become an accredited airborne HCID Centre. On-going HCID training programme for staff and local SIM and induction sessions continue.

Sharp Safety Group: no meetings held in Q2. This operational group is now under the leadership and supervision of the Health & Safety team.

3. Main body of report - 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 Q2, 13 patients had healthcare-associated Gram-negative blood stream infections. Cases were identified in Neonatal (1), Cardiac (1) Oncology (3) Medical wards (5) and Critical Care (3)

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

All of these patients had central vascular catheters in place when they developed bacteraemia so the workplan to reduce Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)) across the Trust has continued during Q2, 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 aureginosa* or *Klebsiella spp.*) to engage with all stakeholders in the development of the CLABSI steering group.

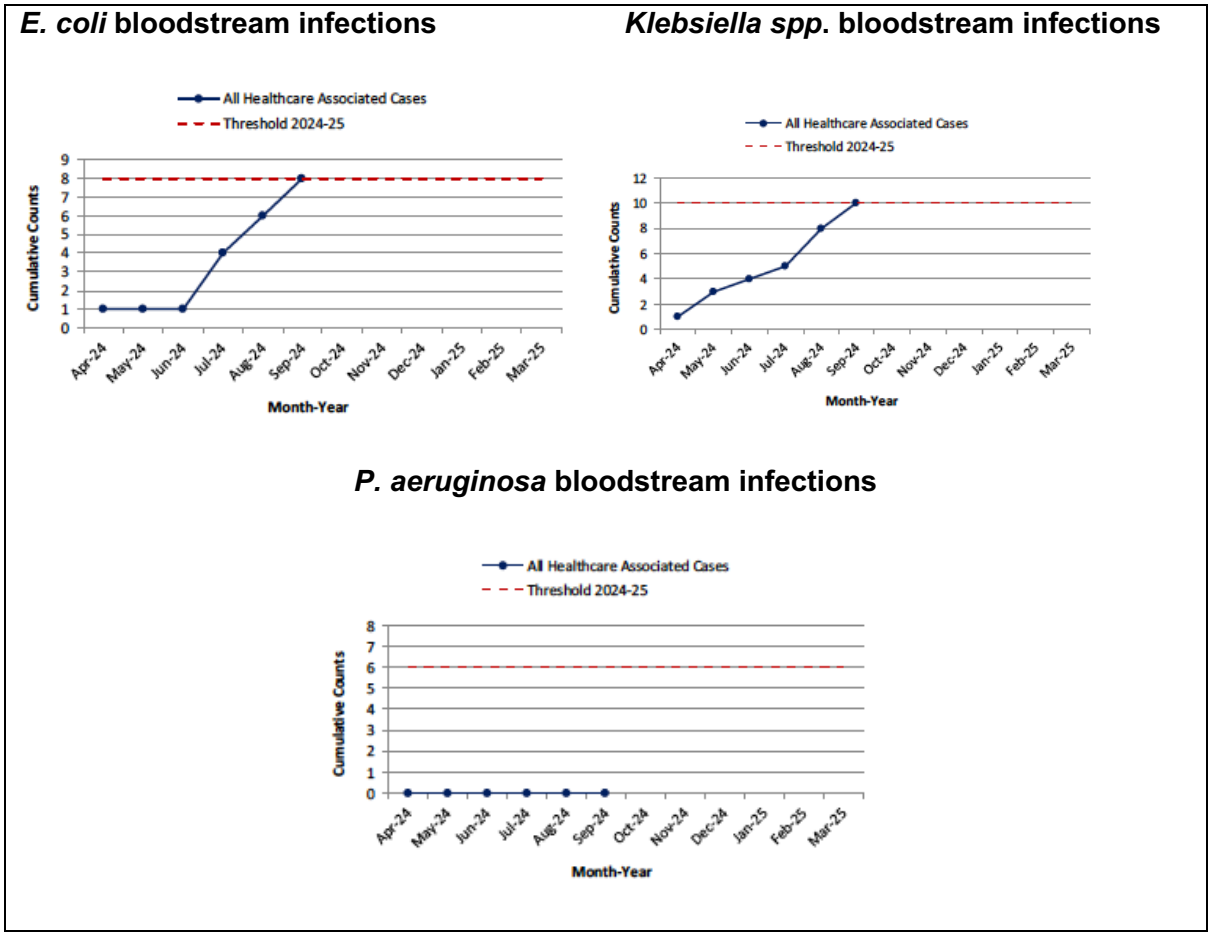


Table-1: UKHSA HAIs monthly tables for Gram-negative bloodstream infections.

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

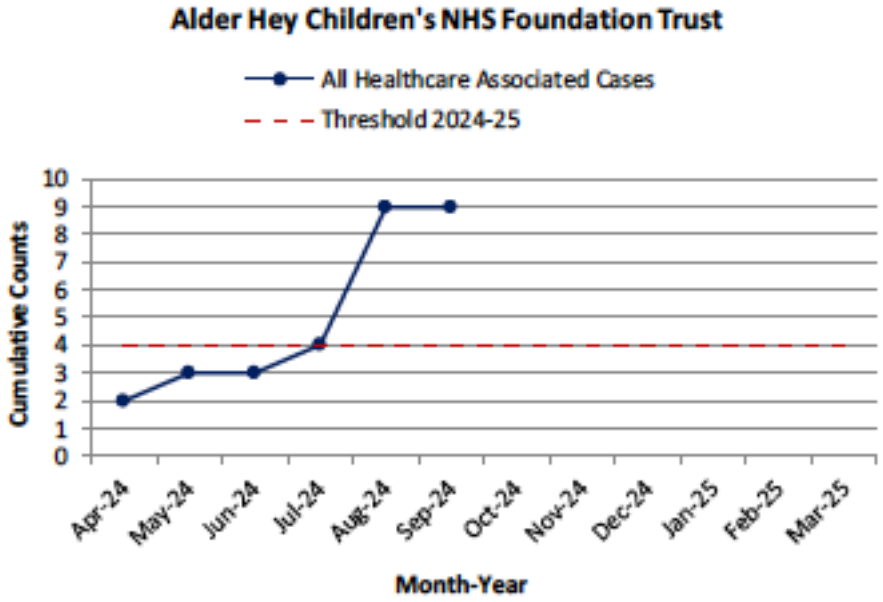
3.1.2 Healthcare-associated *Staphylococcus aureus* bloodstream infections

During Q2, 5 patients had a healthcare associated MSSA blood stream infection. Cases were identified in RDU (1), Oncology (1) Medical wards (2) and Critical Care (1)

The post-infection reviews (PIR) identified that a collaborative attendance is required in the CLABSI steering group and prompted a review of ANTT processes for dressing changes.

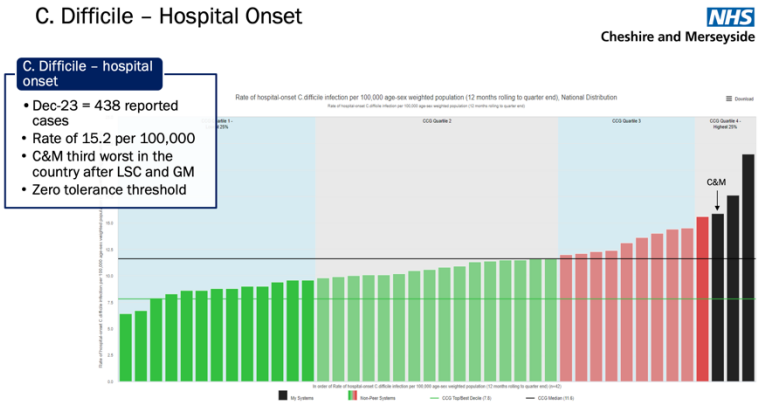
No cases of MRSA bloodstream infection were reported during Q2.

3.1.3 *C. difficile* Infection



During Q2 there were 6 healthcare associated *Clostridiodes difficile* infections identified. All were from Oncology. PIR's for the cases identified that there were no identified lapses in care, all cases were long-term-frequent hospital attenders, and all had exposure to multiple antibiotic treatment prior to their C. diff infection. Out of the 6 cases 4 isolates were sent to UKHSA laboratory for ribotyping, results shown 2 were a match. This is also a match to the strain which is prevalent in the community, so definitive cross-transmission between patients cannot be inferred. 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 to develop a Cheshire & Merseyside *C. diff* reduction toolkit.

3.2 Healthcare acquired viral infections.

3.2.1 Respiratory viral infections

During Q2, we continued to see that a large proportion out of the positive respiratory viral tests analysed in the microbiology laboratory, were obtained on patients admitted for longer than 3 days (*i.e*., viral healthcare acquired infection). We also continue to report rates of inappropriate sue of viral respiratory testing 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. The IPC team sends out monthly newsletters with key messages and updates and provides bespoke education sessions for areas.

3.2.2 Gastrointestinal viral infections

During Q2, there have been no healthcare associated Norovirus cases, and no outbreaks declared. There was 1 case of healthcare associated Rotavirus on a Medical ward.

3.3 Other Notable Infections

3.3.1 Group A *Streptococcus*

1 cases of healthcare associated Group A *Streptococcus* were identified during Q2 24/25. No lapse in case was identified in the PIR.

3.3.2 Measles

There were 2 positive measles cases reported during Q2 24/25. One case exposed 6 patients who were classed a significant contact as per UKHSA guidance and required prophylactic

treatment. The other case was found to be vaccine related. There was a decrease in patients presenting to ED with suspected measles requiring contact tracing (8 cases Jul-Sept 2024). 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. Conclusion

During Q2, the IPC department has continued to maintain their increased visibility across the Trust through daily isolation ward rounds and monthly steering group meetings. Despite low staff capacity within the team have actively worked alongside the DIPC and deputy director of AHP for the majority of Q2. Despite challenge, the IPC team was able to perform its daily activities and actively participate in the response to outbreak incidents within the Trust.

IPC workforce recruitment update:

- Associate DIPC interviews are scheduled to take place on 04.12.2024.
- Band 5 Programme Administration Manager successfully recruited – awaiting start date.

IPC Committee governance 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 also report to the IPC Committee.

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

6. Recommendations & proposed next steps

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

Appendix 1- IPC Associated Risks

Risk Number InPhase ID	Ulysses ID	Risk Description	Initial Risk score	Target risk score	Risk score Q2 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	3	CLOSED	Risk closed
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. Awaiting installation date and schedule 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. Risk remains static and will be reviewed after next IPCC in Q3.
00002715	2749	Lack of advanced data skills within the	12	3	9		Funding secured for ICNet.

		IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data					Action closed. New action for the implementation of ICNet will take some months, Implementation group formed and plan progressing with provider.
00002710	2744	Non delivery of IPC standards due to insufficient IPC staffing levels	12	6	9		All band 6 posts are now fully in post and being trained by the existing band 6 team member. 0.5 WTE post still remains vacant and will go to recruitment in the future. Organisational change is still in progress and once the outcome is known the risk will be reviewed. Currently Lead nurse off sick and service safe with input and support from DIPC. Band 4 coordinator left due to unexpected personal issues - will recruit at outcome of org change. Score remains static at 9 until next review.

BOARD OF DIRECTORS

Thursday, 5th December 2024

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 20th November 2024**
Report of:	**Fiona Beveridge, Committee Chair**
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 20th November 2024, along with the approved minutes from the 23rd October 2024 meeting.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐

Risk Number/s	Risk Description	Score
BAF Risks 1.1 1.2 1.4	• Inability to deliver safe and high-quality services • Children and young people waiting beyond the national standard to access planned care and urgent care • 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	3x3=9 4x5=20 3x5=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. Introduction

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

Minutes of the meeting held on 23.10.24	Minutes approved
Antimicrobial Resistance Deep Dive	Deferred to December meeting
ED Monthly Report	Report noted
Nuclear Medicine CQC Report	Report noted
Cardiac Surgery Action Plan	Report noted
Divisional Updates	Reports x4 noted
Safeguarding Quarterly Report	Report noted
Patient Safety Strategy Update	Report noted
Compliments, Complaints and PALS Report	Report noted
Patient & Family Feedback	Report noted
CYP Engagement Report	Report noted
Clinical Audit Assurance Report	Report noted
Clinical Effectiveness & Outcomes Group Report	Report noted
Liverpool Neonatal Partnership Monthly update	Report noted
National Institute for Health and Care Excellence	Report noted
Board Assurance Framework Report – Oct 2024	Report noted
Emergency Preparedness, Resilience & Response	Report noted

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

- Despite a positive overall picture in relation to the ED metrics, the Committee noted the challenges with discrepancies in NWAS data reporting. A plan is in place to remain in communication with the NWAS team to understand why this is happening.
- Divisional updates
    - Community and Mental Health – ongoing challenge in relation to interpreter service letters not going out in 1st language. Immediate action has been taken with OPD colleagues.
    - Medicine – ongoing challenges in relation to staffing (sickness) and administration of IM injection antibiotics for suspected sepsis cases. A discussion regarding the potential cultural issues here are being picked up through a local working group.
    - Surgery – currently have a young person on 3A with complex physical and mental health needs. Regular MDT meetings are being held to enable close monitoring of the situation.
    - Research – concerns raised regarding research lab support; the Division will continue to monitor this closely with a view to adding to the risk register.

- Level 3 safeguarding training is still slightly under the 90% trust target (86.62%), a training needs analysis is to be undertaken in order to provide assurance that the correct staff are being asked to undertake the training.
- Emergency Preparedness Resilience & Response – despite an improved position from the previous month, non-compliance against the core standards remains a risk for the Trust. The team remain in close contact with the ICB to continue to work through the remaining actions.
- Liverpool Neonatal Partnership Integrated Governance Report – the deep dive into 1C turnover provided assurance that staff are not leaving due to being unhappy but there are still gaps in provision. Safer staffing is being adhered to, however.
- Clinical Audit – challenges noted regarding the Epilepsy 12 data submission owing to lack of resource. This matter has been escalated to senior staff within the Medicine Division and it remains on the risk register. The ACN for Medicine has been asked to provide an update outside of the meeting.
- CEOG Chairs Report – SQAC was informed of the work ongoing to move away from the current Document Management System and consider alternative options in order to comply with NHS Digital Standards. Costing information is being obtained on the preferred option and will be presented to Executive Team for consideration.

4. Positive highlights of note

- Divisional updates
  - Community and Mental Health – Achievement of full QNIC accreditation for Sunflower House (until 2027)
  - Surgery – a long period of no grade 2 pressure ulcers was reported and celebrated. Learning to be shared both locally and nationally.
  - Medicine - no overdue reviews or actions on the risk register for the last three months. No overdue actions for investigations for the last six months.
- SQAC received strong assurance respect of the progress against the Nuclear Medicine CQC Action Plan and welcomed a debrief / learning review at a future meeting.
- The open and honest appraisal of issues within cardiac surgery was very much welcomed. In summary, the review highlighted several areas of good practice along with areas for improvement. Good progress had been made against all actions with most already implemented. Only a small number remained outstanding. A further report will be brought back to the Committee.
- The new style Safeguarding Report was received highlighting a number of positive areas including the scrutiny visits undertaken by C&M ICB for the commissioning standards and the Named Nurse for Safeguarding was now in post.
- The new A3 style PALS and Complaints Report was very well received and a great demonstration of efficient and effective reporting.
- Thorough update of BAF 1.1 undertaken during October with additional controls to be added to risk 1.2 in relation to follow ups.
- Emergency Preparedness Resilience & Response – the committee noted the Trust level debrief following the Southport incident and welcomed the change to the cascade process due to be implemented in 2025. This will improve cascade time throughout the Trust for major incidents.

5. Issues for other committees

None to report.

6. Recommendations

The Board is asked to note the contents of the report.

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 23rd October 2024
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing, AHP & Experience Officer, Chair (ACCN)	(NA)
	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Divisional Director – Community & MH Division	(LC)
	Gerald Meehan	Non-Executive Director	(GM)
	Laura Rad	Head of Nursing – Research	(LR)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Catherine Wardell	Associate Chief Nurse, Medicine Division	(CW)

In Attendance:

24/25/149	David Porter	Consultant Infection & Immunology, Sepsis Lead	(DP)
24/25/151	Dr Matthew Neame	Consultant General Paediatrician, Chief Clinical Information	(MN)
24/25/152		Officer, Division of Medicine	
24/25/155	Nik Barnes	Consultant Radiologist, Deputy Clinical Lead for Radiology	(NB)
24/25/133		Lead Radiographer for Nuclear Medicine	
	Emma McDonough	Clinical Lead for Nuclear Medicine	(EM)
	Jill Preece	Governance Manager	(JP)
	Paul Sanderson	Chief Pharmacist	(PS)
	Bea Larru	Director of Infection Prevention & Control	(BL)
	Peter White	Chief Nursing Information Officer	(PW)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)

Apologies:

Pauline Brown	Director of Nursing	(PB)
Ian Gilbertson	Deputy Chief Digital and Information Officer	(IG)
John Grinnell	Managing Director	(JG)
Susan O'Neil	Deputy Head Neonatal Nursing Liverpool Neonatal Partnership	(SN)
Rachael Pennington	Associate Chief Nurse – Surgery Division	(RP)
Melissa Swindell	Chief Peoples Officer	(MS)

	Welcome and Apologies The Chair welcomed everyone to the meeting.
24/25/144	**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.
24/25/145	**Minutes of the Previous Meeting** The Committee members were content to APPROVE the notes of the meeting held on 25th September 2024.
24/25/146	**Matters Arising/Review of Action log** The action log was reviewed and updated.

24/25/147	*Assurance on Key Risks* *Delivery of Outstanding Care* *Safe* **Patient Safety Strategy update** JR provided an update from the Patient Safety Strategy meeting on 26.9.24. Patient Safety Strategy had applied scrutiny to workstreams, 1, 7,8, 10, 15 and 22, Quarterly Assurance Reports had been received for HMRG, Trauma Quality & Safety, Transfusion Committee and Resus Team. FB referred to the summary sheet on the education and training workstream and stated that there are two milestone actions that have incomplete actions and that the dates had passed and requested that future reports contain clarity regarding timeline for completion of actions. KB referred to the transition report and requested clarity regarding the aims, baselines, goals and measurable information, and queried whether this should be aligned within Vision 2030 programme to enable strategic support. JR advised that from her understanding the Parity of Esteem workstream struggled to fulfil the A3 for Brilliant basics. JP referred to Parity of Esteem and stated that there are 5 different workstreams, JR referred to the patient safety element which related to restrictive practice. JP described the difficulties the with multiple elements in following the A3 format given the separate questions. JP advised that she had collaborated with different people to provide details within the report, and that she is happy to review this further offline with JR/CT/JW and any other colleagues. Action. KB welcomed feedback from JG & NA to ascertain whether Patient Safety element required scoping to Patient Safety Strategy Board and whether the wider cultural piece should be addressed within Vision 2030. NA stated that he is happy to support JP if required. NA advised on the need to clearly identify the remit, scope and aim of each of the sections to enable assurance to be provided. NA advised that the next update could include a deep dive which would give clarity for the committee on the full remit of the parity of esteem work. JG referred to when projects have a large cultural change, and thinking about whether they may align more centrally within the Vision 2030 programme governance versus where there is more specific safety work. **Action** JG & NA discuss offline. FB stated that there are two different things operating simultaneously - one driving parity of esteem through everything and then separating from areas where specific interventions are underway or need to be undertaken. JG thanked JR for the excellent update and stated that he is interested in safety partners and sought clarity whether SQAC could receive a greater understanding of safety partners in the future. FB stated that once they had been appointed and trained would be helpful to receive different perspective from safety partners and other parts of the organisation, FB stated that is likely to be 25/26 when colleagues would appreciate impact of the patient partners. JR described the innovative approach taken by Alder Hey. LC sought assurance that these would cover Community & Mental Health Services externally and that the safety aspect are also very different to the acute Trust. JP confirmed Community & Mental Health would be included. **Resolved**: SQAC received and NOTED the Patient Safety Strategy update.
24/25/148	**ED monthly report: MH attendances and ED@its best** CW presented the ED Monthly Report sharing key highlights. SQAC noted the Forward look update with the SQAC meeting pack.

	GM referred to the number of consultants who are absent within ED and sought clarity regarding which forum currently has oversight of mitigations and Human Resources issues and sought clarity regarding target for issue to be resolved. CW advised that this is being closely monitored and reviewed on a weekly basis within the Division of Medicine. UD stated that the Clinical Director of Acute is a paediatric emergency consultant and that UD regularly meets with the Clinical Director. UD stated that HR are closely involved with the consultants and that the Division are also supporting these staff. The Division are reviewing mitigations and UD referred to a proposal regarding the Clinical Director stepping down from his CD role to enable additional clinical work to be undertaken, colleagues are reviewing the rota to review. UD stated that it is going to be a difficult winter period. **Resolved:** SQAC received and NOTED **the** ED monthly report: MH attendances and ED@its best
24/25/149	**Sepsis Quarterly Update** DP presented the Sepsis Quarterly update on behalf of the Sepsis Team and provided an update on progress made since the last Sepsis update provided to SQAC in July 2024. DP provided on overview of current progress regarding the sepsis dashboard/ED/inpatient working and training. FB referred to the timeline for Meditech development on the work on vitals and sought clarity regarding assurance regarding handover with the two systems. KW advised that the current contract runs until September 2025 and that the Trust is looking likely for April 2025 go live. KW advised that the model that the Trust is planning on implementing would be more automated for nurses and should reduce the risk of transcription errors with manual entry, there is formal governance in place, with plans for retesting of the solution and Standard Operating Procedures and training for nurses. KB referred to Sepsis mandatory training and sought clarity regarding what actions need to be taken to improve Sepsis mandatory training compliance. JG referred to the additional annual leave thank you day and welcomed an update in 3/6 months' time regarding feedback in terms of any increased Sepsis mandatory training compliance. Action. DP stated that there had been previous complaints regarding the ease of accessing the package previously, and stated that it is available through ESR, DR advised that there are occasional glitches, which would be rectified with the new package. DP stated that he could not understand the reasons regarding the low compliance for sepsis training compared to other mandatory training, and whether this is due to a reluctance of staff to engage, or whether colleagues feel the training is too complicated. DP referred to introducing a sepsis basic package for health professional who just need oversight and awareness. DP stated that there needed to be more emphasis placed on the importance of staff undertaking mandatory training and to have consequences in place for those staff not undertaking training. NA advised that he welcomed the review of the two-tier approach which would help professionals who just require access to the package. NA stated that NHSE are undertaking a central review of mandatory training and reviewing the central resources that are used. ABa stated that this had also been linked to appraisal with the need to provide mandatory training record within appraisal. ABa stated that there is a need to reflect on this with common sense approach, as on review of overall mandatory training compliance levels is in excess of 90%, and staff are engaging in overall mandatory training. ABa described his personal experience of Sepsis training which was cumbersome as the system had not recorded completion of training, ABa referred to the discrepancy between the overall mandatory training record which is vastly improved over the last 3-5 years, and queried whether there is a more profound issue with registering completion for the Sepsis training package. FB stated that colleagues should review offline.

	DP stated that KW points are valid, and that he is hopeful of a seamless transition. DP stated that he envisaged that there would need to be a split in the sepsis entries, and colleagues would work closely with IM&T to ensure a seamless transition process. DP referred to the comments raised by ABa regarding issues experienced regarding recording Sepsis training results and stated that Sepsis team had received those reports and that the training team had not been able to identify why this occurs within the package, it is hopeful the new system would address this issue. DP queried whether Sepsis training needed to take place on a yearly basis or whether Sepsis training could move to 2 yearly. DP confirmed that he planned to raise this issue at the next Sepsis Steering Group to consider whether this could be moved to 2 yearly, this would also be discussed with L&D colleagues. Action. **Resolved:** SQAC received and **NOTED** the Sepsis Quarterly Update
24/25/150	**Drugs & Therapeutics Quarterly Report** PS presented the Drugs & Therapeutics Quarterly Report and provided an overview of the Drugs & Therapeutics Terms of Reference which had been created to ensure that there is a clear supporting structure in place which would enable assurance regarding medicine management and medicine safety. ES referred to the Ethics Committee and where the Ethics Committee is placed on the organogram. ES stated that the Ethics Committee is not an assurance Committee of the Board and that this committee should be positioned on the same line of the Drugs & Therapeutics Committee as the committee performs an operational function and is part of the peer process, rather than a reporting process. LR sought clarity whether the ToR had received input from Research colleagues and queried whether any representation is required from colleagues within the Research Division. PS would review offline. PS advised that there were no overall concerns to raise at SQAC. PS provided an update regarding a Deep dive into Risk #1706 -oxygen prescribing. PS stated that it is now extremely easy for clinicians to prescribe oxygen, colleagues had seen an increase of compliance from 20% in 2023 to 40% in 2024, PS advised that he is hoping to see an ongoing significant improvement. FB stated that report is extremely clear and referred to the Controlled Drugs Accountable Officer narrative within the table and referred to Compliance in Q2 24/25 and welcomed an update within the next report. FB welcomed any feedback or comments from SQAC regarding formatting and the clarity of the report GM stated that the report is very technical and referred to the supplies of medicines, and stated that he could not see reference within the report to supplies and whether there is a general issue regarding medication supply. PS confirmed that this information is not included within the report, as this is a significant issue within the supply market at present. PS stated that the next DTC report could include an update on the ongoing work regarding ADHD medicines to ensure the supply of this medication to patients. PS stated that it may be helpful to include a very brief summary. PS stated it may be helpful to provide a future update on the ongoing work with Community & Mental Health/pharmacy and ICB partners regarding access to these medicines. FB queried whether Pharmacy need to include where Pharmacy are making contributions to managing other people's risks. LC advised that ADHD Medication reports are regularly shared at Executive Team meetings and that there is a report being presented to Executive Team on 24.10.24, this is also discussed at Trust Board on a monthly basis with oversight at Trust Board and Executive Team oversight. NA stated that he is happy to discuss offline with PS. NA would value a summary table detailing issues, by exception detailing any additional information at the end of the report regarding any ongoing issues/challenges which impacts on patients. PS expressed thanks to SQAC for ongoing support. **Action:** NA & PS to discuss offline **Resolved:** SQAC received and **NOTED** the Drugs & Therapeutics Quarterly Report

24/25/151	**Diagnostics notification update** MN presented the Diagnostics notification update which included a comprehensive overview of the ongoing challenges, ongoing efforts made by MN to improve compliance; with CMO personally contacting those clinicians and clinical leads with high numbers of notifications on a monthly basis. MN described the increasing challenges regarding resident trainee doctors, who short placements and then move on. On review of the clinical incidents that had identified that had occurred in relation to the system, appears a trend translates identified 4 incidents relating to the use of the system over the last year, and the interaction with junior doctors/resident doctors and the system seems to be a factor in 3 out of the 4 incidents occurred. AB stated that it may be worth liaising with innovation team to ascertain whether an AI solution is available. ABa stated that the Trust had successfully managed to broadly achieve a culture change, through training and monthly letters issued by ABa, with a personalised supportive email. ABa referred to the issue regarding resident doctors who order patient tests on behalf of a consultant, and that potentially due to the short tenure of these doctors or that they may be unaware that they are due to review the notices. ABa described process of a mandatory field within meditech if a resident doctor books a test have to link to consultant who had requested test, both would receive result and would need to acknowledge it ABa advised that over 80,000 notifications had been acknowledged and that there had been a significant improvement on the system. FB referred to the additional advantage of ensuring that the consultant is linked and has oversight, and whether consultants would welcome this. ABa stated that it is going to be a communication issue. MN referred to the cultural change and advised that there is some push back from colleagues who feel that the balance is not correct as they get more results, and that this group would need some careful communications. LR stated that the Research Division are not receiving any research notifications as consultants are aligned in other divisions, LR queried whether there was any feedback for research and asked that this be shared in the future. FB welcomed an update, and sought clarity regarding a suitable timeframe regarding impact. MN advised that he envisaged that it would be 6 months at the earliest to determine whether this is having a significant impact. **Resolved:** SQAC received and **NOTED** the Diagnostic Notifications Update and welcomed an update at April 2025 SQAC meeting.
24/25/152	**CQC Nuclear Medicine Improvement Programme** ES presented the first CQC Nuclear Medicine Improvement Programme Report and advised that she is the Executive sponsor in relation to the regulations. ES advised that the report is a combined joint report which included a detailed Action Plan and CQC report as an Appendix. ES provided a summary of the background detail and advised that a taskforce had been established since the Improvement Notice was received. ES proposed for SQAC to receive monthly CQC Nuclear Medicine Improvement Programme updates until the Improvement Plan is submitted to CQC in mid-December 2024 and until such time that the improvement notice is rescinded to provide assurance. NB provided a detailed overview of the current position following the Nuclear Medicine modality receiving a CQC Improvement notice on 19.09.24, which detailed the contravention of two regulations: • Regulation 6, Employer's duties: establishment of general procedures, protocols, and quality assurance programmes • Regulation 12, Optimisation The improvement notice was accompanied by a schedule detailing remedial of four contraventions that are required by 13.12.24. The report instructs the Trust to submit a project action plan to CQC Inspectors by 8.11.24, with remediation of the regulatory contraventions by 13.12.24. • Employers process and procedures, the Trust had been requested to write these in a different way. With approximately 11 Standard Operating Procedures required to written.

	• That the Trust must ensure referral guidelines for medical exposures are available to all referrers. NB advised that all referral guidelines had since been written. • The Trust must ensure that arrangements are in place to designate carers and comforters in line with professional guidance. Relevant procedures must include sufficient information and guide duty holders to manage expectation. NB referred to the set of regulations which are mostly covered by correcting the 3 issues and the only item that is not covered is the relationship with the medical physics advisors, colleagues have been rewriting the Service Level Agreement to ensure that they are more involved with Trust quality assurance processes and policies and procedures. NB advised that all the required protocols are written and are due to be reviewed on 23.10.24 and would then be shared at appropriate Trust committees for sign off. NB confirmed that the Action plan is in place. NB referred to issues that are outside of Radiology control – i.e. intranet to enable I refer, and ensuring it is not removed from the website, ensuring that the nuclear medicine guidelines referrals are hosted on the intranet and remain on the intranet. NB advised on the potential to create a video for children and young people that explain risk of radiation exposure for children, given that the average reading age is 9 years old. NB provided assurance that actions are on trajectory to meet all requirements of the CQC Improvement Notice. FB expressed thanks to NB and Team. GM stated that he is extremely assured by this update and thanked the team for work undertaken. GM sought clarity whether there are any lessons that could be learned for future CQC visits. NB stated that the Trust did have all of the documentation that was required and that it was not in the format required by CQC. NB stated that colleagues should not underestimate the work required to ensure policies and procedures are kept up dated, and that appropriate resources need to be considered. NB stated that a general issue related to the medical physics experts who were not engaged as they should have been. NB stated that it would be helpful if CQC provided templates or examples of good practice. FB stated that colleagues were assumingly unaware of the shift of CQC in this area. UD stated that there is a great deal of learning for the division, and it is important to ensure that the Division of Medicine is always CQC ready, this is being reviewed within the Division and learning from this is going to be disseminated across Radiology and across the Division. UD referred to the Trust relationship with external partners, UD personally met with colleagues at LUFT, this was an extremely positive meeting, with good engagement and lessons learned. KB stated that it is a very specific service and regulations and queried whether there are any other areas within the Trust whereby the Trust may want to undertake a peer review. ES advised that this was discussed at Executive Team approximately 3 weeks ago, with an intention to specific service level regulations– i.e. medical gases, transfusion, and is a piece of work that would be pursued. AB referred to all services that have external accreditation and ensuring appropriate governance and that had been discussed at Divisional discussion meetings on 27.10.24. AB stated that he envisaged that JR and Divisional Governance manager could promptly create a new forum that pre- empt reviews peer reviews. NB stated that most of CQC stated applies to radiology department, and there is currently a meeting taking place to update on progress and ensuring appropriate dissemination where appropriate. NB advised that all procedures would be upto date. FB acknowledged that SQAC recognise the time that is required to ensure policies are kept updated, however it is about ensuring this is actioned on a rolling basis and ensuring policies are upto date, and aiming at best in class and not just meeting compliance standards. FB expressed thanks to NB and Team for continuing support.
	Caring *Effective*
24/25/153	**Board Assurance Framework**

	ES presented the Board Assurance Framework • ES referred to the new risk regarding ADHD medication. • ES referred to the updates to Risk 1.1. and the gap in control regarding IRMER, tracking the risk in relation to this substantive action. • Ongoing nature regarding the excess risk that AB is the risk owner for, with a particular gap in assurance regarding urgent care may be liable to be reduced, continue to review. • Follow up work, actions highlighted to be in place. ES advised that the overall control risk environment is under the correct level of scrutiny, with opportunity to think across to other assurance committees in relation to any areas that other groups may wish to review e.g. whether DTC may be one of them. FB stated that it was not obvious to her why some of the risks had been scored more highly and risen to corporate this month, FB referred to Risks 2290 'A child may be harmed in the process of holding them to complete an intervention anywhere in the Trust' which is a business support risk and referred to Community risk 2206 'Children at risk of a decline in clinical condition requiring Emergency Department attendance and/or Hospital admission' and queried whether this related to the virtual ward. FB welcomed feedback regarding these two risks. JP advised that risk 2206 relates to the challenge of finding respiratory physiotherapist, in the absence of them children may need to attend ED. JP confirmed that the risk was raised as a member of staff retired, however the Division had since recruited someone who wanted to work additional hours and that the Division was able to support, therefore this risk would be reduced once the individual is in post. JP referred to the restrictive practice risk and stated that this had increased this month as the Trust had changed training provider, and that there is a potential risk during the handover whilst transition takes place to the new provider. JP stated that this is about acknowledging that when there is change that there is potential for increased risk, about ensuring refreshing the training needs analysis to ensure all areas and that the correct people are identified to enable refresher training in timely way. ES referred to the corporate risk register and advised that there is scrutiny of the highly rated risks on a bimonthly basis. **Resolved:** SQAC received and **NOTED** the Board Assurance Framework.
24/25/154	**Clinical Effectiveness & Outcomes Group Chairs Highlight report** JR presented the Clinical Effectiveness & Outcomes Group Chairs Highlight report from the meeting held on 11.10.24. • CEOG acknowledged continued compliance with NICE guidance. • Continuing improvements noted with oversight and learning from clinical audit. • Nationally mandated audits Epilepsy 12 (cohort 6) and NDA on trajectory with data submission • Clinical audit registration form and reminder process being reviewed as a Quality Improvement Project with Brilliant Basics. • First iteration of Policies and Guidelines report developed under Brilliant Basics format. Plan to establish a task and finish group to review policies. • Collaborative working across divisions with NG43 Transition as part of the transition steering group. • UK Renal Registry Chronic Kidney Disease Audit (CKD) discussions are ongoing, programme is in place indicative of 8 weeks, update to SQAC also being monitored at CEOG. **Resolved**: SQAC received and NOTED the Clinical Effectiveness & Outcomes Group Chairs Highlight report
24/25/155	**Liverpool Neonatal Partnership Assurance Report** SQAC noted the Liverpool Neonatal Partnership Report within the meeting pack. KB referred to turnover on 1C which is 20% and queried how many staff had left in the last 12 months, how many staff had leaver interviews, whether colleagues know the reasons why the staff had left and what actions are being taken and sought clarity whether this required discussion at SQAC or at LNP Board. NA stated that his understanding is this is the turnover rate and that this is not relating to leavers and relates to the movement of staff including those who had been successful in obtaining a promotion within the service.

	NA stated it would be helpful to receive a deep dive into the staffing position at the next LNP Board meeting, ABa/NA would follow up with LG at LWH to ensure focus for the next LNP meeting. Action KB stated that she had attended the previous workforce meeting for LNP and felt the overall workforce data along with recruitment looked really positive and echoed NA comments regarding movement of staff. **Resolved**: SQAC received and **NOTED** the Liverpool Neonatal Partnership Assurance report
24/25/156	**Divisional Update** **Division of Surgery** – KB presented the Division of Surgery update • Divisional wellbeing committee is in month 5, committee is successful with good engagement, Division had been targeting celebrating excellence, reward and recognition and the health, wellbeing and resilience of staff. The meeting is well attended and is well support by Human Resources. • The Division had been successful in winning awards in 3 categories at the staff Awards. • During September 2024 the Division have had the first discussion regarding the Divisional Winter People Plan, with a number of positive ideas and strategies discussed to support teams during the most challenging months, which was well received. • The Division have had no category 3 pressure ulcers for 751 days and no category 4 pressure ulcers for 994 days. During the last 6 month period, the Division had undertaken targeted work regarding the prevention of category 2 pressure ulcers, with 1 Grade 2 pressure ulcer during the last 6 month period. • The Division noted a marked improvement in temporary spend in relation to nursing in September 2024, this is as a result of maintaining safe staffing levels and delivery of high quality care • The Division have 0 patients waiting over 65 weeks for surgery, with 383 children waiting for 52 weeks • Through the productive theatre programme, the Division had seen an increase in patients following a day case pathway, there had been increased activity, however the data is reflecting a decline in the utilisation regarding touch time, this requires some consideration regarding how this data is presented as this is an improvement. • The Was not brought rate is higher than the Divisional target and is being monitored within the division, with various workstreams and actions targeting specific areas of concern. • A new risk had been added regarding the registrar rota within paediatric surgery with a gap of 2.5 WTE, actions are in place, with the worst case scenarios would be for the potential of consultants working down, which would compromise service delivery, a meeting is due to take place on 28.10.24 to discuss this further with relevant teams. KB referred to the risk section of the Divisional report and stated that it looks there were 47 risks from September last year to 32 risks this year and sought clarity regarding how this reduction had been achieved. KB stated that she would need to review this offline. **Action** KB requested if JR could review through the Risk Management Forum **Community & MH Division** – JP Presented the Community & MH update • Giardia outbreak had successfully been concluded; all children had now been cleared. • Compliance regarding initial health assessment reviews for Looked After Children, despite challenges across safeguarding had remained above 90% for a 4 month period. • Division are experiencing challenges regarding Sepsis training compliance, colleagues who have outstanding training are being met with to enable improved compliance. • Low occupancy level at Sunflower House, the new leadership team are proactively connecting with specialist CAMHS services across the region and continue to attend the NHSE gateway meetings. It is suspected that this is due to the move from the previous location and the change of leadership team. • Change in provider of training for safe physical intervention/restrictive practice - a plan is in place, and the training needs analysis is being refreshed. **Medicine** CW provided the Divisional update.

	• There had been a reduction in the number of Children and young people waiting over 65 weeks, for treatment, there is ongoing work with neurology in this regard, there is 1 Child/young person waiting at the end of September 2024. • Continued challenge regarding Haematology and Transfusion staffing and service provision in labs, this remains a risk of 25, it is envisaged that in December this Risk would be reduced, with ongoing focus, there is a plan in place should a critical incident arise. • Sepsis training compliance is above 90% in all ward areas and specialist nursing teams, with continuing work to ensure medics are above 90% • The Division have no risks or risk actions overdue for review, with good risk management seen with new risks and closed risks as well as reviewing risk score. • Focus on CQC Improvement Notice in Nuclear Medicine. KB requested CW to review the level of assurance for future reports, with 3 risks with scores of 26, 16 and 16 which are not at target, KB referred to relationship scores and language used regarding risk. Action. **Research Division** – LR presented the Research Divisional update • Lab's support had been a challenge for the Division, as a result the Division are trialling a period of research staff to enable research samples to be processed for studies. This had been challenging at times; however, staff are performing well and there had been minimal disruption to date. • Quality Assurance Officer had now been appointed and is due to commence in post in October 2024 • The Division had a further delayed SAE reporting within oncology clinical trials portfolio, after previous work with the team the Division are now undertaking more targeted response with individuals and are undertaking retraining. Learning would also be shared through the Incident bulletin which is shared division wide. • GCP training for PIs had decreased in month, a research facilitator is targeting those staff to ensure that they remain research active and to ensure that their certificates are updated. • There had been a decrease in patient feedback, this is partially related to the decrease in recruitment as the portfolio had changed with a number of the larger recruited studies which had finished, with more commercial studies that have a target of 1 or 2. This is being reviewed within the Division to ascertain whether this could be improved. **Resolved** SQAC received and **NOTED** the Divisional updates
24/25/157	**Antimicrobial Resistance Deep Dive** SQAC agreed to defer the Antimicrobial Resistance Deep Dive report until November 2024 SQAC meeting. Colleagues agreed it would be helpful to receive this deep dive within matters arising section at November SQAC meeting. **Resolved:** SQAC welcomed the Antimicrobial Resistance Deep Dive at November 2024 meeting.
24/25/158	*Well Led* *Responsive* **Transition update** SQAC received the Transition report which detailed success, challenges and next steps. In terms of future reporting, JP and NA agreed to hold an offline discussion. Action. KB – queried whether KB and NA could liaise offline regarding context, KB stated that it appeared that JP had been given two significant areas to deal with. A**ction:** KB & NA to undertake offline discussion. **Resolved:** SQAC received and **NOTED** the Transition Report
24/25/159	**RM50 Labelling Packaging Handling and Delivering Lab Specimens Policy** FB advised that RM50 Labelling Packaging Handling and Delivery Lab Specimens Policy had been scrutinised elsewhere and sought feedback from SQAC whether SQAC were happy to ratify this policy. SQAC were content to RATIFY M50 Labelling Packaging Handling and Delivery Lab Specimens Policy

	Resolved: SQAC **RATIFIED** RM50 Labelling Packaging Handling and Delivering Lab Specimens Policy
24/25/160	**Any other business -** None.
24/25/161	**Review the key assurances and highlights to report to the Board.** • QAC noted the Patient Safety Strategy update • SQAC received the ED monthly report, ED@ its best update • SQAC received the Sepsis Quarterly report with good discussion held • SQAC received the Drugs & Therapeutics Quarterly Report • SQAC received the Diagnostics notification update and welcomed the focus on ensuring notices to trainees would also be shared with consultants, ensuring they could have oversight of unacknowledged notices and manage these. e.g. where trainees had moved out of the organisation. Progress could be assessed in six months. • SQAC received the Nuclear Medicine CQC Improvement Notice update. SQAC would receive monthly updates until all actions are complete and until the CQC Improvement Notice is discharged. • SQAC received the Board Assurance Framework • SQAC received the Clinical Effectiveness & Outcomes Group Chairs Highlight report • SQAC Noted the Liverpool Neonatal Partnership Integrated Governance Report within the SQAC meeting pack. • SQAC received the Divisional updates and noted the successes and challenges across the divisions. • SQAC received the Transition update • SQAC received and Ratified RM50 Labelling Packaging Handling and Delivering Lab Specimens Policy • SQAC agreed that the Antimicrobial Resistance Deep dive would be deferred to 20th November SQAC meeting.
	Date and Time of Next Meeting: 20th November 2024 at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 5th December 2024

Paper Title:	**Chair's Report from the Futures Committee meeting held on 26th November 2024**
Report of:	**Shalni Arora Committee Chair**
Paper Prepared by:	Amanda Graham, Executive Assistant

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information:	Futures Committee minutes from the meeting that took place on 30th September 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 ☑ **Strong Foundations** ☑
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks						
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 Futures Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

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

- Demonstration of Lyrebird AI consultation aid
- NIHR Research Funding Awards overview
- Updates from the four Futures Pillars
- Charity Investment Strategy update
- LCR Investment Zone update
- Futures Development in Global Arena update
- Alder Hey Anywhere update

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

No key risks or matters of concern to be escalated.

4. Positive highlights of note

- Visible progress being made under each of the four Pillars
- Beginning to deliver against Futures strategy
- Informative to have Pillar updates within meeting pack in advance

5. Issues for other committees

No issues for other committees.

6. Recommendations

The Board is asked to note the Chair's Highlight report for the meeting that took place on 26th November 2024.

Alder Hey Children's NHS Foundation Trust

Futures Committee

Confirmed Minutes of the meeting held on Monday 30th September 2024

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. A. Bateman	Chief Operating Officer / Managing Director Futures	(AB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. G Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	(late) Managing Director/Chief Finance Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
In Attendance			
	Dr. K. Birch	Academy Director	(KB)
	Ms. L. Brown	Associate Director Digital Transformation	(LB)
	Mr. D. Cole	Senior Project Adviser	(DC)
	Mr. D. Gates	Consultant PICU /Innovation	(DG)
	Mr. D. Hawcutt	Head of Research	(DH)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Mr. M. Jennings	(part) Director, Strasys	(MJ)
	Mrs. D. Jones	Chief Strategy & Partnerships Officer	(DJ)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Ms. S. Leo	Head of Research	(SL)
	Ms. L. Rad	Associate Chief Nurse Research	(LR)
	Dr. L. Tume	(part) Associate Professor Child Health	(LT)
	Ms. A. Graham	Committee Administrator	(AG)
Observing:	Ms. F. Ashcroft	CEO of the Charity	(FA)
Apologies:	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. C Beaver	Deputy Director of Communications	(CB)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)

24/25/47 Apologies

The Chair noted the apologies that were received.

24/25/48 Declarations of Interest

There were none to declare.

24/25/49 Minutes of the Futures Committee Meeting held on 26th June 2024

The minutes from the meeting of the Futures Committee Meeting held on held on 26th June 2024 were agreed as an accurate record of the meeting.

24/25/50 Matter Arising and Action Log

Matters Arising

24/25/08.1 – Completed
24/25/18.1 – Meeting arranged
24/25/19.1 – Meeting arranged
24/25/27.1 – Completed
24/25/28.1 – Ongoing – JC to capture updates for reporting
24/25/31.1 – Closed – slides to be circulated
24/25/38.1 – Ongoing – JC to bring paper to next meeting
24/25/39.1 – Completed
24/25/40.1 – Ongoing – demonstration to be brought to next meeting

Action Log

All remaining actions on the log will be addressed during specific items on the agenda.

24/25/51 Futures Business Case

AB gave a brief update on the Futures Business Case, noting that this was the full and final iteration following discussions recommending some enhancements, an organogram and more detail around dispersing / repurposing vacancies and resources. This is in line with Option Two detailed within the paper, which sets out kick-starting Futures by mobilising and resourcing the Develop and Grow Pillars. This will also involve establishing the leadership team and resourcing capabilities in particular around developing growth and working with the Academy to offer enhanced learning for colleagues. The Business Case was approved by the Executive Team in August 2024, and some work on switching of resources and repurposing of budgets has begun although there will be some workarounds when it comes to recruitment, including adhering to new guidance from the ICB.

The Futures team have been working hard to ensure the Innovation and Research teams have bought into this process and support sessions for the Innovation team through this and the preceding period of uncertainty have been provided by senior colleagues from HR, Research and Psychological Services. Following a recent review session, it was felt that although there was still work to do, things are feeling very different. IH agreed that the team are much more settled. JK asked how much of this was predicated on the Investment Zone bid; AB responded that this is not so much in the short term while everyone is being brought together, but in the longer term yes that is the case.

Resolved:
The Committee received the Futures Business Case for approval.

24/25/52 Pillar One: Discovery – overview and update

SL gave a brief presentation to update on the four Discovery workstreams, with IH noting that there is now a good mix of people within the Hub. A route / process is needed for directing problems to the right place / person, but discussions are ongoing with LB on this.

Slides to be circulated following the meeting.

24/25/52.1 Action: AG

Resolved:
The Futures Committee noted the updates on Pillar One workstreams.

24/25/53 Discover Pipeline: alignment to Discover themes and funding allocations

SL gave an overview of the Pipeline and submissions made to access NIHR research capability funding, six of which have been funded and are now matched against the Discovery themes. These projects are all due to complete by the end of March 2025. IH noted that there is a disconnect between an innovation which saves thousands of hours and that saving been demonstrated in Innovation metrics, and that saving does not come back to Innovation .JK noted that there should be a transferable benefits programme for that; AB added that there is a case study with RPA where benefit is split 50/50 between the Division and Innovation. IH commented that what is perceived to be brand value may not always have financial benefit; DJ noted that there may be social value. RL commented that how value is measured will be looked at for 2025/26.

Resolved:
The Futures Committee noted the presentation on the ongoing Discover Pipeline projects.

24/25/54 Northern Institute for Child Health & Wellbeing

JC gave a brief update on the newly formed Institute, noting that recruitment is due to commence for a Foundation Director and that it is hoped that the official opening on 2nd October will be performed by the Right Hon. Wes Streeting MP, Secretary of State for Health. The facility will be a multi-faculty collaboration, not just health and life sciences. Apologies were given for the confusion around dates & times, which were due to restrictions on the Secretary of State's diary.

Resolved:
The Futures Committee received an update on the Northern Institute for Child Health & Wellbeing.

24/25/55 Pillar Two: Develop Our People – overview and update

KB gave a brief update on the current position, noting that resource has been secured to support the development of pillar scoping and design of professional development focussing on career pathways & development. Work on profiling careers is on track along with integrating Futures into the wider workforce development work. In terms of resource secured, work can now begin on scoping the parallel track for Innovation and look at profiling Futures roles further along the pipeline five to ten years ahead. Starting Well funding has been secured for early career researchers which links into the work supporting non-medical clinical researchers.

Resolved:
The Futures Committee noted the update on work in the Develop Our People Pillar of the Futures Strategy.

24/25/56 Clinical research development programme for non-medical staff

SA welcomed Professor Lyvonne Tume, Programme Director for the Clinical Research Development Programme for non-medical healthcare professionals, who gave a presentation on the programme.

A discussion followed with the following points raised:

- Alignment to Futures objectives with interlinking between education and research;
- Not all Futures specific but there are elements that will flow into Futures;

- Alder Hey within top 10% of hospitals across England in non-medical research programmes;
- Not yet linked to multi-university Equity in Doctorial Education partnership programme:
- Low numbers of publications and external presentations being made:
- External skills resources identified to support training on writing for publication & presentation:
- Not all studies are disseminated internally in line with Research Strategy but are assessed and reviewed for effectiveness:
- UTC evaluation would be useful for business case and for taking to ICB:
- Need to be clear links between initiatives and 2030 Strategy:
- 2024 workplan to be taken to Strategy Board:
- Work external to CRD is feedback and evaluated at Divisional level:
- Resource is an issue:
- The Charity have supported this work for some time.

Slides to be circulated following the meeting.

24/25/56.1 **Action: AG**
2024 list of projects to be taken to Strategy Board

24/25/56.2 **Action LT / SL**

Resolved:
The Futures Committee received a presentation on the clinical research development programme for non-medical staff.

24/25/57 **Pillar Three: Grow – overview and update**

SL shared a slide showing progress for Pillar Three, noting that work is ongoing to secure external investment by building upon the grant-achievement track record and establishing a professional bid writing and coordination service with horizon scanning; to growing new revenue streams through the development of partnerships with commercial, not-for-profit and public sector organisations; and to enable productivity and efficiency by creating clinical capacity.

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

24/25/58 **NIHR capital award and CRF funding**

SL gave a brief update, noting that further NIHR funding of £1.1m has been secured with a funding extension until 2029 for the Clinical Research Facility also granted.

Resolved:
The Futures Committee received an update on the NIHR capital award and CRF funding.

24/25/59 **Investment Zone Green Book**

DC gave a brief update on the current position following review of the submission to the LCR, noting that the feedback was that the Paediatric Open Innovation Zone proposal was a “very compelling case”. The next step is to work with the LCR for external panel review in November, and if successful that will be followed by internal panel review in December. Emphasis has been made to areas of collaboration across the LCR, with further detail provided on some areas. JC noted that it is expected that

final decisions will be made in the New Year and that as it is still very much a work in progress.
The Committee discussed the governance process for sign off of the proposal before submission. SA raised a concern that the business case involved a possible change in strategic direction which would then need committee sign off. JK raised concerns over delivery risk and financial commitments made without committee approval. RL responded that an internal process for bid sign off is under review at Executive level.

Futures Committee to be updated on bid submission process flow.

24/25/59.1 **Action: RL**
RL & JC to define exceptions to process for research grants.

24/25/59.2 **Action: RL/ JC**
Bid visibility protocols & exceptions to be brought to future Futures Committee.

24/25/59.3 **Action: AB / AG**

Resolved:
The Futures Committee received an update on the Investment Zone green book.

24/25/60 **Strasys Partnership**
The Committee received an update from MJ on the partnership with Strasys which has now been in place for over twelve months. An initial investment of £250k from Alder Hey has been matched in Year 1 by Strasys, although currently there is a net balance owing to Alder Hey after this year, for which there are action in progress. It is proposed to extend the agreement by a further twelve months from the end of Year 2 and work will begin on securing appropriate contractual agreements to protect IP, data etc. Work has progressed from reviewing many projects and ideas from Innovation and focus is now settling on some specific, larger scale strategic opportunities to progress to next stages. These include work in the Global arena, within workforce decision intelligence and building on the Vision 2030 with opportunities for Alder Hey to have a louder voice both nationally and internationally. There will also be a refresh for Year 2, both in line with changes in leadership and for governance overall.

JK noted the need for parameters and also some visioning of what “stop” looks like. JG noted that this and the direction of travel will be included within the contract for Year 2. SA requested that Global be an agenda item for the next meeting to discuss available opportunities and development.

RL to manage contract process for Strasys partnership Year 2.

24/25/60.1 **Action: RL**
Global to be an item on next Futures Committee agenda.

24/25/60.2 **Action: AG / AB**

Resolved:
The Futures Committee noted the Strasys Partnership update.

24/25/61 **Securing new investment: horizon scan and status update**
DH gave an update on potential opportunities that have been identified, noting that the trust were awarded £3.2m from the NIHR capital investment fund to purchase the new MRI scanner, which is now in place. The first patients will be from Manchester via an agreement to support reductions in their waiting times. The CRF contract has been extended to 2029, bringing in a further £621k of funding. There have also been further capital awards from NIHR for ophthalmology equipment, additional MRI equipment to enhance range & quality of imaging for certain conditions and a mobile research unit, all of which will enhance research and clinical ability at Alder Hey. There was some

discussion around the increased capacity of the scanning suite enabling existing equipment to be available for private / non-NHS / external user with the potential to generate income to offset running costs of approx. £1m over three years. The MRI scanner will also undertake imaging for the AMRC funded C-GULL research project with the University of Cambridge. DJ noted the connection to Jenny Dalzell for work around North Liverpool & Sefton; DH added that work is ongoing to develop models for those areas that ensure the costs are covered.

SL gave a brief update on new investment, noting that since March 2024, £3m had been achieved by Research & Innovation in direct awards, including £220k for the Little Hearts at Home project, which has been funded by the British Heart Foundation. There is a further £7m of funding awaiting decision, which includes the Paediatric Open Innovation Zone application of £4.1m. SL also explained the process for holding funding for multi-collaborator projects. DH added that it is planned to seek agreement with UoL that Alder Hey will hold NIHR monies awarded for projects as we receive RCF, while they will hold non-NIHR grants as they receive their HEE funding on the bottom line of those funding awards and this would maximise the income for each partner. RL agreed that this would be a good positive development.

SL also shared an update on horizon scanning across a complex landscape, noting that the majority of forthcoming opportunities are likely to come from a small number of known funders, and the team must capitalise on the extensive knowledge and experience held by colleagues. This resource is not widely known or recorded and must be tapped into as part of the process of funding readiness. Mapping this resource, along with key relationships and collaborations, preparation of documentation & risk registers is part of the proposed approach, which with the formation of a central register of grant opportunities will build deeper insight into what future opportunities could exist.

Resolved:
The Futures Committee noted the update on securing new investment and horizon scanning.

24/25/62 Pillar Four: Transform - overview and update

The Committee received a brief update on the Transform pillar, noting that a Clinical Insights Lead is to be appointed to provide some dedicated resource to support development of this Pillar. The Lyre Bird contract is due to be signed shortly, with small pilots are expected to start in Outpatients and Neurodiversity, and a demonstration will be given at the next meeting. Work is ongoing with the Data Strategy project, with a recent workshop and conversations between key leads and the governance group to ensure it is developing in line with the aims. Supplier engagement for the patient portal to support implementation of Alder Hey Anywhere is also due to begin with a preferred supplied expected to be selected by the end of October.

JG asked if there was to be a bigger review of the Alder Hey strategy as part of the work on Alder Hey Anywhere; LB noted that will be part of the wider governance piece, with scope and terms of reference to be finalised. SA asked that the Data Strategy is given time on the next agenda to inform the committee. DJ asked if there could be a conversation outside the meeting to confirm the connection between the new Clinical Insights Lead and the overarching strategic long term outcomes dashboard.

24/25/62.1 LB to bring Lyre Bird demonstration to November meeting
Action: LB / KW

24/25/62.2 Conversation around Clinical Insights Lead & measurement of long-term outcomes to take place outside the meeting
Action: DJ / LB

Resolved:
The Futures Committee noted the Transform Pillar update.

24/25/63 AI Coding Case Study

The Committee received a brief update on the AI Coding project in conjunction with Phare Health, which hopes to utilise AI to augment future ability by improving of accuracy of clinical data and reducing potential financial penalty for mis-coding which excludes a procedure or acuity from being counted. GA noted that the outcomes of increasing accuracy and relieving burden on coding staff would include summaries with key allocation reasons, linking back to supporting documentation, highlighting unclear documentation and identifying trends and issues in advance by use of cross-specialty and provider analytics. As part of the partnership, the system developers utilise clinical coding knowledge for training the AI and enabling it to re-learn finer nuances. The proposed partnership would be a commercial model, with the expectation of the fixed implementation fee to be recoverable by the benefit gained, with a risk share-based fee of additional revenue / savings paid by Alder Hey and potential revenue share from commercial sales within the UK.

JK asked for clarification of the financial impact of incorrect coding; RL replied that it hasn't been valued but that knowledge in terms of monthly worth would be very useful evidentially. SA & DJ both noted that there will be a limit on how much the ICB will actually be able to fund in any given year. RL noted that while there will be work not being done that is paid for, there will also be work being done that is not paid; there is always the risk that ultimately Commissioners may state they will not pay, but that would be a different conversation. JG noted that it is really important to front this with the benefits to CYP, what the patient benefits will be. AB noted that there are emerging pressures on infrastructure, the data warehouse, capacity of data engineers, the secure data environment etc. and agreements need to be reached on that infrastructure, otherwise everything will be slowed down. This and Lyre Bird are good examples of having commercial partnerships rather than contracts, with both of these projects being early case studies for the Accelerator. RL agreed that the case needs to be changed around; it also needs to be clear and not shy away from conversations around workforce changes in the future due to the difficulty of recruiting clinical coders. JG noted there needs to be thought about being agile in implementation. Discussion followed around implementation timescales which are between 6-12 months, with the general view being that implementation rather than running a pilot and defining the proposal should be run in parallel, to enable traffic build and constructive discussion. DJ asked whether there is clarity around learning strategic intelligence from the AI augmented approach, for example around more complex cases and how many struggle with accessing multiple services; GA replied there is certainly capability to answer the question and produce intelligence outputs. JK asked whether there would be the ability to develop coordination of care, for example if a child is having anaesthetic for one thing whether they can have dentistry done at the same time; GA noted that will be one of the questions put to the Phare Health team.

Resolved:
The Futures Committee noted the presentation around AI Augmented Coding.

24/25/64 Research and Innovation Finance Report

EK gave a brief overview of the Research and Innovation Finance Report, noting that there has been little change over the quarter. Income is forecasting slightly ahead of plan with £2m income and £1m costs. Full spend is still forecast for Legal, Marketing and Seed Fund, but all have some levers to reduce if required. Research are £200k underspent YTD and are forecasting to retain that position to year end.

Resolved:
The Futures Committee received the Research and Innovation Finance report.

24/25/65 **Overview of Operational Performance in Research and Innovation**
The Overview of Operational Performance in Research and Innovation paper was taken as read with no comments.

Resolved:
The Futures Committee noted the Overview of Operational Performance in Research and Innovation update.

24/25/66 **Programme summary overview**
The Programme Summary Overview paper was taken as read with no comments.

Resolved:
The Futures Committee noted the Programme Summary Overview.

24/25/67 **Risk Register Overview**
The Committee received a brief update on existing risks.

Resolved:
The Futures Committee noted the Risk Register update.

24/25/68 **Board Assurance Framework (BAF) and Risk Appetite**
The Committee received the Board Assurance Framework Report (BAF) for August 2024. SA noted that in the absence of ES this report would be taken as read.

Resolved:
The Futures Committee noted the contents of the BAF report for August 2024.

24/25/69 **Any Other Business**
There was no other business**.**

24/25/70 **Review of the meeting**
The Chair felt that the meeting was very productive with rich discussion and a lot of work ahead. It was noted that the Strategy document was very well written with its supporting implementation plan. The Chair thanked everyone for their feedback on the various agenda items discussed during the meeting and looked forward to the next meeting. It was confirmed that there were no areas of concern to be raised with other Assurance Committees.

Date and Time of the Next Meeting:
26th November 2024, 1pm.

0119 VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 5th December 2024

Paper Title:	**People Plan Highlight Report, encompassing:** • One Alder Hey & Thriving • Professional Hub • Future Workforce
Report of:	Melissa Swindell, Chief People Officer
Paper Prepared by:	Jo Potier, Associate Director of Organisational Development Sharon Owen, Deputy Chief People Officer Katherine Birch, Director, Alder Hey Academy

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

Does this relate to a risk? Yes ☑ No ☐
If "No", is a new risk required? Yes ☐ No ☐

Risk Number	Risk Description	Score
2.2	Culture	

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 paper outlines the progress made against core workstreams of the People Programme, as agreed at Trust Board October 2024. Together they comprise the key elements of our culture evolution, creating the right conditions for our people to thrive, learn and work differently to deliver a healthier, happier fairer future for CYP.

It will focus on the priority actions agreed at October Board in these workstreams for 2024-26 which are: inclusion & belonging (EDI), a revised set of values, restorative just and learning culture, thriving leaders framework, thriving teams index and thriving staff index. These are complemented by a refreshed framework to support personal and professional development, alongside a focus on our Future Workforce.

Significant progress has been made in EDI and the thriving leaders framework with progress also being made in restorative just and learning approaches and support. Progress against the Thriving Staff Index has been slower than anticipated due to internal resource constraints. Scoping is underway to develop the Thriving Teams Index and the work to revise our values is yet to be scoped. Progress against key actions within the Professional Hub workstream are on track. Wider discussion will be required into 25/26 in respect of talent management to support this programme.

Inaugural discussions have taken place in respect of the diversified and accessible recruitment workstream. Some immediate interventions have been identified to removing barriers and taking positive action to promote more inclusive practises, whilst identifying key strategic work to achieve the vision of becoming a great place to work that attracts and retains the best talent, as well as becoming and exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside.

Both the ED&I steering group and Networks are identified key stakeholders and ‘critical friends’ to the diversified and accessible recruitment workstream. Regular meetings into 2025 are currently being scheduled to support this wider programme of work.

2. Background

To achieve Vision 2030, the Board have agreed that by 2030 our aim is to have:

- One vision for CYP and staff
- One Alder Hey where everyone belongs
- One inclusive community united by a core set of values expressed by everybody, everyday, everywhere, in every interaction
- One unifying approach for individuals, leaders, teams, organisation, reducing inconsistency of experience & performance
- One integrated safety culture
  AND
- Values & behaviours that are clear, agreed, visible and translated into lived experience for every member of staff
- A real time feed of staff & team functioning (measuring success & difficulty)
- Intelligence that is used effectively to create systems that continually improve the quality of management (& intervene early when problems arise)
- Empowered teams able to manage issues themselves with clear guidance on where to go if need support

- Development opportunities which are more personalised, more frequent and cover the whole life cycle of people's time with us, whatever their job role or level
- Colleagues feeling supported to develop new skills (aligned to our core priorities/Futures) and to adopt new ways of working
- A great place to work that attracts and retains the best talent
- An organisation that is an exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside
- Exemplar People Practices. Working in Partnership with staff side and unions to create a positive working environment and adopting best people practises, thus preventing avoidable employee harm
- Business Critical roles that are identified with a diverse and readily available pipeline for replacement.
- Embedded new roles that focus on the skills, values, tasked and competencies to complement our existing roles to deliver future models of care.
- A clinical strategy that is underpinned by sustainable workforce models and workforce plans

3. Priority actions:

One Alder Hey & Thriving

A full list of the priority actions can be found in Appendix 1. Of note for the Board is progress against the following actions:

Inclusion & belonging:

- The Alder Hey Anti-Racism Statement and Commitment has been approved and launched at 'Ask the Execs'. We will continue to promote our commitment and work towards fulfilling the objectives set out in the statement. We will continually evaluate the progress against the actions we have set in the statement.
- Our staff networks continue to be a driving force of positive change, supporting the workforce, working to enhance the experiences of our staff working at Alder Hey. At the November Trust Board, the networks presented their 'asks' to the board in terms of support and actions and we are working with the network leads to support these actions.
- The Trust has undertaken a range of activities to support the implementation of the NHS EDI Improvement Plan and the 6 High Impact Actions. A full action plan with key actions and progress against the plan is monitored through the Trust ED&I steering group.

Values:

- Revised values work to be scoped and agreed

Integrated safety culture:

- Avoidable Employee Harm workshop held with senior HR team to reflect on current state and assess work needed to embed restorative just and learning approaches into all people practices. Agreed to convene a second workshop to collectively define avoidable employee harm and assess changes needed to policy and practice to reflect the evolving culture.
- Ensure work relating to staff safety culture and patient safety are aligned and visible to the People Committee and Patient Safety Boards.

Thriving Leaders framework:

- Clinical Leads listening exercise complete with 50 interviews held with clinical leaders from across the 3 main professional groups. Feedback presented to Clinical leads at the

Clinical Leaders summit in November. Programme of work to commence to focus on leadership design, development and support based on the data gathered.
- Management Essentials programme reviewed with core HR training programmes now to be developed for inclusion.
- Aspiring Chief Medical Officer programme announced at the Clinical Leaders summit with call for expressions of interest from medical colleagues.
- Coaching offer in development with Transformation colleagues for groups of leaders across the trust to engage them with and empower them to deliver Vision 2030.

Thriving Teams:
- Thriving Teams MDT operational to more effectively, and collectively, address the needs of fragile teams and services
- Thriving Teams Index currently being scoped including resource and capability needed to develop the Index. To be explored further with Futures with a view to harnessing expertise from research, digital and innovation.

Thriving Staff Index:
- Resource and capability secured to further develop the Index for full implementation in January 2025

Professional Development / The Development Hub
A full list of the priority actions can be found in Appendix 2. Of note for the Board is progress against the following actions:

- Detailed mapping of roles and **career pathways** is underway, capturing the opportunities available for staff across a number of core staff groups, grades areas and roles.

- Development of **virtual hub**. The design and development of a virtual hub is on track. The new Hub will provide a range of information, advice and guidance (IAG) for colleagues as well as offering the opportunity for 121 discussions. IAG will include, inter alia, information on career pathways, preceptorship and preceptorship+, apprenticeships, coaching and mentoring as well and signposting to internal and external workshops and courses, signposting and funding support. Colleagues will also be able to access a detailed and focused skills scan which will inform and support next step discussions, as applicable. Discussion is ongoing as to the location of the physical hub.

- Following feedback from colleagues about the nature and type of support which they would find useful (recruitment focus), **new sessions and guidance** have been developed to support staff in applying for new roles / redeployment. These are currently being piloted.

- An **extended programme of learning and development** opportunities is now in place (including a wide range of clinical and non-clinical opportunities). Full details are in the Prospectus, available on the Intranet and also accessible from staffs' ESR landing page. These are complemented by additional local development opportunities. The L&D are working with subject matter experts and key leads to continually review and refresh the programme.

Future Workforce

A full list of the priority actions can be found in Appendix 1. Of note for the Board is progress against the following actions:

- **Diversified and accessible recruitment –** inaugural meeting has taken place to identify some immediate interventions as well as exploring key strategic initiatives to achieving vision

2030. The Trust wide Recruitment & Selection training is currently being rewritten and will include much more interactive practice on ED&I and will include input/sessions from our Network chairs. Recruitment and Selection training is scheduled to be relaunched in February 2025 for all those who are involved in Trust recruitment processes. Review of all traditional recruitment methodologies is underway and introduction of enhanced and user-friendly assessments, with particular review on neurodiversity and the impact of the traditional panel interviews on candidates who are neurodiverse. 'Golden ticket' process in place for supported internships and scoping other areas where a similar process can be offered. A review of Consultant Recruitment process is also underway.

- **People Practices -** The Deputy Chief People Officer is working closely with the Staff side Chair as well as union leads to enhance the partnership agreement and approach by adopting an approach of everyone learning to improve in respect of people practices and embedding a just and restorative culture. Sessions led by the Deputy Chief People Officer and Associate Director of Organisational Development will take place Jan/Feb 2025 with Staff side and HR colleagues on avoidable employee harm through people practices.

- **Supporting Services and Teams –** review of Trust Workforce planning is underway and aligned to the workforce efficiencies programme that is currently in place and led by the DCPO. Comprehensive workforce planning templates are being drafted, to shape discussions aligned to vision 2030 as well as operational need. HR and finance colleagues working closely on Trust workforce numbers currently.

4. Conclusions & next steps

Whilst there has been good progress against some of the priority actions, focus needs to be given now to the revised values, safety culture and the development of the new thriving metrics alongside embedding refreshed approaches linked to staff development and establishing strong partnership working to embed just and restorative people practises.

Appendix 1: One Alder Hey & Thriving Priority actions

Our Strategic Ambitions	How are we doing?	Priority Actions	Evidence of success?
One Alder Hey where everyone is included and belongs	Staff networks fully established and active Improved WRES & WDES indicators	Assess belonging across the Trust through listening events and data gathering Inclusive teams to share learning with teams who are struggling and mentor/buddy Enhance EDI training including Inclusive Leadership component of Strong Foundations Ensure that our recruitment and development practices are values-based and inclusive	Improved WRES & WDES Staff Survey Thriving Teams Index
One core set of values expressed by everybody, everyday in every interaction	Our current values are not fully owned or understood, not observable or embedded in all of our processes and practices. Our behavioural framework has become obsolete and needs revision with local ownership	Engage organisation in conversation via service based listening events around a revised set of values Develop corporate and locally "translated" behavioural frameworks to enhance meaningfulness and ownership Develop and deliver training in the new values Revise branding and make new values visible across the organisation Incorporate meaningfully into recruitment, PDRs, job descriptions etc.	Values are visible, usable and translated into a lived experience for everyone who works here Staff Survey data Improved safety culture indicators (Thriving Teams Index) Improved Thriving Staff Index Improved WRES and WDES
One integrated safety culture where patient safety and staff	Safety culture part of new Patient Safety framework	Roll out Safety Culture training with Human Factors across the Trust	Improved Safety Culture indicators Increased error reporting

safety are connected and viewed through a unifying restorative, just and learning lens.	Safety culture training developed and piloted in PICU Proposal for implementation across the Trust developed and being considered Restorative, just & learning approaches trialled through recent Learning Review HR policies reviewed through a restorative, just & learning lens and workshop planned to discuss Avoidable Employee Harm (AEH) and restorative, just and learning practices with HR team	(combining resources and expertise from the STAT programme) Define Avoidable Employee Harm in the context of all People processes and practices with a view to enhanced recognition, prevention and mitigation of risks and harms identified. Implement restorative practices into people processes Progress the development of an Integrated Safety Committee/Forum	Incidence of Learning Reviews Staff and family experience of learning reviews Improved learning from errors Staff Survey Thriving Teams Index Reduced contacts to SALS and FTSU following employee investigations, organisational change processes. Reduced incidence of detriment after speaking up to FTSU

Our Strategic Ambitions	How are we doing?	Priority Actions	Evidence of success?
Thriving Leaders framework to develop and support our leaders to deliver Vision 2030	Strong Foundations reviewed and refreshed with increased capacity to train more leaders every year. New programme includes sections on Culture, Kindness and Belonging Management Essentials programme launched and being reviewed Clinical leaders listening sessions underway to inform Clinical Leadership design, development and support Operational leaders programme	Clinical Leadership programme of work to be agreed following feedback from listening sessions at next Clinical Leaders summit Progress development of Operational leaders programme with key stakeholders Continue to develop the Management Essentials programme with priority focus on key HR training and EDI Develop Leadership Faculty (see Professional Hub)	Staff Survey Thriving Teams Index Standardised leadership job descriptions with agreed set of core leadership competencies reflecting values and responsibility in building culture

	proposed and being scoped Internal coaching and mentoring service active Leadership induction developed including focussed leadership development conversation for all new leaders Links with NW Leadership Academy strengthened by CPO Board membership	Embed measure of leadership in Thriving Teams Index	
Thriving Teams Index to provide a real-time measure of team functioning to reduce inconsistencies in team experience and performance across the Trust	Thriving Teams MDT operational and building shared intelligence and effective intervention with teams. Currently not formally reporting Working Safe & Well team temperature check developed and used by OD team as diagnostic and outcome measure for team-based interventions	Thriving Teams Index to be developed to measure: Safety culture (including FTSU data); Wellbeing/stress; Belonging (include data relating to discrimination); Engagement; and Management for sustainable engagement. Linked to relevant worforce metrics, patient experience measures and relevant qualitative data. Secure resource and capability to develop and pilot the Index	Thriving Teams Index developed and used routinely by teams. Data reported to People Committee
Thriving Staff Index to provide a real-time measure of staff personal and professional wellbeing	Index developed and pilotted. Being scoped for further development by the Innovation team	Resource and capability secured to further develop the Index for full implementation in January 2025	Roll out of the Thriving Staff Index TSI response rates increasing

Appendix 2: PERSONAL & PROFESSIONAL DEVELOPMENT			
Our Strategic Ambitions	How are we doing?	Priority Actions	Evidence of success?
Development opportunities which are more personalised, more frequent and cover the whole life cycle of people's time with us, whatever their job role or level	Progress on track Enhanced programme of L&D opportunities available (now moved to BAU) Core pathways being mapped Generic support and guidance to support staff in applying for new roles / redeployment [currently being piloted] 25/26 detailed analysis of participation to inform discussion re. enhanced offer for under-represented groups Some **challenges remain** in terms of time to learn and differential in funding available by staff group	Establishment of the Hub (virtual 24/25; physical 25/26) Detailed mapping of a number of core roles and career pathways 24/25; 25/26 Suite of clear career pathways guidance and advice in place Effective information, advice and guidance in place to support those new to the organisation and under-represented groups Expand programme of L&D opportunities	Hub (virtual) offering IAG which is positively rated by staff (detailed metrics in development – also linked to Matrix accrediation for IAG) Increase in staff survey metrics (we are always learning) across all staff groups Enhanced focus on personal development within appraisals and talent conversations L&D embedded from the outset (induction onwards)
Colleagues across the organisation actively engaging in conversations about their role, their development, their ambitions and feeling supported to achieve these	Revision to TNA framework (24.25) Review of PDR process Some **challenges remain** in terms of time to learn and differential in funding available by staff group Talent management strategy required	Refreshed approach to PDRs and TNA at team and individual level Managers Toolkit reflects team and individual expectations	Enhanced focus on personal development within appraisals and talent conversations Increase in staff survey metrics (we are always learning and feeling suported) Hubusage and associated KPIs

Colleagues feeling supported to develop new skills (aligned to our core priorities/Futures) and to adopt new ways of working	Initial mapping underway Refreshed L&D programme (to reflect different ways of working) being explored Clarity required from wider leads as to the knowledge, skills & behaviours implications of new ways of working	Incusion of Futures focus in career mapping exercise 25/26 Refreshed programme which links shifts required in terms of knowledge and skills to development opportunities.	L&D offer reflects core workstreams across Vision 2030. Targeted suport for specific roles / groups

Appendix 3.

Our Ambitions	Progress	Priority Actions	Evidence of success
We are seen as a great place to work, that attracts and retains the best talent **&** **We are an exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside**	Digital capabilities have streamlined and improved transactional recruitment processes. Candidate experience is largely positive. Reductions seen in time to hire as a result of automation. These changes have now allowed for review of candidate experience	Focus on enhanced employer brand – (Vision 2030), as part of our attraction strategy. What makes us stand out from other employers (USP) – Develop Values based recruitment (Link to Culture) Develop suite of recruitment material for advertising- bespoke packages for hard to fill roles. Recruitment tailored to meet needs of those from under presented backgrounds, working with local community organisations and LCR. WRES/WDES actions to be embedded. Including removing barriers via traditional recruitment methodologies (Golden ticket – for supported interns) Review and enhance Consultant recruitment, induction and development process. Using new approach as a	Stable turnover rates. Diverse pool of experienced candidates Positive candidate and Recruitment Manager experience. Increased % of underrepresented groups appointed. Reduced time to hire. Improved patient and colleagues experience (Staff/patient survey) Reduced Vacancy rate

		blueprint.	
A leader demonstrating best practice in people Practices. Working in partnership with staff side and unions to create a positive working environment, and adopting best people practices, thus preventing avoidable. employee harm	Policies relaunched in line with a just and restorative approach. Working closely with Staff side colleagues	The implementation, coaching and education of the people policies is crucial in creating a positive working. environment. It is therefore the vision that training and education on people practices is also undertaken in partnership, also adopting a learn & improve approach.	Reduced Grievances, Disciplinaries & ET's
Ensuring business critical roles identified, with a diverse and readily available pipeline for replacement	Job redesign/review currently in place, at point of Organisational change. Enhanced processes in respect of Job evaluation in place.	Future Talent management development Identify plans for Executive roles and critical service roles AH Community Portfolio careers (beyond retirement) Future entrepreneurs Identify future role requirements for revolutionising care.	Staff identified for all business critical roles Reduced time to hire for business critical roles Increased job satisfaction (staff survey) Workforce pipeline identified with increased stability reduced turnover

We will create new roles that focus on the skills, values, tasks and competencies to complement our existing roles to deliver future models of care. **We will ensure that delivery of the clinical strategy is underpinned by sustainable workforce models and workforce plans**	Annual operational planning in place. Development of Workforce planning templates in development to support consistent workforce plans across the Trust	Consistent methodology for developing robust plans at divisional level	Reduced Temporary and variable workforce spend

BOARD OF DIRECTORS

Thursday, 5th December 2024

Paper Title:	**Chair's Report from the People Committee meeting held on 13th November 2024**
Report of:	**Jo Revill, Committee Chair**
Paper Prepared by:	Jo Revill

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information:	People Committee papers from the meeting that took place on the 13th November 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 ☑ **Strong Foundations** ☑
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks						
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 People 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

- PC received the Internal Communications update report. The report highlighted the successful Staff Star Awards, which has really excellent feedback from all attendees. The Communication Team continue to forward plan all future activities.

- PC received a progress update on the people plan, with an updated Plan and refreshed workforce segmentation data.

- PC received the Trust Wide Metrics: PDRs remain an area of focus.

- PC received the Divisional Metrics Reports. Divisional metrics continue to be managed and maintained by the divisional senior leaders with a continued focus on Appraisals, Mandatory Training and Sickness Absence.

- PC received the Workforce Efficiencies update and received good assurance on progress to date.

- PC received the Organisational Health & Wellbeing Plans and received a good overview of current progress and activities taking place across the Trust.

- PC received the Raising Concerns/FTSU update. All ongoing projects remain on course.

- PC received the Non-AFC Pay Update. The Committee agreed the proposal to apply the 5.5% pay award to on-call allowance payments, backdated to 1st April 2024.

- PC received the Health & Safety Dashboard. The Committee received good assurance of activity in this area.

- PC received the Equality, Diversity & Inclusion Plan – Monitoring Process of High Impact Changes. The Committee received assurance that all high impact actions continue to progress.

- PC received the Board Assurance Framework.

- PC received the BAF Risk 2.3 (EDI).
- PC received the LNC Minutes for information.
- PC received the EGC Minutes for information.
- PC received the Health & Safety Minutes for information.
- PC received the EDI Steering Group Minutes for information.

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

Key risks all being managed, the deep dive of BAF risk 2.3 demonstrates strong understanding of the risk and appropriate actions being taken.

4. Positive highlights of note

Good progress on the next iteration of the People Plan in support of Vision 2030**.**

5. Issues for other committees

n/a

6. Recommendations

For the Board to note progress on all key strategic areas.

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 19th September 2024
Room 6 (Mezzanine)

Present:

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

In attendance:

Joe Fitzpatrick	Internal Communications Manager	(JF)
Veronica Greenwood	Acting Director of Allied health Professionals	(VG)
Audrey Chindiya	Associate Finance Director	(AC)
Sharon Owen	Deputy Chief People Officer	(SO)
Darren Shaw	Head of Organisational Development	(DS)
Kerry Turner	FTSU Guardian	(KT)
Jennie Williams	Head of Quality Hub, Brilliant Basics	(JW)
Angela Ditchfield	EDI Lead	(AD)
Adam Bateman	Chief Operating Officer	(AB)
Garth Dallas	Non-Executive Director	(GD)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Nathan Askew	Chief Nursing, AHP and Experience Officer	(NA)
Jill Preece	Governance Manager	(JP)
Alfie Bass	Chief Medical Officer	(AB)
John Chester	Director of Research & Innovation	(JC)
Urmi Das	Director, Division of Medicine	(UD)
Pauline Brown	Director of Nursing	(PB)
Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
Greg Murphy	Local Security Management Specialist	(GM)
Lisa Cooper	Director of Community & Mental Health Services	(LC)
Julie Worthington	Staff Side Representative	(JW)

24/25/039 **Declarations of Interest**

No declarations were declared.

24/25/040 **Minutes of the previous meeting held on 17th July 2024.**

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

24/25/041 **Matters Arising and Action Log**

Action log was updated accordingly.

Alder Hey Children's NHS Foundation Trust

24/25/042 **Internal Communications Update:**

The Committee received the Internal Communications Update report. JF drew the committee's attention to the following highlights:

The Internal Communications Team continue to plan activities in connection to the People Plan agenda.

The Internal Communications Team continue to monitor the effectiveness of internal emails and are continuing to trial an analytical process with the Medication Safety Group and the Pharmacy Team with a view to rolling out to other service areas.

JF noted that following the Southport incident the internal comms team are continuing to provide a sense of assurance and safety as a priority across the organisation. There are plans in place to re-start event sessions and a re-launch of the weekly broadcast meetings in support of safety and reassurance for our colleagues.

Alder Hey Staff Awards had received 133 nominations to date with each one detailing a patient story. The Team plans to revisit and push this forward in terms of sharing more widely for awareness.

JR asked how the team plan to carry this success forward. JF stated that various data was being used to think about how we move forward more widely. JF went on to inform colleagues that as part of individuals' induction process there are plans and opportunities to share stories internally and externally. Further plans for 2025 are now in motion.

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

24/25/043 **Monitor Progress against the People Plan:**

The Committee received a verbal update on the progress against the People Plan. MS drew the Committees attention to the following:

MS noted following recent feedback, sessions have now been arranged relating to the direction of travel, deployment and resources aligned to the trust board commitment and 2030 Vision following existing evidence. All action planning continues to head in the right direction in terms of progressing the people plan agenda.

MS added next steps will consists of a piece of work to be undertook alongside Strays in support of refreshing and resetting data.

Resolved: The Committee noted the contents of the People Plan update.

Trust Wide Metrics

The Committee received the Trust Wide Metrics report.

The Committee received and noted the content of the metrics report which showed a good trend of improved data across the Trust. All areas will undergo initial focus to manage and maintain in line with trust guidance.

- **Divisional Metrics**

Surgery Division

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

- Mandatory Training reported at Trust target.
- Staff Turnover shows a slight increase in August data due to the Junior Doctors turnover. All data continues to be closely monitored.
- PDR compliance remains stabilised with action plans in place to address and monitor across service provisions.

JR asked if there are any underlaying issues we could identity resulting in timeframes being met. CL provided assurance that all data was being reviewed and is being regularly monitored to ensure all deadlines are met accordingly.

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

Clinical Research Division

The Committee received the Community & Mental Health Division metrics report (August 2024) data and noted progress to date. SL pulled focus to the following:

- Turnover reported slightly below trust target. Hot spot areas continue to be monitored for opportunities of improvement.
- Sickness Absence shows an improvement in long term sickness. Short term sickness shows no change. All cases are managed and maintained accordingly in line with trust guidelines.
- Mandatory Training is above trust target and making good progress.
- Return to Work is 100% to date.
- PDR Compliance continues to be well managed with action plans in place to cover the next 12-month period.

SL informed the committee there are wellbeing activities taking place across the trust which includes big conversations to help improve figures.

The Innovation Team will hold a sleep session to talk about how we can improve our sleep as part of our wellbeing activity.

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

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (August 2024) data and noted progress to date. RG highlighted the following:

- Turnover remains high but stable and continues to be monitored.
- Sickness Absence shows an increase above trust target compared to previous months data. Plans are in place to stabilise and monitor.
- Mandatory Training remains high in connection to medical appraisals. Senior Leaderships continue to monitor and manage to help stabilise.
- PDR compliance appears slightly below target for the rolling 12 months period. There shows an improvement for band 7 positions and above.

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

Medicine

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

- Mandatory Training is making some positive improvement and remains static.
- Staff Turnover has increased associated with the MARS Scheme. Senior Leaderships continue to regularly monitor across all services.
- Sickness Absence shows positive increase in figures.
- Return to Work has an improved position and continues to be well managed.
- PDR compliance remains challenging with plans to in place to help stabilise. Division is now taking this into account while preparing for winter.

The Medicine division has formed a Wellbeing Committee which took place this month as the first meeting. This has been established as part of a sub meeting for the people committee meeting to help drive improvement across the organisation.

MS referred to the medical appraisals and asked if we could conduct a piece of work to review data in terms of recording to ensure the correct information is being reported.

Action: KB to review medical appraisals reporting to ensure all data is being recorded accurately.

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

Corporate

The Committee received the corporate metrics report (August 2024) data and noted progress to date. ES pulled focus to the following highlights:

- Sickness Absence remains an area of focus for long term sickness. There are robust action plans in place to ensure processes are being followed accordingly
- PDR completion shows an improvement.

- Return to Work reported an increase of over 80% to date.
- Risk Assessments continue to be targeted and managed accordingly.
- Mandatory Training continues to be well managed and maintained supported.

ES noted that the Collaborative Meeting took place in August 2024 and continues to review all metrics data in detail to identify any hot spot areas for priority focus.

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

24/25/044 **Staff Temperature Check**

The Committee received the Staff Temperature Check Report. DS drew the committee's attention to the following highlights:

- The pilot of the Staff Index which launched in 2024 was well received.
- The Innovation Team will undergo some further aspects of work to establish and develop further improvements.
- All ongoing projects will undertake a review to ensure targets are being met in terms of good engagement and communication around the people pulse.

DS added the current data is not where we expected to be in terms of current position but assured the committee there are further deep dives to explore all possible ways of improvement. There is a new proposal being introduced for Quarter in 2025.

The Internal Communications Team continue to provide support on all projects.

Action: DS will report back to the committee in November for an update on progress.

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

24/25/045 **Overpayments**

The Committee received the Internal Communications Update and noted the contents. KJ pulled the committees focus to the following:

- There are some significant improvements to the overpayment position showing a reduced of 29% to date for 2024.
- The last 3 months showed there was 23 cases of late notifications of change. HR continue to support senior leaders to ensure the process is being following correctly and timely.
- HR meet with payroll on a monthly to discuss and review actions including any initial complications.
- An overpayments guidance document will launch to help provide support.
- The overpayments policy is currently being reviewed in line with Finance before it can be ratified.

RG asked if any training sessions are available for managers to support in ensuring all processes are being following correctly. KJ commented advising HR are conducting panel sessions in support of this – all welcome.

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

24/25/046 **Equality, Diversity & Inclusion Plans Update:**

Workforce Race Equality Scheme
Workforce Disability Equality Scheme

The Committee received the Workforce Race Equality Scheme and the Workforce Disability Equality Scheme and noted the contents. AD highlighted the following:

Recent data of the reports shows improvements are being made to ensure colleagues feel safe when in the workplace with ongoing support by the Staff Networks. AD referred to the metrics data shows some challenges ahead and provided assurance noting all developments and processes continue to be well managed and maintained.

JW asked if we are seeing a narrower gap. AD commented advising there appears to display a narrower gap closing in similar in both reports but in terms of similarity we have action plans in place for each with key priorities to help improve all data.

JR referred to the career opportunities and asked what measures are in place around this data. AD assured that the team are working closely with the recruitment team to review all processes including reasonable adjustments and looking at languages to ensure colleagues feel safe while in the workplace.

24/25/047 **Gender Pay Gap**

The Committee received the Gender Pay Gap Report and noted the contents. AD drew the committee's attention to the following:

AD advised the committee has been working with recruitment on showcasing what we are doing at Alder Hey in relation to trust policies and medical support groups. The NHS Employers self-assessment guidance is being reviewed in terms of the disability pay gap and continue to abide to the recommendations on how we support career progression for all colleagues within the organisation.

Resolved: The Committee received and acknowledged the Gender Pay Gap.

24/25/048 **Improving Working Lives for Junior Doctors Report**

The Committee received the Improving Working Lives for Junior Doctors Report. KB drew the Committees attention to the following:

The People Committee received an update on the action plan relating to GRIDE trainee experience together with progress to achieve compliance against the IWL framework and was provided with assurance and oversight. This risk remains on the risk register and has a submission deadline date of March 2025.

KB noted following recent guidance, the title for Junior Doctors will now be referred to as Resident Doctors.

JR asked what it is specifically that makes Alder Hey different to other NHS Trusts. KB commented that Alder Hey provides a good quality of training and engagement. There are various counter parts where Alder Hey exceeds positive communication and engagement across the organisation in comparison to other NHS Trusts. KB added that initial reviews are conducted to highlight and spot areas of challenge to prioritise the need for improvement.

JR asked for confirmation of assurance we have it right at Alder Hey. KB noted there is positive working relationships involving the Medication Team and Rota Lead to achieve good levels of support.

MS formally thanked KB for the detailed update and report.

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

24/25/049 **Annual Employee Relations (ER) Report**

The Committee received the Annual ER Report. SO drew the Committee attention to the following:

There were 33 formal employee relation cases which has decreased compared to 2023 data. This showcases a good downward trajectory in terms of volume. The HR Team continue to follow trust process and further work is being reviewed and guided through following the previous recommendations.

MS highlighted the Disciplinary Policy is under review in light of lessons learnt and will be submitted to the People Committee meeting for final review and ratification by the membership in due course.

Resolved: The Committee noted the contents of the Annual ER Report to date.

24/25/050 **Whole Time Equivalents (WTE) – Workforce Efficiencies Programme**

The Committee received the Whole Time Equivalent – Workforce Efficiencies Programme update. SO highlighted the following to the committee:

There is a challenging push from the ICB following all recommended actions which continues to be well managed.

There is a newly formed workforce efficiency meeting set up to review. The plan is to look at the workforce and previous spend and review in terms of winter planning.

Resolved: The Committee noted the WTE Workforce Efficiencies Programme update

24/25/051 **Board Assurance Framework – monitoring of strategic workforce risks**

The Committee received and acknowledged the Board Assurance Framework Report.

ES noted all mitigations remain stabilised and in place.

ER added, following trust board submission in September 2024 there will be a more detailed profile around appetite in relation to our workforce risks and noted NED input is welcomed.

Resolved: The Committee received and noted the Board Assurance Framework

24/25/052 **Policies for ratification**:

- **The Uniform Policy & Dress Code Policy**

The Committee received the Uniform Policy and Dress code Policy and noted the detailed overview of recent updates.

Resolved: The Committee APPROVED the Uniform and Dress Code Policy.

- **Capability & Performance Policy**

The Committee received the Capability & Performance Policy and noted the detailed overview of recent updates.

Resolved: The Committee APPROVED the Capability & Performance Policy.

- **Supporting Colleagues Policy**

The Committee received the Supporting Colleagues Policy and noted the detailed overview of recent updates.

Resolved: The Committee APPROVED the Supporting Colleagues Policy

24/25/053 **LNC Minutes**

The Committee received the approved minutes of the LNC meeting held on (April 2024)

24/25/054 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the EGC meeting held on (June 2024)

24/25/055 **JCNC**

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

24/25/056 **Health & Safety Committee**

The Committee received the approved minutes of the Health & Safety meeting held on (April 2024)

24/25/057 **Equality, Diversity & Inclusion Steering Group (EDISG) Minutes**

The Committee received the approved minutes of the EDISG meeting held on (May 2024)

24/25/058 **Any Other Business**

No issues raised.

24/25/059 **Review of Meeting – Chair's Report to Board**

Internal Communications:
Internal Comms continues to make good headway in terms of staff engagement and communication.

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.

Annual ER Report
The Annual ER Report shows a decrease in the number of formal cases which is a positive improvement.

Trust Wide Metrics:
The Trust Metrics remains stable and continues to be monitored.

Mitigation remains in place to review manage and maintain.

Policies for Ratification: APPROVED
- **The Uniform Policy & Dress Code Policy**
- **Capability & Performance Policy**
- **Supporting Colleagues Policy**

The Chair noted good progress being made across all areas.

Date and Time of Next meeting.
Wednesday 13th November 2024 at 2pm via Teams

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 5th December 2024

Paper Title:	**Chair's Report from the Finance, Transformation & Performance Committee meeting held on 2nd December 2024**
Report of:	**John Kelly Committee Chair**
Paper Prepared by:	Amanda Graham, Executive Assistant

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☑
Summary / supporting information:	Finance, Transformation & Performance Committee minutes from the meeting that took place on 28th October 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 ☐ **Strong Foundations** ☐
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐

Risk Number/s	Risk Description	Score
BAF Risks	1.2, 1.3, 1.4, 3.1, 3.2, 3.4, 3.6, 4.2	

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

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

- Workforce Efficiency Programme
- Top Five Risks - update
- M7 Finance Report
- 2030 Review of Strategic Progress
- M7 Integrated Performance Report
- Corporate Division update
- Liverpool Neonatal Partnership update
- Campus update
- Approval to progress change of OH service provider

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

- Financial position & mitigations to be taken to Trust Board part 2
- Request for delegation of approval for two capital-funded business cases.

4. Positive highlights of note

- Operational performance is good.

5. Issues for other committees

No issues for other committees.

6. Recommendations

The Board is asked to note the Chair's Highlight report for the Finance, Transformation & Performance Committee meeting that took place on 2nd December 2024.

Alder Hey Children's NHS Foundation Trust

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Monday 28 October 2024 at 1:00pm**
Room 2 & 3, Innovation Park

Present:	Mr J. Kelly	Non-Executive Director (Chair)	(SA)
	Dame. J. Williams	Non-Executive Director	(GD)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. J. Grinnell	Managing Director/Chief Finance Officer	(JG)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mrs. R. Lea	Director of Finance and Development	(RL)
In Attendance:	Mr. N. Askew	Chief Nursing Officer	(NA)
	Ms. J. Halloran	Deputy Development Director	(JH)
	Mr. A. McColl	Associate Director of Finance	(AMc)
	Ms. N. Palin	Director of Transformation	(NP)
	Mr. G. Wadeson	Associate Director of Finance, Income	(GW)
	Ms. A. Chindiya	Associate Finance Director – Operational Finance	(AC)
	Mrs. E. Matthews	Head of Service Development & Performance	(EM)
	Ms. C. Lea	Associate COO – Surgery	(CL)
	Mr. G. Montgomery	Business Accountant – Surgery	(GM)
	Mr. M. Upton	General Manager – Surgery	(MU)
	Ms. R. Greer	Associate COO – Community/MHLD	(RG)
	Ms. E. Evans	Business Accountant – Community/MHLD	(EE)
	Mrs. S. Calderwood	Associate COO – Medicine	(SC)
	Ms. L. Simon	Business Accountant – Medicine	(LS)
	Mrs. J. Dalzell	Associate Director of Strategy & Partnerships	(JD)
	Mrs. E Rees	Executive Assistant (minutes)	(ER)
Apologies:	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. E. Kirkpatrick	Associate Director of Finance	(EK)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. M. Swindell	Chief People Officer	

24/25/105	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
24/25/106	**Minutes of the Previous Meeting** The minutes from the meetings held on the 30 September 2024 were agreed as an accurate record of the meeting.
24/25/107	**Matters Arising and Action Log** The action log was updated.

24/25/108	**Declarations of Interest** There were none to declare.
24/25/109	**<u>Top 5 Risks</u>** **Immediate Financial Performance (including system position)** RL advised that there remains a gap in the system forecast to the plan agreed at the start of the year, and monthly meetings were ongoing involving the ICBs, National Teams and PWC. A weekly command meeting led by the ICB, is in place for the 5 organisations most challenged. All organisations were required to submit a weekly report on areas related to workforce, finance, and efficiency. As yet no feedback has been received on our submissions. It was noted that the NW region was one of the top regions for being off plan, but nationally a number of organisations were in the same position. It is not expected that any funding will be made available for winter pressures as already contained within allocations. **Capital** RL advised that the Trust had not been given its capital allocation yet for 25/26 but it is likely to be a 1 year allocations, moving to 3-year allocations in 2025 with short-term and medium plans. Organisations would likely to be given a base allocation then would start to look at clinical and safety risks and adjust accordingly. JK referred to the issues at year end 2023/24 and that the Trust need to avoid this. RL advised that there was a process in place to ensure this didn't happen again and it was agreed to bring a capital report back in Q4 to ensure the committee were sighted before year end on any issues arising. RL advised that work was in progress on the capital programme and the 5-year capital plan would be taken to Board in November. It was noted that there needed to be a process of review for business cases that have been approved to ensure they were providing the agreed benefits realisation. **Action:** • Capital report to be brought to the meeting in January 2025. (RL) • Benefits realisation information for all the business cases and include review dates when cases are approved to be shared with the committee. (RL) **<u>Efficiency</u>** It was noted that a workforce plan had been established and would be brought back to the meeting in November and that there would be greater focus on workforce at the Strategy Board in December. **Action:** • Workforce update to be brought to the next FTPC meeting (MS).

	Benefits Realisation NP advised that the recent stocktake on the Vision 2030 would form the basis of the Strategy Board in December. It was agreed to bring this back to the next meeting before it went to the Board. **Action:** • The results of the recent stocktake on Vision 2030 to be presented to the next committee meeting before presenting at the Strategy Board. (NP) **Campus** To be presented under the agenda item. **Resolved:** The Committee received and noted the Top 5 Risks.
24/25/110	**Finance Report (Month 6)** AC reported that the Trust was reporting a £1m in September, and YTD the deficit still stood at £2.4m aligning with the overall plan. The Trust are still forecasting a £3.3m surplus for the financial year with a best endeavours approach to deliver an additional £1m above plan to support the wider system. However this is subject to an emerging pressure on the recent pay award which could impact on the Month 7 position and overall year end forecast. Month 6 saw ERF lower than expected but this was off set by underspend in pay and a small income benefit. Non pay remained a significant challenge due to inflationary pressures particularly in Drugs with a deepdive underway. Efficiency savings of £12.9m has been posted recurrently, with the recurrent forecast of £14.1m. **Resolved:** The Committee noted the Finance Report.
24/25/111	**M6 Integrated Performance Report** The Committee received the M6 Integrated Performance Report for Month 6. **Resolved:** The Committee noted the M6 Integrated Performance Report.
24/25/112	**Debt Write Off Report** The Committee approved the write off the three debts above up to the value of £10,585.51. **Resolved:** The Committee approved the Debt write off.
24/25/113	**Medicine Division** The Committee received an update on the current position within the Medicine Division. The key points to note were: • YTD £2.5 from plan mainly due to pay pressures, drugs and non delivery of CIP.

	• Year-end forecast is a significant risk and has deteriorated in month. A mitigation plan is underway to understand what actions can be put in place to recover and improve the overall position. • Actions include; deepdive on drugs, acceleration of business development opportunities including Private Patients, resolution of ongoing pay challenges, and `was not brought` review. **Resolved:** The Committee noted the update on the Medicine Division.
24/25/114	**Community & MHLD Division** The Committee received an update on the current position within the Community and MHLD Division. The highlights were: • YTD favourable position with underspend in pay due to vacancies and income above plan due to additional activity. • Year-end forecast continues to remain a favourable position. **Resolved:** The Committee noted the update on the Community Division.
24/25/115	**Surgery Division** The Committee received an update on the current position within the Community and MHLD Division. The highlights were: • YTD £1.9m adverse from plan but improved position from previous month with key drivers being; improved ERF performance and continued challenge in medical workforce and theatres non-pay. • Year-end forecast has improved since M3 and the financial improvement plan was put in place but does include additional ERF income linked to productivity and throughput. The Committee discussed the various issues of non-pay spend, drugs, activity, and pay issues. **Resolved:** The Committee noted the update on the Surgery Division.
24/25/115	**Business Cases** It was noted that going forward the committee would receive an update on any business cases approved that are below the approval limit for the committee for awareness and transparency. **Resolved:** The Committee noted the item will be a standing item.
24/25/116	**Campus Update** JH advised that the work on the swale is now completed and final works are in progress ready for handback. The next focus was vacating the histopathology building ready for demolition.

	A review is underway of options linked to the sprinkler system with an update going to the Executive meeting in November and Board in December. Development of the overall masterplan continues and ongoing discussions with key stakeholders and partners regarding potential opportunities to develop the site. A group will be put in place including NED lead to take forward with regular updates being provided through the campus report. **Resolved:** The Committee noted the campus update.
24/25/117	**Liverpool Neonatal Partnership** CL gave an update on the programme and highlighted the risks for completion within the timeframes. She noted the report detailed the in-depth financial analysis and identified potential financial challenges that are being reviewed. It was noted that there would be a deep dive taking place on the medical equipment and furniture budgets to mitigate any risk. **Resolved:** The Committee noted the Liverpool Neonatal Partnership Update
24/25/119	**Board Assurance Framework** The Committee received the Board Assurance Framework Report (BAF) for September 2024. **Resolved:** The Committee noted the Board Assurance Framework Report.
24/25/120	**Any Other Business** There was no other business.
24/25/121	**Review of the Meeting** The Chair highlighted that the meeting had been fruitful and the updates gave a good understanding of the Trust's operational and financial performance.
	Date and Time of Next Meeting: Monday 2 December 1pm via Teams

24/25 FTPC Key Risks – Month 7 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M7
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 7 position reported £0.7m adverse to plan – reporting a £1.6m deficit ytd. Forecast for year remains in line with plan £3.3m, however this now includes stretch of £1.2m to mitigate pay award risk. It is unlikely that ambition to go £1m further than plan will now be possible given pay award pressure. A number of mitigations are being explored, including reduction increased technical adjustment, income opportunities and programme/vacancy slippage giving the trust assurance to continue to report a forecast to plan at ICB level. If divisional positions continue to deteriorate additional grip and control may be required to hit plan. System gap remains stands at circa £73m ytd with ongoing national discussions . Weekly gold command now in place FICC return from all providers.	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. Recent discussions with execs re emerging need 2nd CT and Alder Park redevelopment. Commitment to both strategic priorities and need to explore solutions and progress with need to divert CDEL allocation from other areas. . Some head room (circa £0.8m) created by loss on disposal of IT assets in year (disposal of assets with NBV). National funding recently made available for bids that fit certain criteria (e.g. revenue reduction, decarbonisation or national programme at risk). Number of requests submitted – currently awaiting outcome. Detailed forecast being undertaken to highlight risks and opportunities in year.	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	M7 reporting in line with plan and forecast to achieve in full in year. Recurrent CIP forecast now stands at £14.4m (green and amber schemes) significantly higher than previous year achievements. Planning underway for 25/26 CIP development	Medium
Benefits Realisation	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	Medium	We have completed a stock-take on our approach to 2030 delivery and the results from the which have been reviewed alongside the benefit review and assessment on our delivery milestone. A paper is shared with FTP which summaries the results and recommendations.	Medium
Campus	Complex campus programme across multi sites.	Medium	All schemes progressing as detailed in the Campus Update within the full Committee pack. Two risks are highlighted for the attention of Committee members in relation to construction completion dates for Elective Surgical Hub and Alder Park (EDYS).	Medium

BOARD OF DIRECTORS

Thursday, 5th December 2024

Paper Title:	**Board Assurance Framework (BAF) Report October 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 ☑ **Strong Foundations** ☑
Resource Implications:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
As detailed in the report	This report provides an update against all Board Assurance Framework Risks for the month of October 2024.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2024/25

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 15 principal risks aligned to the Trust's strategic objectives and delivery of Vision 2030.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Finance, Transformation and Performance Committee
1.4	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.5	Lack of visibility at Board level across the Gender Service	Trust Board
1.6	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	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	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	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 11th November 2024

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	FT&P / SQAC	**4x5**	3x3
1.3 AB	Building and infrastructure defects that could affect quality and provision of services	FT&P	4x3	2x3
1.4 LC	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	FT&P / SQAC	**3x5**	3x3
1.5 LC	Lack of visibility at Board level across the Gender Service	Trust Board	4x2	4x1
1.6 LC	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board	**4x4**	4x2
STRATIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People Cttee	3x4	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Cttee	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus ***(score reduced in month)***	FT&P	4x2	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 ***(score reduced in month)***	FT&P	4x3	4x2
3.4 JG	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	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 October 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  Risk has been reviewed. Some actions have been closed as complete and moved to monitoring through BAU. Gaps in control and associated plans have been reviewed.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  Risk reviewed and scoring remains the same. Review undertaken 2 weeks prior. Additional controls, gaps and actions added and underway.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  - Review of BAF risk and actions undertaken. Some actions completed. Attended national NHS England meeting on 15 October 2024, no national resolution to current issues available. Paper taken to executives on 24 October 2024 with updates and additional actions to be considered.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in October maintains above the national standard of 78%, achieving 81.6%.

  There has been an increase in DM01 performance for the month of October from 83.07% in September to 90.63% for October. Nationally, the target remains to achieve 95% by March 2025, however Cheshire & Merseyside ICB have challenged Trusts to achieve this by December 2024 and the trust is on course to achieve this target as required for most specialities. However, sleep studies remains a concern and latest trajectories show we will meet the 95% target by end of February 2025.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. Whilst the trust had zero patients waiting longer than 78 weeks in October, the number of patients waiting over 65 weeks at month end increased to 12; one for a complex patient, eight for patient choice (both Paediatric Dental) and three due to capacity issues within Paediatric Neurology, all patients have plans for November. The Trust is focused on sustaining zero patients above 65 weeks, and working towards the Cheshire & Merseyside ICB ambition to have zero patients waiting over 52 weeks by end of March 2025.

- ***Building and infrastructure defects that could affect quality and provision of services (AB).***
  Project Co. have advised 10 no. items left to be addressed as of 30/09/2024. An updated report is due to be received confirming red and amber status pipework repairs. This will be uploaded to the risk as soon as it lands.

  Internal AH staff pipework meetings have taken place.

  Leak incidents have reduced over the last three years although three have occurred in the last four weeks.

  Out-of-range water temperatures continue to be monitored and local mitigations are in place such as filters on water outlets. Booster pumps installed

on the hot water system have proved effective and this will now be discussed as to introduce to cold water.

Joint water safety workshops continue. The dosing system is being reviewed after several discussions over the last few weeks and with the improvement of the booster pumps this may well be the better option.

Skylight works are now complete and the risk will be closed.

Five chillers in operation out of six. Awaiting details of fully commissioned sixth unit.

Green roof works are also complete.

- ***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).***
  BAF risk reviewed and actions updated as required. Issues relating to MHSDS and reporting remain, agreed with relevant exec director that a priority for action and divisional will support with additional funding for a temporary post to resolve. Updated to be provided by 30 November 2024.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  Risk review, actions on track and aligned to priorities set out in the people plan 2030. No current change to risk score.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed and all actions reviewed and updated. New action added to reflect evolving work in restorative just and learning culture and avoidable employee harm. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risks reviewed. No change to score progress being made and review of progress against the 6 HIA's set out in the NHS EDI Improvement Plan. EDI training launched but we need to continuously review this and monitor the number of staff engaging with the training.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed - score reduced to 8 to reflect completion of main park (phase 1) and confirmed target completion for phase 2 (swale).

- ***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).***
  Following the Board review, the BAF risk score for the programme (Risk 3.2) has decreased from 15 to 12, reflecting improvements in programme governance and assurance. The recent stock-take highlighted areas for enhanced oversight, particularly in decision-making agility and prioritised resource allocation. In response, the Programme Management team has refined resource forecasts to focus efforts on high-impact areas, alleviating pressure on individual clinical teams.

  The findings from the benefits review undertaken in September were presented to the 2030 Programme Board and the Finance, Transformation

and Performance Committee. The overall risk assessment remains Amber.

While short-term risks are being managed through planned mitigations and focused reviews, there remains a critical focus on safeguarding the long-term strategic vision, particularly against pressures for immediate financial gains. Continued alignment and strategic oversight are essential to protect the broader goals of Vision 2030.

Given these factors, the updated risk score has been reduced to 12 this month.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (JG).***
  Risk reviewed with no changes to the risk score. Emerging pressures for the in-year forecast relating to the recent pay award and divisional pressures. Agreement to refocus SDG on 4 key areas reporting into FTPC for greater oversight and assurance. 25/26 efficiency programme in development with alignment to the 2030 programme.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; no change to score in month. Actions reviewed and 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).***
  All actions reviewed and updated. Recruitment processes for all new Futures infrastructure posts (from business case) underway. Commercial research income forecast remains ahead of target. Investment zone application remains under review.

- ***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 and updated due to issues with aging hardware/devices in clinical areas. Score remains static with new action added relating to device estate. AlderCare Phase 2 progresses well with Stabilisation Phase to be closed in December. Optimisation plans being developed for 2025, including roadmap to future versions. Cyber Plans are being refreshed and will be ratified through relevant committees. Awaiting feedback on bid for regional funding. Increased focus on device refresh programme and mitigation work underway to improve log in times and performance of equipment within the current financial constraints.

5. Corporate risks (15+) linked to BAF Risks (as at 1st November 2024)

There are currently 20 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
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	4x5	Medicine	1.2	Jul 2021	Mar 2024
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	2.1	Feb 2023	Mar 2024
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
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Business Support	2.1	Jan 2020	*Apr 2023
2487	Disruption in patient's supply of medication and / or treatment	4x4	Community		Apr 2023	July 2024
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	4x4	Surgery	3.4	Aug 2022	Feb 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	2.1 & 2.2	Aug 2022	Jan 2024
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post. ***(NEW)***	4x4	Medicine	2.1	Feb 2023	Oct 2024
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	2.1	Apr 2023	June 2024
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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2290	A child may be harmed in the process of holding them to complete an intervention anywhere in the Trust	4x4	Business Support		Oct 2020	Sept 2024
117	Safe follow up care	4x4	Business Support	1.2, 2.1 & 2.2	Dec 2023	Dec 2023
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.6	Jun 2024	Jun 2024
253	Loss of GRID posts	4x4	Business Support		Sept 2024	Sept 2024
2606	Children at risk of a decline in clinical condition requiring Emergency Department attendance and/or Hospital admission	3x5	Community		Apr 2022	Sept 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	2.1	Oct 2022	Sept 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support	1.2, 2.1 & 2.2	Feb 2024	Feb 2024
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties	3x5	Business Support		Mar 2024	Mar 2024
189	EPRR Assurance Non-Compliance	3x5	Business Support		Jul 2024	Jul 2024
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)						
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.4	Jul 2021	*Apr 2023
117	Safe follow up care	4x4	Business Support	1.1, 2.1 & 2.2	Dec 2023	Dec 2023
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (3x5=15)						
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1	Dec 2019	*Apr 2023
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2	Jul 2021	*Apr 2023
1.5 Lack of visibility at Board level across the Gender Service (4x2=8)						
	None					
1.6 Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (4x4=8)						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.2	Jun 2024	Jun 2024
STRATEGIC OBJECTIVE: Support our people						
2.1 Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (3x4=12)						
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	4x4	Medicine	1.1	Jul 2021	Mar 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	1.1	Oct 2022	Sept 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
2782	There is a risk that the Trust will be unable to fulfil the role of the Named Doctor for Safeguarding which is a statutory requirement of all NHS Trusts	4x5	Community	1.1	Feb 2023	Mar 2024
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.2	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.2	Dec 2023	Dec 2023
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	1.1	Apr 2023	June 2024
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Business Support	1.1	Jan 2020	*Apr 2023
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post. ***(NEW)***	4x4	Medicine	1.2	Feb 2023	Oct 2024
2.2 Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (3x3=9)						
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1	Feb 2023	*Apr 2023

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	4x4	Surgery		Aug 2022	Feb 2024
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (3x4=12)						
	None					

* 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.

Nov 2024	
Control Description	Control Assurance Internal
Monitoring of KPIs at SQAC and within divisional governance structures	Monitored monthly through SQAC
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
Proactive programme of work to reduce medication errors	Monitored via Patient Safety Board

Gaps in Controls / Assurance
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis 2. Robust Programme in the number of medication incidents and near misses 3. Compliance with Ionising Radiation (Medical Exposure) Regulations 2017 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	November 2024	
		Due Date	Action Update
7. Alder Care (Expanse)	7. The risks to quality and safety need to be monitored during the period of stabilisation	30/11/2024	No further controls required, monitoring controls are in place.
1. 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.	31/03/2025	There has been improvement in administrations times which continue to be monitored through SQAC to embed improved performance.
3. Compliance with Ionising Radiation (Medical Exposure) Regulations 2017	3. Working Group formed to review the recommendations from the CQC Inspection of the nuclear medicine department	12/12/2024	
2. Medication Errors and Near Misses	2. Proactive programme of work in place to reduce medication errors	31/03/2025	Monitoring control in place – no further controls required
4. New CQC Assessment Framework	4. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2025	Monitoring control in place – no further controls required
6. New Models of Care	6. Clinical leaders will need to be appointed to oversee the process and provide challenge on the principles of the strategy	31/03/2025	Clinical summits have been held which will prioritise the changes that will have the biggest impact.

Children and young people waiting beyond the national standard to access planned care and urgent care	
Risk Number	Strategic Objectives
1.2	Outstanding care and experience

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Responsive		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
20	9	Finance, Transformation & Performance Committee

Description
Children and young people waiting beyond the national standard to access planned care and urgent care

Nov 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 reports to Operational delivery group -@ Performance reports to FTP 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 FTP 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 SAL T -@ Corporate report and divisional Dashboards -@ Performance reports to FTP 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	November 2024	
		Due Date	Action Update
Reduce the long-wait backlog for planned care	Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	30/09/2024	Deadline extension to achieve zero 65 weeks extended by NHSE to 30th September 2024. Vast majority of services have already reached this target but concern remains in Paediatric Dentistry and Paediatric Neurology. Whilst there is capacity in dentistry within the month of September to meet target there is a risk due to to patient cancellations or was not brought that the target may not be met. Within the Paediatric Neurology service there are concerns regarding capacity which are being reviewed by the service, currently a risk of 7 patients not meeting the 65 week target.
Urgent and Emergency Care Standards	Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	31/01/2024	Actions implemented to date have led to improved access to A&E, which is now exceeding the 85% national standard

Building and infrastructure defects that could affect quality and provision of services	
Risk Number	Strategic Objectives
1.3	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	Finance, Transformation & Performance Committee

Description
Building defects that remain unresolved by Project Co could impact on patient services, reputation and financial sustainability

Nov 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 FTP 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	November 2024	
		Due Date	Action Update
	Corroded pipework 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 apermanent solution is agreed. I have extended the date range for completion. A board to board meeting was held on the 5th June where option where discussed with Exec reps.

Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	
Risk Number	Strategic Objectives
1.4	Outstanding care and experience

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
15	9	Finance, Transformation & Performance Committee

Description

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.

Nov 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 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	November 2024	
		Due Date	Action Update
Continued workforce planning	Continued workforce planning including: - introduction of new roles - continued representation at C&M workforce meetings - review of all job descriptions and person spec to ensure consistency and ability to progress - development of preceptorship/development pathway	31/12/2024	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting.	31/01/2025	Extended date due to MHSDS work ongoing.
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/12/2024	email sent re. implementation phase. original request to start implementation was sent on the 19.02.24 - was advised that implementation takes around 28 days - I've emailed to chase where things are up to and will update BAF once I receive a response
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/12/2024	
Proceed with changes to CAMHS internal waiting times measures	Proceed with changes to CAMHS internal waiting times measures including: SOP/Pathway to be created Training plan for clinical and admin staff to be created and rolled out Data and reporting	31/10/2024	Extended to end Dec in line with MHSDS and ROMs actions

Lack of visibility at Board level across the Gender Service	
Risk Number	Strategic Objectives
1.5	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner
Safe Responsive		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
8	4	Trust Board

Description
The role of host/contract holder of the Children and Young People's Gender Service (North West) presents a wide range of risks which could impact the organisation in terms of clinical quality, service and corporate capacity reputationally and financially.

Nov 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
Regular operational performance report (to be further developed as the service embeds) to SQAC	Operational Performance Reporting
Regular reports to Parts 1 and 2 of Board from Director Community & Mental Health Services on development of the GDS within Alder Hey and nationally, and on the relationships with other providers	Board reports received

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	November 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	reporting into Divisional Integrated Governance to be embedded.
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	
Annual Review of Gender Service to Board	Provide an annual review of Gender Service to Board / SQAC to consider learning from current and prior years to identify potential changes in treatment pathway and follow up of prior CYP to understand if they subsequently dropped out of the service or transitioned / de-transitioned and potential learning from this.	15/10/2025	
Comprehensive suite of KPIs to be developed	Comprehensive suite of KPIs for GDS to be developed and reported to Board / SQAC including: demographics or referrals (1), compliance with services specification relating to number of appointments / interventions and time taken (2), compliance with the % drop out rates at the various assessment stages in the service specification (3), any contact from external activists / pressure groups (4), trends in active caseload and waiting list size (5), referrals to research trials, income/expenditure v budget (6), complexity of cases (e.g. what % have eating disorders, ASD/ADHD/OCD (7), details of % staff time spent inside / outside of the service by individual (8), gap between appointment versus service specification requirements (9), compliance with data recording requirements (10).	01/14/2025	

Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	
Risk Number	Strategic Objectives
1.6	Outstanding care & experience

CQC Domains	Linked Risks	Owner
Effective Safe Responsive		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	4	Trust Board

Description
Risk that ADHD treatment will be interrupted due to unavailability of the prescribed medication, that commencement of ADHD treatment is delayed due to unavailability of medication and waiting times for assessment will increase, due to workforce being deployed to support the safety of prescribing activity.

Nov 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	November 2024 Due Date	Action Update
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	31/12/2024	
Risk 236 - Action 2	Increase capacity to the prescription rota to cover the additional work.	31/12/2024	This work continues as the medication shortage continues. More nurses have now completed their V300 training and will be ready to support the rota by February 2025. Pharmacy technician is being recruited to support the advice and guidance and support elements of the prescription rota.
Action 9	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary.	30/09/2024	Ongoing
Risk 236 - Action 6	Plan for a “Super Saturday” with clinical teams and Pharmacy	31/12/2024	Some challenges regarding the availability of medics to support additional Saturday clinic. Also further review of records as needed as medication type in short supply has now changed so different cohort requires follow up.
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	31/10/2024	Medication shortage continues; still reviewing this weekly (not on a daily basis). This is because all other stocks of ADHD medications are now at sufficient supplies within our area. 12 hour medications prep still unable to obtain supplies, Alder Hey ADHD CYP being moved over to different medications. Currently no end date.

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
Failure to maintain a suitable workforce which impacts on the trust’s ability to deliver high quality care for children and young people.

Nov 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 intranet
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 PC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PC 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 PC
Nursing Workforce Report	Reports to PC, SQC and Board
Nurse Retention Lead	Bi-monthly reports to PC
Recruitment Strategy currently in development	progress to be reported PC
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
Ensuring we have inclusive practices embedded throughout the organization, is addressed in the People plan 2030	

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	November 2024	
		Due Date	Action Update
1. Not meeting compliance target in relation to some mandatory training topics	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	31/03/2025	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	Ongoing interventions remain in place to support the management of sickness, however until the absence has had a sustained reduction it will continue to be 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 practices to increase diversity across the organisation	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.

Nov 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to PC
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PC (agendas and minutes)
Values and Behaviours Framework	Stored on Trust Intranet and accessible for staff
People Pulse results to People and Wellbeing Committee quarterly	PC 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 PC as part of the People Paper
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PC
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 PC bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PC
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	November 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. Thriving staff index and Thriving Teams Index to be developed.	31/03/2025	Draft People Plan presented to October Board with agreement for priority actions for 25/26 to include development and roll out of Thriving Staff Index and Thriving Teams Index. Capability and resource to be scoped for both in discussion with Innovation Team (Futures).
Culture strategy development to include governance framework	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 Committee. supporting culture work	16/12/2024	Culture presentation given at June Trust Board and broadly supported with agreement to move into next steps/agreeing and defining actions. Further meeting to be held with MD and CPO to agree actions with comms and engagement plan. Will inform reporting.
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/03/2025	Meeting with Director of Transformation on 4th April to discuss @its Best MDT model and underpinning resource. Output to be reviewed with Head of OD. Consider next stepts in terms of building capability across HR and other supportive People functions.
Safety culture training	Safety culture training to be developed and implemented with teams to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	29/09/2025	No further progress with this action. Proposal still with execs and resource to be agreed for the delivery of the training. Meeting held to look at integration of safety culture training and STAT programme running in theatres. Further meeting to be arranged by Patient Safety lead to be confirmed
Thriving Leaders framework	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focused 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.	31/03/2025	Clinical leads listening session complete and feedback to be presented at Clinical Leads Summit on 15th Nov with a view to agreeing next steps in consultation with clinical leads. Management essentials session reviewed with plans for further development of the programme agreed.
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.		Draft People Plan presented to October Board with proposal to undertake values work as priority action 25/26 to support Vision 2030. Work to be scoped as part of new culture workstream (One Alder Hey).
Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training.	31/03/2025	Avoidable employee harm session delivered to senior HR colleagues on 9th October to discuss this concept and reflect together on how we need to develop as an organization to understand and minimize the risk of harm to employees that can come through people and change practices/ Agreed to run a second workshop with case examples on 13th November and then agree next steps in terms of implementation of this approach in policy and practice.

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 successfully embed workforce Equality, Diversity and Inclusion across the organisation.

Nov 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	Mandatory EDI Training for all staff. current compliance 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	
People Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PC
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	monitored through PC
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 PC.
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 PC.
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 PC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People and Wellbeing Committee

Gaps in Controls / Assurance
1. Multi-factoral issues spanning training and education 2. Sufficient EDI resources to support the EDI agenda 3. Cultural awareness and understanding

Action	Description	November 2024	
		Due Date	Action Update
1. Multi-factoral issues spanning training and education	Education and training programme launched. Conversations underway to implement EDI training as mandatory	13/12/2024	
2. Sufficient EDI resources to support the EDI agenda	Business case for additional resource to be developed.	08/11/2024	
3. Cultural awareness and understanding	Programme of awareness in train including establishment of Staff Networks, devoted sessions at 'Ask the Execs'. Regular commutations, atrium events, celebrations and awareness raising emails issued to all staff.	31/03/2025	

Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	
Risk Number	Strategic Objectives
3.1	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Responsive		Rachel Lea

RM03 Risk Rating		
Actual	Target	Assurance Committee
8	6	Finance, Transformation & Performance Committee

Description
Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus

Nov 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 FTP 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 FTP via Project Update
Monthly reports to Board & FTP	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	November 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 FTP and Trust Board as appropriate
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	30/04/2025	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves: 1) Vacate 3SM & move staff to former police station and other (Summer 2024) 2) Vacate Histopathology and mover staff to alternative accommodation (Winter 2025)	28/02/2025	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell
Weather conditions causing potential delays	Dry season now upon us – all works now in accordance with revised programme and on target.	30/11/2024	

Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	
Risk Number	Strategic Objectives
3.2	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	8	Finance, Transformation & Performance Committee

Description
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

Nov 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. 2030 delivery programme and plan in development 2. Failure to develop capacity for delivery 3. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy 4. Failure to deprioritise to enable requisite focus on areas of need and transformational change 5. Risk of 'mission creep' associated to the Strategy

Action	Description	November 2024	
		Due Date	Action Update
1. 2030 delivery programme and plan (24/25) .	The Annual Plan / Strategic Plan for 24/25 was approved April 24. The strategic delivery of the programmes has formed the basis of the plan, which is monitored through Vision 2030 Programme Board, FTP and Trust Board	31/03/2025 31/03/2024	
2&3 Developing skills and capacity to deliver the Strategy 2030	This approval of the People Plan on 24th September by the Trust Board marks a significant milestone in ensuring we understand the skills and capabilities needed for our Future Workforce 2030. The upcoming phase in our strategic plan, Shape of Alder Hey 2030, will further allow us to access the broader skills and capabilities our workforce will require to meet future needs.		
4. Failure to deprioritise to enable requisite focus on transformational change	Focus on transformational chance	12/12/2023	
5. Risk of mission creep associated to the Strategy	Sharp focus at Strategy Board on core mission	12/12/2023	

Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments.					
Risk Number			Strategic Objectives		
3.4			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		John Grinnell	16	12	Finance Transformation & Performance Committee

Description
Failure to meet financial targets, changing NHS financial regime and inability to meet the Trust's ongoing capital commitments.

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
Capital Planning Review Group	-@ 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 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	Minutes from SDG
- SDG Meetings - Oversight of Plan delivery	

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	November 2024	
		Due Date	Action Update
Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan.	31/03/2025	
Delivery of 5 year programme	4. Risks around Capital Plan to be monitored	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 FTP and TB once full risk is known.
Devolved specialist commissioning	3. Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk	31/03/2025	
High risk recurrent Efficiency programme	6. Transformation efficiency schemes now in place and monitored through Sustainability Group to ensure financial saving captured.	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.		
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.	31/03/2025	
Underfunding of Long Term tariff arrangements for complex children	2. Regular reporting to strategic execs and assurance to FTP and Trust Board. Use of SLR and PLICS to understand tariff shortfall and reasons and then build case for discussion with commissioners.	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.
		31/03/2025	

System working to deliver 2030 Strategy	
Risk Number	Strategic Objectives
3.5	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	9	Trust Strategy Board

Description
Risk of inability to control execution of 2030 Vision due to system complexities and evolving statutory environment. Risk of failure to secure sign up from partners to engage in a new Strategy for CYP given the wider NHS context and competing priorities. Potential failure to land our 2030 Strategy with key partners within the wider system impacting on our reputation and long-term sustainability. Risk of poor relationships and strategic connection at Place, leading to mis-alignment of priorities and inability to execute Vision 2030. Risk of lack of focus on CYP agenda in febrile system environment; leading to lack of pace, resource and investment.

Nov 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	November 2024	
		Due Date	Action Update
1. Uncertainty over future commissioning intentions	Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services.	31/03/2025	Continual influencing of commissioning priorities to align with AH Vision 2030 ambitions e.g. Place priorities, C&M CYP Committee priorities, influencing NHS 10YP at National Level
2. Future delegation of Specialist Commissioned services into ICSs	Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2025	Delegation in shadow form of specialised services completed into ICBs. NW Joint Specialist Committee established – leadership via 3 x ICB CEOs. Low emphasis on specialist services in current NHS policy / 10 year plan development – however Alder Hey and Children's Hospital Alliance incorporating clear asks pertaining to acute CYP illnesses into 10YP engagement process.
3. Executing the comprehensive Stakeholder Engagement Plan	Complete partner engagement	01/10/2024	
4. National mandates forcing us to prioritise unexpected programmes of work	Horizon scanning	31/03/2025	Formal contribution to NHS 10 YP development on behalf of both Trust and CYP being undertaken by Chief Strategy Officer and Policy Lead/Advisor to CEO – in order to optimise reference to CYP and AH priorities within 10YP.

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.

Nov 2024	
Control Description	Control Assurance Internal
Finance, Transformation & Performance Committee (FTP) 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 FTP
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	November 2024	
		Due Date	Action Update
2a. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2025	
2b. Activity Levels	Review of CRD trials portfolio. Activity levels currently stable and building capacity to increase AH led research.	31/03/2025	
3a. Financial Model	Case for internal and multi-sector inward investment. Plans underway through £10m club to secure external funds for internal investment to grow through Futures. Futures bid coordinator started in post in July.	30/06/2024	
3b. Financial Model	Development of new commercial partnerships Commercial pipeline in research - multiple studies in set-up. New partnerships being explored by commercial research working group.	31/03/2025	
4. Capacity and capability	Greater engagement with and education of R&I communities Futures people pillar established, Futures programme Board to commenced in May 2024. New infrastructure being established followjbg approval of business case in August	31/03/2025	
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	
5. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy. New post agreed (CRD funded) to support marketing and comms for Futures - est start date Sept 24	31/03/2025	

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families					
Risk Number			Strategic Objectives		
4.2			Revolutionise Care		
CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
Effective Responsive		Kate Warriner	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.

Nov 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 FTP	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	November 2024	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2025	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/08/2024	Programme to commence Nov 2023
Cyber Assurance Framework	This has replaced the action around Cyber Essentials +.	31/07/2025	
Experienced Resources	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce	28/02/2025	